Open Agenda

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

Tuesday 15 October 2013
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership

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

Reserves

Councillor Neil Coyle
Councillor Patrick Diamond
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: 7 October 2013

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

Tuesday 15 October 2013
7.00 pm
Ground Floor Meeting Room G02A - 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** To approve as a correct record the Minutes of the open section of the meeting held on 4 September 2013.	1 - 10
5.	**MENTAL HEALTH STRATEGY - SOUTHWARK CLINICAL COMMISSIONING GROUP** The SCCG Mental Health strategy was requested at the last meeting with specific reference to the ongoing review into 'Access to Health Services in Southwark' and the reported increase in the number of people with Mental Health issues going to A & E and the accessibility of primary care & other relevant services.	11 - 26

Item No.	Title	Page No.

6. MENTAL HEALTH , FAITH AND BME COMMUNITIES 27 - 47

This paper was requested to assist the ongoing review into 'Prevalence of Psychosis and access to mental health services for the BME Community in Southwark'.

7. REVIEW: PREVALENCE OF PSYCHOSIS AND ACCESS TO MENTAL HEALTH SERVICES FOR THE BME COMMUNITY IN SOUTHWARK 48 - 51

This item will take evidence from community organisations and consider the next steps for the review.

8. FRANCIS INQUIRY REPORT 52 - 155

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013 and can be accessed here : http://www.midstaffspublicinquiry.com/report

All relevant health agencies are expected to consider the report. Reponses are included from:

- SLaM Foundation Trust
- Guy's and St Thomas' Foundation Trust
- Healthwatch
- SCCG
- Southwark Adult Social Care response

9. PRIMARY CARE AND GENERAL PRACTICE 156 - 197

An overview of the role of SCCG and NHS England in commissioning, providing and promoting good access to local GPs with reference to the review on "Access to Health Services in Southwark", and comment on the below questions:

- What service pressures are local GPs facing?
- How easy is it for patients to access GP surgeries?
- What are the waiting times for appointments?
- How easy is it for new patents to register with a GP surgery?
- What could be better done by the Health and Adult Social Care system to reduce service pressures and better direct people to the right services?

Date: 7 October 2013

Open Agenda

Agenda Item 4

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

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Wednesday 4 September 2013 at 7.00 pm at Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Denise Capstick
Councillor Neil Coyle
Councillor Dan Garfield
Councillor Eliza Mann

OTHER MEMBERS PRESENT:

OFFICER & PARTNER SUPPORT: Mr Michael Marrinan - Executive Medical Director , King's College Hospital (KCH)
Ms Briony Sloper - Deputy Divisional Manager for Trauma and Emergency Medicine, KCH
Dr Patrick Holden - Urgent Care clinical lead , Southwark Clinical Commissioning Group SCCG
Andrew Bland - Chief Officer, SCCG
Hayley Sloan, 111 lead, SCCG
Dr Katherine Henderson - Clinical Lead, Guy's & St Thomas' NHS Foundation Trust (GST)
James Hill - Head of Nursing for the Emergency Dept, GST
Angela Dawe - Director of Community Services, GST
Dr Sarah K Corlett - Consultant in Public Health Medicine; Lambeth & Southwark Public Health Team
Julie Timbrell - Scrutiny Project manager

1. APOLOGIES

1.1 Apologies for absence were received from Councillors Davies, Situ and Mitchell. Councillor Garfield and Mann attended as substitutes. Councillor Capstick gave apologies for lateness.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 Councillor Capstick declared an interest as an employee of a 111 service provider - Harmony (this was done under item 7).

4. MINUTES

4.1 The chair drew the committee's attention to a note about the minutes of 15 July, item 6, on Healthwatch, received from Barry Silverman, Former Chair/Joint Chair of LINk Southwark. The scrutiny project manager, Julie Timbrell, read out the contents of his note:

"This minute is potentially misleading:

- The inherited membership of LINk Southwark was disbanded as soon as LHW came into being – former members were invited to become supporters and, subject to interview, could become volunteers
- Neither supporters nor volunteers participate in any process of democratic management relevant to the activities of LHW
- All of the interim Board have been appointed and/or selected by CAS Management
- No constitution for LHW has yet been published that provides for a democratic membership that could support a Membership Drive; it is not a Membership Organisation
- The specialist membership that led and operated Work Streams, such as Maternity/Early years which were a feature of the LINk. These have all been disbanded and the Members who freely contributed their skills and time dispersed on disbandment. "

4.2 The project manager then relayed that she had contacted Healthwatch for comment on Barry Silverman's note. Healthwatch agreed that there might have been a slight confusion with the terminology, but were unsure if the term 'Membership' was used or not in the meeting. Healthwatch clarified that Healthwatch does not have Members, but Supporters. These are interested individuals who receive the latest E-News and are asked for feedback on issues. Healthwatch said the 'Membership drive', referred to in the minutes, is probably referring to recruiting Supporters and Volunteers. The governance of Healthwatch is an interim arrangement until a governance recommendation is made. The Interim Board are a range of partners who contributed to the Healthwatch bid contract and will also contribute to Healthwatch's strategic development. There has been a pause in 'Supporters' being actively involved in Healthwatch activities,

whilst Healthwatch set up a strong infrastructure to enable Healthwatch to carry out its functions and activities. Healthwatch are now actively recruiting for 'Volunteers' to assist in roles such as Representation, Communication Engagement, and Intelligence analysing.

RESOLVED

Barry Silverman's comments will be noted, along with Healthwatch's response. The minutes of the meeting held on 15 July were agreed as an accurate record.

5. ACQUISITION OF PRINCESS ROYAL UNIVERSITY HOSPITAL BY KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

5.1 The chair invited Mr Michael Marrinan, Executive Medical Director, and King's College Hospital (KCH) to present. He explained that the paper was pitched at a high level and subject to final agreement; KCH are expecting a dissolution notice this week. KCH are now jointly managing the Princess Royal University Hospital with the office of the Trust Special Administrator and do not become officially accountable until 2 October - if all goes to plan.

5.2 He explained that King's College Hospital at Denmark Hill needs to decompress, particularly to relieve pressure of space in Accident and Emergency. There are three specific services that are planned to move out of the KCH Demark Hill hospital: Orthopedic elective surgery, Gynecology elective surgery and Bariatric surgery. The Orthopedic Centre will be a major elective centre located in Orpington Hospital and will serve a large local population who are elderly. It is hoped that KCH will also be able to entice Southwark patients, and crucial to this is the provision of transport. This will probably be provided in black cabs. Additional provision of transport for family visits is being discussed. The Executive Director explained that the elective surgery centre is not for accidental injuries such as fractures or serious injuries, nor is it for people with co-morbidities who require more intensive facilities.

5.3 A member asked what Bariatric surgery is and the Executive Director explained that this term describes a number of surgical treatments for obesity, such as bands. The member also asked how many beds would be freed up and the Medical Director said this would be about a 1/17th of the present capacity of KCH at Denmark Hill.

5.4 The Executive Director was asked how people will be 'encouraged' to use the elective centre and what would happen if a patient did not want to go. He explained that complex, high intensity work will stay at Denmark Hill so people can opt for this but this will be less reliable.

5.5 A member asked about the cost of taxis and he responded that the service is looking at around 200 trips a year for 70 % or more of the patients. He was asked why hospital transport would not be used and he responded that taxis are often better because they are roomier and can operate door to door, with no requirement

to pick up lots of people. The Medical Director explained that the Trust would pick up the bill and this would come out of the margin the hospital is paid. A member asked if people without family could nominate neighbours or friends to visit and the Medical Director explained that the Trust would take a pragmatic view , but at the moment the Trust does don't offer transport.

5.6 Members asked who the KCH Trust would be reporting to on the acquisition and management of the Princess Royal University Hospital and he explained that bodies include Bromely Scrutiny, CQC and Monitor.

RESOLVED

The committee asked King's College Hospital Foundation Trust to share the PRUH Full Business Case and the Executive Medical Director agreed to take the request back to the board.

6. ACCIDENT & EMERGENCY

6.1 The chair invited Dr Patrick Holden, Urgent Care clinical lead for Southwark Clinical Commissioning Group (SCCG) and Andrew Bland, SCCG Chief Officer, to present on the Lambeth & Southwark Urgent Care Network Board paper. Dr Patrick Holden commented that nationally Accident and Emergency care has seen performance deterioration, therefore the Department of Health required the SCCG to produce a plan to improve.

6.2 He explained that there are two main reasons for the increase in pressures on A & E - acuity is going up and Mental Health is going up, including in people not previously known to services. The plan to improve the increase in 'acuity' includes enhanced rapid response and home wards, which enable people be discharged. Mental Health is being tackled through the community care plan. Andrew Bland explained that further work is ongoing by the Urgent Care Network Board on Mental Health and they have talked about escalations between providers and provided the Department of Health with iterations of the plan.

6.3 The aim is to get plans up and running well before winter and agree the plan by 1st September. The SCCG also expect that A & E will receive more money from central government to deal with increased demand over the winter; however the details are not clear yet. A member commented that he had heard that there will be £500 million for the whole country. Andrew Bland responded that traditionally this is received in the middle of winter, but where will it be targeted is the most pertinent question. He added that the performance of King's College Hospital at Denmark Hill and Guy's Hospital is very good - but this is partly a result of additional money.

6.4 A member commented that he suspected that the increase in patients experiencing mental health issues was to do with the impact of welfare reform. Andrew Bland emphasized that all partners are seeing a greater number of patients with mental health problems and that the Urgent Care plan is about treatment, but prevention is an important issue, and the SCCG have a longer strategy about mental health.

6.5 Members asked about patient behaviour and how to best direct people to the most appropriate services. Andrew Bland reported that the SCCG have been putting information in surgeries, however they have discovered that information needs to be targeted otherwise it has not been found to be useful. He reported that the SCCG is working with Healthwatch on this.

6.6 The chair then invited hospital trust representatives to briefly present their papers and take question on access to A & E and Urgent Care. Dr Katherine Henderson, Clinical Lead, Guy's & St Thomas' (GST) ; James Hill, Head of Nursing for the Emergency Dept, GST ; Angela Dawe, Director of Community Services, GST ; Ms Briony Sloper Deputy Divisional Manager for Trauma and Emergency Medicine , Kings College Hospital (KCH) presented.

6.7 A member asked if Guy's Urgent Care service had a performance indicator for access and emergency staff from GST responded they had a four hour target which they achieve easily. They reported that the Urgent Care centre is not overwhelmed.

6.8 Members asked about the proportion of patients who attend an A & E department who could have been treated at GPs, and commented that constituents have reported that they find it difficult to access GP appointments. The emergency staff reported that around 20% are more minor aliments that could be treated out of A & E / Urgent Care, however they explained that it is hard to turn people away as this is a difficult conversation to have with patients presenting at an emergency department. The reasons for attending may be complex and to do with deprivation or the level of medical concern. For example parents may well bring in young children because they are worried and this is particularly true for people who need more support – for example single parents whose first language is not English .With the economic downturn some people , like cleaners, are justifiably worried that if they lose a shift they will lose their job.

6.9 The KCH representative explained that King's College Hospital at Denmark Hill has seen an increase in acuity, particularly among older people, which means the number of people being admitted into beds, has increased. People arriving at A & E are sicker people, more likely to be admitted, who stay longer and are harder to get home. She explained that has been an increase in attendance by ambulances. The majority of attendances are from Lambeth and Southwark. She reported that the King's A & E was built for 900000 but is now seeing much more. A temporary ward block has been added and another one is now being put in place, which is relieving pressure.

6.10 Guy's and St Thomas' staff reported that up to 40 % of the patients who turn up at A & E / Urgent Care are not from Lambeth or Southwark, and many are not from London or the UK. Many people who arrive are from Europe and they often come back because many are homeless.

6.11 Emergency staff reiterated that mental health is a key issue - and public health education. Staff reported that it is not just sick people, but also people who have higher social care needs and A & E departments are getting a surge of iller patients later in the day - nobody knows way .Emergency staff emphasized that while there

is an issue of people not accessing the right place to receive the most appropriate care there is also the issue of people presenting too late.

6.12 Members asked what the driver is for poor mental health. Emergency staff explained that the national increases in the breach of the 4 hour access target are a symptom of a system under strain. Emergency departments become the default when people can't access services they need in other places; A & E are trying to manage this, but there is an issue about turning people away. It is not a simple as saying 'go away' as there is a need for efficient signposting and also to ensure that other services are very accessible. Sometimes it is better and easier to treat someone. Staff reported that they have a 10'% increase in attendance but a 30 % increase in the need for assessments, which is very significant. Staff reported that people are getting very distressed and there is difficulty in moving people to the right bed.

6.13 Emergency staff were asked what steps are being taken to keep older people out of hospital. Dr Holden, CCG, responded that often the provision of good soft care can keep people at home and that the use of 'rapid response' has been very good, but the 'home ward' effectiveness has been more limited. The SCCG added that they are launching a home and community care strategy which they think that will make a difference.

6.14 Members asked how patients are dealt with at A & E who might not need an emergency response. Staff explained that patients are met and then people may get streamed to a GP and or an emergency nurse. Members asked about the payment the hospital receive if they do not need emergency care and emergency staff explained that hospital may get a paid the lower tariff - but none of the emergency tariffs cover the actual cost.

6.15 Members commented that many local walk-in centers have a very low waits and suggested that these were promoted more. There was a discussion about terminology used and services available; for example someone could not go to the Lister Centre for a fracture, but this would be available at Guy's Urgent Care centre. Members commented that there is confusion about where to access minor and urgent care.

6.16 Andrew Bland cautioned that a disproportionate focus on minor presentations at A & E would not be justified and emergency staff agreed, commenting that acuity and the level of dependence are the main issues. A member commented on the evidence that many of the attendances were from Europe and asked if anything could be done to mitigate this; however emergency staff commented that the central location meant this was inevitable. Emergency staff also added that in their view prevention rather than restricting access at the door would be preferable.

6.17 Members referred to the report and noted that A & Es seem to particularly struggle in February and July. Emergency staff agreed and said this was virus time and it was also difficult in December, however August was usually slow, but this year there has been no drop in acuity.

RESOLVED

The SCCG will bring their Mental Health Strategy to the committee.

SCCG and Healthwatch will provide an update on their targeted campaigns to increase signposting, access and engagement with the right health services.

7. 111 SERVICE

7.1 Dr Patrick Holden, CCG clinical lead for Urgent care; Hayley Sloan 111 lead and Andrew Bland, Chief Officer, SCCG briefly presented on the 111 service plans.

7.2 Hayley Sloan explained that a Southwark resident accessing the national NHS 111 service would receive advice from a non clinician, who will redirect patients to service end points. She explained that the provider NHS Direct has left the market and commissioners are negotiating with new providers - often ambulance providers. Members asked if there is a cost overlap because of the need to commission duplicate services and she said that there was.

7.3 Members asked how the service was being reviewed for quality and she reported that the service conducts surveys and there is an 80 % call back satisfaction rate. She referred to the Healthwatch report and explained that the online form has been modified following the feedback received. A member asked if all adverse incidents were recorded and she assured the committee that they were.

7.4 Andrew Bland commented that the test of the 111service is if it will generate demand, or if it will it help route people to the right service. He said he thought it was too early to say. Hayley Sloan concurred and said that they are looking at a winter campaign -but they don't want to put too much pressure on the service and over direct people to 111. Andrew Bland reported that Lewisham have had a very good urgent care campaign however they have also had a larger rise in emergency attendance.

7.5 A member asked where calls are handled from and Hayley Sloan explained that there is a call centre in Beckenham, with an overflow to a Milton Keynes call centre.

RESOLVED

Provide the results of the call back survey on the service.

8. REVIEW: ACCESS TO HEALTHCARE IN SOUTHWARK

8.1 The committee discussed revisions to the review's Terms of Reference.

RESOLVED

The Terms of Reference for the 'Access to Healthcare in Southwark' review will be updated to ensure they make clear that the review will be:

- Seeking to establish how easy it is for patients to access surgeries.
- Considering GP surgeries in neighbouring boroughs that Southwark resident's use.

Once the review is completed the resulting report will be sent to relevant commissioners outside of Southwark.

9. PSYCHOTIC DISORDERS IN ETHNIC MINORITY POPULATIONS IN LAMBETH & SOUTHWARK

9.1 Dr Sarah Corlett, Consultant in Public Health Medicine, Lambeth & Southwark Public Health Team, presented the paper circulated and then the chair invited members to ask questions.

9.2 It was noted that Lambeth has better data than Southwark, and Sarah Corlett responded that there is a plan for Southwark to collect similar data, in conjunction with KCH, but this is dependant on the co-operation of GPs.

9.3 A member commented on the evidence that members of BME communities are more likely to be subject to coercive treatment and said that that it would be useful to see data on rates of incarceration and sectioning and Sarah Corlett responded that it would be possible to supply this. She was then asked if there is any comparative data on the quality of treatment for physical health that people with mental health conditions receive. She responded that this could be more challenging to provide, but it could be possible to get some useful data through examining health check records, for example, but this would require scoping and resourcing.

9.4 Members asked if there is an issue of people being late in seeking help and if this impacts on type or success of treatment. She responded that Southwark has a very good Oasis service which sees a higher proportion of BME community members, partly because there is outreach to community and faith groups.

9.5 The evidence that BME communities at high densities have lower level of psychosis was discussed and it was explained that this is at 'super output' level, so at very local levels. It was noted that psychosis particularly affects immigrant communities, whatever the ethnicity.

9.6 Members asked Sarah Corlett what recommendations she could make to prevent psychosis and she suggested more work with parents whose children have conduct or a behaviour disorder and noted that there is gap in provision for adolescents, as problems have to be severe for CAMHS (Child and Adolescent Mental Health Services) to accept a referral.

9.7 Members commented that earlier the committee had heard about the rising presentation of people with Mental Health needs at A & Es, and this evidence contradicts the reports assertion that people are receiving early help. Sarah Corlett agreed that this needs more research and commented that this is sometimes tricky as mental health can be a secondary symptom and will not necessarily be recorded. A member added that it would be useful to know the origin of people and how many are from Europe. A member indicated that he was keen to ensure that services are accessible to all.

RESOLVED

Provide information on the number, and ethnicity, of people:

- Sectioned or held in secure accommodation.
- Presenting at A & E with mental health needs

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

10.1 The committee discussion revisions for the reviews Terms of Reference.

RESOLVED

The Terms of Reference will be amended to ensure they make clear that the review will be looking at:

- The *likely* prevalence of Psychosis in the BME community in Southwark
- The accessibility and quality of community care

11. WORK-PLAN

11.1 The work-plan was agreed.

12. REPORTS FOR INFORMATION

12.1 Correspondence with NHS Property Service was discussed.

RESOLVED

Ask Councillor Mitchell if he has any further quires following the response from NHS Property Services to the chair's recent letter.

Write back to NHS Property Service to seek more information on the formalisation of occupancy arrangements "in the coming period" and to ask more about any additional Business Cases and their timelines.

Joint Mental Health Strategy

Draft discussion document for Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee Meeting on 15th October 2013

1. Introduction

1.1 This paper provides an overview of the work being led by Southwark Clinical Commissioning Group (the CCG) to produce a Joint Mental Health Strategy for Southwark.

1.2 The London Borough of Southwark (the Council) and the CCG recently commissioned a review of the partnership arrangements in place for delivering mental health services in the borough. The review made a number of recommendations to strengthen partnership working in the area of mental health and endorsed the lead commissioner role of the CCG. The review recommended the development of a new Mental Health Strategy for Southwark to set out clearly the vision, outcomes and key actions to be taken across partners to deliver better mental health for the population of Southwark.

1.3 The paper sets out the strategic background to the preparation of this Strategy, touches on the process in place for delivering it and identifies some of its core components.

2. Strategic context

2.1 Significant reforms to the strategy and policy landscape for the public services have strengthened a number of themes to set a clear strategic framework for mental health services in Southwark. These include:

- Focus on increasing independence and moving people on from dependency through personalisation, normalisation and reforms to welfare benefits
- Renewed emphasis on making local government, the NHS and other sectors work together with greater impetus for integration
- Increased significance of prevention and early intervention
- Importance attached to person-centred care, with attention given to co-designing services and achieving outcomes in partnership with patients and users to give them more choice and control
- Prioritisation of responses to mental health to put it on a par with physical health
- Drive for efficiency and budget savings in the context of pressures on the public purse from the economic climate and demographic growth

2.2 The current health and social care policy framework is still developing and is marked by considerable continuity with previous policy, strategy and legislation in this area. The central idea is to transform the health and social care systems from being based on crisis response

and dependency to promoting independence and wellbeing through an emphasis on prevention, early intervention, outcomes based practice, care nearer home and personalisation.

2.3 No Health without Mental Health, the cross government mental health outcomes strategy for people of all ages published in 2011, remains the key mental health policy document. As the 2011 national strategy states:

Mental health is everyone's business[....]good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.

2.4 The strategy points out that there is both a personal cost and a wider economic burden to poor mental health. Whilst the strategy uses national data the picture it paints is very relevant to Southwark today.

2.4.1 The personal costs include distress, isolation and low self-esteem which can reverberate on the individual, their family and their community. Many mental health problems affect people when they are young, disrupting their education and limiting their life chances.

2.4.2 On a macro level, mental ill health is the largest single cause of disability in the country and estimates have suggested that the cost of treating mental health problems could double over the next 20 years from the current estimated cost of £105 billion per year. Mental health problems increase the costs of education, criminal justice and homelessness and are one of the most common reasons for incapacity benefits claims.

2.5 Many mental health problems start early in life. One in ten of all children aged between 5 and 16 years will have a mental health problem. Half of those with lifetime mental health problems first experience symptoms by the age of 14. Mental health highlights wider inequalities too - our most deprived communities have the poorest mental and physical health and wellbeing and people with severe mental illnesses have a lower life expectancy than the general population.

2.6 Increasingly, at both national and local level, it is understood that improving the mental health and wellbeing of the population is not the responsibility of one or two agencies but requires a cross-sectoral response which seeks to address the causes of poor mental health, offer early help and engage fully with those affected by mental illness, their families and communities. The increasing emphasis on the ability of those with mental health problems to be partners in their own recovery is a marked shift from previous policy in this area.

3. Why do we need a strategy?

3.1 There are a number of drivers for developing a Southwark Mental Health Strategy.

3.1.1 First, whilst the current approach delivers high quality, specialist and often intensive services to the minority in highest need, we know things aren't working optimally in the way services are currently configured. People with mental health problems often:

- have fewer qualifications

- find it harder both to obtain and stay in work
- have lower incomes
- are more likely to be homeless or insecurely housed
- are more likely to live in areas of high social deprivation
- are more likely to have poor physical health

3.1.2 Second, users of public services have expectations of personalisation and wish to move away from dependency on a narrow range of services towards developing the resilience to seek the solutions to the problems they face within themselves, their families and their communities.

3.1.3 Third, the system is facing increasing demand from a growing population (and a growing older population with projected higher levels of organic mental illness such as dementia) and a population better able to identify mental health needs.

3.1.4 Finally, the economic climate and the pressures on the public purse locally are such that all areas of health, social care and public health funding need to demonstrate their effectiveness, efficiency and value for money in the context of growing demand.

3.2 These drivers support the view that it is unsustainable to continue solely with the current approach and model of service and that new solutions, created together with service users, need to be found. Partners will need to work together in new ways and the development of the Strategy will both be a way to create ways of working strongly together and a confirmation of shared purpose and approach.

4. Strategy overview

4.1 To oversee the development of this Joint Mental Health Strategy for Southwark a steering group is being established, comprising representatives from the CCG, the Council, Public Health and HealthWatch the voluntary and community sectors and providers. Users of mental health services - across the ages - will be engaged in the production of this strategy and the design of services commissioned as a result of it.

4.2 The local strategy will incorporate many of the key components of the national picture whilst making them relevant for Southwark. To do this, the Strategy will be based securely on the Joint Strategic Needs Assessment. The Strategy will be a five year strategy in the first instance, refreshed at key points when, for example, policy, demand or funding levels change. It will have the following core components:

4.2.1 Vision

The Vision will be developed in partnership with a range of stakeholders including those directly and indirectly affected by mental illness and commissioners and providers of services.

4.2.2 Scope

It is proposed that the Strategy will be all age. Half of all mental health disorders in adulthood arise before the age of 14 and it is only through intervening early and taking a life course approach that we may be able to affect this. References to people therefore will cover:

- children and young people
- working age adults
- older people experiencing both functional and organic mental illness

In adopting a life course approach, the Strategy will advocate services centred around the needs of those experiencing poor mental health rather than around ease of service delivery, increasing capacity to respond to transitions and to achieve agreed lifetime outcomes. There will be specific areas where the Strategy may need to focus including dementia care, co-morbidity of mental health and substance misuse, criminal justice and homelessness for example and the all age scope will not detract from this.

It is important to recognise that the Strategy will not focus solely on designated mental health services but also on what the wider community - including the whole Council, the CCG, schools, NHS providers and a range of other agencies - can do to promote, enable and maintain good mental health through the provision of mainstream (universal and targeted) services. These could include access to appropriate housing, family support, education and employment options supported by timely advice, information and primary prevention. The Strategy will importantly nurture resilience and capacity within individuals, their families and carers, to manage their own care and to develop sustainable solutions independent of commissioned services.

4.2.3 Objectives

It is proposed that the Strategy is outcomes based and offers tangible ways to achieve the following high level outcomes, in partnership with those with mental health needs:

(i) More people will have good mental health
More people of all ages and backgrounds will have better wellbeing and good mental health and fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

(ii) More people with mental health problems will recover
More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

(iii) More people with mental health problems will have good physical health
Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

(iv) More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

(v) Fewer people will suffer avoidable harm
People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

(vi) Fewer people will experience stigma and discrimination
Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

4.2.4 Approach

There are a number of core approaches, set out in the Southwark Direction of Travel Statement, which the Strategy will explore in greater detail. Key will be a shift towards prevention and early intervention and towards solutions co-designed and co-delivered with patients and service users. The areas to be amplified further in the Strategy include:

- Prioritising prevention and early intervention
- Tackling stigma and discrimination in the wider community to reduce inequalities of access and aspiration
- Developing personalisation, independence and resilience supported by co-production, peer support and responding holistically to a person's needs
- Shaping services to respond to transitions from childhood through to old age
- Increasing the availability of, and equity of access to, community based support including primary care
- Grasping opportunities offered by innovation - including integration, use of technology and newly developed best practice
- Improving the physical health of those affected by poor mental health
- Raising the quality and effectiveness of services to intervene quickly at times of crisis
- Supporting carers

4.2.5 Commissioning

The Strategy will contain the commissioning strategy for the CCG, in its role as lead commissioner for mental health services. It will therefore identify the funding available and how that funding will be reshaped to respond to the strategic imperatives outlined above.

4.2.6 Evaluation of impact

A significant amount of public money is spent on responding to the needs of those with mental health problems. The thrust of this Strategy will be that we believe some of this money could be spent more efficiently if it were used to prevent mental illness, to intervene early when need is first identified and to sustain recovery through support for areas such as employment, housing and social relationships. We are committed to evaluating our new Strategy and approach and to working with organisations such as the Early Intervention Foundation to determine best practice and evidence based innovation in this field.

5. Conclusion

5.1 Producing this Strategy for Southwark offers an exciting opportunity to develop and implement a comprehensive, new and innovative approach to improving the mental health of the children, young people, working age adults and older people of Southwark.

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Mental Health
BME Communities

Gwen Kennedy

Director of Client Group Commissioning

NHS
Southwark
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Two papers previously submitted to Southwark Health, Adult Social Care, Communities and Citizenship Scrutiny Sub Committee

- **Psychosis in BME Communities (incidence and access) - Philippa Garety PhD (SLaM)**

- **Psychotic disorders in ethnic minority populations in Lambeth & Southwark – An introduction – L&S Public Health Team September 2013**

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Key findings support that:

- **There is an expected increase in the number of people presenting with Psychosis in Lambeth and Southwark linked to the population growth in some BME groups**

- **There are clear differences in health outcomes for people with Serious Mental Illness (SMI) who experience poorer health than average and are at increased risk of premature death due to higher rates of Diabetes, Coronary Heart Disease and Hypertension**

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Access to health services

- There are legitimate concerns about ensuring the BME communities obtain access to primary care as the evidence suggests that people who have good access to health care have better health outcomes
- SLaM data shows that often black people come into contact with SLaM services in crisis and at later stage in the illness and need coercive measures to manage their care
- Early detection and access to treatment and care can reduce the impact of illness, duration and length of stay in hospital
- Public health is working with both Lambeth and Southwark Councils and CCGs to improve access to information and to build the case for appropriate interventions to prevent mental illness and promote wellbeing. A Programme Manager has been appointed to help mobilise practices to collect ethnicity data, extract a baseline for Southwark and to ensure patient participation in feedback.

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Black Majority Churches (BMCs) - Pilot

- **Paper – Working with BMCs to improve the mental health & wellbeing of Southwark People**
- **Southwark has around 240 BMCs in the borough with an estimated 20,000 people gathering to worship in Southwark each week. Southwark has the largest number of African and Caribbean residents of all the London boroughs**
- **Based on research by University of Roehampton (Being Built Together – A Story of New Black Minority Churches in the London Borough of Southwark June 2013)**
- **National community events about mental illness within the Sikh, Muslim and BMC faith organisations & Church of England 'Time to Change' commitment to tackle mental health stigma**
- **SLaM's Charitable Trust 'Faith and Mental Health Pilot' with BME churches in 4 London Boroughs including Southwark is training faith leaders to promote mental health awareness**

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Added value of BMC's Pilot

- **The role of faith groups in reducing stigma and discrimination – using community faith groups as a resource**
- **Support faith communities to understand more about mental illness and our services / how to keep well / seek help earlier to prevent crisis presentation Prevention and promotion of mental wellbeing with young people, especially young black men**
- **Faith leaders to become mental health champions cascading their learning**

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Helping to Build Capacity and Engagement

- **Tackle stigma and discrimination – leads to social exclusion**
- **Must not make assumptions about what people know and understand**
- **Promote good knowledge and provide accessible information about health and social services**

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Joint Mental Health Strategy for Southwark

- Review of Partnership Arrangements in place for delivering mental health services in the borough – endorsed lead commissioner role of the CCG
- Paper - Development of a strategy that sets out the vision, outcomes and key actions to be taken across partners to deliver better mental health for the population of Southwark –Backdrop - significant reforms to the strategy and policy landscape for public services, impetus for integration and impact of economic climate in the context of growing demand
- Transformation - promoting independence and wellbeing through an emphasis on prevention, early intervention, outcomes based practice, care nearer home and personalisation
- Equality and Fairness in service provision at the heart of the MH strategy

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Discussion

- **Questions welcome**

Agenda Item 6

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Working with Black Majority Churches (BMCs) to improve the Mental Health & Wellbeing of Southwark people

Introduction

Recent years have seen an increasing focus by commissioners and providers of mental health services to work with faith organisations to raise awareness of mental illness and tackle stigma. There have been some notable national community "events" about mental illness within the Sikh, Muslim and Black Majority Church faith organisations. Moreover, through the "Time to Change" initiative, the Church of England has also made a commitment to tackle mental health stigma. Dr Rowan Williams, the former Archbishop of Canterbury, pledged to tackle "outdated taboo" of mental health.

South London and Maudsley NHS Trust (SLaM), through its Charitable Trust has piloted a "Faith and Mental Health Training" project ('the project") with a number of Black and Minority Ethnic (BME) Churches in 4 London Boroughs including Southwark. The project has made links with both local and faith communities and increased mental health literacy as well as improved communication and understanding between mental health services and BME communities.

More and more people are attending the workshops that have been run these include: Training in Spiritual and Pastoral Care in Mental Health, Mental Health Awareness (MHA), Mental Health First Aid (MHFA), and more recently Time to Change national campaign. Through this work families are benefiting by becoming more involved and more informed about this health condition. With the right help and information they can take steps to prevent mental illness and be aware of the practical ways to access a range of services early before things get out of control and end up in crisis.

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Opportunity knocks for commissioners/providers to work with BMCs

A new report published by the University of Roehampton (Being Built Together – A Story of New Black Majority Churches in the London Borough of Southwark – Final Report - June 2013), shows that Southwark has seen a huge surge in the number of new churches, particularly BMCs, many of which are Pentecostal with a largely Caribbean or African membership. The study found that an estimated 20,000 people gather to worship in around 240 different churches across Southwark each week.

SLaM's project trained faith leaders to promote mental health awareness within community groups often described as hard to reach and to facilitate engagement with SLaM services. The initiative has proved to be far-reaching in its penetration in improving understanding, engagement and relationships between mental health services and Caribbean and African faith communities. The project began in 2010 and currently running its 6th cohort training course which is due to end on 18 November 2013.

The project has now trained a hundred people from a variety of faith groups predominantly from across SLAM Boroughs, Southwark, Lambeth , Lewisham and Croydon. **Appendix A** below provides a snap shot evaluation of cohort 4 which shows the shift in attitude in reducing stigma and discrimination of mental health within the BME community. Cohort 4 was hosted in Lambeth and for the first time cohort 5 was hosted in Southwark (the evaluation is still pending).

The project has concretely demonstrated the impact of taking a dual approach (spirituality and medicinal practice) to addressing mental illness within the BME community. The mental health courses on the pilot for local faith groups were oversubscribed, and the conference held to celebrate the completion of the courses and discuss the issue of spirituality and mental health attracted over 130 local people from BME communities and highlighted the need for more training in mental health issues within faith groups.

Pastors have spoken eloquently about how they have "seen the light" following the mental health awareness training. Armed with a better understanding of the causes and cures of mental illness, they have been able to provide a far better and pragmatic pastoral care for those in their congregation. The biggest change that these trained Pastors have initiated is that they no longer take the approach to mental illness as a form of demonic possession, but that members of the congregation must see a health professional, take their medication and that the church will also continue to support them spiritually. Some of the participants of the pilot have said:

"I no longer see mental illness as incurable"
" I feel better to be around people who may have mental health issues"
"My response to suffering has changed. Prayer does not always make a difference"
"I will now not treat every individual regarded to have mental health issues with suspicion".

The project has been strongly influenced by a service related project exploring perceptions of 'well-being' in BME clients accessing a service for people at risk of developing psychosis. This study involved semi structured interviews with services users to ascertain their thoughts about recovery and which factors help them on this journey. Clients reported feeling that a positive relationship with religion and spirituality were key to becoming 'well'. These results showed that there may be perceptions of wellness specific to BME groups that are distinct from the medical view of wellness promoted within services. This has recently been published by Behavioural and Cognitive Psychotherapy.

One of the other positive outcomes from the project has been the fostering of good opportunities to link with services to ensure the continued support for the church's congregation. The presentation element of the course provides an opportunity for participants to think about their role in the faith group and what they will do with this training, what difference their contribution can make and how to build capacity. In so doing, they come into contact with some of the internal challenges of their faith group and how to begin overcome them.

The graduates of this project have gone on to do voluntary work in mental health residential settings, and psychiatric inpatient wards. The Faith groups have held:

- Retreats on faith and wellbeing,
- Conferences
- Harvest service
- Put mental health on their training programme for ministry teams
- Support member of church into hospital
- Support other faith leaders with spiritual and mental health issues
- Attend local community events on health
- Invited health practitioners into church to look at the physical health and mental health

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Southwark demographics and the rise of the Black Majority Churches

Southwark's population grew from 256,700 in 2001 to 288,300 in the 2011 census – an increase of 12.3% (compared to 7.1% across England and Wales). Ethnicity is potentially significant for understanding BMCs in Southwark.

In both the 2001 and 2011 censuses, Southwark had the highest percentage and number of African residents for all London Boroughs. Southwark also has the highest percentage and number of African residents of any local authority in Britain (Office for National Statistics, 2013; Southwark Council, 2011). It is truly England's African capital with 16.40% of Southwark residents identified as African in 2011, and 16.07% in 2001 (Office for National Statistics).

