ADULT AND COMMUNITY POLICY DEVELOPMENT AND SCRUTINY COMMITTEE

Minutes of the meeting held at 7.00 pm on 21 September 2010

Present:

Councillor Judi Ellis (Chairman)
Councillor Roger Charsley (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Simon Fawthrop, Peter Fookes, Diana MacMull and Diane Smith

Dr Angela Bhan, Angela Clayton-Turner, Richard Lane, Leslie Marks, Lynne Powrie and Gill Rose

Also Present:

Councillor Graham Arthur and Councillor Stephen Carr

33 APOLOGIES FOR ABSENCE AND NOTIFICATION OF ALTERNATE MEMBERS

Apologies were received from Councillor William Huntington-Thresher and Councillor Charles Rideout, Councillor Simon Fawthrop attended as Councillor Rideout's alternate. Apologies were also received from Mr Keith Marshall.

34 DECLARATIONS OF INTEREST

Councillor Roger Charsley declared he was a Member of Bromley Autistic Trust and SLAM.

Councillor Reg Adams declared that his wife was an employee of Bromley Community Counselling Service.

In respect of Item 11, Mr Richard Lane declared that he was a Member of Bromley LINk.

35 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

One written question and four oral questions were received from Members of the Public and these are attached at Appendix A to the minutes.

Mr Richard Lane reported that he felt strongly that Mrs Sulis' questions should be read out and a public response provided. The Chairman responded that in the past Mrs Sulis had asked a Member of the Committee to read out her

questions but that no arrangements had been made for this meeting. The Chairman reported that all the questions received would be appended to the minutes and that arrangements could be made for Mrs Sulis's questions to be read out in the future.

36 MINUTES OF THE MEETING OF ADULT AND COMMUNITY SERVICES PDS COMMITTEE MEETING HELD ON 27TH JULY 2010.

A Member highlighted a typing error on page 10 of the minutes *Special* awareness should be *spatial* awareness.

RESOLVED that the minutes from the meeting held on 27th July 2010 be agreed, subject to the amendment outlined above.

37 MATTERS ARISING FROM PREVIOUS MEETINGS

Report LDCS10147

The Committee considered recommendations from previous meetings which continued to be outstanding.

A Member highlighted that the dates for the Blue Badge Update should be 25th January 2011.

RESOLVED that progress on recommendations made at previous meetings be noted.

38 QUESTIONS TO THE ADULT AND COMMUNITY PORTFOLIO HOLDER FROM MEMBERS OF THE PUBLIC AND COUNCILLORS ATTENDING THE MEETING

Three oral questions were received from Members of the Public and these are attached at Appendix A.

The Portfolio Holder reported that the Thyme Out had attracted further publicity over the summer, winning a Bromley Star award and attracting a Green Flag. The Portfolio Holder reported that all the participants in the scheme would be gaining a City and Guilds qualification. A further intake of 20 participants would start the scheme next month.

The Portfolio Holder also reported that he had attended the Champions Evening in the Great Hall and had been invited to take part in the opening of Stafford House.

The Portfolio Holder commented on the publishing of the Health White Paper and the far reaching implications that it would have for the Borough.

39 PORTFOLIO HOLDER DECISIONS TAKEN SINCE THE LAST MEETING

The Committee noted decisions taken by the Portfolio Holder since the last meeting held on 27th July 2010.

40 PRE-DECISION SCRUTINY OF ADULT AND COMMUNITY PORTFOLIO REPORTS

A) SUPPORTING INDEPENDENCE IN BROMLEY

Report ACS10055

The Portfolio Holder introduced a report outlining the future changes to the care management arrangements arising from the revised business operating model for the delivery of adult social care assessment and care management services in the light of the Supporting Independence Programme.

The Assistant Director (Care Services) and the Programme Manager, Supporting Independence in Bromley introduced the report and highlighted the diagram of the Business Operation Model outlined on the last page of the report.

A Co-opted Member asked Officers to clarify what would happen to the programme when the Transforming Social Care Grant ceased. Officers confirmed that the grant had been used to set up new services such as re-ablement and that future efficiencies from these services would make them sustainable.

Another Co-opted Member asked if there was any interaction with health services at the bottom tier of the Business Operation Model. The Programme Manager, Supporting Independence in Bromley reported there had been discussions with the PCT about the development of an integrated service in the future.

The Committee considered issues surrounding delays in assessments and the uncertainty this could cause for services users regarding their eligibility for services. Officers provided assurances that work was being undertaken to develop information, advice and guidance and that individuals would be supported in accessing the available information.

The Director ACS highlighted that as part of these proposals Care Management Teams would be reorganised. This would involve staff moving into different areas and undertaking different roles. He pointed out that formal consultation with staff would be undertaken and whilst there would be changes in the numbers and grades of staff, it was not anticipated that this would result in significant job losses or redundancies.

The Portfolio holder reported that he had received positive feedback regarding the services under consideration. He went on to highlight the importance of rapid assessments and targeted, rapid intervention.

RESOLVED that the Portfolio Holder be recommended to endorse the revised care management arrangements arising from the revised business operating model.

B) REVIEW OF IN HOUSE HOMECARE SERVICE

Report ACS10053

The Portfolio Holder introduced a report providing information about the direction of travel of the in-house home care service and proposals about the future of the service contained within the Direct Care Services annual business plan.

The Portfolio Holder provided an overview of the report. Following this summary, the Unison Staff Side Secretary read a statement to the Committee. The Staff Side Secretary made a number of points:

- Clients had the right to choice;
- 130 workers were facing redundancy as a result of this decision;
- The notion that the in-house service was no longer viable was 'a fantasy';
- Levels of care would be lost;
- It did matter to clients who provided their care;
- Agencies did not provide the same level of care as the in-house service;
- Clients would lose the carers that they knew;
- In the past, when a service had been privatised the Council had been undertaking the process openly and honestly but that this was not the case with this decision;
- There had been no consultation regarding the decision;
- The duty of the elected Councillors was to the residents.

The Staff Side Secretary questioned why the decision had to be taken before the outcome of the comprehensive spending review had been announced and suggested that a portion of the Council's reserves could be utilised to protect the service. In concluding, the staff Side Secretary urged Councillors to reject the proposal.

The Director ACS responded to the statement and highlighted the need to ensure that suitable care arrangements were in place for the residents of Bromley in order to meet increasing demand for services and also to be able to respond to the challenges of the future

The Assistant Director (Care Services) provided an overview of the report and explained to the Committee that in Bromley approximately 13,000 hours per

week of care were provided by the independent sector, compared to the 3,000 hours of care provided by the in-house service. The personalisation agenda had a significant impact on the service due to the increasing number of people receiving personal budgets. The resources available were increasingly limited and the available resources had to be used wisely. The Assistant Director (Care Services) stressed that the proposed changes would not affect the pattern of care provided to service users.

A Member questioned whether the 30% higher costs of the in house home care service solely related to staff salaries or other issues. The Interim Head of ACS Finance reported that the difference in costs were influenced in part by competition within the market place but noted that Council services also carried a higher degree of overheads.

The issue of client choice was also raised and the Director ACS reported that there had not traditionally been a large degree of choice as the logistics of the service meant that carers were allocated on the basis of availability, but as the use of personal budgets increased service users would expect to exercise choice and that this would also involve them needing to compare the cosrts of different service options.

A Co-opted Member questioned the timeliness and speed of the decision. The Director ACS reported that over the past five years there had been a steady reduction in the amount of in-house care provided and an increase in the level of private care provided. The Director ACS stressed that the decision had not been rushed. The Director reported that if there were redundancies these would be one off costs but that he was unable to disclose specific figures at this stage. He also stressed that it was the intention to minimise redundancies through recruiting home care staff to the new reablement service and through other redeployment opportunities across the department.

Another Member questioned whether the current in-house care staff could be given the opportunity to utilise their skills and form their own company or set up their own social enterprise. The Assistant Director (Care Services) reported that the Department was developing a re-ablement service which would provide ring-fenced employment opportunities for staff employed in the in-house service to utilise and develop their existing skills where appropriate. The Assistant Director acknowledged that a social enterprise could be a possibility and that any staff wishing to explore this would be signposted to organisations that could provide advice.

A Member raised issues surrounding the auditing and scrutiny of private care services. The Chairman reported that in April 2010, the Committee had reviewed the quality of domiciliary care services. The Assistant Director (Care Services) reported that as part of the complaints and quality assurance process spot checks were carried out on an announced and unannounced basis.

A Co-opted Member highlighted that Bromley had always prided itself on its local provision and that preference should be given to local providers as the existing local knowledge should be retained. The Co-opted Member also stressed that independent providers should be regularly monitored and that a substandard service should not be tolerated to support a reduction in costs.

