

START WELL, LIVE WELL, AGE WELL



South West London  
Health and Care Partnership

# SOUTH WEST LONDON HEALTH AND CARE PARTNERSHIP: ONE YEAR ON.

Discussing with you how we deliver better health  
and care for local people



# FOREWORD

Local NHS clinical commissioning groups, provider trusts, local authorities and patients' representatives across South West London make up the STP's South West London Health and Care Partnership.

The partners are:

- Our six Clinical Commissioning Groups (CCG) of: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our six Local Authorities: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our Acute and Community Providers: Central London Community Healthcare, Croydon Health Services NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Hounslow and Richmond Community Healthcare, Kingston Hospital NHS Foundation Trust, Royal Marsden Foundation Trust, St George's NHS Foundation Trust and Your Healthcare
- Our two Mental Health Providers: South West London and St George's Mental Health NHS Trust, South London and the Maudsley NHS Foundation Trust
- The GP Federations in each of the six boroughs
- The London Ambulance Service
- Healthwatch

We've listened to local people, our partners, politicians and experts like the King's Fund, and have worked together to refresh our vision and strategy for south west London. This had been brought this together in this discussion document.

**This document is for discussion with local organisations and stakeholders and is not a final document.**

We will continue to work with Local Authorities, the voluntary sector, local Healthwatch groups as well as the NHS to produce "Local health and care plans" in June 2018. These plans will provide clear and detailed actions to address the local challenges we have set out in this discussion document.

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# 1. INTRODUCTION

The South West London Sustainability and Transformation Plan (STP) was published in November 2016. It set out how health and care organisations would work together to improve care and services for people in South West London.

The South West London Health and Care Partnership: One year on provides an outline of the progress we have made in the first year and outlines for discussion our plans for the next two years. The progress we have made is summarised in Section 6 and shows that by working together and in different ways, we have already delivered improvements for local people. Thank you to all those who have been involved in the first year of our delivery.

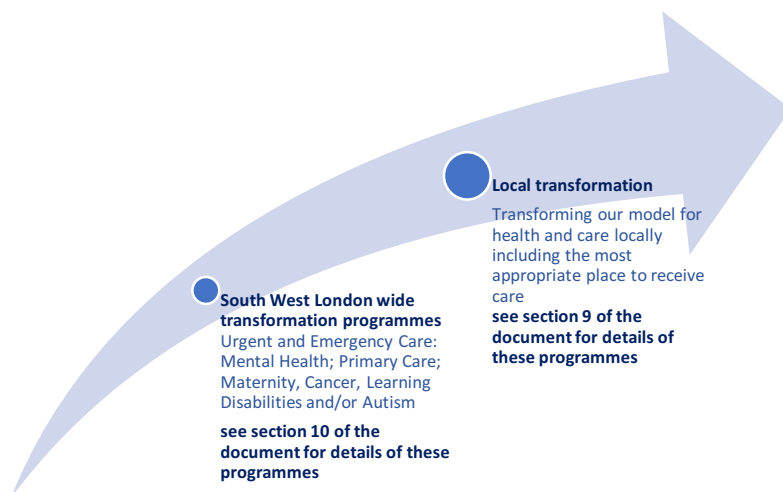
Over the past year, we have been talking to local people across south west London. We talked to over 5,000 people and have in-depth reports that have analysed their feedback. Some of the consistent and core themes that people told us about were: they want to be able to get care when they need it; that they want organisations to work well together to provide that care, in particular joining up mental health and physical health services; that when there is difficult news to tell about their health that it is given sensitively and further support options are explained; and that we encourage people to lead healthier lifestyles, particularly children and young people.

As well as listening to local people, we have learned a lot over the last year from our partners and stakeholders, and as a result our focus over the next two years will be on the following:

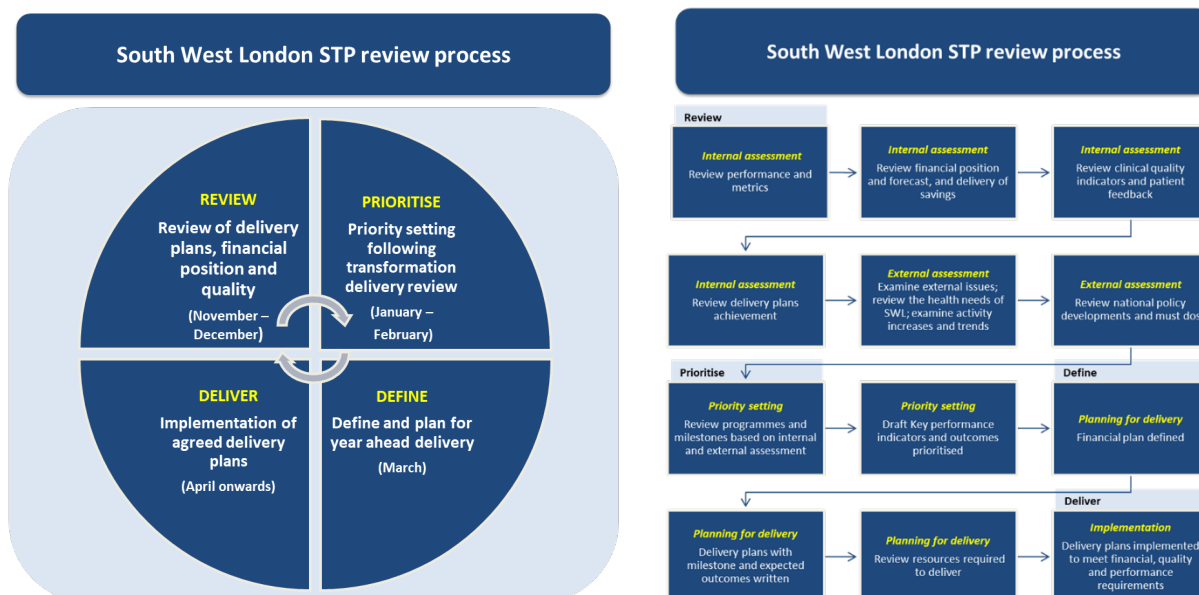


- **A local approach works best for planning:** After talking to local people and communities, we believe a local approach works best for planning health and care. We have set up four local health and care partnerships in Croydon, Sutton, Merton/Wandsworth and Kingston/Richmond to drive the improvement of services at local level.
- **Care is better when it is centred around a person, not an organisation:** Clinicians and care workers tell us this: These four health and care partnerships, are about the NHS and Local Authorities in those local areas, coming together to look at what services their local people need, rather than continuing to provide services within traditional organisational boundaries.
- **Bottom-up planning at borough level, based on local people's needs:** These local health and care partnerships at borough level are looking at where is the best place for people to receive their care. For example in the community, their local hospitals, their GP practice, or the local pharmacy. They are making local plans to work together to provide more joined up health and social care services, and how to make these local systems clinically and financially sustainable.
- **Strengthening our focus on prevention and keeping people well:** the greatest influences on our health and wellbeing are factors such as education, employment, housing, healthy habits in our communities and social connections. We want to strengthen the focus on reducing health inequalities, and keeping people healthy at home by treating them earlier. We want to stop people from becoming more unwell and give them the right support at home so that they don't need to be admitted to hospital.
- **The best bed is your own bed:** We will work together to keep people well and out of hospital. Working together, one or more of our four health and care partnerships, may want to provide some services together where it makes sense for patients, for example musculoskeletal services for conditions that affect the joints, bones and muscles.
- **Likely to mean changes to services locally to improve care for local people:** we will need to change how some services are delivered, and we will of course be open and transparent about this and involve local people. We will continue to need all our hospitals though we do not think every hospital has to provide every service.

Transforming care in South West London occurs through both local and South West London wide transformation programmes. In the sections that follow we identify how we will continue to do both over the next two years.



It is important that we make sure that our plans continue to reflect the needs of local people and services. To do this we will review our transformation plans every two years. The diagrams below show how we will do this:



The years ahead will undoubtedly be challenging, but by working together and focusing on the needs of local people we will deliver the ambitions outlined in this document.

**Sarah Blow**

Senior Responsible Officer for South West London Health and Care Partnership

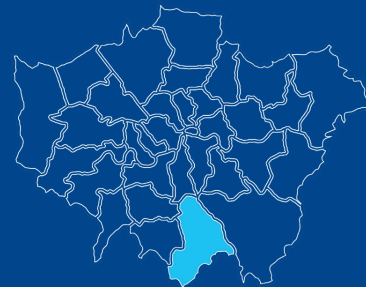
**Dr Andy Mitchell, MBBS FRCPCH**

Consultant Paediatrician and Chairman of the South West London Health and Care Partnership

## 2. SOUTH WEST LONDON IN CONTEXT



### Key facts about Croydon



The Croydon Transformation Board is a partnership of the NHS, Croydon Council and Healthwatch Croydon. The LTB includes CCG, CHS, Croydon Council, SLAM, GP Collaborative and Healthwatch.



#### Your health and social care in Croydon

The population of Croydon is expected to grow significantly by 2027, particularly the younger population. Life expectancy has increased however there are very big differences in the health for our residents across the borough.

#### Compared to the average Londoner, people in Croydon ...



...are more obese as children



... have higher rates of diabetes and heart disease



...take more exercise, especially walking



...are less likely to smoke as teenagers

#### The population in Croydon ...



#### Main health challenges for Croydon today

- 1 inequality in life expectancy,
- 2 high number of people who are obese
- 3 high prevalence of diabetes, a growing and diverse population

#### Over the next three years, the LTB will focus on...

supporting more people to stay healthy and active for as long as possible and able to live as independently as possible  
early detection and diagnosis of health conditions such as diabetes,  
support older people to keep well and stay in their home

#### Key facts on health in Croydon

Population of over  
**380,000**  
and rising by over  
**6%** over next 5 years

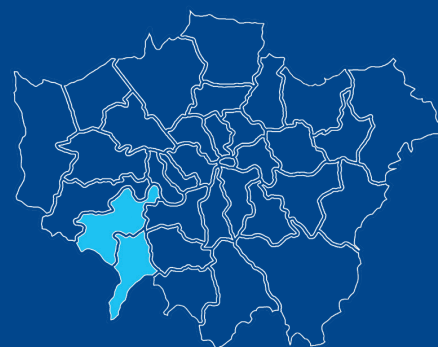
There are  
**57** GP practices in Croydon

Life expectancy is

**9.7**  
years lower for men  
and  
**6.1**

years lower for women in the most deprived areas of Croydon than the least deprived areas.

# Key facts about Kingston & Richmond



Produced by the Kingston & Richmond Local Transformation Board (LTB) 2017  
The LTB includes Kingston & Richmond Clinical Commissioning Group and Kingston & Richmond council.



## Your health and social care in Kingston & Richmond

The residents of Kingston and Richmond are, on average, less deprived compared to other borough in London. The number of over 65 year olds is projected to increase by over 50% in the next twenty years.

## Compared to the average Londoner, people in Kingston & Richmond ...



...are more obese as children



... have lower rates of diabetes.... But this is a leading cause of illhealth



...take more exercise, especially walking



...are less likely to smoke as teenagers

## The population in Kingston & Richmond ...



## Main health challenges for Kingston & Richmond today

- 1 Too many people die too early of cancer
- 2 Too many people are developing diabetes and heart disease
- 3 Too many people, especially young people, are suffering with mental health problems

## Over the next three years, the LTB will focus on...

- ... early diagnosis and treatment of cancer
- ...more community support to prevent long term diseases
- ... more specialist mental health care, especially for young people
- ...supporting older people to keep well in their own homes.

## Key facts on health in Kingston & Richmond

Population of around

**420,000**

in Kingston & Richmond including East Elmbridge

There are about

**57**

GP practices in Kingston & Richmond

Life expectancy is

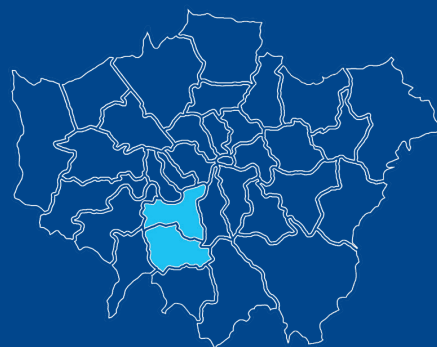
**81.8**

years for men and

**85**

years for women which is slightly above the national average

# Key facts about Merton & Wandsworth



Produced by the Merton & Wandsworth Local Transformation Board (LTB) 2017  
The LTB includes Merton & Wandsworth Clinical Commissioning Group and Merton & Wandsworth council.



## Your health and social care in Merton & Wandsworth

The residents of Merton and Wandsworth are, on average, less deprived compared to other boroughs in London. However significant health and social inequalities in both boroughs with an associated gap in life expectancy.

## Compared to the average Londoner, people in Merton & Wandsworth...



...are more obese as children



... have higher rates of diabetes and heart disease

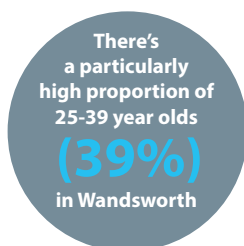


...take more exercise, especially walking



...are less likely to smoke as teenagers

## The population in Merton & Wandsworth...



## Main health challenges for Merton & Wandsworth today

- 1 Too many people die too early of cancer
- 2 Too many people are developing diabetes and heart disease
- 3 Too many people, especially young people, are suffering with mental health problems

## Over the next three years, the LTB will focus on...

- ... early diagnosis and treatment of cancer
- ...more community support to prevent diseases, like diabetes
- ... more specialist mental health care, especially for young people
- ...supporting older people to keep well in their own homes.

## Key facts on health in Merton & Wandsworth

Population of over  
**585,000**

There are about

**65**  
GP practices in Merton & Wandsworth

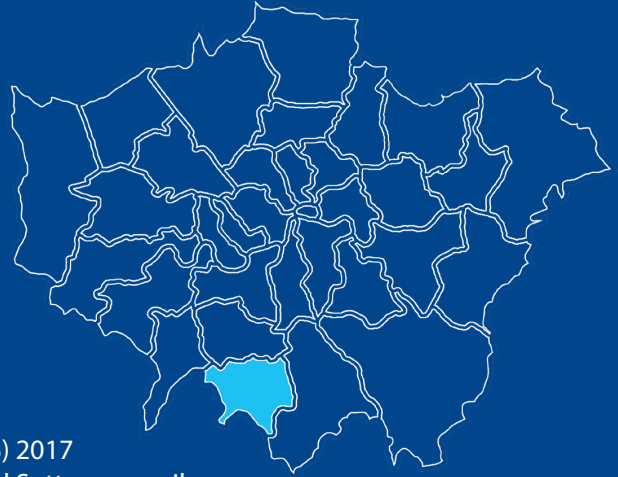
In Merton over

**5,900**  
over 75 year olds live alone

Life expectancy is

**9.3**  
years lower for men and  
**4.5**  
years lower for women in the most deprived areas of Wandsworth than the least deprived areas.

# Key facts about Sutton



Produced by the Sutton Local Transformation Board (LTB) 2017  
The LTB includes Sutton Clinical Commissioning Group and Sutton council.



## Your health and social care in Sutton

Sutton residents live in one of the healthier boroughs in England, and has an increasingly young population. People living in Sutton live longer than average and are less likely to have illnesses like diabetes. However, there are big differences across the borough.

## Compared to the average Londoner, people in Sutton ...



... live longer



... have lower rates of diabetes and heart disease



... do less than the recommended amount of exercise each day



... are more likely to be aged either 5-19 or 30-49

## The population in Sutton ...

... are positive about their health. In a recent survey, 75% said they feel in good or very good health.

... can feel lonely, with one in ten people saying they do not get enough social contact

... is younger and less diverse than the London average.

## Main health challenges for Sutton today

- 1 Too many people die too early from cancer
- 2 There are big differences in how long you live across the borough
- 3 Too many people, especially young people, are suffering with mental health problems

## Over the next three years, the LTB will focus on...

... early diagnosis and treatment of cancer  
... giving everyone across the borough the same high standard of support to live well  
... more specialist mental health care, especially for young people  
supporting older people to keep well in their own homes.

## Key facts on health in Sutton

Sutton is home to around

**200,000**  
people

There are over

**25**  
GP practices in Sutton

There are over

**1,800**  
careers in Sutton

Life expectancy is

**80.8**  
years for men and  
**83.5**  
years for women which is slightly above the national average



### 3. SERVICE QUALITY

We firmly believe that for transformation and improvement to be successful it needs to be local, responding to local needs, issues and context. So, in early 2017 we set up four Local Transformation Boards to work together to transform care and services for local people. Made up of representatives from the Local NHS, Local Authorities, patient representatives and, in some the voluntary sector, Local Transformation Boards come together to plan how best to meet the needs of their local population; at a borough and wider level to transform health and care services.

The South West London Health and Care Partnership are committed to continuously improving the standards of care in hospital, specialist and community settings and to reduce inappropriate variation in care across South West London. This section outlines evaluations into the standard of some care in hospitals across all four Local Transformation Board areas.

In October 2017, the South West London Clinical Senate agreed a set of clinical standards (see appendix 1) for six clinical services in hospitals: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Hospitals in South West London were asked to self-assess their services against the agreed clinical standards and to feed this work into their local transformation boards as they progress their local health and care plans. This is the first stage of wider evaluation work into sustainability in each of our local transformation board areas across South West London. This assessment provides a clear position for these specific clinical services for each of the South West London hospital sites.

With the exception of Epsom and St Helier University Hospitals NHS Trust, hospital trusts believe that taking this self-assessment into account, with their knowledge of their individual staffing, estates and operational issues and plans that they are clinically sustainable in these six clinical services.

Taking all of these areas into account, Epsom and St Helier University Hospitals NHS Trust have clearly set out a case for change and a scale of challenge that states that they are unable to deliver all of these services without a level of change to their clinical model. Through an engagement exercise, held between July and September 2017, the Trust has set out their views on potential scenarios for the future.

No decision has been made on the future of Epsom and St Helier University Hospitals NHS Trust. Local clinical commissioning groups will develop a formal process to consider the future of services at Epsom and St Helier University Hospitals NHS Trust, and other issues such as their estate, and how they will be able to deliver sustainable services for the local population. Commissioners and the local system are fully committed to consultation with the public if this process suggests significant change.

Further information on this evaluation can be found in the Local Transformation Board sections. A copy of the full evaluation summary is given in appendix 2.

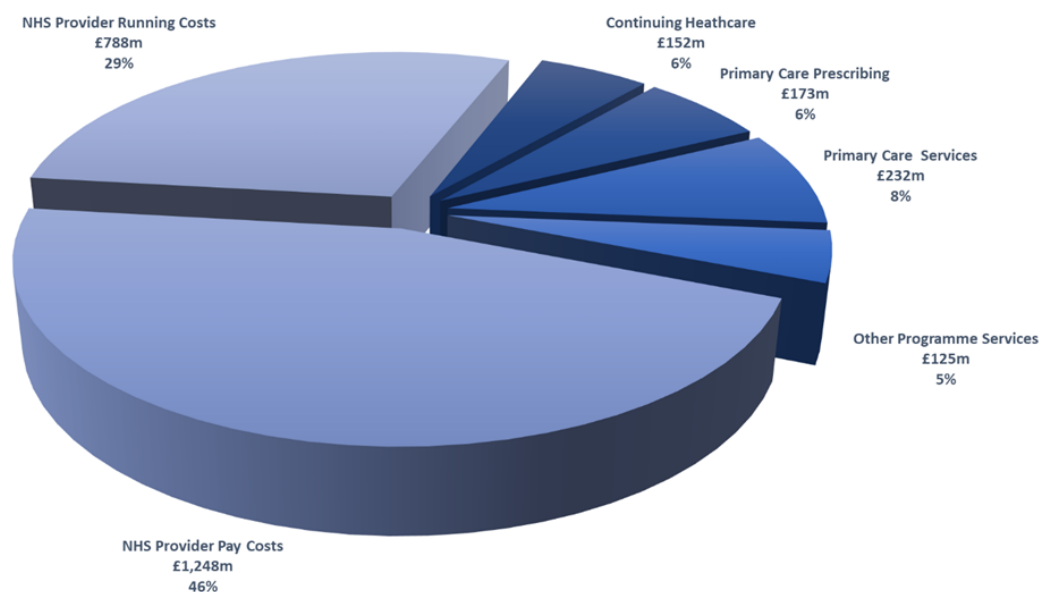
Local health and care partnerships will continually evaluate the quality of services across community, primary care, mental health and hospital services.

## 4. OUR FINANCIAL POSITION

Nationally, the health and care system faces a challenging financial position as it works hard to keep service provision in line with service demand. South West London is no different to this

and we have a number of challenging financial pressures within our partnership.

The NHS in South West London currently spends £2.7 billion across a range of services as highlighted in the analysis below.



In the current financial year (2017/18) NHS providers and commissioners in the South West London Health and Care Partnership have identified an underlying deficit of £166 million with a further risk of £38 million which they are managing through a number of one off measures and central NHS support. The South West London Health and Care Partnership is working hard to improve our financial position during the current year and will take stock of our achievements and review our underlying position going forward. While we will have delivered a significant element of the Partnership's £560 million saving target (providers and commissioners share only) there will be an unresolved gap which will need to be addressed going forward.

In the next two years, based on current NHS allocation projections south west London is likely to receive a further increase to its funding of £220 million by 2020/21. However, based on our current estimates we think our costs providing services over those years are likely to increase by £422 million. This is a result of:

- Increased activity from local people needing health services
- Cost increases due to inflation
- Technological and medical advancements - such as new drug therapies and innovative new treatments meeting new and better quality of care standards for our patients and to strengthen clinical sustainability

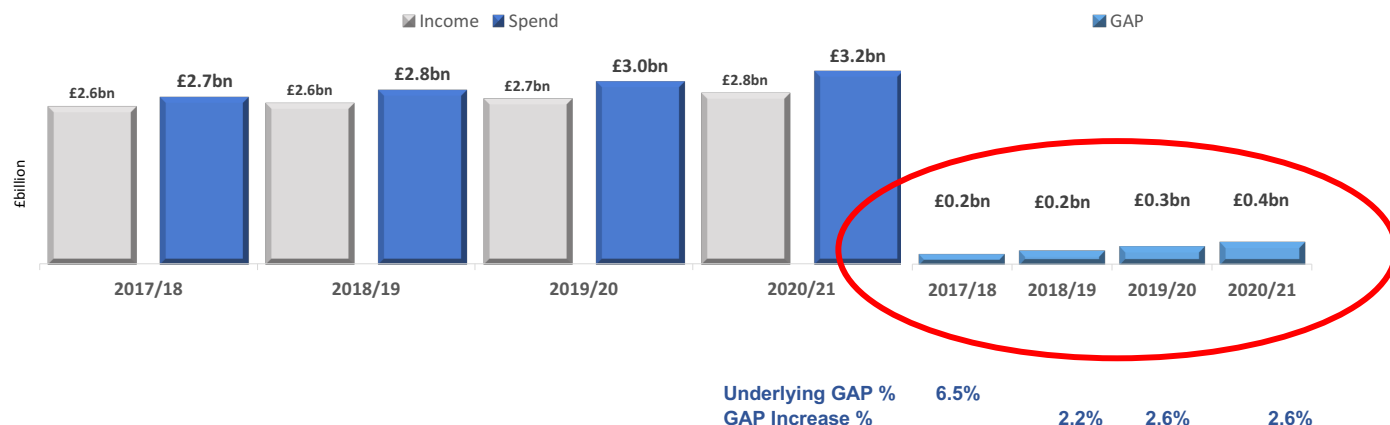


Investments in key service areas such as urgent care, mental health and cancer

We are also reviewing how other factors such as delivery of NHS national policies, removal of the

public sector pay cap, the impact of the November 2017 Chancellor's budget statement the impact of Brexit on our workforce and rising costs and inflation may impact on our financial position going forward.

Increasing financial challenge of c£365 million by 2020/21



The table above shows how the gap between income and expenditure grows if local providers and commissioners do not find financial savings over the next four years. The table excludes the challenge faced by specialised services in South West London which are commissioned by NHS England. In the original STP this was calculated at rising to £99 million by 2020/21.

Local Authority social care in south west London faces an equally challenging financial position as demand for, and costs of, providing social care services increases and government funding decreases. South west London boroughs made £250 million savings to their social care budgets between 2011/12 and 2016/17 and are estimated to need to make a further £163 million savings between 2017/18 and 2020/21.

While south west London has historically made significant savings each year, we recognise that

we will need to take a different approach to deliver savings by:

- organisations working more closely together to avoid duplication:
- sharing back-office services to reduce costs where it make sense
- organisations coming together to buy products and services more cheaply together
- re-designing the way we provide clinical care, firstly to improve care for patients and secondly to reduce costs
- reviewing where hospitals can work closer together to provide clinical services across south west London more efficiently
- developing early intervention and prevention care models to support people to live independent lives and reduce their need to access services

- using new technology to support self-care for the population, new ways for patients and service providers to interact and share information, and for providers to operate more effectively
- reviewing the buildings we use and under-use in the public sector to make the most of the buildings and money we have
- taking waste out, by developing “lean” processes to free-up the time of our skilled health and care staff to focus on patients
- developing new workforce models which make sure our most skilled health and care staff can focus on the people who have the highest need

- looking at the day-to-day running costs in all organisations to make sure we are making the best use of the money we have
- comparing what we do against local and national best practice to see where we can improve services and become more productive

As part of the Local Transformation Boards ***Local Health and Care Plans***, each Local Transformation Board will work through the local financial pressures, at a borough and wider level, to understand the challenges the system faces and the local solutions to resolve these.

# Capital

The health and care services across south west London operate from a number of different sites across London including hospitals, GP practices, community and care facilities. Each of these facilities need to be accessible to the public, safe, fit for purpose for running the required services and cost effective.

Each individual health and care organisation retains responsibility for managing this but we recognise that we need to work better together across south west London to make sure that we make most effective use of our health and care estate.

The original STP (published in November 2016) estimated that we needed £1.3bn to deliver our plans to improve our buildings and estate. We are now reviewing this requirement at a Local Transformation Board level so that each area can review its combined organisational capital plans alongside its developing health and care models. This will look at how we currently use our buildings against future requirements and see where we need to invest, and equally where we are able to dispose of buildings to provide funds for re-investment in new and upgraded facilities.

This will provide us with broad types of capital expenditure:

- Maintaining our existing buildings to a high standard

- Building new facilities or adapting current facilities to mean we can change the way we provide or local services
- Major transformational schemes which require a wider south west London or even London perspective. The timescales for delivery of these schemes will be after 2020 but the preparation and planning work needs to start now

We are developing a pipeline of schemes for south west London in line with Local Transformation Board ***Local Health and Care Plans***. We think that doing this may increase the identified need for capital. While we will release funds to support this from the sale of unwanted buildings, we know that this will not be sufficient to meet our capital funding requirements. We will therefore need to secure additional capital funding. While there will be some NHS capital funds available, in the current economic climate these may be limited and therefore alternative funding sources will need to be explored.

South west London is playing a full part in the development of the London Estates Board which has been created as part of the London devolution process and we will work with the Board to identify and secure the required capital streams to help us realise our wider plans.

# 5. WORKING IN PARTNERSHIP

## The South West London Health and Care Partnership

Local NHS clinical commissioning groups, provider trusts, local authorities and patient representatives across South West London came together to form the South West London Health and Care Partnership.