Around three fifths of the African population of the Borough were born in Africa in 2001 (Southwark Analytical Hub), and this proportion was approximately the same in 2011 (Office for National Statistics, 2013). African residents are predominantly from Nigeria and other parts of West Africa (Southwark Council, 2011). The proportion of Black Caribbean residents in Southwark is somewhat different, decreasing from 8.0% in 2001 to 6.2% in 2011 (Southwark Analytical Hub).

The 2011 census also showed that Southwark is only second to Lambeth with the highest percentage of Black population (77,511). Although not quantified, the "Being Built Together" report suggests that Southwark is the African capital of the UK and probably given that the new 240 BMCs in the borough could also represent the greatest concentration of African Christianity in the world outside of Africa.

The report goes not to suggest that according to its analysis of ethnicity and culture, BMCs in Southwark are mostly African-led with a large proportion of congregants being of West African origin. Thus BMCs provide a 'home from home', a safe place for those finding their way in a new country, with attendant benefits for such communities, local authorities and London.

BMCs the report suggests serve dispersed communities across London that few other agencies can reach. They provide a 'safe haven' for migrant communities, meeting their spiritual needs alongside assisting with issues such as family, health, law and order. Consequently, BMCs are a spiritual, social and economic asset to the city and its boroughs

Context of the Faith and Mental Health Project

- BME clients are more likely to have a distressing and convoluted pathway to care, often through the judicial system, and they are more likely to be detained under the mental health act (Morgan, Mallett & Hutchinson, 2005).
- SLaM data on people using their inpatient service shows that often black people come into contact with SLaM services in crisis and at later stage in the illness. Yet we know that that early detection, earlier access to treatment and care can reduce impact of illness, duration and length of stay on in hospital. Earlier access with support also improves patient experience reduces fear and anxiety
- SLaM has the largest number of African and Caribbean residents of all the London boroughs further highlighting a need for those providing services in this area to identify the specific needs of this population
- There is increasing recognition of the importance of spirituality in mental health as evidenced by 'Spiritual Care Matters'(NHS Scotland, 2009) and recent production of guidance on Spirituality and Mental Health by the Royal College of Psychiatry (RCP, 2010). Equally, much attention has been given to the need for enhanced understanding of the interaction between psychosis and culture.
- The NICE Schizophrenia guidelines (NICE, 2009, Update) recommend that services should address cultural differences in treatment, expectations and adherence, and clients' explanatory models of illness should be better understood.
- It is important to note the significantly negative experiences of Black African and Black Caribbean service users accessing mental health services in the UK. A glaring account of such discrepancies, detailed in Breaking the Circles of Fear (The Sainsbury Centre for Mental Health, 2002), indicates why research into mental health service provision is necessary.
- As indicated, for example, through early detection services such as OASIS (Outreach and Support In South London) which aims to intervene at the earliest point of illness, there are both social and economic gains for SLaM and the wider society (Valmaggia et al, 2009) in both supporting, providing education and helping to prevent young people making a transition to a serious mental health difficulty such as psychosis.
- There is a need for mental health commissioners/providers to recognise that the cultural and religious diversity of its inhabitants means that Western models of help seeking and explanations of illness may not be understood and may require different metaphors and language use.

- Research reports elevated rates of psychosis in the Caribbean and Black African populations in the UK ranging between two and 14 times higher than for the White British population (Cantor-Graee & Selten, 2005; Sharpley et al., 2001). This prevalence has been found to be consistent over time and it has been documented that there is an elevated risk of developing psychosis in second generation immigrants (Cantor-Graee & Pedersen, 2007). The unwavering high rates of psychotic disorders in second and third generation immigrants and the absence of raised rates in native countries (Cantor-Graee & Selten, 2005) suggests that there must be a strong environmental component involved in the development of psychosis. It has been suggested that the rates of psychotic disorders are not reflective of genuine illness but rather evidence of professionals' failure to understand and accommodate the cultural background and explanations of symptoms provided by clients (Zandi et al., 2010). This issue is still highly contentious and it is possible that further research will help to elucidate this controversy
- Many black SLaM service users are members of local faith communities and receive considerable support within the community. However, faith communities are uncertain how to deal with mental health problems in their congregations and there are often disparities between cultural and religious explanations of distress and the Western conceptualisation of mental health difficulties promoted in our service. Hence the relevance of exploring the religion and psychosis within SLaM.
- One step towards ensuring equity of access to care and facilitating engagement for our burgeoning global population may be to support faith communities in dealing with mental illness. Particularly, to help faith communities to understand more about mental illness and our services, how to keep well; and more importantly work collaboratively to validate the added value the role of faith groups in reducing stigma and discrimination, prevention, support, detection, and recovery.
- Within a strained economic climate, the capacity within the NHS to treat illness in increasingly stretched. There is a need to work closely with the faith community to build an understanding of mental health and mental health services to create better engagement with BME communities and increase the number of BME service user accessing services earlier rather than presenting in crisis. There are huge potential cost savings and economic benefits of early referrals to SLaM
- There is further a need to support the prevention and promotion of mental wellbeing with young people, and in particular with young black men.

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Why work with Black Majority Churches?

Community faith groups are a resource, which have seldom been targeted effectively by commissioners/providers. Focused and evidenced-based interventions can:

1. **Increase capacity of faith leaders to run training and events around mental health and wellbeing**

- Over the last 3 years 100 faith leaders from across the 4 boroughs have been through a 10 week community spirituality and mental health course previously developed and tested on funding by the SLaM charity.
- Building on this engagement and recruiting more faith leaders from Southwark to become mental health champions for their communities and to help facilitate future training courses. This will provide religious leaders with skills and confidence to offer basic mental health awareness training to other members of their religious community and congregation.

2. **Build Capacity of faith organisations to promote mental health and wellbeing**

- The mental health champions will cascade their learning through increasing awareness in mental health issues, enable understanding the role of religion in mental health, develop the ability to reflect on both good and bad practices within faith groups and a deepening self-knowledge and awareness
- Evaluation of two sets of 10 week workshops previously run showed significant reductions in stigmatising attitudes towards people with mental health problems after the training.
- Faith leaders are also able to run a series of local activities for faith groups to encourage inclusion of mental health on the agenda.

3. **Increase understanding of faith communities by commissioners/providers**

- Learning and feedback from the programme will inform best practice linking into key group within the CCG/Trust including Community engagement, Mental Health Promotion, Equality and Human Rights forum, Psychosis CAG, Public Relations, Social Inclusion; which will in turn benefit our service users.

- Staff interested and engaged in the role of mental health and spirituality will be encouraged and supported to feedback to their teams about how mental health is understood within different religious frameworks.
- Delivering the training will and also give faith leaders direct contact within NHS staff and more personal contacts should they need advice about how to support people to seek help.
- We hope that participation in the training will contribute to staff CPD portfolio.

4. Improve relationships and engagement with faith communities and mental health services

- Building an understanding of mental health and mental health services within faith communities will create better engagement with BME communities and increase the number of BME service user accessing services earlier rather than presenting in crisis
- Building capacity with faith communities to promote mental health and well-being for their congregations
- Creating a core of faith leaders who can run spirituality and mental health training courses themselves.
- Creating strong links and dialogue between faith communities and mental health services that could lead to addressing other health inequality issues.
- Production of a specialist Mental Health Awareness capacity building training Package for faith communities that can be replicated.

Conclusions

With 20,000 attending around 240 BMC's each week in Southwark alone, SLaM's project has begun to put mental health on the agenda for faith groups across at least 4 boroughs. The positive results of the project show how education and engagement with faith communities on mental health can be positive drivers for change. Improving mental health literacy generally with a specific focus on understanding psychosis will help members of community experiencing the symptoms of early psychosis engage with services at an earlier point. This project also demonstrated that new routes into mental health services can be established which could improve how the BME community access, engagement and self-capacity built around mental health and wellbeing. Moreover, the project has embedded the culture of having mental health on the agenda of faith groups independently and established an informed working relationship with mental health services.

It requires courage to breakdown the stigma and barriers to accessing mental health services within the BME community. The SLaM project has highlighted that it is possible to develop meaningful relationships with BMCs and therefore the BME community. This, however, takes time, requires the fostering of mutual trust and addressing sensitivities.

Recommendations

- That Southwark CCG and Southwark Council jointly consider commissioning a bespoke Pastoral mental health awareness training programme across established BMCs in Southwark adapting SLaM's faith and mental health model

- That Southwark CCG and Southwark Council jointly consider commissioning further Mental Health First Aid training specifically aimed at established BMCs across Southwark

Report author: Harjinder Bahra, Equality & Human Rights Manager, Southwark CCG
October 2013

Appendix A

Spiritual and Pastoral Care in Mental Health Programme: Cohort 4

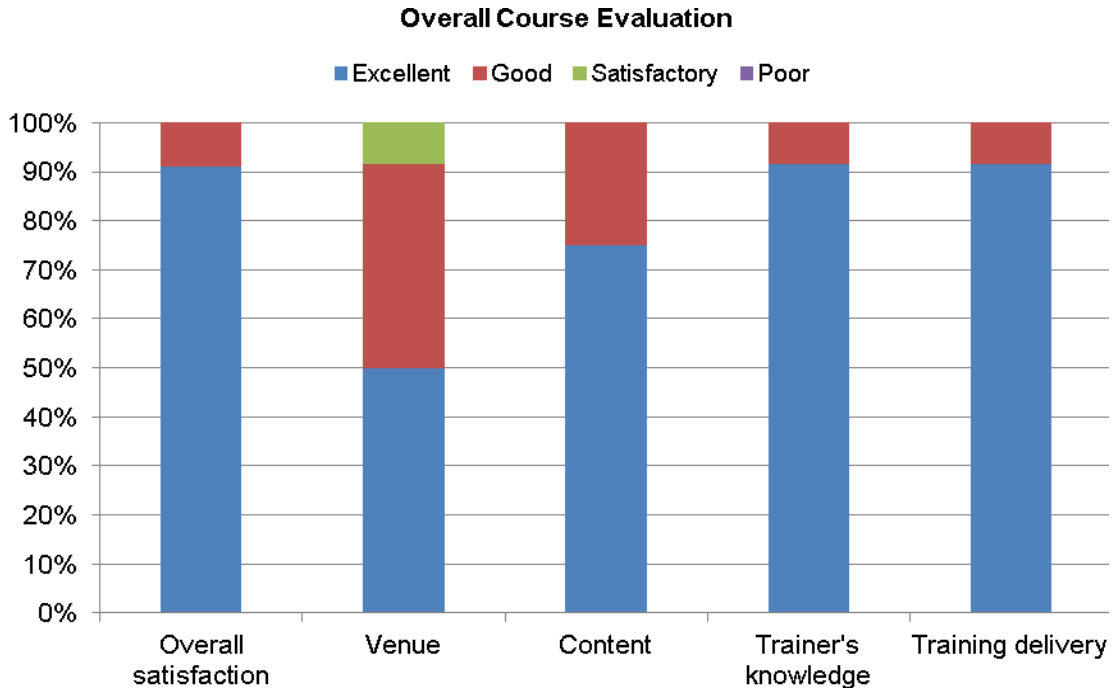
The Spiritual and Pastoral Care in Mental Health course ran weekly over a period of ten weeks. Due to feedback from previous courses, each session was extended an extra thirty minutes to two and a half hours per week.

PARTICIPANTS

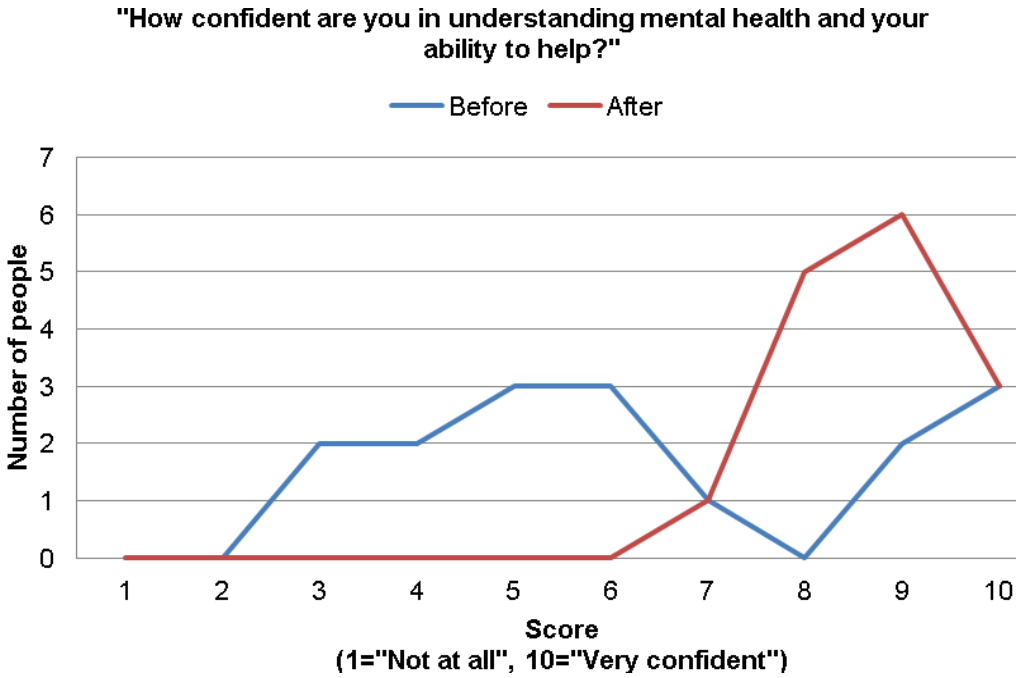
Eighteen people initially signed up to the course. Over the course of the ten weeks, three people left the course due to bereavement or sickness. Cohort four therefore comprised of fifteen participants who completed the course fully.

GENERAL COURSE EVALUATION

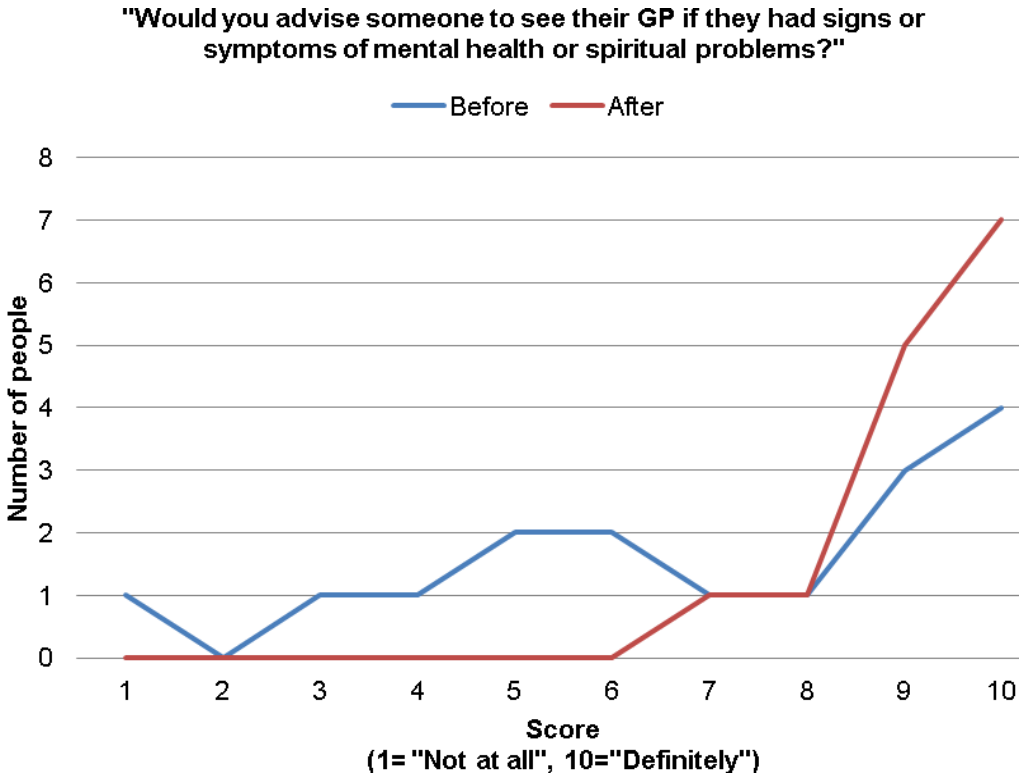
All participants rated the overall course as “excellent” or “good”. Other scores were similarly high, with the majority of or all participants giving “good” or “excellent” ratings for the venue (92%), content (100%), trainer’s knowledge (100%) and training delivery (100%).



Before and after the course, participants were asked how confident they were in their understanding of mental health and their ability to help. Before the course, participants' confidence scores ranged from 2 to 10 with an average of 6.15 (standard deviation=2.54). At the end of the course, many more participants felt confident, with scores ranging from 6 to 10 and an average of 8.73 (standard deviation=0.88).



Participants were also asked whether they would advise someone to see their GP if they had signs or symptoms of mental health or spiritual problems. At the start of the course participants scored a range of 1 to 10, with the average score being 7 (standard deviation=2.97). At the end of the course this increased to a range of 6 to 10 and an average score of 8.87 (standard deviation=1.85).



SOCIAL DISTANCE SCALE

The Social Distance Scale[i] contains items that measure participants' willingness to have close associations with people that have mental health conditions. The scale was administered at the beginning and end of the course. Scores are rated from 0 (definitely unwilling) to 3 (definitely willing), with a minimum score of 0 and a maximum score of 21.

The table below shows the average score for each item in the scale before and after testing. Shifts in attitudes were measured by calculating the difference in scores before and after the course. The results from Cohort 4 indicated a positive change in attitudes for every item in the scale. This indicated that participants were more willing to have closer associations with people with mental health conditions at the end of the course.

Modified Social Distance Scale Items

How would you feel about…	**Before**	**After**	**Difference**

(3=definitely willing, 0=definitely unwilling)	Course (Mean)	Course (Mean)	In scores (Mean)
Renting a room in your home to a person with severe mental illness?	1.44	1.93	**+0.49**
Working in the same job as a person with severe mental illness?	2.06	2.60	**+0.54**
Having a person with severe mental illness as a neighbour?	1.94	2.60	**+0.66**
Having a person with severe mental illness as a carer of your children for a couple of hours?	0.78	1.60	**+0.82**
Your children marrying a person with a severe mental illness?	1.00	1.53	**+0.53**
Introducing a person with severe mental illness to a close friend of yours?	2.28	2.67	**+0.39**
Recommending a person with severe mental illness to work for your friend?	1.94	2.33	**+0.39**
Mean Social Distance Score	**1.64**	**2.18**	**+0.54**
Total Social Distance Score	**11.93**	**15.27**	**+3.34**

VIEWS ON MENTAL ILLNESS SCALE

Participants were also administered the Views on Mental Illness Scale, which comprised of fifteen items taken from the Opinions About Mental Illness Scale[ii] and the Community Attitudes Toward the Mentally Ill Scale[iii]. Responses were rated from 1 (strongly agree) to 5 (strongly disagree) and some of the items were reversed, so there was no general direction for positive or negative responses.

As such, shifts in attitude were evaluated separately for each item in the scale. A positive shift in attitude was observed for thirteen of the items, indicating that the program was largely successful in improving participants' attitudes towards people with mental health conditions.

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In general I believe... *(1=strongly agree, 5=strongly disagree)* **=reversed item*	**Before Course** **(Mean)**	**After Course** **(Mean)**	**Difference in Scores** **(Mean)**
People with mental health problems are able to work	2.17	1.53	**+0.64**
***Psychiatric hospitals are the most appropriate settings to treat people with mental health problems**	3.50	3.67	**+0.17**
***Mental health services should be kept out of residential neighbourhoods**	3.89	3.27	**-0.62**
People with mental health problems are far less of a danger than most people believe	2.76	2.00	**+0.76**
***People with mental health problems should be forced to take medication**	3.63	4.07	**+0.44**
People with mental health problems are as unpredictable as the general population	2.72	2.60	**+0.12**
***People with mental health problems are a burden to society**	4.00	4.27	**+0.27**
***People with mental health problems are difficult to talk to**	3.89	3.67	**-0.22**
***Mental health problems can never be cured**	4.12	4.27	**+0.15**
***People with mental health problems are difficult to deal with**	3.39	3.73	**+0.34**
Most people with mental health problems can, with treatment, get well and return to lead normal lives	2.00	1.50	**+0.50**
***People with mental health problems should not be given any responsibility**	4.11	4.27	**+0.16**
We all have mental health needs	1.83	1.47	**+0.36**
***People with mental health problems are likely to**	3.17	3.60	**+0.43**

become violent

IMPACT ON UNDERSTANDING OF MENTAL HEALTH

At the end of the programme, participants were asked how the course impacted on their understanding of mental health. This was asked in terms of how participants now **think**, **feel** and **behave**.

Thinking

Several participants stated that they felt they had *"gained a deeper understanding of mental health and wellbeing"*. This included increased knowledge, a positive shift in attitude and increased confidence, e.g.:

- *"I am more **knowledgeable** and **confident** to discuss the topic in a **non-judgmental** way, more aware of stigma and high prevalence"*
- *"I have gained a much greater **understanding** and different aspect on what mental illness is"*
- *"This course has made me more open and a lot **less fearful"***
- *"The course has immensely **broadened my concept** and understanding of mental well being and the professional response to providing help and assistance to the patient"*
- *"I have become **more open minded**, more **confident** to speak to individuals with mental health problems"*
- *"I am more **open to listen** and help others and it has helped me to be **less judgmental** in certain areas"*
- ***"**More **positive attitudes** towards mental health, increase curiosity in gaining further understanding"*

Feeling

When asked how their feelings had changed, participants indicated that there had been a change of feelings both externally, towards people with mental health conditions and internally, concerning how they feel about themselves.
Some participants stated that they felt more positive and confident with regards to mental health conditions as well as feeling less fearful, e.g.:

- *"I feel more **positive**, assertive and more useful to be of some kind of positive confident supporter"*
- ***"Less fearful**, and now have opened me up to be able to speak"*

- ***"Confident** and proud to be part of this course"*

Several participants reported feeling more compassionate towards those with mental health conditions:

- *"The course makes me **feel more for people** with mental health problems and feeling more to contribute to their well being"*
- *"I feel that everyone should find the time to listen and care for each other and **show respect** regardless"*
- *"I feel more able in my working life/personal life to **empathy** more and feel more for others"*
- *"More **compassionate** and **sympathetic** towards the plight of people coping with mental illness"*

Some participants also reported an interest in furthering their support towards people with mental health conditions, e.g.:

- *"I feel very **optimistic** about furthering my involvement in this area"*
- *"I feel quite confident about setting up a **mental health team** in my church"*
- *"I feel I would be able to respond more appropriately to someone in my community/church with mental health issues and I could competently **refer them on"***

Behaviour

Many participants stated that their perceptions had improved and that they would behave in a more accommodating way towards people with mental health conditions, e.g.:

- *"The course has caused me to be more **accepting** and **open** towards mental illness"*
- *"I am now able to behave in a way, concerning mental health with a **positive outlook** to **change people's perception** towards mental health issues"*
- *"My mind has altered to **accept** what is placed before me and to deal with it with an **open mind"***
- *"I feel my behaviour towards this subject has shifted and I am more **sensitive and conscious** to some basic needs"*

This included behaving in a more compassionate and respectful way:

- *"My behaviour towards mental health patients are more of **wanting to help** and to know more about the course of their situations"*

- *"I **will behave good** towards people suffering from mental health illness. I will **find the time to listen, care and show respect** to people with mental illness"*
- *"More **respectably** in a way that helps the person realise they are loved and not alone"*

Several participants also stated that their communication skills had improved since taking part in the course:

- *"I have found myself more **careful of how I speak** to others and aware of my body language"*
- *"I will be open, and know that how I react, and that my **body language** is important"*
- *"It has improved my **listening skills**, **empathy** and be **non judgemental** now"*
- *"I am more **aware** of my behaviour when dealing with others, even close friends & family"*

Some participants felt confident in furthering mental health support within their organisations:

- *"Bold and **empowered** enough to give presentation to whole church and research into what provisions/procedures exist at my church"*
- *"I have told my church I am **willing to speak with individuals"***

Course Content

Participants were asked to name the three most important learning experiences for them and comment on the reasons why.

The majority of participants (73%) mentioned "**Communication**" as an important topic for them. This included general skills and techniques as well as learning the **SAGE & THYME** method, a strategy that enables people to have conversations that identify "the need" of the person with mental health conditions, especially when time is limited.

47% of participants stated that **Dr Pereira's presentation ("Understanding Illnesses of the Mind")** on chimp and human brains helped them to better understand the brain and its role in influencing emotions.

Several participants stated that having a better **general understanding** of mental health issues was very important for them, including facts about the **prevalence** of mental health conditions, applications and sections of the **Mental Health Act** and the **stigma** faced by people with mental health conditions.

Related to this, many people found it useful to know about the **resources** available to support people with mental health issues. This included signposting to **services** such as those in SLaM, GPs and IAPT.

Some found it helpful to understand **ethnic and cultural factors** that may be related to the prevalence of particular mental health conditions, access to services and how quickly someone seeks support for mental health related issues.

Similarly, a presentation on **spirituality** helped many participants to better understand the **role of faith groups** in supporting people with mental health conditions. They found the discussion of the relationship between **spirituality and mental health** helpful. Furthermore, they found it useful to understand the need to be clear about the **differences between religion and spirituality** and how to be supportive to people whilst keeping these factors into consideration. For example, it was important to consider spiritual thoughts and practice as a separate thing to religious practice and understanding. Overall, it enabled faith leaders to understand what kind of help they could offer in the context of their spirituality as well as encouraging them to be open-minded about people engaging in spiritual practices that were outside of their religion.

Finally, being clear about fundamental issues such as **roles, boundaries, confidentiality and safety** helped participants to understand how they might best support others. Participants liked discussing their role in **different settings**, such as at a church and in an inpatient setting. They also found it useful to consider how they might obtain supervision and guidance for themselves when working in this supportive role.

CHALLENGES

Participants were asked what they found the most challenging during the course.

Some participants found it difficult to consider mental health in a holistic and systemic way. For example, many found it challenging to consider the spiritual aspect of mental health and the factors related to it. Others found it difficult to integrate their understanding of western cultures with their own value system. Furthermore, because the course was open to a range of people, some participants found it difficult to accept or understand the faith-related practices of other participants.

Some participants also mentioned the challenge of changing their mind set to integrate their new knowledge of mental health conditions, procedures and legislation. One participant stated that having greater awareness of mental health issues challenged them to become more involved in their local church. Another stated that the most challenging thing for them was to self-reflect and question themselves.

Finally, one participant said that having to give a presentation and discuss vignettes was the most challenging thing for them, as they had to apply the skills and knowledge they gained to real life settings.

FUTURE COURSES

100% of participants felt that course met its aims and objectives. When asked if there was anything they would like to change, seven participants (47%) said they would like the course to be longer or to have a second part so they could discuss the topics further. Other participants stated that they would not change anything or that they would have liked to have studied the topics in more depth.

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Agenda Item 7

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 likely 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 accessibility and quality of community care

5. 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).

Cllr Rebecca Lury
Chair, Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
160 Tooley Street
London

Scrutiny Team
Direct dial: 020 7525 0514

20 September 2013

Dear Sir / Madam

Prevalence of Psychosis and access to mental health services for the Black and Minority Ethnic (BME) Communities in Southwark: Call for Evidence

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.

We want the best health outcomes for Southwark people including mental health and wellbeing. The 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.

We would like your views.

The review

The scrutiny committee is made up of locally elected councillors and one of its roles is to undertake reviews and then make recommendations to the Cabinet, who run Southwark Council. The inquiry will cover the following issues:

1. The likely 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 accessibility and quality of community care
5. The ways in which mental health services currently interact with each other throughout Southwark.

How to give evidence

There are a number of ways you can give evidence. Your organisation is invited to send in written evidence by 25 November 2013.You are also invited to give evidence in person at our next meeting, which will be held on 15 October 2013 7pm at 160 Tooley Street SE1 2QH. Please book a place on the contact details below. We can arrange transport if you need it, pay for care expenses and help with any access needs. Alternatively a member of the committee could come and visit your organisation and hear from your members/ service users directly.

How scrutiny will hold the review and make recommendations.

The committee will consider lots of evidence from different people in the community who might be affected by psychosis, particularly the BME community, people who have a professional responsibility for delivering mental health and psychosis services, as well as voluntary groups working with people experiencing mental distress. We have already asked Public Health and SLaM to give evidence.

If you give evidence we will make a note of this and then publish it, but we will not use your name unless you want us too. Once we have gathered all the evidence a report will be written. We will then send it to decision makers, such as the Cabinet, who run Southwark Council, and the local health services. We will also send you a copy if you give us your address.

Further information

If you have any queries or access issues, please contact scrutiny project manager Julie Timbrell on 0207 525 0514 or julie.timbrell@southwark.gov.uk.

Yours faithfully

Cllr Rebecca Lury
Chair, Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

Agenda Item 8

South London and Maudsley NHS
NHS Foundation Trust

Culture, Quality and Transformation: Delivering our Vision and Values

An Organisational Response to the Francis Report – Summary Report

Introduction

The government commissioned Robert Francis QC to report on failings at the Mid-Staffordshire NHS Foundation Trust, between 2005 and 2008. His report is damning, and makes very uncomfortable reading, with stories about patients left in their own faeces, patients so thirsty they had to drink water from flower vases and patients suffering without adequate pain relief. It became clear that some of the worst stories from the hospital were not isolated incidents, but the culture at Mid-Staffs had become insidiously so damaged that such occurrences had become normal practice.

One of the overwhelming messages of the report is that the 'culture' within Trusts (and perhaps the wider NHS) needs to change. Too often the system makes it easier to comply with poor care, rather than challenging it.

All Trusts and FTs are expected to carefully consider the Francis report and its recommendations and produce a response which is right for the organisation. A response which is agreed by the Trust Board is expected both by our regulators and commissioners.

The SLaM Francis Working Group has been tasked to develop an organisational response to the Francis Report, and draft a proposal. The group acknowledge that an Organisational Development strategy would be the usual and logical vehicle for delivering a programme of culture change. The Trust does not have a current OD strategy, and it is expected that the Trust's OD strategy will be developed over the next year, with the full involvement of the new Chief Executive. The essential elements of this Francis response will be considered in the light of the development of that strategy. Also in this context the Workforce Strategy also encompasses some principles of our Francis response within its broad themes of organisational development, leadership, productivity and engagement.

It is acknowledged that SLaM is in a period of transition and the plan may need to be adapted. Nevertheless progress has been and can continue to be made in developing a coherent approach to the provision and development of quality patient centred care, within available financial resources.

Purpose

The purpose of this paper is to present a model which has four essential elements as the vital components of SLaM's Francis report response. It will provide some background information and a framework with some quick gains within SLaM, and plans for other longer term pieces of work. It outlines what we are aiming to achieve in terms of organisational culture, and the values which we wish to embed.

Background – the Trust's Mission, Goals, Purpose, Approach and Ways of Working

This paper refers you to the Trust's Mission, Goals, Purpose, Approach and Ways of Working set out in the Trust's Strategic Framework 2012-15.

There are many elements of our Strategic Framework which are particularly relevant to culture, quality and transformation, such as our mission 'Everything we do is to improve the life experience and outcomes of people who use our services and to promote mental health well-being for all'.

Our five commitments are paramount to building mutual and respectful relationships with each other and service users:

- ★ *be caring, kind and polite*
- ★ *be prompt and value your time*
- ★ *take time to listen to you*
- ★ *be honest and direct with you*
- ★ *do what I say I am going to do*

The Trust's Strategic Framework provides the authority to move forward on all aspects to embed within our Trust cultures which would protect against any future widespread failure of care. A new model is emerging from conversations within the Trust, which consists of just four essential elements

1. Creating the right culture for positive challenge and positive action
2. Working with service users in a spirit of co-creation and co-production
3. Looking after staff, each other and ourselves
4. Assuring the quality of patient care in every corner of the Trust

The Francis Report calls for a change in culture. The risk of stating that "cultural change is needed" is that the precise changes needed to improve quality are not identified and therefore real change that 'sticks' such as change in practice and process is not achieved.

In complex multifaceted organisations there is likely to be sub-cultures within an overarching culture and hence there may be nuances in cultural differences in teams and services, and professional groups. The Francis Report provides an opportunity for individuals, teams, professional groups the CAG Executives, Trust Executive and Board to:

- Identify and keep the components of organisation culture that are working well
- Identify and change those components that have a negative effect
- Provide a framework and systematic approach within which teams and individuals can take responsibility for making changes to practice

Working to achieve cultural change is not a new phenomenon within SLaM and for staff at all levels of the organisation - since the Trust's inception in 1999 staff have been actively involved in retaining and changing components of the cultures.

SLaM developed five commitments (indicated earlier) that identify the core behaviours expected of everyone. In addition to these, it is helpful to identify core

leadership and management expectations and behaviours to achieve change in systems and practice. In order to help identify where the effort needs to be focussed, it is helpful to consider this at organisation, team and individual level.

1. Organisation culture is set by the top of the organisation, the Board, Trust Executive, CAG Executives and corporate leadership/management teams have a responsibility to make explicit the espoused values and align these values through their behaviour. They also have a key role to support and challenge teams and individuals to act in a way that consistently demonstrates the Trust values to each other, patients, families, carers and stakeholders. As the Board holds overall responsibility for assurance, clear methods to assess against standards are required. The Board needs to be visible, listen and respond to feedback from patients, families, carers, staff, stakeholders, partners and commissioners.

2. Team effort focuses on ensuring teams have a clear purpose, objectives, adequate resources, leadership, management, clear roles and responsibilities. Engagement in reflective practice, team appraisals, clear measures of success for performance, team coaching and links with other teams and stakeholders are cited in the research as important components of effective team work. It is important to have clear methods to listen and respond to feedback from patients, families, carers, staff (such as colleagues, professional supervisor, line manager, other teams) and external stakeholders.

3. Professional group effort focuses on developing professional practice, competency, confidence and excellence.

4. Individual effort focuses on recruiting and developing the right people with behaviours aligned to the organisation's values. Individuals need timely, day to day feedback on successes and areas for development as well as through formal processes such as appraisals, supervision, talent management systems and development programmes. It is important to have clear methods to listen and respond to feedback from patients, families, carers and staff (such as line manager, colleagues and professional supervisor). Individuals need to have clear expectations regarding work role and opportunities to develop and care for self and others.

The Model

Since the Francis report was published there have been many conversations and events were staff have had the opportunity to discuss the implications of the report for the NHS and the Trust. The Francis working group have distilled these thoughts and ideas in to a simple model from which a plan for change is emerging. There are four essential elements to the model:

1. Creating the right culture for positive challenge and positive action.

One of the aspects of the culture at Mid Staffs was that staff did not feel able to challenge poor or unacceptable practice, and that challenge fell on deaf ears.

A culture of positive challenge goes hand in hand with a culture of positive action where staff and patients can see problems and concerns being addressed, and improvements made as a consequence. Staff will not challenge poor or unacceptable practice if the belief is that nothing will be done to change it.

2. Working with service users in a spirit of co-creation and co-production.

Mental Health services have always acknowledged the importance of working collaboratively with service users as individuals and groups. This ideal has been enforced by successive national mental health strategies. The Francis report recommends strong collaboration as a key defence against poor patient experience, and the development of damaging cultures.

3. Looking after staff, each other and ourselves

One of the key challenges of the Francis Report is to ensure that the organisation, CAGs, teams and individuals within it, continue to provide compassionate care. The research literature strongly supports the position that failures of compassion are normal, and compassion is highly influenced by working relationships, staff support systems, organisation factors, and the senior leadership. The question for the Trust is; what is it about the organisation's systems, processes and culture which would stop staff from adopting behaviours consistent with the 5 commitments.

The evidence is clear that trusts with higher levels of staff engagement have higher patient satisfaction scores, have consistently safer services and they also perform better financially. The key principle here is, that it is easy to blame individuals rather than fix the faults which lie within the organisational systems, processes, and culture.