A Member asked if there were any additional measures that could be put in place to ensure that standards of care remained high. The Assistant Director (Care Services) suggested that a report providing more detail on quality assurance measures would be provided to the Committee at a future meeting and the Chairman reported that this was already included within the Committees work programme.

The Portfolio Holder acknowledged that quality should underpin the services provided and confirmed that the responsibility for care remained with the Council.

A Member suggested that current home care staff be assisted with setting up as an independent provider. As a result of this, a Member suggested that the Committee add a further recommendation for consideration by the Portfolio Holder. The Recommendation proposed by Councillor Adams was:

"That every help and facility be given by Bromley Council to DCS employees to enable them to establish a social enterprise, which would have as its key objective the provision of home-care services to the frail, elderly and disabled within the Borough of Bromley and that social enterprise should be allowed to compete on equal terms with other agencies for the Council's home-care service contracts."

Councillor Fookes seconded this motion and suggested that that a further recommendation be presented to the Portfolio Holder requesting that service users be consulted on the proposed changes. This additional recommendation was supported by Councillor Adams.

Councillor Fawthrop suggested that the recommendation proposed by Councillor Adams be amended to read:

That *advice* be given by Bromley Council to DCS employees on how they might explore the options of establishing a social enterprise to provide home-care services to the frail, elderly and disabled within the Borough of Bromley and that social enterprise should be allowed to compete on equal terms with other agencies for future contracts for home care.

The amendment was seconded by Councillor Macmull.

Following a vote the amendment to the recommendation was carried.

The Committee went on to vote on the recommendation proposed by Councillor Fookes that services users be consulted regarding the changes and following the vote this recommendation fell.

RESOLVED that (1) the Portfolio Holder be recommended to endorse the proposals for the In-house Home Care Service, subject to the outcome of consultation. (2) That *advice* be given by Bromley Council to DCS employees on how they might explore the options of establishing a social enterprise to provide home-care services to the frail, elderly and disabled within the Borough of Bromley and that social enterprise should be allowed to compete on equal terms with other agencies for future contracts for home care.

C) 'A PICTURE OF HEALTH' UPDATE

Oliver Lake, Director at the SE London Sector of the NHS and Dr Andrew Parson, Chislehurst GP and the Clinical Commissioning lead for Bromley attended the meeting to provide Members with an update on the 'A Picture of Health' Programme. The presentation provided to the Committee is attached at Appendix C to these minutes.

Members requested an update on the Birthing Unit. Mr Lake explained that the co-located Birthing unit on the PRUH site would go ahead. There had been concerns about the viability of the Queen Mary Sidcup proposals.

With regards A Picture of Health, Mr Lake stressed that the uncertainty that had been created was not good for the staff, service or service users. It was hoped that the evidence of compliance with the tests would be submitted by the end of the month and a decision would be taken shortly after the beginning of October 2010.

Mr Lake reported that the views expressed by Members of the public during previous consultations had been forwarded to the Stakeholder Reference Group. The Chairman urged Members of the Committee and the public to forward their views to the web address that had been set up for the consultation.

41 ACS BUDGET MONITORING 2010/2011

The Portfolio Holder introduced a report providing the budget monitoring position for the first two months of 2010/2011 for the Adult and Community Portfolio, based on expenditure and activity levels up to 31st July 2010. The Portfolio Holder highlighted the projected overspend reported and suggested that in the short term the situation was likely to worsen before it improved. The Portfolio Holder also outlined service areas that were currently causing pressure on the budget.

The Interim Head of ACS Finance reported that the Department was taking action in order to minimise the impact of the pressure on the budget.

A Member congratulated Officers on the reduction that had been achieved in the deficit and asked what controls were being used to bring the current overspend back in line. The Interim Head of ACS Finance reported that all

departmental expenditure was being reviewed and drew the Committee's attention to the Chief Officer comments outlined in the report.

The Portfolio Holder reminded the Committee that in recent years the Department had recorded an underspend in the budget. This year there were a number of additional budget pressures, not least in housing. The Portfolio Holder reported to the Committee that the budget pressures were constantly under review with action being taken to minimise the impact of the pressures.

RESOLVED that the Portfolio Holder be recommended to note that a projected overspend of £451,000 is forecast for the Adult and Community Services Portfolio as at 31st July 2010.

42 CAPITAL PROGRAMME MONITORING - 1st QUARTER 2010/11

On 21st July 2010, the Executive received a report summarising the current position on capital expenditure and receipts following the 1st quarter of 2010/11 and agreed a revised Capital Programme for the four year period 2010/11 to 2013/14. The Portfolio Holder considered a report which highlighted changes agreed by the Executive in respect of the Capital Programme for the Adult and Community Services (ACS) Portfolio.

RESOLVED that the Portfolio Holder be recommended to confirm the report.

43 UPDATE FROM SOUTH LONDON HEALTHCARE NHS TRUST

Ms Jennie Hall and Dr Moray from South London Healthcare NHS Trust attended the meeting to provide Members with an update on progress by South London NHS Trust.

Ms Hall reported that there had been no cases of MRSA since April 2010 and that levels of CDif were well ahead of target for the year. A&E performance was over 96% and the Trust was aiming to achieve 98%. In terms of safeguarding, the Trust would be declaring full compliance by the end of the month. Building work was also underway for the co-located birthing unit.

In terms of the challenges faced by the Trust, pressure points had been identified in A&E and Midwifery services. The Trust was still experiencing problems with the recruitment and retention of midwives and had implemented a targeted recruitment programme to address this.

Turning to the questions raised by the public in July 2010, Ms Hall reported that all the issues raised by clinicians had been fully investigated. The Trust was continuing to work with clinicians and their concerns would continue to be investigated. In response to a question from the Committee, Ms Hall reported that around 77 clinicians had expressed concerns in July 2010 but that it was difficult to give an accurate number as one of the elements of the complaint had been a letter placed in the media. The Chairman asked for the

Committee to be provided with feedback as to how the issues raised by the clinicians as the complaint had been made public and therefore the resolution should also be public.

Referring to the issue of pressure ulcers, Ms Hall reported that the Trust had undertaken a programme of work to address those issues identified. Changes were being implemented against a national framework which would encourage best practice to be imported into the Trust. Bromley LINk had asked to be involved in this work and this had been agreed. The Chairman asked if the Trust had been investing in additional equipment to help resolve the issue of pressure ulcers. Ms Hall reported that equipment was in place and that early assessment and staff training were important in minimising the instances of pressure ulcers.

A Co-opted Member suggested that it might be helpful to have some written information from South London Healthcare Trust presented to members of the Committee prior to each meeting. The Chairman agreed that this may be helpful in the future.

44 CANCER AND CARDIOVASCULAR PRESENTATION

Mark Hindmarsh, Senior Project Officer, Commissioning Support for London attended the meeting to provide Members with an overview of the recently published case for change and proposed model of care for future cardiovascular service provision in London. The presentation provided to the Committee is attached at Appendix D to these minutes.

A Member asked if high risk cardiovascular cases could be taken directly to specialist centres and Mr Hindmarsh reported that this was the aim.

Another Member asked about weekend cover for cardiovascular services and Mr Hindmarsh reported that the service specification was clear that cover would have to be provided on a 7 day a week basis.

Tom Pharaoh, Senior Project Officer, Commissioning Support for London, provided an overview of the recently published case for change and proposed model of care for future cancer service provision in London.

The Chairman stressed that transport was an important issue for Bromley residents. Mr Pharaoh reported that the consultation was emphasising localism. Dr Angela Bhan reported that the possibility of bringing services back to local hospitals had been investigated and that the PCT had been looking at developing a satellite service for radiotherapy in South East London.

A Co-opted Member asked about the timeframe for responses to the consultation. Mr Pharaoh reported that the questionnaire would be open until 31st October 2010 and the questionnaire could be accessed at www.csl.nhs.uk.

45 ACCOMMODATION AND CARE FOR ADULTS REFERENCE GROUP - REVISED TERMS OF REFERENCE

Report ACS10057

The Committee considered a report seeking Members' endorsement of revised terms of reference for the Care Home Reference Group to encompass all issues relating to accommodation with care for older people.

RESOLVED that the proposal to expand the focus of the Care Home Reference Group to encompass all accommodation with care issues for older people (including a change of name to Accommodation with Care for Older People Reference Group) and the revised terms of reference be endorsed.

46 WORK PROGRAMME

Report LDCS10148

The Committee reviewed its Work Programme for 2010/2011. The Chairman reported that the Committee would continue to monitor domiciliary home care. The Committee also requested an update on the Health White Paper at the next meeting.