South West London's Health and Care Partners are:

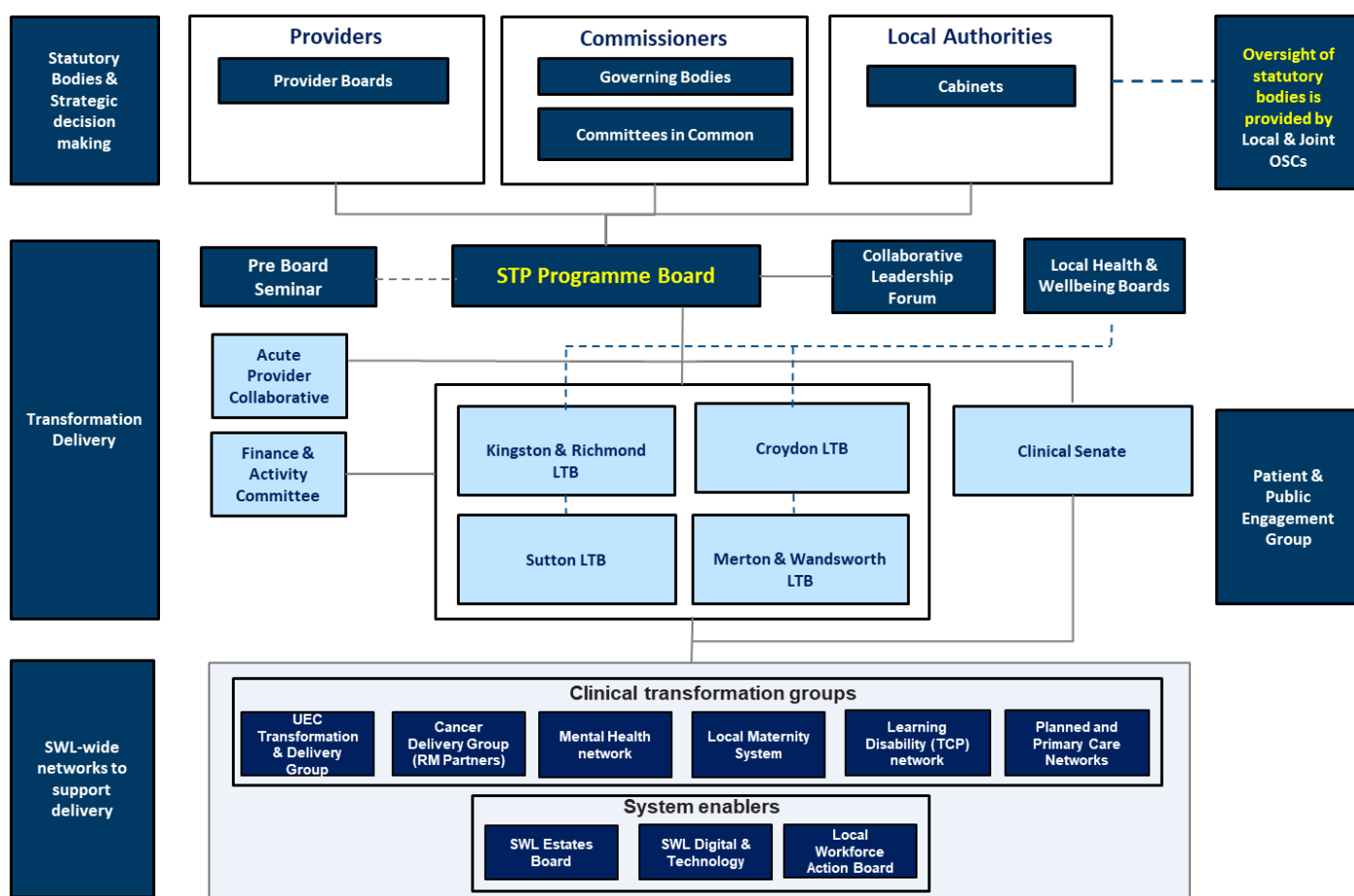
- Our six Clinical Commissioning Groups (CCG) of: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our six Local Authorities: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our Acute and Community Providers: Central London Community Healthcare, Croydon Health Services NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Hounslow and Richmond Community Healthcare, Kingston Hospital NHS Foundation Trust, The Royal Marsden Foundation Trust, St George's NHS Foundation Trust, and Your Healthcare
- Our two Mental Health Providers: South West London and St George's Mental Health NHS Trust, South London and the Maudsley NHS Foundation Trust
- The GP Federations in each of the six boroughs
- The London Ambulance Service
- Healthwatch
- Our Health and Social Care Partnership works together in a number of different ways:
  - **Health and Wellbeing Boards** in each borough that are made up of local councillors, senior clinicians, NHS and social care managers, public health experts and Healthwatch. Their role is to plan how to meet the needs of local people and to tackle inequalities in health.
- The Clinical Senate that is made up of senior Clinicians across all south west London organisations, and representatives from the Royal College of Nursing, the Local Medical Committees, Allied Health Professionals, NHS England and the Patients and Public Engagement Steering Group. The Senate have oversight of the implementation of the South West London clinical model, drive forward the work programme for specific clinical pathways which it has agreed should be considered across South West London as well as ad hoc matters in relation to clinical models.
- Four Local Transformation Boards (LTBs) in Croydon, Merton and Wandsworth, Kingston and Richmond and Sutton that are made up of representatives from the Local NHS, Local Authorities, patient representatives and, on some the voluntary sector. LTBs bring leaders of organisations together to: plan how best to meet the needs of their local population; and transform health and care services to deliver joined up services that improve care and reduce health inequalities. LTBs will develop **Local Health and Care Plans** for health and care services in their area. These plans will reflect and incorporate individual borough level plans for delivery.
- **Local Overview and Scrutiny Committees** (OSCs) that are made up of local councillors to oversee and scrutinise local health services on behalf of the electorate. Where major service change is being considered, representatives of

each OSC may form a Joint Health overview and Scrutiny Committee covering more than one borough.

- **Patient and Public Engagement Steering Group** that is made up of Healthwatch, the voluntary sector and patient representatives from each borough, whose role is to oversee and advise the South West London Health and Care Partnership on patient and public engagement.

- **Clinical networks** including urgent and emergency care, cancer, mental health, maternity, learning disabilities, and planned and primary care, that are made up of local clinicians, NHS and local authority managers and patient representatives. Their role is to develop plans and proposals for their clinical area, for discussion and agreement by Local Transformation Boards and the Clinical Senate.

The diagram below summarises the governance arrangements:



# 6. SOCIAL CARE

## Adult Social Care

Adult social care is a vital part of the south west London health and care system supporting people to keep well and independent in their own homes and communities. It offers help and care to people with a wide range of needs arising from age, disability, illness or other life situations helping them to keep well and live independently, protect them from harm and provide essential help at times of crisis. In 2015/16 the six south west London boroughs provided long and short term support to over 25,000 people and spent £464 million on adult social care.

Adult social care focuses on the whole person and their overall life, and enables their family support and community networks. It supports carers in their very important role so they can live their own lives, remain well and avoid stress and crisis. It works closely with the community and voluntary sector to support people to live in their own homes and be active in their own communities.

By focusing on prevention, providing early and short term support in people's own homes and communities social care is a critical component in managing the demand for hospital and NHS services. Adult social care also provides long term support for some of our most vulnerable

residents enabling them to live fulfilling and as independent lives as possible in their communities. It helps people to navigate the complex healthcare system and access the services they need - at the right time in the right place.

Social care needs to be at the heart of integrated community based health and social care. In developing Local Health and Care Plans local authorities and the NHS will work with their voluntary and community sector partners to build this partnership and ensure that contribution of social care is fully reflected in developing high quality integrated and holistic community based health and social care support.

**Adult Social Care** – delivered through our 3 pillars of support:



## Children Services

The above focusses on adult social care and we will work together with Directors of Children's Services, Directors of Public Health and other

partners to ensure children's needs are addressed in developing the local health and care plans.

# 7. ONE YEAR ON: OUR PROGRESS SO FAR

**The NHS and local authorities across the six boroughs of South West London are working together to improve care and support for all our residents.**

Here's an update on our progress in 2016/17



## Making it easier to see a GP

This is a top priority as we know how important it is to see a GP quickly. We are investing to make it easier for you to see a GP quickly. If you need an appointment at short notice, you may not see your usual GP, but one as close to where you live as possible.



Extending GP hours from 8am – 8pm in every borough to ensure patients have access to an additional 15,000 appointments per month



Residents in Merton, Wandsworth, Kingston and Richmond can now pre-book appointments on line as well as by phone

## Better urgent and emergency care

Getting the right advice and care in an emergency really matters. We are working hard to get this right.

Getting it right means fewer people, especially older residents, having an unplanned overnight stay in hospital when they don't need one.

111 has more doctors and nurses at the end of the phone to give advice

Expert clinicians on hand for care homes and ambulance crews to get the right care for older residents

Did you know? - SW London has the best ambulance response times in London for the most serious calls

## Helping older people stay well in their own home

Get home  
**4**  
days  
sooner

In Sutton, if an older person has to go to hospital, they take a red bag with all their relevant information, medicines and personal belongings. This speeds up care, so they get off the ward and back home four days earlier on average.

Personal independence co-ordinators providing support for older people with long term health conditions in Croydon, as part of a partnership between Age UK, local GPs, the NHS and Croydon Council.

Teams of doctors, nurses, mental health experts and therapists across Merton and Wandsworth working together to respond rapidly when older people are taken ill – and to help them to be treated in their own home when possible



## More mental health support

Investing in a 24/7 safe house to look after people suffering a mental health crisis in Kingston and Richmond has meant nine out of ten visitors return home without needing to stay in hospital. Every hospital in SW London now has 24/7 psychiatric support in place.

An additional  
**£400,000**  
of funding for NHS 111, with more doctors and nurses available to give advice to patients, care homes and the ambulance service over the phone



# 8. WHAT LOCAL PEOPLE HAVE TOLD US ABOUT OUR SERVICE

It is essential that the views and experiences of local people are at the heart of our plans, driving forward the changes needed to improve local services. We believe in on-going conversations and making sure that the needs of local people are central to what we do. Nobody knows more about how we can make things better than the people who use our services.

Over the last year we have spoken to over 5000 local people, including those who less often share their views about our plans and their experiences of services. We ran a public event in each borough which was open to members of the public, as well as running an extensive programme of grassroots outreach work delivered in partnership with local Healthwatch organisations. These events allowed us to have in-depth conversations and the feedback has been independently analysed, written up and published on our website. This feedback has been integral to shaping this discussion document. We have summarised the headline findings below, but more detail can be found throughout this document and in appendix 3.

## Overarching themes

Several common issues emerged which are common across work streams and local areas:

- Concerns about a perceived **lack of funding** and resources to invest in service changes, particularly in the light of local services already being changed.
- **Capacity concerns** that the current local services would not have the capacity to take

- on additional work in order to reduce the burden on hospital services.
- Improving and **increasing signposting** to services to make the public aware of services in the area, as well as educating people about health care choices. And difficulty in changing behaviour of the public and staff.
- Concerns over **quality of services** and of **equality in accessing** these services.
- The need to improve **staff communication** skills so that patients and carers are treated with empathy and respect, especially those with complex or additional needs.
- The need for more **joined-up IT systems** to aid communication between services and avoid patients having to repeat themselves.

## Work stream specific themes

**Seven day hospital services-** While people agreed with the aim to reduce the number of patients using Accident and Emergency (A&E), there were concerns about what alternatives would be available. There was low awareness of NHS 111, and those who were familiar with it were not confident it would reduce demand on A&E. It was also felt that GP access was a significant issue, and potentially driving perceived misuse of A&E.

Some felt existing urgent and emergency care and acute services need to be improved to ensure they are inclusive and meet the needs of diverse users. There were concerns about mental health



crisis care, and lack of mental health awareness in A&E.

**More care closer to home** - Overall, while the idea of having more care closer to home was supported questions were raised about the feasibility of extending out-of-hospital services, when there are already insufficient staff to cover the current provision (especially GPs). People gave examples of difficulties getting appointments and with the accessibility of GP services. Also, people often felt that receptionists were put in the position to be gatekeepers.

The introduction of new roles such as care navigators were positively received but many wanted more detail about how these teams would support local patient care in practice.

**Prevention and early intervention** - Most people, although they supported the increased focus on prevention, thought it would be challenging to achieve. Specifically, they felt it would be under-resourced. People emphasised that communication is key to ensuring change in behaviour for prevention, and participants agreed the NHS must improve its outreach and links with the voluntary and community sector for this to be successful.

**Mental health** - Overall, there was low confidence in current mental health services due to perceptions of poor quality, closures, long waiting times, underfunding and inability to cope. People supported a holistic approach, incorporating physical conditions and coordinating with multiple organisations, but questioned how this would work in practice. It was felt that significant investment in training and additional skills would be needed for GPs. There was a consistent view that there needs to be 24/7 crisis support for people with mental health conditions and their families.

**Learning disabilities** – People felt that there should be more awareness of annual health checks for children with learning disabilities, including reminders from the GP surgery, and that people should be offered longer appointment times if necessary. It was strongly felt that staff need to communicate more clearly with those with learning disabilities, and involve them in their care (not just their carers).

**Children's services** – Overall it was felt that the NHS needs to promote awareness and signposting to available services. There was also a desire for more education and information to support healthy lifestyles for children and families – both inside and outside school. People believed that to reduce the burden on hospital services, more flexible GP services are needed.

**Maternity services** – People were concerned about the shortage of midwives – particularly as many saw the benefits in having a consistent point of contact through their maternity journey. Post-natal care was highlighted as a service that required improvement. Communication and attitudes of staff were seen as variable and in need of improvement in order to adequately support women giving birth and their families.

**Cancer care** – People felt more work could be done to increase uptake of screening, and to increase preventative care and guidance to those at higher risk of cancer. It was felt that delivering news of a diagnosis should be delivered with empathy and sensitivity. There was a desire for NHS south west London to set the 'gold standard' for cancer diagnosis, treatment and care, including being proactively involved in trials and new treatments.

**Planned care** – People felt that they were more prepared to travel for non-urgent elective care, but highlighted that ensuring appropriate transportation would be important. It was felt that

there is scope for current practices around discharge and aftercare to be improved. Many people noted there should be improved internal and external communication between services, including GPs, hospitals and social care providers.

## Local Transformation Board Area specific issues

Many of the issues raised were common across south west London. The feedback below highlights specific comments or perceptions that were felt more strongly in each LTB area.

**Croydon Local Transformation Board Area** - There was a feeling that, in Croydon, local circumstances exacerbate a need for changes to the health service (e.g. Croydon has a large and diverse population). There was also a feeling that the plans were not realistic in the context of the resources available. Concerns were raised around mental health services, of note insufficient capacity in Improving Access to Psychological Therapies currently leading to long waiting times and, more broadly, the local borough not receiving their 'fair share' of funding for Mental Health services. It was felt that children, particularly, benefit from seeing the same health care professional and that this is often compromised as there is a high staff turnover (for example in occupational therapy). It was felt that there was more scope to encourage children to have healthier lifestyles both in and out of school. Overall there was a general consensus that Croydon University Hospital had improved.

**Kingston and Richmond Local Transformation Board Area** – Overall people felt that the STP published in 2016 was too high level and aspirational, they wanted to see more detailed

plans, figures, modelling and timelines. There were concerns around money and how the NHS would balance funds between health and social care. People felt that public health and educating and informing the public was very important in order to support the prevention agenda, including further working with the voluntary community sector and increasing the use of technology. People were more confident in pharmacists, than in other areas, but felt that in order to reduce the burden on GP services, pharmacists would need to receive further training and adapt their services.

**Merton and Wandsworth Local Transformation Board Area** - Three discussion topics were very popular in Merton and Wandsworth: care closer to home, prevention and early intervention, and mental health. For many people, their primary concern was uncertainty in NHS funding. Others were concerned about how staff would be attracted and retained especially in light of upcoming changes such as Brexit and the rise of living costs in London. Concerns were raised about the hospital bed reduction targets and how these would be achieved. People supported the idea of encouraging individuals to take more responsibility for their own health and lifestyles but emphasised that a culture shift is required for this to be successful.

**Sutton Local Transformation Board Area** – Overall people felt that problems with capacity are likely to be exacerbated by a growing population in Sutton. There were local concerns that there is insufficient capacity in A&E and that any move to reduce services would exacerbate waiting times. People suggested, that instead of trying to change A&E and how it is used, it would be worth considering co-locating GPs and social care there. There was strong support for St Helier Hospital although some concerns about communication

within St Helier, and between St Helier and other organisations. There was scepticism about alternatives to seeing a GP or attending A&E, with many people feeling that they would not go to a pharmacist as a first choice for care. There was support for local GPs with many sharing their positive experiences. People were worried that

despite an identified need to address mental health more holistically, several mental health centres in the Sutton area have closed and concerns were raised as there wasn't a local mental health crisis centre. Praise was given for South West London Elective Orthopaedic Centre.

# 9. OUR HEALTH AND CARE PARTNERSHIP COMMITMENTS

Overall, the South West London Health and Care Partnership are committed to delivering joined-up services for local people and through this improving their health and care. Specifically over the next two years we will focus our joint efforts on the following:

Prevention	We will strengthen our focus on prevention and on keeping people well, and will take into account that the greatest influences on people's health and wellbeing are factors such as education, employment, housing, healthy habits and social connections
Urgent and Emergency Care	We are committed to improving services for people when they are at their sickest and are in need of urgent or emergency care ensuring that, for those with non-life threatening but urgent needs, they are treated as close to home as possible, and for those with more serious or emergency needs that they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.
Primary Care	We are committed to ensuring that general practice is accessible and co-ordinated with community and social care services. This will mean people receiving the right care closer to home, so that they can live healthy and independent lives for as long as possible.
Mental health	We are committed to improving how we prevent, support and care for people experiencing mental health problems and make sure we treat their physical and mental health together
Children and young people	We are committed to helping children have the best start in life and to supporting children as they develop into adults
Learning Disabilities and/or Autism	We are committed to transforming services for people with learning disabilities and/or autism so that they are supported in the community to live fulfilling and independent lives
Maternity	We are committed to improving maternity services so that women have choice about where to have their baby, that every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances
Cancer	We are committed to improving cancer survival rates, ensuring that more people are diagnosed and treated earlier and that we provide the highest quality of care and support for people living with and beyond cancer
Hospital, Specialist and Community	We are committed to continuously improving the standards of care in hospital, specialist and community settings and to reducing inappropriate variation in care across south west London
Money	We are committed to being efficient, using our money wisely and making sure that we get best value from every public sector pound
Buildings and estate	We are committed to improving our buildings so that we can deliver high quality care from all south west London sites
Workforce	We are committed to making South West London a great place to work so that we attract and keep our excellent staff
Harnessing technology	We are committed to using technology to be the "electronic glue" which helps health and care organisations work better together, enables our frontline staff to provide the best care possible and enables people to make the best lifestyle and health choices

## ABOVE ALL...

The Health and Care Partnership are committed to working together to improve health and care services and outcomes for people in South West London, and to ensuring that our organisational boundaries do not get in the way of providing the very best care for local people.

# 10. LOCAL TRANSFORMATION BOARDS: A LOCAL FOCUS ON IMPROVEMENT

We firmly believe that for transformation and improvement to be successful it needs to be local, responding to local needs, issues and context. So, in early 2017 we set up four Local Transformation Boards (LTBs).

The four Local Transformation Boards in South West London are:

- Croydon
- Merton and Wandsworth
- Kingston and Richmond
- Sutton

Made up of representatives from the Local NHS, Local Authorities, patient representatives and, on some the voluntary sector, LTBs bring leaders of local health and care organisations together to: plan how best to meet the needs of their local population; and transform health and care services to deliver joined up services that improve care and reduce health inequalities.

This document identifies a number of challenges for the local health and care systems. Between December 2017 and June 2018, LTBs will draw up Local Health and Care Plans. Local Health and Care plans will outline:

- The LTB's vision for health and care locally
- Their model for health and care locally
- Their local context and the challenges they face, including any financial and clinical sustainability issues
- Their plan to improve health inequalities in order to address the wider determinants of health (Health inequalities are systematic, avoidable and unjust differences in health and wellbeing between groups of people)
- Their priorities, actions and focus to meet the health and care needs of their local population and plans to address any financial and clinical sustainability issues. Services are delivered and managed at different scales across south west London and LTBs will work together to identify the best scale to develop our plans.
- What will be different for local people in two years' time (measurable outcomes)
- Where LTBs cover more than one borough, individual ***Local Borough Health and Care Plans*** (that will be named by local areas) will be written so that borough level issues, priorities and plans are identified. Borough level ***Local Borough Health and Care Plans*** will then be brought together to create the LTB's overarching Health and Care plan.

## **11. LOCAL TRANSFORMATION BOARDS IN FOCUS**

# Croydon Local Transformation Board

## Our joint vision

We have a clear vision in that:

- We want people to live longer, healthier lives
- We want to reduce health inequalities and improve health outcomes for Croydon people
- We will support local people to look after themselves and those they care for
- We will make sure local people have access to high quality, joined up physical and mental health and care services when and where they need them
- We must do this within the resources available to us for the population of Croydon.

In delivering this vision we recognise that, at the same time, we need to work within the context of a growing and an ageing Croydon population. This means that, while average life expectancy increases, the health and care system needs to support individuals and communities to be as healthy and independent as they can be, if we are to ensure that increased demand for care can be met within the resources available to us. We also know that within our Croydon population a wide range of health inequalities already exists and that

the borough is becoming increasingly diverse, so changing the health needs of people in the borough. Variation also exists in the quality and performance of our services, leading to varying experiences of care and outcomes for people. All of these issues establish the context within which we wish to transform services to be better able to support Croydon people.

**We will achieve our vision in Croydon by:**

- Joining up care seamlessly around the needs of the individual
- Transforming and joining up health and social care across primary, community and hospital settings to provide proactive, safe and high quality care for all local people
- Supporting people to live healthy and independent lives
- Working in partnership across organisational boundaries, across both the statutory and voluntary sector
- Exploring innovative and radical ways of working to plan for the future

## Our model for health and care

Health, social care and voluntary sector partners are working together to achieve a more personalised and joined-up approach to health and care services for the people of Croydon.

Croydon's Outcomes-Based Commissioning programme (OBC) is a radically different approach to the funding and delivery of services designed to get the best value out of the health and care

sectors in Croydon, whilst delivering the outcomes local people want.

The new way of working is a result of an alliance agreement between six organisations in the borough – Croydon Clinical Commissioning Group (CCG), Croydon Council, Croydon GP Collaborative, Croydon Health Services NHS Trust,

the South London and Maudsley NHS Foundation Trust and Age UK Croydon.

The partnership will mean a single, joined-up service for people over 65 needing health and social care support, from help with leading a healthier lifestyle through to avoiding unnecessary hospital stays and supporting people in their own homes and community.

The main principle is to move towards funding people's care based on the delivery of successful outcomes, helping them to live more independent and active lives for as long as possible.

The launch follows engagement with the local over-65 community during which they identified

those things that mattered most to them, from staying independent to receiving tailored support.

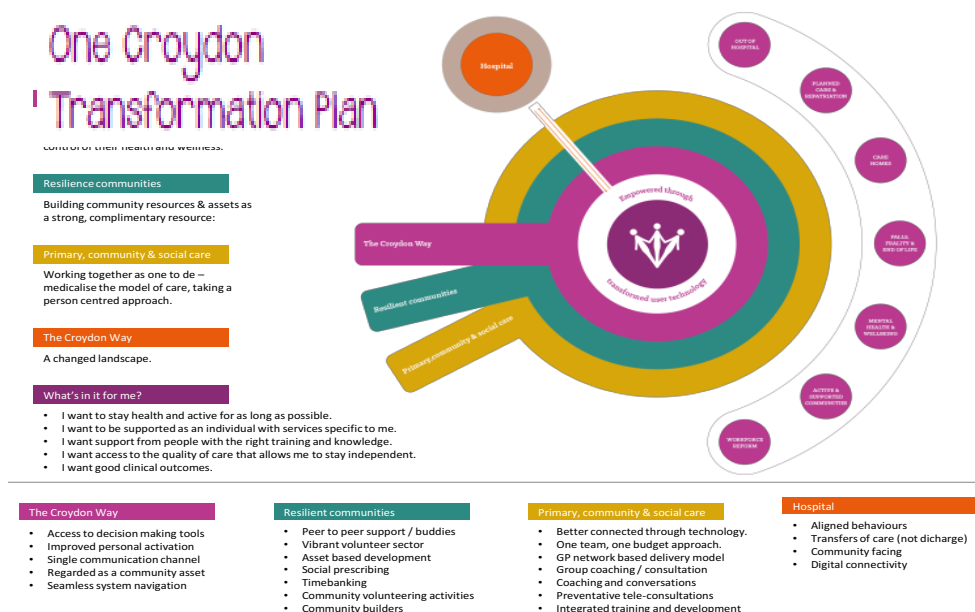
We aim to extend this model and approach beyond the over 65s to encompass services for the whole of the Croydon population, including children and families, working age adults and people with disabilities, including serious mental illness.

This alliance of commissioners and providers from health, social care and the third sector in Croydon is being called One Croydon. Each organisation has its own culture and history but we share a common goal to improve outcomes for people in Croydon.

## Vision:

*'Working together to help you live the life you want'*

One Croydon alliance partners are coming together to deliver a shared vision with a single set of outcomes operating from one budget.





## Our health and care partners

- Croydon Clinical Commissioning Group
- Croydon Council
- Croydon GP Collaborative
- Croydon Health Services NHS Trust
- South London and the Maudsley NHS Foundation Trust

## Our context and challenges

- **Significant population growth** Over the next five years, Croydon's population is expected to grow by 6%, from approximately 380,500 in 2015 to 403,500 by 2022,
- **Deprivation:** Croydon is the 17th most deprived borough in London out of 33. 10,261 of Croydon residents live in the 10% most deprived areas in the country. The wards of New Addington, Fieldway and Broad Green are the most deprived wards in Croydon.
- **Ethnic diversity:** Over half of the Croydon population are non-White British. This figure rises to 62.9% for the under 18 population. A more diverse population leads to more diverse health needs.
- **Inequality in life expectancy:** In the most deprived areas of Croydon, life expectancy is significantly lower than for the least deprived areas:
  - 9.7 years lower for men at 75 years old rather than 84 years old for men; and
  - 6.1 years lower for women at 80 years old rather than 86
- **Obesity**
- **Diabetes** Croydon has a higher prevalence of people with diabetes than London.

- Healthwatch Croydon

Age UK is also a partner of the Croydon Health and Care Alliance Board and the Alliance agreement for One Croydon.

- **Smoking:** Smoking prevalence in Croydon is lower than the national average. Just over one in eight adults in Croydon smoke, which is lower than the national average of around one in five.
- **Health Screening:** Breast and cervical cancer screening rates are both significantly lower than the national average which can lead to worse outcomes if cancers are not detected at an early stage.

In Croydon an estimated **1 IN 13** people has diabetes

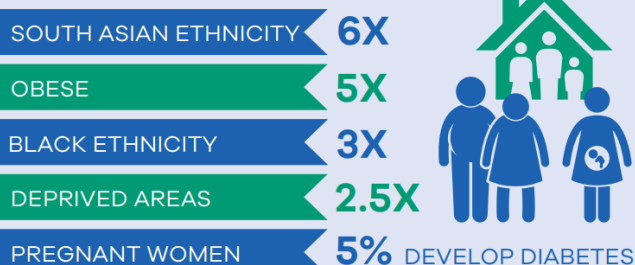


AROUND **19,900** PEOPLE HAVE BEEN DIAGNOSED



AN ADDITIONAL **6,400** DON'T KNOW THEY HAVE IT

### WHO IS AT RISK FROM TYPE 2 DIABETES?



- The **prevalence of severe mental illness** in Croydon is significantly higher than the national average, but similar to London. **Admissions for mental health conditions for under 18s** is higher than London and national averages.
- **Employment:** Croydon's unemployment rate is 5.2%, which is the 15th lowest rate in London. The median gross pay in Croydon is £602.80

per week which is the 11th lowest in London (Annual Survey of Hours and Earnings, 2016).

- **Housing:** In Croydon, in June 2017 there were 2,406 households in temporary accommodation, which is the 8th highest borough in London.
- **Social Isolation:** Loneliness can have serious consequences for mental and physical health. It is linked to obesity, smoking, substance abuse, depression and poor immunity.



of Croydon population is aged 65+. This is the 12th highest proportion in London. This equates to 49,300 people which is the 3rd highest number in London.



of Croydon population is aged 75+. This is the 12th highest proportion in London. This equates to 23,000 people which is the 3rd highest number in London.

## Care and quality challenges

- **London Quality Standards** were developed to address variations found in service arrangements and patient outcomes between and within hospitals, and between weekdays and weekends. The standards represent the minimum quality of care that patients should expect to receive in every acute hospital in London. Of the 172 applicable London Quality Standards, Croydon Health Services met 99 standards and did not meet 61 standards in 2016.
- Croydon Council took immediate action to improve its Children's Services after an Ofsted inspection rated some areas of the service inadequate earlier this year. The council accepted the findings and is working with

Ofsted to make the necessary changes needed to deliver better services for children and young people in the borough. The council is addressing all the issues raised as a priority. It has already invested further funding to help support and modernise working practices for all its children's social workers and frontline staff.

- Across GP practices there are a number of variations in quality and performance, including rates for diagnosis and referrals, which leads to a varying experience of care and outcomes for people across the borough.
- **NHS RightCare** is a national NHS England-supported programme committed to

delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes. As part of this, Croydon CCG has been benchmarked against similar CCGs across the country for different service areas. Through this we found that 18% of inpatients with dementia could have avoided admission to hospital and a further 39% could have benefitted from being discharged home earlier. We have since increased post dementia diagnosis support in the borough through investment in an Older Adult Home Treatment Team. This team works with those who are acutely unwell to avoid inpatient admissions as well as supporting them to be discharged earlier.

- 44% of the hospital spend is on patients attending hospitals outside of Croydon. We

believe that at least 17% of this could be repatriated to Croydon Health Services so that patients are treated closer to home and the local hospital trust can become more financially sustainable.

- Independence and independent living.
- **Patients living at home:** The percentage of older people still at home 91 days after discharge from hospital into re-ablement and rehabilitation services decreased by 3% to 84.7% in 2015/16 and is below the London average of 85.4%.
- **Social care-related quality of life** People reported quality of life score in 2015/16 was 18.6 compared to 18.4 the previous year and the national average of 19.1.

20,019 

people aged 65+ are unable to manage at least one domestic task on their own. This is 40.6% of the 65+ population (POPPI\* estimate).

16,402 

people aged 65+ are unable to manage at least one self-care activity. This is 33.3% of the 65+ population (POPPI\* estimate).