4. Assuring the quality of patient care in every corner of the Trust

The Board is accountable for the quality of all services throughout the Trust and in order for the Board to be assured of that quality; they have to have information and intelligence which can be triangulated to give robust evidence of service quality.

Whilst the Trust has volumes of information about its services, this information is not always the right information, and is not always used effectively to manage service quality. This is about ensuring that the right metrics are chosen, the chosen metrics are presented in a way which they can be understood, and the information is used to monitor and drive quality improvement.

These four elements will be driven by the leadership (note: leadership does not always follow heirarchy), and leadership commitment to quality of care, and organisational and cultural change. These are in line with the key messages from the Francis report and analysis from health leaders from the Kings Fund, professional bodies and other commentators.

Two other essential ingredients are vital if the model is going to work. They are:

- Enagaging all staff as the model is developed and implemented
- Simplifying the message. The message must be clear and simple and confident – a mantra.

Within each element there are long term work streams and quick wins. The table below unpicks these quick wins and work streams and presents them in the form of a summary plan.

The following summarises actions for embedding this model in different ways across the Trust.

	Existing work streams and quick wins	Longer term work
1.Creating the right culture for positive challenge and positive action	▪ Commit to a schedule of leadership walk rounds in all CAGs. 'Walkrounds' are designed to encourage a mature attitude towards reporting and resolving risk and quality issues, by inviting staff to discuss issues with senior leaders and other stakeholders. ▪ Recruitment – testing for 5 commitments in addition to clinical/ technical/ leadership/management competencies in place ▪ Programmes developed and dates set for the autumn for leaders managers and frontline staff to participate in coaching conversation training and development ▪ Senior clinical staff co –delivering coaching programme project for front line clinical staff	• Conduct a programme of facilitated conversations with staff about: o The Francis report o Culture within teams o basic care and compassion o personal / and professional responsibility. o Removing the obstacles for all staff to challenge poor practice in all corners of the Trust. • Developing a culture of intolerance to problems which impact on patient care. • Affirming positive challenge with positive action. Identifying key niggles which can be fixed to make life easier for staff and patients. e.g. reducing the number of ePJS screens for mandatory completion. • Central SLaM QI resources working collaboratively to ensure a coherent, systematic approach to team based improvement work and team development.
2. Working with service users in a spirit of co-production and co-creation	▪ Review the structure and process for service user participation. Move to non-hierarchical and widespread – (involving as many as possible). ▪ Recruit service users and carers to internal inspection (PAV) Teams ▪ Deliver planned Carers coaching programme	• Removing the obstacles to participation of service users/carers within key operational meetings. • Introduce a process whereby skills can be given to/ gained by staff who have no experience of working collaboratively with service users. • Set % targets to achieve meaningful user involvement in key roles / positions/ professions • Develop policy of service user involvement in all key recruitment processes

3. Looking after staff, each other and ourselves	▪ Invite Trust Board and Executive to review their behaviours and the impact of those behaviours on the way the organisation works. ▪ Commit to the mental health promotion team's well being initiatives. Promoting staff mental well-being with a series of interventions at individual, team and organisational level to promote the positive mental health and wellbeing, including mindfulness, stress awareness, mental health awareness for line managers and Mental Wellbeing Impact assessments. ▪ Deliver Service line leader/ senior clinical programme over autumn 2013. (A shared leadership pilot has been completed within Psychosis CAG; for team leaders and Consultants). ▪ Joint HR Business and SP programmes to help leaders and managers manage change and develop best performance ▪ Non clinical staff programme being negotiated ▪ Deliver service user involvement training / responsibilities for Senior Managers.	• Promoting and marketing SLaM values, and expected behaviours. • Conduct staff support surveys informed by information systematically collected about staff experience (SEDIC) • Plan to address wider psychological / organisational impact of violence and aggression. • Launch Schwartz rounds as a means of allowing staff to get together to reflect on the stresses and dilemmas that they have faced • Joint HR Business and SP programmes to help leaders and managers manage change. • Consider developing a senior role leading staff partnership and engagement (as Oxleas have done successfully).
Assuring quality of care in every corner of the Trust	Focus on two big ticket high impact items from the Quality Governance Framework review: 1. Commit resources to delivering an early warning quality indicator 'cockpit' capable of reporting down to team level. 2. Invest in an annual schedule of standardised self assessments and validation against essential / fundamental standards of care.	• Aligning the Measurement of Quality throughout the organisation, making a clear link between Quality Governance and Quality Programme delivery so that when problems are identified and prioritised to take through to projects to lead to improvement. • Conduct detailed review of Quality Governance arrangements.


Creating the right culture for positive challenge and positive action
Working with service users in a spirit of co-creation and co-production
Assuring the quality of patient care in every corner of the Trust
Looking after staff, each other and ourselves
Leadership - stable, shared and collective

Guy's and St Thomas' NHS
NHS Foundation Trust

Report to Southwark Overview and Scrutiny Committee

September 2013

1.0 Introduction

The Trust has been asked to report on its progress following the publication of the Francis Report earlier this year. As a Trust we have undertaken a comprehensive review of the report and its recommendations and the summary below sets out what the Trust has done, supported by the detail which is set out in the two attachments.

2.0 Trust approach following publication of the report

The Chairman appointed the Chief Nurse & Director of Patient Experience to the be Trust's Executive Lead for the response to the Francis Report.

In April 2013, the Chief Nurse presented a summary of the report to the Trust Board following its publication on 6th February 2013.

The Chief Nurse held a number of Trust wide drop-in events for all Trust staff during the month of February where approximately 600 staff attended.

Following the Trust wide drop-in events, each clinical directorate was asked to undertake their own listening events and to pose the following questions to its staff. Approximately 1,300 staff participated in 100 local focus groups in March.

1 Theme: Putting patients first all the time;

- at your best, what do you do now to put patients and their needs first?
- what should we do to put patients and their needs first all the time?

2 Theme: Speaking up safely;

- what currently enables you to speak up about any concerns you have?
- what would enable you always to be able to speak up when you have concerns?

3 Theme: Listening to our patients and staff;

- how do we know at the moment what our patients and staff think and feel?

- what would be the most effective way of finding out what our patients and staff think and feel?

Additionally posters were put up in ward staff rooms so that staff who were unable to attend a focus group could still contribute – 24 wards took part in the listening exercise using this method and many more staff contributed through informal discussions and groups.

The feedback was collated and summarised. The attached detailed report summarises the key messages from the Trust workforce. (Att1)

Following completion of the listening events, it was clear that taking an action planning approach would not deliver the changes required and would lead to yet another 'tick box' exercise. It was clear from staff that to be successful, it needed to become part of everyday business embedded within our values and under the umbrella of the Trust's 'Showing we Care' strategy.

To ensure the Trust has a clear, coordinated approach to quality it was agreed that the response to the Francis report; the Trust's Quality Accounts; and other quality initiatives would come together under a new 'Showing we Care' strategy which is set out under each of our Trust values. (Att2).

Each value has two pledges to our staff and patients and a set of actions the Trust is taking forward over the coming year.

The Trust has adjusted its reporting arrangements to the Board and the quarterly Quality Committee will now receive a report structured under the Trust's five values and will also receive a report as appropriate on the actions set out in attachment two.

Att1 – Francis Board Report April 2013
Att2 – Our Values & Pledges

Eileen Sills CBE
Chief Nurse & Director of Patient Experience September 2013

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

Date of Meeting 24th April 2013

Attachment [number to be entered by Assurance Dept.] *(Arial 12)*

Our response to the Mid Staffordshire NHS Foundation Trust, public inquiry by Robert Francis QC

Status:	A paper for Report/ Decision/Information
History:	CEBM – date / TME – date / BoD – date (Arial12)

Eileen Sills
Chief Nurse & Director of Patient Experience

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

Date of meeting 24th April 2013

Report prepared by: Eileen Sills, Chief Nurse & Director of Patient Experience and Claire Macdonald
Presented by: Eileen Sills, Chief Nurse & director of patient Experience

Our response to the Mid Staffordshire NHS Foundation Trust, public inquiry by Robert Francis QC

1.0 Introduction

Post the publication of the findings of the Mid Staffordshire Public Inquiry all Chairs and Chief Executives were asked to ensure their organisations considered the report in full, considered whether it accepted the 290 recommendations and to undertake a listening exercise with its staff. The outcome of which must be presented to a public board meeting. This has now been completed and this paper sets out the outcome of this exercise. The paper is presented in the following sections:

- Presents an overview of the findings of the public inquiry
- Presents the findings of our own listening exercise with staff
- A summary of the DH response to the recommendations
- Recommendations to the Board of Directors on a set of proposed actions/next steps
- Appendix 1 provides a response to the 290 recommendations

2.0 Overview of the findings of the public inquiry

2.1 The previous government ordered an independent inquiry into the failings of care at Mid Staffordshire between 2005-2009. This reported in 2010, making a number of recommendations. When the Coalition government came to power the then Health Secretary, Andrew Lansley requested Robert Francis to lead a further inquiry. The purpose of which was to establish how such failings could have been allowed to happen and to go unnoticed for such a long period of time and what were the lessons for the wider NHS. The report was published on the 6th February 2013.

2.2 The Francis report is 1782 pages long and is presented in 3 volumes, supported by an executive summary and 290 recommendations. Designed to change the culture and ensure 'patients not numbers come first,' by creating a common patient safety culture across the NHS. The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting patients first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern.
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients - individuals and organisations properly accountable for what they do and to ensure that the public is protected from those not fit to provide a service.
- Provide a proper degree of accountability for senior managers and leaders to protect the interests of patients.
- Enhance the recruitment, education, training and support of all the key contributors to healthcare, in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything we do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3.0 Outcome of the Trusts listening exercise

3.1 Following the publication of the report the Trust set out its plan to brief and engage its staff in the findings of the report and took the following approach:

- To hold a number of Trust wide 'drop in' briefing sessions, where all staff were welcome and they received a presentation on the findings from the Chief Nurse. In addition specific briefings were undertaken at the February private board meeting and for the Council of Governors. In total approximately 600 staff attended. In addition, the Deputy Chief Nurse for Community held three briefings for community staff.
- Local listening events were then established across the Trust led by the directorate management teams and supported by the OD team to enhance alignment with the values and behaviours framework. The purpose of which was to engage and to listen to as many staff, who were posed the following questions:

- Theme: Putting patients first all the time
  - At your best, what do you do now to put patients and their needs first?
  - What should we do to put patients and their needs first all the time?
- Theme: Speaking up safely
  - What currently enables you to speak up about any concerns you have?
  - What would enable you always to be able to speak up when you have concerns?

- Theme: Listening to our staff and patients
  - How do we know at the moment what our patients and staff think and feel?
  - What would be the most effective way of finding out what our patients and staff think and feel?

- In addition to the focus groups we also put up posters in the majority of ward staff rooms for those staff who were unable to attend a focus group but wanted to contribute.

3.2 The engagement exercise was very successful and X number of staff had the opportunity to contribute to the focus groups.

3.3 More here and in an appendix

Focus Group findings for Board report on Francis Report

Participation

3.3 Almost 1300 staff attended 90 focus groups across the Trust during March 2013. In addition data was collected via posters in wards – 24 wards took part in the process using this method.

3.4 The spread of staff involved in this exercise was fairly representative, other than from Bands 1-4 as shown in figure 1.

Staff Grade	Number	%
Band 1-4	137	11%
Band 5-6	454	35%
Band 7-8b	393	31%
Band 8c plus	43	3%
Consultants	124	10%
Training grades (ST/FY)	99	8%
Student Nurse or AHP	31	2%
Total	1281	

Figure1. Staff Attending Focus Group by grade

3.5 Across the 1300 participants there was broad representation from different staff groups – the graph in figure 2 gives the percentage breakdown of attendees by professional group

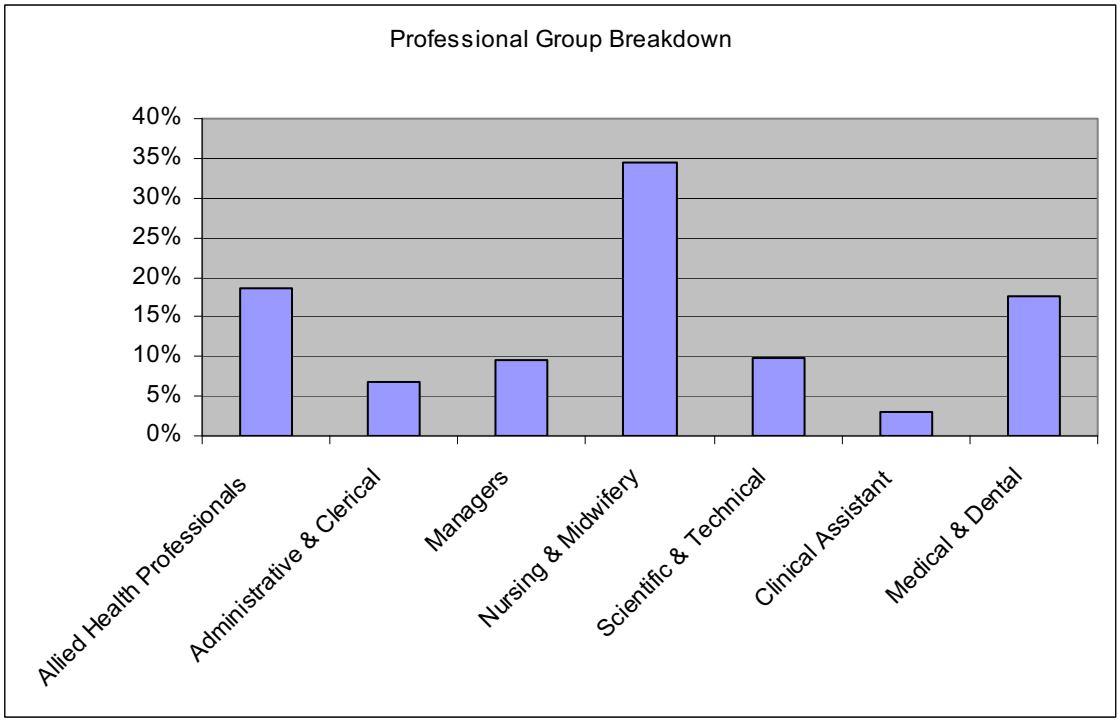

Figure 2. Staff Attending Focus Group by Profession

3.6 Staff from all clinical directorates and many corporate areas took part in focus groups. The level of participation in this process is a tribute to managers and senior staff across the Trust, both those involved in running focus groups (50 senior staff) and those enabling the process to occur through publicity, encouragement, role-modelling and giving staff time to attend. It should be recognised that the lead-time to organise this process was just two weeks.

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3.7 Finally, it should be noted that the level of participation recorded formally for this report is the *minimum level* of involvement in the Trust; many more staff contributed to this process through ward posters, informal discussions or more formal groups where attendance was not recorded.

Analysis

3.8 The Organisational Development team analysed the data under each of the headings and have identified both themes and commonly occurring terms. The commonly occurring terms are shown visually in the Wordles in Appendix X. The larger the font, the more often the word or phrase was used.

Putting patients first all the time:

1. **At your best, what do you do now to put patients and their needs first?**
2. **What should we do to put patients and their needs first all the time?**

3.9 The focus group participants and contributors to posters named dozens of ways in which they currently put patients and their needs first. This was true of frontline staff and of staff in corporate areas. The themes were:

Theme	Examples
Attend to the basics	Pay attention to dignity, safety and confidentiality and deliver evidence based care
Interactions	Listen to patients, ask how they are, be friendly and empathetic
Involvement and individualised care	Provide individualised, holistic care and involve patients and their families and give them the time they need
Prioritise patients and their needs	Manage the workload to prioritise patients, inform and advocate for them
Seeking feedback	Conduct patient surveys and act on audits
Systems that support	Appropriate care planning, training to do the job, planning convenient and flexible services and having appropriate staffing mix and levels
Effective team working	Listen and communicate with the team

3.10 It was striking that much of the language used by staff mirrored that of the Values and Behaviours Framework.

3.11 The themes were the same for both the first and second question, but the emphasis shifted from the personal responsibility for listening and communicating, to the team and Trust responsibilities for teamwork and appropriate systems and resources. This can be seen in the first two Wordles in Appendix X.

3.12 As a contributor said, we all need to do more of what we do on a good day.

Speaking up safely

1. **What currently enables you to speak up about any concerns you have?**
2. **What would enable you always to be able to speak up when you have concerns?**

Theme	Examples
Approachable/visible manager	A supportive and visible manager who listens
Clear standards	Being clear about the appropriate standards of care
Completing the action/ feedback loop	Knowing that your concern will be acted on
Culture	Feeling safe and an open and honest culture with no fear of repercussions
Guidance & Process	Knowing what the policy and processes are and who to raise concerns with
Personal qualities	Self confidence, passion for patient care and professional responsibility
Space and time	Individual and team meetings
Support	A supportive team

3.13 By far most important single factor enabling staff currently to speak up was a supportive and visible manager. The single most important factor that would encourage more speaking up was the knowledge that there would be action taken and feedback given, whether through managers or through formal mechanisms such as Datix. This was followed by the need for an open and supportive culture where staff felt safe to raise concerns.

Listening to our patients

1. **How do we know at the moment what our patients think and feel?**
2. **What would be the most effective way of finding out what our patients think and feel?**

Theme	Examples
Create the right culture through behaviours	Talk to patients (speak to/ask/listen/discuss), create a culture of listening, look at patient's body language, have friendly body language, make time for this
Formal feedback	Surveys, complaints, PITS/PALS, patient fora, review survey questions
Informal feedback	Compliments, thank you cards, asking for feedback after an interaction/intervention, follow up phone calls
Completing the feedback loop	Discussing and displaying findings, giving feedback on comments, using Datix/SUI information

3.14 The strongest theme in this question was feedback through formal mechanisms, particularly noting what we do now using surveys, complaints data, PALS/PITs, closely followed up by informal feedback we receive now such as compliments and cards. The theme identified around 'closing the loop' occurred again, as under 'speaking up safely'. This shows how important it is not only to gather information, but to feedback to staff. The other strong theme here was around behaving in a way that enable patients to be heard and creating the right culture for this.

Listening to our staff

1. **How do we know at the moment what our staff think and feel?**
2. **What would be the most effective way of finding out what our staff think and feel?**

Theme	Examples
Relationship with manager	Appraisals, 1:1s, feeling listened to and valued, getting feedback, being approachable, clinical supervision
Meetings and fora	Team meetings, MDTs, joint managerial and clinical fora, open fora
Metrics	Staff survey, attendance, employee relations & turnover data, incident forms

3.15 The majority (2/3) of the comments from staff on this question were on what is good now including appraisal, team meetings and being listened to. The main areas which staff thought could be more effective was in the approachability of managers, getting feedback and in having regular 1:1s. Staff also listed a wide range of metrics used to listen to and gauge staff views, notably the staff survey. The weight of appreciative data on what is good now aligns with our excellent staff survey results.

Recommendations

Celebrate the current good practice
This exercise was designed to help staff think about what we currently do well under the three themes identified. However, an overwhelming amount of data was generated on our current good practice (on all questions there was more data about 'good now' than 'better if') with high levels of consistency across the Trust. This needs to be recognised and celebrated; the process modelled this but the Board should acknowledge it.

Spread the good practice
A large amount of data collected in this exercise is repeated in the 'good now' and 'better if' questions, suggesting we have the organisational capacity for great practice (congruent with our patient safety record, patient feedback and staff survey) but do not practice it in all areas of the Trust. What this process

highlights are the areas staff think we should focus on in making improvements. Spreading good practice is a perennial issue for the Trust but a message from the top on what is valued in the organisation and role modelling of what is valued by staff will help managers be clear on what is expected to create areas of best practice.

Closing Feedback Loops
In questions on both speaking up safely and on listening to patients, staff valued feedback on issues that have been raised or on feedback such as survey data and were keen for this to be done consistently.

There is a specific action to be considered in how Trust level and Directorate data is fed back to staff in a way that is useful and meaningful. In addition, there is an opportunity to use this process as a way of modelling closing the feedback loop (as one participant suggested). Plans have begun to use the Trust-wide Fit for the Future launch to feed back on this process, and consideration needs to be given to other ways to thank and acknowledge staff contribution as well as demonstrate actions taken.

Don't take our eyes off some of the basics
There is clear message from staff in this process that basics of caring for patients safely and kindly, having clear processes to follow, regular meetings/appraisals and feedback are all valued and needed to do the best that they can for patients.

Support managers to support their staff
Staff clearly value visible, approachable and accessible managers at the line and at more senior levels. The success of this process has shown how well staff respond to effective management action. However, managers often feel squeezed between helping staff deliver front-line services and meeting organisational targets. We recommend that the Board and other senior layers of management acknowledge the importance of managers in providing a safe and supportive environment for patients and staff.

Set aside further time
Undertaking this process has sent a clear message from the Trust's senior leadership regarding the importance of the Francis report and of putting patients at the centre of what we do. It is suggested that the Board of Directors continue by setting aside further time to consider the specific themes and actions from this research and the implications on the Board itself. This could be combined with the previously agreed session on Trust Values and Behaviours.

4.0 Summary of the DH response to the Francis Inquiry

4.1 The DH response was published on the 26th March, the title of which is 'Patients First and Foremost'. The document sets out an initial overarching response on behalf of the whole health system. It details key actions to ensure that patients are ***'the first and foremost consideration of the***

system and everyone who works within it' and to restore the NHS to its core humanitarian values. It sets out a collective and commitment and plan to eradicate harm and to aspire to excellence. This is a call to action for every clinician and everyone working within health care. The DH sets out a 5 point plan to end the failure and issuing a call for excellent.

A. Preventing problems
B. Detecting problems quickly
C. Taking action promptly
D. Ensuring robust accountability
E. Ensuring staff are trained and motivated

4.2 Preventing Problems

The need to secure a consistent culture of compassionate care. With both commissioners working with Trusts to tackle poor care and the appointment of a Chief Inspector of Hospitals, who will shine a powerful light on the culture of hospitals. To do this however leaders need time to lead and staff need time to care. Therefore there will be a review of the paperwork and 'box ticking' and duplicatory regulation. In addition the NHS Commissioning Board has appointed Don Berwick to advise them on how to create a safety culture and a zero tolerance of avoidable harm and that this becomes embedded within the DNA of the NHS.

4.3 Detecting Problems Quickly

4.3.1 The Care Quality Commission will appoint a Chief Inspector of Hospitals, who will be supported by an expert group of inspectors who will have walked the wards, spoken to patients and staff and looked the board in the eye. The Chief inspector will make an assessment of every NHS hospitals performance.

4.3.2 Generalist inspectors will be replaced by experts who will get to the heart of how hospitals are serving their patients and a 'comply or explain' approach will be used in inspections.

4.3.3 There will be a new ratings system established for the CQC to apply and they are currently working with the Nuffield Trust. In addition the CQC will appoint a Chief Inspector of Social care.

4.4.4 To support the new spirit of candour and transparency, hospitals will not be subject to just aggregate ratings but you will be able to drill down to individual specialities. Mortality data must be accurate but interpreted with care so that members of the public and patients can trust that what they are hearing is a fair and honest account. There will be tough penalties and potential legal sanctions on Boards who re found to be 'massaging' figures or concealing the truth about their performance. In addition their will be a statutory duty of candour on all providers to inform people if they believe treatment of care has

caused death or serious injury, and to provide and explanation even if they have not asked for one.

Contractual clauses to prevent NHS staff speaking out on patient safety issues will immediately stop and the final are of action in this section is the commencement of a national review of best practice in handling complaints.

4.4 Taking Action Promptly

4.4.1 The CQC, working with NICE, commissioners and professionals, patients and the public will draw up a new set of simpler fundamental standards, which make explicit the basic standards beneath which care should never fall. These are likely to include:

- Patients getting their correct medicines at the right time
- Patients getting food and water and assistance to eat and drink when they need it
- Patients being assisted to go to the lavatory when they need to go to prevent any patient having to soil their clothes or their bed
- Patients being asked to consent to treatment and all staff to communicate with patients effectively about their care

4.4.2 The Chief Inspector of Hospitals will develop a new 'time limited 3 stage failure regime' for quality as well as finance. The first stage setting out the responsibilities of the Board to work with commissioners to resolve the failings, the second stage would require the CQC to call in Monitor and the final stage if the failings had still not been addressed would lead to the Chief Inspector initiating a failure regime in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

4.5 Ensuring Robust Accountability

4.5.1 At a national level the proposals within this section will resolve the confusion of roles and responsibilities in the system so it is absolutely clear where the 'buck' stops. The Chief Inspector will identify failing standards in the NHS Trusts and Foundation Trusts.

4.5.2 Where the Chief Inspector identifies criminal negligent practice the CQC will refer the matter to the Health and Safety Executive to consider whether a criminal prosecution should be considered for either providers or individuals. The DH will ensure there is sufficient resource for the H&S Executive to fulfil this remit.

4.5.3 Urgently the GMC and NMC and other health care regulators are hampered by outdated legislative frameworks. As part of the Law Commissions review the DH will seek to legislate at the earliest opportunity the possible opportunity to overhaul radically 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.

4.5.4 The DH will implement a national barring list for unfit managers based on the barring scheme for teachers.

4.6 Ensuring Staff are Trained and Motivated

4.6.1 Starting with a pilot, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant. To enable them to gain experience in front line care and also the role of the HCA and their future management of them. The scheme will need to be tested and carefully implemented and managed.

4.6.2 Building on the historic introduction of medical revalidation the DH wish to work with the NMC to introduce an affordable and proportionate national scheme to ensure all practising nurses are up to date and it to practice.

4.6.3 There is a national review underway to ensure that healthcare assistants can provide safe and compassionate care and that every organisation will have to demonstrate that all HCA's are properly trained and inducted. This will be supported by a national code of conduct, but there will be no national statutory regulation framework or a separate barring scheme for HCA's.

4.6.4 Each organisation should have a clear aspiration to treat its staff well, with robust recruitment, induction and appraisal programmes in place, and all organisations will have to ensure it has the right staffing profile to be able to provide the right level of care. Therefore there will be no mandated minimum nurse staffing levels, as this does not provide for local flexibility. But the expectation will be that all Trusts will have to have in place an accredited tool to assess the workforce requirements and as a minimum these are presented to the Boards on a six monthly cycle.

4.6.5 All Trusts will be expected to make progress with the implementation of the national nursing vision 'Compassion in Practice – 6C's' and as part of this those wards across the country who do not have intentional hourly rounding in place will be expected to do so as well as give due consideration to ensuring Ward sisters/Charge Nurses are in a supervisory role.

4.6.6 The Francis inquiry recommended the creation of a separate registered older persons nurse. However given that many of older people are cared for in many parts of the NHS the DH recommends that they will strengthen the training on the care of the frail older person throughout all programmes. So that all adult trained nurses have the right set of skills to care for our most vulnerable patients.

4.6.7 To ensure that the NHS creates the cultural change it needs, it requires leaders who have the skills and abilities to do this therefore the NHS leadership Academy which has already been established will programmes that support the development of leadership skills from Board to Ward. Building the capacity and ability of our top leaders.

4.6.8 The final recommendation in this section is aimed at Ministers and Civil Servants who will be expected to have front line clinical experience. GSTT has been asked to support those based in London by offering them volunteering and work shadowing placements.

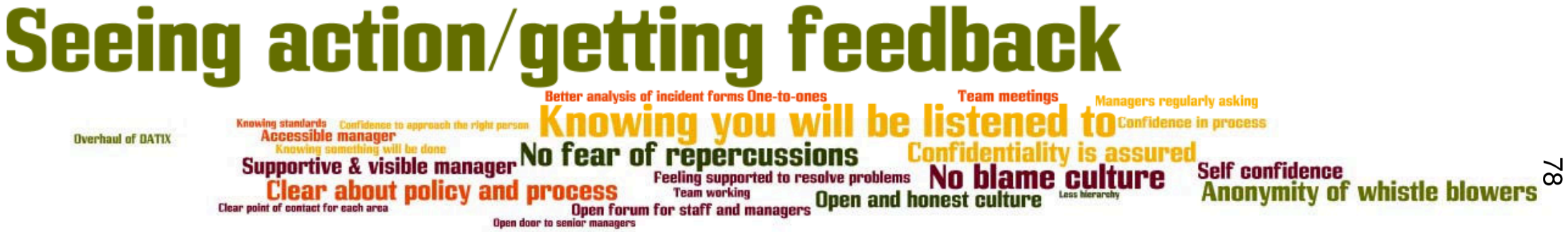
Appendix

Put Patients First – Good Now

Put Patients First – Even Better If

Speak up – Good Now

Speak up – Even Better If

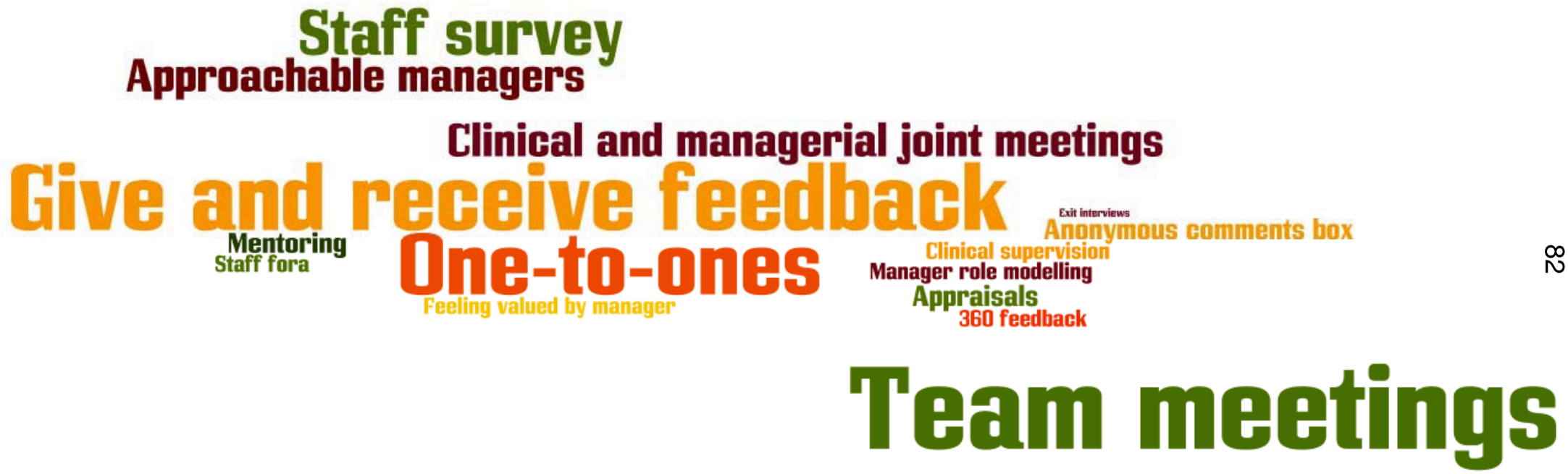


Listening to Patients – Good Now

Listening to Patients – Even Better If

Listening to Staff – Good Now

Listening to Staff – Even Better If



Our values and our pledges to patients and staff

showing we care

Put patients first

- You will receive a professional standard of care delivered with kindness, dignity and respect
- We will support our staff to listen to you

Take pride in what we do

- Our staff will ensure that your care and treatment is safe
- We will ensure our staff have the right skills and resources to provide the most effective care

Respect others

- We will always treat you with the utmost kindness and respect
- Our staff will treat each other with dignity and respect

Strive to be the best

- We will ensure your care is based on clinical evidence and best practice, and delivered efficiently
- We will support our staff to deliver the best possible care 24 hours a day, seven days a week

Act with integrity

- We will be open about our mistakes and work hard to put them right
- We will listen to our staff and support them if they raise concerns

How will we deliver our pledges?

We will

- ensure that all of our patients' basic needs are met all of the time
- ensure our staff honour the pledges to patients and staff set out in the NHS Constitution
- improve the way that we include patients and their carers in decision making
- develop new ways to receive feedback from our patients
- support and develop our staff so they always act in the patient's best interest
- ensure our Board of Directors and governors are visible to patients and staff

We will

- ensure that we have the right staff with the right skills caring for each patient
- foster a safety culture which is based on transparency and openness
- implement a zero tolerance approach to avoidable harm
- continue to support our staff to develop the skills they need to provide safe high quality care
- constantly monitor standards of care and respond quickly if there are concerns

We will

- develop a range of initiatives that support our staff and help them to demonstrate the right values and behaviours at all times
- ensure staff respect their colleagues and respond positively to our diverse workforce and local comunity
- ensure leaders at all levels are visible and model the Trust values and behaviours

We will

- balance safety, quality and efficiency
- seek to be a national leader in patient safety
- build on Barbara's story and seek to be nationally recognised for the provision of exceptional care for our most vulnerable patients
- continue to develop our workforce so that all our staff strive to do their best

We will

- ensure our staff feel listened to
- provide regular feedback to our staff
- ensure our staff are supported always to have the courage to speak up if they have any concerns

Put patients first

- You will receive a professional standard of care delivered with kindness, dignity and respect
- We will support our staff to listen to you

How will we deliver our pledges?

showing we care

Ensure the basic fundamentals of care are delivered at all times to an exceptional standard

- ensure the environment where patients are cared for is clean
- protect patients from abuse and discrimination
- protect patients from harm during their care and treatment
- ensure patients have their pain relief and medication on time
- patients will be given enough food and drink
- patients who need help to go to the toilet and to wash will have this assistance when needed
- patients will not be held against their will, coerced or denied care and treatment without their consent or the proper legal authority

All of our staff will understand and honour the pledges to patients and staff set out in the NHS Constitution

- raise the profile of our values and behaviours and ensure they are underpinned by the pledges set out in the NHS Constitution

Improve the way that we include patients and their carers in decision making

- develop a scheme to support those who have responsibility for caring for a patient with a dementia
- each clinical service will review how they include patients and carers in decision making and we will look for examples of best practice nationally and internationally

Develop new ways to receive feedback from our patients

- roll out the national Friends and Family test
- create a new integrated complaints and PALS service which is more responsive to patients and carers
- develop patient forums and involve patients in the design of our services
- continue to implement our mystery shoppers scheme

Our staff will be supported and developed to always act in the patient's interests

- all patients will know the name of the doctor, nurse or therapist looking after them
- continue the roll out of 'Barbara's story'
- dignity ambassadors will be appointed in all clinical areas
- every clinical service will have a dementia champion
- recruit and train staff on our values and behaviours
- implement and honour the Duty of Candour

Our Board of Directors, governors and senior managers will be visible and available for patients and staff to talk to and will proactively monitor the experience of care provided

- relaunch 'clinical Friday' with all senior leaders visible in the clinical areas
- our Non-Executive Directors will 'buddy' with a clinical area
- our Council of Governors will participate in the annual 'safe in our hands' accreditation audit across all clinical services

Take pride in what we do

- Our staff will ensure that your care and treatment is safe

- We will ensure our staff have the right skills and resources to provide the most effective care

How will we deliver our pledges?

showing we care

Ensure we have the right staff with the right skills caring for each patient

- review how we provide a 24/7 service, to ensure we have the right clinical and non-clinical staff in the right place at the right time
- have in place an annual education and development plan for all areas
- formally review our nursing and midwifery workforce numbers and skills every 6 months
- have in place recruitment strategies for the hard-to-recruit-to areas
- our ward sisters and charge nurses will be in a supervisory role

Foster a safety culture which is based on transparency and openness

- use the range of information available that tells us how safe our services are, including mortality data, safety thermometer data and medicines errors and create a 'hub' of quality and patient experience information on our website
- make it as easy as possible to report a near miss, error or incident and ensure our staff receive feedback
- embed the use of data systems, such as the safety thermometer, and roll out across all community services
- our clinical areas will display how well they are doing

Implement a zero tolerance approach to avoidable harm

- further reduce hospital acquired infections, falls with harm and Trust acquired pressure ulcers
- all of our appropriate staff will use the WHO surgical checklist

Continue to support our staff to develop the skills they need to provide safe high quality care

- develop our simulation training to ensure it is patient driven and covers compassion and dignity
- provide communication training to our clinical staff, such as Sage and Thyme and Human Factors training
- prioritise and support our students and those in training

Constantly monitor standards of care and respond quickly if there are concerns

- continue to build and strengthen our weekly 'safe in our hands' briefing
- review our clinical governance structure to ensure it is responsive
- publish on our website and in designated clinical areas 'how we are doing' against outcomes

Respect others

- We will always treat you with the utmost kindness and respect
- Our staff will treat each other with dignity and respect

How will we deliver our pledges?

showing we care

We will deliver a range of initiatives that ensure our staff can demonstrate the right values and behaviours at all times

- have leaders at all levels that are highly visible and exemplar models of the values and behaviours in action
- implement the national nursing strategy 'Care and Compassion' and the 6 C's - care, commitment, courage, competence, communication, compassion - mapped to our 5 values and supporting behaviours
- recruit against our values and behaviours and also ensure our contractors abide by them
- train and suport managers on how to use and develop the values and behaviours within their teams
- develop easy ways for our staff and patients to know how we are doing – 'you said this..we did this'
- support managers and teams to live the values through offering cultural change programmes
- use our staff survey to gain feedback from our staff in order to test and improve the culture of all our services
- bring together feedback from our staff and patients and identify common themes and priority areas to work on

Strive to be the best

- We will ensure your care is based on clinical evidence and best practice, and delivered efficiently
- We will support our staff to deliver the best possible care 24 hours a day, seven days a week

How will we deliver our pledges?

showing we care

Balance safety, quality and efficiency

- implement over the next five years our *Fit for the Future* programme, to raise the standards of safety, quality and efficiency in an integrated way
- implement e-prescribing and e-noting
- develop technical solutions to support record keeping in the community

Seek to be a national leader in patient safety and to achieve the best outcomes for our patients

- implement the national outcomes strategy and quality standards for the specialist services we provide

Seek to be nationally recognised for the provision of exceptional care for our most vulnerable patients

- implement our dementia strategy
- roll out our older people's training programme, building on the success within the older people's unit
- all our staff will have the appropriate level of training to care for our most vulnerable patients

Continue to develop our workforce so that all our staff strive to do their best

- develop a scheme that spots talent and develops our future leaders
- continue to develop our frontline leaders
- support staff applying to participate in programmes provided by the NHS Leadership Academy
- continue to provide junior doctors with leadership opportunities and recognise their importance to delivering safe, compassionate care 24 hours a day
- offer a coaching and mentoring programme to all levels of staff

Act with integrity

- We will be open about our mistakes and work hard to put them right
- We will listen to our staff and support them if they raise concerns

How will we deliver our pledges?

showing we care

We will support our staff to ensure they feel listened to, they receive feedback and have the courage always to speak out if they see something that causes concern

- foster a culture of trust, openness and honesty by giving regular feedback
- ensure all staff have regular one to ones with their managers
- all of our staff will feel part of and meet regularly as a team
- all of our staff will have an annual appraisal and we will develop and roll out an assessment process where staff are assessed against the Trust's values and behaviours
- set up regular listening events for our staff and develop creative ways to communicate with them
- have in place a reward/recognition scheme for all of our staff
- implement Schwartz rounds to enable clinical teams to discuss the care of a patient in a safe, confidential way and for staff to learn from each other
- support our staff to be open about mistakes and learn from them
- support our staff to raise concerns and provide feedback when they do
- launch a revised whistle-blowing policy

Item No.	Classification: Open	Date: 15/10/2013	Meeting Name: Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Report title:		Adult Social Care response to the Francis Report	
Ward(s) or groups affected:		All	
From:		Sarah McClinton, Director of Adult Care, Children's and Adults Department	

RECOMMENDATION(S)

1. That the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee note this report.

BACKGROUND INFORMATION

2. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee requested a report from a range of health and social care bodies in Southwark on their response to the report of the Francis Inquiry. This report sets out the response of Adult Social Care.