RESOLVED that the Committee's Work Programme for 2010/2011 be noted.

47 LOCAL GOVERNMENT ACT 1972 AS AMENDED BY THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006 AND THE FREEDOM OF INFORMATION ACT 2000

RESOLVED that the Press and public be excluded during consideration of the items of business listed below as it is likely in view of the nature of the business to be transacted or the nature of the proceedings that if members of the Press and public were present there would be disclosure to them of exempt information.

48 EXEMPT MINUTES OF THE MEETING OF ADULT AND COMMUNITY SERVICES PDS COMMITTEE HELD ON 27TH JULY 2010

The exempt minutes of the meeting held on 27th July 2010 were agreed.

49 PRE DECISION SCRUTINY OF PART 2 ADULT AND COMMUNITY PORTFOLIO HOLDER REPORTS

A) COMMISSIONING ARRANGEMENTS FOR WOMEN'S REFUGE SERVICE - EXTENSION TO EXISTING CONTRACT

Report ACS10054

The Portfolio Holder introduced a report requesting that the Portfolio Holder agree a waiver of financial regulations to enable an extension of the current contract until 31st December 2010 to allow for further consideration of the most advantageous procurement route.

A Member expressed concerns about waiving financial regulations. The Director ACS explained why the Portfolio Holder was being asked to waive financial regulations.

The Chairman reported that she endorsed the proposals in the report and the Portfolio Holder reported that he was satisfied with the case that was being made.

RESOLVED that the Portfolio Holder be recommended to agree under Rule 13 of the Council's Financial Regulations that a contract for support services to women's refuges be entered into with Bromley Women's Aid for a period of 3 months from 1st October 2010 until 21st December 2010.

The Meeting ended at 10.55 pm

Chairman

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ADULT AND COMMUNITY PDS COMMITTEE: PUBLIC QUESTIONS
21st September 2010

Public Questions to the Chairman at Adult and Community PDS Committee from David Mott:

Q1: Was outsourcing to Rapid Surgical Solutions (and the other three companies being used by SLHT) subject to competitive tendering – if not, what was the reason for not putting this contract out to competitive tendering (34)

Reply

South London NHS Healthcare Trust undertook to provide a response to Mr Mott's question before the Trust's Board meeting on 29th September.

Supplementary Question:

Is the Committee aware that some SLHT orthopaedic patents have been advised by Rapid Surgical Solutions that the treatment agreed with their SLHT surgeon should be changed, for example, instead of a partial knee replacement they are being offered a full knee replacement. Patients chose to see a particular surgeon at Princess Royal and, instead, some are being outsourced to a surgeon they have never met – how does this comply with the two agendas of patient choice and creating a patient led NHS?

The Chairman responded that she would ask South London Healthcare Trust to respond to the points that had been raised.

Q2: How did Rapid Surgical Solutions become aware that SLHT was looking to outsource - on what date did they submit their tender - whose decision was it to allocate the contract to them and what date was the first SLHT patient referred to them for treatment (44)

Reply

South London NHS Healthcare Trust undertook to provide a response to Mr Mott's question before the Trust's Board meeting on 29th September.

Supplementary Question:

Having personally spoken with Rapid Surgical Solutions I am informed that SLHT id their sole client/contract. Does this committee not think it is questionable that SLHT orthopaedic patients are being referred for their surgery to an orthopaedic surgeon at a private facility who co-incidentally has the same surname as as Director of Rapid Surgical Solutions?

The Chairman reported that she was unable to respond as this matter did not fall under the remit of the Committee.

Q3: What date did the Rapid Surgical Solutions contract commence - when does it terminate - will it be extended and who vetted them to ensure that they were a fit and proper company to treat SLHT patients, particularly as the company only came into being in February of this year (48)

Reply

South London NHS Healthcare Trust undertook to provide a response to Mr Mott's question before the Trust's Board meeting on 29th September.

Supplementary Question:

You have had in your possession papers concerning Rapid Surgical Solutions for two months now and I would hope these papers have been shared with other Members of the Committee. Can you advise what enquiries you have made about the activities of this company and the way in which SLHT provides services to their patients or is your only action to invite a Member of the Trust to update you with yet another of their subjective views? It appears to me that within SLHT there seems to be an alternative method of business practice to the norm cornering the way in which some services are being outsourced to private providers. Isn't it the duty of this committee to scrutinise on behalf of the patients and public of this borough and not to rely solely on the subjective views of the Trust representatives by way of a verbal update?

The Chairman responded that the Committee had a role in scrutinising the Health Trust and would be receiving an update from the Trust at this meeting. The Chairman went on to say that she was unable to to give a fuller response to the question as she was not in possession of all the information and therefore unable to provide an informed response.

Public Question to Portfolio Holder at Adult and Community PDS Committee from Peter Moore

Q1: An early August Newsshopper article suggested Bromley was proposing cuts of 25% to their budgets. At a more recent meeting of providers and 'dragons' and to the apprehension of most present, a figure of £45 per day allowance was slipped in to the discussions. I understand the current figure for the provision of a day service is £60; this is 25% less.

Can you advise how this difference will be made up or do you expect the service provider to reduce its rates?

Reply

"The discussion that the questioner refers to was about the calculation of a notional personal budget for the purposes of two specific day activities projects which are under way with people who meet the Council's eligibility criteria. There is no single standard cost of day activities– it will vary by client

group, the dependency or needs of the individual as well as by the activity offered."

Supplementary Question:

This will leave less personal choice as larger bidders would be able to meet the reduced costs which smaller more local providers may struggle to meet. Will this jeopardise care and lead to the bankruptcy of local providers?

The Portfolio Holder responded that the costs involved related to a notional figure. There had been two separate stories in the press regarding two separate issues and there was no link between the 25% cut in budget and the reduction in the cost of day services.

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ADULT AND COMMUNITY PDS COMMITTEE: PUBLIC QUESTIONS
21st September 2010

Public Written Question to Chairman at Adult and Community PDS Committee from Mrs Susan Sulis, Secretary, Community Care Protection Group

With regard to ACS 10055 "Support Independence in Bromley –Changes to Care Management Arrangements" – Assessing Future Need:

Q1: This report states (para 3.4.9) that a smaller number of users will require Long Term Care.

Earlier studies by Laing and Buisson, commissioned by ACS show a significant increase in elderly population requiring LTC.

Before accepting significant reductions in the Homecare service, will Members require officers to procure an updated study?

Reply

There are no plans to reduce the provision of home care or domiciliary care services to people who meet the Council's eligibility criteria. The Council currently purchases the majority of that care through a range of independent sector care providers and a decreasing amount has been delivered through an in-house service.

Over recent years there has been a consistent and steady increase in the amount of the Council's budget used to purchase domiciliary care on behalf of residents and a decrease in the use of long term residential and nursing care. With the continuing projected increase in the elderly population, this is likely to continue.

Our Supporting Independence Programme is helping to address these demands and through reablement is aiming to ensure that as many people as possible are encouraged to regain their confidence and skills following an illness or perhaps a fall, and therefore have a reduced reliance on care.

Public Written Questions to Portfolio Holder at Adult and Community PDS Committee from Mrs Susan Sulis, Secretary, Community Care Protection Group

With regard to ACS 10053 "Review of In House Homecare Service – Consultation with Users:

Q1: Cllr Arthur was quoted in the Bromley Times (2.9.10) as saying: *"At the moment, we are finding out people's views and I don't want to comment, as I don't want to prejudice the outcome"*

When will users of the service, who are clearly concerned about these changes, be consulted?

Reply

It is our standard practice that Care Management staff make contact with any service user where a change to their care arrangements is being considered. This includes circumstances where the organisation providing the care is changing. In respect of the changes being considered for the in-house home care service this process is underway and each service user and their family are being contacted in advance of any change being made to their care arrangements

Q2: Will he ask officers to explore the feasibility of setting up a scheme to allow service users to retain their usual carers via personal budgets or Direct Payments if the in-house scheme is to be abandoned?

Reply

With regard to whether existing Home care staff could establish themselves as self employed carers or personal assistants, that is a matter for those interested individuals to pursue independently There is a vast amount of information available via the internet about how direct payments work for both service users and carers and interested individuals are free to seek advice and assistance in how to explore these options.

South London Healthcare NHS
NHS Trust

Trust Headquarters
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DA14 6LT

Direct Line: 0208 308 3191
Fax: 0208 308 3074

28th September 2010

Dear M

Further to the questions you raised at the Bromley HOSC meetings in July and September 2010, I respond as follows:

"Is this Committee aware that some patients are being outsourced to a Private company and many patients have been sent a letter which informed them that their treatment will be delayed if they don't agree to this option? What about patient choice and creating a patient led NHS?"