## Patient experience

Analysis of user surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality

- **Access to GP services:** Patient experience feedback for how easy it is to get an appointment with their GP has risen by half a percent to 72.3% in 2015/16. However, it remains slightly below the national average of 73.4%.
- **Community mental health:** Patient experience has fallen during 2014 from a score of 8.75 to 7 out of 10. The community mental health overall patient experience score is a combined score including access and waiting and safe, high quality, coordinated services.
- **Hospital care for inpatients:** Patient experience has improved for 2016/17 to 71.8% from 70.6%. It is however below the

national average 76.7%. Inpatient overall patient experience score is a combined score for areas including access and waiting, clean, friendly comfortable place to be and safe, high quality, coordinated services.

- **Carer with social services:** Satisfaction in 2014/15 has fallen from the previous survey 25.5% from 29.2% and remains below the national average of 41.2%. This measures the satisfaction with services of carers of people

using adult social care, which is directly linked to a positive experience of care and support.

- **People who use services with their carer and support:** Satisfaction has fallen to 53.2% in 2015/16 from 59% the previous year. It remains below the national average 64.4%. This measures the satisfaction with services of people using adult social care which is directly linked to a positive experience of care and support.

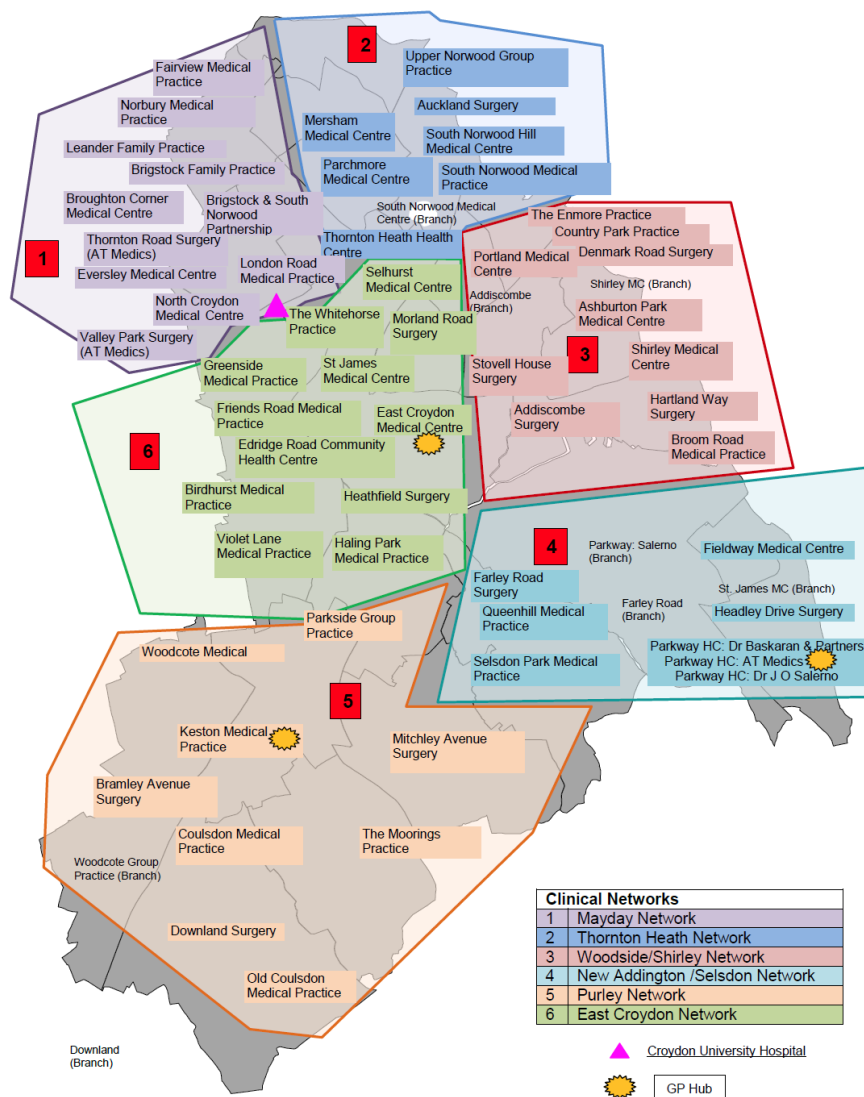
# Size and shape of health and care services

NHS Croydon CCG is responsible for the local NHS commissioning budget of around £489 million. There are 57 GP practices in the borough divided into six Localities – Mayday, Thornton Heath, Woodside and Shirley, New Addington and Selsdon, Purley and East Croydon. While having a range of single handed practices and some challenging estates issues, 82% of patients surveyed rated their experience of their GP surgery as fairly or very good in this year's GP patient survey.

There is an 'extended hours' service in place, meaning that patients can book to see a GP between 8am and 8pm, seven days a week, at two hubs in the borough. The extended hours primary care service is provided by Croydon GP Collaborative, a federation of GP practices in the borough.

Residents are served by one main acute trust, Croydon Health Services NHS Trust, which also provides community services for the borough. Patients requiring specialist acute care including stroke and trauma services are mainly treated at tertiary care centres such as St George's University Hospitals NHS Foundation Trust in Tooting, Guy's and St Thomas' NHS Foundation Trust in central London and King's College Hospital NHS Foundation Trust based in Camberwell. Community and acute mental health services are provided by the South London and the Maudsley NHS Foundation Trust.

Local and specialist cancer services are provided by the Royal Marsden NHS Foundation Trust. The CCG also commissions services from a range of local voluntary and third sector providers.



## Service quality

In October 2017, the South West London Clinical Senate agreed a set of clinical standards for six clinical services in hospitals: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Medical Directors from each Hospital Trust were then asked to self-assess their services against the agreed clinical standards see appendix 1. This evaluation provided an assessment of current consultant staffing against the clinical standards for these agreed six core hospital services.

The evaluation highlighted that, Croydon University Hospital is clinically sustainable in those six core services, in regard to consultant staffing. The evaluation showed that there are gaps currently in a number of the six core services, but that these are relatively small and being managed by the Trust through a dedicated commitment to ongoing recruitment and retention efforts, and supported through the use of locum staffing. With its knowledge of local services and wider staffing issues, Croydon Health Services NHS Trust is confident that it can recruit the necessary additional consultants and that they are therefore clinically sustainable in the six core hospital services. A copy of the full evaluation summary is given in appendix 2.

The Croydon Local Transformation Board will continually evaluate the quality of services across community, primary care, mental health and hospital services.

## Our progress one year on

Over recent years Croydon has been on a journey, with local partners, to transform a range of services that will lead to more effective and sustainable health and care services that address the needs of Croydon residents more proactively, improve their experience of care and support and address care quality. An important element of this is supporting people to better manage their health risks and the impact of their identified health conditions and in so doing support them to remain independent and in their own homes.

Our transformation programmes have included outcomes-based commissioning for the over 65s, enhanced community-based services, including in GP practices, for people living with long term health conditions, services for children, young people and families, better support to people living with mental health conditions, and for those people needing care urgently better and faster access to local services.

Our approach to redesigning services is to make them more effective and implement new, innovative services, thus better integrating care into the system and improving services for local people whilst also tackling our resource challenges.



## Hospital services

- We have reduced unnecessary referrals to hospital by 9% and outpatient attendances by 7.9%
- We have seen a reduction of 3.2% in non-elective activity and a 6.9% reduction in A&E attendances for patients who could be better treated by their GP or at one of the borough's new GP hubs

## Mental health services

- We have reduced the average length of stay for Croydon patients in a mental health bed from 58 to 35 days, supporting people to go home earlier
- We have reduced the number of delayed discharges from a peak of 22 to seven in November 2017
- We have reduced the number of patients in out of borough beds from a peak of 36 to zero in November 2017

## Primary care GP access

- We have increased access to primary care through the new urgent care GP hubs in Purley, New Addington and East Croydon which opened in April 2017 and provide same day pre-bookable and walk-in access for patients 8am till 8pm, seven days a week.
- We have improved patient reported access to GPs

Here are some of the schemes we have successfully implemented during 2016/17:

- Prevention, shared care and shared decision making
  - We have implemented a training programme across all Croydon's GP practices to support clinicians to deliver shared decision making. Shared decision making is when health professionals and patients work together. This puts people at the centre of decisions about their own treatment and care.
- Outcomes-based commissioning
  - We have developed six integrated community networks, one around each of our existing GP networks. An integrated community network is a team of health and social care practitioners who work together in a joined up way to support patients and service users with the greatest needs or most complex clinical or social problems. The networks aim to support individuals to manage their own care, help them prevent illness and promote independence. Professionals have regular "huddles" in GP practices to talk about how to best support patients with the greatest needs.
  - We now have six Personal Independence Coordinators (PICs) working in the borough to support elderly people with chronic long-term illnesses who have been hospitalised in the past year. PICs make home visits and provide the link between various agencies as well as offering isolated people access to community groups and volunteering opportunities. The PIC Programme is a joint initiative between the NHS, Croydon Council and Age UK Croydon signalling a shift towards offering more care closer to people's

homes. GPs initially identify their most 'at risk' patients and later use the information gathered by the PICs to gain a better understanding of patients' circumstances. Each PIC works with three GP surgeries and we plan to roll this out to the whole borough over the next six months.

- Living Independently for Everyone, (LIFE), is an integrated service that brings together intermediate care and rehabilitation services from across health, social care and the voluntary and private sector. LIFE aims to reduce hospital admissions and care home placements as well as helping support people to return home quickly and safely.
- Urgent and emergency care system
  - People in Croydon now have access to a wide range of urgent care services, including GP appointments available from 8am to 8pm, seven days a week. Three 'GP Hubs' opened in April 2017 across the borough to treat children and adults with urgent care needs. This has contributed to CHS's A&E having achieved 90% target and above for patients being seen within four hours of arrival since September 2017.
  - GP hubs are becoming more and more popular as the public become more aware of their services, with a 37% increase in the number of visitors since they first opened in April 2017. Croydon now has an integrated ambulatory care service which allows the London Ambulance Service (LAS) to refer patients who don't need to be admitted to hospital directly to the GP hubs and to the Rapid Assessment Unit at the Edgecombe Unit at CHS. This has reduced attendances at A&E so that

patients can be seen in the right place the first time and improves the quality of services.

- Adult community services
  - We have implemented a GP roving service which provides urgent home visits for local residents which also supports patients being discharged home over the weekend.
- Planned care
  - We are focussing on transforming planned care services to bring them closer to the homes of local people, make them easier to access and improve quality, patient experience and outcomes. The specialties we are focussing on are musculoskeletal, gynaecology, dermatology, ophthalmology, digestive diseases, diabetes, respiratory, cardiology and neurology. These have been selected as specialties that when benchmarked against other CCGs offer opportunities to reduce the number of unnecessary hospital appointments for patients and also offer contractual opportunities for better value for money for the NHS. As part of this programme we will also be working to support local people to change their behaviour to improve their health and well-being, looking at the culture and structure of the workforce and integrating clinicians from across secondary and primary care.
  - Croydon's GP practices have a peer review system where GPs in each practice regularly peer review their assessments of some patients so that they can make sure referrals to hospital are always best option



for the individual. We have also been promoting and incentivising the use of e-Referrals to GPs which combines electronic booking with a choice of place, date and time for first hospital or clinic appointments.

- In order to support the connection between GPs and consultants at Croydon Health Services we are introducing the Specialist Advice and Guidance feature on the e-Referral system (eRS), this autumn. This is an opportunity to improve access between clinicians in Primary and Secondary Care by using existing digital connectivity to benefit patients and avoiding patients having to travel to hospital.
- Primary care and primary care variation
  - Working toward the implementation of all 17 standards for primary care set out in the GP Five Year Forward View which included:
  - piloting a group consultation model to support patients with long-term conditions to develop the knowledge, skills and confidence to manage their own health and care which has showed significant success so far
  - introducing GP peer review programme where GP colleagues review each other's assessment for some patients which has reduced unnecessary referral rates to hospital and reduced inappropriate attendances at A&E
  - implementing a number of social prescribing initiatives so that GPs and practice staff can connect more easily with

the community. Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

- Mental health
  - We have introduced a 24-hour mental health crisis telephone line staffed by clinicians to provide support at times of crisis for local people. It is also available to users of services and statutory organisations, including the police and The London Ambulance Service. The service receives approximately 140 calls to the Crisis Line each month and supports the needs and care of those individuals.
  - Croydon now has a 24-hour Home treatment team that offers an alternative to mental health inpatient hospital care. This means that the Home treatment team can make an assessment 24 hours a day to make sure that all community options are explored before a person is admitted as an inpatient. The team will then work with the patient to plan their care and recovery so that they can be treated in their own home. Care is planned and agreed and independence is promoted.
- Child and adolescent mental health services (CAMHS)
  - The number of children and young people aged under-18 with a diagnosable mental health condition receiving NHS community services treatment increased from 16.8% in 2015/16 to 32% in 2016/17. We expect to be able to sustain this level and improve it in the coming year.

- We have met the waiting time standard for children and young people with eating disorders so that treatment starts within a maximum of four weeks from the first contact with a designated healthcare professional for routine cases and within one week for urgent cases.
- We have met the waiting time standard for early intervention in psychosis services so that more than 50% of people experiencing first episode psychosis are treated with a NICE-approved care package within two weeks of referral.
- We have increased access to the crisis team for young people under 18 who are experiencing a mental health crisis.
- CAMHS in Croydon can be accessed through a Single Point of Access which brings together all the local services offering emotional support, counselling, mental health assessment and parenting support. Representatives all meet to make sure referrals for children, young people and their families are offered the most appropriate specialist help based on their presenting concerns, needs and referral information.
- Diabetes
  - Diabetes is a particular focus for our population and we have implemented and promoted the National Diabetes Prevention Programme that focusses on supporting patients who are at higher risk of developing the disease and those who are classified as “pre-diabetic”. Through community outreach sessions, Croydon Voluntary Action help us identify people at risk, as well as through their GPs and the council’s Just Be programme. We currently

have 60 places on the programme and hope to expand this to 105 places. Attendees of the 18 month programme are then given one to one sessions with a health advisor to support them to understand the impact of their diet and exercise and how making simple changes can reduce their risk of developing diabetes.

## How we have involved patients and residents

There have been extensive local and innovative engagement activities over the past year.

- In the **Big Ideas** initiative, the CCG asked patient and public representatives, staff, partners and stakeholders for ideas about how the NHS can address financial challenges. There were 2,229 observations captured from 155 participants who attended one of the four events.

- Across the south west London CCGs held 88 **grassroots outreach** sessions alongside local Healthwatches, 11 of these were in Croydon, and a **health and care forum** in each borough focussing on patient experience and the transformation of health and social care to help inform the Sustainability and Transformation Partnership refresh.

Hundreds of local people across a range of communities have contributed to the feedback, providing thousands of observations and comments. These have been distilled into key themes and key issues below:

### Grass Roots

Access to GPs was a significant issue  
General consensus that Croydon Hospital has improved  
Frustrations with receptionists  
Long waits for Improving Access to Psychological Therapy Services  
Need a holistic physical and mental health approach  
Support for Children and Young people to lead healthier lifestyles

### 'Big Idea' Themes

Digital developments  
Medication waste  
Communication – signposting  
Access – convenience  
Self-care – independence and well being  
Integration – system, funding, data  
Support network – voluntary sector  
Workforce – training and integration

## Our focus

We have set out some of our many successes to help sustainably improve health and wellbeing and improve care and quality of services, however we recognise that there is still much to do over future years.

Whilst we will build on the our current programmes we will consider how we could extend the positive results from our outcomes based approach to beyond over 65s to benefit the whole population of Croydon, across both physical and mental health, including children and families, working age adults and people with disabilities.

The Croydon Health and Care Alliance for older people is helping to remove barriers to commissioners and providers working together alongside an outcomes-based contract. In addition the GP engagement is being strengthened through developing the Croydon GP Collaborative, which will allow for greater flexibility in how primary and community services come together.

Transforming the health and care system through transformational change will require fundamental changes to the way health and care services are provided. Our workforce will need to be trained, recruited and deployed accordingly. Staff will be required to work in different and more flexible ways and to deliver new care pathways that will be predominantly in a community or primary care setting. Therefore, a planned shift of services and

teams from acute to primary and intermediate care settings will be required with the creation of more joint working and roles across agencies within the Croydon system.

As we move toward a whole population programme the Croydon Transformation Board will be considering the development of an accountable care type arrangements that will help partners in Croydon take on clear collective responsibility for population health in Croydon and ensuring we can collectively maximise the value of the resources we collectively deploy on behalf of local people.

Our focus will be to improve outcomes by:

- supporting more people to stay healthy and active for as long as possible and able to live as independently as possible
- early detection and accurate diagnosis of serious health conditions and illnesses
- quality of care and patient experience
- work satisfaction of our health and care professionals
- making sure we achieve financial sustainability

This will be the focus as we develop our *Local Health and Care Plan* between now and June 2018.

# Merton and Wandsworth Local Transformation Board

## Our vision

Our agreed joint vision is to enable the people in Merton and Wandsworth to live healthy, independent lives for as long as possible.

Our vision is to have health and care services where:

- we work together to prevent ill health and reduce inequalities
- health and care are co-ordinated around the needs of the individual
- the experience of using health and care services is seamless – we break down barriers between primary, community, social and mental health services
- we ensure prompt access to services which mean that people are treated as close to home as possible and that only the people who really need to go into hospital do so
- care for patients with long-term and complex needs is tailored to the individual so that the care they receive meets their personal needs
- hospital services are accessible, high quality and joined up with other health and care organisations
- local people are confident to manage their own health and wellbeing
- people receive a consistent service and we ensure those with the greatest needs get a service that fully reflects their challenges

## Our model for health and care

This will be achieved through:

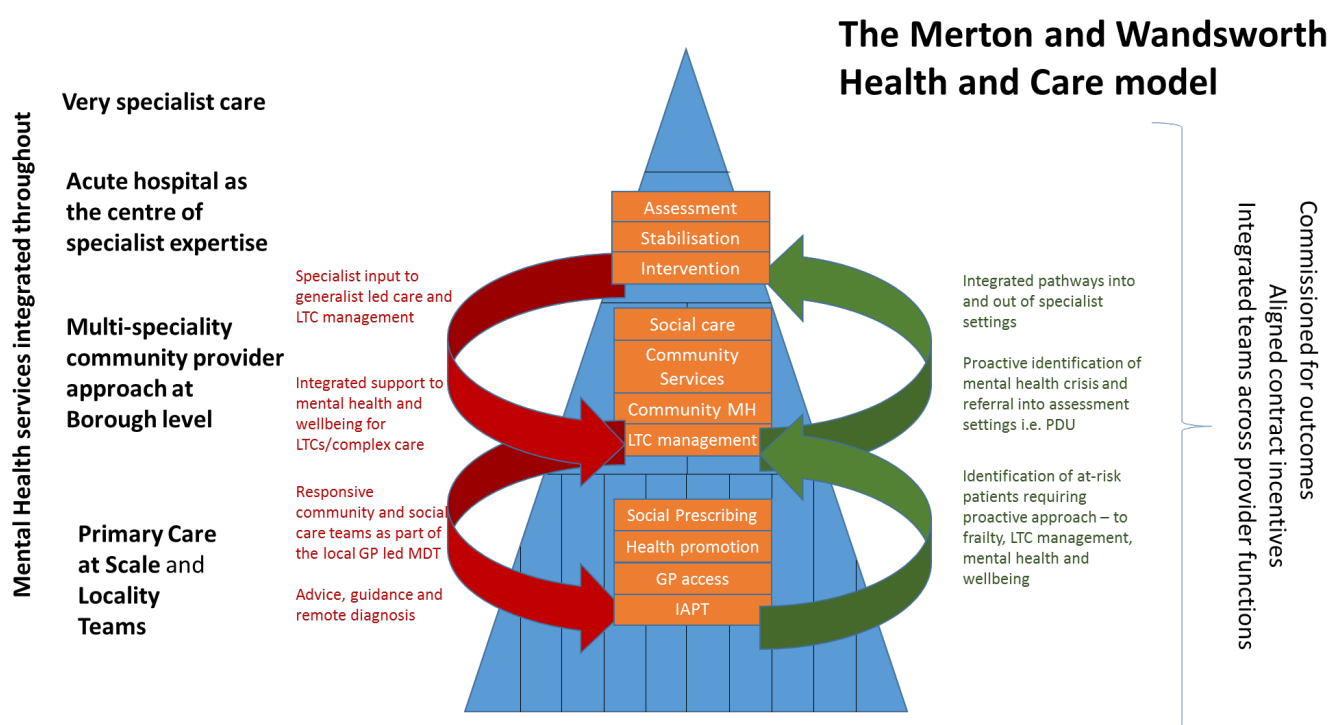
- **General practice working together in networks** aligned to the local delivery model for integrated care. Delivering resilient, responsive and sustainable primary care.
- **A Multispeciality Community Provider approach in each borough** which is responsible for integration of primary care networks, community care and social care provision along with third sector input to deliver proactive, co-ordinated management of individuals with long term conditions, complex needs, risk of physical or mental health crisis or who are at the end of life.
- **The hospital as the centre of specialist physical health expertise and care** – for people who have an identified need for specialist intervention and require diagnosis, stabilisation and treatment. In both planned and emergency care, this means that the hospital workforce will operate across hospital and community settings, providing specialist expertise to generalist-led services as well as high quality, accessible services in the hospital setting using modern service models. St

George's hospital will play a critical SWL-wide role in ensuring that there is a sustainable, networked approach to acute care across the STP and will continue to develop its vision for local system integration.

- **Mental health services integrating with each element of the system** and providing specialist intervention – diagnosis, stabilisation and

treatment as well as integration with physical health services

- **A commissioning system in health and social care which moves into a strategic role**, aligning incentives to support transformation including resource allocation/shifts between MCP, hospital and Mental Health



- We know this vision requires further iteration and development:
- Patients in the LTB area access acute services at St George's, Epsom and St Helier, Chelsea and Westminster and Kingston Hospital and so our transformation vision must reflect this. Merton CCG will work closely with partners in Sutton and Surrey Downs to address the service quality issues at Epsom and St Helier raised elsewhere in this document
- In both boroughs, Health and Wellbeing Boards (HWBBs) are responsible for joint health and wellbeing strategies at borough level. The strategy of the LTB needs to align to

each HWBB, reflecting areas of shared challenge but also distinct differences in each borough. The context for each HWBB is the Joint Strategic Needs Assessment in each borough, which has informed the 'context and challenges' section below.

- Although we have a broad aspiration to integrate physical and mental health care, we need to work through the detail of how mental health services can be fully integrated in every part of our proposed model
- We need to ensure that this vision and strategy is fully owned across health and social care and reflects appropriately, a social care

view of the challenges facing that sector over the medium to long term. We know that the health and care sectors are co-dependent and

we rely on each being sustainable and effective for the whole health and care system to flourish

## Our health and care partners:

- Central London Community Healthcare
- Local Medical Committee
- London Borough of Merton
- London Borough of Wandsworth
- London Specialised Commissioning
- Merton Clinical Commissioning Group
- Merton GP Federation

- Merton Healthwatch
- South West London and St. George's Mental Health Trust
- St Georges University Hospitals NHS Foundation Trust
- Wandsworth Clinical Commissioning Group
- Wandsworth GP Federation
- Wandsworth Healthwatch

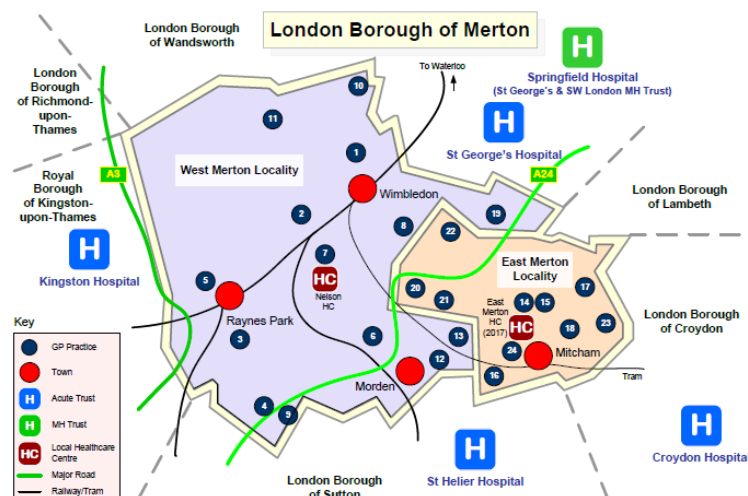
## Our context and challenges

Across the two boroughs we have

- 65 practices
- A population of 585,000 people
- Five GP localities

The health of people in Merton is generally better than the London and England average. Life expectancy is higher than average and rates of death considered preventable are low. This is largely linked to the lower than average levels of deprivation in Merton. We have a range of community assets that are important to health; there are many green spaces, educational attainment is high and we have high levels of volunteering.

The populations of Merton and Wandsworth are predicted to grow over the next 10 years. In Merton we expect it to rise by 10% (20,000 more people) and in Wandsworth we expect it to rise by



7% (24,000 more people). The greatest increases will be seen in older age groups:

- 65-84 year olds are projected to increase by around 20% in both boroughs
- 85+ year olds are projected to increase by 22% in Merton (800 more people) and 34% in Wandsworth (1,300 more people)



- Minimal changes are expected in the numbers of 0-4 year olds in the boroughs

**This growth in the populations will have the biggest impact on services for older people**, e.g. home care, care homes, falls, dementia, emergency care, rehabilitation and reablement (Reablement involves, intensive support to help people recover independence following crisis or hospital discharge so that they are able to live as independently as possible). In addition, growth in older populations has a significant impact on how we spend our resources, as outlined in the *NHS Five Year Forward View* “it costs three times more to look after a 75 year old and five times more to look after an 80 year old than a 30 year old”. We know we will need to support older people to live more independently for longer, with greater ability to manage their own health. More integrated health and care in the community would make us less reliant on hospitals, which could then focus on helping people in need of specialist care.

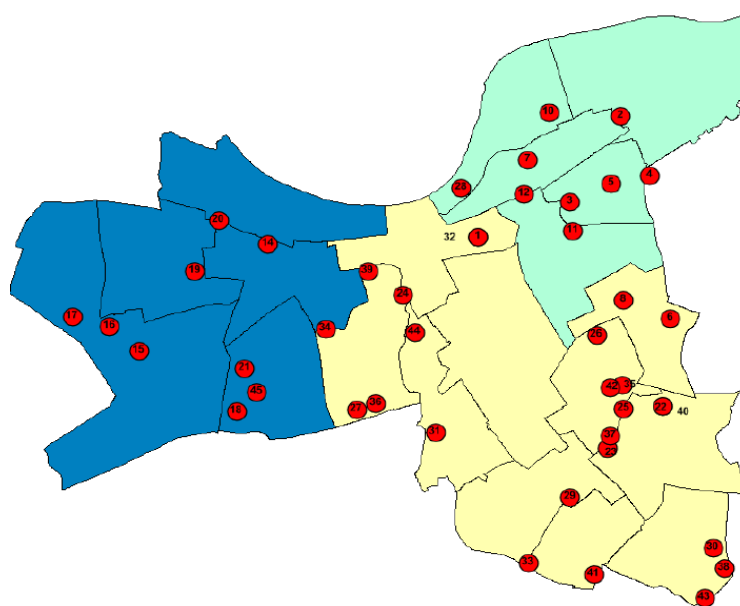
Significant social inequalities exist within Merton. The eastern half has a younger, less affluent, and more ethnically mixed population. The western half is more affluent, with a higher average age. The life expectancy gap between the most and least deprived wards in Merton is 6.2 years for men and 3.9 years for women and nearly twice as many people die prematurely in the East of the borough than the West. 6% of the population of Merton has diabetes which places pressure on primary care services to ensure patients receive optimal treatment.

Wandsworth is a vibrant and well-connected borough, with many community assets, attractions and facilities that support and can be further utilised to improve healthy lives. Black and Minority Ethnic (BME) groups make up 29% of the population, which is an important consideration in

the planning of services and BME children make up 69% of those who are Children Looked After (CLA). The population is growing and diverse, provided for by good schools, accessible parks and green spaces and thriving businesses. The Council is working hard to ensure that its ambitious regeneration schemes create opportunities for residents to lead more prosperous, active and healthy lives.

However, the borough has a number of challenges. There is a significant health burden from poor air quality and homelessness has increased by a third in five years, linked to rapidly rising housing costs. The gap of life expectancy between the most and least deprived wards is 9.3 years for men and 4.5 years for women.

Wandsworth has the highest levels in London of alcohol consumption above recommended levels and 15,000 people have diabetes (4.8%). 39% of those over 65 live alone and this is set to increase further, which increases the challenges in providing co-ordinated, proactive care for older people. It is unsurprising in this context that rates of falls by older people are significantly higher than national and regional averages.





## Service quality

In October 2017, the South West London Clinical Senate agreed a set of clinical standards for six clinical services in hospitals: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Medical Directors from each Hospital Trust were then asked to self-assess their services against the agreed clinical standards (see appendix 1). This evaluation provided an assessment of current consultant staffing against the clinical standards for these agreed six core hospital services.