KEY ISSUES FOR CONSIDERATION

3. The Francis Report into events at mid-Staffordshire NHS Foundation Trust raised a wide range of concerns about patient care, safety and dignity and about the attitudes and approaches of managers and staff within the trust. The report also highlighted the failure of the wider health system to ensure services of an adequate quality were being delivered from the trust, including the systems of inspection, regulation, commissioning, contract management, complaints, clinical governance, quality assurance, regional NHS management and performance management arrangements. The failure of the Link and the local authority health scrutiny committee to identify the problems was also highlighted.

4. The inquiry found that the organisational culture, characterised by a lack of transparency and openness, together with an excessive focus on financial and performance targets led to a system that did not put patient care at the centre of what it did.

5. There are a large number of detailed recommendations and we believe it is important for adult social care to draw lessons from what happened. Although the focus of the inquiry was hospital services the findings all clearly translate to adult social care, in particular in relation to care provided in care home settings, where the risk of comparable institutional abuse is significant. The same

principles apply to services provided to vulnerable people in their own home and to any other services.

6. It is evident that there are some clear areas that we should all consider relating to the dignity with which people are treated and the compassion with which they are cared for. Key to ensuring that care in all settings is the kind of care we would want for ourselves and our relatives is for us to listen to staff and to the people who use services and their families. Leadership at all levels of organisations is key to improvement and, in Southwark, this is why we started with investment in My Home Life leadership development programme with our local care homes.

7. At a strategic level, the council has built on this leadership development programme to create 'My Home Life Southwark', which is our Quality Improvement Strategy for Care Homes aimed at delivering system-wide change. This strategy is attached as it is substantively a major part of our response to the Francis Report (see appendix 1).

8. My Home Life Southwark applies to all care groups but has a specific focus on older people's homes locally. Separately, the council has considered the lessons from Winterborne View in the light of shocking scenes depicted on Panorama in 2011. Events at Winterborne View and the Serious Case Review that followed highlighted a catalogue of failings in the care system and the need for a culture and a way of working that challenges poor practice and promotes compassionate care. Locally we have set up a Winterbourne View Steering Group to improve services for people with learning disabilities and challenging behaviour with the goal of ensuring there is no such failing for our residents. Progress on implementing the Winterborne View Concordat has been reported to the Adults Safeguarding Partnership Board and the Health and Wellbeing Board. For the purposes of this report the focus is on My Home Life Southwark: Care Home Improvement Strategy.

Summary of 'My Home Life Southwark': Care Homes Improvement Strategy

9. 'My Home Life Southwark': Care Home Quality Improvement Strategy 2013-15 (see appendix 1) has been developed through a partnership group comprising representatives from across the Council and NHS Southwark CCG, the Care Quality Commission, Lay inspectors, Age UK and care home providers.

10. We have been supported by the work of My Home Life which developed an evidence base for improving quality of life in care homes. My Home Life was referenced and supported in the White Paper 'Caring for our Future – reforming care and support'. The strategy has also been informed by the recommendations made in the Cavendish Review 'An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings' and the Berwick Review published in August 2013 'A promise to learn – a commitment to act" which highlights the need to place the quality and safety of patient care above all other aims for the NHS.

11. The Strategy responds to the recommendations from The Francis Review 2013 which highlighted a number of key themes: common values, accessible standards and means of compliance, monitoring of non compliance, openness, transparency and candour, strong leadership and support for leadership roles, accountability and ensuring information is accessible and useable. The

Strategy confirms the sector's commitment to working partnership to provide high quality care.

12. The Care Home Quality Improvement Strategy focuses on both care homes with nursing and residential homes and has five key work streams:-
    - Quality Assurance
    - Safeguarding
    - Working together in the future
    - Workforce Development each with a detailed action and implementation plan.
    - Integrated working

13. Delivery of the Care Home Quality Improvement Strategy will be overseen by a steering group who will have membership from all partners and will meet quarterly to review progress and measure the impact of this on the quality of care, based on measures developed through the Quality Assurance work stream.

APPENDICES

No.	Title
Appendix 1	'My Home Life Southwark': Care Home Quality Improvement Strategy 2013-15

APPENDIX 1

My Home Life Southwark

Care Home Quality Improvement Strategy

2013-2015

92

Treating residents as we would wish members of our own families to be treated

Index

My Home Life Southwark: Care Home Quality Improvement Strategy

Forward from Cabinet Member for health, social care and equalities, Catherine McDonald

We are committed to treating every resident the way we would wish members of our own families to be treated, and for every care home resident to have the kind of high quality care each of us would want for our own relatives. The council's fairer future promises underline our strong commitment to high quality personalised services and this is why I am pleased to present *My Home Life Southwark,* which sets out our strategy on how we will work together to improve the quality of care in our local homes.

Care homes in Southwark provide essential support to people who are no longer able to live in their own homes. Our vision is that each individual is supported to live their lives in accordance with their own beliefs, preferences and culture so they feel comfortable and 'at home'.

High quality of life is made possible when it is grounded in the relationships between the people who receive, provide or support care and this in turn fosters a culture of respect, dignity and compassion. I recognise that delivering high quality care to a wide range of individuals is complex as each person has their own individual needs, values, aspirations and preferences. This strategy recognises that sustained quality improvement will only be achieved if we re-orient the whole system and all play our part to ensure local homes are not 'islands of the old' but actively supported and open to the community. At the heart of this is ensuring our residents get the best possible care and experience good quality of life.

My Home Life Southwark brings together the Council, NHS colleagues, providers and the voluntary and community sector around a joint vision for the highest possible standards of care and a practical set of actions that will help to deliver this. I am pleased to be able to present this strategy and look forward to an update on progress in 6 months.

Introduction

1. With life expectancy increasing and growing numbers of older and disabled people needing care and support, there is a spotlight both nationally and locally on the quality of care they receive. In Southwark, we are committed to ensuring that our residents have access to high quality care and support in local care homes to support the best possible quality of life, within their own communities. This means every individual is treated with compassion, dignity and respect and, like all our citizens, has access to local health and community services.

2. Our aim in Southwark is to support residents to remain in their own homes where possible, which is what people have told us they want. However, where people need to use residential and nursing homes, it is essential that the care delivered is high quality, promotes good quality of life and provides a safe and healthy environment.

3. We expect a culture of care that puts people first. Where people are seen as individuals, their preferences and care needs are well understood by staff and they are supported to live as independently as possible. We expect to see people come before tasks, care to be respectful and social interactions valued.

4. This strategy sets out our agreed joint vision for what quality looks like so this is clear, the work that we will all do to ensure that this is what people get, and how everyone can contribute to ensuring this. The strategy aspires to improve quality of life for individuals across all care homes but has a focus on the larger care homes working mainly with older people. The approaches to monitoring and driving quality will apply across all care homes. This strategy will ensure all partners are working to the same vision and values and provide a mechanism for partners to measure progress in making changes across the system that will improve the quality of care.

5. Our vision set out in the section below is based on the national evidence-base developed by *My Homelife* and work that has been done locally with a wide range of stakeholders across our local system. My Homelife is a collaborative partnership aimed at improving the quality of life of those who are living, dying, visiting and working in care homes. My Homelife works with homes, councils, residents, families and carers to improve the quality care.

Southwark vision for promoting quality of life

1. People who live in residential and nursing homes should expect to be treated with dignity, respect and get excellent care. In Southwark, we expect every individual to be treated as we would want our own family members to be treated.

2. This means that in care homes, we expect to see systems that identify individual needs and preferences, support accurate record keeping and identify people at risk. Processes should be in place to protect people from the risk of abuse and both staff and people living in homes should know how to raise concerns. Staff need to be well trained to promote dignity and respect, to respond to complex needs, including the impact of dementia, and be used flexibly as needs change.

3. The evidence base developed by *My Homelife* has identified that what is important to older people living in care homes is the ability to emotionally connect with staff and relatives through high quality relationships. In order to create the conditions where this will happen naturally, it is important to retain those things that make a difference to us all as individual human beings, care professionals and members of society, to our quality of life. Then this can be applied to the residents and relatives to improve their quality of life. The key elements that are known to bring out the best behaviours in people are when they feel the following:
   - a sense of security: *we must feel safe*

- continuity: *we need to experience links and connections*
- belonging: *we need to feel part of things*
- purpose: *we need to feel motivated*
- achievement : *we need to see ourselves progress*
- significance: *we need to feel we matter as an individual*

4. We expect our care homes to be responsive to the different needs of the diverse group of residents, including cultural, gender, sexuality, age, religion, and disability. Homes are expected to have a personalised plan for each resident that ensures their needs are met and that they can live their lives in accordance with their preferences and wishes.

5. To promote quality of life for our residents and to support relationship-centred care, we have set out a clear vision of 'what good looks like' for older people which identifies 8 important areas where we want to see improvements:
   - Managing transitions
   - Maintaining identity
   - Creating communities
   - Sharing decision-making
   - Improving health and healthcare
   - Supporting good end-of-life
   - Our workforce
   - Promoting a positive culture of compassionate care

6. In full, the vision is about:

Managing transitions

Most of us would wish to be cared for in our own home, but increasing physical, mental and social frailty in older age does not always make this the best option.

Moving into a care home is a major transition in life which may involve considerable losses but, with appropriate planning and support, it can bring benefits and improved quality of life for older people and their families. Many older people regain confidence and begin to 'thrive' when they start their new supported life in a care home.

For relatives, it is important that they can contribute to decisions being made about their loved one's care and are supported to deal with the emotional impact of the move on them and their loved one.

Case example: **Regaining a sense of purpose**

Mr R was always very restless and paced up and down. He was very difficult to engage with any activity. A project which included a carpentry workshop has really helped him engage. He used to do this type of activity previously. He can now take part for up to one hour.

Maintaining identity

Given the considerable losses that older people experience when moving to a care home (loss of health, family, community, home); there is a real risk that older people can lose their sense of identity, culture, religion and self-esteem. Care homes can play a major role in helping residents regain a sense of worth.

Many care homes make real efforts to learn about the older people they care for; not just in terms of their current needs, but also about their culture, religion, interests, strengths and whole life history. This can help them engage with older people in a more meaningful, compassionate and positive way.

Creating communities

Care homes have been described as ‘islands of the old’ – we tend to think about ‘them’ not ‘us’, even when we know we will also grow old and frail!

Quality of life can be enhanced by creating a sense of community, both within the care home, and between the care home and its local diverse communities. Links with local organisations, such as schools or voluntary groups, can be very helpful to older people for social engagement and also rewarding for those that visit.

Southwark example:
A Christian group visit weekly and many residents attend. Catholic priests visit and give Holy Communion enabling residents to practice their faith.

The residents attend Darwin bowling club every week to watch bowling and can take part if they choose. In the same afternoon the local pub is visited, keeping people involved in their local community.

The Irish pensioners group visit the home and people attend the group. This keeps people linked with their friends and maintain their life outside the home.

Southwark have just started a pilot with ATTEND who will be working with residents, staff, relatives, local organisations and volunteers to generate diverse and creative ways to engage the local community.

Sharing decision-making

For many, going into a care home can feel like a move away from being in control of one's own life. Collective living with others can be a new experience for many and the importance of feeling involved in decisions-making in relation to both their care and the wider running of the home, should not be underestimated.

In some care homes, older people get involved in maintaining the garden, being responsible for pets, helping out with housekeeping, planning the decor, recruiting staff and carrying out internal audits.

Did you know?

An estimated 40,000 older people in care homes in England have no regular contact with people outside of the care.

Improving health and healthcare

Older people living in care homes have substantial and complex healthcare needs which require the full range of healthcare services.

They should have access to the same healthcare they would be entitled to if they were living in their own homes. Health can also be improved by spending time with residents in personally meaningful and enjoyable ways.

Did you know?

There are more 'care home beds' than hospital beds' across the UK.

Supporting good end-of-life

Care homes are places where all residents live and where many will ultimately die. Many homes have excellent skills in supporting end of life including accommodating the different cultural and spiritual wishes of the residents and their relatives. In society, there is a real taboo about talking about dying and death, but it is important to have opportunities for discussion around this subject at a time conducive to older people.

"My Friend Betty"
Words from a care home resident about a friend who died in the same care home.

Betty had been very poorly for a couple of days, and in the middle of the night the staff came and woke me up and said "We think Betty hasn't got long. Do you want to come and say goodbye to her?" So I put my dressing-grown on and went down the corridor and they left me with her. I climbed on the bed next to her and put my arms around her and told her what a good friend she had been to me. She died in my arms'

Our workforce

We want to make quality and compassionate care central to care homes in Southwark. We will recruit and retain the right people with the right skills to provide high quality care and support to our residents. Our workforce provides a critical role in our community. Raising the profile of a career in the profession will be our objective to ensure we are attracting and retaining high calibre people to work in our homes.

Promoting a positive culture of Compassionate Care

A positive culture of compassionate care in a care home is one where routines and structures revolve around the older person rather than simply fit with the needs of the organisation. A good atmosphere in the home is based upon positive relationships, mutual appreciation and some blurring of roles between staff, residents and relatives. Promoting a positive culture also takes into account the older person's diversity (such as age, disability, gender, race, religion or belief and sexual orientation) and provides compassionate care that meets those needs.

Roles of service users, families, carers and the community

7. It is clear that for this strategy to improve the quality in care homes demands each part of the system taking responsibility for their part in delivering high quality care. This includes residents, where that are able, and their families and carers to taking an active role in quality assurance.

8. Experience has shown that people can sometimes have low expectations of care and may express satisfaction with a level of quality that professionals and partners perceive differently. For this reason, it is essential that people who live, work in and visit care homes also understand our vision of what high quality looks like and work with professionals as partners to promote this.

Working in effective partnership

9. Consistently delivering high quality care to a diverse group of people with changing needs within an inner city area is not easy. This strategy recognises that a long-term view is needed to work with people across the sector so we are all contributing to achieving our vision. Providers are responsible for ensuring the quality of the services they deliver, however we also recognise that way we commission these services is important, the support available from the wider health and care system is critical and that residents, friends, families, carers and the community all have a vital part to play.

10. Together we will champion the needs of our most vulnerable older and disabled people and work in partnership with private and independent sector care home providers. We will support them to ensure that their homes have the right culture and robust systems in place to deliver the best possible standards. Working in effective partnership underpins the entire strategy and the action plans that will deliver the changes required. Continuous improvement will be achieved by commitment from across the partnership so all parts of the system are supporting and enabling each other to deliver quality care and promote quality of life. However, the council will continue to hold providers to account when standards are not met.

11. Improvements can only be maintained and built on by having a comprehensive and cohesive approach to quality that is embedded throughout the cycle, from the way care is commissioned right through to the staff that provide care to an individual on a day-to-day basis. A key element of this is to focus on a strong and confident workforce and ensure they are supported to develop their skills and deliver high quality care. In Southwark we want to see work in the care sector as a career of choice for local people so they are able to take advantage of employment opportunities and so that this work is seen as rewarding. We will have robust systems for quality assurance that are focussed on people's experience of care and where all partners actively contribute to enable a deeper understanding of the quality of care being provided and the impact this has on people's quality of life. In the same way that safeguarding is everyone's responsibility, we all have a role to play in quality assurance.

12. Partners can achieve this by respecting and trusting one another, recognising our joint vision and goals and sharing responsibility for improving the quality of life of residents. Alongside this we need to recognise areas where we have individual goals and take care that these do not undermine or derail our joint work. As part of our work together, a partnership agreement has been signed which sets out some principles to guide working together (this is reproduced at the end of the strategy).

13. Underpinning this work are the views and input from residents, their families and carers, supported by national evidence from My HomeLife[1]. My HomeLife have talked to service users and also shared their evidence based approach that has come from residents. Partners from across the sector who have contributed include the council, the NHS, providers, lay inspectors, Age UK, the care quality commission, and Healthwatch

National and local context

14. This strategy is set within the national policy context of Putting People First: a shared vision and commitment to the transformation of adult social care and anticipates changes on the horizon as a result of the Care Bill, which proposes to strengthen the accountability that local authorities will have for providers within their locality such that the Council will need to ensure continuity of provision if the market

[1] http://myhomelife.org.uk/

fails. This provision means the local authority will need to know what is happening in care homes and work in partnership to seek to prevent service breakdown.

15. Equity and Excellence: Liberating the NHS sets out the national framework for NHS services and in the wake of the Francis report there is fresh impetus to focus on cultures which promote patient safety. Don Berwick's recent report commissioned by the Prime Minister [2] sets out what needs to change and a summary is attached in paragraph 21. This approach is equally applicable to the care home sector.

16. Locally this strategy aims to deliver Southwark council's fairer future principles, particularly treating residents as we would want members of our own families to be treated. Southwark introduced a Charter of Rights (for people who need social care) in 2012 and our plans support delivery of this, particularly focusing on
    - You should be treated with dignity and respect and be treated fairly.
    - Vulnerable people, those who are at risk due to disability or frailty, have the right to be safeguarded from abuse.

    The Council has published The Southwark Economic Wellbeing Strategy 2012-20: what the Council will do. We recognise that over the longer term we will not be able to make a significant impact on local provision unless there is recruitment and retention of high quality staff and we would also like the care sector to offer employment opportunities for local people. The workforce plans are therefore a critical element of our strategy.

17. The strategy has been produced within the context of wider initiatives taking place through the Southwark and Lambeth Integrated Care Programme (SLIC), which has the overall aims to reducing unnecessary admissions to hospitals and care homes. Within the SLIC programme, the importance of and role of care homes is being considered within four projects: falls, infections, nutrition and dementia.

18. Having a clear and agreed strategy for ensuring the quality of care in homes in Southwark enables us to:
    - measure the effectiveness of initiatives, in achieving the vision we have agreed
    - ensure that initiatives complement each other and contribute to achieving the vision
    - maximise use of resources by avoiding duplication of effort and joining up work where appropriate.

19. The range of people who have contributed to this work highlights the recognition of all partners of the importance of keeping a focus on quality and safety and that no one group can achieve sustainable improvements without commitment from the others.

[2] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

The Southwark approach

20. In order to work towards our vision the partners acknowledge the needs to influence change across 5 key areas, which have been broadly described as:

- quality assurance – how do providers, partners and regulatory bodies work together to have a complimentary and useful quality assurance system? There is a need to review current systems, to set out the roles and responsibilities of all who can contribute to this and to revise systems so they are aligned to our vision.

- integrated working – partners all have different skills, experiences and resources available which can help to develop and embed quality practice. How do we break down existing barriers and use what we have most effectively? There is a need to ensure homes are 'islands of the old' but have good support available from the NHS and are integrated into the community.

- safeguarding – all partners are responsible for safeguarding. We want to ensure services promote good quality of life for vulnerable people and protect them from abuse. Where safeguarding alerts are made we ensure we focus on the resident and ensure learning contributes to a healthy and positive approach to risk management.

- working together in the future – There is a need to take a new approach to the way we commission services. What can we learn from elsewhere and how can we adapt for the future?

- workforce development – How can we support and encourage staff and managers in the industry and make this an attractive career option? Quality of life rests largely in the relationship the individual resident has with the individual care worker, who needs to be well-trained, well led, compassionate and committed.

21. Workforce development is the keystone work-stream as motivated, well-trained staff with the right values who are appropriately paid and valued is the foundation on which quality care is built. The recent Cavendish Review 'An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings'[3] sets out 18 recommendations under the headings; Recruitment, Training and Education; Making Caring a Career; Getting the Best out of People. Leadership, Supervision and Support; and Time to Care. This report, published in July 2013, validates the approach we have outlined as part of this Strategy and further reinforces how essential care staff are to providing care.

22. In addition, the Berwick Review published in August 2013 'A promise to learn – a commitment to act. Improving the Safety of Patients in England) sets out four guiding principles:

[3] https://www.gov.uk/government/publications/review-of-healthcare-assistants-and-support-workers-in-nhs-and-social-care

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times
- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

This strategy is the work of a group of people from across the sector who have given their time to honestly and frankly explore the challenges of delivering high quality care and have together come up with an approach that confronts these complex challenges using an array of initiatives and proposals. This is entirely consistent with Berwick's principles about quality and safety being a focus, talking to the people in the system, valuing and develop staff and being transparent, so we are accountable, respect and trust each other.

23. It is important to recognise that this is not an overnight fix but requires all partners to commit and invest in working together into the future to achieve sustainable improvements. Therefore, while some elements can be put in place quite quickly, others will require a longer view to be taken. For this reason, the strategy and action plan will be refreshed in 3 years to consider what progress has been made, the impact of these changes, and what areas need further work and development.

24. As noted above, partners are committed to exploring new and innovative approaches. It can take time to give something new a chance to embed and really assess the effectiveness of it (and in some cases they may need reviewing or redirecting). This means some elements in the existing action plans may be amended or deleted as the work progresses. For this reason, a steering group will retain oversight of the strategy and its delivery, meeting quarterly to review the progress and more importantly, what impact the work is having on quality. An update of progress will be provided to the Cabinet Member from the steering group after the first six months to ensure accountability is maintained and to guide ongoing work.

Actions plans

Quality assurance **– how do providers, partners and regulatory bodies work together to have a complimentary and useful quality assurance system?**

Objective / area of improvement	Action	Prerequisites / interdependencies	Person/s responsible	Target date for completion	Status
Understand all systems currently in place	• Stock-take of all current quality assurance systems (provider, partner, statutory, council). • Review best practice to see what could be applied in Southwark.	Nil	Rochelle Jamieson	November 2013	In development
Service user voice	• Describe all mechanisms available to residents / families / carers to participate in the quality assurance system. • Ensure the system has a variety of clear and accessible mechanisms for residents and their families / friends / carers to participate in quality assuring their own services. • Involve the community and other partners in quality assurance.	Nil	Rochelle Jamieson	November 2013 April 2014 April 2014	In development
Partnership	• Map all feedback mechanisms for the quality assurance system (formal and informal) and how these contribute to improved quality. • Map all connections between the quality assurance team and strategic partners e.g. safeguarding	Nil	Rochelle Jamieson	November 2013	In development
Promoting a positive culture of compassionate care.	• Redesign quality assurance system so it is clear, accountable, promotes partnership and continuous improvement, and focuses on the quality	Workforce development	Jonathan Lillistone	April 2014	In development

	of the service from a resident's perspective. System to have mechanisms for formalising concerns and working with partners to address these. • Quality assurance system to emphasize homes being responsible for, and demonstrate they are providing, high quality care and evidence this. • Dignity champions / approach to be embedded into quality assurance system.				
Continuous improvement	• Review operation of new quality assurance system to ensure it is delivering on the vision and is operating within the spirit of the partnership agreement.	Above	Rochelle Jamieson	April 2015	To commence as per timetable
Continuous improvement	• Meet with key stakeholders to ensure the quality assurance system is contributing to improved quality and how this can be strengthened.	As above	Rochelle Jamieson	April 2015	To commence as per timetable
Care Home Quality Improvement Strategy	• Develop systems to measure the effectiveness and impact of the work completed under the Strategy. • Set up steering group to monitor delivery of, and updates to, the Strategy.	All other work-streams	Rochelle Jamieson and Sarah McClinton	February 2014	In progress

Integrated working **– partners all have different skills, experiences and resources available which can help to develop and embed quality practice. How do we break down existing barriers and use what we have most effectively?**

Objective / area of improvement	Action	Prerequisites / interdependencies	Person/s responsible	Target date for completion	Status
Improving the Quality of Primary Care to Care Homes with Nursing	Strengthen the primary and secondary care for clients in nursing beds in care homes		Kate Moriarty-Baker & Ray Boyce	Business case to be completed by end of July	In progress

	Develop a business case to increase primary & secondary care and social care: - Development enhance contract for primary care and care homes which set out clear expectations for the delivery of primary care services and outcome measures to be monitored. - Increase the Consultant sessions with the CHST from 1 to 2 per week. This will support provide additional support to GP practices delivering this contract and help to foster a collaborative approach, to the delivery of primary care services, jointly with Lambeth CCG - WTE social worker post to be created within the CHST to work jointly with health to support care homes deliver high quality care. - Increased access MH support for care homes in Southwark via Note all stakeholders will be			Discussions with Clinical Commissioning Group – Sep 2013 Implementation December 2013 In progress through the Mental Health for	Post agreed with Social Care

	involved in development of specification for this (particularly provider)			Older Adults Group	
Improve the access for clients in nursing care beds to Allied Health Professional	Work with Social Care to explore resource and capacity issues in order to achieve equitable access for clients in nursing care beds Review access systems for care homes (covered by primary health care contract).		Kate Moriarty-Baker, Alex Laidler	August/September 2013	
Implement integrated care approach to nutrition, fall, dementia and	Working jointly with SLIC to identify and implement key recommendations from the four care pathways work around fall, dementia, nutrition and infection		SLIC	September / October 2013	In progress
Keeping People Connected & Attend Programme	Supporting people admitted from hospital to a care home to keep connected with their communities. City University to provide academic support, supervision and evaluation. This project will link to the Attend programme – recruiting volunteers across eh care homes in Southwark to provide sustainability.		Age UK & Ray Boyce	Started 5 August 2013	
Improving End of Life outcomes for people in care homes	St Christopher's jointly commissioned to work with care homes in Southwark to improve end of life care outcomes – monthly monitoring on actions		Kate Moriarty-Baker & Ray Boyce		On going

	and achievements to commence from August 2013				
Creating Leadership in Care Homes	Work with My Home Life to improve the leadership within care homes and extending he existing project to Deputies		Ray Boyce		On going

Safeguarding **– all partners are responsible for safeguarding. How can we ensure that this process focuses on the resident, identifies areas for development / change, and contributes to a healthy and positive approach to risk management?**

Objective / Area of improvement	Action	Person/s responsible	Target date for completion	Status
To implement the recommendations of the safeguarding review	• Membership of Safeguarding Board to be reviewed to ensure that needs of the Care Bill are met and also voice of the service user is heard	Paul Willmette/John Emery/ New Independent Chair (when appointed)	December 2013	Lisa Greensill (Time and Talents) SAPB member representing voluntary sector GP representative member of the Board
	• The SAPB sub-group structure to be simplified to two groups: I. Prevention and Awareness Raising to concentrate on training and development for all staff working with vulnerable adults in Southwark. II. Quality and Performance to consider quality issues in all services across Southwark	Paul Willmette/John Emery/New Independent Chair Quality Assurance work-stream		Full SAPB and Sub-group Review under discussion

To implement the safeguarding thresholds as recommended by the safeguarding review and adopt these across Southwark To identify care planning issues/effective partnership working rather than use safeguarding protocols for eating/drinking	• Consultant currently working on developing jointly agreed safeguarding thresholds for both Southwark and Lambeth	Marian Harrington/Paul Willmette/John Emery/SAPB Southwark Lambeth Integrated Care work on nutrition.	December 2013	Report on thresholds in development Threshold documentation to be produced Roll out programme for implementation of new thresholds to be agreed
Protocols for investigation of institutional abuse to be developed	• Currently under development	Lily Lawson/John Emery with input from provider stakeholders	October 2013	Roll out of protocol across the partnership to be ratified by SAPB. Training requirements to be identified.
To work in Partnership with Stakeholders to develop effective communication particularly around the response to allegations and outcomes and when alerts are eliminated at screening	• Meet monthly with Care Homes to discuss current safeguarding alerts, avoid escalation and make sense of what is happening. • Review/Revise SA Communication Protocol	Ray Boyce/John Emery/Commissioning QA Team Paul Willmette/John Emery/stakeholders Organisational	September 2013 December 2013 November 2013	Programme to be developed Development of revised local SA policies under discussion

	• Emphasis to be placed on Communication and partnership working in safeguarding training	Development in conjunction with Training Partners		
To ensure the voice of the service user and families are central to the SA process	• To develop a 'co-production' SA model • Undertake a service user survey to identify their experience to inform development of 'co-production' model	Sam McGavin/John Emery/stakeholders Paul Willmette/John Emery		Currently under discussion Work underway to identify a provider/agency to carry out survey
Ensure policy and procedures are Southwark specific	• Using Pan-London policies and procedures as a baseline and work described above to produce local Southwark SA policy and procedures	Paul Willmette/John Emery/SAPB/Stakeholders		

Working together in the future **– planning now for the future, and thinking about how we will commission services so they are set up to succeed is essential. What can we learn and how can we adapt for the future?**

Objective / area of improvement	Action	Prerequisites / interdependencies	Person/s responsible	Target date for completion	Status
Work-stream 4 – Working better together in the future (Commissioning)	To establish a medium term framework contractual arrangement with the local nursing homes, that incorporates London Living Wage, embeds a partnership approach to achieve continuous and sustained improvement in nursing care home quality	Agreement of the local nursing homes can be negotiated that meets the council's requirements	Andy Loxton OP Commissioning	31/01/14	In progress

Work-stream 4 – Working better together in the future (Commissioning)	To develop an agreed contract management partnership approach for care homes that is inclusive, quality-focussed and recognises the roles and responsibilities of all parties. For example ▪ Residents and families ▪ The workforce ▪ The provider ▪ The council ▪ NHS partners ▪ Community and voluntary sector	Agreement brokered with the local nursing homes	Andy Loxton OP Commissioning	31/01/14	In progress
Work stream 4 - To develop a market position statement for nursing, registered (As well as extra care) specialist supported accommodation for older people, that will identify both the supply needs and future proof approach that will need to be adopted to ensure the highest possible standards of care is provided	Complete a draft market position statement identifying an analysis and gaps of current supply as well as long term long term needs, to establish requirements over the next 10-15 years Incorporate outcomes of consultation exercise into the document and seek appropriate approval of the market position statement	Development of extra care and community based alternatives to residential and nursing care, including effective integrated care with NHS partners. Link in with workforce development work to project requirements in the future and profile the profession	Andy Loxton OP Commissioning	31/09/13 31/03/14	In progress
Develop market position statements for specialist	Expand market position statement to include younger adults with disabilities	Support younger adults to live independently in	Jon Lillistone Head of commissioning	31/03/15	

accommodation needs of younger adults, specifically people living with a learning disability and those with a physical disability.		their own home as far as possible, but ensuring any registered care home placement is of a sufficiently high quality.			
To ensure that the voice of the service user, their families, as well as internal and external key stakeholders representing various elements of the older customer's journey through the care home sector is informs the approach to be taken by the council.	Build upon the existing consultation and engagement with older people and their representatives on the council's plans and the developing market position statement for specialist accommodation for older people.	As above plus an ability to consult with harder to reach older people who traditionally do not engage in formal consultation forums.	Andy Loxton OP Commissioning	31/12/13	In progress
To ensure that the physical designed environment at Tower Bridge care home is improved to incorporate best practice principals in relation to dementia care	Renovations to the entire home , using funding from Department of Health Capital Grant	Full funding being made available via the DOH Dementia Grant Programme.	Andy Loxton Gordon Thresher (HC1)	31/12/13	In progress
Develop a community in reach programme into care homes	Pilot Attend project initially in two care homes and then expand dependant upon the efficacy and development of the funding model	Success and lessons learned from pilot	Andy Loxton OP Commissioning	12/12/13	In progress

Workforce development **– the staff who deliver services are the core of quality services. How can we support and encourage staff and managers in the industry and make this an attractive career option?**

Objective / area of improvement	Action	Prerequisites / interdependencies	Person/s responsible	Target date for completion	Status
Workforce development	To create a workforce development plan, providing the right interventions, to create and retain high calibre people, with the right skills, providing high quality care to our citizens.	Systemic diagnostic involving a six stage process - **see attached work stream approach**	John Howard	30th November 2013	Project group set-up meeting 10th July (four more planned) Approach and actions agreed and in progress.
	Dialogue / focus group meetings with staff (Anchor & HC1): - long term employed - recent starters - "zero hours"		Annie Stevenson Harjinder Bahra Annette Rhoden-Harrison	July / August	Meetings being arranged
	Dialogue with residents – **"what makes a good carer"** (Anchor, HC1 & Elms)		Annie Stevenson Harjinder Bahra	August	Meetings being arranged
	Site visit to **JCP** to review job applicant search process and referral process (& current job market)		Alan Palmer Angela Magill	July / August	Meeting being arranged
	Dialogue / focus group with Elm's management and staff (high retention & staff moral is reported)		Annie Stevenson Harjinder Bahra	August	Meeting being arranged
	Site visit with Human Resources		John Howard	September	Meeting being

	(Anchor & HC1) to research current **recruitment approach**, obtain workforce data – numbers, roles, service, turnover		Angela Magill		arranged
	Site visit to L&D Managers/team (Anchor & HC1) to review **induction**, current **training programmes** and approach to maintaining CPD.		John Howard Angela Magill	September / October	Meeting being arranged
	Nursing staff - Review of approach to promoting **employment pathways** into care homes, recruitment & **retention** – link review involving: Anchor & HC1 CCG GSTT Higher Education / Uni's		John Howard Annie Stevenson Harjinder Bahra Judith Knight GSTT Kings	October	
	Analysis of focus group feedback to create "development standards framework" – identifying the **differentiating behavioural competencies – the right people skills**. The **"how"** that makes the difference for future **"aptitude & attitude"** at recruitment, induction and ongoing management.		John Howard	September	
	Analysis of findings (further research if necessary) and development stages of a sustainable workforce development plan and programme of		Project Group	September to November	Project Plan "milestones" being finalised for sign-off on 19th August

	interventions.				2013

Partnership Agreement

Our commitment to partnership working...