The Trust is committed to meeting patient access targets. Unfortunately in some circumstances the demand for services is larger than the capacity that the Trust can deliver in house. In these circumstances the Trust will offer patients the opportunity to have their treatment in the private sector. This has been the case for several years. In June this year the Trust expanded the number of providers to ensure adequate competition and to drive value for money.

All patients still have patient choice and do not have to accept this outsourced option. They are able to have their operation with their desired surgeon but are being given another choice if they wish to accept.

"Was outsourcing to Rapid Surgical Solutions subject to competitive tendering- if not what was the reason for not doing so?"

A one-year contract was awarded following submissions by a number of external providers which were reviewed on the basis of price, efficiency and availability of

immediate capacity for the specialties required. Patient safety and quality of care for outsourced patients was underpinned within the contract by the Care Standards Act 2000 compliance requirements.

The use of Rapid Surgical Solutions is part of a range of solutions the Trust uses to ensure patient waiting times and ensure a quality service.

"Is this committee aware that some SLHT orthopaedic patients have been advised by RSS that the treatment agreed with their SLHT surgeon could be changed. For example instead of a partial knee replacement they are being offered full knee replacement. Patients chose to see a particular surgeon at the PRUH and instead are being outsourced to a surgeon they have never met. How does this comply with the 2 agendas of Patient Choice and creating a patient led NHS?"

As mentioned above, the Trust is committed to meeting patient access targets. Unfortunately in some circumstances the demand for services is larger than the capacity that the Trust can deliver in house. In these circumstances the Trust will offer patients the opportunity to have their treatment in the private sector. This has been the case for several years. In June this year the Trust expanded the number of providers to ensure adequate competition and to drive value for money. On two occasions patients requiring a partial knee replacement rather than a total knee replacement were offered surgery with RSS; this was an error and the patients were immediately brought back to SLHT for treatment.

All patients still have patient choice and do not have to accept this outsourced option. They are able to have their operation with their desired surgeon but are being given another choice if they wish to accept.

"How did RSS become aware that SLHT was looking to outsource, on what date did they submit their tender, whose decision was it to allocate the contract to them and on what date was the first patient referred to them for treatment?"

The first formal conversations with RSS took place on 4th February 2010, with the contract commencing from 26th May 2010. The first patients were treated on 14th June 2010. The company approached the division directly on a speculative basis.

As mentioned above, a one-year contract was awarded following submissions by a number of external providers which were reviewed on the basis of price, efficiency and availability of immediate capacity for the specialties required. Patient safety and quality of care for outsourced patients was underpinned within the contract by the Care Standards Act 2000 compliance requirements.

The use of Rapid Surgical Solutions is part of a range of solutions the Trust uses to ensure patient waiting times and ensure a quality service.

This involved discussions with some senior clinicians and senior managers about the options for outsourcing to Rapid Surgical Solutions in order to meet access targets and treat patients in a timely way. Rapid Surgical Solutions were the cheapest of several options. The decision has ensured competition amongst providers and has led to lower charges from other providers.

"Having personally spoken with RSS I am informed that SLHT is their sole client. Does this committee not think it questionable that SLHT orthopaedic patients are being referred to for their surgery to an orthopaedic surgeon who co-incidentally has the same surname as a Director of RSS?"

With small companies it is likely that the Director of the company may be the person carrying out the work. There is no conflict of interest here as the orthopaedic surgeon is not the one referring the patients to the company to be treated. A conflict of interests may occur if the surgeon worked for SLHT and then referred patients to his/ her own company.

The use of RSS has actually improved any conflict of interest as it uses consultants that do not work for SLHT. The Trust is satisfied that there is clear segregation of duties.

"What date did the RSS contract commence, when does it terminate, will it be extended and who vetted them to ensure that they were a fit and proper company to treat SLHT patients particularly as the company only came into being in February of this year?"

The first formal conversations with RSS took place on 4th February 2010, with the contract commencing from 26th May 2010 (reviewed annually). The first patients were treated on 14th June 2010. The company approached the division directly on a speculative basis.

As mentioned above a one-year contract was awarded following submissions by a number of external providers which were reviewed on the basis of price, efficiency and availability of immediate capacity for the specialties required. Patient safety and quality of care for outsourced patients was underpinned within the contract by the Care Standards Act 2000 compliance requirements.

The use of Rapid Surgical Solutions is part of a range of solutions the Trust uses to ensure patient waiting times and ensure a quality service.

This involved discussions with some senior clinicians and senior managers about the options for outsourcing to Rapid Surgical Solutions in order to meet access targets and treat patients in a timely way. Rapid Surgical Solutions were the cheapest of several options. The decision has ensured competition amongst providers and has led to lower charges from other providers.

Yours sincerely

Jennie Hall
Director of Nursing, Governance & Patient Experience

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A Picture of Health
(APOH)

Bromley OSC: 21st September 2010

APOH in History

- Service model development began in 2007
- 14 week public consultation in early 2008
- Consultation with the Joint Health Overview and Scrutiny Committee
- Integrated Impact Assessment used to inform decision-making
- Joint Committee of Primary Care Trusts decision in July 2008
- Referral to Secretary of State November 2008
- Secretary of State requested review by IRP
- IRP review completed in March 2009
- Process of clinical redesign began
- Lewisham Implementation complete
- SLHT Implementation was planned for Autumn 2010

Where we are now…

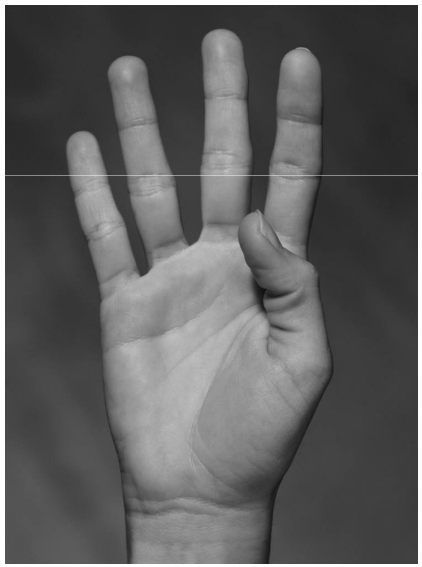
- On the 21st May 2010 the Secretary of State announced all existing & future reconfigurations should demonstrate that they met four key tests

- A programme of work commenced to provide assurance & evidence that the APOH reconfiguration was compliant

- The Clinical Cabinet is responsible for assessing whether the threshold for the four reconfiguration tests has been met

The Four Tests

The four tests as outlined in the 29th July 2010 letter from Sir David Nicholson:



1. **Support from GP commissioners**
2. **Strengthened public and patient engagement**
3. **Clarity on clinical evidence base**
4. **Consistency with current and prospective patient choice**

Local Responses

The **Clinical Cabinet** is leading the process to gather evidence for tests:

1. Support from GP commissioners
3. Clarity on clinical evidence base

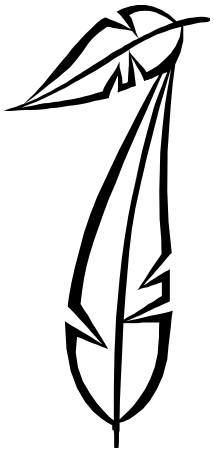
The **Stakeholder Reference Group** (SRG) is gathering evidence for tests:

2. Strengthened public and patient engagement
4. Consistency with current and perspective patient choice

Both groups will assess whether tests have been met & discuss their findings at the **Reconfiguration Test Task Group**

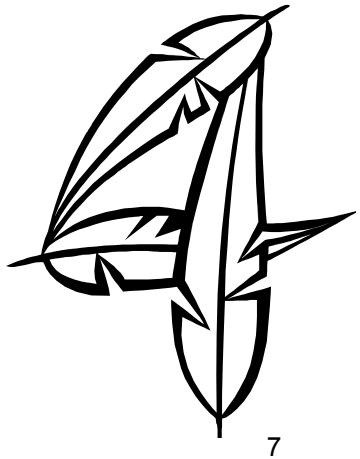
The Clinical Cabinet

- Set up in June 2010
- Chaired by Bexley GP Dr Joanne Medhurst
- Membership comprises of GP leads from Bexley, Bromley and Greenwich PCTs
- Collect evidence for tests 1 & 3
- Provide assurance to the NHS SE London Sector Chief Executive that all four tests have been met
- The cabinet has established a Reconfiguration Test Task Group to seek advice on tests 2 & 4



Stakeholder Reference Group (SRG)