### St George's Hospital

The evaluation highlighted that St George's Hospital is clinically sustainable in those six core services, in regard to consultant staffing. The

evaluation showed that there are gaps currently in a number of the six core services, but that these are relatively small and being managed by the Trust through a dedicated commitment to ongoing recruitment and retention efforts, and supported through the use of locum staffing. With its knowledge of local services and wider staffing issues, St George's NHS Foundation Trust is confident that it can recruit the necessary additional consultants and that they are therefore clinically sustainable in the six core acute services.

### Epsom and St Helier Hospitals

The evaluation highlighted clinical sustainability issues in two of the six clinical services that were assessed at Epsom and St Helier. These are summarised in the table below:

*Table: Current consultancy staffing against standards at Epsom and St Helier*

Hospital service		Current consultant workforce	Clinical Standards Requirement	Gap
<b>ED</b>	Current consultant headcount	14	24 (12 for each site)	10
<b>Obstetrics</b>	Current consultant headcount (consultants with the competencies to cover acute obstetrics on calls <sup>1</sup> )	26	22 (Epsom – category A, St Helier – category B)	No gap
<b>Emergency general surgery</b>	Current consultant headcount (consultants who contribute to the emergency general surgery rota)	10	10	No gap
<b>Paediatrics</b>	Current consultant headcount (consultants with the competencies to cover acute paediatrics on calls)	26 <sup>2</sup>	24 (12 at each site, as activity levels are lower)	No gap
<b>Acute medicine</b>	Current consultant headcount – dedicated acute care physicians	11	24 (on two sites)	13
	Current consultant headcount – total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians <sup>3</sup> )	30	24 (on two sites)	No gap
<b>Intensive care</b>	Current consultant headcount (consultants who contribute to the critical care rota(s))	7	9 (for HDU at Epsom and ICU at St Helier) <sup>4</sup>	2

<sup>1</sup> Note that gynaecology work may also be a significant part of some of these consultants' job plans.

<sup>2</sup> This includes 8 WTE acute paediatric consultants who manage the paediatric Emergency Department service on both sites

<sup>3</sup> Given the complexity of the acute medical rota, we have included the figures for dedicated acute care physicians and for the total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians). The requirement is met by a combination of dedicated acute care physicians and non-acute care physicians.

<sup>4</sup> Epsom Hospital has an adult critical care facility that has the ability to treat and stabilise level 3 patients. There is an expectation that such patients will either step down or be transferred to the intensive care unit at St Helier if they require ongoing level 3 care. In addition, there is a PACU, staffed 24/7 by consultant intensivists, on the Epsom site (within SWELEOC).

The table shows that Epsom and St Helier, as currently configured, meets the standards for obstetric and paediatric services.

For Intensive Care, Epsom and St. Helier currently operates a service whereby Level 1 and 2 critical care is provided within Epsom's High Dependency Unit, and Level 3 patients are stabilised and transferred to St. Helier, which has a Level 3 Intensive Care Unit. The trust has confirmed that the current gap of 2 intensive care consultants is manageable within the context of this service model and plans to appoint a further two consultants at St Helier.

For Emergency Department services, the figures demonstrate that the Trust does not currently meet the standards. It has a gap of 10 consultants between its current staffing and the agreed quality standards.

The Trust also faces particular workforce pressures in acute medicine. Epsom & St Helier has the fewest number of dedicated acute care physicians per acute inpatient site and a current gap of 13 consultants against the agreed clinical standards (if only acute care physicians are taken into account).

The Trust currently manages the implications of these shortfalls on a daily basis to ensure care is safe across the two sites, in a number of ways including: using a mix of staff rotations; temporary staff; and consultants covering for middle grade doctor vacancies. But the size of the Emergency Department and Acute Medicine consultant

workforce gaps is considerable and the challenges for the trust will increase as the move to fully deliver a 7 day service model intensifies.

A copy of the full evaluation summary is given in Appendix 2.

Epsom and St Helier have clearly set out a case for change and a scale of challenge that states that they are unable to deliver all of these acute services without a level of change to their clinical model. Through an engagement exercise, held between July and September 2017, the Trust has set out their views on potential scenarios for the future.

No decision has been made on the future of Epsom and St Helier University Hospitals NHS Trust. Merton clinical commissioning group will work with local commissioners to develop a formal process to consider the future of services at Epsom and St Helier University Hospitals NHS Trust, and other issues such as their estate, and how they will be able to deliver sustainable services for the local population. Commissioners and the local system are fully committed to consultation with the public if this process suggests significant change.

The Merton and Wandsworth Local Transformation Board will continually to evaluate the quality of services across community, primary care, mental health and hospital services.

# Our achievements

## Cardiology

- We have improved access to services closer to home following a recent review of GP referrals which has led to the optimisation of diagnostics within primary care
- We have improved pathways for the transfer of the management of Ambulatory Blood Pressure and Anti-Coagulation services to primary care

## Dermatology

- Shorter waiting times are being experienced by patients as a result of new dermatology services we have put in place this year
- Community dermatology service - Clinicians are developing a community 'One Stop Shop' and tele-dermatology service
- We have improved dermatology pathways by providing clear advice and referral pathways for GPs

## Ambulatory Emergency Care

Ambulatory care is where a patient is treated and stabilised at hospital without being admitted. It ensures rapid access to specialist expertise whilst maintaining a patients' independence and support network at home.

- In 2016/17 our average performance for ambulatory care rose to 22.6% (of all potential care which could be managed this way) which is an improvement of nearly 5% over the year compared to the year before when it was 18%

- In February 2018, St George's Hospital will open new ambulatory care capacity which is projected to take performance above 30%

## Diabetes

- Diabetes clinics hosted in practices with video-consultant calling in once a month with the patients: Consultant support in primary care is underway as part of the GP Federation work in Wandsworth, learning will be shared across the both boroughs
- Rapid access for professional advice and guidance by GPs is now available via our community specialist nurses
- Specialty outreach into GP practices to discuss at risk patients, review referrals, hold virtual clinics

## Ear, Nose Throat (ENT)

- Shorter waiting times are now being experienced by patients through our new ENT services
- Virtual clinics - Patients are now receiving improved access to ENT follow up appointments through our new 'virtual clinics'

## Musculoskeletal services

- An innovative Single Point of Access service in Merton now accepts self-referral as well as managing Musculoskeletal pathways in the

borough. This has helped direct patients to the most appropriate care including physiotherapy rather than a hospital appointment where not appropriate. This model is also being put in place in Wandsworth.

## Neurology

- GP Direct Access Hot Clinics - GPs are now able to refer patients who are rapidly deteriorating to an Urgent Neurology Clinic instead of an Emergency Department
- We have put in place Open Access follow ups – this is where patients can request a follow up appointment when they experience symptoms rather than have a regular booked follow-up which may not coincide with feeling unwell. This has led to:
  - Reduction in referrals to acute headache clinics
  - Reduction in waiting times and backlogs
  - Reduction in attendances and re-admissions through Emergency Department/Acute Medical Unit
  - Reduction in attendances within primary care

## Intermediate Care, Discharge to Assess and Rapid Response

- A three month pilot for a single health & social care re-ablement/rehabilitation pathway started in August 2017 at St George's Hospital on three wards. This uses a 'Discharge to Assess' principle i.e. all agencies ensure the support is put in place for the patient to go

home, and assessments for care are made in the patients' home rather than hospital. The impact has been that all social care referrals made by pilot wards have been responded to within 2 hours, with a decision. This model is being rolled out across wards

## Enhanced Support to Care Homes

- In-reach nurses have taught approx. 60 nurses/carers in over half of the care homes in Wandsworth their training sessions focused on how to recognise a deteriorating patient, chronic obstructive pulmonary disease (COPD) and asthma management.
- The "Red Bag" scheme implementation underway in both boroughs
- A Merton Joint Intelligence Group has been established which now meets monthly. The group brings together a range of professionals and organisations across health and social care to share information relating to the quality of care being delivered in care homes. Areas of potential risk are identified so that we can respond quickly to concerns and agree action plans where appropriate.

## Extended Access to Primary Care

- There is now 7 day, 8am-8pm access to Primary Care in Wandsworth and Merton. This is provided through a combination of individual practice extended opening and Primary Care Access Hubs which launched in April 2017 (Merton) and May 2017 (Wandsworth).

- Merton has 2 Primary Care Access Hubs which provide primary care services to cover 4.00pm-8.30pm on weekdays and 8am to 8pm weekends and Bank Holidays (1 hub opens on a Sunday). The hub service also offers a wound care clinic for daily dressing needs. Wandsworth has 3 Primary Care Access Hubs which provide a primary care service to cover 6:30-8:00pm on weekdays, 8am-8pm on weekends and 8am-8pm on bank holidays (not all hubs are open at all times). They operate alongside extended hours schemes in practices which mean some Practices are also open until 8pm on weekdays and on Saturday mornings.
- Practices in both Boroughs are also signed up to deliver urgent on the day appointments within 4 hours, where it is determined that a patient has a clinical need for such an appointment.
- Practices in both Boroughs are signed up to accept patients redirected by the Accident & Emergency (A&E) navigator between 9am –

3pm. Plans to develop direct booking from A&E are in progress.

- In total this means that there are approx. 6000 additional primary care appointments available each month across Wandsworth and Merton. Utilisation is currently around 75% therefore capacity is available to manage increased demand.

## Mental Health

- The Local Transformation Board (LTB) works with partners across South West London to progress the transformation of mental health services and in order to focus effort on these system-wide changes has not established a separate work stream at LTB level. However, significant local change has been achieved with the institution of improved psychiatric liaison services at St George's Hospital, the opening of Crisis Cafes and Single Point of Access models for mental health.

## Developing Local Health and Care Plans

The information contained in this section will be used as we develop our *Local Health and Care Plan* between now and June 2018.

As our Local Transformation Board covers two boroughs, we will develop individual *Local Health and Care Borough Plans* (that will be named by local areas) so that borough level issues and

priorities are identified and plans developed to address these.

Our two individual Borough level *Local Health and Care Borough Plans* will then be brought together to create our Local Transformation Board Health and Care plan.

# Kingston, Richmond and East Elmbridge Local Transformation Board

## Our joint vision

To deliver improvements in the health and well-being of people living in Kingston, Richmond and East Elmbridge and focus on the priorities laid out in the Joint Strategic Needs Assessments and by the Health and Well-Being Boards.

The population of Kingston, Richmond and East Elmbridge is healthy with the life expectancy for both females and males above the national average. However, the population is ageing and with this comes the challenges of caring for increased numbers of people with ill-health and multiple long-term conditions. We are also seeing growth in the number of children and young people who live and study across the three areas. To ensure we meet the diverse needs of a growing population the Local Transformation Board (LTB) has agreed to improve the following areas:

- Improve prevention and support people to live independent lives for longer
- Improved outcomes for children who experience significant mental health challenges
- Reductions in the time people spend in hospital in the last year of their lives and help them to decide on their preferred place of death
- Putting in place health and care services that are person-centred whilst being both financial and clinically sustainable

To deliver these key areas, the Local Transformation Board has agreed to build upon

the principles of trust and partnership to enable improved care outcomes and financial sustainability.

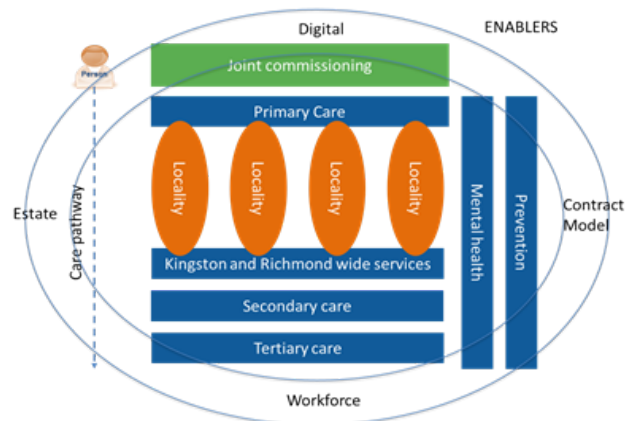
## Our model for health and care

The Local Transformation Board is developing the detail on how the vision will be achieved and the key metrics for success. The areas that we will be focusing on include:

- Developing a locality team approach based around populations of 50,000 that are simple and coherent, to ensure consistency and based on shared models and best practice
- Primary care at scale with practices working together as networks, and through the three GP Federations, so that care is provided in a joined-up way for patients and that access to, and resilience of, GP practices are improved
- Bringing together physical and mental health to improve outcomes for people with long term conditions and reduce the health inequalities in people with serious mental health illness
- Building on foundations already in place across Kingston and Richmond boroughs to focus support for those with learning disabilities
- Enabling a workforce that is empowered to work across organisational and professional

boundaries, to provide high quality and safe care for the population

The diagram below shows the health and care system in Kingston and Richmond.



## Our health and care partners

The health and social care partners in Kingston, Richmond and East Elmbridge are:

- Chelsea & Westminster NHS Foundation Trust
- CSH Surrey
- Hounslow and Richmond Community Trust
- Kingston GP Chambers
- Healthwatch – Kingston Upon Thames
- Kingston Hospital NHS Foundation Trust
- Kingston Voluntary Action
- NHS Kingston CCG
- NHS Richmond CCG
- NHS Surrey Downs CCG
- Richmond Council for Voluntary Service
- Richmond GP Alliance
- Healthwatch - Richmond Upon Thames
- Royal Borough of Kingston Upon Thames
- London Borough of Richmond Upon Thames
- South West London and St George's Mental Health NHS Trust
- Surrey and Borders Partnership NHS Foundation Trust

- Surrey County Council
- Healthwatch - Surrey
- Surrey Medical Network
- Your Healthcare



# Our context and challenges

## Richmond and Kingston – Healthy, wealthy and wise (Combined population 422k)

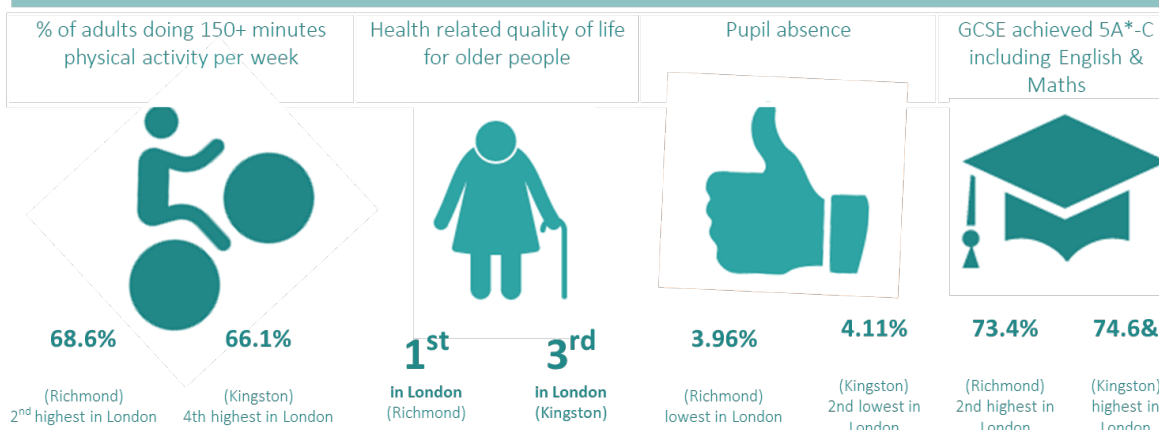
Employment rate (aged 16-64)

% of the population aged 16+ who are unemployed

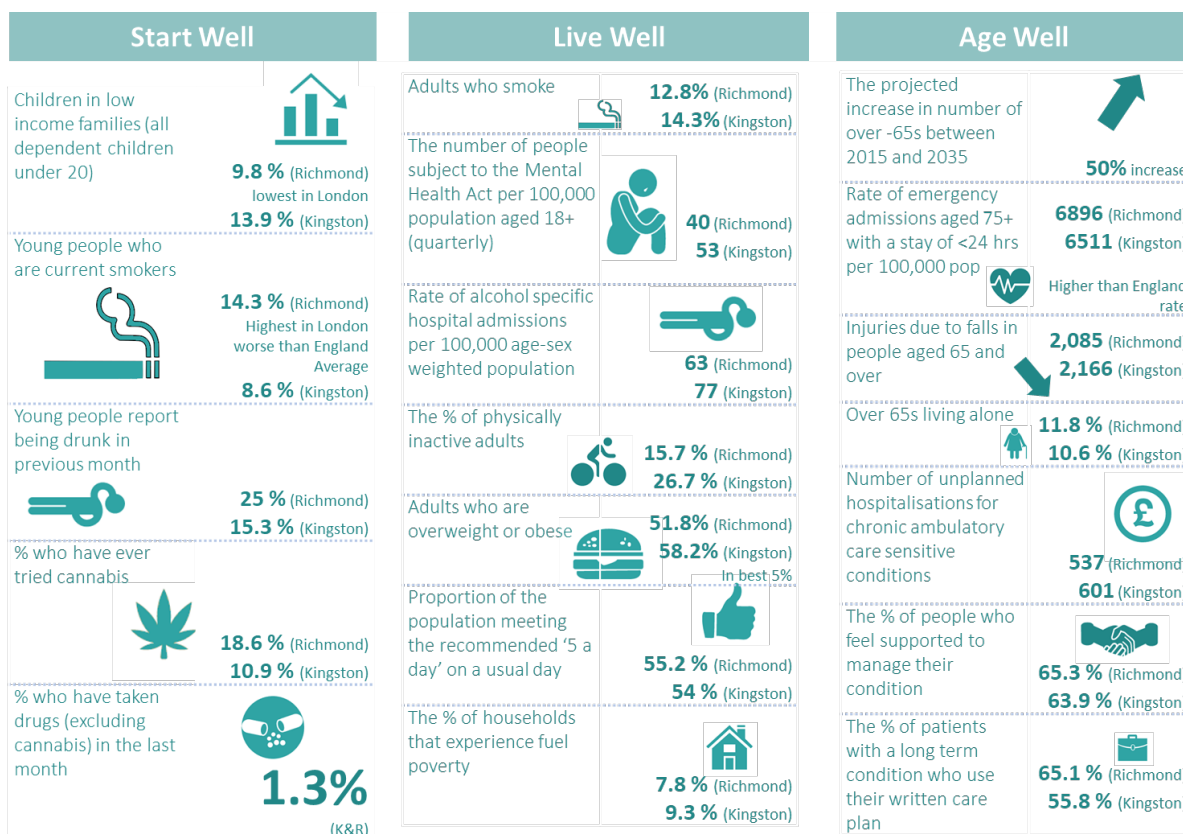
Life expectancies



## Richmond and Kingston lead London in terms of.....



## But with significant room for improvement in several areas....



# The populations and demand on services

The registered population of the Local Transformation Board is broken down as follows:

- Kingston 207,000
- Richmond 215,000
- East Elmbridge 65,000

The percentage of over 65s living in the Local Transformation Board area is higher than most of London (13% for both Kingston and Richmond) with a projected increase of 50% across Kingston and Richmond by 2035.

Whilst people are living longer there is an increased incidence of people with living with one or more long term conditions. Nearly one in three people have a long term condition in Kingston and Richmond and nearly one in ten people are living with three or more long- term conditions.

Coronary heart disease in Kingston is predicted to be 3.2%, in Richmond it is predicted to be 3.4%, compared to the England average of 4.6 %. Although the prevalence is lower than England coronary heart disease is the leading cause of death in men.

Diabetes prevalence in Kingston is 6.6%, in Richmond it is 6.8%, compared to the England average of 8.5%. Although the prevalence rates are lower than England, diabetes is a leading cause of ill health in the boroughs, and there is a large number of people still undiagnosed in our community.

One in four people will experience mental illness in any year. One in six people have a common mental health disorder at any point in time. Most common mental health disorders take the form of anxiety and/or depression which are experienced by 10%

of people in both Kingston and Richmond at any point in time.

To meet these challenges our plans have to ensure that the services we put in place are both clinically and financially sustainable.

## Size and shape of health and care services

The relatively large number of the health and care organisations in the Local Transformation Board region means that services and relationships to deliver care are more complex than many health and care economies and has resulted in fragmented service delivery. This has been recognised and is in part being addressed through programmes like Kingston Co-ordinated Care and Richmond Outcome Based Commissioning.

### General Practice

Across Kingston, Richmond and East Elmbridge there are a total of 57 GP practices (Kingston 21, Richmond 28 and East Elmbridge 8). Generally we have a good quality of primary care across all three areas with a large number of practices receiving a rating of “Good” from the Care Quality Commission. Our population also generally rate the quality of the GP services highly as demonstrated by the results of the national GP survey with many of the responses rating the services equal to or above national average.

We also have three GP Federations working across the Local Transformation Board area, which support us to deliver care in a joined-up way for patients and improve access to, and the resilience of, GP practices.

## Hospitals

When hospital care is required the population of Kingston, Richmond and East Elmbridge access two hospitals – Kingston and West Middlesex Hospital in the majority of instances. Sometimes when more specialist hospital care is required patients may travel to tertiary centres such as St George's University Hospitals NHS Foundation Trust or Imperial College Healthcare NHS Trust.

## Service quality

In October 2017, the South West London Clinical Senate agreed a set of clinical standards for six clinical hospital services: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Medical Directors from each Hospital Trust were then asked to self-assess their services against the agreed clinical standards see appendix 1. This evaluation provided an assessment of current consultant staffing against the clinical standards for these agreed six core hospital services.

The evaluation highlighted that, Kingston Hospital is clinically sustainable in those six core services, in regard to consultant staffing. The evaluation showed that there are gaps currently in a number of the six core services, but that these are relatively small and being managed by the Trust through a dedicated commitment to ongoing recruitment and retention efforts, and supported through the use of locum staffing. With its knowledge of local services and wider staffing issues, Kingston Hospital NHS Foundation Trust is confident that it can recruit the necessary additional consultants and that they are therefore clinically sustainable in the six core acute services. A copy of the full evaluation summary is given in appendix 2.

The Kingston and Richmond Local Transformation Board will continually evaluate the quality of services across community, primary care, mental health and hospital services.

## Community care

Across Kingston, Richmond and East Elmbridge community care is provided by three community providers – Central Surrey Health Hounslow, Hounslow and Richmond Community Healthcare and Your Healthcare.

## Social Care

Social care is provided by East Elmbridge Borough Council, London Borough of Richmond and the Royal Borough of Kingston Upon Thames.

## Voluntary and Community Sector Support

We are fortunate in our Local Transformation Board area to have a strong voluntary and community sector (VCS) which provides a range of support that can help people to live independently in the local community and makes a significant contribution to preventing ill health and maintaining people's wellbeing. Increasingly we are looking for opportunities for joint working; for example there is VCS involvement in the Richmond outcome based commissioning programme and the Kingston Coordinated Care programme where VCS groups are involved in the multidisciplinary team meetings in New Malden.

# Our progress so far – one year on

## Improving care for people in crisis

Over the last year we have piloted a new service in Kingston and Richmond introducing an alternative to hospital admission for people experiencing a mental health crisis. Now, people living in Kingston and Richmond who are experiencing a mental health crisis have access to a “safe haven” residential home in the community where they can stay for up to five days. The house is staffed - by specialist support workers 24 hours a day who provide personalised support which focus on helping the person to stabilise and recover. The service is linked to community and home treatment teams for clinical support. Between July 2016 and February 2017 over 100 people accessed the service, with over 80% of them returning home without needing admission to hospital. 5136 detentions (known as “sections” under the Mental Health Act) for Kingston and Richmond residents have dropped by 32% compared to the average for the previous two years.

## Improving Access to Psychological Therapy

In Richmond we have piloted expanded our *Improving Access to Psychological Therapy* services to support people with long term conditions such as diabetes and chronic obstructive pulmonary disease to have easier access to talking therapies, to give them more support to self-manage their conditions to help improve their health outcomes.

## Working together to provide joined-up Community Care

As part of Kingston Co-ordinated Care in Kingston we have implemented:

**MTDs and Locality teams:** A multi-disciplinary locality team (MDT) that meets monthly with each General Practice to review individual patients who have high unplanned use of services and complex problems, based on their health and care needs and builds a care plan for each patient to implement and address these needs. Progress so far includes:

- Three months of MDT’s in New Malden in each of the 5 practice cluster.
- Learning on risk stratification, support requirements, system requirements.
- MDT commenced with Kingston Health Centre at the beginning of November.
- Further interest from practices in other localities to roll-out the approach.

**Access and Triage:** Your Healthcare duty /triage functions and Royal Borough of Kingston Adult Social care triage functions have been co-located to create ‘Access’ team who have been:

- Undertaking process redesign to reduce duplication between services
- Identifying opportunities to work more effectively as a whole team.
- Conducting workshops with Mental Health services to review existing processes.

**Workforce Development:** Staff workshops to identify and trial new ways of working based on population cohorts have taken place throughout October and November.

A role framework has been developed to map capabilities and roles scoped for Health Education England funding including:

- Locality Coordinator
- Trusted Assessor function
- Community Referrer
- Boundary Workers

**Informatics and Evaluation:** development and utilisation of Kingston Care Record (KCR) with a Task and Finish group focussed on:

- Care Plan in KCR ( visible to all)
- Flagging to support evaluation
- Summary page
- Utilisation
- Risk stratification
- GP's support access to free text information to support integrated single view of care plan in KCR.

In Richmond the Outcome Based Commissioning approach has been developed, with an established governance framework across health and social care, to deliver new integrated models of care and improve outcomes for patients and their carers.

Examples include:

- Rapid redesign of the inpatient unit pathway at Teddington Memorial hospital to ensure a greater focus on rehabilitation so that people regain their independence in a supported environment to support them to get home faster. The result is that people stay for less time and we have created capacity to allow step up from people's homes if they are not coping which avoids an admission to hospital. We are treating the same number of patients

in less beds which has released money to be reinvested elsewhere in the local health system.

- The locality model, which is premised on strong research evidence that more personalised care can be delivered to populations of around 50,000, is being developed and tested in Teddington & Hampton locality. By combining the capacity, skills and knowledge of GPs, community staff and social services at this level, we have demonstrated that patients can be better supported in their own homes through joined up care. The model will be extended to the remaining three localities over the next six months.
- Long term condition specialist pathways have been redesigned because it was evident that too many patients were being referred to hospital for ongoing care when the expertise exists in the community to provide that care and support. Diabetes hub clinics, community heart failure clinics and increased cardiac rehabilitation provision have been implemented.
- New respiratory pathways have been established and BREATH education classes are in place to support patients to self-manage their condition. The outcomes of these interventions are currently being measured.
- A hospital transfer pathway 'red bag scheme' has been rolled out across care homes in Richmond with the anticipated impact of a 2-3 day reduction in length of stay for patients based of evidence from the Sutton Care Homes Vanguard.

## Primary Care

Across both Kingston and Richmond we have made improvements in primary care access. We now offer seven-day access to a GP, between the hours of 8am and 8pm. We have also introduced online services across all GP practices so that people can now book appointments, order repeat prescriptions and access their health records online.

GP services are now co-ordinated by three GP federations that work across practices to share information and drive improvements in care that is best provided close to home.

We are also developing primary care-led urgent care services in both boroughs. We are redesigning the Walk in Centre at Teddington Memorial hospital to become an urgent treatment centre. This will ensure seven day walk-in and bookable services provided by a mix of GP and urgent care practitioners to meet the expressed needs of the local population. The service will also support the public to adopt safer and healthier lifestyles and to use the broad range of services in the community to manage their health such as pharmacies, opticians and the voluntary sector. It will continue the emphasis on local services for local people. A linked service for people in the East of the borough is also being explored.

This service is already supported by the Richmond rapid response team which combines, community and social services staff (supported by a GP) to respond to urgent requests for home-based intervention and ongoing care. The team responds to the majority of requests within 2 hours and can arrange medical, social care and home adaptations

which support people to stay at home and avoid having to be admitted to hospital.

## Social Prescribing

In both Kingston and Richmond we have started rolling out social prescribing across our communities through pilot schemes that are delivered in partnership with the voluntary and community sector. In Richmond we have started in Barnes with the focus on improving people's wellbeing by prescribing social and leisure activities and volunteering opportunities, as well as addressing other non-medical needs. In Kingston, in partnership with Macmillan, we are focusing on providing social prescribing to people living with and beyond cancer

## Developing Local Health and Care Plans

The information contained in this section will be used as we develop our ***Local Health and Care Plan*** between now and June 2018.

As our Local Transformation Board covers two boroughs, we will develop individual ***Local Health and Care Borough Plans*** (that will be named by local areas) so that borough level issues and priorities are identified and plans developed to address these.

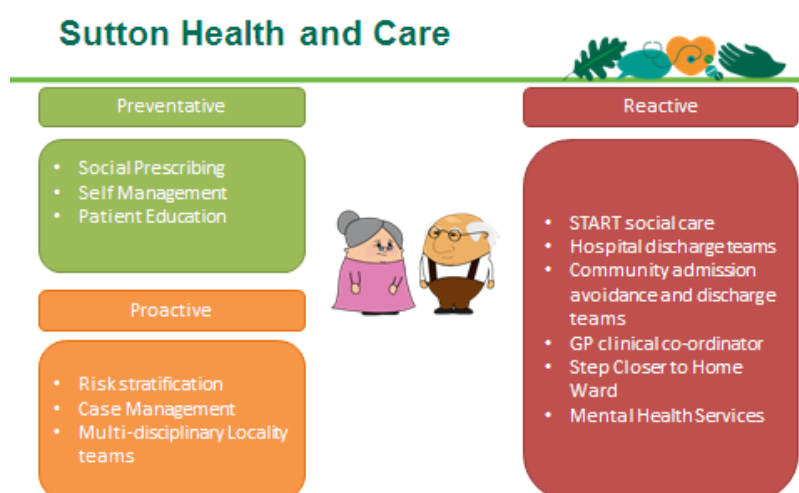
Our two individual Borough level ***Local Health and Care Borough Plans*** will then be brought together to create our Local Transformation Board Health and Care plan.