As your colleagues with our shared goal of delivering high quality care for older people, We commit to the following:

THE VISION

SHARED VISION FOR QUALITY/ COMPASSIONATE CARE

VALUING + INCLUSING EACH OTHER – SHARING EXPERTISE

TRUST, HONESTY + RESPECT

TAKING OWNERSHIP + RESPONSIBILITY

RESPONSIVE + FLEXIBLE – SPEAKING PLANNED AHEAD CARE

Signed...

Home life

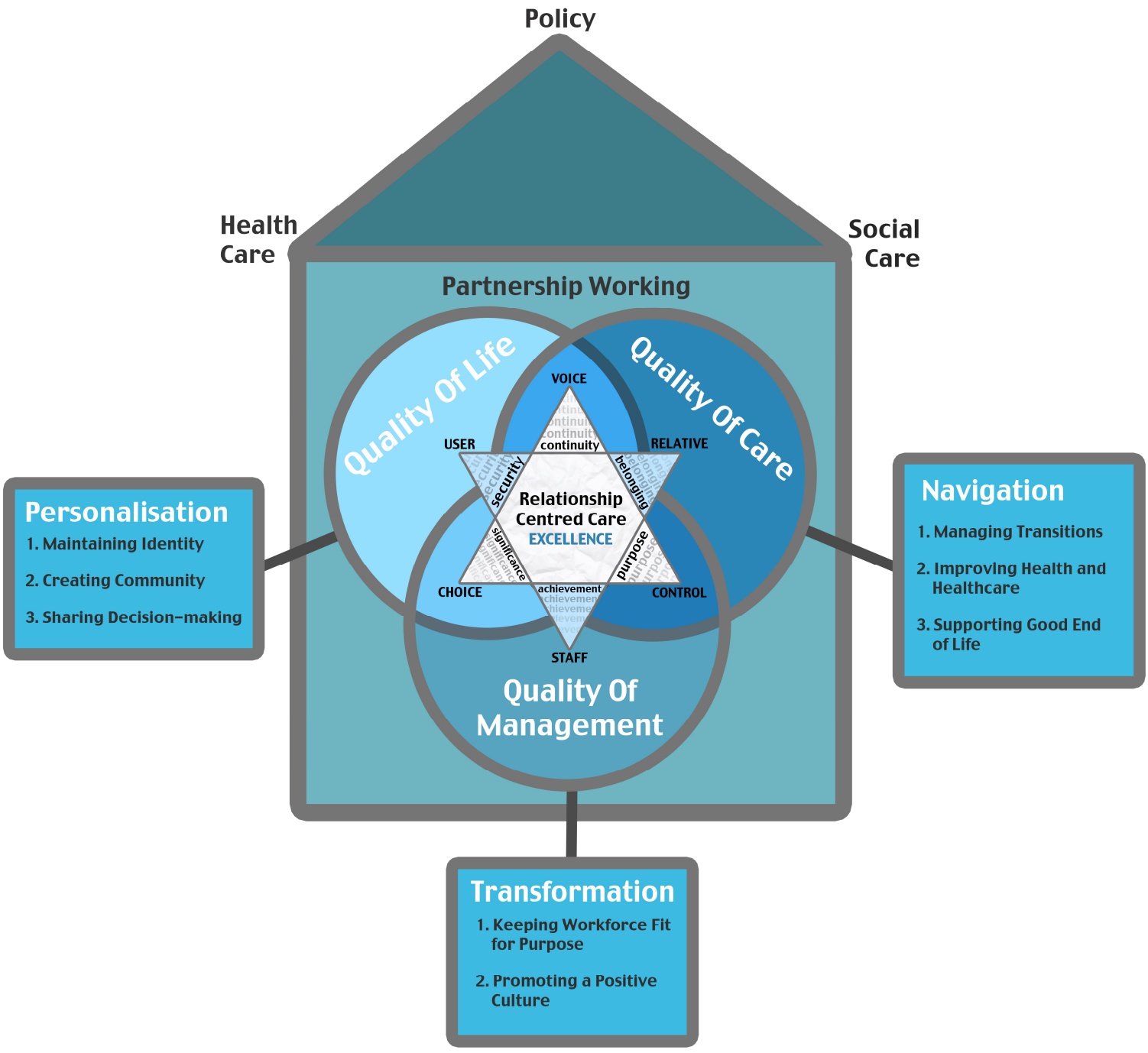
Stakeholders

This strategy is the work of partners who were involved as follows:

Task and Finish Group:

Chair – Sarah McClinton – Director of Adult Social Care	John Howard – Head of Organisational Development, Southwark Council
Alex Laidler – Head of Disability & Independent Living	Kate Moriarty-Baker – Head of Continuing Care and Safeguarding, CCG
Andy Loxton – Commissioning Manger, Older People	Kulvinder Sidhu – Tower Bridge Care Home Manager, HC-One
Annie Stevenson – Director: Integration In Care, My Home Life	Les Alden - Age UK Care Home Lay Inspector
Brigid Sedour – Operations Manager, HC-One	Liz McAndrew – Programme Manager (SCIL)
Christine Jones – Service Manager, Southwark Council	Ray Boyce – Head of Older People Services, Southwark Council
Gwen Kennedy – Director of Client Group of Commissioning	Rochelle Jamieson – Business Unit Manager, Contracts, Quality and Market Management, Southwark Council
Haley Malm – Care Quality Commission	Rsunderalingam Rajadurai – Manager, Camberwell Green, HC-One
Jacky Bourke-White – Age UK	Stephen Rees – HC-One
Jean Young – Head of Primary and Community Care Development	Tamsin Fulton – Southwark and Lambeth Integrated Care
Jean Young – Head of Primary and Community Care Development	Tamsin Hooton – Director of Service Redesign – NHS Southwark CCG
John Emery – Safeguarding Adults Manager	Vy Franklin – Deputy Manager, Tower Bridge, HC-One

Virtual contact group:
Fiona Crispin-Jennings – District Manager (London), Anchor
Jonathan Lillistone, Head of Commissioning, Southwark Council
Jacquie Hibbs, Contract Manager, Southwark Council
Older People's contract management team, Southwark Council


Policy
Health Care
Social Care
Partnership Working
Quality Of Life
Quality Of Care
Quality Of Management
VOICE
USER
RELATIVE
CHOICE
CONTROL
STAFF
continuity
security
belonging
significance
purpose
achievement
Relationship Centred Care
EXCELLENCE
Personalisation
1. Maintaining Identity
2. Creating Community
3. Sharing Decision-making
Navigation
1. Managing Transitions
2. Improving Health and Healthcare
3. Supporting Good End of Life
Transformation
1. Keeping Workforce Fit for Purpose
2. Promoting a Positive Culture

NHS
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Clinical Commissioning Group

Southwark CCC Response to the Public Inquiry in to Mid-Staffordshire NHS Foundation Trust 'The Francis Report'

Towards an approach to Commissioning for Quality March 2013

1. Introduction

The Public Inquiry into the failings of care at the Mid Staffordshire NHS Foundation Trust was commissioned by the Secretary of State in order to provide an understanding of how conditions arose within which such poor care could have been allowed to persist for so long. The Francis Inquiry was asked to recommend what changes to the healthcare regulatory and supervisory system, and to the wider culture of the NHS, would be required to guard against such poor quality care going undetected and unchallenged in the future.

This paper summarises the findings of the Public Inquiry into care at Mid Staffordshire NHS Foundation Trust and considers the implications of the Francis report of the Public Inquiry for the healthcare regulatory system and for commissioners. One of the first recommendations in the Francis report is a requirement for all NHS organisations, including commissioning organisations, to consider and respond to the report. This paper reflects on how Southwark CCG, as a commissioning organisation, should respond to the Francis Inquiry and offers some recommendations for improving the CCG's approach to quality, both in the immediate and the longer term.

2. Summary of the Findings of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust

There are 290 recommendations in the report of the Public Inquiry. Francis summarises the key aims of those recommendations as being to:

- Foster a common culture shared by all in the service of putting the patient first
- Develop a set of fundamental standards easily understood and accepted by patients, the public and healthcare staff, breach of which should not be tolerated
- Provide professionally endorsed and evidence based means of compliance with these fundamental standards which can be understood and adopted by staff who have to provide the service
- Ensure openness, transparency and candour throughout the system about matters of concern
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values in everything they do
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public and all other stakeholders in the system.

The recommendations are grouped into themes, some of which are more relevant to commissioners that others. The key themes relevant to commissioners are:

- Putting the patient first
- Fundamental standards of behaviour
- A common culture made real throughout the system
- Enhancement of the role of supportive agencies
- Commissioning for standards
- Performance Management and Strategic Oversight
- Patient, public and local scrutiny
- Openness, transparency and candour
- Leadership
- Information

The full set of recommendations is to be found as Appendix 1 to this paper (in separate pdf file).

On reading the Francis report, a very strong message emerges that the healthcare system needs to support a significant change in culture; away from complacency and defensiveness, and towards a culture where all parts of the system are alert and vigilant in respect of the quality of care being provided. NHS staff, and this is particularly relevant for commissioners and the regulatory parts of the NHS system, need to be willing to ask for more assurance when the facts point to legitimate cause for concern.

Southwark CCG recognises and supports the basic principle of 'putting the patient first'. The requirement to respond to the Francis report gives the CCG the opportunity to review its current processes and culture in respect of quality. In particular, we need to ensure that we learn the lesson of not placing too great an emphasis on performance and financial balance at the expense of patient care.

Section 5 of this paper recommends a range of actions that Southwark CCG should take in order to respond to Francis' recommendations.

3. Quality in the New Health system and other contextual considerations

The Department of Health published a guidance document 'Quality in the New Health System – maintaining and improving quality from April 2013' in January 2013, which sets out a framework for considering quality in the new system, and which embodies much of the learning from the Mid Staffordshire failings. The DH defines quality as being care that is 'effective, safe, and provides as positive an experience as possible', which reflects the three dimensions of quality articulated in the NHS Next Stage Review. This definition is a helpful one, and is one that the CCG should adopt in its thinking about quality.

Quality in the New System sets out some expectations of how organisations will ensure quality in the new NHS system from April 2013. In particular, it requires local areas to set up Quality Surveillance Systems. These will be led by the NCB Local Area Offices, and will be a forum for bringing together intelligence on quality and safety, and for sharing good practice. Southwark will be part of the South London Quality Surveillance Group, which will be led by Jane Clegg, Nursing lead for South London.

The changes as a result of the Health and Social Care Act 2012 mean that there will no longer be a SE London Cluster assurance process. The CCG needs to be able to assure itself of the quality of services received by all

Southwark patients, working within the increasingly complex set of responsibilities and relationships within the new NHS system. In particular, the CCG will need to deliver its approach to quality in partnership with the Commissioning Support Unit (CSU) and Local Authority, as well as the National Commissioning Board, and this will necessitate different ways of working.

4. Overview of current Southwark CCG arrangements for Quality

The CCG Governing Body has ultimate responsibility for assuring the quality of the services commissioned for Southwark patients. Responsibility for commissioning quality services is discharged through the governance structure of the CCG, via its sub-committee structure.

The Integrated Governance and Performance Committee (IGP) plays an important role in overseeing performance and quality issues, including complaints and Serious Incidents. The IGP considers an integrated Performance Report on a monthly basis, which gives an overview of financial and performance information relating to commissioned services, including key quality indicators.

The Governing Body (CCC) meetings take place in public each month, and the role of the Governing Body is to assure itself that the responsibilities of the CCG are being properly discharged, including the responsibility to commission safe, high quality care for Southwark patients and to promote improvement in the quality of primary care. The CCC considers the Integrated Performance report, as well as the minutes of sub-committees including the IGP and the Patient Experience and Engagement Group.

Assurance that commissioned services are providing an acceptable level of quality is managed largely through provider specific monitoring processes. For acute providers, and particularly Kings Healthcare and Guys and St Thomas Foundation Trusts, the CSU co-ordinates quality monitoring, with clinical and managerial input from the CCG. Southwark plays a lead role in arrangements for commissioning from Kings, and a Southwark clinical lead is the Chair of the Kings Clinical Quality Review Group. A wide range of quality indicators, including patient experience and complaints information, is reported to the CCG on a monthly or quarterly basis, and commissioners bring challenge to providers where the data indicates poor quality. The CCG is currently reviewing how these quality monitoring processes are run, in part as a response to the Francis Inquiry. In particular, the CCG and CSU need to consider how to ensure that there is a focus on quality in the broadest sense, including on clinical and patient outcomes, as opposed to a focus on performance and process measures.

All CCGs have responsibility to ensure providers are delivering safe services and, should a serious incident[1] (SI) occur, have investigated it in a thorough and robust manner. NHS Southwark CCG meets with its providers at least monthly to review any incidents which have occurred, and assures itself that a thorough investigation and remedial action has taken place. NHS Southwark CCG reports SI numbers and themes through the IG&P to the Governing Body.

The CCG has developed a Quality Alerts process through which Southwark GP practices can raise quality issues relating to commissioned services. The CCG, through its contracting arrangements, ensures that these Quality Alerts are investigated and that the relevant provider gives an appropriate response, including remedial actions

[1] SI: something out of the ordinary or unexpected,with the potential to cause serious harm and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

and changes to contracts as required. The CCG is able to review the Quality Alerts and monitor trends/themes emerging from Quality Alerts, which are fed into the broader commissioning process.

A diagram showing the CCG's governance structure, including the IG&P, is included as Appendix Two.

5. Recommendations for Southwark CCG

The Francis report challenges the entire NHS to undergo a fundamental culture change, something which is not easy to describe or achieve in a planned way. The CCG will seek to generate a culture of openness and transparency, and develop an integrated approach to quality. The recommendations below are intended to address the themes that Francis highlights. They do not exhaustively address all of the relevant recommendations in the Francis report, but recommendation 1 suggests that a further piece of work is undertaken to progress this :

Recommendation 1: Commissioning for Quality. It is recommended that the CCG develop a Southwark approach to 'Commissioning for Quality' which embodies the lessons learnt from Mid Staffordshire, and reflects the new arrangements for quality in the Healthcare system post April 2013. This would provide a formal framework articulating the CCG's values and describing Southwark's processes and structures for quality assurance and quality improvement. The document will also need to address how the CCG will respond to some of the broader cultural and organisational development issues that are required to strengthen the NHS's approach to quality.

The CCG's approach to commissioning for quality should have a balanced emphasis on each of the three dimensions of quality; clinical effectiveness, patient experience and patient safety. In particular, the framework should articulate how the CCG will maximise the benefits of clinical commissioning to improve clinical effectiveness and commission for improved outcomes for Southwark patients.

In developing this framework, the CCG should outline how it will address all of the individual recommendations in the Francis report which are relevant to commissioning organisations. A working group including GP clinical leads and other key CCG staff should be tasked with taking this forward.

Recommendation 2: Quality Reporting. It is recommended that some changes are made to the CCG's Integrated Performance Report to provide a richer source of intelligence in relation to quality. The enhancements to the current report would include:

- Inclusion of CQC information relating to local providers
- Narrative commentary on the key quality issues identified with each provider, on a quarterly basis, along with a summary of commissioner's actions in respect of these
- More detail on patient experience, including summaries of provider data on patient experience, national patient surveys and intelligence on issues raised by patients and the public
- A summary of Quality Alerts raised by Southwark practices, including key themes and outcomes from alerts
- Summaries of any relevant site visits or clinical audits
- An action log of quality issues identified at the IGP or through other routes (e.g. provider specific quality monitoring processes)
  An example template for Quality section of the revised Integrated Performance report is included as Appendix 3.

Recommendation 3: Structure of Integrated Governance and Performance (IGP) Meetings

The agendas of the IGP meetings should be structured so as to allow sufficient scrutiny, discussion and challenge of the reported quality positions, as well as to provide an environment where 'under the radar' issues can be identified. Committee members will be expected to have pre-read the Integrated Performance and Quality report, and the discussion at the meeting will allow sufficient time for members to explore any issues of concern. The IGP meeting papers should include an action log of concerns/questions raised by members, and the chair will ensure that issues are followed up/closed/escalated as appropriate. The action log will be reported to the SCCC . A way of linking the issues raised at EPEG and at the IGP should be found, so that patient experience concerns arising from the PPG pyramid or via other means are formally considered by the IGP alongside the Integrated Performance and Quality report.

Recommendation 4: Understanding Patient Experience Information. The CCG should work closely with providers to review and understand the full range of available data on patient experience, including looking at variations in experience between and across wards and different clinical areas.

Recommendation 5: Developing innovative approaches to hearing the patient voice. The CCG should review how it currently engages with patients and the public, including reviewing national best practice and explore innovative approaches to gathering and learning from a wider range of patients.

Recommendation 6: A focus on all providers' performance. Provider-specific performance management structures relating to Southwark's three main NHS providers (Kings College Hospital NHS FT, Guys and St Thomas NHS FT and South London and the Maudsley NHS FT) are relatively strong and transparent, although we should not be complacent about this, and there will always be potential for strengthening these processes. Quality and performance management of other commissioned services is less well developed, and in particular there is a need for a stronger approach to quality assurance in services commissioned from the independent sector, and particularly in relation to care homes. The CCG is already looking at this area, and it is recommended that the CCG work jointly with Southwark Council and Lambeth CCG to develop an approach to improving quality in this area.

Recommendation 7: Making quality everyone's business. The CCG should ensure that all CCG staff are aware of the Francis Inquiry and its key recommendations. Staff development events should focus on the role that all staff can play in being vigilant about, and supporting the quality of patient care.

Recommendation 8: Review Serious Incident Processes. It is recommended that Southwark CCG review its management of Sis in conjunction with the CSU and neighbouring CCGs in order that process are aligned and meet good practice in all respects, and that we work collaboratively with partners to ensure that Southwark CCG has equally robust assurance of all providers. The IGP should maintain an overview of the SI processes and receive quarterly reports on Serious Incidents, including the learning from these.

Recommendation 9: Clinical Service visits and audits

To enhance commissioners understanding of the quality of patient care, it is recommended that CCG clinical leads and staff spend more time visiting clinical services and undertaking clinically focussed audits. The CCG should work with the CSU and providers to determine a work programme, focussing on priority areas in 2013/2014.

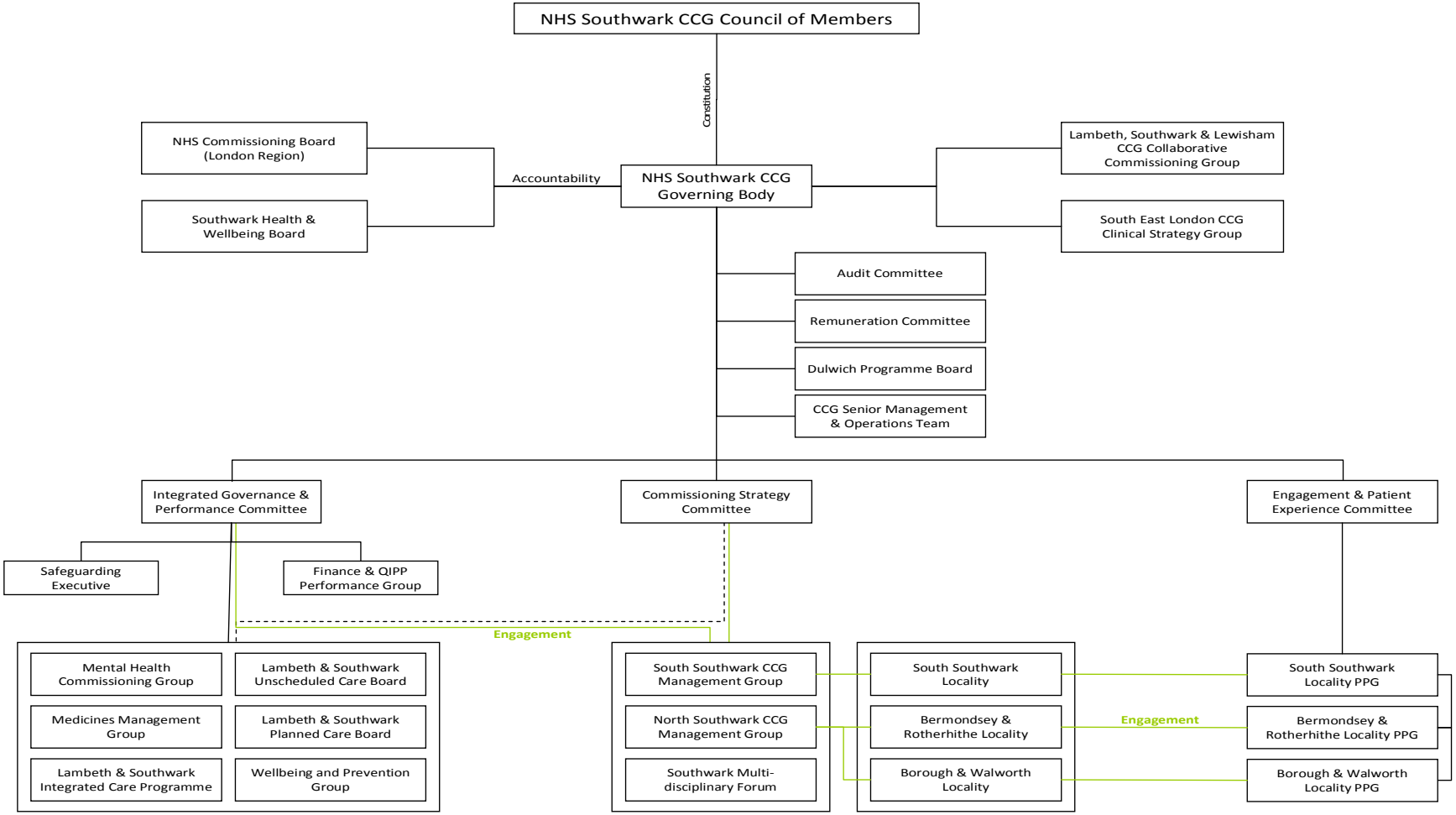
6. Conclusion

The events at NHS Mid-Staffordshire amounted to an unacceptable failure of the NHS as a system to safeguard patients and to ensure the provision of adequate care. However, Southwark CCG welcomes the Francis report as a forceful reminder that the NHS as a whole should have quality and the needs of the patient as its central concern. We accept the key findings and aims of the Francis report's recommendations and are committed to ensuring that the CCG takes those recommendations forward, through implementing the recommendations made

in this paper, and in having a consistent focus on quality throughout the CCG's future commissioning responsibilities.

NHS Southwark Clinical Commissioning Group

Appendix Two – Southwark CCG Governance Structure



The best possible outcomes for Southwark people

Quality Section of Integrated Performance Report

2013/14

Month X

28 February 2013

Section 1: CQC Intervention

Name of Provider	CQC Intervention Action Reported	Date of CQC Intervention	Description of CQC Enforcement and Agreed Improvement Plan / Trajectory	Description of CCG Process of Assurance (Note: Responsible Clinician and Officer)

Section 2: Quarterly Key Quality Issues and Action Plans (by Provider)

King's College Hospital NHS Foundation Trust			
	Quality Issue Identified	**Commissioner Action**	**CCG Group with Oversight**
1			
2			
3			
4			
5			

Guy's & St. Thomas' NHS Foundation Trust

	Quality Issue Identified	Commissioner Action	CCG Group with Oversight
1			
2			
3			
4			
5			

Guy's & St. Thomas' NHS Foundation Trust – Community Health Services

	Quality Issue Identified	Commissioner Action	CCG Group with Oversight
1			
2			
3			
4			
5			

South London & Maudsley NHS Foundation Trust

	Quality Issue Identified	Commissioner Action	CCG Group with Oversight
1			
2			
3			
4			
5			

Independent Sector Providers (including nursing and domiciliary care)

	Quality Issue Identified	Commissioner Action	CCG Group with Oversight
1			
2			
3			
4			
5			

Primary Care (including WIC, community outpatients etc.)

	Quality Issue Identified	Commissioner Action	CCG Group with Oversight
1			
2			
3			
4			
5			

Section 4: Patient Experience (All Providers)

Patient Data Source	Summary of Patient Experience Data (all providers)	CQC Actions	Issues added to Quality Log? (Reference)
National Surveys			
Provider Generated Survey (e.g. KCH 'How are we Doing Survey')			
Complaints – Key Themes			

Patient Data Source	Summary of Patient Experience Data (all providers)	CQC Actions	Issues added to Quality Log? (Reference)
Patient Engagement – Key Themes			
Other patient/public key themes – Media / national reports etc.			

Section 5: Summary of Quality Alerts Flagged by Southwark Practices

Quality Alerts			
	Quality Alerts Raised	**Alerter**	**Date**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

For common themes and actions see table below

Quality Alerts: Themes & Actions

	Quality Alerts Theme	CCG Actions	Outcomes
1		1. 2. 3. 4. 5. 6.	1. 2. 3.
2		1. 2. 3. 4. 5. 6.	1. 2. 3.
3		1. 2. 3. 4. 5. 6.	1. 2. 3.
4		1. 2. 3. 4. 5. 6.	1. 2. 3.
5		1. 2. 3. 4. 5. 6.	1. 2. 3.

Southwark Clinical Commissioning Group

Section 6: Clinical Visits and Clinical Audits

Clinical Site Visits & Audit

Provider Audited/Visited:	
Name and Purpose of Audit/ Visit:	
Description of Audit / Visit	

	Key Actions Agreed	By Whom	By When
1			
2			
3			
4			
5			
6			

Clinical Site Visits & Audit

Provider Audited/Visited:	
Name and Purpose of Audit/ Visit:	
Description of Audit / Visit	

	Key Actions Agreed	By Whom	By When
1			
2			
3			
4			
5			
6			

Section 7: An Action Log of Quality Issues Identified

Reference	Quality Issue	Description of Quality Issue	RAG			Actions Planned	Responsible Officer	Date Quality Issue Fully Mitigated
			Likelihood	Severity				
CCG1					1			
					2			
					3			
					4			
					5			
CCG 2					1			
					2			
					3			
					4			
					5			
CCG 3					1			
					2			
					3			
					4			
					5			
					1			
					2			
					3			
					4			
					5			
					1			
					2			
					3			
					4			
					5			
					1			
					2			
					3			
					4			
					5			

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Southwark CCG's response to the Francis Enquiry

Health Scrutiny Committee 15th October 2013

The best possible health outcomes for **Southwark people**

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Content:

- Key recommendations of the Francis report
- Southwark CCG's response March 2013
- What the CCG has done to implement its recommendations
- Future priorities

Francis Report:
Key recommendations

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Clinical Commissioning Group

- Foster a common culture shared by all in the service of putting the patient first
- Develop a set of standards easily understood and accepted by patients, the public and healthcare staff, breach of which should not be tolerated
- Provide professionally endorsed and evidence based means of compliance with these standards which can be understood and adopted by staff who have to provide the service
- Ensure openness, transparency and candour throughout the system about matters of concern
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values in everything they do
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public and all other stakeholders in the system.

Key themes for commissioners:

NHS Southwark Clinical Commissioning Group

- Putting the patient first
- Fundamental standards of behaviour
- A common culture made real throughout the system
- Enhancement of the role of supportive agencies
- Commissioning for quality/standards
- Performance Management and Strategic Oversight
- Patient, public and local scrutiny
- Openness, transparency and candour
- Leadership
- Information and reporting on quality are crucial

Southwark CCG's response:

NHS Southwark Clinical Commissioning Group

Proposal for an immediate response to the Francis Report taken to the CCG Governing Body meeting on March 2013

Southwark CCG report proposed a series of recommendations for action by the CCG

Recommendations accepted by the Governing Body

CCG Senior Management Team convened as Quality SMT, meeting first fortnightly and now monthly to take the recommendations forward

CCG is a member of King College Hospital Francis working group – greater openness between commissioners and providers re quality

CCG engaged in Quality Surveillance Group across London

Southwark CCG's recommendations:

NHS Southwark Clinical Commissioning Group

1. Develop an explicit Commissioning for Quality framework
2. Improve information and reporting on Quality
3. Use Governance Structure to focus on quality in all its dimensions
4. Make better use of information on Patient Experience
5. Develop innovative approaches to hearing the patient voice
6. Focus on patient journeys rather than a few key providers
7. Make quality the business of all CCG employees
8. Review processes for Serious Incidents
9. Site visits and audits of clinical services

What progress have we made:

NHS Southwark Clinical Commissioning Group

- ✓ The CCG now monitors quality in a fuller way, using a richer quality information data set distinct from performance
- ✓ Quality agenda sits with Integrated Governance and Performance Committee,
- ✓ Quality focus to all Governing Body meetings
- ✓ Reviewed the information that we have on patient experience and how we use it in commissioning and assurance processes
- ✓ Agreed approach to co-production and co-design with patients
- ✓ Developed our approach to clinical site visits and begun to carry these out
- ✓ Staff away days focussing on quality
- ✓ Quality embedded in objectives for all staff

What have we still got to work on:

NHS Southwark Clinical Commissioning Group

- Develop more and better ways to hear patient's views and link them into our commissioning and monitoring processes
- Publish our commissioning for quality framework and take forward some further recommendations into our commissioning processes
- Embed clinical effectiveness in all our commissioning and redesign plans
- Link up better with regulatory bodies and other commissioners

This paper contains Healthwatch Southwark's initial response to the issues raised within the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, the Francis Report.

Our commitment
Our vision is that allSouthwark residents can access and expect the best possible health and social care services. As the 'consumer champion' & patient and public voice Healthwatch Southwark is committed to the monitoring of the following:

- Patient experience, engagement and involvement across health and social care organisations and commissioning structures
- Quality of services
- Patient Safety
- Reduction of Health inequalities and inequalities in social care services provision

We will work with residents, Providers and Commissioners to ensure that care services are monitored to the best of our ability. We know that we are not the only body where patients and the public can get involved in their local services however, we want to be recognised as the most effective body that we can be. There will be times where we need to "hold to account" and act as a "critical friend" to the NHS, Southwark Council and other publicly funded organisations. In all of our actions we will reflect the needs of our population.

Patient and Public Engagement & Involvement
The failures at the Mid Staffordshire NHS Foundation Trust concerned a wide range of bodies including the Trust itself whereby there were a plethora of systematic failures, the Health Scrutiny Committee and the Stafford Local Involvement Network (LINk) & their ineffectiveness. Patients and Carers were not listened to and their concerns were not acted upon. The culmination of these issues led to the terrible tragedies of the loss of lives and the poor care received people in the Stafford Hospital. A quote from the Francis Report about the LINk reads…

"Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all."

Healthwatches need do what they were set up to do. We need to be outward looking whilst ensuring that we have the inwards systems in place to deal with issues of concern that arise.

Methods of monitoring
Some of the ways we will monitor services are below:

- *Collecting local views and experiences*- this includes the views of local residents, workers and students about Health and Social Care services

- *Healthwatch England* - having an effective relationship and cascading service issues when necessary
- *Quality Accounts*- Healthwatch provides comments each year to Guy's & St Thomas', Kings College Hospital& South London &Maudsley NHS Foundation Trusts and monitor these & other subjects throughout the year in meetings with the Trusts
- Local Authority *Local Accounts* and Healthwatch involvement in Quality monitoring mechanisms
- Local Authority *Partnership boards & groups* e.g. London Borough of Southwark Mental Wellbeing Partnership Group
- Local Authority *Care Home Quality Strategy* Steering Group
- *South London Quality Surveillance Group* (part of wider London region Group)
- *Clinical Commissioning Group (CCG)* Governing Body and its various committees
- Contribution to CCGs *quality* focused documents
- *Health & Wellbeing Board*
- *Healthwatch England*

What does this mean in relation to our Priorities
The table below outlines our four priority areas for the next 12 months (till 09/14) including the rationale. We will also monitoring other areas on a 'watch list' such as services for people with Diabetes & Cancer care. We will need to ensure that in each of our four areas we consider patient experience, patient safety, inequalities and quality of services.

Priorities (next 12 months till September 2014)	**Rationale**
Mental Health services (Access to)	Major changes happening in Social care Day service opportunities, service user involvement within South London & Maudsley NHS Trust, primary and community care.
GP Access	Different communities have raised issues re. physical access, appointments, registration. Health & Adult Social Care CC Scrutiny Sub-committee have GP Access as a priority
Social Care (focusing on those not meeting the FACS eligibility criteria)	A range of sources siting concern around the availability of support/ services for those who do not qualify to receive Personal Budgets
Sexual & Reproductive Health Services	Major issues in Southwark (& Lambeth) around HIV diagnosis, young people's sexual health.

Next steps…We will produce a joint statement of intent to work with Healthwatch Lambeth & Lewisham and the other South East London Healthwatches to monitor quality, patient experience and patient safety.

NHS
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Clinical Commissioning Group

Southwark's Primary and Community Care Strategy

2013/2014 – 2017/2018

Southwark Primary and Community Care Strategy

2013/2014 – 2017/2018

Table of Contents

Executive Summary

Southwark is a highly diverse borough, which is changing fast. Health outcomes and life expectancy are improving, but there are still significant health needs and wide variations in outcomes for individuals within the borough.

Primary and community care services are the first point of contact with the NHS for most people. Primary and community care services include GP practices, dentists, optometrists and pharmacists, as well as community services such as health visiting, district nursing and more specialist community services. GP practices are often termed the 'bedrock' of the NHS, providing continuity of care for people over their lives; supporting the prevention of ill health, and providing a range of care to keep people well and to manage health problems when they arise.

This plan concentrates on the provision of services by GP practices as well as community health services. It describes how we will achieve our aims to improve outcomes for patients as well as providing better value for money.

Some of the care provided for Southwark patients is excellent and there are many examples of innovative and high quality care. We know that Southwark people value primary and community care services highly, and want to see a better range of services available outside of hospital, either in or close to their home.

However, our primary and community care services are under increasing pressure from increasing demand as well as constraints on funding. Despite improvements in some areas over recent years, overall the quality of care and outcomes from Southwark's primary care services are not as good as we would like them to be. The range of services and the quality of those services is sometimes patchy across the borough, and patients do not all receive the same range and standard of services. This plan outlines how we will improve the consistency and equity of services available to Southwark people, supporting improved outcomes.

Within Southwark we have an ambitious vision for the provision of care out of hospital. To deliver on this vision we need to make sure that our primary and community care services are fit for the future. This will mean that the way that services are organised will need to change, to ensure viability for the future and to be able to meet the requirements of the population.

Key themes within this strategy:

Population health management and reducing inequalities: Good primary and community care services are fundamental to managing the health of populations and reducing health inequalities. Southwark CCG intends to strengthen the capacity and capability of its services in order to continue to focus on population health management in future.