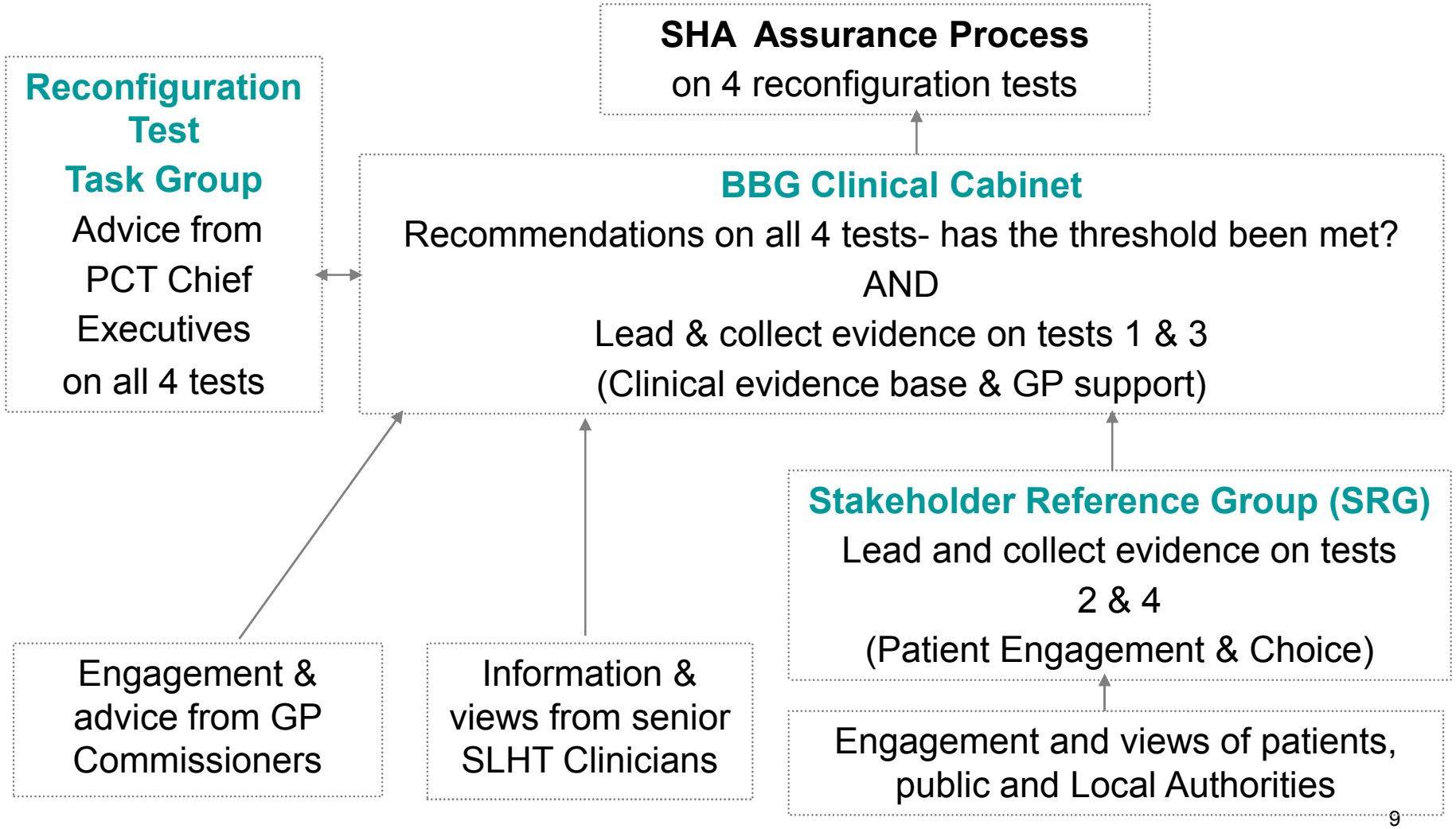
- Established in 2009 following IRP review
- APOH obligation to involve patients in service design
- Membership includes elected Borough Councillors & representatives of LINKs
- Gather evidence relating to tests 2 & 4
- Assess whether tests have been met & present findings



Reconfiguration Test Task Group

- To be established by the Clinical Cabinet
- Membership will comprise senior Clinical and non Clinical Commissioners
- Support assessment of whether four tests are met
- Decisions will then be finalised by the Clinical Cabinet

Overview


SHA Assurance Process
on 4 reconfiguration tests
Reconfiguration Test Task Group
Advice from PCT Chief Executives on all 4 tests
BBG Clinical Cabinet
Recommendations on all 4 tests- has the threshold been met?
AND
Lead & collect evidence on tests 1 & 3
(Clinical evidence base & GP support)
Stakeholder Reference Group (SRG)
Lead and collect evidence on tests 2 & 4
(Patient Engagement & Choice)
Engagement & advice from GP Commissioners
Information & views from senior SLHT Clinicians
Engagement and views of patients, public and Local Authorities

Emerging Views of the Clinical Cabinet

- Asked GPs views on original Case for Change & reconfiguration proposals
- Emerging position statement developed
- GPs broadly supported proposals, comments about standalone MLBU, Finance, Quality
- Feedback form sent to GP commissioners asking for views
- Further opportunity to meet with members of the Cabinet & SLHT clinical service leaders
- Cabinet will analyse views expressed that counter the proposal

Impact on Bromley

Maternity

Residents will lose option of QMS

Strengthened Maternity service at PRUH

Co-Located Midwife Led Birthing Unit

Ante/Post Natal care remains unchanged on all sites, or more local

Elective (Planned)