# Sutton Local Transformation Board

## Our joint vision

The Sutton Local Transformation Board (LTB) has endorsed a vision of integrated working for the population of Sutton through the development of “Sutton Health and Care”. Sutton Health and Care (SHC) is an ambitious programme to integrate services around the needs of people, particularly frail older people in the first instance. The programme is planned to encompass all elements of care - prevention, proactive planned care and reactive crisis care - with the aim of supporting people in their homes to be as independent and healthy as long as possible.



## Our model for health and care

The Sutton Health and Care model has been developed through multiple engagement events with staff, patients and the public using the stories of ‘Bob and Barbara’, two Sutton residents in their eighties living independently. As Bob and Barbara age and become increasingly frail, engagement events have modelled the current health and care pathways that support the couple through specific episodes.

There is widespread agreement that, despite individual services and staff members providing high quality, compassionate care to Bob and Barbara, the system is fragmented and duplicative, leading to poorer outcomes and increased dependency for older people. The same

engagement events identified the way we collectively want to work together around Bob and Barbara, offering integrated, responsive and personalised care, with improved outcomes and independence for older people.

Delivering better outcomes for Bob and Barbara also transforms the efficiency and effectiveness of services, making the health and care system in Sutton sustainable for the future.

The first focuses on ‘reactive’ care, the rapid response services that aim to avoid an admission or enables a faster discharge from hospital so that older people can live at home for longer.



## Our health and social care partners

- London Borough of Sutton
- Sutton Healthwatch
- Sutton Clinical Commissioning Group
- Epsom and St Helier University Hospitals NHS Trust
- The Royal Marsden NHS Foundation Trust
- Sutton Centre for Voluntary Services (CVS)
- South West London and St George's Mental Health NHS Trust
- Sutton GP Services
- Sutton (LBS) Public Health

## Our context and challenges

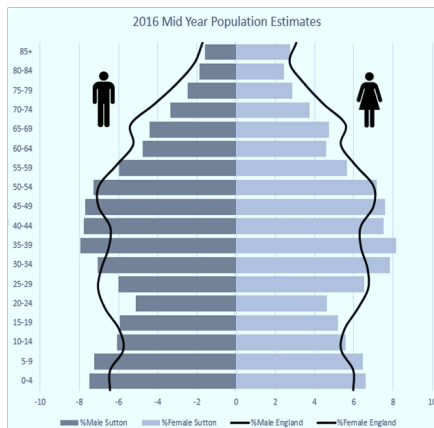
The population of Sutton is growing and local people are tending to live longer; however, there are a significant number of people living with one or more long-term medical condition. In addition Sutton experiences a high level of mental health problems for children and young people, an area of particular focus for us. Meanwhile medical technology continues to advance as new or improved treatments and medicines are made available to patients.

This means that there is more demand than ever on our health services, and this demand is continuing to increase. The Sutton Local Transformation Board recognises that we need more and better services provided outside of hospital – in GP surgeries, community services, social care and, where appropriate, at home. People, in particular the older population, need to be supported to live healthier lives, to avoid becoming ill and to maintain their independence.

More integrated health and care in the community would make us less reliant on hospitals, which could then focus on helping people in need of specialist care. There is substantial evidence that a focus on prevention and proactive care, alongside high quality rapid response services in a crisis situation, leads to better outcomes for patients and greater system sustainability.

## Population: summary characteristics

### Age profile



Sutton ranks as one of the healthier boroughs in England, with mortality rates lower than the averages for England and for London. 1,527 Sutton residents died in 2016, 714 male and 813 female. (Sutton JSNA)

### Sutton population (2016 ONS mid year population estimates)

	Males	Females	Persons
Population (2016)	98,593	103,627	202,220
% people from an ethnic minority group	26.5%	23.8%	25.0%

### Sutton population aged 65 years and older (2016 ONS mid year population estimates)

Age	Male	Female	Total
85+	1,552	2,863	4,415
80-84	1,836	2,542	4,378
75-79	2,436	2,972	5,408
70-74	3,313	3,863	7,176
65-69	4,345	4,885	9,230
Total	13,482	17,125	30,607



### Care homes

In Sutton there are 19 nursing homes (approximately 647 beds) and 11 residential care homes (approximately 298 beds).

### Population: change, summary characteristics

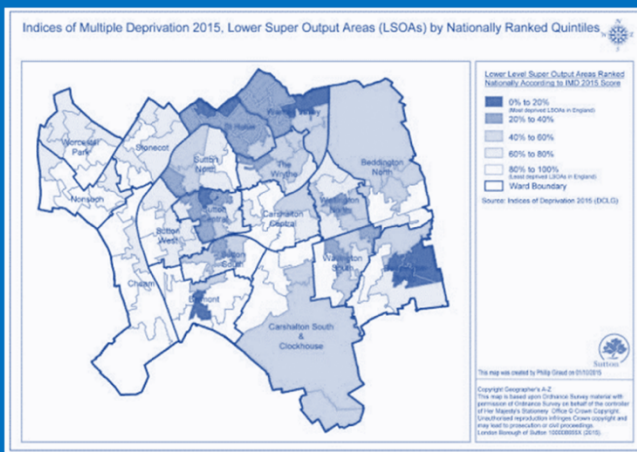
The profile of Sutton is changing. By 2024 the population is expected to increase and to be more ethnically diverse. According to ONS, Sutton's population will increase by around 12.7% from 2014 to 2024, which is similar to London (13.7%) and higher than England (7.5%).

The population of children and young people aged 0 to 19 years is expected to increase by 16.6%, higher compared to London (14.8%) and for England (7.8%).

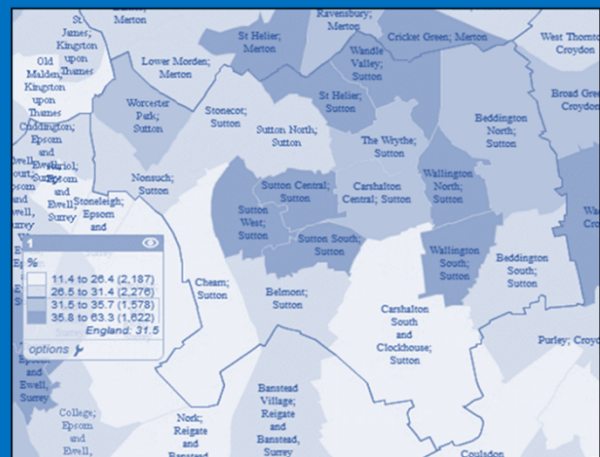
The proportion of older people aged over 65 is expected to increase by 19.7% by 2024, less than for London (23.6%) and England (20.4%). Similarly the population aged over 75 is expected to increase by 29.1% by 2024, higher than 26.1% for London, but less than the 33.9% projected increase for England.








(Sutton JSNA)









### Indices of Multiple Deprivation 2015, Lower Super Output Areas (LSOAs) by Nationally Ranked Quintiles



### Pensioners living alone, aged 65 years and over, Source PHE Local Health Tool 2011 Census



					
Smoking	Physical Inactivity	Excess Weight	Healthy Eating	Flu Immunisations	Hypertension
<p>In 2016 it was estimated that 12.8% of adults in Sutton smoked, statistically similar compared to London (15.2%) and England (15.5%).</p> <p>Suttons smoking prevalence is higher for people in routine and manual occupations 19%, which is statistically similar to London (23.9%) and England (26.5%).</p> <p><b>1 in 6 adults smoke in Sutton</b></p>	<p>In 2015-2016 it was estimated that 21% of adults in Sutton did less than the recommended daily amount of exercise, similar to London (22.2%) and England (22.3%).</p> <p><b>1 in 5 adults in Sutton do less than the recommended amount of exercise each day</b></p>	<p>Between 2013-2015 it was estimated that 60.5% of adults were overweight (including obese), this was statistically similar to London (58.8%) and better than England (64.8%).</p> <p><b>60.5% of adults in Sutton are overweight</b></p>	<p>In 2015 it was estimated that 48.9% of adults in Sutton were meeting the recommended 5-a-day on a usual day, statistically similar to London (49.4%) and England (52.3%).</p> <p><b>Nearly half of adults in Sutton meet the recommended 5-a-day</b></p>	<p>In 2016-2017 in Sutton population vaccination coverage flu (65+) was 64.5% lower than the England average (70.5%)</p> <p>In the same year population vaccination coverage flu in 'at risk groups' was 46.3% lower than the England average (48.6%)</p> <p>Population vaccination coverage flu in children 2-4 years was 34.5% lower than the England average 38.1%.</p> <p><b>There is scope to improve population vaccination coverage. The flu season is the key driver of antibiotic use throughout the world. Increasing vaccination coverage could impact on antibiotic use.</b></p>	<p>In 2015 the number of people in Sutton with recorded hypertension was 12.4% which is lower than England (13.8%) and higher than London (11.0%)</p> <p>The ratio of those diagnosed with hypertension versus those expected to have hypertension is 0.57. This compares to 0.59 for England This suggests that 57% of people with hypertension have been diagnosed.</p> <p><b>In Sutton a proportion of people living with high blood pressure are undiagnosed. People with high blood pressure are three times more likely to develop heart disease or have a stroke than a person with healthy blood pressure.</b></p>
 <p>In Sutton (2013-14 Q1- 2017-18 Q1) 70.1% of the people eligible for an NHS Health Check had been invited for a Check and 29.7% of the people eligible for an NHS Health Check had received one. Worse than the national average for these indicators. <b>There are opportunities to improve Sutton's performance in the NHS Health Check Programme.</b></p>					

						
Diabetes	CKD	AF	CHD	COPD	Mental Health	Falls
<p>The estimated total prevalence of diabetes in NHS Sutton CCG is 7.8% (diagnosed and undiagnosed).</p> <p>In addition, it is estimated that 11.1% of people in NHS Sutton CCG are at increased risk of developing diabetes.</p> <p><b>Nearly 1 in 5 of the population in NHS Sutton CCG are estimated to have diabetes, or to be at high risk of developing it.</b></p>	<p>In 2016 Sutton had a recorded prevalence of CKD of 2.8%</p> <p>The ratio of those diagnosed with chronic kidney disease versus those expected to have chronic kidney disease is 0.62. This compares to 0.68 for England and suggests that 62% of people with chronic kidney disease have been diagnosed.</p> <p><b>In Sutton a proportion of people living with CKD are undiagnosed.</b></p>	<p>In 2016 Sutton had a recorded prevalence of AF of 1.4%</p> <p>The ratio of those diagnosed with atrial fibrillation versus those expected to have atrial fibrillation is 0.63. This compares to 0.7 for England this suggests that 63% of people with atrial fibrillation have been diagnosed.</p> <p><b>In Sutton a proportion of people living with AF are undiagnosed. AF can increase the risk of stroke fivefold.</b></p>	<p>In 2016 Sutton the recorded prevalence of CHD was 2.5%, compared to 3.2% nationally.</p> <p>Estimated prevalence based on statistical modelling (3.8%) would suggest that a larger number of people in Sutton have CHD than is reported, implying that a proportion of cases remain undiagnosed.</p> <p><b>In Sutton a proportion of people living with CHD are undiagnosed.</b></p>	<p>In 2014-15 Sutton had a recorded (QOF), prevalence of 1.4% for COPD compared to 1.8% (1 in every 57 people) nationally. This represents 2,704 people in 2014-15. However, it should be noted that QOF figures will be an underestimate as they only include disease that is both recorded and registered.</p> <p><b>In Sutton 1 in every 71 people has COPD however a proportion of cases remain undiagnosed.</b></p>	<p>In 2016 the percentage of patients aged 18+ with a diagnosis of depression on GP register (QOF) was 7.8% which was lower than the England average (8.3%)</p> <p>In 2017 the recorded dementia prevalence (%) for people aged 65+ (as recorded on practice disease registers) was higher in Sutton (4.96) than London (4.48) and England (4.29)</p> <p><b>In Sutton 1 in 13 adults aged 18+ have a diagnosis of depression.</b></p>	<p>Rates of emergency admissions due to falls in people aged 65 years and over are higher in Sutton (3,003) than both London (2,253) and England (2,169) and have been for the past three years.</p> <p>(Age standardised rate per 100,000 population)</p> <p><b>Sutton has a higher rate of emergency hospital admissions for falls in people aged 65 years and over than London and England.</b></p>
<p><b>Polypharmacy and medicines safety</b></p> <p> A person taking ten or more meds is 300% more likely to be admitted to hospital</p> <p>6.5% of hospital admissions are for adverse effects of medicines this rises to 17% in the over 65 age group.</p> <p>30 – 50% of people do not take their medicine as intended by the prescriber.</p> <p>Over 70% of hospital admissions for adverse reactions to medicines could be avoided.</p> <p><b>National evidence suggests that there are opportunities to improve medicines safety in Sutton</b></p>						

## Size and shape of health and care services

Sutton CCG is responsible for the local NHS commissioning budget of around £240 million.

There are twenty-five GP practices in the borough with every practice receiving a CQC rating of Good in the recent inspections. The practices are divided into three Localities – Carshalton (8 practices), Sutton and Cheam (10 practices) and Wallington (7 practices). While having a range of single handed practices and some challenging estates issues, primary care in Sutton also came out as the top performer, or within the top three responses in London, in answers given by local residents to the national GP practice patient satisfaction survey. There is an 'extended hours' service in place, meaning that patients can book to see a GP between 8am and 8pm, seven days a week, at two hubs in the borough. The extended hours primary care service is provided by Sutton GP Services, a federation of GP practices in the borough.

Residents are served by one main acute trust (Epsom and St. Helier University Hospital NHS Trust, with patients mainly accessing services on the St Helier site) with community services provided by the Royal Marsden NHS Foundation Trust, via Sutton Community Health Services. Patients requiring specialist acute care are mainly treated at St George's University Hospitals NHS

Foundation Trust in Tooting. Community and acute mental health services are provided by the South West London and St. George's Mental Health Trust, which is also a provider in an alliance contract for the Sutton talking therapies service called Uplift. Local and specialist cancer services are provided by the Royal Marsden NHS Foundation Trust. The CCG also commissions services from a range of local voluntary and third sector providers.

Social care services are provided by the London Borough of Sutton.

## Service quality

In October 2017, the South West London Clinical Senate agreed a set of clinical standards for six clinical services in hospitals: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Medical Directors from each Hospital Trust were then asked to self-assess their services against the agreed clinical standards see (appendix 1). This evaluation provided an assessment of current consultant staffing against the clinical standards for these agreed six core hospital services.

The evaluation highlighted clinical sustainability issues in two of the six clinical services that were assessed at Epsom and St Helier. . These are summarised in the table below:

*Table: Current consultancy staffing against standards at Epsom and St Helier*

Hospital service		Current consultant workforce	Clinical Standards Requirement	Gap
ED	Current consultant headcount	14	24 (12 for each site)	10
Obstetrics	Current consultant headcount (consultants with the competencies to cover acute obstetrics on calls <sup>5</sup> )	26	22 (Epsom – category A, St Helier – category B)	No gap
Emergency general surgery	Current consultant headcount (consultants who contribute to the emergency general surgery rota)	10	10	No gap
Paediatrics	Current consultant headcount (consultants with the competencies to cover acute paediatrics on calls)	26 <sup>6</sup>	24 (12 at each site, as activity levels are lower)	No gap
Acute medicine	Current consultant headcount – dedicated acute care physicians	11	24 (on two sites)	13
	Current consultant headcount – total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians <sup>7</sup> )	30	24 (on two sites)	No gap
Intensive care	Current consultant headcount (consultants who contribute to the critical care rota(s))	7	9 (for HDU at Epsom and ICU at St Helier) <sup>8</sup>	2

<sup>5</sup> Note that gynaecology work may also be a significant part of some of these consultants' job plans.

<sup>6</sup> This includes 8 WTE acute paediatric consultants who manage the paediatric Emergency Department service on both sites

<sup>7</sup> Given the complexity of the acute medical rota, we have included the figures for dedicated acute care physicians and for the total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians). The requirement is met by a combination of dedicated acute care physicians and non-acute care physicians.

<sup>8</sup> Epsom Hospital has an adult critical care facility that has the ability to treat and stabilise level 3 patients. There is an expectation that such patients will either step down or be transferred to the intensive care unit at St Helier if they require ongoing level 3 care. In addition, there is a PACU, staffed 24/7 by consultant intensivists, on the Epsom site (within SWELEOC).

The table shows that Epsom and St Helier, as currently configured, meets the standards for obstetric and paediatric services.

For Intensive Care, Epsom and St. Helier currently operates a service whereby Level 1 and 2 critical care is provided within Epsom's High Dependency Unit, and Level 3 patients are stabilised and transferred to St. Helier, which has a Level 3 Intensive Care Unit. For Intensive Care, Epsom and St. Helier currently operates a service whereby Level 1 and 2 critical care is provided within Epsom's High Dependency Unit, and Level 3 patients are stabilised and transferred to St. Helier, which has a Level 3 Intensive Care Unit. The trust has confirmed that the current gap of two intensive care consultants is manageable within the context of this service model and plans to appoint a further two consultants at St Helier.

For Emergency Department services, the figures demonstrate that the Trust does not currently meet the standards. It has a gap of ten consultants between its current staffing and the agreed quality standards.

The Trust also faces particular workforce pressures in acute medicine. Epsom & St Helier has the fewest number of dedicated acute care physicians per acute inpatient site and a current gap of 13 consultants against the agreed clinical standards (if only acute care physicians are taken into account).

The Trust currently manages the implications of these shortfalls on a daily basis to ensure care is safe across the two sites, in a number of ways including: using a mix of staff rotations; temporary staff; and consultants covering for middle grade doctor vacancies. But the size of the Emergency Department and Acute Medicine consultant workforce gaps is considerable and the challenges for the trust will increase as the move to fully deliver a seven day service model intensifies.

A copy of the full evaluation summary is given in Appendix 2.

Epsom and St Helier University Hospitals NHS Trust have clearly set out a case for change and a scale of challenge that states that they are unable to deliver all of these acute services without a level of change to their clinical model. Through an engagement exercise, held between July and September 2017, the Trust has set out their views on potential scenarios for the future.

No decision has been made on the future of Epsom and St Helier University Hospitals NHS Trust. Sutton clinical commissioning group will work with local commissioners to develop a formal process to consider the future of services at Epsom and St Helier University Hospitals NHS Trust, and other issues such as their estate, and how they will be able to deliver sustainable services for the local population. Commissioners and the local system are fully committed to consultation with the public if this process suggests significant change.

The Sutton Local Transformation Board will continually evaluate the quality of services across community, primary care, mental health and hospital services.

## Our progress so far – one year on

Local Sutton health and care services have seen significant improvements over the last year. Highlights include:

Extended Hours GP Access. Sutton CCG commissioned the local GP Federation, Sutton GP Services, to provide primary care services from 8am to 8pm, seven days a week, from two hubs (Old Court House Surgery and Wrythe Green Surgery). The service delivers more than 1100



additional appointments a week, has a low DNA rate and a very high (90%) patient satisfaction rate.

Enhanced Care in Care Homes. Building on the success of the Sutton Homes of Care Vanguard the main pillars of service improvement (staff training, care planning, medicines review) have been extended from nursing homes to residential homes, allowing more care home residents to access the improvements delivered by the Vanguard (a reduction in non-elective admissions of 20% and a reduction in length of stay in hospitals per admission of around four days)

Sutton Homes of Care Vanguard – red bag. We worked with care homes, the Ambulance Service, social services and hospitals to provide more joined up care to people living in care homes. Now when a care home resident needs an emergency hospital admission they are transferred with a “red bag” which contains their health and social care information, their medicines and personal belongings. The “red bag” pathway has improved patient care and communication between the hospital and the care home. It has also helped improve the discharge process and resulted in reduced length of stay in hospital by 4 days. Increased multidisciplinary working and training has led to a significant reduction in unnecessary ambulance call outs and hospital admissions. The service has received national acclaim and support.

Musculo-Skeletal Pathway (MSK). Sutton CCG has implemented a new MSK pathway that ensures all patients access urgent physiotherapy assessment and treatment in advance of any decision about surgical intervention. This ensures that patients have therapeutic support as soon as possible, reducing pain and morbidity, as well as ensuring only appropriate patients go on to require hospital services. This has resulted in a significant

reduction of people needing secondary care referrals and treatment with a waiting time reduced from 9 to 4 weeks. Significant savings have been released to be invested elsewhere in services

Children and Adolescent Mental Health Services (CAMHS). Responding to an increase in identified need in the borough, Sutton CCG has worked with the London Borough of Sutton and South West London and St George’s Mental Health NHS Trust to increase the responsiveness of CAMHS services. This has included increased hours of senior psychiatric CAMHS liaison support at the St Helier Emergency Department and increased nurse support to the Single Point of Contact referral line for multi-agency referrals. The service will be reviewed towards the end of 2017/18 to see how the overall service configuration can be addressed to deliver services at the times and places needed by patients and families.

New primary care estates. We are building two new practices in Sutton, one at South Sutton (the site of the former Henderson hospital) and the second at Hackbridge (as part of a new residential development).

Social Prescribing. Working with the London Borough of Sutton and local voluntary and third sector providers, Sutton CCG has led the development and implementation of a social prescribing pilot (using the Healthy London Partnership framework and definition of social prescribing). Starting with one practice, the pilot has been used to demonstrate that a GP can use a limited number of well-established third sector providers (starting with the Citizen’s Advice Bureau) to refer a patient for specific support and track the outcomes for the patient. Once the pilot is complete, it is expected that the social prescribing referral process will be rolled out across Sutton (firstly with one practice in each



locality, then increased numbers in each locality, until there is comprehensive coverage).

Health Champions. Sutton CCG and the Sutton Centre for Voluntary Services have developed a health champions project to develop and train 30 local people to sign post patients to appropriate health services. Training started in September 2017 and champions will be in place from October 2017 through to May 2018.

## Developing Local Health and Care Plans

The information contained in this section will be used as we develop our *Local Health and Care Plan* between now and June 2018.

## 12. SOUTH WEST LONDON-WIDE IMPROVEMENTS

# Health Promotion and Prevention

**We will strengthen our focus on prevention and on keeping people well, and will take into account that the greatest influences on people's health and wellbeing are factors such as education, employment, housing, healthy habits**

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

Health promotion and disease prevention programmes are designed to keep people healthy. Health promotion engages and empowers individuals and communities to engage in healthy behaviours, and make changes that reduce the risk of developing chronic diseases and other morbidities. While disease prevention focuses on prevention strategies to reduce the risk of developing chronic diseases and other morbidities.

Members of the Health and Care Partnership in South West London cover all aspects of health as well as influence the wider determinants of health (*such as education, employment, housing, healthy habits in our communities and social connections*) and by working together on a small number of priorities can make a significant difference together.

**The South West London Health and Care Partnership has therefore made a joint commitment to champion children and young peoples' mental health and well-being as a shared health promotion and prevention priority. This is because:**

Nationally, we know that 50% of all mental health problems are established by the age of 14, rising

to 75% by age 24. One in ten children aged 5-16 has a diagnosable mental health condition, such as conduct disorder, anxiety disorder, attention deficient hyperactivity disorder (ADHD) or depression. We also know that we need to improve care for young people with eating disorders.

Across South West London we know that:

- **Sutton has a larger than average number of children who self-harm** compared to other London boroughs. The rate of admission for self-harm in Sutton has been increasing year on year and at a faster rate than most adjacent boroughs.
- **In Richmond self-harm** in those aged 10-24 years, equates to the 4th highest rate in London. The highest rates of self-harm related A&E attendances and hospital admissions are in females aged 15-24 years, mostly due to self-poisoning (92%). Increasing levels of self-harm is an issue in each of our Boroughs.
- The **prevalence of severe mental illness in Croydon** is significantly higher than the national average, but similar to London. Admissions for mental health conditions for under 18s is higher than London and national averages.
- Kingston has one of the highest estimated prevalence rates for both **Eating Disorders and ADHD** in the older age group (16-24).

- **Child admissions for mental health in Wandsworth** were higher than in London and England.
- **Merton has the second highest rate of child mental health admissions** compared to comparative boroughs (122.7 per 100,000, equivalent to 56 admissions, 2014/15). This is the higher than the average for England (87.4 per 100,000) and London (94.2 per 100,000).

We will work together as a Health and Care Partnership so that collectively we support children to have the best start in life.

Our joint focus on children and young peoples' mental health and well-being will not detract from the excellent health promotion and prevention activities, that take place in each of our health and care organisations in each Borough including stopping smoking, alcohol and obesity. As we develop ***Local Health and Care Plans*** we will identify the year one actions we will take and the actions that individual organisations will take to improve our care for children and young people with mental health needs.

# Cancer

**We are committed to improving cancer survival rates, ensuring that more people are diagnosed and treated earlier and that we provide the highest quality of care and support for people living with and beyond cancer**

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

The national Independent Cancer Taskforce has produced a helpful report (Achieving World Class Cancer Outcomes - A Strategy for England 2015-2020) in which it sets out six priorities that could save 30,000 lives in the UK a year by 2020. These are around prevention, early diagnoses and treatment, and a better experience for patients:

- A radical upgrade in prevention and public health
- A national ambition to achieve earlier diagnosis
- Establish patient experience on par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer
- Make the necessary investments required to deliver a modern, high-quality service
- Ensure commissioning, provision and accountability processes are fit-for-purpose

The *Five Year Forward View* set the overall goals and outcomes for Cancer, these include:

- Significantly improving one-year relative survival to achieve 75% by 2020 for all cancers combined (up from 69% currently)
- Patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP

Across south west London:

- Cancer is one of the top three causes of premature death across all six south west London CCGs
- There is a predicted increase in prevalence of cancer across south west London due to the ageing population and more complex care needs.
- Uptake for breast, bowel and cervical screening across south west London is generally below national averages and there is significant variation across CCGs, with our breast screening rates between 33% and 53% (against a national average of 67%) and our bowel screening rates between 68% and 93% (against a national average of 85%)
- Patient experience in Cancer services is generally good in south west London, with an average overall patient satisfaction score of 8.75 out of 10\*. However there is variation and improvement required around patients feeling supported by GPs and nurses during

their cancer treatment. (\*National Cancer Patient Experience Survey, 2016).

- Over the last year, there were significant improvements across south west London in the number of people receiving a definitive diagnosis and treatment for cancer within 62 days and work continues to achieve and maintain this.

Local people have told us about their views and experiences of Cancer services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across south west London are explained below:

- **Local people told us...**that getting an early diagnosis is really important in order to avoid the need for more aggressive forms of treatment and to improve their chances of getting better. People valued screening programmes and felt that they worked well for the most part, but more could be done to reach all parts of our diverse community. Once diagnosed people felt that the NHS provides excellent clinical care. However, further training could be given around delivering news sensitively. Whilst people valued the specialist treatment they received (for example at the Royal Marsden) many felt that they would prefer having all of their treatment in one place – rather than going between sites. People also felt that their GP could play a greater role in their follow-up care – signposting them to other support and offering cancer reviews that could pick up on their physical and mental wellbeing.

Over the next two years we have set the following priorities to improve Cancer care and services:

## Improving screening and early diagnosis

We will improve the uptake of cancer screening tests so that more people are diagnosed earlier and therefore have earlier access to treatment. We know that earlier diagnosis of cancer significantly improves survival rates.

Across South West London, bowel screening rates are lower than the national average and there is significant variation across CCGs. Bowel cancer screening involves a test to look for hidden traces of blood in stools and aims to detect bowel cancer at an early stage before symptoms develop.

We will work together to improve the rates of bowel cancer screening through implementing a Bowel Cancer Screening Communication Service. This service will work with CCGs, Cancer Research UK facilitators, Macmillan GPs, existing screening services, GP practices and their staff, to telephone people directly and to talk them through the bowel screening process; why it is important and address any concerns they may have. The service will work closely with GP practices and their staff in order to ensure they are engaged and supported to encourage people to undertake the bowel screening test. This will be a service delivered across south west London and north west London across a combined population of 3.6 million people and will be launched from January 2018.

Clinical commissioning groups will continue to drive improvements in screening rates for breast and cervical screening by promoting these tests to patients and the public through the national “*Be Clear on Cancer*” campaigns.

In Kingston, we are testing ways in which to target cancer screening for people who may not easily

access the tests, in particular people with learning disabilities.

## Cancer waiting times

The increasing and ageing population, and more people coming forward for investigative tests means that the healthcare system needs to enable quicker access to the right diagnostic services and treatment when it is required.