Improving outcomes: Southwark CCG's mission is *'To achieve the best possible health outcomes for Southwark people'.* We will do this by commissioning services which focus on targeting health inequalities and by ensuring that primary and community care services are strong and able to deliver consistently high quality care for all patients. The way that services are organised will need to change to make this a reality. This strategy sets out the

need for the development of services based on localities within Southwark, with services working together at greater scale to share resources and good practice to deliver better quality care.

Improving access: The CCG believes that all patients should have access to the same range of and quality of services to meet their health needs. We also plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. To achieve this, we will commission more consistent community based services, and co-locate services in community health centre 'hubs' where this allows for better clinical care and is cost effective.

Integrated services: People should experience care that is seamless and tailored to their individual needs. Southwark is working to integrate health and social care services so that people receive better co-ordinated care, regardless of the agency which provides that care. Strong primary and community care services are fundamental to the development of more integrated care. Our plan describes how we will support better integrated care, including how the organisation of services will need to change in order to make truly integrated care a reality.

Providing more care out of hospital: This plan is part of the way that Southwark CCG will achieve its objective of providing more care out of hospital. This will include more preventative care, more home based care and an extended range of services available in primary care to prevent the need for more specialist treatment. We will commission a greater range and volume of care outside traditional hospital settings, where this provides better clinical care, patient experience and value for money.

Organisational development: Primary and Community care services are under a lot of pressure and will not be able to respond at pace to the need for improvements in care without significant changes to the way that they work. This will mean services working together at greater scale to deliver service improvement. We plan to support the development of locality based care as a way of bring services together to meet the needs of local populations within the borough, working outside the traditional remit of individual GP practices. This plan lays out how we will support a programme of development for GP practices to build their capability for improving care and providing an extended range of services in future. This will also extend to supporting GP practices to work better with other agencies to provide more integrated care.

Enabling improvements: To enable delivery of this strategy we will focus on developing the primary and community care workforce, improving premises and developing integrated IT systems. We will also need to change some of the ways that we commission and contract for care in order to make some of our planned improvements happen, particularly ensuring more consistent service provision and better outcomes for all.

Summary: This plan describes Southwark CCG's intentions to build strong local services to meet the challenges of improving care over the next five years. It is supports a range of our other plans and priorities as well as reflecting national policies and thinking on the best way to ensure that primary and community care services are fit for the future.

Southwark's Primary and Community Care Strategy

2013/2014 – 2017/2018

1. Introduction

Good primary and community care services are a cornerstone of the NHS, playing a vital part in improving population health and preventing ill-health. Primary care services often provide the first point of contact for people when they become unwell and, together with community based services, co-ordinate the care of people with long term conditions, older people and those reaching the end of their lives. Primary and Community care services also provide some of the most important universal services for babies and children in their early years, supporting parents to keep their children well.

Southwark people have told us how much they value primary and community care services, and that they increasingly want to be able to access a wider range of services without having to attend hospital. As more and more care can be provided in, or close to, patients' homes we need to ensure that Southwark's services are fit for the future; that they can take up the challenge of providing excellent and innovative care, centred around individuals, as well as being able to continue to provide the range of core services which are an essential part of the NHS system.

This document outlines how Southwark CCG plans to improve the quality, capacity and capability of primary and community care services in the borough in order to meet that challenge. This strategy has been developed as a result of engagement with a wide range of stakeholders, Southwark patients and members of the public.

1.1 Drivers for Change

Southwark Clinical Commissioning Group (CCG) was created in April 2013 as a result of the wide-ranging changes to the NHS system in England within the Health and Social Care Act. The CCG is responsible for commissioning a wide range of health services for the Southwark population, including many community services, and for improving health outcomes and reducing health inequalities. Although CCGs are not responsible for directly commissioning primary care services (including GP services, dentists, pharmacies and opticians), they do have a statutory duty to improve the quality of primary care. This strategy has been developed in response to describe how the CCG will carry out its responsibilities within the new National Health System.

In addition to changes to commissioning structures within the NHS, there are a number of factors leading to the need to a clear strategy for changing the way that services are delivered in Southwark. Some of the key drivers for change are described below:

i) Variability in quality and outcomes. We know that there is a wide range in the quality of care provided by GP practices and some community services. This is not something unique to Southwark, but is still something that results in unwarranted variation in outcomes for patients. In developing

this Strategy, we carried out a review of the current situation in terms of the quality, outcomes, capacity and capability of Southwark services. This has informed the determination of our strategic priorities and is described more in section 4.

We believe that variations in the quality of care that are due to the organisation of services are not acceptable. The priority actions put forward in this strategy are our response to the extent of variation in quality and delivery that currently exists, and form Southwark's plan to improve access to high quality care for all patients.

ii) Primary and Community Care services are under pressure. Demand for healthcare increases every year as a result of a combination of factors including; population growth, an aging population, increasing expectations of patients and advances in medical science. Investment in primary and community care services has not always kept pace with these increases in demand and services in Southwark, as in other parts of the country, are under increasing pressure. In addition to increasing demand for care, GP practices are now required to take responsibility for commissioning as members of the CCG, which adds an additional responsibility to their clinical work. The analogy of 'a hamster in a wheel' is frequently used by primary care professionals to describe how they work, and staff report being too busy to take time to develop innovative ways of delivering care and to focus on service and quality improvement. In developing our strategy, we sought to address how services can respond to increasing demand by working differently.

iii) Responding to financial pressures and creating a sustainable local health service for the future
Primary and Community care services often provide a low cost service focussing on prevention, keeping people well and the early identification and diagnosis of health problems, all of which have positive benefits in terms of people's well being as well as helping to avoid the costs of more expensive treatment when conditions go undetected or are not well treated in the early stages.

NHS services are under increasing financial pressure, and Southwark CCG is no exception to this. As we face financial constraints over the next five year, we need to provide better value healthcare. Strong primary and community care services can help us to provide more value based healthcare, by preventing the need for more expensive treatments, and by moving some care out of hospital, where it can be more cost effectively be provided in a primary or community care setting.

iv) Supporting the integration of services
Southwark CCG is committed to developing more integrated services, which offer a patient centred and seamless response, through agencies working together in a co-ordinated way. Southwark CCG is working with the Southwark and Lambeth Integrated Care programme (SLIC) and we have made some good progress locally towards developing integrated care, beginning with services for the frail elderly. To be able to fully adopt new ways of working in the interests of better patient care, traditional organisational and professional boundaries may need to change. We believe that integrated care for the future needs to be based around the care of local populations, and to take a more person-centred approach. This will mean that primary and community care staff will need to work differently in future, working more closely with a range of other professionals and agencies to co-ordinate the care of individuals in response to their needs.

v) Addressing key health issues and reducing health inequalities

Although life expectancy is increasing rapidly in Southwark, there are still dramatic differences between the life expectancy and health outcomes for patients in different parts of the borough, and between men and women. We have developed this strategy in response to what we know about poor health outcomes in Southwark and the reasons for them, and this is described in more detail in sections 3 and 4.

This strategy takes as two of its key principle aims improving equality of access to care in accordance with the needs of the individual, and improving health outcomes for Southwark patients. Our strategic objectives and our proposals for improving services reflect our approach to delivering this, working in partnership with other stakeholders, and in particular Southwark Local Authority and the Health and Well Being Board.

Taken together, these drivers for change mean that primary and community care services need to work differently in future to meet the challenges of providing high quality healthcare.

1.2 Links to Other Strategies

Southwark's strategy for primary and community care sits within our overall approach to commissioning better health services and making best use of our financial resources. Developing a strategy for better primary and community care services is central to the delivery of Southwark CCG's Integrated Plan, and links to a number of other key strategies. In particular, this strategy is consistent with and supports the delivery of the following strategies and plans:

1.2.1 Southwark CCG's Integrated Plan - *The best possible outcomes for Southwark People*

The Integrated Plan is the CCG's main strategic document and sets out a plan for the things the CCG will work to achieve over the medium term. The purpose of the Integrated Plan is to set out our ambition for the local health economy over the next 5 years. The plan specifies the CCG's priority areas for improvement, the major work programmes and commissioning activities we will undertake. This document also sets out the key outcome indicators we will use to gage progress over the lifetime of the strategy.

The five strategic goals within the CCG's Integrated Plan are:

- To achieve a reduction in health inequalities
- To achieve a reduction in premature mortality
- To achieve a reduction in the variability of primary care outcomes and quality
- To have all practices play and active part in commissioning
- To have patients play a central role in commissioning

The Southwark Integrated Plan can be accessed by following this link:

http://www.southwarkccg.nhs.uk/about/Our-Plans/Documents/

The CCG will shortly be revising and refreshing its overall commissioning strategy to cover the period 2014 – 2019. The revised CCG Integrated Plan will incorporate the objectives and planned actions of this Primary and Community Care Strategy.

1.2.2 South East London Community Based Care Strategy

One of the key drivers in developing Southwark's Primary and Community Care Strategy was to describe how Southwark will achieve the aspirations of the South East London Community Based Care (CBC) Strategy, with particular emphasis on the workstream on Primary and Community Care.

The CBC strategy is a collaborative programme to develop out-of-hospital and community care across six south-east London boroughs. The transformation of our community care is fundamental to improving services to patients and local people, and the aim of the CBC strategy is to support the hospital change programme across South East London by accelerating the development of community based care.

The CBC programme recognises that each borough has a different starting point and very different populations and needs. Each CCG has committed to achieving commons aspirations, so an ethos of '*shared standards, local delivery'* has been adopted. Where there is a common need for change the CCGs will work together, but much of the strategy will be delivered by boroughs working singly or in pairs.

There are three main work streams within the CBC strategy, which are:

- **Primary and Community (including Urgent Care):** providing easy access to high quality, responsive primary and community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy.

- **Integrated Care (people with long term conditions including mental health problems):** Ensuring there is high quality integrated care for high risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health and social care) are working together, with the patient at the centre.

- **Planned Care:** for episodes where people require it, they should receive simple, timely, convenient and effective planned care with seamless transitions across primary and secondary care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics

There are five enabling work streams for the CBC strategy which are:

- Workforce
- Self Management
- Information Systems
- Contract Levers
- Communications and engagement

The full strategy can be accessed via the following link:

http://www.tsa.nhs.uk/document/appendix-o-strategy-community-based-care-south-east-london

1.2.3 Southwark's Health and Wellbeing Strategy

Health and Wellbeing Boards are statutory groups which are responsible for improving population health and wellbeing at a borough level. Southwark's Health and Wellbeing Board is in place after

operating in shadow form over the last year, and is a multi-agency group chaired by the Leader of Southwark Council, with strong representation from the CCG, the Police and other agencies. The Board's remit is to promote and deliver joint working across the Local Authority, Health and other agencies to reduce health inequalities and address the wider determinants of ill health, such as poverty, joblessness and other social issues. The Health and Wellbeing Board agreed its initial 2013/2014 strategy in July 2013, committing to three priority areas that the partners on the Board will address both collectively and individually. Those priorities are:

- The best start for children, young people and families
- Building healthier and more resilient communities and tackling the root causes of ill health
- Improving the experience and outcomes of care for our most vulnerable residents and enabling them to live more independent lives

The Primary and Community Care Strategy is one of the ways in which the CCG will deliver its commitment to work on the above three priorities, through delivering strong primary and community care services with an emphasis on providing universal, preventative services which have a focus on patient centred care and supporting people to be more in control of their health.

1.2.4 Other National Publications and Policies

The development of this strategy was also informed by a number of policy and research publications which address the transformation of primary and community services. Some of the documents which have informed our thinking include;

- The Kings fund (2011) *Improving the quality of care in general practice – report of an Independent Inquiry commissioned by the Kings Fund*
- The Kings Fund (2012) *General practice in London: supporting improvement*
- The Kings Fund and Nuffield Trust (2013) *Securing the Future of general Practice: New Models of Primary Care*
- The Royal College of General Practitioners (2012) *General Practice* 2022 A vision for General Practice in the future NHS
- Department of Health (2011) *Transforming Community Services*

2. How we engaged with people in developing this strategy

2.1 In developing this strategy, Southwark CCG sought to engage widely with patients, the public and key stakeholders, to ensure that our strategic direction reflected the views of people who use, and work in, health services in Southwark. We worked with patients and members of the public, as well as other stakeholders to co-produce the strategic objectives of the strategy, and inform our vision of how services should be developed over the next five years.

The development of this strategy was led by a steering group including Healthwatch and NHS England, and the steering group designed a programme of engagement events.

We held an open event for patients, the public and interested stakeholders including as community health staff, community pharmacists and the voluntary sector, focusing on some key questions:

What do good primary and community care services look like?
How should services be organised in future?

Other ways in which we sought input were by holding discussions and sharing drafts of this document with a range of stakeholders including:

- key provider organisations including GST community services, Kings College Hospital and GST acute services
- Southwark CCG's member practices, through the locality groups, via CCG communications and an event for all practices
- Southwark Local Authority, particularly Public Health
- Southwark and Lambeth Integrated Care programme
- The CCG Engagement and Patient Experience Committee
- Southwark Local Medical Committee

2.2 Links to the consultation of services in the Dulwich locality

This strategy was developed at the same time as the CCG was consulting on specific proposals to improve services in the Dulwich locality, in the south of the borough. The engagement with the public in respect of Dulwich services helped us to get a view from patients on the range of services that they would like to see provided out of hospital, and how they would like to see primary and community care services organised in future. This consultation has led to some specific recommendations about the organisation of services in future, including the development of more services out of hospital, and the creation of community health centres or 'hubs'.

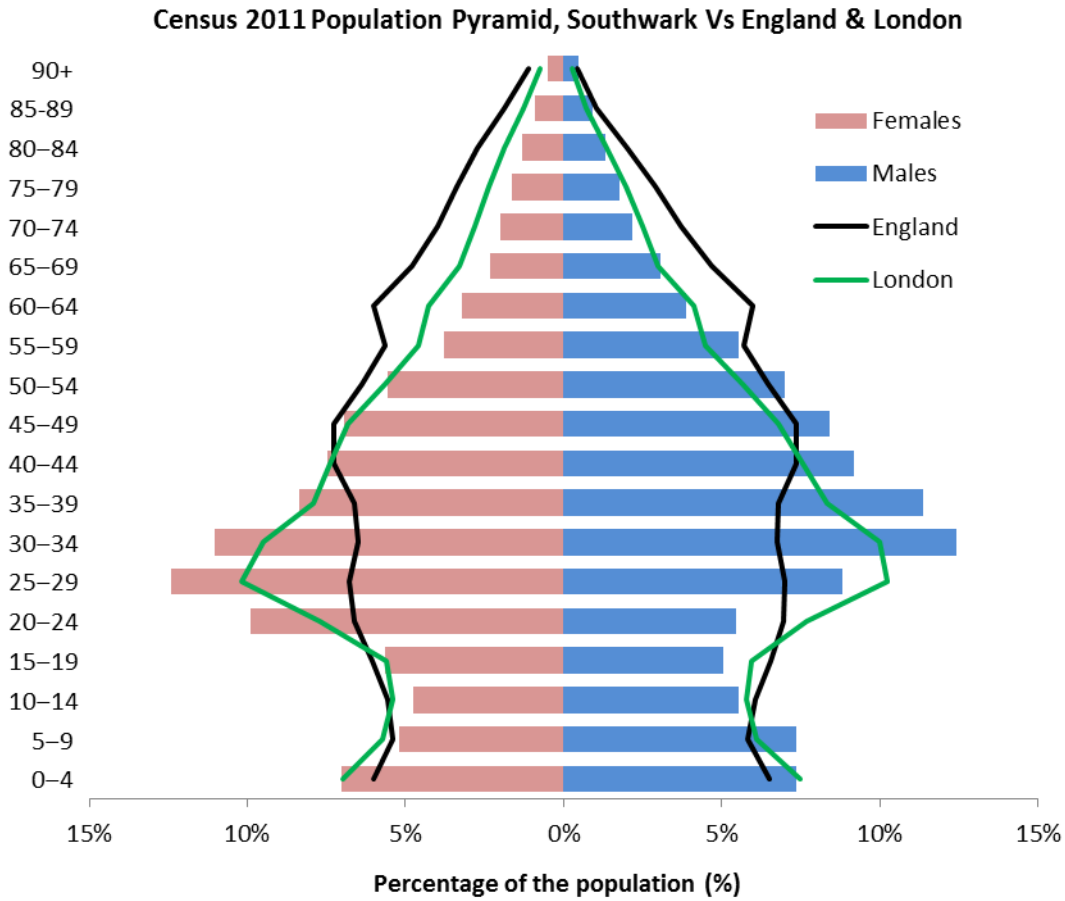
The development of services which serve local communities better is an important part of this strategy and is described in more detail later in this document. Developing services in the Dulwich area, including proposals for a community hub, is one of our priorities for implementing this strategy, and will be followed by specific proposals for out of hospital services in the other parts of Southwark.

3. Southwark's Population and Health Needs

3.1 Southwark's Population

Southwark is a densely populated, geographically small and narrow inner London borough that stretches from the banks of the river Thames to the beginnings of suburban London south of Dulwich. The population is relatively young and ethnically diverse, with significant contrasts of poverty and wealth. There is wide distribution in educational achievement, access to employment and housing quality. Major regeneration programmes have been underway for some time leading to significant changes in landscape and population structure and this continues to be the case. Major health indicators such as mortality and life expectancy have improved, but there are significant inequalities in these indicators for people living in different parts of the borough.

Southwark's population is growing fast. The 2011 Census recorded Southwark's resident population at 288,200 which is an increase of 18% since 2001. The latest mid-year estimate (2012) estimated the population at 293,530. The population registered with Southwark general practices has also increased from 298,000 in 2007-08 to 305,841 by April 2013. The population pyramid (below) created using Census 2011 resident population data, shows a younger population in Southwark compared to England and London.



58% of Southwark's population are aged 35 or under and Southwark has the 9th highest population density in England and Wales. Southwark is ethnically diverse with highest proportion of residents born in Africa in the country (12.9 per cent), as well as significant populations from Latin America, the Middle East, South East Asia and China. 75% of reception-age children are from Black and Minority Ethnic (BME) groups with over 120 languages are spoken in Southwark.

The population is expected to continue to grow. By 2031, the Southwark resident population will have grown by 26% to 369,000 individuals compared to 288,200 at present. The adult population aged 18-64 will see the largest growth followed by the <18 and 65+ population.

3.2 Key Health Facts for Southwark

- Male Life expectancy is 78.2 years compared to 78.5 years in England.
- Female Life expectancy is 83.4 years compared to 82.5 years in England.
- Infant mortality rate (death in babies under 1 year) has decreased year on year and but is 6.17 per 1000 live births compared to 4.29 in England.
- Lifestyle risk factors such as alcohol/substance misuse, smoking, unhealthy diet (e.g. child obesity) and unprotected sex continue to be a major risks to good health in the population.
- As a consequence there is higher incidence of emergency hospital admissions due to alcohol related conditions, high rates of teenage pregnancy and HIV, high rate of premature deaths from cancer and cardio-vascular diseases and high prevalence of mental illness in the local population.

- Coronary heart disease, malignant neoplasms (cancers) and respiratory diseases remain the top 3 causes of death in the population.
- Disease prevalence models have shown that there are high numbers of undetected cases of diabetes, hypertension and heart disease in the Southwark population. Early detection and treatment is beneficial for patient's health outcomes as well as cost of treatment to the NHS.

- High unemployment, poor housing and poverty impact on the health of Southwark people and can lead to poor physical and mental health in children and adults

The Southwark Joint Strategic Needs Assessment can be accessed via the following link:

http://www.southwarkjsna.com

4. Primary and Community Care Services in Southwark

This section describes the current range of services provided in Southwark in terms of the provider landscape, the capacity and capability of primary and community care providers, and the quality of care provision, including variation in patient outcomes.

4.1 Scope of the strategy

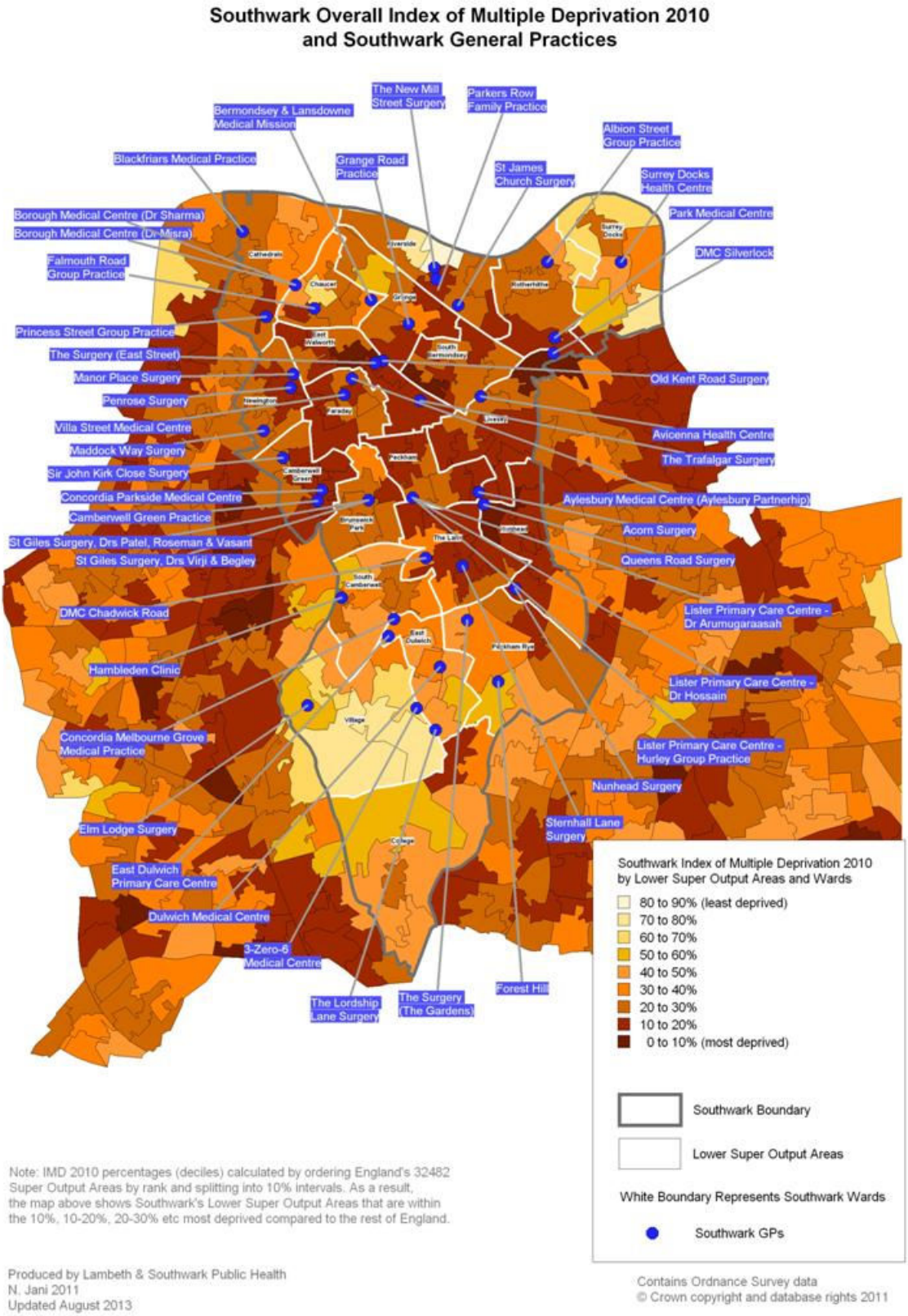
The main focus of this strategy is on primary care services delivered by GP practices. . We recognise that dentists, community pharmacists and optometrists' services play a vital role in health promotion, screening and the provision of health advice and treatment. Wider primary care providers can contribute to providing more care out of hospital and play a role in managing demand for other health services. We will explore the potential of other primary care services to support the redesign of care pathways, including providing better access to health advice and treatment, and support for self-care and self management. Dentists, community pharmacists and optometrists are commissioned by NHS England from the 1st April 2013.

Southwark CCG will seek to involve a wider range of providers in delivering healthy living services in future, working with the Local Authority to do this. In addition to traditional community health services, a variety of community resources can support people to keep health and well, and the CCG wants to involve a range of providers, including non-NHS and third sector organisations, in developing innovative approaches to preventing ill-health, supporting people to manage their health and to become part of integrated health and social care services.

4.2 GP Practice Services

There are 45 practices GP practices in Southwark with a combined registered patient list of 305,841 on 1st April 2013. GP practices are grouped into three localities for the purposes of the Clinical Commissioning Group, Bermondsey and Rotherhithe, Borough and Walworth and South Southwark.

Table 1: Map of Southwark GP practices against index of multiple deprivation



All Southwark practices are required to be open from 8.00 – 6.30 pm. Outside of these core practice opening hours, urgent primary care is provided by Out of Hours Services. The majority of Southwark practices have not opted out from responsibility for Out of Hours Care, and are members of South East London Doctors' Co-Operative (SELDOC), a co-operative organisation of member practices which provides Out of Hours Services across Lambeth, Southwark and Lewisham CCGs, including telephone advice, GP consultations and home visits. A small number of Southwark practices have opted out of Out of Hours Care, and the CCG commissions Out of Hours services for the patients of those practices from SELDOC.

In addition to SELDOC, there is an 8am-8pm GP Led Health Centre at the Lister Health Centre in Peckham, which provides walk-in based care for registered and un-registered patients, 7 days a week. At the time of writing, the national 111 phone service has not been fully rolled out in Southwark, and telephone advice for patients continues to be largely provided by SELDOC.

4.3 Community Services

'Community services' is used in the context of this strategy to describe a range of health services which are not based in traditional acute hospitals or in traditional GP practices. Community services include a very broad range of services, including community pharmacies, community nursing and community mental health services, as well as some more specialist services. Many community services are provided on a domiciliary basis, in patients' own homes, and community services are a vital service for patients who are housebound or who have mobility problems. Community services also include range of specialist community services or out of hospital services which provide intermediate outpatient services in a community setting, and prevent the need for people to attend hospital clinics for diagnosis and treatment of some simple conditions. Within Southwark, there are community based clinics for a range of conditions including dermatology, diabetes and heart failure, which offer an intermediate level of service avoiding the need for patients to be seen in hospital.

Community services will play an important part in the transformation agenda, including developing integrated care services and providing more services out of hospital and in people's own homes.

4.3.1 Community Health Services:

The majority of community health services for Southwark patients are provided by Guy's and St Thomas' Community Health Services, part of Guys and St Thomas' NHS Foundation Trust. A full list of community services is included as Appendix 1.

Responsibility for commissioning community services underwent significant changes from 1st April 2013. Some services, including Health Visiting and pharmacies, transferred to the commissioning responsibility of NHS England, while other services transferred to the responsibility of Local Authorities, including sexual health services and school nursing. Southwark CCG will continue to act as the lead commissioner for most of these services on behalf of either NHS England or the Local Authority, and will work in partnership with responsible commissioners and Lambeth CCG in respect of the commissioning of Guys and St Thomas' NHS Foundation Trust.

Community services in Southwark play an important part in supporting general practice teams to keep people well in their own homes, as well as providing a range of more specialist services for adults and children. Southwark CCG has made recent investment in community services to support people to remain at home instead of needing a hospital admission and we will continue to support the development of community services to deliver integrated care and better care-co ordination.

Our priorities for community care include developing services that integrate well with the development of locality based primary care services. Through our commissioning we will focus on ensuring that community services support better outcomes for patients and become more productive.

4.3.2. Community Mental Health Services

Community mental health services in Southwark are provided by South London and Maudsley Foundation Trust (SLaM) and are included in the list of services in Appendix 1. Community Mental Health Teams (CMHTs) provide assessment and treatment of patients and triage for onward referrals to specialist services or inpatient care. GPs also have the option to refer patients to the Improving Access to Psychosocial Therapies (IAPT) service or their own practice based counsellor (PBC). The IAPT service along with PBCs treat patients with mild to moderate anxiety and depression and increasing the uptake of this service is a national priority. The CCG has made recent investments to increase the capacity of the IAPT service, to help meet national targets for access to psychological therapies.

The CCG plans to make to improve the skill mix of clinicians assessing patients in Community Mental Health Teams. Enhancing the 'front-end' assessment and triage function will make it easier and quicker for GPs (and others) to refer patients into the system, strengthen the trust's ability to manage demand for services and ensure that patients are directed to the most appropriate mental health service to meet their needs. CMHTs will benefit from extended/out of hours services, and improved GP liaison with secondary care services will allow GPs to more easily refer patients into CMHTs. Home Treatment teams will work more closely with community assessment to keep people in primary care where possible. The enhanced CMHT service will include a re-ablement team to facilitate, where appropriate, the management of patients with social care needs in primary care. As well as improving patient experience and service quality, it is expected that this service development will reduce the number of unnecessary admissions to hospital.

With an ageing population treating people with dementia is an area Southwark CCG is focusing on. Investment will be made to increase capacity within the Dementia Service which works alongside the Mental Health for Older Adults community service to help manage the increased number of referrals expected in 2013-14. A Dementia Adviser from the Alzheimer's Society will signpost and facilitate access to other services in Southwark (such as Peer support groups and/or a referral to a Dementia Support worker, as appropriate to the needs of the person with dementia). The service will also link closely with the Care Navigators model that aims to ensure older people (and their carers) with long term and complex care needs are accessing the most appropriate services and support to maximise their physical, emotional and social wellbeing.

The CCG is currently reviewing its Mental Health strategy and intends to produce a revised strategic document for 2014/2015.

4.4 Analysis of Primary and Community Services

In developing this Strategy, the CCG commissioned a review of the current quality, capacity and capability of primary and community care services in Southwark. The aim of this review was to provide a thorough and objective picture of the quality and outcomes of current services, to inform the CCG's strategic priorities and development of an approach to improving quality, in line with the strategic goals of the Integrated Plan.

The benchmarking review concentrated on GP practice provision and community services provided by GST Community Trust. The full results of the analysis can be accessed via the following link:

http://www.southwarkccg.nhs.uk/newspublications/news/pages/improvingoutofhospitalhealthservicesacrosssouthwark check right link

More information on health outcomes in Southwark and variation across primary care can be found within the Southwark Annual Public Health report.

http://www.southwark.gov.uk/downloads/download/3408/previous_annual_public_health_reports

4.4.1 Key Findings of the review:

The key findings of our review of primary care summarised below:

There is a wide range of variability in the quality and outcomes provided by GP practices in Southwark. There is some excellent care, but there is also a very wide range of performance between practices and between different care indicators, and the level of variation cannot be explained by the differences between patients registered with different practices. These wide variations between practice level performance significantly impact on the average performance for Southwark, and indicate that the care received by patients differs widely across the borough.

There is also wide variability between the productivity and outcomes from different community health services such as community matrons, and between different district nursing teams. This is evidenced by contract and quality monitoring as well as the benchmarking review.

Specific clinical areas where primary care performance or patient outcomes in Southwark on average are lower than would be expected are:

- Long term conditions screening and management (including detection and clinical control of key long term conditions such as diabetes, cardio-vascular disease and respiratory diseases)
- Immunisations (particularly childhood immunisations and flu vaccines for at risk groups)
- Identifying Cancer

- Mental Health support and mental health reviews in primary care
- Low and variable level of delivery by practices of additional services such as the NHS vascular health check and frail elderly integrated care

In terms of access to GP appointments, an audit undertaken for this strategy suggests that overall there is sufficient capacity in terms of numbers of appointments across the borough and across days of the week, but that this overall finding masks wide variation between different practices and across the days of the week. We also know from our engagement with patients that patients sometimes find appointment processes difficult and stressful, and find it hard to book a GP appointment when they need one, or with the GP they would like to see.

The review of primary and community care and feedback from our patient engagement event highlighted that non-core or 'enhanced' primary care services and some specialist community services are inequitably distributed across the borough. This is confusing for patients to access, and means that there is variability in the services offered to patients depending on where in the borough they live or which GP practice they are registered with.

5. Our Strategic Vision for Primary Care: Principles, Objectives and Clinical Priorities

5.1 Strategic Principles:

We have agreed a number of principles which guide Southwark's approach to improving primary and community services. These principles were chosen as a result of our engagement with patients, the public and other stakeholders, and are consistent with the vision and values and goals in Southwark's Integrated Plan. They are:

- All Southwark patients should have consistent access to high quality care, including enhanced services, regardless of where in the borough they live.
- Services should be safe, evidence-based and focused on improving outcomes for patients.
- Services should target health inequalities.
- Services should be patient centred, seamless and accessible.
- Where services can be effectively provided out of hospital and closer to patients' homes, they should be.

These principles inform the strategic objectives that we have chosen to focus on in future, as well as the specific actions that will take forward to develop and improve Southwark services.

5.2 Strategic Objectives:

Our strategic objectives describe the main aims that we want to achieve, to improve local services. The strategic objectives address the issues that we have identified in our review of local services and in our conversations with patients and the public about the kind of service that they would like to receive in future.

Our strategic priorities are:

- Ensuring **high quality** in all services by **reducing variation** in the quality of and outcomes from services

- **Integrated services**, with better co-ordination of people's care
- Improving **access** to services for all
- Improving the range of community based services and **out of hospital services** in Southwark

Within these priorities, we will focus on a number of key clinical areas where we know from our review of services and the Southwark JSNA that outcomes need to be improved. These clinical priorities also support our Integrated Plan clinical priorities and the Health and Well Being Board Strategy.

Our key clinical priorities are:

- Long Term conditions
- Cancer and End of life
- Mental Health
- Children and Early years

Our plans for improvement against these clinical priorities are not described in detail in this Primary and Community Care Strategy document. They are addressed in more detail in the CCG Operating Plan for 2013/2014 and in the CCG Integrated Plan, and will be developed further in our commissioning intentions for each clinical area for 2014/2015 and beyond.

Our plans and aspirations to deliver each of our strategic objectives across Southwark's services are described in more detail in section 7.

6. Developing locality based models of care

6.1 The rationale for change

Services will need to work very differently in order to be able to provide the type of care that the CCG wishes to commission in future. Primary and community care services will need to be more accessible and better integrated as well as providing a consistent range of services or 'offer' for Southwark patients. They will also need to be more productive in response to the financial challenges facing the NHS locally and nationally.

Organisational change and organisational development are a key theme of our strategy, in response to these challenges. Services working together at greater scale will enable us to deliver our aim to provide more consistent access to high quality services.

The CCG has considered a range of options to address the issues of health inequalities and the fragmentation of current provision, and our preferred option is to develop locality networks of care. The rationale supporting locality models of care starts from the premise that non-specialist care should be based around local populations, allowing the organisation of services in a way that is accessible and local to patients, which supports a preventative and holistic approach to patients' care over time, but which also allows the benefit of working at scale and the sharing of resources to deliver high quality and cost-effective services. Services need to be delivered in a way that uses a range of different staff to deliver services effectively, rather than placing additional requirements on over-stretched GPs. The role of practice and community nurses, health care assistants and other

health professionals will be critical in delivering services at scale. Making best use of staffing and other resources in primary care to cover populations larger than the traditional GP practice is needed in order to be able to meet the future demands on health services in the borough within the financial constraints we will face over the next five years.

Locality networks of care provide an opportunity for providers to work together at greater scale, through collective working, collaboration or formal merger. Locality models of care could include 'core' GMS/PMS services and cover a range of extended services, including enhanced and non-core services, as well as some community specialist services, depending on the scale that these services are offered at (i.e. borough, locality or other).

Although the CCG does not directly commission core GMS/PMS primary care services, there is a clear interplay between the provision of core primary care services and extended primary care services, and there are benefits for patients of having these services closely aligned and co-located where possible, delivered by a team of professionals within a locality network.