Non-complex planned surgery moves to QMS

Day surgery/outpatients stays at current locations

Reliable, Safe, Low Infection, productive service

Centre of excellence

Impact on Bromley

Emergency

QMS A&E to close

24 Hour urgent Care Centre at QMS

Strengthened A&E service at PRUH

UCC at PRUH + others…

Care out of hospital schemes

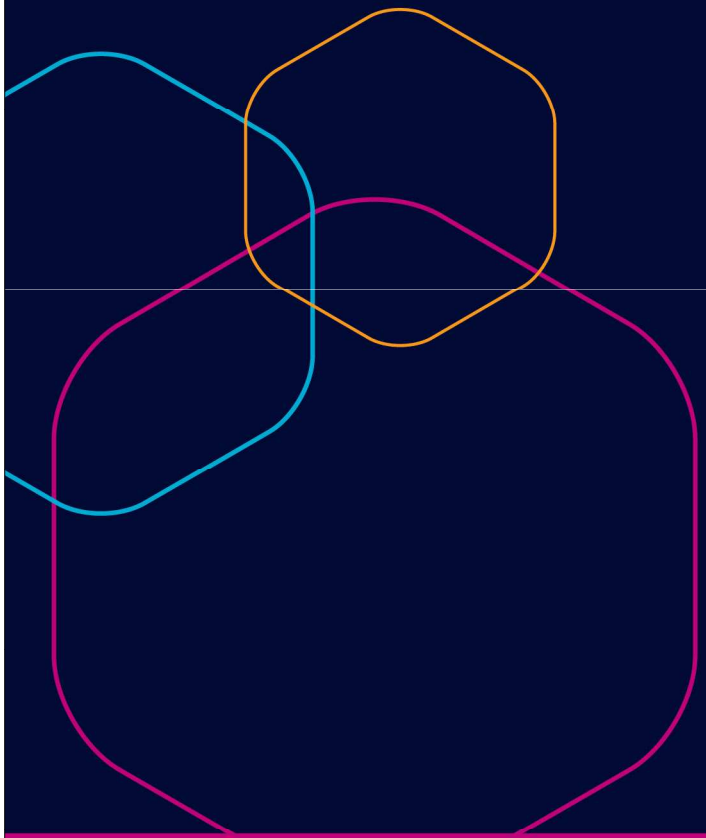
NHS

Commissioning Support for London

A proposed model of care for London cardiovascular services

Mark Hindmarsh

Senior Project Officer



Providing clinical and business support to London's NHS

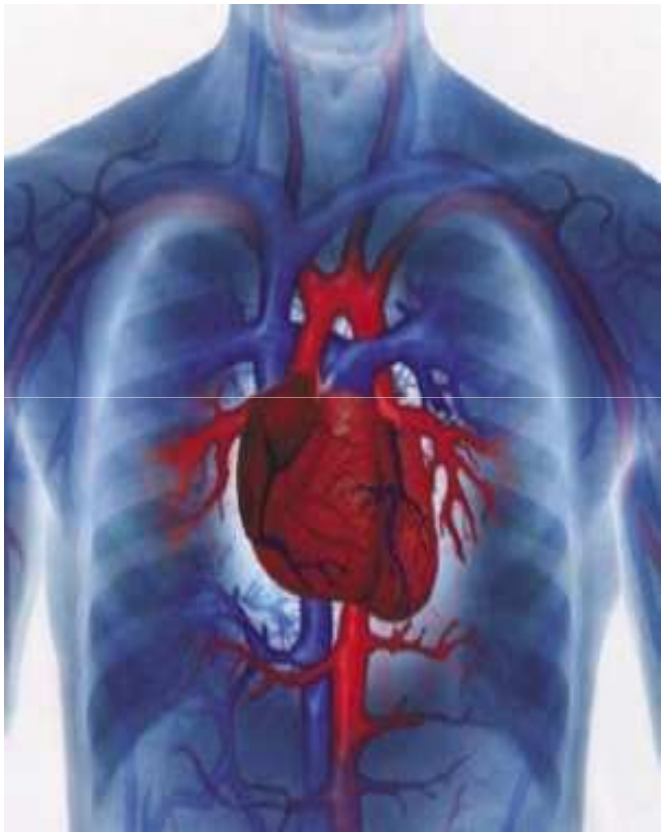
Project structure

Focus on emergency and complex hospital care

Vascular surgery
Surgery on veins and arteries

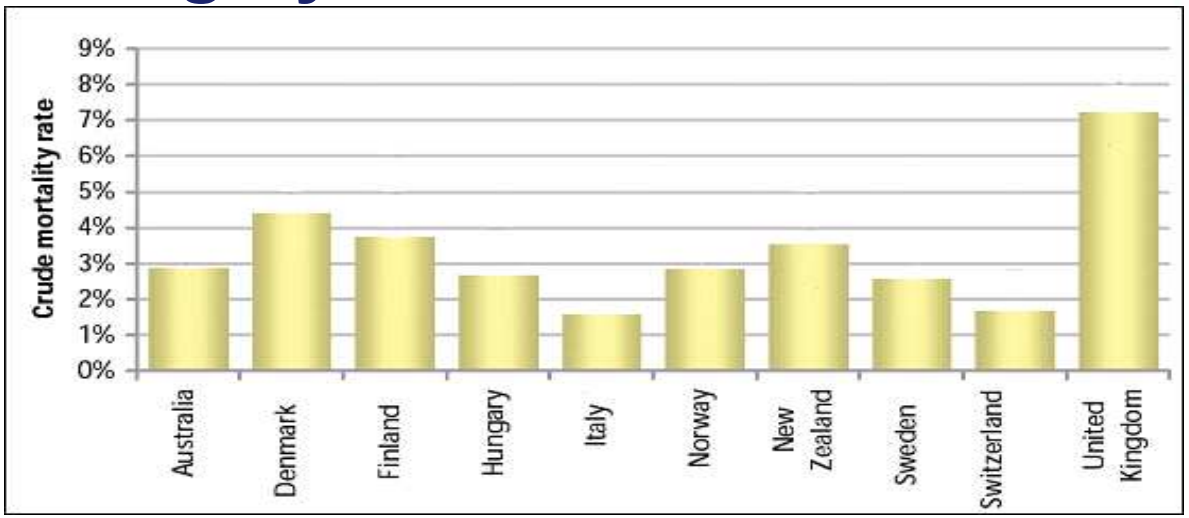
Cardiac surgery
Surgery on the heart

Cardiology
Less invasive procedures on heart



Project led by:
- clinical expert panel for each area
- patient panel

Vascular surgery



Case for change

UK has the poorest outcomes for complex vascular surgery in Europe

In London, 75% of complex vascular surgery takes place in six hospitals, 25% is spread across 13 sites

Medical evidence shows higher volume hospitals & the experience of surgeon gives better outcomes – practice makes perfect

Model of care

All emergency and elective complex vascular surgery should be centralised into high volume hospitals

Local hospitals will continue to deliver the bulk of the vascular service:

- Outpatients & diagnostics
- Varicose vein surgery

Cardiac surgery

Case for change

Pathway length for urgent heart bypass surgery in London varies from 18 to 52 days

- 14 days in the United States
- 20-25 days in the rest of the UK

Medical evidence shows mitral valve repair gives better outcomes than mitral valve replacement

Proportion of patients having mitral valve repair over replacement is low

Model of care

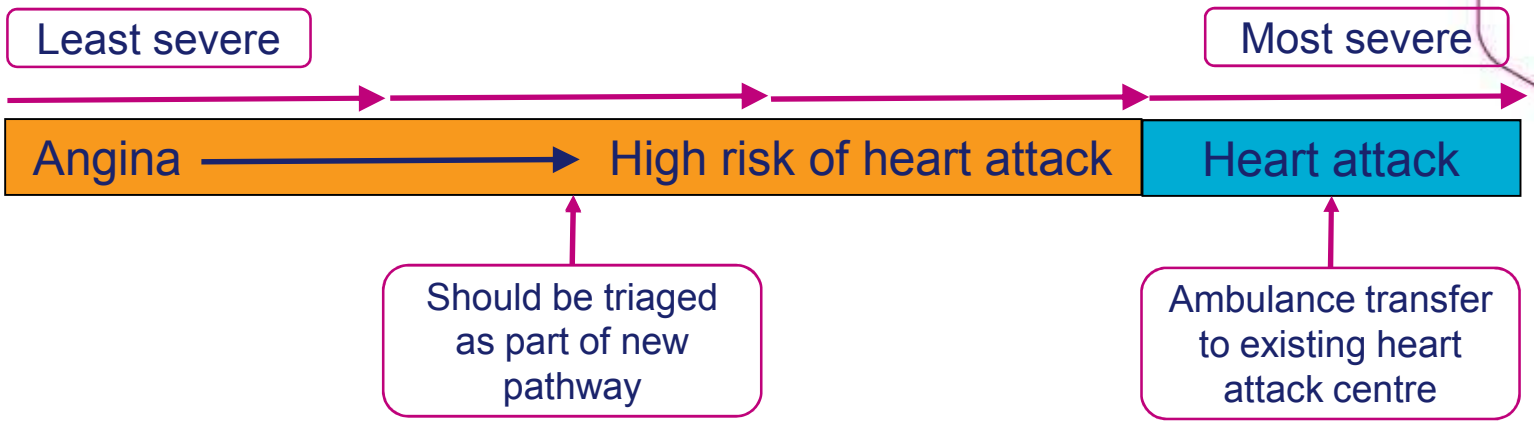
No changes to **where** heart bypass surgery is provided, changes to **how** cardiac surgery is organised

Recommendations to improve urgent cardiac surgery

- Use of electronic referral system
- Standardised method of assessing the urgency of each patient

Concentrate expertise of surgeons and teams performing mitral valve surgery

Cardiology



Case for change

Patients at high risk of having a heart attack who are given an early angiogram have improved outcomes
- NICE guidance, March 2010

The UK implants fewer corrective heart rhythm devices than European comparators

There is huge variation across London PCTs

Model of care

Patients should be risk assessed at local A&E departments

High risk patients should be transferred to a centre for an angiogram within 24 hours

Hospitals organise into electrophysiology networks

Local hospitals should implant simple devices and link to specialist sites for complex care

Scale of change

Vascular surgery

- Approx 2,500 arterial procedures per year
- Approx 75% of cases already performed in six Trusts

Centralisation likely to affect less than 700 cases per year

Cardiac surgery

- Approx 3,000 non-elective cases per year (increasing)
- Approx 1,000 mitral valve procedures per year