All hospital Trusts across South West London will continue to work in partnership to ensure that more people have timely access to diagnosis and treatment. Specifically we will focus on:

- Improving care from diagnosis to treatment for prostate cancer patients by providing faster access and ensuring more tests are provided in a fewer number of hospital visits. This will also help patients to access diagnostic tests more quickly. This is being tested at St George's Hospital and St Helier Hospital. If successful, this will be rolled out across other hospitals in south west London.
- Reviewing where treatments are provided across south west London for people with head and neck cancers so that they can access care closer to home, quickly.
- Speeding up diagnostic tests and biopsies for people with suspected lung and colorectal cancers so that clinicians can interpret the tests quickly and that patients can receive their results and start treatment sooner.
- Improving hospital systems, processes and communications between clinicians and cancer multidisciplinary teams to ensure minimal delays, that patients are adequately reviewed and that their care is planned for appropriately.

- Improving the processes for patients starting their cancer care with one hospital, but requiring further specialist treatment at another hospital, so that delays and late referrals are minimised.

## Supporting people living with and beyond cancer

Everyone who gets cancer is different, and the care and support people need to live with a cancer diagnosis will be different too. We want to accelerate support available for people affected by cancer to live as healthy and as happy lives as possible.

We will improve the support to people living with and beyond cancer through:

- **Putting in place a follow-up programme for prostate cancer patients.** This is a programme for patients who have had successful treatment for prostate cancer, and whose condition is stable for two or more years. GPs and practice nurses will regularly follow-up care and monitor patients so that they do not need to attend hospital for unnecessary hospital appointments. This programme is already in place in Croydon and Sutton and has been shown to improve care and patients' experience. We plan to roll this out across south west London.
- **Rolling out a "Recovery Package".** Over the last few years, the NHS across south west London has worked to implement the 'Recovery Package' that makes sure the individual needs of all people going through cancer treatment and beyond are met by tailored support and services. The Recovery Package is about the patient and their lead



clinician working through the care and support the patient will need once their hospital treatment has finished. The package is shared with the patient's GP and will explain the treatment they have received in hospital, the support they will need once the patient is at home, and include the option of attending 'health and wellbeing events'.

- Patients will be offered an annual cancer **care review with their GP after their treatment**. This will include a conversation regarding the person's health and mental well-being needs.

This is currently in place in Wandsworth and Richmond and we will implement this across all other CCGs over the next two years.

- **Training our primary care nurses to better support people with cancer** - Over the next 2 years, we will put in place a Macmillan Primary Care Nursing Leadership team to work across south west London to develop nurses and equip them with the expertise and confidence to better support people living with and beyond cancer.

# Mental Health

**We are committed to improving how we prevent, support and care for people experiencing mental health problems and make sure we treat their physical and mental health together**

The NHS Five Year Forward View for Mental Health sets out the 'must-dos' for transforming and improving mental health care and states that *"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services"*. It outlines that:

*"Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. "*

In south west London, we know that:

- We need to do more around prevention and early intervention, to help keep people well and get them the support they need as early as possible
- We need to improve support for people with Long Term Conditions, whose mental health is often not dealt with, or dealt with separately from their physical health needs.

- We need to provide better care for both young people and adults experiencing a mental health crisis, including alternatives to admission and improved pathways for those people with a mental illness who are removed from a public place by either the police or by medical services (known as the s136 pathway), and ensuring people experiencing first episodes of psychosis receive timely treatment
- We need to provide better support for the 3-5% of women who experience moderate to severe mental health problems during the perinatal period
- We need to improve support to people at risk of suicide
- Local people have told us about their views and experiences of Mental Health services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across South West London are explained below:
  - **Local people told us...**that they were worried that not enough money is being invested in mental health services in order to meet the growing demand. People felt that more should be done to provide 24/7 crisis support for adults and children with mental health conditions and their families – they agreed that Accident and Emergency Services are not the best place

to receive this care. It was also felt that we need to support people to maintain their health and wellbeing so they don't reach a crisis point. People felt that there is still a lack of parity between the treatment of physical illness and mental health illness by the NHS, with physical health conditions treated before mental health, or with the conditions being treated completely separately. Parents told us that they found it hard to navigate the system and know where to find help - more could be done to signpost them to local support services and help their children transition smoothly to adult services.

## Improving care for children and young people

50% of all mental health problems are established by the age of 14, rising to 75% by age 24. One in ten children aged 5-16 has a diagnosable mental health condition, such as conduct disorder, anxiety disorder, attention deficient hyperactivity disorder (ADHD) or depression. Most children and young people do not get enough support for this and, for those that do, face long waiting times. We also need to improve care for young people with eating disorders. To address this we will take the following actions:

- Children and young people with a diagnosable mental health condition will receive treatment from an NHS-funded **community mental health service**. The national target for the NHS of reaching at least 70,000 more children and young people annually from 2020/21 is expected to deliver increased access from 25% to 35% of those with a diagnosable condition.
- By 2020/21 the major hospitals in south west London will have **mental health liaison teams** in place in emergency departments and in-patient wards. The funding will be used to increase the number of hospitals where children and young people will have access to 24/7 **crisis resolution and liaison mental health services**.
- Children and young people will have access to an **improved neurodevelopmental pathway** by April 2019/2020. The pathway will be redesigned with parents to improve assessment and will offer individual support for parents as well as peer group support.
- We will speed up the time it takes for children and young people with an **eating disorder** to

receive treatment, seeing the majority of those with urgent needs within one week of referral and all others within four weeks of referral in line with National Access and Waiting Time standards.

- We will invest in **community based eating disorder teams** to reduce the need for children to be admitted into specialist in-patient wards.
- South west London mental health network is currently **reviewing the future mental health workforce** with an expectation of recruiting new specialist staff and putting packages in place to retain our expert staff.

## Improving prevention and early intervention

- People with a common mental health problem, such as anxiety and depression, will receive early intervention. We will do this through **expanding talking therapy services**, with a particular focus on ensuring that talking therapies are integrated into care for people with long term conditions to ensure their mental health needs are met alongside their physical healthcare needs. We are also looking at how to increase access to high quality information online, through making best use of the London-wide *GoodMinds* website
- We will **increase the number of physical health checks** we offer to people with severe and enduring mental health in primary care, and in secondary care mental health settings so that they have better physical health.
- **Speeding up diagnosis and treatment for people with Dementia**. People suspected of having dementia will be diagnosed and start

treatment within six weeks of referral for example South West London and St George's Mental Health NHS Trust are reviewing their memory services so that people can be seen and treated faster.

- Local Authorities are putting in place updated **suicide prevention plans** by the end of 2017. These plans will include working with GPs to support them to identify those at risk of suicide. Plans will also include activities such as working with the rail and river networks to reduce access to means of suicide.
- We will also remain engaged with the **Thrive London Programme**, and build on this locally to promote a conversation about mental health with our population.
- We are seeking national funding so that women experiencing mental health problems during the perinatal period will be supported by **new specialist perinatal community mental health teams**, with phased implementation from April 2018. These new teams will support women and their families, and work with other healthcare professionals to provide education and training around perinatal mental health.

## Improving support and services for people in mental health crisis

- We want to make sure that people who are being treated in an in-patient service are as close to their home as possible. We are reviewing all our patients who are receiving treatment out of their local area to plan to see if we can move people to a service closer to home.
- **Hospitals will have 24 hour psychiatric liaison services** in place to ensure that patients with a mental health crisis are seen by the appropriate experts. This is already in place in St. George's, Croydon will be in place by December 2017 and Kingston and Epsom & St. Helier by April 2018.
- Subject to full public consultation, a new pan-London pathway for patients experiencing mental illness who are removed from a public place by either the police or by medical services (section 136) will be implemented in 2018 so that people experiencing a mental health crisis are treated in high quality service.
- **We will review our community mental health services** to understand how we will meet the needs of patients in the future and meet national standards. An example of this is understanding the additional capacity needed to ensure that all Crisis Resolution Home Treatment Teams can deliver care 24/7.
- **We will improve our service for people experiencing a first episode of psychosis** by putting in place more expert care within two weeks of their episode.

# Urgent and Emergency Care

**We are committed to improving services for people when they are at their sickest and are in need of urgent or emergency care ensuring that, for those with non-life threatening but urgent needs they are treated as close to home as possible, and for those with more serious or emergency needs that they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.**

Urgent and emergency care in south west London is made up of a number of complementary parts: NHS 111; improved access to GP practices, the London Ambulance Service; Urgent Treatment Centres, Accident and Emergency departments (A&E) as well as hospital, community and social services.

In south west London, A&E attendances have stabilised over the last few years with fewer peaks and troughs than were seen in the past. Despite this, performance against the 4 hour A&E standard has deteriorated which is likely to be due to increased numbers of very sick patients as well as complex and variable processes in hospital systems. Emergency admissions into hospitals have in turn increased across south west London year on year. Between 2012 and 2017, there has been almost a 50% increase in the numbers of people admitted to hospital in an emergency. There are also many patients staying in hospital longer than is necessary which affects flow resulting in less beds available for sick patients coming into A&E. The only hospital that has managed to consistently meet the 4 hour target is Epsom & St Helier; the learning from the improvements they have made is being shared across SWL.

South west London's demand on the London Ambulance Service has also risen steadily over the last 4 years since 2013 affecting their ability to respond to patients quickly. Despite this, we have seen the highest performance of response times to Category A calls in London, which is to reach emergency calls. This section outlines how we will improve in all these areas over the next two years.

- Local people have told us about their views and experiences of Urgent and Emergency Care services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across South West London are explained below:
- **Local people told us...**that too many people use Accident and Emergency (A&E) because they can't get an appointment with their GP or they don't know where else to go – very few people had heard of NHS 111. People thought that even with clear information, it would be hard to change people's behaviours and their use of A&E, and suggested that instead we consider co-locating other services in A&E departments. People felt that A&E services were already operating above capacity and that changing the number of sites would only exacerbate the problems. Concerns were also

raised about discharge from hospital – some people being discharged late at night with problems occurring because care packages were not in place when they got home. It was felt that the NHS needs to work more closely with local authorities.

## Accessing urgent healthcare in the most appropriate place

We want to help our residents access the most appropriate urgent care for their needs as not only will this reduce the pressures on our accident and emergency departments, it will also enable patients to have better health outcomes by helping them to stay at home and accessing the most appropriate services more locally.

There are a number of ways that we will achieve this:

- We are introducing an **extended 111 service** to help our residents receive the most appropriate healthcare. It will be the first point of call for patients to access urgent care services providing access to advice, onward referral including appointments and direct booking into other health services. This new service will be in place during 2018.
- We are developing a **111 online service** where patients can enter their symptoms and receive specific advice on their health needs or a call back from a healthcare professional so that we offer an increasingly personalised, and faster experience to patients.
- We will **employ more clinicians** in our new 111 service so that over half of our 111 calls are handled by a clinician by March 2018. This will mean that more patients get a full response to

their concerns without the need to seek further help.

- We have heard our residents tell us that they are frustrated when they cannot get a GP appointment. To resolve this issue we have already provided more GP capacity in each of our boroughs to ensure that our residents can access GP services from 8am-8pm, 7 days a week at one of the GP hubs that exist in each borough. In total, we have created more than 15,000 additional appointments per month. We are on track to open two additional hubs in Croydon by the end of 2017. This additional capacity will support people to access primary care when they need it, and we are working to improve the links between primary care capacity and other parts of the system. For example, we are piloting a system so that when people call 111, they can be booked an appointment directly in primary care. We are also implementing systems so that staff in A&E departments can book patients primary care appointments, if this is the best place for them to be seen. This will go live at St George's Hospital by December 2017.
- We will continue to work with the London Ambulance Service (LAS) to reduce the number of patients using their services inappropriately so that it is available for the patients who really need an emergency response. Every clinical commissioning group has put in place services that meet urgent care needs, such as multi-disciplinary team rapid response for older patients who have fallen at home and can be helped to safely remain at home. LAS can quickly refer patients to these services rather than take them to Accident & Emergency Departments.
- We know that it is sometimes confusing for residents to understand what urgent care



services are provided where. To help resolve this we are reviewing current urgent care services across south west London so that they meet the new London specification for **Urgent Treatment Centres**. Urgent Treatment Centres will cover everything that used to be done by Minor Injuries Units, Walk-In Centres and Urgent Care Centres. Urgent Care Centres are currently already in place at Croydon Hospital, St Helier Hospital and St George's Hospital and a new Urgent Care Centre opened at Kingston Hospital in November 2017. Our aim is for all four Urgent Care Centres to be designated as meeting the Urgent Treatment Centres service specification by the end of 2017. Over the next two years, we will also agree and implement future plans for urgent care services to be provided at Queen Mary's Roehampton Minor Injuries Unit, Clapham Junction Walk-In Centre and Teddington Memorial Hospital.

- Where an emergency has resulted in a 999 call for an ambulance we will implement a new way of assessing patients and sending ambulances to our sickest patients. The **Ambulance Response Programme** will ensure early recognition of life-threatening conditions, particularly cardiac arrest. A new set of questions will be asked so that when you dial 999 those patients in need of the fastest response are identified. New nationally set response times will free up more vehicles and staff to respond to emergencies. For a stroke patient this means that the ambulance service will be able to send an ambulance to convey them to hospital, when previously a motorbike or rapid response vehicle would 'stop the clock' but could not transport them to Accident & Emergency. From now on stroke patients will get to

hospital or a specialist stroke unit quicker because the most appropriate vehicle can be sent first time.

## Improving urgent and emergency services

- Some urgent health conditions can be treated without the need for an overnight stay in hospital. This is called ambulatory emergency care (AEC) and in south west London all our hospitals offer some AEC services. This is a service for patients who would otherwise have needed to stay in hospital but with AEC can receive specialist help and return home the same day. We will expand AEC delivery across south west London to ensure that they are open 14 hours a day, seven days a week. St George's is seeking to expand its AEC Unit to increase their opening hours to 16 hours a day every day.
- The NHS constitution mandates that 95% of patients who access emergency services at hospital should be seen within 4 hours. One of our hospitals, Epsom and St. Helier, has consistently achieved this target and we will share learnings across providers in south west London to deliver best practice for hospital flow and patient review so that all our hospitals see all patients within 4 hours.
- South west London hospitals consistently look to improve how they care for their patients. They are currently working to implement best practice to ensure that patients are supported to get well as quickly as possible. This is referred to as the "SAFER bundle" and means that patients will have a review by a senior clinician before midday, all patients will be given an expected date of discharge soon after admission, patients will be admitted as early

as possible in the day from the assessment units and will be discharged before midday wherever possible. Where patients stay in hospital for more than seven days they will be assessed by a multi-disciplinary team with a clear “home first” mind-set. The SAFER bundle aims to get patients to the right place as soon as possible, including home, to avoid unnecessary delays which lead to poorer health and social outcomes for patients. Our intention across south west London is that all hospital wards will have implemented the SAFER bundle during 2018.

- All of our hospitals currently have 24 hour all-age psychiatric liaison services and we are now working towards having enhanced services to ensure that patients with a mental health crisis are seen by the appropriate experts. This is already in place in St. George’s, Croydon will be in place by December 2017 and Kingston and Epsom & St. Helier by April 2018.

## Improving discharge and support after hospital

We recognise that sometimes we are unable to discharge patients who are medically fit or who no longer need to be cared for on a hospital ward and that this may have an adverse impact on their overall health. This could sometimes be helped by organisations who, together, have responsibility for a patient’s care working more closely together. We will continue to work together to enhance services in the community including proactive management for the most complex patients, ensuring good crisis response and on facilities to provide intermediate care, so that patients can be discharged as soon as they are well enough to

leave hospital. This work is being undertaken by our four Local Transformation Boards. There are a number of ways that we will reduce the levels of these delayed discharges:

- To ensure that patients do not spend any longer in hospital than they need to **new locality teams** will be established across south west London. These new teams will offer multidisciplinary support both to patients with a long term condition and also those who are discharged from hospital and need additional support. As part of these teams there will be ‘in reach’ teams who actively go into hospitals to ensure that patients who are ready to go home are not delayed, freeing up vital bed space and also ensuring that patients don’t spend any longer in hospital than necessary.
- NHS **continuing healthcare** (CHC) is a free package of care for people who have significant ongoing healthcare needs. Delays to assessments being carried out can lead to delays to funding and care being received by those who need it most. To change this across South West London we will:
  - Reduce the number of CHC assessments carried out in hospital (by using Discharge to Assess) so that, by March 2018 only 15% of all CHC assessments will be carried out in hospital, a reduction from the current 47.4% across South West London.
  - Increase the speed with which we carry out CHC assessments so that, by March 2018, 80% of assessments will be carried out within 28 days of referral. This will be an improvement against the current 42.4%.
  - Coupled with the above, we have been working across south west London to ensure that both health and social care services, including community nursing, rapid response

and early supported discharge services are available seven days a week. **Seven day services** will help ensure that patients are

discharged from hospital as soon as they are able, and should not be delayed because it is the weekend.

# Primary Care

**We are committed to ensuring that general practice is accessible and co-ordinated with community and social care services. This will mean people receiving the right care closer to home so that they can live healthy and independent lives for as long as possible.**

General Practice, and other primary care services are the first point of contact a person has with the health service, and are essential to delivering excellent healthcare. Primary care services ensure we treat people in the best place and that they only go to hospital when they absolutely need to.

We have a number of challenges in general practices (GP):

Increased demand for services, due to a growing and aging population with increasing frailty and health need.

- Extending the services offered through, or alongside, primary care offers the opportunity to provide a greater range of intermediate/complex care co-ordinated through a patient's GP practice and in a place closer to home. In order to fulfil the ambition to offer more services in primary care, workforce and other implications will need to be considered.
- Whilst most of our GP practices perform well there are some which need to be improved. The variation in the way primary care is delivered across SWL results in varying patient experience and outcomes.
- We have many staff vacancies with a large number of GPs and nurses approaching retirement (in south west London 21.8% of GPs and 39% of nurses are over the age of 55).

- Some of our primary care estate is outdated and not fit for purpose; there is a large variance in premises in costs, size and quality across south west London and some potentially under-utilised space.
- We know that we will need additional capacity, particularly in high growth areas such as Croydon and Nine Elms, Vauxhall.
- We could do more to use technology to support both patients and our primary care staff.

Our primary care priorities in south west London are focused on delivering the key aims set out in the *General Practice Forward View*, and are also informed by the publication from NHS England London region: *Strategic Commissioning Framework for Primary Care*, which sets out 17 specifications to deliver accessible, coordinated and proactive care in primary care.

Local people have told us about their views and experiences of GP services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across south west London are explained below:

- **Local people told us...**that they struggle to get an appointment with a GP and that, ideally, they would like consistency so that they can build trust and not have to repeat their

stories. People often felt like receptionists were put in the position to be gatekeepers. In general people accepted that other healthcare professionals, such as pharmacists, could play a bigger role in primary care, but that more would need to be done to raise public awareness and build confidence in their skills and roles. Many people, including carers, said that they find the health system difficult to navigate and welcomed new roles, such as care navigators, particularly if their job includes patient liaison and support for both patients and carers.

Our focus over the next two years will be:

## Improving access to GP practices and services

We have already made sure local people have greater access to same day appointments 8am-8pm, seven days per week. We want to further improve access to our primary care so that people can be seen by the healthcare professional who can best meet their needs.

## Improving the quality of our primary care services

We are working with individual practices to strengthen their services. Practices who would most benefit have been identified across SWL and will receive tailored support. Examples of support include:

- Tailored investment and resource to solve individual issues e.g. recruitment of key staff, premises relocation, clinical audit

- Peer support around the workforce to support practices: to review and plan staffing, improve recruitment, and introduce new initiatives such as nurse mentorship
- Supporting practices to streamline back-office systems
- IT support – practice level training and support on IT and clinical systems

## Ensuring that we have enough primary care staff in the future

General Practice faces unprecedented demand and in London it is estimated that 20% of patients consult their GP for what is primarily a social problem (Low Commission, 2015). Over the next two years:

- We are working to **extend our primary care workforce**. We are seeking to increase the number of GPs working within General Practice through activities to support retention, such as mentoring and peer support programmes, as well as exploring international recruitment. We are also increasing the number of physicians' associates, clinical pharmacists, medical assistants and care navigators that we have within general practice. In the future south west London residents will have a greater number and range of people who can provide care, referral and advice working in a primary care team.
- Support implementation of **high impact actions** that have been identified as increasing the ability of GPs, nurses and other practice staff to improve care and develop services
- Support implementation of **GP Nurse 10 point plan**. This is a national action plan which aims to increase the nursing workforce within

general practice in response to the rising demand by attracting new recruits, supporting existing general practice nurses, and encouraging return to practice.

- We are introducing **social prescribing** which supports primary care by offering GPs referral and support options for people with predominantly social needs. For example, we are currently piloting a number of link-worker roles in some GP practices in south west London, for example for cancer survivors in Kingston. Link-workers talk to patients and agree a 'social prescription. This is a plan that meets their social, emotional or practical needs, often using non-clinical services provided by the voluntary and community sector.

## Improving care through the use of technology

General practices already use technology to care for patients and to help them be well-organised. We want to increase the use of technology to help patients access their care more easily and to help health care professionals offer better care. For example, we will increase the opportunities for patients to use online services to access health advice, to book and cancel appointments, to contact their GP and to manage their prescriptions and health record. Further information on our plans is given in the ***Harnessing Technology*** section.

**We are committed to improving maternity services so that women have choice about where to have their baby, that every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances**

In 2016/17 there were around 19,000 births in South West London. A significant proportion of mothers in South West London are over the age of 35 years old. This is higher than the national average.

In South West London we know that:

- The Care Quality Commission's national maternity survey in 2015 indicated that South West London performed in the lowest quartile for women's experience of maternity services.
- The still birth rate per 1,000 live births in south west London was 4.9%. This is lower than the national average and there is some variation across our clinical commissioning groups.
- 5.4% of women smoke at the time of giving birth, compared to a national average of 12%

Local people have told us about their views and experiences of maternity services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across south west London are explained below:

- **Local people told us...**that their care would be improved if they had the same midwife throughout their maternity journey. They felt that not only would this help them to build trust and have confidence in their care, it would also enable the midwife to get to know them and pick up on the softer signs of their physical and mental wellbeing. People wanted to be empowered to have more choice in their maternity care. However, some questioned what choice really meant and whether it extended passed what hospitals they gave birth in. Above all, people told us that their safety, and the safety of their child was of paramount importance. People want high quality and consistent care throughout their pregnancy, birth and post-birth, tailored to their cultural and clinical needs.

We are working to ensure that all maternity services across south west London:

- Prepare women and their partners for pregnancy, labour, birth and parenthood through education and up-to-date, evidence-based information
- Provide care to women as individuals, with a focus on their needs and preferences



- Invest in improving continuity of care and carer, with a strong emphasis on midwifery-led care for normal pregnancy and birth
- Provide care which meets high clinical quality standards for all women and their babies
- Value and take on board feedback from women, their families and the local community to drive continuous improvement in the quality of care

Over the next two years our focus will be on:

## Supporting choice and personalisation of maternity care

We want women to feel positive about their experience of care when they are pregnant or if they have just had a baby. We will achieve this by:

- Making sure that most women see the same midwife or team of midwives, throughout their maternity care. We expect to achieve improved clinical outcomes as a result of midwifery-led continuity of carer; reduced episiotomies or instrumental births, increase in spontaneous vaginal delivery and an increase in births in midwifery units or at home.
- Ensuring women and families feel more informed about the choices available in maternity services across South West London so that they can make more informed decisions about their care. We have started this by piloting *My Maternity Journey in SWL* which summarises all the services available to women when they are pregnant as well as providing consistent information about what to expect from maternity services during and after pregnancy. We plan to make this

available to all women across SWL as well as developing this into a web-based resource.

- Training and coaching midwives, GP and other health professionals involved in delivering maternity care to improve the conversations they have with women and families, so that they understand the choices that are available to them and that they are able to make informed decisions and take control of their maternity care, for example, keeping healthy during pregnancy and making the choices that are right for their needs.
- Helping women access maternity services earlier.

## Improving perinatal mental health

South west London does not currently have a specialist perinatal community mental health service and we need to provide better support for the 3-5% of women who experience moderate to severe mental health problems during the perinatal period. We are seeking national funding so that women experiencing mental health problems during the perinatal period will be supported by new specialist perinatal community mental health teams, with phased implementation from April 2018. These new teams will support women and their families, and work with other healthcare professionals to provide education and training around perinatal mental health. Additionally, we are committed to ensuring that all women who may require emotional support during and after pregnancy can access the right level of care, through improving signposting to services such as access to psychological therapies or more specialist support through specialist midwifery teams.

### 11.6.3 Improving safety of services

We are committed to delivering the national ambition to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. All of our maternity providers are fully engaged in the developments and implementation of the national NHS Improvement Maternal and Neonatal health safety collaborative over the next two years. This programme will help hospitals make improvements to the safety of their maternity services by assessing local services and developing specific action plans for improvements in each hospital.

All our organisations will continue to investigate and learn from incidents and share this learning through the Local Maternity System where all providers are represented.

To reduce variation in the quality, safety and experience of maternity services, we are improving the way we monitor the quality and safety of maternity services across south west London so that hospitals and commissioners understand where there is best practice as well as those areas requiring improvement. A set key of measures has been agreed and this will be

developed into a full maternity quality and safety framework for south west London.

## Improving post-natal care

The care that women and their babies receive after they give birth has a significant impact on the life chances and wellbeing of the woman, baby and family. Feedback from women and families in south west London is that our postnatal care needs improving. We are improving the way the provide postnatal care focusing on the continuity of midwifery carer, developing personalised care plans, reviewing and making the postnatal care pathway more consistent across hospitals, and ensuring we have the right staff in place to provide that care including Maternity Support Workers.

During winter 2017 further work will be undertaken to define additional actions to deliver the south west London vision for maternity services.

# Improving care for people with Learning Disabilities and/or Autism

**We are committed to transforming services for people with learning disabilities and/or autism so that they are supported in the community to live fulfilling and independent lives**

In 2011 the Department of Health led a review in the immediate aftermath of the exposure of serious abuse of patients with learning disabilities at Winterbourne View hospital. The Government and leading organisations across the health care system pledged to improve care and secure better outcomes for all people with learning disabilities and/or autism and behaviours that challenge, by shifting services away from learning disability/mental health hospital institutional care towards community-based settings and reduce reliance on in-patient beds.

Local people have told us about their views and experiences of learning disability services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across South West London are explained below:

- **Local people told us...**that doctors, pharmacists and receptionists need more training in how they speak to people with Learning Disabilities. People with learning disabilities told us that they want doctors to speak to them and not their carers, and for information to be sent to them in Easy Read format or explained to them in person. People felt very strongly that annual health checks are very important – but not routinely offered. They felt that all GPs should be aware of them

and should offer them to all patients with a Learning Disability.

The national plan, “Building the Right Support” document (October 2015) supported the creation of 48 Transforming Care Partnerships across England. In April 2016, South West London Transforming Care Partnership published our plan on how we would realise the aims of programme. Over the next two years we will:

- Work with patients and their families to **reduce the number of people living in a learning disability or mental health institution** by transferring patients into a community setting
- **Ensure that staff are trained in positive behavioural support (PBS)** so that staff caring for people with learning disabilities and/or autism, with behaviours that challenge, can assess, prevent and respond to incidents of challenging behaviour. This will minimise escalation of issues and reduce harm to the patient(s) and others.
- We will seek to improve **south west London crisis management support** to provide patients with a place to stay during crisis, where they can be supported by expert staff, in a safe environment, with the aim to support the patient to move back into the community. This will also reduce admissions and re-admissions into learning disability or mental health

institutions and also offer a place of respite for families, at a time of crisis.

- Work with Health Education England to **develop a workforce plan** so that we have the right staff, with the right skills, to meet the needs of people with learning disabilities now and in the future.
- Use the information gained from our housing/accommodation needs analysis,

to **develop a housing plan** to support current and future accommodation needs of people with learning disabilities and/or autism, with behaviour that challenges.

# Children and Young People

**We are committed to helping children have the best start in life and to supporting children as they develop into adults**

Initially, our children's programmes are focused on two areas: improving support for those with a mental health need and ensuring that we enhance our support for children who need urgent and emergency care. Local Transformation Boards through their *local health and care plans* will identify local priorities for children and young people.

In south west London, we know that:

- We need to do more around prevention and early intervention, to help keep people well and get them the support they need as early as possible
- We need to provide better care for both young people experiencing a mental health crisis, including alternatives to admission and improved pathways for those people with a mental illness who are removed from a public place by either the police or by medical services (known as the s136 pathway), and ensuring people experiencing first episodes of psychosis receive timely treatment
- We need to improve support to people at risk of suicide

Local people have told us about their views and experiences of children and young people services. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across South West London are explained below:

- **Local people told us...**that they supported the idea of reducing the number of unnecessary visits to A&E. However, it was felt anxious parents often do not think there is a flexible, high quality alternative. Improving access to GPs was therefore considered to be fundamental to reducing the number of children unnecessarily in A&E. People felt that more needs to be done to support children and young people with mental health conditions. Diagnosis needs to be quicker, and more needs to be done, inside and outside schools, to provide early support and prevent conditions from escalating. It was felt that the waiting times to receive
- support through CAMHS were too long, the process is confusing, and the thresholds for support are too high.