As a commissioning organisation, Southwark CCG cannot and should not determine the precise make up of provider organisations. However, in line with our duty to support improvements in the quality of primary care, the CCG plans to encourage and facilitate the development of locality working across Southwark. As part of the implementation of this strategy we will put in place a programme of development for locality working. This will include support for clinical and support teams to work together to design and implement service improvements together at locality level. Practice managers will play an important role in developing new ways of working and supporting clinical teams to design and carry out changes to the way that patient services are delivered. Alongside a programme of organisational development for primary care the CCG will also put in place an extended programme of training and development for clinical and administrative staff in practices.

6.2 Commissioning an extended range of services across localities

Extended services are those which can be provided in primary and community care settings, which go beyond the core range of primary care services available in every GP practice. Historically these services have been developmental or innovative, and their provision was usually fragmented and dependent of whether particular providers wished to participate in providing particular services. 'Extended services' as used in this strategy includes a wide range of services, including health promotion and preventative services, screening and diagnostic services. The term is also used here to cover previous non-core practice services and incentive schemes for additional services and service quality commissioned by the CCG. Extended primary and community care services may be provided by a range of professionals, and are not restricted to general practices. Some may require specialist clinical skills and training, and others may be more generic.

The CCG's strategic commissioning intention is to commission a significant proportion of extended primary care services and community specialist services on a locality basis in future. This will enable us to ensure the consistent provision of an extended range of services, with the same 'offer' to all patients. It will also enable the CCG to specify and monitor the achievement of consistent

outcomes, to improve the quality of care. We will commission extended services in line with clear specifications which will include the consistent provision of a range of services to all patients in a locality. Specifications for extended services will also be clearer in future about quality standards relating to patient care.

Locality networks of care will be better placed to interface with other elements of an integrated care system, including supporting Community Multi-Disciplinary teams. Community services such as district nursing and community admission avoidance services should also be organised on a locality basis, along with specialist community clinics such as out of hospital outpatient care.

6.3 Locality Services and Community Hubs

Locality networks will have community hubs at their centre. Community hubs will provide space for co-locating services, where this is the best way of providing cost effective care out of hospital, or where there are benefits in having services working side by side so that they can offer better joined-up care for patients. We will develop plans for community health centre 'hubs' across the borough over the next five years. In Dulwich we are already taking this forward, following a formal public consultation on the provision of services in that locality.

7. Our plans for improvement

This section outlines the key actions that the CCG will take forward against each of our strategic objectives, in order to support improvement. It is not a detailed implementation plan, nor is it an exhaustive description of Southwark's commissioning intentions for primary and community care. The following sections show what actions we will take across different tiers of care: core GP services, 'extended' primary care services, community and specialist community 'out of hospital services' and finally, where relevant, the impact of our strategy on acute hospital services.

7.1 Reducing Variation

We will reduce variation through a combination of re-organising services and through supporting service improvement. Our proposed actions to reduce unwarranted variation in care include structural changes such as developing more locality based services, as well as supporting clinical teams to work together on improving quality and developing innovative approaches to improving services.

To support this, contracts will increasingly be outcome based, and outcomes will be linked to the key health improvement priorities identified in the Southwark JSNA and the CCG's Integrated Plan.

Service area	Priority actions
Core Primary Care Services (NHS England commissioned)	Work with NHS England to ensure consistent performance management, (led by NHS England) Agreed practice quality improvement plans where performance improvement is required Practices share resources and collaborate to improve quality, to include training, peer review and audit Use of 'Productive Practice' or other tools Programme of Training and Support (CCG-led) Provision of up to date performance information to practices to support improvement
Extended Services	Commission a consistent Extended Service offer for all patients Services bundled and commissioned as a locality specification with clear KPIs LES/LIS and other non-core services replaced with new contracting model, clear outcome and quality requirements, consistent performance management Locality based primary care development plans, focussing on improving outcomes
Community Services including out of hospital services	Improve consistency of service provided and the productivity of different teams and staff members Develop more outcome based contract specifications for community services Focus on quality, outcomes and productivity in contract management Use of AQP or other commissioning routes where appropriate to improve quality Provide support to practices to develop skills to follow best practice referral guidelines and manage conditions in primary care where appropriate. Clear referral processes, including use of Single Point of Referral or PRS
Impact on acute services	More appropriate and consistent pathways into and out of acute care, outlined in contract specifications and involving the decommissioning of some acute services

7.2 Improving Access

Good access to care covers a range of different aspects, from the availability of appointments, booking processes and waiting times, to the geographical location of services and the nature of the buildings they are located in. Access is also affected by transport routes to services, the level of information given to patients to enable them to choose the right service and the language used by services. All these issues impact on access to care, and may impact on different sections of the population differently. We aim to address all of these issues

Service area	Priority actions
Core Primary Care Services (NHS England commissioned)	Access Collaborative work, support for demand and capacity work (CCG-led) Clear arrangements for extended hours care in primary care Consistent Urgent Care Access model, including integration with patient's own practice and Out of Hours care Use of community pharmacies to give advice and information and to support better care More support for self-care and self-management
Extended Services	Extended service specification provided through locality models as means of providing consistent access for patients Clear communications and signposting for patients Consideration of location and distribution of services – whether in GP premises or in hubs Potential to use a range of providers to ensure universal access, e.g. pharmacists and voluntary sector Model should include open access to some services, including community outreach or walk-in services for some types of care
Community Services including out of hospital services	Development of more services in community hubs, including LTC and some outpatient services Review Urgent Care provision including Walk in Centres. Develop services based around locality populations, including Single Points of Access to community services Improve booking processes, communication and responsiveness of community services
Impact on acute services	Clearer communications with patients on access, particularly for urgent care and in relation to choice and booking processes Redirection from acute services where appropriate

7.3 Integration and better care co-ordination

Ensuring that health and social care services are better integrated, to provide person-centred and seamless care is a key objective for Southwark CCG, and is reflected in the CCG's Integrated Plan, the South East London CBC strategy as well as in national policy. The CCG will continue to work with our local partners across Southwark and Lambeth within the SLIC programme to progress an ambitious programme of integration. In relation to our specific plans for primary and community care service, integration is fundamental to achieving our aims of improving outcomes for patients and improving their access to care. This means that services will need to increasingly work together, to co-ordinate their response to the needs of individuals, and to work flexibly to offer better value care.

Our proposals for locality models of care are one of the main ways that we wish to support further integration for local people. Locality working will not only support GP practices to share resources but allows them to interface with a range of other services, based around local populations and communities. We will explore and encourage greater integrated working between services at locality level, with community health centres as 'hubs' where patients can receive more joined up care.

Service area	Priority actions
Core Primary Care Services (NHS England commissioned)	Primary care services should be a key element of integrated care pathways Integration based around populations with focus on shift to a preventative approach, Primary care case management adopted as a core approach to co-ordinating the care of patients
Extended Services	Patient-centred care planning and care co-ordination rolled out as a generic approach to supporting self-management Integrated care pathway elements should be included in the locality model Development of the integrated case management model beyond frail elderly to younger adults with LTCs or raised risk, and to children
Community Services including out of hospital services	Investment in integrated pathways for elderly and those with LTCs, including admission avoidance and community LTC services Care-co-ordination central to integrated pathways, supported by Community Multi-Disciplinary teams Community services integrated into care pathways (e.g. diabetes and respiratory). Integrated community services developed around localities, including social care services, and co-located in 'hubs' where appropriate Develop plans for the integration of children's services
Impact on acute services	Acute services part of integrated pathways, including potential to develop Academic Integrated Care Organisation for Southwark and Lambeth Flexible deployment of staff into the community and to support primary care Aim to reduce admissions and length of stay Redistribution of financial resources to support redesigned services

7.4 Enhancing the range of services available in the community

Southwark already has a range of community based services available. Patients and the public have told us that they would like to have a wider range of services available outside hospital settings and closer to their homes. This will mean commissioning more home based care, a greater range of extended primary care services and community based services and specialist out of hospital services. We will only commission community alternatives to hospital based care where it is safe and effective, from a clinical and cost perspective, to do so.

Service area	Priority actions
Core Primary Care Services (NHS England commissioned)	n/a
Extended Services	Better range of extended services, consistently provided should reduce reliance on acute services or other commissioned services, and support effective pathways, Screening, diagnostics and management of non-complex conditions in non-acute settings, included in locality offer Commissioning of non-complex diagnostics
Community Services including out of hospital services	Development of community hubs, co-locating services Increased range of out of hospital care, including potential for gynaecology, more LTC clinics, ophthalmology, therapies, early years services and others Community based admission avoidance services, linking to integrated pathways Availability of wider range of direct access diagnostics in community hubs where this supports effective pathways out of hospital
Impact on acute services	Decompression of acute sites though provision of more care out-of hospital in key pathways

8. Enablers

In order to be able to deliver the level of improvement we aspire to over the next five years, there are a number of enabling workstreams. These enablers seek to address some of the barriers to making change happen at a practical level.

The four enablers of our Primary and Community Care Strategy are:

- Workforce
- Premises
- Information Sharing and Information Technology
- Contracting and Procurement

This section describes what we will seek to do in each of these four areas.

There is a significant overlap between the enablers for this strategy and the enablers in the South East London Community Based Care Strategy (section 1). We will work collaboratively with the

other CCGs in South London, and with other partners including NHS England, the SEL CSU and the SLIC programme, where this will enable us to have faster, wider reaching impact on the enablers of our local borough strategy.

8.1 Workforce

- Developing a flexible workforce that can deliver the kind of integrated, person centred care that is needed in the future
- Support for leadership development in primary and community services, including clinical and managerial leadership
- Ability to rotate staff across acute, community and primary care settings, and redeploy staff in response to service transformation
- Sharing staff between different providers
- Support for recruitment and staff development
- Development of a wider skill mix, including development of more health care assistants
- Support for skills development and training including care-co ordination and case management
- More mobile working for community and domiciliary staff, IT enabled

8.2 Premises

- Commission an audit of practice and community premises to assess the current state of premises and the level of premises utilisation
- Develop a premises strategy, in partnership with NHS England, NHS Property Services, as an immediate priority
- Identify funding sources to develop community hubs and primary care estate in line with agreed models of care, maximising sources of funds from section 106 and regeneration
- Identify potential community hubs in each locality and develop business cases where required

8.3 Information sharing and Information technology

- Ensure inter-operability of all main IT systems
- GP practices to upgrade to EMIS web or other systems which will enable shared working in future
- Agree information sharing protocols across services, including primary, community, acute and social care
- Work with SLIC to deliver a shared clinical system to support integration
- Develop clear information for patients on consent and the use of personal information
- Flexible IT solutions to support mobile working and case conferencing

8. 4 Contracts and procurement

- Clear procurement strategy, including approach to procuring locality based services
- Use of competition and tendering to secure required level of quality, where this is in patient's interests
- Development of more outcome related contracts
- Exploration of capitated budgets to support population based integrated care

- Consistent performance management
- Effective use of incentives including quality premiums and CQUINS
- Payments linked appropriately to achievement of agreed quality and outcome thresholds

9. Financial Implications of this strategy

9.1 The financial outlook

The forward outlook for the CCG over the next five years is one of substantial change. The national funding formula for CCGs is being reviewed and changes to our allocation levels are expected. Currently Southwark is slightly under its target level of allocation by 1.5%, and we therefore expect to receive at least the average inflationary uplift of circa 2% per annum. However, this uplift will not be sufficient to cover the rising demand for and costs of healthcare, and in each year of the next five years the CCG will expect to have to make significant savings in the cost of overall care in order to meet rising demand. Our savings and productivity plans are known as Quality, Innovation, Productivity and Prevention (QIPP) plans. Our financial forecasts assume annual QIPP saving requirements of at least 6% per year in 2014/2015 and subsequent years. Our plans to achieve these cost reductions focus on reducing the costs of care through improving prevention and early management of health problems, as well as transforming the way that care is delivered in order to provide quality care at lower costs. Our programme of primary and community care redesign is of prime importance to delivering these productivity improvements.

9.2 Resources to support this strategy

The CCG will need to commit some additional resources in order to implement this strategy, including the costs of pump priming new service developments in community and primary care settings, and the costs of developing locality based models of care.

Over the period 2013/2014 to 2015/2016, the CCG has earmarked 1% of its non-recurrent reserves each year to fund the costs of implementing the South London CBC strategy and our borough based work on developing primary and community care sits within that commitment. The CCG therefore expects to be able to resource the reasonably anticipated costs of implementing this strategy, although further work will be needed to establish the funding requirements for each of the main strategic objectives, and to agree the allocation of resources to individual projects and service developments over the next three to five years. The CCG's Commissioning Strategy Committee will be responsible for overseeing the development of detailed commissioning and service development plans, and will consider business cases for individual projects and workstreams.

We will look innovatively at how we can fund premises improvements to deliver out of hospital services, working with NHS Property Services and NHS England. There is likely to be very little capital funding available for NHS commissioners over the next few years, so many of our premises improvement projects will require revenue funding, including contributions from Section 106 or funds from regeneration projects, where possible.

Premises development costs will therefore be funded from a mixture of capital and revenue solutions. Business cases for capital developments will be required for approval with NHS England London Area Team.

10. Implementing the strategy – how we will achieve our goals

10.1 Developing an implementation approach for the strategy

The work to take forward this strategy will be led within the CCG by the Primary and Community Care Strategy Steering Group, and managed in close collaboration with the South East London Community Based Care programme.

Section 7 of this document outlines our plans for improvement against each of our main objectives. Detailed project plans will be developed for each of these areas, including resource requirements and milestones. Appendix 2 outlines the high level milestones to progress each of the key actions with the expected timeframes for implementation in the first year of our work. This will be developed further into a more detailed implementation plan in the weeks and months following the agreement of this strategic document.

10.2 Key next steps

10.2.1 Equalities Impact Assessment

The CCG believes that the changes we have outlined in this plan will have a positive impact on equalities, and help to reduce health inequalities and improve access for different patient groups. We have not yet carried out a full equalities impact assessment, but will take this forward, in order to inform the development of our detailed implementation plans and future commissioning intentions.

10.2.2 Developing a programme of organisational development for primary care

One of the immediate priorities for action by the CCG will be to agree a programme of development for practices to work at greater scale.

The precise scope of an organisational development programme for primary care will need to be developed in discussion with Southwark GP practices. It is envisaged that the programme will need to cover the following areas:

- Facilitating discussions about ways of working together at scale
- Determining models for locality working
- Support for making organisational change happen at an operational level
- Leadership development and building capacity for service improvement within localities

10.2.3 Developing a procurement approach for 2014/2015

This plan describes how the CCG will commission primary and community care services in future. To take this forward, the CCG will need to

Community contract re-procurement: The CCG's current contract for community services with GST ends in March 2014. The CCG is currently developing its commissioning intentions for procuring future community based services. Our decisions around the future procurement of community services will need to reflect the strategic objectives of this strategy, including the drive for more integrated services, designed around local populations and focussed on improving patient outcomes. We will also be reviewing the range of community based services that we currently commission, and taking decisions about the future commissioning of a number of individual services, including diabetes and CHD. It is likely that the current contract will be extended to March 2015, to allow enough time for detailed commissioning plans to be developed and for any procurement exercise to be properly managed. We will also work closely with Lambeth CCG in order to determine the timing and shape of any future re-commissioning of community services.

We will review community services each year and determine where there is scope to use contracting routes such as the Any Qualified Provider contract to deliver community services, where greater choice of provider has the potential to improve the quality and accessibility of local services.

Extended services procurement: Commissioning extended services on a locality basis is one of the ways that we propose to improve equity and the quality of services. The CCG will specify the range of extended services that it will commission for April 2014 as a priority action. A procurement approach for commissioning those extended services will be agreed to support this, taking into account national procurement guidance, and our local strategic intentions in relation to improving patient care.

All the CCG's commissioning and procurement proposals will be taken in accordance with our conflict of interest policy.

11. Reviewing this strategy

Change is a constant in the NHS, as in other public services. This strategy has been developed to respond to the likely future context for primary and community care services in Southwark but there will inevitably be unforeseen changes, for instance in the national policy context. At the time of writing, A Call to Action is taking place nationally, and may lead to significant changes in the services the NHS provides in future.

Our aim is to ensure that we commission strong, viable primary and community services that are sustainable and flexible and that can respond to the changing demands of patients as well as a changing financial and political environment.

The CCG's Primary and Community Care Strategy Steering Group will play a key role in monitoring the implementation of this strategy, ensuring that improvements in quality are achieved and maintained over the next five years. The Steering Group will also ensure that this strategy is reviewed regularly in response to changes in the national policy context for primary and community services, as well as to the changing financial situation of the CCG, and to changes to NHS service configuration across South East London.

APPENDIX 1: LIST OF COMMUNITY SERVICES IN SOUTHWARK, WITH COMMISSIONER

Adult Community Services	Commissioner	Provider
Community Nursing / Matrons	CCG	GST CHS
Heart Failure Team	CCG	GST CHS
Care Home Support Team	CCG	GST CHS
Tissue Viability	CCG	GST CHS
Multiple Sclerosis Service	CCG	GST CHS
Continence Nursing	CCG	GST CHS & LHT
Diabetes Specialist Nursing	CCG	GST CHS
Young People with Disability (YPD)	CCG	GST CHS
Home Ward	CCG	GST CHS
Acupuncture	CCG	GST CHS
Neuro Rehab	CCG	GST CHS
Complex Rehab	CCG	GST CHS
Supported Discharge	CCG	GST CHS
Foot Health	CCG	GST CHS
Podiatric Surgery	CCG	GST CHS
Three Boroughs Homeless Team	CCG	GST CHS
Adult Learning Disability	CCG	GST CHS
Enhanced Rapid Response	CCG	GST CHS
Community Mental Health Team	CCG	SLAM NHS FT
Homeless Assertive Outreach Service	CCG	SLAM NHS FT
Psychosis: Early Intervention Community Service	CCG	SLAM NHS FT
Home Treatment Team	CCG	SLAM NHS FT
Mental Health for Older Adults and Dementia Team	CCG	SLAM NHS FT
Chlamydia Service	Local Authority	GST CHS
Reproductive & Sexual Health	Local Authority	GST CHS
Sexual Health Outreach Team	Local Authority	GST CHS
HIV & Sexual Health Promotion	Local Authority	GST CHS
Stop Smoking Service	Local Authority	GST CHS
Substance Misuse Treatment Service (Community Drug Action Team (CDAT))	Local Authority	GST CHS
Needle and Paraphernalia Exchange Coordination Service	Local Authority	GST CHS
Dietetics	CCG	GST CHS
Audiology Services (Hearing assessment and aids)	CCG	Various
Community Dermatology Services	CCG	Aylesbury Medical Services
Home Enteral Nutrition (HEN) Service	CCG	LHT
Community Head and Neck Team (CHANT) Service	CCG	LHT
Non Specialist Orthotics and Wheelchairs Service	CCG	GST CHS
Ears, Nose, Throat Advice Service	CCG	Rila Group
Specialist Rehabilitation, Orthotics, Wheelchairs,: Amputee Rehab	NHS England	GST CHS
Children's Community Services		
Aiming High (Specialist Equipment)	CCG	GST CHS
Children Continuing Care	CCG	GST CHS
Children's Diabetes Specialist Nursing	CCG	GST CHS
Children's Occupational Therapy	CCG	GST CHS
Children's Physiotherapy	CCG	GST CHS
Community Paediatricians	CCG	GST CHS
Looked after Children	CCG	GST CHS
Special Needs Health Visiting	NHS England	GST CHS

Special Needs School Nursing	NHS England	GST CHS
Child and Adolescent Mental Health Services	CCG	SLAM NHS FT
Children's Speech & Language Therapy	Local Authority/CCG	GST CHS
Nutrition & Dietetics	Local Authority/CCG	GST CHS
School Nursing	Local Authority	GST CHS
Child Immunisations Support Service	NHS England	GST CHS
Family Nurse Partnership (FNP)	NHS England	GST CHS
Health Visiting	NHS England	GST CHS
National Hearing Screening Programme	NHS England	GST CHS
Paediatric Audiology Service	NHS England	GST CHS
Children's Community Nursing Team	CCG	LHT

Key
GST CHS Guys & St Thomas' Community Health Services
LHT Lewisham Healthcare Trust
CCG Clinical Commissioning Group
SLAM NHS FT South London And Maudsley NHS Foundation Trust

APPENDIX 2: PRIMARY AND COMMUNITY CARE STRATEGY: PRIORITY ACTIONS, TIMEFRAMES AND MILESTONES

1. Reducing Variation

Priority Actions	Milestones	Timeframe	Inter-dependencies
Development Plans for improvement: NHS England led process for Quality Improvement plans at practice level for outlying performance. Locality improvement plans outlining development plans for local populations	Establish quarterly review process for primary care quality, jointly with NHS England Agree performance information data set to support performance review NHS England to lead agreement on Southwark practices needing practice level quality improvement plans Agree format and scope of locality improvement plans Locality Improvement Plans in place, agreed between CCG and Localities, linking to support and development requirements	Quarterly beginning Jan 2014 November 2013 December 2013 December 2013 March 2014	NHS England
Locality-led programme of peer review, audit and collaborative improvement	Agree reporting and information requirements for practices to support improvement Review use of productive practice and other tools Develop proposals for support for developing service improvement capability at locality level Localities to agree mechanisms for peer support and shared learning, with CCG support and facilitation	November 2013 November 2013 December 2013 February 2014	CSU
Training and Development to support improvements in quality, capacity and capability	Review and evaluate current range of training activities Develop training and development plan, with identified resources, for implementation from January 2014 Provide support to practices to develop skills to follow best practice referral guidelines and manage conditions in primary care where	October 2013 December 2013 March 2013 and	HESL CBC workforce group SLIC

	appropriate. Recruitment and retention to support new ways of working	ongoing	
Strengthen Community services contract and performance management, focussing on quality, outcomes, and productivity	Agree revised quality standards and KPIs for GST contract Agree Community CQUINS, including system wide improvements Agree Community service workplan for improving productivity, service responsiveness and quality	February 2013 March 2013 March 2013	Lambeth CCG, GST FT
Commission enhanced services in order to improve consistency of outcomes and to improve access for all patients	Agree bundles of services to be procured at locality level Review LIS and LES contracts, to be replaced with locality enhanced services contracts Agree specification for enhanced bundles, including quality and outcomes standards Agree procurement approach for enhanced services Begin procurement , to conclude with new contracts from April 2014	September 2013 November 2013 December 2013 September 2013 November 2013	SLIC Local Authority
Review Commissioning Intentions for community services	Review use of AQP to secure improved quality and choice for patients Agree any procurements via AQP Agree any services to be tendered	September 2013-Jan 2014 Jan 2014	

2. Improving Access

Priority Actions	Milestones	Timeframe	Inter-dependencies
Improve consistency of access to commissioned services for all patients	Commissioning of consistent service offer through localities – see plans re commissioning enhanced services	April 2014	
Agree future location of Out of Hospital Services, including pharmacies, GP surgeries and community hubs	Agree service model and proposed location of services provided out of hospital Develop Dulwich business case based on above model Develop proposals for community hubs in other parts of Southwark, following engagement with patients and other stakeholders	November 2013 November 2013 April 2014	
Communications to patients to support access to care	Agree local communications for urgent care for winter 2013/2014 Agree plans for 111 implementation across LSL Develop materials for Southwark patients on services, access and self-care	November 2013 March 2014 June 2014	CSU
Implementation of Urgent Care strategy, following NHS England review of Emergency Services	Review urgent care strategy and re-commissioning Southwark services including: Review of Lister Walk in Centre Review of KCH Primary Care Service Review use of pharmacies/minor ailment services Review Single Point of Access to community admission avoidance services Review location of Out of Hours bases and integration with UCCs Re-commissioning of urgent care services in line with above, to deliver a	June 2014	NHS England KCH Lambeth and Lewisham CCGs

	consistent Urgent Care Access model, including integration with patient's own practice and Out of Hours care		
Primary Care appointment access	Programme of collaborative support for access improvements Clear arrangements for urgent access to GP appointments and extended hours in primary care, linking to CCG's future commissioning of Urgent Care Services	November 2013 – June 2014	
Improve booking processes for patients	Agree improvement plan for community services booking and response times to practices and patients Continue to implement Choose and Book improvements, prioritising Kings and Community services Monitor cancellations and re-scheduling of care, including analysis of patient experience and quality alerts, taking action via contract and performance management routes Undertake some focused work with patients to understand access and experience of booking and waiting, to inform further improvements	March 2013 Ongoing April 2014 June 2014	GST, KCH, Connecting for Health

3. Integration and better care-co-ordination

Priority Actions	Milestones	Timeframe	Inter-dependencies
Investment in integrated pathways for elderly and those with LTCs, including admission avoidance and community LTC services	Homeward rolled out across Southwark as part of @Home model Re-commission diabetes community service Agree specification for community respiratory service Evaluation of SLIC frail elderly pathway Agree approach to integrated care for LTC Community services integrated into pathways, including diabetes, respiratory, district nursing, foot health etc	October 2013 April 2014 December 2013 March2014 March 2014 March 2015	SLIC, Lambeth CCG, GST
Care-co-ordination central to integrated pathways, supported by Community Multi-Disciplinary teams	Patient centred care planning and support for self management agreed as generic framework, included in locality service specifications Primary care case management adopted as a core approach to co-ordinating the care of patients, supported by risk stratification and locality based integrated service models	March 2014 March 2014	SLIC
Integration based around populations with focus on shift to a preventative approach	Services commissioned through locality networks of care, based around populations, as key mechanism for co-ordinating integrated care and interfacing with other agencies to provide more patient centred care Link to new contractual models and financial flows	April 2014	
Changing contracts and financial flows to support integration	Agree scope for capitated budgets and commissioning arrangements to support further integration Shadow capitated budgets Business case for Integrated Care Organisation for consideration	February 2014 September 2014 February 2014	SLIC

Develop plans for the integration of children's services	Develop plans for the integration of children's services, working with Lambeth and Southwark integration project	September 2014	Evelina project, Local Authority
Integrated community services developed around localities, including social care services, and co-located in 'hubs' where appropriate	Development of service model for community hubs Review of community services interface with primary care;	November 2013 for Dulwich September 2014	

4. Increasing the range of services out of hospital

Priority Actions	Milestones	Timeframe	Inter-dependencies
Planned care – commissioning of community clinics where this is clinically and cost effective	Priorities include: Gynaecology Ophthalmology ENT Cardiology Paediatrics Headache Pain Management	Timeframe to be determined for each specialty	CSU,
Diagnostics: secure quality assured diagnostics for LTC care as part of locality model, agree strategy for extended direct access diagnostics where this complements more streamlined and cost effective planned care pathways	Spirometry service implemented at locality level Business Case for Phlebotomy Procurement for Phlebotomy and ABPM Diagnostics review completed Procurement of direct access diagnostics, complementing community hub and locality networks model	December 2013 October 2013 April 2014 February 2014 Begin in April 2014	CSU
Screening, diagnostics and management of non-complex conditions in non-acute settings, included in locality services	Agree commissioning intentions for Healthchecks and other screening services with Local Authority	November 2013	Local Authority and Public Health

Increased home based care, including accelerated discharge, support for frail elderly	@Home model rolled out Better take up of integrated approach to frail elderly , including locality networks linking to CMDTs Improved discharge arrangements, with support from integrated social care and health services – testing of new service	October 2013 October 2013 October 2013	GST, SLCI, Local Authority
Use wider range of providers to support care out of hospital including pharmacies and third sector	Links to other workstreams, including review of Public Health contracts, planned care and urgent care commissioning intentions,	Ongoing	Local Authority, LPC, CAS,

Glossary of Terms

ABPM – Ambulatory Blood Pressure Monitoring, where blood pressure monitoring is carried out over a period of time.

Acute - describes a disease or illness that comes on quickly, severe symptoms and brief duration.

Acute care - healthcare, usually secondary care services, that responds to a critical or episodic health need. Acute services are typically hospital based services.

Any Qualified Provider - patients or GPs can, for certain conditions, choose from a range of approved providers, who have met the strict criteria for and are approved under the AQP regulations.

Care co-ordination – the process of joining up or planning the provision of health or other care services that an individual needs. This is normally done by an individual called a care-co-ordinator, who takes responsibility for ensuring that an individual's needs are met by a range of different services or agencies in a planned way.

Choose and Book - Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

Commissioning - the planning and organising, procurement, monitoring and performance management of health and health care services for a local community or specific population.

Community based services/ community care – health services that are not provided by secondary care or by primary care, and are provided in patients' own homes, health clinics or health centres. A fuller list is included in Appendix 1.

CQUINs (Commissioning for Quality and Innovation) - a contractual mechanism that allows commissioners (e.g. CCGs) to pay providers (e.g. hospitals) for completing activities that directly relate to improving the quality of care received by patients, through linking a proportion of the provider income to achieving the improvement goals.

Extended services – this term is used in this document to mean a range of services that can be provided in primary and community care but which are not included in the core GP contract. It includes, but is not necessarily restricted to historic locally enhanced services, non-core funding, incentive schemes or other newly commissioned services.

Health and Well-being Board – a statutory group which is responsible for improving population health and well-being at a borough level. It is a multi-agency group chaired by the Leader of the Council, with strong representation from the CCG, the police and other agencies.

Health Inequality - the generic term used to designate differences, variations, and disparities in the health outcomes of individuals and groups, for example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes.

Healthwatch- the independent consumer champion for the voices of the Southwark population concerning health and social care services, established by the Health and Social Care Act 2012.

Health Education South London – A strategic board which exists to ensure effective and efficient investment of education funds for staff, ensuring security of supply of the workforce for south London.

Joint Strategic Needs Assessment - a document which analyses the health needs of a population to inform the commissioning of health, well-being and social care services. This document is updated on an annual basis.

Integration – the bringing together of different health and/or social care services to work together in an organised way to meet the needs of a group of patients. This may involve co-location or single management of services.

Local Enhanced Service – local scheme of additional services provided by GPs (agreed by the CCG) in response to local needs and priorities, sometimes adopting national NHS service specifications.

Local Incentive Scheme - a process to engage GPs in working to address specific health objectives for the local population. This has included long term conditions (such as COPD and diabetes), early cancer diagnosis and effective prescribing.

Local Authority – also known as the Council, a statutory organisation of local government which provide or arrange a range of services including education, housing, leisure and social care.

Local Medical Committee – a statutory Local Representative Committee representing the interests of all GPs working in the NHS.

Locality – a geographic area or neighbourhood. GP practices within Southwark are currently organised into locality groups for the purposes of commissioning. This document suggests that GPs are also organised into localities in order to collectively provide services to the population of that locality.

Out of Hours - services available between 6.30pm and 8.00am during the week and during the day on Saturdays and Sundays (including weekends and bank holidays).

Outcomes – the effect of treatment on patients, which can be measured in a number of different ways, including biological measurements (e.g. reduction in blood pressure or treatment of cancer), mortality rates (number of deaths per/1000 population), and patient satisfaction or experience of care.

Primary Care – the collective term for health services that are the first point of contact for patients, including General Practice (GP) services, pharmacies, dentists and optometrists. The following terms relate to GP services:

> **Core** – the services that all GP services have to provide within the national contract for primary care.
>
> **GMS** – General Medical Services – the services which are stipulated in the core GP contract.
>
> **PMS** – Personal Medical Services. A way of contracting for primary care which covers the core contract and a range of quality and care requirements.
>
> **Non-core services** – some GP practices receive funding for providing services that are outside the core GP contract. In Southwark examples include counselling and physiotherapy.
>
> **Enhanced Services** - services provided by general practices in addition to their core contracts on a voluntary basis. Examples of enhanced services include smoking cessation, sexual health, vascular health checks and integrated frail elderly services.

Quality and Outcomes Framework (QOF) - a system of quality requirements for GPs for which practices can receive additional payment for meeting specified standards.

Secondary Care – more complicated or specialist healthcare, either outpatient or inpatient, that is usually provided by hospitals, and is normally received following a referral by another health professional rather than being universal or open access for all patients.

SELDOC – **S**outh **E**ast **L**ondon **Doc**tors – a co-operative organisation of member practices which provides Out of Hours Services across NHS Lambeth, Southwark and Lewisham CCGs, including telephone advice, GP consultations and home visits.

SLIC – Southwark and Lambeth Integrated Care. A programme taking forward integration across Lambeth and Southwark, involving a partnership of the CCGs and Local Authorities, King's College Hospital, Guy's and St Thomas' and South London and the Maudsley Foundation Trusts.

Urgent Care - Urgent care is defined as the delivery of medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment.

Agenda Item 10

Item No.	Classification: Open	Date: 15/10/2013	Meeting Name: Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Report title:		Draft Local Account of Adult Social Care 2012/13	
Ward(s) or groups affected:		All	
From:		Sarah McClinton, Director of Adult Care, Children's and Adults Department	

RECOMMENDATION(S)

1. That the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee note the draft Local Account.

BACKGROUND INFORMATION

2. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee reviewed the 2011/12 Local Account at its meeting in January 2013. One of the comments made was that the committee would like to review the 2012/13 Local Account whilst it is in draft form so as to be able to influence the final document.

KEY ISSUES FOR CONSIDERATION

3. The Local Account is a new form of public performance report, setting out the progress councils have made in delivering national and local adult social care priorities, and the key areas for further improvement in forthcoming years.

4. In our first Local Account covering 2011/12 we described our progress on a range of adult social care priorities and set out areas for improvement in 2012/13. This draft Local Account reports back on our performance in these areas and sets out our priorities for improvement during 2013/14.

5. Following consideration of any comments received from scrutiny committee and a number of other stakeholders a final Local Account will be published during November.

6. The draft Local Account is attached in **appendix 1.**

APPENDICES

No.	Title
Appendix 1	Draft local Account 2012/13 : Promoting independence. Wellbeing and Choice

Lead Officer	Sarah McClinton, Director of Adult Care, Children's and Adults Department
Report Author	Adrian Ward, Head of Performance (Adult Social Care), Children's and Adults Department

Fairer future
Delivering our promises

Southwark Council

Adult Social Care

Promoting independence, wellbeing and choice

Local Account 2012/13

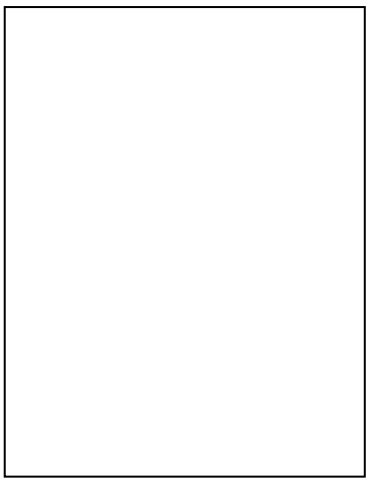
Review of performance and priorities in Adult Social Care

What is a Local Account and why are we producing it?

The Local Account is a new form of public performance report, setting out the progress councils have made in delivering national and local adult social care priorities, and the key areas where further improvement is required. Previously the Care Quality Commission provided an annual assessment report of council care services, on which Southwark's last rating was "good" overall. This has now been replaced by a locally driven service improvement approach called "Towards Excellence in Adult Social Care" which provides an opportunity to focus on local priorities. The Local Account is part of this approach. It is supported by the Local Government Association, the Department of Health and the Association of Directors of Social Services, who monitor the effectiveness of the system. We feel that developing the annual Local Account will help increase transparency and improve understanding about how adult social care services work in Southwark.

In our first Local Account covering 2011/12 we described our progress on a range of adult social care priorities and set out areas for improvement in 2012/13. This Local Account reports back on our performance in these areas and sets out our priorities for improvement in 2013/14. We have taken into account comments received on how to improve the last Local Account and are further developing the way service users shape it in future. We have used case studies to bring to life the issues, showing what our vision for improved adult social care can mean in practice for service users.

Foreword from Catherine McDonald, Cabinet member for health, adult social care and equalities



Catherine McDonald

Cabinet member for health adult social care and equalities

Welcome to our second Local Account of adult social care services in Southwark.

Over the last year we have been investing in services to help everyone in Southwark live long, fulfilling and healthy lives. Our focus has been on supporting people to live independently in their own home, preventing or delaying the need for intensive care and support, in line with what people tell us they want.