Changes in working practices will benefit thousands of patients

Cardiology

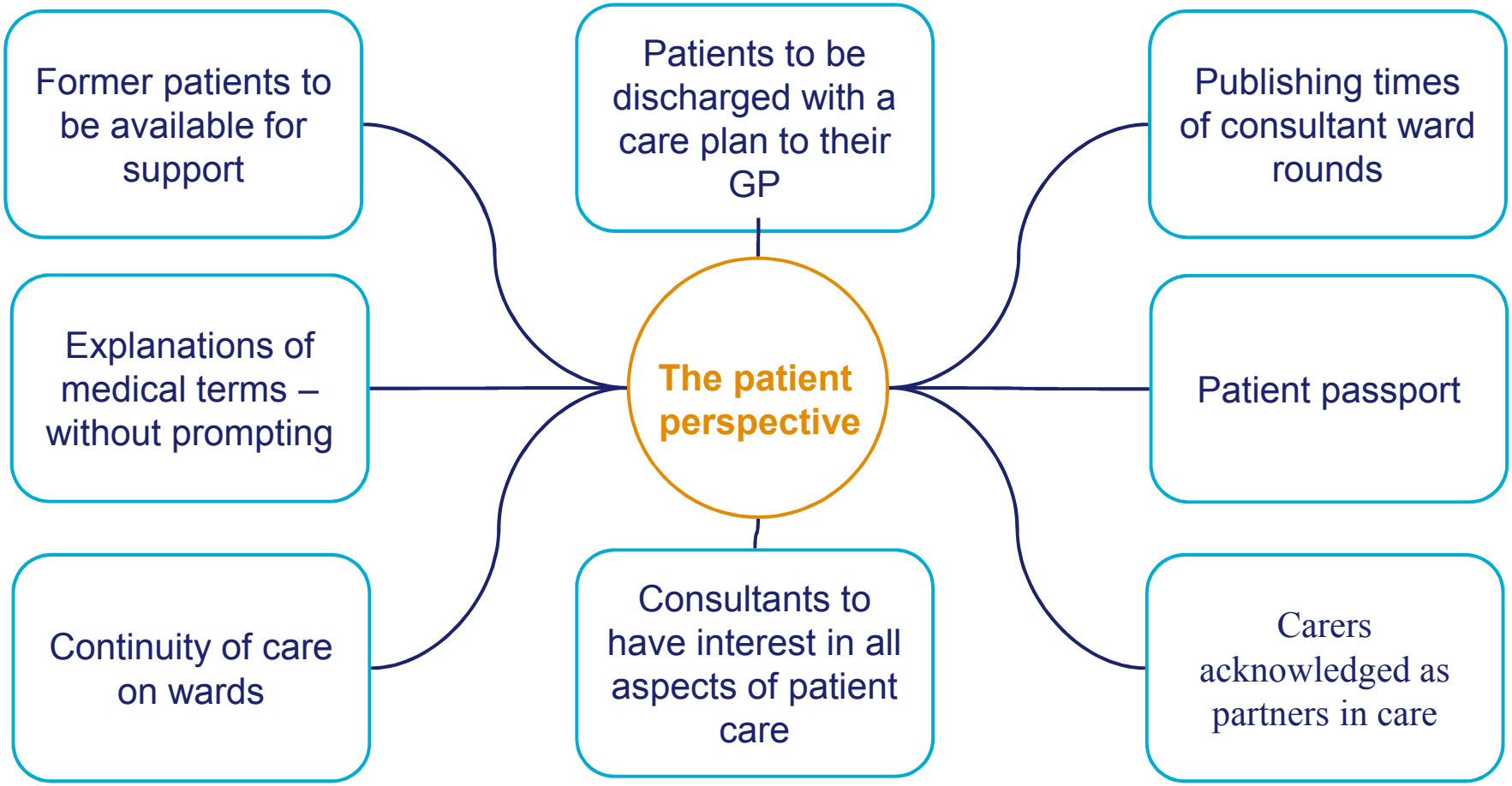
- Ambulance service called out to 60,000 “chest pain” patients per year
- Increase in heart rhythm device implants likely to affect hundreds of patients

Changes to pathways will benefit thousands of patients

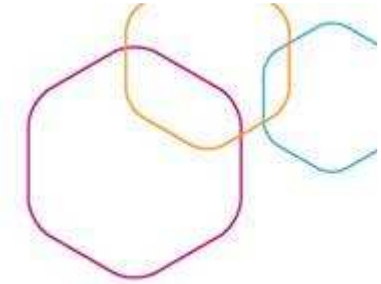
The Patient Perspective

The patient panel fully support the project – it will improve quality, reduce deaths and give people better lives

In addition patients would also benefit from improvements in the following areas:



Engagement plans



www.csl.nhs.uk
Click on “cancer and cardiovascular models of care”

All project documents published on the internet

Online questionnaire available – PLEASE COMPLETE!

Speaking to patient, local authority and GP groups across London

Engagement events to be held in September

Hand over finalised work to commissioners in Autumn 2010

NHS

Commissioning Support for London

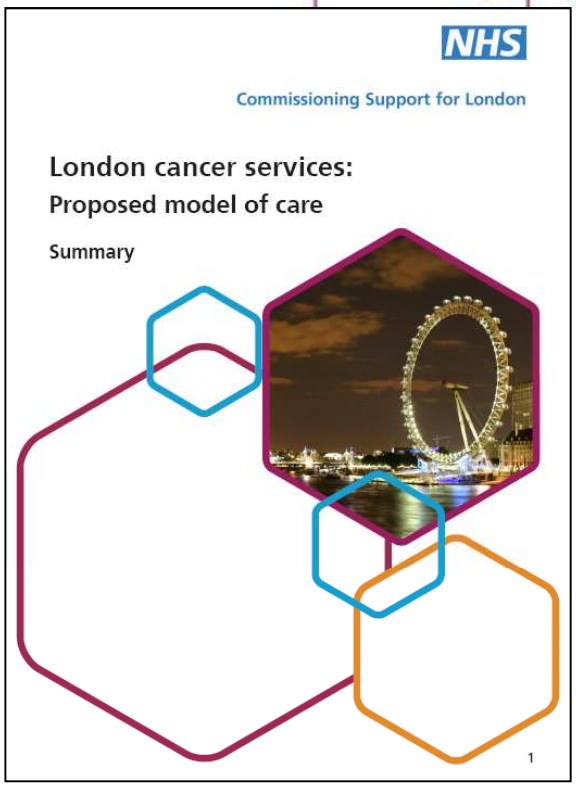
A proposed model of care for London cancer services

Tom Pharaoh

Senior Project Officer

Providing clinical and business support to London's NHS

Developing the proposals



Clinically-led

Three work areas:

- Early diagnosis
- Common cancers and general care
- Rarer cancers and specialist care

Project board informed by:

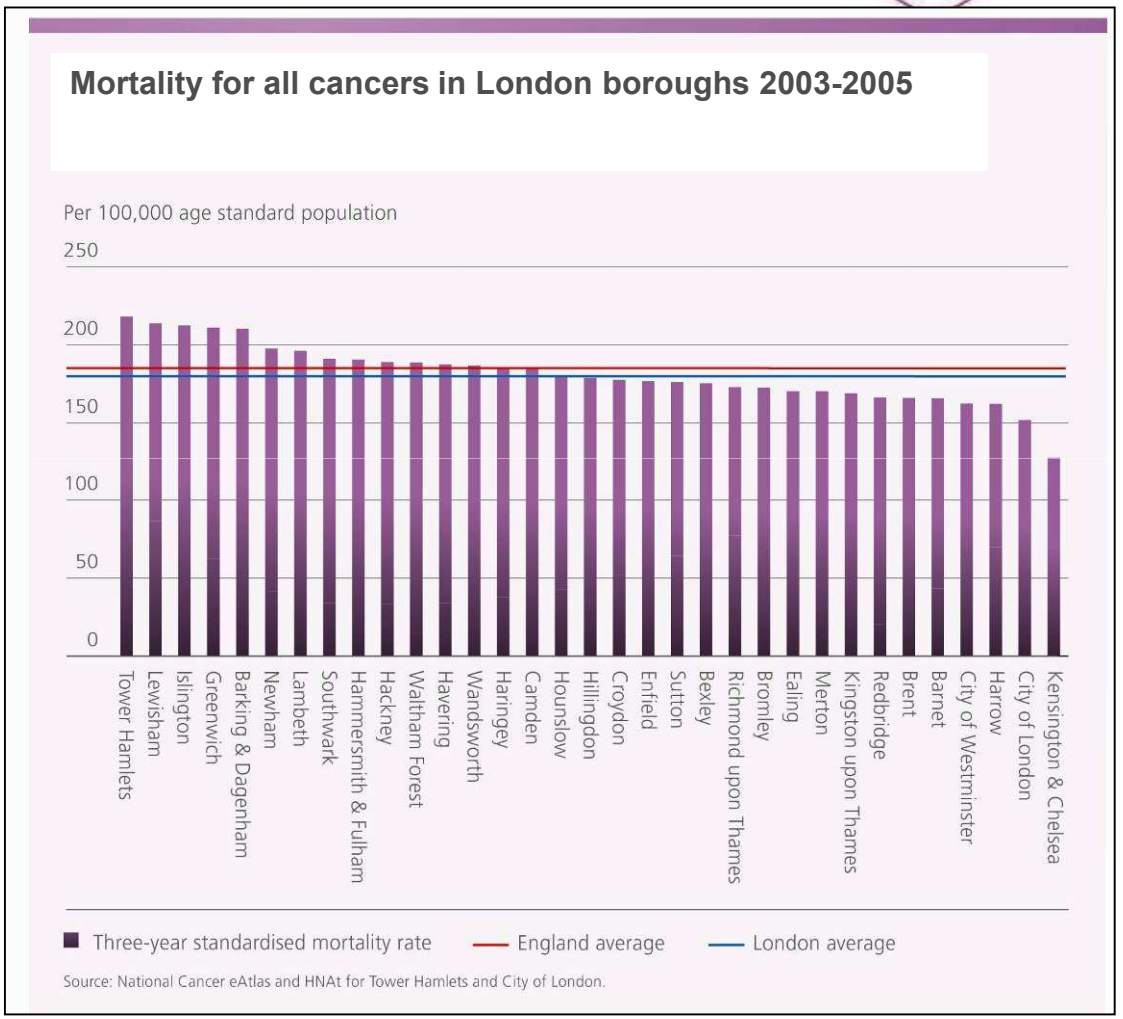
- An expert reference group for each work area
- An overarching expert reference panel
- A patient panel
- Out of London experts