Concerns were also raised about the transition between child and adult mental health services – people felt that organisations need to work better together in order to better support people through this change.

As set out in an earlier section, we have identified children and young people's mental health as our Partnership's health promotion and prevention priority for the next two years. This will build on the work already underway to transform children and adolescent mental health services which will ensure that:

- Children and young people have access to 24/7 crisis resolution and liaison mental health services
- The neurodevelopmental pathway will be enhanced to improve assessment
- We will speed up the time it takes for children and young people with an eating disorder to receive treatment

Where children and young people need urgent and emergency care we will ensure that they and their parents/carers can access the most appropriate services that they require, as close to home as possible through:

- Access to urgent care advice and direct booking to primary care and urgent care facilities if required through NHS 111. This may include advice to visit a pharmacist for self-care. For those with more serious conditions requiring the input from a specialist

children's doctor or nurses, they will be referred to the appropriate hospital services

- Access to extended access to GPs, 8am-8pm, 7 days per week
- Access to urgent treatment centres as required
- Improved access to ambulance services for the most life threatening conditions
- Improved access to hospital care for the most urgent and emergency care where input from specialist children's doctors and nurses are required
- Improved services in the community for children and young people to avoid unnecessary stays in hospital, particularly with long term conditions such as asthma

**We are committed to making South West London a great place to work so that we attract and keep our excellent staff.**

Our highly skilled people that make up the combined NHS and social care workforce within south west London are essential to the delivery of high quality care and transformation of services.

In the “*London Workforce Strategic Framework*” the Healthy London Partnership state that “*The health and social care system is facing many challenges. Greater demand on services is fuelled by an increasingly aged and frail population, whilst patient expectation of services continues to grow. Growing demand continues to put pressure on current services, increasing costs and the demands on the existing medical and non-medical health and social care workforce. It is widely recognised that serving this growth in demand is not sustainable, if we carry on the way we work now. A change in approach is needed if we are to deliver the consistent high quality of care patients expect now and in the future.*”

In south west London we have over 25,000 people working across the mental health, primary care, community, and hospital settings and a further 29,000 jobs within social care. Together the members of the south west London health and care partnership face a number of staffing challenges:

- New models of care and initiatives to meet patient and public needs will continue to need to be developed, and to deliver these new models, changes to workforce numbers, skills and ways of working are likely to be required
- Within south west London our workforce challenges are accentuated by higher costs of

living, availability of affordable housing as well as the competition for talented staff

- Recruiting and retaining staff across south west London is a challenge for us, and nationally there is a shortage of some qualified professions including GPs, senior and middle grade hospital doctors, nurses, paramedics, specialist children’s doctors and social care staff
- Many of the workforce who train in London subsequently choose to move away, and we certainly experience healthcare professions leaving south west London within a few years of qualifying
- Whilst we do not have an immediate challenge with the number of GPs and primary care nurses in south west London, there are a significant number that are nearing retirement age which will create an issue for us in the near future (in south west London 21.8% of GPs and 39% of nurses are over the age of 55)
- Staff turnover is recognised as being higher in London than in other regions

We know that, if demand for our services continues to rise and we continue to deliver care in the same way, without focussing on our people we may not have enough staff to deliver the care that is needed.

Local people have told us about their views about our workforce. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7.



In summary, the common themes across south west London are explained below:

- **Local people told us...**that we need to do more to encourage staff to stay in south west London. People felt that GPs and nurses can be overworked and underpaid. People told us that we needed to look after our staff better. People told us that, in the same way that we need to look after our staff. It was felt that we should be trying to recruit people from diverse backgrounds so that they can relate to the cultural needs of local people. It was felt that more investment was needed to train our staff – particularly on their ‘bedside manner’ and in how they treat people with different needs (for example people with mental health conditions, children and young people or people with learning disabilities).

Over the next two years we will work together to:

- **Make sure we have the right numbers of staff, in the right roles, with the right skills** to provide safe and effective care now and in the future: through effective recruitment and workforce planning. Specific actions include:
  - Improving local uptake of the Capital Nurse initiative. Capital Nurse is a programme of collective action from employers and universities in London, Health Education England, NHS England and NHS Improvement. It’s aims are: to ensure the capital has the right number of nurses with the right skills to deliver high quality person-centred care; and to make it easier for employers to recruit and retain nurses within the capital
  - Develop a joint employer ‘offer’ for south west London, incorporating a common set of commitments

throughout a member of staff’s career - before and at the point of joining, in the first year, developing talent, and helping staff to work for as long as they want to

- Evaluate different approaches to flexible working including piloting self-rostering in a hospital environment
- Develop and support the implementation of south west London Workforce Plans for Primary Care (underway), Mental Health (underway) and Cancer (expected in 2018)
- Developing recruitment campaigns that target people from diverse backgrounds so that our organisations are representative of the communities we serve
- Helping employers to work together to implement a range of apprenticeship schemes to support people into employment
- **Make the best use of our scarce resources:** collaborating where it is right to do so: work has already commenced across hospitals in south west London to implement the first stage of a joint staff “bank” (*a “bank” is a group of temporary staff who work to fill short term gaps in rotas*). The “bank” is currently available for staff nurses and healthcare assistants in three NHS organisations. We will expand it to cover more staff groups in more organisations.
- **Care for our staff:** supporting their health and wellbeing, having a healthy work life balance and eradicating any behaviours that discriminate, harass or intimidate. In addition to actions that individual organisations are

taking in these areas across south west London we will:

- Support employers to progress through the Greater London Authority Healthy Workplace Charter backed by the Mayor of London to make our workplaces healthier and happier for our people. The Healthy Workplace Charter is a set of standards that organisations meet in order to receive an official accreditation (and award). As leading organisations in the public sector we will also promote this initiative outside our organisations because the benefits from such workplace interventions will not only help employers and their people it also helps society as a healthier working population provides health and economic benefits
- **Support our people to develop:** sharing best practice and putting in place shared development so they can continually learn and improve their practice. Specific actions include:
- ‘Growing our own’ senior nurses and Allied Health Professionals by implementing a structured programme to equip staff with the skills and knowledge to progress through the grades from junior posts to senior roles within south west London
- We will continue to work with Health Education England, local academic institutions

and education providers to ensure that their training programmes fit with our changing population health needs. By doing this we will have a sustainable workforce with the right skills and competencies that are right for today as well as our populations future health needs

- Establish a range of training programmes to build skills in prevention of mental ill health in other children and young people, such as young people’s health champions, peer support, community navigators
- **Involve our staff in improving services:** engaging our staff who know our services and patients best, to help us transform and improve the way we work. We will strengthen clinical leadership and involvement across south west London and local health and care partnerships. Over the next few months the Clinical Senate will review what clinical leadership and involvement means across South West London, how we will develop clinical leaders and how we will release their capacity to lead
- Workforce Directors will come together in January 2018 to review our workforce priorities and plans to ensure they are sufficient to meet our challenges going forward, and to discuss whether a joined up approach to workforce issues across health and social care would be beneficial.

# Harnessing technology

**We are committed to using technology to be “electronic glue” which helps health and care organisations work better together, enables our frontline staff to provide the best care possible and enables people to make the best lifestyle and health choices**

Technology is a critical enabler of many of the recommendations that are being made in this plan. We know that sharing information between different health and social care services, is key to delivering more joined-up care. We also know we can use technology to support patients to look after themselves and manage their own conditions and monitor symptoms remotely.

Local people have told us about their views about our use of technology. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across south west London are explained below:

- **Local people told us...**that it can be frustrating when you have to tell your story over and over again to different people and that they would welcome better communication between GPs, community services, hospitals and social care (as long as their data is used confidentially). Many people valued existing advances in technology such as text reminders from their GPs and telephone consultations. However people felt that new technology should complement, not replace, face to face appointments. And while children and young people welcomed the idea of more online support, they also had concerns about whether they had enough storage on their phones to use different apps.

We aspire to be a *Global Digital Exemplar*. A *Global Digital Exemplar* is an NHS organisation that uses world-class digital technology and information. Exemplars will share their learning and experiences to enable others to follow in their footsteps as quickly and effectively as possible.

We will work towards a paper-free health and care partnership so that our front-line staff are able to access information in a secure, timely and reliable manner. This supports effective decision-making to improve health outcomes for people and deliver high quality care.

Going paperless is a high priority as our continued dependence on paper records and manual processes means there is unnecessary duplication, makes care less efficient and risks patient safety.

The first stage on our journey to being a *Global Digital Exemplar* will be our foundation stage: creating a solid information and digital platform. Our stage one actions are outlined below:

We will introduce:

- E-consultations, online or using a mobile app, so that patients can see their GP or health and care professional rather than attending the practice.
- Self-care apps to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.

- A new Electronic Referral System (E-RS) to electronically refer patients to hospitals and other healthcare settings for treatment, diagnosis or care.
- A system that supports GP and other healthcare professionals to make clinical decisions, by giving electronic access to experts in hospital and other settings.
- Access to GP records for urgent and emergency care clinicians, as well as giving GPs access to health information from hospitals, so that the very best joined-up care can be provided to patients.

# Our buildings and estate

**We are committed to improving our buildings so that we can deliver high quality care from all South West London sites**

The estate is a key enabler of the south west London Health and Care Partnership and the future estate will need to support health and social care service delivery and sustainability through provision of fit for purpose and value for money accommodation that:

- Ensure that our estate supports our Local Transformation Board *Local Health and Care Plans*; in particular that there is sufficient capacity in community and primary care settings to relieve pressure on acute sites and provide services like antenatal support, mental health and social care services, deliver seven day services
- Addresses significant backlog maintenance issues on our main hospital sites and ensures all buildings chosen to deliver the agreed clinical configuration are fit for the 21st century
- Re-shapes the mental health estate to meet future service requirements

The current health economy estate across acute, community, primary care and mental health settings (but excluding the local authority estate) has a total estimated annual running cost of £190 million per annum (excluding depreciation and interest) and comprises approximately 700,000m<sup>2</sup> of floor space. There are a number of issues such as:

- Primary care and community services operate from a large number of estates across south west London. In a number of cases this may not be well designed for how we want to deliver services outside of hospitals and will

therefore require either upgrading or replacing. This will need to be in line with the emerging new health and care models being developed by Local Transformation Boards and we will develop a long term pipeline to deliver local facilities. This may mean that some services move from their existing location but will still be accessible to the local population. It may also mean that some services are moved away from a hospital setting into more local facilities. We have recently bid for £10 million to support these type of services changes across Croydon.

Our major acute hospitals all require significant investment to bring them fully up to 21<sup>st</sup> Century standards.

- Both St George's Hospital and Kingston Hospital have identified the need for additional capital since the STP was originally published in 2016 following recent building surveys. These will modernise substantial elements of the existing buildings
- Croydon have recently submitted a bid of circa £120 million to NHS England for site rationalisation and modernisation
- Epsom and St Helier University Hospitals NHS Trust are developing options for the provision of their existing services and have begun engaging their local population on these. This is a long term project which would require investment up to £600 million which will stretch beyond the life of this STP

The original STP (published in November 2016) estimated that we needed £1.3 billion to deliver our plans to improve our buildings and estate. We think this may increase.

Local people have told us about their views on our buildings. We have listened to these views and have adapted our plans and priorities going forward to reflect what they have said. The full summary of what people have said is in section 7. In summary, the common themes across south west London are explained below:

- **Local people told us...** that hospital sites and some wards should be upgraded as they are very old and need to be brought up to modern standards. People felt that the poor environment in hospital wards could impact people's moods and general wellbeing. People felt that some hospitals needed to invest more money to make sure that wards are kept warm, clean and do not have structural issues such as leaking ceilings. People wanted the hospital grounds to be maintained and nice gardens and places to sit, they felt that this would have a positive impact on their mental health. People appreciated the newly established community health settings such as

The Nelson and Jubilee Centre and liked that they no longer needed to visit a Hospital but some felt that as community services become bigger, the standard of care may deteriorate as more people use them.

- We are developing a pipeline of schemes for south west London which will develop in line with Local Transformation Board ***Local Health and Care Plans***. While we will release funds to support this from the sale of unwanted buildings we know that this will not be sufficient to meet our capital funding requirements. We will therefore need to secure additional capital funding. While there will be some NHS capital funds available, in the current economic climate these may be limited and therefore alternative funding sources will need to be explored.
- South west London is playing a full part in the development of the London Estates Board which has been created as part of London devolution process and will work with the Board to identify and secure the required capital streams to help us realise our wider plans.

# 12. SUPPORTING OUR LOCAL COMMUNITIES

The greatest influences on our health and wellbeing are factors such as education, employment, housing, healthy habits in our communities and social connections. As some of the largest employers and organisations within south west London, we recognise the important role we play in our local communities and economies.

To support our local communities we will:

- Help local people into employment, and to stay in employment, by creating apprenticeships and supporting employment of vulnerable individuals in our organisations
- Consider how we can become more sustainable and 'green' organisations and in particular help reduce air pollution. Facilitating more person and environmentally friendly travel options such as walking, cycling and using public transport
- Contribute to tackling obesity and diabetes through providing a healthy food environment in our buildings, for our staff and our service users, including healthy catering and vending machines
- Focus on helping our staff to keep healthy through promoting positive mental health, physical activity and exercise, maintaining a good work-life balance and providing an environment that supports healthy eating



## 13. APPENDIX

# **Clinical quality standards for acute services provided in South West London or operated by a South West London Trust**

September 2017



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# 1 Introduction

The work underpinning this document was led by a Task and Finish Group, comprising the Medical Directors of the four SW London-based Acute Trusts, and was approved by the SW London Clinical Senate on 28 September. The document begins by setting out the recommended clinical standards for six acute clinical services provided in SW London or operated by a SW London Trust elsewhere (section 3). It then covers the key interdependencies between acute and supporting services (section 4). Finally, section 5 covers the workforce and training interdependencies that need to be considered.

It is intended to help each Local Health and Care system, led by a Local Transformation Board, to assess its current and likely future position against the clinical standards that have been collectively identified as key for acute service delivery. These clinical standards will support further work to ensure that acute services in each local system are robust, able to provide the services that the system has agreed are essential for acute service delivery, and to provide the specific acute sub-specialty services, supporting services and elective services that meet the local population's need.

We recognise that the acute standards set out here represent just one part of a wider clinical model for SW London. In particular, demographic change means increasing demand resulting from more complex health needs and this requires all health and care providers, including the voluntary sector and local communities, to work together in different ways.

## 2 Scope of this document

### 2.1 In scope of this document

This document focuses on the key clinical standards that contribute towards improved patient care, safety and experience. We have primarily focused on standards relating to the consultant workforce, but we have referenced standards relating to other key staff groups where applicable. The document sets out the consultant staffing levels that are required to meet the standards. These represent the minimum requirement for consultants, given a sufficient number of mid-grades. If there are mid-grade shortages that cannot be resolved through recruitment or mitigated through other roles, this could result in a higher requirement for consultants than stated in this document.

#### 2.1.1 Services in scope

The SWL Clinical Board identified six services as key to the sustainability of acute services and noted that there were many interdependencies between these services and other supporting services that require further consideration:

- Emergency Department
- Obstetrics
- Emergency Surgery
- Paediatrics
- Acute Medicine
- Intensive Care

#### 2.1.2 Geographic scope

The clinical standards set out in this document should apply to acute services in SW London and/or operated by SW London Trusts. Hence there is currently no expectation that the standards agreed here will apply to any of the services provided at sites in Surrey Downs other than those provided at Epsom Hospital.

The acute services listed above are currently provided on all five acute sites within SW London / operated by SW London Trusts, except for emergency surgery, which is provided on four sites:

- St George's
- Kingston
- Croydon
- Epsom (no provision of emergency surgery)
- St Helier

Having agreed which clinical standards should be applicable to each service, we have developed and agreed a set of workforce requirements to meet the clinical standards at a non-tertiary hospital (Croydon, Epsom, Kingston and St Helier), and at a tertiary hospital / major trauma centre (St George's).

### 2.2 Out of scope of this document

We recognise that there are other areas that impact on clinical quality aside from the consultant workforce. Previous work has identified nursing shortages and delayed patient discharges as particular issues that acute Trusts should seek to address. These issues will be targeted through local initiatives,

while improvements in operational performance, such as Referral to Treatment (RTT) and 4-hour A&E performance, will be targeted through the SWL Sustainability and Transformation Partnership (STP).

Although mid-grade staffing is clearly important, it is beyond the scope of this work. This is because it is difficult to capture the data accurately because it changes so frequently. However, it is important to note the challenges in staffing mid-grade rotas, which could be mitigated in future through better recruitment and retention processes and/or alternative models of care.

## 3 Clinical Standards and Consultant Workforce Implications

### 3.1 Emergency Department (“ED”)

#### 3.1.1 Clinical standards to meet in ED

1. Each ED in SW London or operated by a SW London Trust should meet 7 Day Clinical Standards<sup>1</sup>, including diagnostic standards:
  - a. Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week. Acute trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances
2. EDs should also meet the following London Quality Standards (“LQS”)<sup>2</sup>:
  - a. A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes (Note: this is the key clinical standard determining the consultant staffing requirement)
  - b. A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week
3. EDs should meet mandatory operational standards, in particular:
  - a. The NHS Constitution sets out that a minimum of 95 per cent of patients attending an ED department in England must be seen, treated and then admitted or discharged in under four hours
  - b. All handovers between ambulance and ED must take place within 15 minutes with none waiting more than 30 minutes
4. Each ED should be able to achieve a minimum rating of ‘Good’ in each of the CQC’s 5 domains (especially KLOE S4):
  - a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
5. Each ED should meet the RCP standard that patients referred for emergency mental health care must be seen within 60 minutes (Jan 2014)

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<sup>1</sup> NHS.UK, 2017. *NHS Seven Day Services Clinical Standards*. Last revised Sep 2017.

<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

<sup>2</sup> London Health Programmes, 2015. *Acute, Emergency and Maternity Services, London Quality Standards*. Last revised Nov 2015. <http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/All-London-Quality-Standards-Acute-Emergency-and-Maternity-Services-Nov-2015.pdf>



6. Each ED should meet TARN trauma standards, with additional standards to be met by St George's at a Major Trauma Centre<sup>3</sup>. In particular:
  - a. CT imaging must be performed within 1 hour of arrival for patients meeting the NICE head injury criteria
  - b. If the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC. The consultant can be from any specialty, but must be present within five minutes
7. Every ED must have comprehensive front-door clinical streaming by October 2017<sup>4</sup>
8. Every ED must aspire to having 24-hour "core 24" mental health teams by March 2019<sup>19</sup>

### 3.1.2 Implications for ED consultant staffing levels

Medical Directors of the four SWL acute trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care. As ED consultants seldom work in areas outside of emergency medicine, Medical Directors felt that WTE was the most appropriate measure of consultant availability.

	Hours of consultant cover	Consultant WTE <sup>5</sup>	Reason for requirement
<b>Minimum requirement to meet the standards</b>	16 hours, 7 days a week	12	<p>16/7 cover is required to meet the LQS standard. Analysis of patient arrival times also suggests that activity volumes are high for around 16 hours per day and justifies 16/7 consultant presence.</p> <p>12 WTE would allow for two consultants to be on-site much of the time and three consultants to be on site at some peak times. It would require consultants to work at least 1 in 6 weekends, assuming the lightest weekend model, with one consultant resident at the weekend and another consultant on call.</p> <p>Due to high volumes of activity, there will often be the need for two consultants to be resident at the weekend, resulting in working 1 in 4 weekends.</p>

<sup>3</sup> The Trauma Audit & Research Network, 2015. *TARN Core Standards*.

<https://www.tarn.ac.uk/content/images/53/Standards%20used%20in%20reports.pdf>

<sup>4</sup> Urgent & Emergency Care Delivery Plan & Governance – presentation for ED Delivery Board Chairs meeting 20<sup>th</sup> April 2017

<sup>5</sup> Based on an assumed 10 PAs per WTE. The requirement for WTEs could be reduced if job plans include a higher figure than 10 PAs

<b>Requirement to meet the standards and provide sustainable working patterns if activity is high (&gt; 100,000 attendances p.a.)</b>	16 hours, 7 days a week	12-16	<p>The exact requirement within this range depends on several factors, e.g. the number of direct clinical contact PAs in each consultant's job plan and the robustness of the mid-grade staffing.</p> <p>High volumes of activity mean that there will often be two consultants or more required to be present. Poor patient flow exacerbates this need as patients remain in the department until late at night.</p>
<b>Requirement for a major trauma centre</b>	24 hours, 7 days a week	24	SGH, as a major trauma centre, requires 24 WTE (to enable it to meet the standards associated with the NHS best practice tariff requirement for major trauma)

We also recognise that the Royal College has found there to be a national shortage in the number of registrars in ED. In some cases, this has resulted in consultants on mid-grade rotas, which could in turn result in an increased requirement for consultants.

## 3.2 Obstetrics

### 3.2.1 Clinical standards to meet in Obstetrics<sup>6</sup>

1. Each obstetric unit within SW London or operated by a SW London Trust should meet 7 Day Clinical Standards<sup>7</sup>
2. The Obstetrics Task and Finish Group's consensus (Feb 2016) was that all obstetric units should have 14/7 on-unit consultant cover<sup>8</sup>. (Note: this is the key clinical standard determining the consultant staffing requirement) The services may also be further considered in line with recommendations in the Cumberlege report.
3. Each obstetric unit should be able to achieve at least a rating of 'Good' in the CQC's 5 domains (especially KLOE S4):
  - a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
4. Obstetric units should consider perinatal and antenatal mental health standards that are relevant for workforce planning; however, these do not affect configuration:

<sup>6</sup> The emerging conclusion from the Task and Finish Group was that sites other than St George's (which, as a large tertiary centre, has different requirements) require a minimum of 12 WTE consultant anaesthetists to cover the emergency general surgery and trauma rotas and a minimum of 12 further WTE consultant anaesthetists to cover the emergency obstetrics rota. This conclusion has not been worked through fully. The number of additional consultant anaesthetists that would be required to cover elective cases would be dependent upon the workload at each Trust.

<sup>7</sup> NHS.UK, 2017. *NHS Seven Day Services Clinical Standards*. Last revised Sep 2017.

<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

<sup>8</sup> NHS England, 2016. *Better Births, Improving outcomes of maternity services in England, A Five Year Forward View for maternity care*. <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

- a. Trusts should meet midwife to birth-rate ratios as defined in Birth-rate Plus or an equivalent local standard
5. Each obstetric unit should meet the Royal College of Obstetricians and Gynaecologists' ("RCOG") standards on midwifery staffing numbers<sup>9</sup>:
  - a. Women in established labour should receive one-to-one care from a midwife
  - b. Midwifery staffing levels should be calculated and implemented to provide the midwife-to-woman standard ratio in labour of (1.0-1.4 WTE midwives to woman)
6. Each obstetric unit in SW London or operated by a SW London Trust should meet BAPM guidance on medical and nursing numbers<sup>10</sup>:
  - a. The minimum resident staffing level for a neonatal ICU is one junior trainee (ST1-3) or Advanced Neonatal Nurse Practitioner and one senior trainee (ST4-8), appropriately trained specialty doctor or ANNP, with consultant presence at least 12/7 and more staff required as units increase in size
  - b. All NICUs should have sufficient nursing staff to deliver nurse to patient ratios of 1:1 for an NICU, 1:2 for an HDU and 1:4 for a SCBU
7. Each obstetric unit should meet safe staffing guidance<sup>11</sup>

### 3.2.2 Implications for obstetrics consultant staffing levels

Medical Directors of the four SWL acute Trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care. Note that Medical Directors felt that the number of consultants contributing to rotas was a better indicator of ability to meet the standards than Whole Time Equivalent. This is because obstetricians frequently cover non-acute activity (such as outpatient clinics and elective theatre lists).

	Hours of consultant cover	Consultant headcount	Reason for requirement
<b>RCOG category A; &lt; 3000 births p.a.</b> <sup>12</sup>	14 hours, seven days a week	10	<p>14/7 cover is required to meet the Task and Finish Group's agreed standard.</p> <p>Two consultants should be resident during the week to enable cover of both an elective and emergency procedure and one at the weekend. This results in a requirement of 8 WTE. However, at least 10 consultants are required to contribute to obstetrics rotas (who may also do gynaecology work). This would require consultants to work at least 1 in 5 weekends, assuming the lightest</p>

<sup>9</sup> Royal College of Obstetricians and Gynaecologists, 2016. *Providing Quality Care for Women, A framework for maternity service standards*. <https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf>

<sup>10</sup> British Association of Perinatal Medicine, 2010. *Service standards for hospitals providing neonatal care* (3<sup>rd</sup> edition). [http://www.bapm.org/publications/documents/guidelines/BAPM\\_Standards\\_Final\\_Aug2010.pdf](http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf)

<sup>11</sup> National Institute of Health and Care Excellence, 2015. *Safe midwifery staffing for maternity settings*. <https://www.nice.org.uk/guidance/ng4>

<sup>12</sup> Royal College of Obstetricians and Gynaecologists, 2007. *RCOG Safer Childbirth Report*; table 8, page 34

			weekend model, with one consultant resident at the weekend and another consultant on call.
<b>RCOG category B; 3000 – 4000 births p.a.</b>	14 hours, seven days a week	12	Higher volumes of activity mean that it is likely that (at least at times) two consultants will be required to be resident at the weekend, with another consultant on call. With 12 consultants contributing to obstetrics rotas, this would allow for between 1 in 4 to 1 in 6 weekends worked, depending upon how often two consultants were required to be resident.
<b>RCOG category C1; 4000 – 5000 births p.a.</b>	14 hours, seven days a week	14	Higher volumes of activity mean that at peak times, three consultants are likely to be required, resulting in a requirement of 14 consultants contributing to obstetrics rotas. This would require consultants to work 1 in 6 weekends.
<b>RCOG category C2; &gt; 5000 births p.a.</b>	14 hours, seven days a week	16	If 16 consultants contribute to obstetrics rotas, this would support a model where consultants work a maximum of 1 in 4 weekends, allowing three consultants to be resident for much of the time to manage the highest volumes of activity.
<b>Specialist Centre</b>	14 hours, seven days a week	21	SGH, as a specialist centre, requires 21 WTE, as agreed by the Task and Finish Group.

We also recognise that the Royal College has found there to be a national shortage in the number of registrars in obstetrics. In some cases, this has resulted in consultants on mid-grade rotas, which could in turn result in an increased requirement for consultants. SWL Medical Directors have not found this to be a current issue for SW London rotas but we will continue to monitor this as the evaluation process progresses.

### 3.3 Emergency surgery

#### 3.3.1 Clinical standards to meet in emergency surgery

1. Note that these standards exclude young children, who would continue to be transferred to St George's Hospital for emergency surgery as per the agreed pathway.
2. Each emergency surgery unit in SW London or operated by a SW London Trust should meet 7 day clinical standards<sup>13</sup>, including:
  - a. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time

<sup>13</sup> NHS.UK, 20176. NHS Seven Day Services Clinical Standards. Last revised Sep 20176.  
<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

- of admission to hospital (Note: this is the key clinical standard determining the consultant staffing requirement)
- b. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly, and seen and assessed by a consultant within six hours
  - c. Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected), should be seen and assessed within one hour
  - d. Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients. Acute Trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances
  - e. All patients on the acute surgical assessment unit and other high dependency areas seen and reviewed by a consultant twice daily
  - f. All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients
3. Emergency surgery units should also meet the following LQS standards<sup>14</sup>:
    - a. All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately-trained junior or specialty surgeons
    - b. All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night
    - c. When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments
  4. Each emergency surgery unit should achieve a minimum rating of 'Good' in the CQC's 5 domains (especially KLOE S4):
    - a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
  5. Standards referenced by the National Emergency Laparotomy Audit (NELA) should be considered good practice but not mandatory<sup>15</sup>:

<sup>14</sup> London Health Programmes, 2015. *Acute, Emergency and Maternity Services, London Quality Standards*. Last revised Nov 2015. <http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/All-London-Quality-Standards-Acute-Emergency-and-Maternity-Services-Nov-2015.pdf>

<sup>15</sup> NELA, 2015. *The First Patient Report of the National Emergency Laparotomy Audit*. <http://nela.org.uk/All-Patient-Reports>

- a. Each higher risk case (predicted mortality  $\geq 5\%$ ) should have the active input of consultant surgeon and consultant anaesthetist
  - b. Clear protocols for the postoperative management of elderly patients (over 70) undergoing abdominal surgery should be developed which include, where appropriate, routine review by an MCOP (Medicine for Care of Older People) consultant and nutritional assessment
6. Emergency teams at St George's Hospital, as a Major Trauma Centre, should have a role in supporting the trauma service.
7. Each emergency surgery unit needs to have defined protocols for transferring young children to St George's
8. Each emergency surgery unit should meet safe staffing guidance<sup>16</sup>

### 3.3.2 Implications for emergency surgery consultant staffing levels

Medical Directors of the four SWL acute Trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care. Note that Medical Directors felt that the number of consultants contributing to rotas was a better indicator of ability to meet the standards than Whole Time Equivalent. This is because surgeons frequently cover non-acute activity (such as outpatient clinics and elective theatre lists).