As you will see we are able to highlight good progress in a number of key areas. For example, there has been an increase in the number of people with personal budgets, which enable people to exercise control over their services; more people are benefitting from reablement services which help them get back on their feet after a period of illness or injury; the price people pay for meals on wheels has been reduced significantly; safeguarding measures have improved; there has been increased integrated working with health; access and information has improved, and we have made good progress in shifting the balance of care away from care homes to community support for people with learning disabilities.

However we are fully aware that there is still much to do to improve the quality of services. We are particularly keen to ensure that more people are supported to gain real choice and control from their personal budget arrangements to help them live the life they want to live. We need to make further shifts in the balance of care away from care homes in favour of community based support when this is what people prefer. Our integrated work with health through the Southwark and Lambeth Integrated Care initiative is key in this respect, ensuring people get the right support at the right time in a joined up way to prevent the need for more intensive health and social care support. We are working with care providers to increase the quality of home care and residential and nursing homes, and more progress is expected in this area, with a particular focus on dignity and compassion for service users, and ensuring fair pay for care workers. We are advancing our plans to offer much more “extra care” housing which enables people with relatively high care needs to be supported in their own home as an alternative to residential care. We are also reviewing and improving safeguarding, including our response to the national Winterbourne View recommendations for improving services for people with learning disabilities with high needs.

We expect to see all these service improvements reflected in improved satisfaction levels reported by service users in our customer surveys.

This is all in the context of the council having received large cuts in its budget from central government – a real terms reduction of over £90 million over a three year period to 2013/14, including a reduction of £17m in 2012/13, and an expected further reduction of £20.6m in 2014/15.

There are however a number of exciting opportunities over the coming year. As of April 2013 local authorities took on responsibility for public health, which gives us a great opportunity to ensure that health and wellbeing considerations are fully embedded in the way we deliver all council services. This new remit falls within my portfolio and I am keen to seize the opportunity to work with the new Health and Wellbeing Board to build healthier communities in Southwark.

The health and well being strategy will promote preventative services that help people stay healthy and independent, reducing the pressure on more intensive services. This in turn will help us deliver our goals as set out in this Local Account within reduced resources. Also, there is a strong local and national drive towards further integration with health, including the pooling of budgets enabling a more joined up and cost effective approach which we are taking forward locally through Southwark and Lambeth Integrated Care.

I am looking forward to the implementation of a number of new initiatives, including the Carers Strategy and new day services models. I am particular keen to oversee the development of proposals for a centre of excellence for people with dementia in Peckham, to help address the rising numbers of residents and their carers needing support in the borough.

I would welcome your views on this Local Account using the survey form on the back page. Your views will be noted for the next Local Account and taken into account in planning future service developments.

Catherine McDonald

Our Health and Wellbeing Strategy: key adults priorities

Building healthier and more resilient communities and tackling the root causes of ill health

Improving the experience and outcomes for our most vulnerable residents and enabling them to live more independent lives

Fairer Future - the Council Plan and our vision for adult social care

The Southwark Council Plan, "A fairer future for all", states that

"The council will create a fairer future for all in Southwark by: protecting the most vulnerable; by looking after every penny as if it was our own; by working with local people, communities and businesses to innovate, improve and transform public services; and standing up for everyone's rights".

The plan contains a specific pledge for adult social care to;
"Support vulnerable people to live independent, safe and healthy lives by giving them more choice and control over their care"

You can see more detail about the Council Plan and 2012/13 performance via the following link: http://www.southwark.gov.uk/info/200342/council_plan.

The current council plan runs to 2013/14 and contains targets we have reflected in this Local Account. A new set of priorities and targets will be consulted on for 2014/15 onwards.

Our **vision for adult social care** describes in detail how we are seeking to deliver these goals. Supporting people to live independent lives and encouraging more people to take control over their own care is fundamental to securing a fairer future for all. For the most vulnerable in our society we must also ensure there are sensible safeguards against the risk of abuse or neglect, striking the right balance between managing risk and promoting independence.

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

People tell us that they want to stay living in their own homes, and connected to their communities, for as long as possible, and to avoid going into residential care unless it becomes necessary. We aim to shift the balance of care from residential provision to more effective support for people in their own homes. Transforming day services, as more people take up personal budgets, and, for example, through creating a new centre of excellence for older people, will also allow a more personalised and outcome focused approach and contribute to this goal.

We are improving access and information though our dedicated telephone line for all queries about help for older and vulnerable people and their carers, including information about universal access and voluntary sector services for those not eligible for higher levels of care. There will be enhanced focus on targeting services to better meet the needs of carers.

Partnership working with health services will remain a key priority. In particular, we will continue to ensure people who receive both health and social care services do so in an integrated, seamless way.

See the full vision document via the following link:
http://www.southwark.gov.uk/info/100010/health_and_social_care/2086/vision_for_adult_social_care_in_southwark

Our charter of rights for adult social care

The charter was agreed by the council's cabinet. It reflects the adult care vision and is built into the way we work with people. It highlights what people in Southwark with adult social care needs can expect from adult social care services as follows:

- We will provide you with good information and advice about all the support and services that are available in Southwark.
- You should be treated with dignity and respect and be treated fairly.
- Vulnerable people, those who are at risk due to disability or frailty, have the right to be safeguarded from abuse.
- You are entitled to request an assessment of your social care needs to help you maintain your health and wellbeing and you will be encouraged to complete this yourself.
- Carers are entitled to a separate assessment of their needs to identify what support would enable them to continue in that role.
- Our aim is to assist you to regain your independence so that you do not need long term support.
- If you have longer-term eligible needs we aim to give you control over your social care support so that you can make choices about what works for you.
- We will let you know who to contact in the council if required.
- We aim to have skilled and trained staff to provide timely, clear, high quality responses.
- You will be given information about your statutory rights (for example access to your records, confidentiality, how information about you is shared with other organisations and how to feedback comments during your assessment).

Engagement with service users and carers during 2012/13

As key experts in care and support the experience and input of people using services is vital to improving the quality of care and support locally.

In 2012/13 we engaged with users and carers in a number of ways to help develop our services. For example, we have involved people in detailed consultations to help shape the approach to redesigning day opportunities for people with learning disabilities. We are also working closely with a key group of service users and families to shape our work in developing a centre of excellence for older people with dementia in the borough.

In 2013/14 we want to develop our approach to engagement that focuses on "co-production". This means recognising that everyone has a contribution to make and that people need to be actively involved from the start to the end of the process, especially where the outcome may affect them.

We will also look at how our learning from this work can impact our approach to developing the Local Account in future years. Towards this goal we would welcome any comments you have on this Local Account – please use the feed back form at the end of the document to tell us what you think.

We involved service users and older people in the evaluation of our meals on wheels bidders for our new contract. They took part in tastings and provided valuable input which assisted us in reaching a decision with regards to contract award.

photo

Working in partnership with the voluntary and community sector

Our vision requires us all to build stronger, more resilient and independent communities to help prevent individuals needing intensive social care support. It is essential for the council to work with the voluntary and community sector towards this goal. In 2012/13 examples of partnership have been:

- Working with the Alzheimer's Society to expand the advice and support offer for people living with dementia and their carers after initial diagnosis to plan how to "live well" with dementia now and as their condition progresses
- Establishing a new service with The Stroke Association which is now supporting people following an intensive rehabilitation programme, to provide practical support and advice to people who have experienced a stroke and now recently returned home

In addition, Southwark Council commissions much of the direct care provision from third party providers including the voluntary and not for profit sector. Voluntary sector organisations provide the majority of our residential care services and day care provision.

Through our Innovation Fund we have grant funded a diverse range of voluntary sector projects which help support the independence of people, providing more choice for people with personal budgets, such as support planning, personal assistant recruitment, support accessing public transport and other universal services.

We also fund a range of community support services in the voluntary sector providing advice and information, befriending and other services.

Review of 2012/13 – our achievements and priorities for improvement

This Local Account summarises our progress on the priorities within the council plan and the vision grouped under the key outcomes of the national Adult Social Care Outcomes Framework as follows:

1) Enhancing quality of life for people with care and support needs

2) Delaying and reducing the need for care and support

3) Ensuring that people have a positive experience of care and support

4) Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

For each outcome there is a set of outcome measures to reflect performance trends and comparison to benchmarks. These are shown in appendix 1.

Outcome 1: Enhancing quality of life for people with care and support needs

This means:

- People live their own lives to the full and achieve the outcomes which matter to them by accessing and receiving high quality support and information
- Carers can balance their caring roles and maintain their desired quality of life
- People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs
- People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

Our key achievements last year against the priorities we set in the 2011/12 Local Account are set out below:

Priorities for 2012/13 (from the 2011/12 Local Account)	**Achievements 2012/13**	**Priorities for 2013/14**
We plan to move all eligible community service users to **personal budgets** by 2013/14. We want to ensure that people are able to use their personal budget in a way that really puts them in the driving seat	Good progress has been made with over 90% of eligible service users now on a personal budget. Overall, 74% of all community based service users were on personal budgets, in excess of the national 70% target. Progress has been made in developing the support required to enable more people to take control of their budgets to benefit from them.	Implementation of our revised customer journey under personalisation will lead to 100% of eligible services users having a personal budget - which they can choose to manage themselves or elect for the council or a third party to mange on their behalf. Development of support planning is to contribute to improved rates of self management, and more choice and control.

Priorities for 2012/13 (from the 2011/12 Local Account)	**Achievements 2012/13**	**Priorities for 2013/14**
We want to support service users and carers to experience a higher **quality of life** and feel more in control, and see this reflected in the results of the 2012 surveys of users and carers.	In the 2012 User Survey the "social care related quality of life" measure improved significantly and is now in line with the London average. However the measure on service users feeling in control did not increase. The carers survey reported quality of life measure was in line with London results.	We want further improvements in the quality of life measures of the User Survey, including the feeling in control measure in particular.
We will continue to **transform day services** to allow a more personalised and outcome focused approach, reviewing mental health, learning disability and older people's services	Progress has been made in reviewing the needs of clients using day services and developing personalised service models to meet these needs. The council has provided several apprenticeships for adults with learning disabilities over the past year, working in partnership with a local provider to give people the extra support they needed.	We are implementing the new service models, enabling service users to purchase a range of support options using their personal budget. We are developing the plans for the centre of excellence for people with dementia so as to be ready for 2014/15 implementation. We are commissioning personalised employment support options to assist working age disabled people and carers to obtain and maintain employment
We will increase the number of carers who benefit from a **Carers Assessment**.	In 2012/13 the number of carers assessments increased in line with targets, with over 1300 carers of adults with care needs now benefitting.	We wish to continue to increase the numbers of carers benefitting from an assessment, and a service. More importantly, we are rolling out the carers strategy to ensure carers have the support they need to balance their caring responsibilities with other aspects of their lives.
We will further reduce the charges for **meals on wheels**, bringing the total reduction to 50% since 2010.	The charge for meals was reduced to £2.52 with effect from 1st April 2012, bringing the total reduction to 26% since 2010/11.	As from October 2013/14 the charge for meals further reduces to £1.71, a 50% reduction since 2010 and significantly lower than most other London boroughs.

Case study: Personal budgets making a difference

My name is Isayas Solomon and I am a Southwark resident. I use a self-managed personal budget to directly employ two personal assistants (PAs). As a result of a spinal injury I use a wheelchair. I am unable to grip with either hand so need daily assistance with some personal care tasks and preparing meals.

Before I developed my support plan with the help of a support planner, I used care from an agency. Some of the carers were nice but often they were replaced at short notice and I felt uncomfortable with people I didn't know coming into my home to assist me.

It has meant a lot to me to be able to choose my PAs. I can feel in control of the support that I receive, and comfortable with the person and the way they assist me. We have mutual respect for each other. When interviewing the PAs I look for someone who is a good communicator with a positive attitude and an ability to work flexible hours. It helps if they live locally to me too.

The personal budget is paid into my bank account. I have help from a direct payment support service, which assists me with payroll, recruitment and fulfilling my responsibilities as an employer.

One of the best things about controlling my personal budget is that I can use it flexibly – I arrange to have more support on days that I am not feeling so well and 'save up' some of it for an extra hour of support here or there. Occasionally my PA comes with me to the gym and helps me with the hoist so I can go swimming, or with my grip supports for doing weights to help keep me fit and healthy. It's my preference that the PA comes very early in the morning so I can feel ready to start the day when it suits me.

Making daily choices about how to use my personal budget and feeling comfortable with my PAs helps me to stay positive, and achieve the goals I have set myself. I am a very creative person – I write poetry, draw, paint and compose digital music. I also want to start running creative workshops for young people in the near future. I am a member of the Beam Arts group at Southwark Resource Centre. I am passionate about sport – I have done canoeing, snow skiing and skydiving with the help of the organisation The Back Up Trust. I'm practising my swimming and aim to swim competitively soon.

I would recommend anyone receiving support from the council try a self-managed personal budget – with the right help to manage it, it really has improved my quality of life.

Outcome 2: Delaying and reducing the need for care and support

This means

- Enabling people to stay healthy and independent for longer
- Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.
- Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.
- When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence

Our key achievements last year against the priorities we set in the 2011/12 Local Account are set out below

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
We wish to make further progress in **supporting people at home** and avoid the use of institutional care homes wherever possible	Good progress has been made in reducing the usage of residential care provision for people with learning disabilities where it is appropriate and in line with what people want, enabling service users to live in their own home. 73% now live in settled accommodation, more than the London average. However our target to reduce new permanent admissions to care homes, particularly for older people, was not met in 2012/13 as admission rates increased. This performance is a reflection of growing demand as people live longer. There comes a time when some people need to live with the support available in a care home and this is always an option. Our aim is to reduce that demand by developing better preventative and community services as alternatives to care homes.	For people with learning disabilities we will continue the existing strategy to increase numbers in supported housing arrangements. For older people our target is to reduce new permanent admissions to care homes by 15% from the 2010/11 baseline by providing services that prevent the development of intensive care needs and by developing community support alternatives to care homes, such as “extra care”. This will help us to continue shifting the balance of care away from care homes to people’s own homes for all client groups.

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
	Also the proportion of mental health clients living independently is lower than some other similar boroughs.	We are reviewing mental health accommodation issues to identify a strategy for reducing reliance on care homes.
We plan to substantially increase capacity in **reablement** services, which provide short term rehabilitation support to help people get back on their feet after a period of illness or injury, and enable more people to benefit from these services directly after being in hospital.	Reablement has expanded in line with targets, with 1400 people receiving services - of whom around one third were restored to a level of independence requiring no further ongoing social care support. The service model continues to be developed to improve effectiveness and there remains scope for more people to be helped upon discharge from hospital. The mental health reablement service is an innovative model, one of the first such service nationally, helping people learn to live independently with their condition without the need to become permanent mental health service users	We are further expanding reablement services, and are increasing the focus on outcomes such as the proportion helped to stay living at home in the long term after receiving reablement.
We will work with the NHS on **integrated care** to improve services and reduce unnecessary admissions to hospital and care homes	Integrated workstreams have been in place helping identify a strategic, integrated approach to reducing unnecessary admissions to hospital and care homes, although these have not yet been fully implemented and reductions have not yet been achieved. We have maintained consistently low rates of delayed discharge from hospital showing good services are in place to support discharge.	We are further developing integrated service models with the NHS and Lambeth Council as part of Southwark and Lambeth Integrated Care (SLIC) to deliver improved outcomes and better user experience of seamless health and care services.
We will work with **public health services** to promote wellbeing, and plan ahead for the transfer of these functions to the	Public health functions were successfully transferred to the council on 1st April 2013. The shadow Health and Wellbeing Board informed the	We are working with partners through the Health and Wellbeing Board to develop and deliver a strategy that will deliver improvements in public health

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
council in 2013 to ensure maximum impact.	development of preventative wellbeing services.	and social care. The transfer of public health is enabling us to fully embed health and wellbeing considerations into the way we run all council services, and we are aiming to make the most of this opportunity. For example, the impact on public health of developments in housing, regeneration and children's services, as well as adult care, can be significant, making a real difference to people's lives.

Mental health reablement - case study

Alan (not his real name) had been suffering from depression for some months before being referred to reablement services. He had not been answering phone calls, opening his post or paying bills and was spending the majority of the day in bed. He was distressed about his position as his financial problems were building up. When he had tried in the past to get on top of these by reading his mail and listening to the voice messages he had felt overwhelmed, and that his position was hopeless, making his depression worse.

A reablement support worker went through all his mail and voice messages with him and helped him put the problems in perspective, some of which were less serious than he had thought. Reablement helped him think objectively about ways of tackling the situation, and encouraged Alan to pursue his own idea of enlisting the moral support of a friend when phoning organisations he owed money, agreeing a rent arrears payment plan and obtaining benefits advice to re-instate his cancelled benefits, all of which helped make the situation more manageable.

The final reablement sessions were used to consolidate his learning, identifying what had worked and what he would do if similar problems arose again.

Alan later gave feedback that the reablement service had helped him think positively and made him feel independent again.

Case Study – day activities and support planning

Derek (not his real name) is a 53 year old man who has a learning disability and epilepsy. His 82 year old mother is his main carer and they live together in Southwark. Derek and his mother are very close, and he also sees his brother regularly. He has been attending a local day centre for many years and enjoys spending time with his friends there.

Derek can be shy around people he doesn't know and becomes stressed and anxious in unfamiliar environments or with a change in routine. Apart from a few familiar journeys, Derek requires assistance to access the community safely. His father died a few years ago and as his mother is now quite elderly, he has not been able to get out and enjoy hobbies/activities as much as he did.

Derek's family, social worker and support planner helped him develop his own support plan. Part of the plan involves using Derek's personal budget to employ a key worker from the day centre as his personal assistant. Together they attend football matches, go swimming at the local leisure centre, see films at the cinema and take weekend breaks out of London. Derek still attends the day centre but now has other ways to be sociable and feel part of the community.

Taking the time to explore support options via an in-depth, person-centred planning process means Derek can now experience a greater variety of groups and activities in a way that is comfortable for him, while maintaining support from family, friends and key workers that has always worked well.

Case Study: Successful re-ablement after hospital discharge

Mr. D is 92 and had been admitted to King's A&E on a number of occasions due to serious falls. The Southwark team supported him out of hospital and helped him to achieve much more than his original therapy goals which focused on maintaining his safety in his own home; he can now manage his stairs, outdoor mobility (to Dulwich Park, Sainsbury's Local) and has demonstrated to staff how he makes a tasty chicken casserole!

This was achieved with a range of health and social care inputs including physiotherapy input and an exercise programme supervised by social care staff. Rehabilitation Support Workers attended daily during the 6 week period for all personal care, meals, medication prompting, catheter care and safety checks.

Outcome 3: Ensuring that people have a positive experience of care and support

This means

- People who use social care and their carers are satisfied with their experience of care and support services.
- Carers feel that they are respected as equal partners throughout the care process.
- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.
- People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

Key achievements and priorities

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
We aim to improve the **user satisfaction** levels reported by our customers.	The User Survey shows an improvement on last year, with 84% satisfied and only 7% dissatisfied with services. However user satisfaction remains an area we wish to continue to improve.	We aim to drive up user satisfaction levels so that the proportion reporting that they are very or extremely satisfied are at least in line with average levels in London. **Quality** strategies for improving care homes and home care services will be implemented as part of the actions to improve user experience of services.
The experience **carers** have of the support they receive is to be improved by taking forward the carers strategy following our work with Carers UK. The forthcoming national carer survey will give us information to track progress.	The Carers Strategy developed jointly with the NHS has now been agreed. The national carers survey has been undertaken in Southwark, showing comparatively high satisfaction rates.	We are implementing the Carers Strategy and will monitor the outcomes achieved to demonstrate success.
We will provide a dedicated telephone response for all queries about help for older and vulnerable people and their carers, including **information** about universal access and voluntary sector services.	The dedicated telephone response line staffed by people who are experts on the service has been fully implemented and aims to make sure people get the advice and support they need.	We are making further improvements to advice and information and expect to see that reflected in the user survey result on ease of access to useful information.

Case study: Lay Inspector: Denise

For the past two years Southwark has enlisted members of the public to help us monitor our residential and nursing homes for older people. This role is known as a lay inspector. The lay inspector's main job is to talk to residents and get their personal view of what it is like to live at the home. Both the organisations and the council then use this feedback to support continuous improvement in offering high quality care and support for everyone.

Denise is the newest recruit to the lay inspector team. She has built up a wealth of local knowledge and experience of the support available for older people in Southwark through her membership of the Southwark Pensioners' Centre. She was recently elected as chair of the Southwark Pensioners' Forum. She also has experience of care and support services as her mother is in residential care, and understands that for people and families, knowing there is an independent voice speaking up on their behalf and with a passion for high quality care and support is really important. Denise has always liked the idea of being a lay inspector and feels that by getting involved she can make a real improvement to the lives of older people who live in Southwark.

photo

Southwark Resource Centre - facilitating independence for a deaf and blind client

Martin (not his real name) is a deaf and blind man who attends Southwark Resource Centre three days a week. Martin was born Deaf and lost his vision gradually; he has never learned to speak or to use any formal sign language and he has a moderate learning disability. He has attended day services for approximately 20 years.

Support staff have successfully helped Martin to become much more independent within the centre this year. He is now able to go the toilet and feed himself with minimal direct support; and a programme of activities has been set up, which supports his development in focussing memory and recognition of objects, so that he is much more engaged, independent and active while at the centre than previously.

Martin has a "communication passport" which was developed by the support staff, containing pictures of familiar signs he uses to communicate – this has ensured that other staff members communicate with him in a consistent way. He has now begun to learn new signs and to communicate pro-actively with other people.

One year after his support worker started working with Martin, he has begun to attend community based activities including sailing and cycling and has significantly reduced the level of support he requires during the day.

photo of M sailing at Canada Water

Outcome 4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

This means

- Everyone enjoys physical safety and feels secure
- People are free from physical and emotional abuse, harassment, neglect and self-harm
- People are protected as far as possible from avoidable harm, disease and injuries
- People are supported to plan ahead and have the freedom to manage risks the way that they wish

Key achievements and priorities

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
We will work with all Southwark services and the community to help ensure all our service users **feel safe**.	In the User Survey there was a significant improvement in the proportion reporting they feel safe, which at 58.5% is now close to the London average. The feeling safe measure is a broad reflection of a range of community safety factors. The proportion indicating that adult care services helped them feel safe also improved to 73%.	We expect to see further long term improvements in the User Survey measure on services helping people feel safe as a result of quality improvements. We are developing measures reflecting the views of people who have been through a safeguarding process to identify areas for improving effectiveness. We will be undertaking specific improvements in the quality of services for people with learning disabilities and challenging behaviour through the delivery of our Winterbourne View action plan, which was established to ensure the abuse that happened at this home does not happen to Southwark residents.
We plan to increase the speediness of our **safeguarding** processes, as measured by the case completion rate.	The safeguarding case completion rate improved substantially and is now above the London average, reflecting improved monitoring of the timeliness of safeguarding investigations.	We are ensuring we maintain a timely response to safeguarding concerns. We will implement an overarching review of safeguarding to improve quality assurance of safeguarding processes.
We will ensure there are sensible safeguards against the risk of **abuse or neglect** in our personal budget	As part of our anti-fraud work we have been proactively talking to service users about	We are further developing the safeguarding system in the context of personalisation and more widespread self

Priorities from 2011/12 Local Account	Achievements 2012/13	Priorities for 2013/14
arrangements.	financial abuse and how to report it. Procedures have been developed to identify and respond to any risk of financial abuse of personal budget holders. Where there is deemed to be an ongoing risk of financial abuse the council may manage the personal budget directly on behalf of the client.	management and third party management of budgets.

Safeguarding Case Study: financial abuse

B is a 79 year old woman living with her 52 year old son, who is an alcoholic. She is physically frail and receives a small domiciliary care package for personal care from Southwark Social Services. Her care worker reported they were concerned that there was usually little food in the flat and the rent was in arrears. The suspicion was that her son was taking her pension to spend on alcohol. B confirmed to the social worker this was the case. However, she did not want to involve the Police as she loved her son and did not want to see him get in to trouble.

The social worker obtained the woman's agreement to call a family conference and together with the other family members developed a plan to both protect the woman's finances and get help for her son. A daughter who lived locally agreed with her mother's consent to manage her mother's financial affairs and the son agreed to seek treatment for his addiction.

Budget issues – how we are managing the cuts

Southwark Council needs to cut expenditure in the face of government funding reductions of 29% (around £90m) being made since 2010. As a result adult social care is required to reduce spending by £27m over the 3 year period to 2013/14.

We are committed to implementing savings in a fair and transparent way in line with the council's budget setting principles. Most importantly, we aim to minimise the impact on those most in need of support wherever possible. In line with our vision for adult social care we are seeking to reduce expenditure by transforming services to improve quality and outcomes, in particular by promoting the independence and wellbeing of people, and reducing or delaying the need for intensive support. It is important to note that we are not seeking to deliver savings by tightening eligibility criteria for services. All people with substantial or critical needs remain entitled to a service.

In 2012/13 our adult care budget was £107.7m, which required savings of £10.3m to achieve. The main source of planned savings was:

- Efficiency savings from contracts for Supporting People housing support for people with low level needs, including joint contractual arrangements with Lambeth and Lewisham to achieve economies of scale
- Shifting the balance away from residential care to home and community based support
- Redesigning services of learning disability day services
- Redesigning mental health day services to promote personalisation and independent living
- Workforce initiatives to reduce management costs
- Savings from improved contracting arrangements
- Integrated working with the NHS on reablement

In 2013/14 our adult care budget of £101.5m requires savings of £7.7m. We are making these savings from the following main areas:

- Further efficiencies and reductions in Supporting People costs
- Further shifts away from residential care to home and community based support
- Redesigning services for people with learning disabilities to support the delivery of personal budgets
- Redesigning mental health services to achieve better value
- Workforce initiatives to reduce management costs
- Savings from improved contracting arrangements
- Integrated working with the NHS

Going forward, this financial pressure is not going to reduce. The council expects a further reduction of £20.6m in 2014/15 and yet more substantial reductions of around 10% in 2015/16 as a result of the comprehensive spending review.

More information about the budget is available at:

http://www.southwark.gov.uk/info/200110/council_budgets_and_spending/2108/southwark_councils_budget

Our Services

The services we provided directly to service users in 2012/13 included:

3,978 Community based service users receiving services such as homecare, day care, meals, equipment, transport and personal budgets

4,836 People in Southwark receiving a full community care package following an assessment, of whom 2,977 are over 65.

2,968 Personal budget holders

602 People receiving telecare and **2, 721** People receiving alarms

1400 People receiving community reablement or intemediate care services

540 People receiving specialist occupational therapy equipment

1163 People supported in residential or nursing care, **97** in "Extra Care" housing

1280 Mental health service users receiving professional support through the care programme approach

394 People received meals on wheels

1353 Carers Assessments, 545 leading to a service and 808 to advice and information

2900 People receiving "supporting people" supported accommodation and floating support in their own home

7,831 referrals received, **4,151** assessments undertaken, **4,696** client reviews

753,468 hours of homecare arranged by council, for **1,096** clients

521 day services clients as part of care package

3,000 community support service users (e.g. helpline, befriending)

To put these numbers in context, the 2011 census suggest that there is an adult population in Southwark of 235,200 with 22,300 over 65s in the borough, and 212,900 18 to 64 year olds.

People who are not eligible for tailored formal support are given information and advice and signposted to universal access services that may help them retain independence. We fund a range of voluntary sector services to provide community support services. We also provide simple services that promote independence at the point of contact such as equipment and alarms.

More information about what adult social services provide, including "My Support Choices" is available at:

http://www.southwark.gov.uk/site/scripts/documents.php?categoryID=100010.

Feedback

We would welcome your views of this Local Account. We want future Local Accounts to contain the information that you would find useful so please take the time to complete our short online survey.

Link to feedback form

Glossary:

The meaning of words and phrases commonly used in Adult Social Care Services is attached via the link below:

http://www.thinklocalactpersonal.org.uk/_library/AIJargonBusterFINAL.pdf

Appendix 1:

Key Outcome Indicators

Note for draft: final document will include final local and national Adult Social Care Outcome Framework measures and trends. These have not yet been published by the Department of Health.

Council Plan performance report.

The council plan performance report for 2012/13, including key adult social measures, can be found at the following link:

http://www.southwark.gov.uk/annualreport

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 resulting waiting times for appointments. The review will seek to establish how easy it is for patients to access surgeries. (N.B. the review will consider surgeries in neighbouring boroughs that Southwark residents use)

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

NHS Southwark Clinical Commissioning Group

CCG Performance & QIPP Highlight Report

Month 4, 2013/14

Southwark Council

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

September 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 the first four months 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 provides 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
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	July
KCH (all type)	96.3%	96.4%	96.3%	94.5%
GSTT (all type)	94.6%	96.4%	96.7%	94.5%

Reported Performance Position

•Both Trusts have met the performance standard in most of the first four months of the year since April and have achieved the requisite 4 hour target for Q1 2013/14. Performance in July at both trusts has fell slightly below the 95% standard but unvaldidated data for August and September shows trusts are on track to achieve the target over Q2.

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	July
Southwark CCG	90.6%	88.0%	90.7%	89.3%
KCH	88.8%	88.2%	89.7%	88.1%
GSTT	92.1%	92.0%	92.7%	92.4%

Performance Position

•Admitted performance for Southwark CCG patients has been above the 90% in two of the last four months.

•KCH are 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 remained broadly flat since April. It 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, King's and NHS England.

Actions Agreed to Meet Performance Standard

•KCH have a combination of increased internal capacity and outsourcing to private providers in place.

•Infill 4 development at Denmark Hill and the acquisition of the PRUH will provide further capacity in Q3/4.

•The trust will not achieve the RTT target until March 2014.

• 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	July
Southwark CCG	3	5	7	3
KCH	49	44	31	29
GSTT	9	5	1	1

Current Performance Position

•The 3 Southwark long waiters are patients at KCH.

•Almost all long waits at King's are gastroenterology patients with benign hepato-pancreato-biliary conditions.

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 gastroenterology, the trust plans to clear long waiters in these specialities by the end of October 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	July
Southwark CCG	1.86%	1.95%	1.85%	2.63%
KCH	3.00%	4.20%	2.77%	2.57%
GSTT	2.00%	2.10%	3.08%	3.83%

Cause of Reported Performance Position

•Southwark diagnostic breaches occurred at KCH and GST

•The service areas of concern for Southwark is echocardiography at KCH.

•GST endoscopy is the diagnostic pathway causing an increased % of 6 week breaches

Actions Agreed to Meet Performance Standard

•KCH successfully delivered on their action plans for diagnostic recovery for all areas apart from echocardiography and has reduced total breaches since May 2013.

•For this diagnostic pathway the trust had a deficit in physical and staffing capacity. Both have recently been addressed however there is a lead time for the additional staff to be fully operational. KCH is also outsourcing echocardiography to London Bridge Hospital in the interim.

•GST has recently opened a new larger endoscopy unit. Staffing levels are currently below capacity and the trust is funding more diagnostic sessions. GST anticipate this issue will be resolved by December 2013.

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 & July 2013

•3 reported MRSA cases at GSTT April, May, June & July 2013

•4 Southwark CCG MRSA cases in April, May, June & July 2013 (2 at GSTT and 2 community-acquired)

•12 *c.difficile* cases at KCH in the year to M4 2013 – under YTD trajectory.

•9 *c.difficile* case at GSTT in the year to M4 2013 – under YTD trajectory.

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	July
Southwark CCG	12	6	7	11
KCH	49	19	29	40

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 by the end of October 2013.

Actions Agreed to Meet Performance Standard

•Contractual penalties being applied to breaches

•CCG receives on-going assurance that patient safety is not compromised

Cancer Waits (latest validated data is for April, May & June 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	June	July
SCCG	96.7	98.2	95.8	97.5
KCH	96.9	98.6	96.6	
GSTT	94.4	96.7	95.4	

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

Target = 96%				
Month	April	May	June	July
SCCG	97.1	98.7	95.9	100.0
KCH	100.0	99.0	97.9	
GSTT	98.3	97.9	96.5	

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	June	July
SCCG	83.3	90.2	82.4	96.3
KCH	93.3	87.9	76.7	
GSTT	68.6	80.5	79.7	

Cancer Waits: 62 day pathway

NHS Southwark Clinical Commissioning Group

Reported Performance Position

•GSTT has failed to meet the 62 day target for the first three months of 2013/14 . This pattern has continued from 2012/13 performance.

•Failure of this target is attributable to late referrals from other trusts, in particular from South London Healthcare Trust.

•King's College Hospital also recorded below target performance for June 2013.

Actions Agreed to Meet Performance Standard

•A cross-trust group at GSTT 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.

•KCH performance will be addressed in acute contract monitoring and quality groups in September to understand the cause of performance deterioration and agree action plans.

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 psychiatric intensive care unit 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 (M5)

NHS Southwark Clinical Commissioning Group

Programme Budget	Annual Budget (£k)	Variance to Month 5 (£k)	Predicted End of Year (£k)		Best Case (£k)	Worst Case (£k)
Acute	200,283	-2,340	-8,337		-4,543	-11,892
Client Groups	70,720	50	100		300	-2,800
Community Contract	29,138	-540	-1,300		200	-1,600
Prescribing	31,617	106	200		300	0
Corporate Costs	4,078	50	100		100	0
Earmarked Budgets and reserves	14,747	2,674	9,237		11,387	7,800
Planned Surplus	3,972	1,655	3,972		3,972	3,972
Total	**354,555**	**1,655**	**3,972**		**11,716**	**-4,520**
Month 4 (for comparison)	***348,714***	***1324***	***3,972***		***9,701***	***-4,276***

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

15 October 2013

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

1. At their meeting on the 12 September 2013 the Clinical Commissioning Group Governing Body approved 24 recommendations that were developed on the basis of the Consultation Report – 'Improving Health Services in Dulwich and the surrounding areas' and the Equalities Impact Assessment.

2. The recommendations were developed through an iterative process of discussion including the Clinical Leads and Patient Representatives. They 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

3. The recommendations include the following points:
   - The consultation supports the development of community-based health services, and in particular services for people with long term conditions
   - The CCG should progress discussions with NHS Property Services (the current owners) about the Dulwich Hospital site and the development of a significant health care 'hub'.
   - Plans should include improving the quality of primary care and community service provision
   - Local people value good quality general practice and the CCG should build on this
   - The CCG should develop services in a way that supports integration, continuity of care and which are located in a way that reflects the care pathway
   - Access and transport are critical factors in the plans we are developing, and the hub or centre should be located in a way that maximises transport opportunities
   - Service users should be involved in design
   - There should be a communications and engagement plan that seeks to reach all sections of the community

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4. This list is not exhaustive, and the full recommendations paper can be seen on our website. The full version of the consultation report and its appendices, the Equalities Impact Assessment and the recommendations can be found at:

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

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[i].

6. The next step is to confirm the detail of exactly what services will be provided and how much activity we should plan for. We are doing this through discussions with local service providers (King's College Hospital NHS Trust, Guy's and St Thomas' NHS Trust (who provide our community services on behalf of King's Health Partners), local GPs and other primary care providers), with public health specialists, who will give us information about population changes, and commissioners within the CCG who will tell us about the services they expect to transfer out of hospital and into community settings.

7. As soon as we have a clear picture of the activity we expect to accommodate we will be having discussions with NHS Property Services about a business case for a future building.

Rebecca Scott
Programme Director – Dulwich

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[i] Weblinks for these strategies and programmes are:

Community–based Care Strategy:
http://www.tsa.nhs.uk/document/appendix-o-strategy-community-based-care-south-east-london

Primary and Community Strategy:
http://www.southwarkccg.nhs.uk/about/ourboard/march%202013/ENC%20Ai%20%20-%20NHS%20Southwark%20Primary%20and%20Community%20Care%20Strategy.pdf

Southwark and Lambeth Integrated Care Programme:
http://slicare.org/

Agenda Annex

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

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Dated: September 2013