Case for change

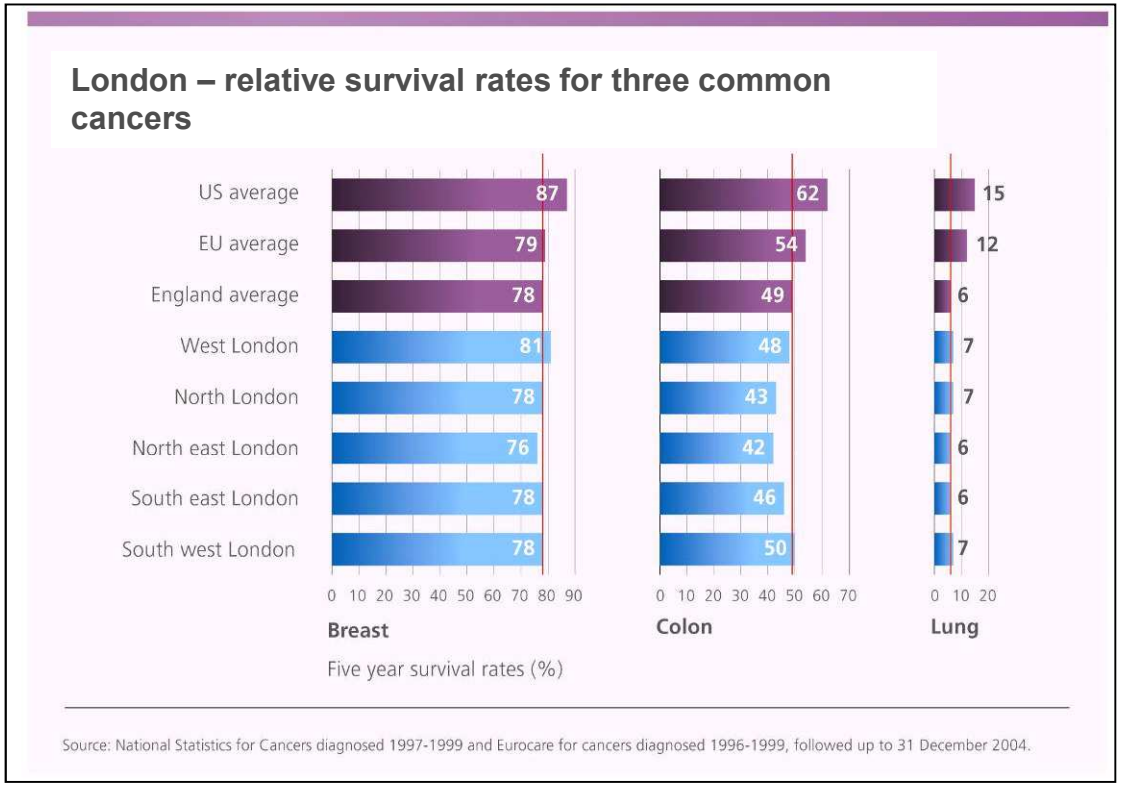
There are areas of excellence in London but significant inequalities in access and outcomes

Learning and best practice should be shared

Treatment and care (such as type of surgery and length of stay) should be standardised



Case for change

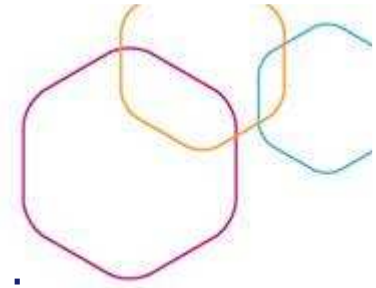


Later diagnosis has been a major factor in causing poorer relative survival rates

Specialist surgery should be centralised: common treatments and surgery should be localised where possible

Strong commissioning of high-quality comprehensive care pathways is necessary; organisational boundaries should not be a barrier

Cancer networks

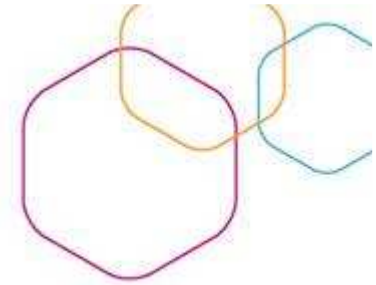


Existing five cancer network teams should focus on giving expert commissioning advice as **cancer commissioning networks**

To ensure that standardised care pathways can be delivered a small number of **provider networks** should be developed

Configuration and number of networks will be driven by implementation of model of care recommendations

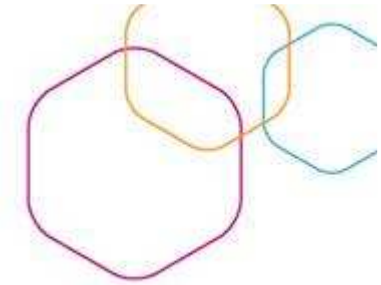
Early diagnosis



Recommendations include:

- Implement recommendations of National Awareness and Early Detection Initiative (NAEDI)
- Direct access to some diagnostic investigations from primary care
- Increase uptake rates of screening programmes
- Understand and address inequalities to increase awareness and reduce late presentation

Common cancers and general care



Recommendations include:

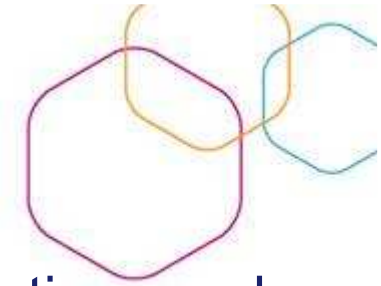
- Centralisation of some surgical services, localisation of others
- Standardised best practice (day case breast surgery, laparoscopic colorectal surgery, enhanced recovery programmes to minimise lengths of stay)
- High quality, safe local delivery of chemotherapy
- Acute oncology services in emergency departments
- Complement traditional follow-up with bespoke follow-up based on survivorship model

Rarer cancers and specialist care

Recommendations include:

- Concentration of some rarer cancer services beyond minimum NICE requirements to help ensure high quality experience and outcomes
- Minimum caseloads for specialist oncologists for each rarer tumour type to maintain their specialist expertise
- Consider centralised commissioning of all radiotherapy (to include specialist radiotherapy) to ensure equal access to treatment for all Londoners

The patient perspective



The cancer patient panel fully support the recommendations and contribute a foreword to the model of care

The key themes that emerged from the panel's discussions were:

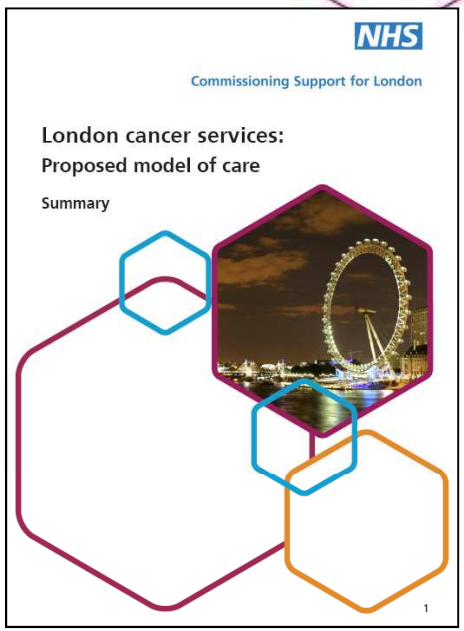
- An increased emphasis on public awareness and problems associated with delays in diagnosis
- The need to have transport considered when patients travel further for the best specialist care
- The need for joined-up pathways of care with designated keyworkers available for all patients
- A holistic approach to patients with carers acknowledged as partners in care

Gathering support

Full clinical model of care was published as a *proposed* model in August 2010

It was released alongside a more accessible summary of the entire review process and its findings

Visit the website to see the **summary** and to give your views via the online **questionnaire**.



www.csl.nhs.uk

Click on “cancer and cardiovascular models of care”