	Hours of consultant cover	Consultant headcount	Reason for requirement
<b>Requirement to meet the standards</b>	14 hours, seven days a week	10	<p>10 consultants contributing to emergency surgery rotas (given high volumes of elective work) allows for a separate consultant to be on call at night and resident in the day time.</p> <p>If elective volumes are lower, and the same consultant can be on call at night and resident in the daytime, then this could accommodate a model with fewer consultants.</p>

## 3.4 Paediatrics

### 3.4.1 Clinical standards to meet in paediatrics

1. Each paediatric unit in SW London or operated by a SW London Trust should meet 7 day clinical standards,<sup>17</sup> including:
  - a. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital

<sup>16</sup> National Institute for Health and Care Excellence, 2014. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. <https://www.nice.org.uk/guidance/sg1>

<sup>17</sup> NHS.UK, 2017. NHS Seven Day Services Clinical Standards. Last revised Sep 2017. <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

- b. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed promptly by a doctor, or advanced non-medical practitioner with a similar level of skill, and seen and assessed by a consultant within six hours (note that the paediatric Task and Finish Group agreed that all sites should have 14/7 consultant cover)
  - c. Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week and completed within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients. Acute Trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances
  - d. All patients on the acute medical unit (AMU) or the equivalent paediatric admissions unit and other high dependency areas are seen and reviewed by a consultant twice daily
  - e. Where a mental health need is identified following an acute admission, the patient must be assessed by psychiatric liaison / CAMHS within 1 hour for emergency care needs and within 14 hours for urgent care needs
  - f. All patients admitted acutely to be continually assessed using the Paediatric Early Warning Score (PEWS). The PEWS competency based escalation trigger protocol should be used for all patients.
2. All paediatric units should meet the following LQS standards<sup>18</sup>:
- a. When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments
  - b. A consultant paediatrician to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership available to cover extended day working (up until 10pm), seven days a week.
  - c. All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open
3. Paediatric units should also meet the following Healthy London Partnership standards<sup>19,20</sup>:
- a. The Paediatric Assessment Unit should be geographically co-located with an Emergency Department or in-patient ward
  - b. Equipment must be available to support the day to day activity on the unit as well as resuscitation, stabilisation and transfer of children who become critically unwell

<sup>18</sup> London Health Programmes, 2015. *Acute, Emergency and Maternity Services, London Quality Standards*. Last revised Nov 2015. <http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/All-London-Quality-Standards-Acute-Emergency-and-Maternity-Services-Nov-2015.pdf>

<sup>19</sup> Healthy London Partnership – Transforming London’s health and care together, 2017. *London’s paediatric assessment unit standards for children and young people*. <https://www.healthylondon.org/sites/default/files/Paediatric%20Assessment%20Unit%20Standards.pdf>

<sup>20</sup> Healthy London Partnership’s Children and Young People’s Programme, 2016. *London acute care standards for children and young people*. [https://www.myhealth.london.nhs.uk/system/files/HLPCYP\\_Acute%20Standards%2025%20May%202016.pdf](https://www.myhealth.london.nhs.uk/system/files/HLPCYP_Acute%20Standards%2025%20May%202016.pdf)



- c. All children accessing a Paediatric Assessment and Short Stay Unit (PASSU) must have a standardised initial assessment including pain score within 15 mins of arrival, if this has not taken place in the ED
  - d. The PASSU should work within an integrated system with community services and hence promote ambulatory and community-based care to support admission prevention, care at home and reduced length of stay
  - e. Paediatric nurse staffing should comply with Royal College of Nursing (RCN) guidelines and regular audit of patient acuity using appropriate tools should inform workforce planning
  - f. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade (ST4 +) or consultant rota within four hours of admission
  - g. A consultant paediatrician is to be present and readily available in the hospital to cover extended day working (up until 10pm), seven days a week
  - h. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care, which includes having a named consultant paediatrician and a named consultant surgeon
  - i. All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on-site consultant presence during times of peak attendance
  - j. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent)
  - k. When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments (during resident hours but not on call)
4. Each paediatric unit should be able to achieve a minimum rating of 'Good' in the CQC's 5 domains (especially KLOE S4):
- a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
5. For services with a Local Neonatal Unit and paediatric inpatients:
- a. There must be at least one daytime medical rota to cover the neonatal unit and at least one separate daytime medical rota to cover paediatric inpatients
  - b. It **may** be sufficient to have a single night-time medical rota to cover both the neonatal unit and paediatric inpatients. The night-time cover must include, as a minimum, one doctor on site who is ST4 or above and, if the doctor on site is not a consultant, an additional consultant on call. The decision about whether a single night-time rota is sufficient should be based on a local risk assessment that includes consideration of the following factors: volume and acuity of paediatric admissions, number of inpatients, level of paediatric input required on the neonatal and maternity units, and the number and competency of the middle grade paediatric doctors
6. If a service has a Special Care Unit and paediatric inpatients, it is usually sufficient to have a single daytime or night-time consultant rota that covers both areas

### 3.4.2 Implications for paediatrics consultant staffing levels

Medical Directors of the four SWL acute Trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care. Note that Medical Directors felt that the number of consultants contributing to rotas was a better indicator of ability to

meet the standards than Whole Time Equivalent. This is because paediatricians frequently cover non-acute activity (such as outpatient clinics).

	Hours of consultant cover	Consultant headcount	Reason for requirement
<b>Minimum requirement to meet the standards at a non-tertiary centre</b>	14/7 hours of consultant cover with an on-call rota at all other times	12 consultants contributing to paediatric and NICU rotas	<p>14/7 consultant cover is necessary to meet the Task and Finish Group's agreed standard.</p> <p>This requires a minimum of 8 WTE.</p> <p>The same consultant can be resident at the weekend and on call at night. However, if consultants are also contributing to NICU rotas, this would require a minimum of 12 consultants contributing to rotas for consultants to work an average of 1 in 6 weekends.</p>
<b>Requirement to meet the standards and manage large volumes at a non-tertiary centre (&gt;2.5k emergency admissions p.a.)</b>	14/7 hours of consultant cover with an on-call rota at all other times	16 consultants contributing to paediatric and NICU rotas required to manage high volumes of activity	<p>The same consultant can be resident at the weekend and on call at night. However, if consultants are also contributing to NICU rotas, this would require a minimum of 12 consultants contributing to rotas for consultants to work an average of 1 in 6 weekends.</p> <p>In addition, given large volumes of activity (&gt;2.5k emergency admissions p.a.), it may be necessary for two consultants to be resident at weekends, which will require 16 consultants to contribute to rotas.</p>
<b>Requirement for a specialist centre (to cover acute general paediatrics only)<sup>21</sup></b>	14/7 hours of consultant cover with an on-call rota at all other times	10.0 WTEs <sup>22</sup>	For large hospitals where rotas for general paediatrics are entirely separate from specialist paediatrics (including NICU), the requirement is 10.0 WTEs <sup>23</sup>

<sup>21</sup> Specialty paediatrics (including NICU) are not included, as the scope of this document is the 6 core services, including general paediatrics

<sup>22</sup> Facing the Future: Standards for Acute General Paediatric Services (revised 2015).

<http://www.rcpch.ac.uk/sites/default/files/page/Workforce%20Implication%20of%20FTF%202015%20FINAL.pdf>

<sup>23</sup> Assumes 2.5 SPAs in a large service. The requirement for other service sizes can be found in the "Number of SPAs" table, section

## 3.5 Acute medicine

### 3.5.1 Clinical standards to meet in acute medicine

1. All acute medical wards in SW London or operated by a SW London Trust should meet 7 Day Clinical Standards<sup>24</sup>, including:
  - a. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed promptly by a doctor, or advanced non-medical practitioner with a similar level of skill, and seen and assessed by a consultant within six hours (Note that the acute medicine Task and Finish group agreed that, although 12/7 cover satisfies the minimum requirement, all sites should have 14/7 consultant cover to provide a safe service for patients)
  - b. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital
  - c. Consultant involvement for patients considered high risk (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within 1 hour
  - d. Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients. Acute Trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances
  - e. Hospital inpatients must have timely 24-hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols. These interventions would typically be: critical care, interventional radiology, interventional endoscopy, emergency general surgery, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention, cardiac pacing (either temporary via internal wire or permanent)
  - f. All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway<sup>25</sup>
  - g. All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients

<sup>24</sup> NHS.UK, 2017. NHS Seven Day Services Clinical Standards. Last revised Sep 2017.

<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

<sup>25</sup> NHS.UK, 2017. NHS Seven Day Services Clinical Standards. Last revised Sep 2017.

<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

2. Each acute medical ward should also meet the relevant sections from LQS<sup>26</sup>:
  - a. When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments
3. Each AMU should achieve at least a rating of 'Good' in the CQC's 5 domains (especially KLOE S4):
  - a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
4. During daytime hours Monday-Friday, teams from the key supporting specialties must be available to review patients on AMU when required so that delays to patient care and unnecessary transfers to other wards are minimised. These supporting specialties include, but are not limited to: cardiology, respiratory, gastroenterology, elderly medicine, acute oncology and palliative care. For some specialties, such as palliative care and acute oncology, the support may be provided through a blended rota of consultants and specialist nurses
5. Formal network arrangements must be in place so that staff from each AAU have access to tertiary-level specialist telephone advice 24/7. Specialist transfer protocols must also be in place.
6. Each AMU must be supported by a 24/7 gastrointestinal bleeding rota (which could cover more than one Trust)
7. Each AMU should ensure that nursing staff levels follow safe staffing guidelines<sup>27</sup>, although this will not materially affect the clinical model as staffing levels are predominantly driven by activity rather than number of sites:
  - a. For example, while there is no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient wards, there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shift and consequently senior management and nursing managers or matrons should take this into account
8. Royal College of Nursing staffing guidelines should be considered as best practice but not as mandatory standards to be met<sup>28</sup>:
  - a. The composition of nursing staffing on acute wards should include at least 65% registered nurses

### 3.5.2 Implications for acute medicine consultant staffing levels

Medical Directors of the four SWL acute Trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care. Note that Medical Directors felt that the number of consultants contributing to rotas was a better indicator of ability to meet the standards than Whole Time Equivalent. This is because physicians frequently cover non-acute activity (such as outpatient clinics).

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<sup>26</sup> London Health Programmes, 2015. *Acute, Emergency and Maternity Services, London Quality Standards*. Last revised Nov 2015. <http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/All-London-Quality-Standards-Acute-Emergency-and-Maternity-Services-Nov-2015.pdf>

<sup>27</sup> NICE, 2014. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. <https://www.nice.org.uk/guidance/sg1>.

<sup>28</sup> Royal College of Nursing, 2011. *Guidance on safe nurse staffing levels in the UK*. <https://www.rcn.org.uk/professional-development/publications/pub-003860>

	Hours of consultant cover	Consultant headcount	Reason for requirement
<b>Requirement to meet the standards</b>	14/7 hours of consultant cover, with an on-call rota at other times	12 consultants contributing to acute medicine rotas	<p>8 consultants will allow two consultants to be present 14/7.</p> <p>However, even given the lightest weekend model, with one consultant resident at the weekend, and another on call, this would require consultants to work 1 in 4 weekends.</p> <p>12 consultants contributing to acute medicine rotas would allow consultants to work 1 in 6 weekends (given the lightest weekend model) and 1 in 4 weekends if two consultants were required to be resident; this is therefore a more sustainable model.</p> <p>Note: this requirement does not equate to the body of consultants required to review ward inpatients on a once daily basis.</p>

## 3.6 Intensive care

### 3.6.1 Clinical standards to meet in intensive care

1. Each intensive care unit in SW London or operated by a SW London Trust should meet 7 Day Clinical Standards<sup>29</sup>, including:
  - a. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital (Note: this is the key clinical standard determining the consultant staffing requirement)
  - b. All patients on the Intensive Care Unit (ICU) and other high dependency areas are seen and reviewed by a consultant during twice daily ward rounds (including all acutely ill patients directly transferred and others who deteriorate)
  - c. To maximise continuity of care consultants should be working multiple day blocks
  - d. All patients admitted acutely to be continually assessed using appropriate ICU protocols.
  - e. Consultant involvement where a patient is unstable and not responding to treatment as expected should be within 1 hour.
  - f. Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging

<sup>29</sup> NHS.UK, 2017. NHS Seven Day Services Clinical Standards. Last revised Sep 2017.  
<https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

(MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients. Acute Trusts should make a judgment through their clinical governance processes and in discussion with their commissioners regarding which diagnostic tests their patients require access to 7 days a week and whether these are delivered on site or via a formal networked arrangement. A networked approach may involve patient transfer, image transfer or diagnostician in-reach in differing circumstances

- g. Hospital inpatients must have timely 24-hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols
2. Each intensive care unit should also meet the following LQS standards<sup>30</sup>:
    - a. Consultants freed from all other clinical commitments when covering critical care services
    - b. Critical care units to have out-of-hours consultant intensivist rotas dedicated to critical care
    - c. All referrals for admission to intensive care to be immediately reviewed by the critical care team and discussed with a consultant
    - d. Medical staff capable of providing immediate life sustaining advanced airway support to be available to the critical care unit 24 hours a day
    - e. Once a patient is discharged from the critical care unit to another ward in the hospital, critical care team review to be available to review the patient 24 hours and 48 hours after discharge
    - f. No non-clinical critical care transfers out of a hospital to take place with an operational standard of  $\leq 5\%$
    - g. All discharges from a critical care unit (including a step down in critical care level 3 to level 2 that involves a change in location) are to be to an appropriate named consultant
    - h. 100% of discharges to be between 08.00 and 20.00. 80% of discharges from critical care to wards to be during the normal working day for that ward, normally 08.00 to 17.00
  3. Each intensive care unit should be able to achieve at least a rating of 'Good' on the CQC's 5 domains (especially KLOE S4):
    - a. Staffing levels and skill mix should be planned and reviewed, so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available
  4. ICUs should consider Intensive Care Society (ICS) (2015) guidelines<sup>31</sup> (e.g., a guideline consultant/patient ratio of between 1:8 – 1:15) but not as mandatory standards. Other ICU guidelines to consider include AHP and nursing standards:
    - a. Critical care should be delivered as a multidisciplinary team.

<sup>30</sup> London Health Programmes, 2015. *Acute, Emergency and Maternity Services, London Quality Standards*. Last revised Nov 2015. <http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/All-London-Quality-Standards-Acute-Emergency-and-Maternity-Services-Nov-2015.pdf>

<sup>31</sup> Intensive Care Society, 2015. *Guidelines for the Provision of Intensive Care Service, Edition 1*. [https://www.ficm.ac.uk/sites/default/files/GPICS%20-%20Ed.1%20\(2015\)\\_0.pdf](https://www.ficm.ac.uk/sites/default/files/GPICS%20-%20Ed.1%20(2015)_0.pdf)



- b. The ICU lead dietitian will be involved in the assessment, implementation and management of appropriate nutrition support route, in collaboration with the rest of the MDT team
  - c. Level 3 patients (e.g., ICU) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care
  - d. Level 2 patients (e.g., HDU) require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care
  - e. Each designated Critical Care Unit will have an identified lead nurse who is formally recognised with overall responsibility for the nursing elements of the service
  - f. A minimum of 50% of registered nursing staff will be in possession of a post registration award in Critical Care Nursing
5. Each ICU unit in SW London or operated by a SW London Trust must have the ability to provide intensive care outreach to other services (e.g., acute medicine). Consultants should be available to discuss and review patients for whom there is a question about whether the patient should be admitted to ICU for management

### 3.6.2 Implications for intensive care consultant staffing levels

Medical Directors of the four SWL acute Trusts agreed that the following consultant staffing levels are required to meet the above clinical standards and provide sustainable care in the SWL ICUs. Note that Medical Directors felt that the number of consultants contributing to rotas was a better indicator of ability to meet the standards than Whole Time Equivalent. This is because intensive care consultants frequently cover non-acute activity (such as anaesthetic lists).

	Hours of consultant cover	Consultant headcount	Reason for requirement
<b>Requirement to meet the standards</b>	12/7 hours of consultant cover with an on-call rota at all other times	9 consultants per unit contributing to the rota	<p>9 consultants contributing to the rota allows for a separate consultant to be on call at night and resident in the day time (with a responsibility to cover ICU patients as well as outreach patients as required).</p> <p>It would be possible to meet the standard of 12/7 hours of consultant cover with an on-call rota at all other times with fewer than 9 consultants. However, the view of the Task &amp; Finish Group is that this would become unsustainable (due to the disproportionate number of nights and weekends that consultants would be required to work).</p>

## 4 Clinical interdependencies

In addition to defining the clinical standards for acute services, the question of clinical interdependencies is also an important issue to consider. Our expectation is that the Trusts will work

together wherever possible to support each other and optimise delivery of services. We recognise, however, that each Trust must provide the services required to support their local population, and this may result in some variation in the sub-specialties provided at each site and in the provision of services outside of these core acute services. There may also be other areas outside of these core acute services where Trusts will need to work together to deliver services (for example, using network arrangements).

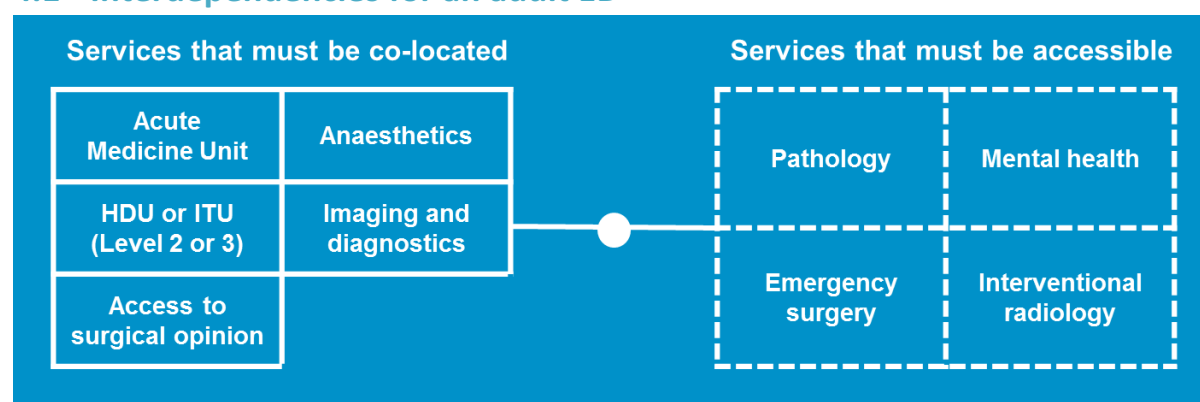
The analysis here lays out a suite of services that are core to delivery of an acute service model. The proposed interdependencies are based on discussions with Medical Directors (Jan 2017), previous work undertaken by the Task and Finish Groups (Jan – June 2016), SWL Acute Provider Collaborative clinical workshops (Dec 2015) and previous work undertaken by the Better Services Better Value programme and Clinical working groups (2012).

The aim was to identify (primarily focusing upon clinical viability):

- Which services must be delivered on site as part of an acute model
- Which services could be networked from a clinical perspective (accessible rather than co-located)

This analysis points to three key sets of interdependent services, each associated with a main entry point into a site; adult ED, children's ED and obstetrics. In addition, Medical Directors agreed that when delivering acute services in SW London or operated by a SW London Trust all three main entry points must be provided.

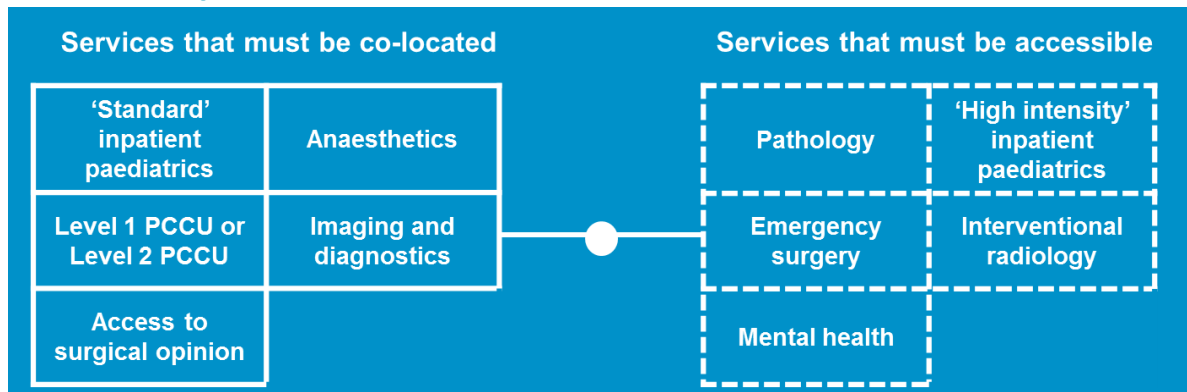
## 4.1 Interdependencies for an adult ED



- Acute medicine, by definition, provides assessment, investigation and treatment for patients admitted urgently or as an emergency through ED and hence must be co-located with ED
- Intensive care, by definition, provides treatment and monitoring for patients in a critically ill or unstable condition and hence must be co-located with ED
  - However, an HDU rather than an ICU might be appropriate in certain circumstances, for example, if volumes of activity are insufficient to fill a full rota's worth of beds / if there is no emergency surgery on site
- Anaesthetics must be co-located with critical care
- The Task and Finish Group agreed that emergency surgery does not need to be collocated with all EDs although there should be access to appropriate surgical opinion
  - A model of surgical transfer similar to Epsom and St Helier was proposed and agreed as a clinically appropriate way forward

- 7 Day Clinical Standards state that hospital inpatients must have scheduled seven-day access to key diagnostic services (e.g., x-ray, ultrasound, CT, MRI, pathology), including access within 1 hour for critical patients
  - High volumes of activity mean that imaging and diagnostic services must be co-located with ED
  - The Task and Finish Group agreed that pathology and interventional radiology do not need to be co-located but there must be timely access from each site with an adult ED

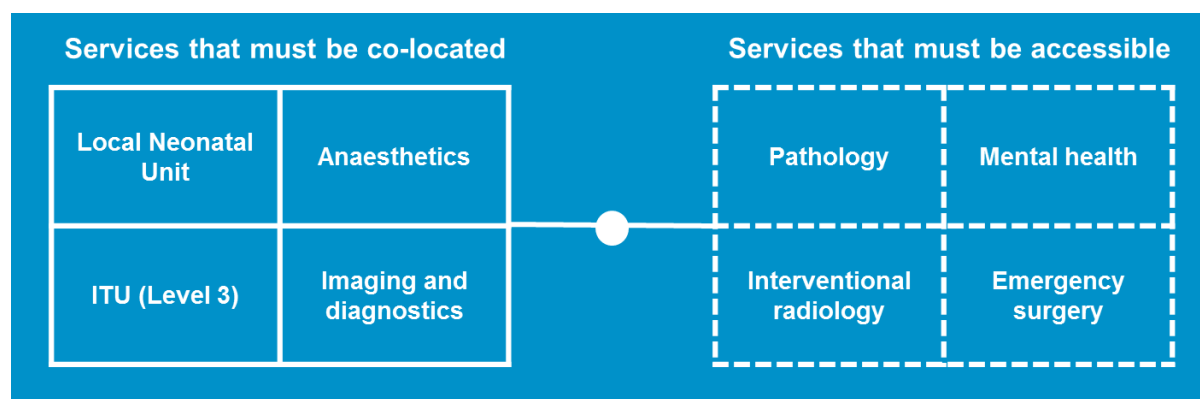
## 4.2 Interdependencies for a children's ED



- The Task and Finish Group concluded that all EDs in SW London or operated by a SW London trust needed at least to have facilities for children to be observed in a bed, stabilised, and transferred if necessary
  - Medical Directors differentiated between a 'standard' inpatient paediatric ward, which is consultant-led (14/7 on-site and on call at all other times) and manages low to medium acuity conditions, and a 'high intensity' inpatient paediatric ward, also consultant-led, which manages medium to high acuity conditions and provides advanced critical care in a Level 3 Paediatric Critical Care Unit
  - Medical Directors agreed that all sites should, as a minimum, have a 'standard' inpatient paediatric ward on site, but not all sites require co-located 'high intensity' inpatient paediatrics; it would be feasible and safe, for example, to have high intensity inpatient paediatrics with access to advanced critical care at St George's Hospital, and 'standard' inpatient paediatrics on the other sites
- Anaesthetics must be co-located with critical care
- The Task and Finish Group agreed that emergency surgery does not need to be co-located with all EDs although there should be access to appropriate surgical opinion
- 7 Day Clinical Standards state that hospital inpatients must have scheduled seven-day access to key diagnostic services (e.g., x-ray, ultrasound, CT, MRI, pathology), including access within 1 hour for critical patients
  - High volumes of activity mean that imaging and diagnostic services must be co-located with ED
  - The Task and Finish Group agreed that pathology and interventional radiology do not need to be co-located but there must be timely access from each site with a children's ED

### 4.3 Interdependencies for an obstetric unit

**Note that this clinical model applies to obstetric units with unselected takes, which require a Local Neonatal Unit and ITU on site. If an obstetric unit has a selected take, then a Special Care Unit and HDU would be sufficient.**



- Obstetrician-led maternity services are not a requirement in an acute model but the view of clinicians is that they should be provided on all acute sites because a very high proportion of the population will need them at some point and they should thus be kept as close to the patient as possible
- If obstetrics services are to be provided with unselected takes, they must be co-located with a level 3 ICU, anaesthetics and a Local Neonatal Unit
- The Task and Finish Group agreed that emergency surgery does not need to be co-located with all EDs although there should be on-site access to appropriate surgical opinion
  - A model of surgical transfer similar to Epsom and St Helier was proposed and agreed as a clinically appropriate way forward
- 7 Day Clinical Standards state that hospital inpatients must have scheduled seven-day access to key diagnostic services (e.g., x-ray, ultrasound, CT, MRI, pathology), including access within 1 hour for critical patients
  - High volumes of activity mean that imaging and diagnostic services must be co-located with ED
  - The Task and Finish group agreed that pathology and interventional radiology do not need to be co-located but there must be timely access from each site with an adult ED

### 4.4 Implications of interdependencies for acute services

The view of Medical Directors is that where acute services are delivered in SW London or operated by a SW London Trust, they should have an on-site adult ED, children's ED and obstetric unit. Medical Directors have then agreed upon the interdependencies for each of these three core services.

The implications are that all acute service models in SW London or operated by a SW London Trust must have the following services on site if they have unselected takes:

- Adult ED
- Children's ED
- Consultant-led obstetrics unit
- Acute medicine

- ICU (Level 3, as required to be co-located with obstetrics)
- Anaesthetics
- Imaging and diagnostics
- 'Standard intensity' inpatient paediatrics
- Neonatal (Local Neonatal Unit, as required to be co-located with obstetrics)

All acute service models in SW London or operated by a SW London Trust must have timely access to the following services, which do not necessarily need to be on each site:

- Emergency surgery
- Interventional radiology (accessible within 1 hour if required)
- Pathology
- 'High intensity' inpatient paediatrics
- Mental health

## 5 Workforce and training interdependencies

The ability to meet training and workforce requirements is also critical to the long-term sustainability of services in SWL. We have therefore gathered information around the training and workforce requirements for consultants, mid-grades, nurses and allied health professionals (AHPs) working in the six core acute services (Table 1).

Table 1: Workforce and training interdependencies by core acute service and staff group

Core acute service	Consultants	Middle grades	Nurses & AHPs
<b>Elements that cut across all 6 services</b>	<ul style="list-style-type: none"> <li>Many of the workforce constraints are associated with the EWTD. We do not yet know how these constraints will be affected by Brexit.</li> </ul>		
	<ul style="list-style-type: none"> <li>All staff must have protected time for continuous professional development.</li> </ul>		
	<ul style="list-style-type: none"> <li>The Consultant contract must be adhered to.</li> <li>Consultants must be able to fulfil the requirements for revalidation.</li> <li>Consultants with a substantial academic component to their job must have protected PAs for research and/or teaching.</li> <li>Consultants with managerial responsibilities must have protected PAs to cover this.</li> <li>Consultants responsible for training junior doctors must have protected PAs to cover this (e.g. a training endoscopy list). These PAs must be on top of the PAs for elective work that are necessary for them to maintain their own competencies.</li> </ul>	<ul style="list-style-type: none"> <li>The new junior doctor contract must be adhered to.</li> <li>Specialty registrars must be able to fulfil the requirements for Annual Review of Competence Progression.</li> <li>Specialty registrars are entitled to: <ul style="list-style-type: none"> <li>“either day release for the equivalent of 1 day per week during university terms; or</li> <li>up to a maximum of 30 days in a year; and</li> <li>study leave to sit an examination for a higher qualification where it is necessary as part of a structured training programme (up to 2 occasions).”<sup>32</sup></li> </ul> </li> <li>SAS doctors must be able to fulfil the requirements for revalidation.</li> </ul>	<ul style="list-style-type: none"> <li>The AFC T&amp;Cs must be adhered to.</li> <li>Safe staffing guidance must be adhered to.<sup>33</sup></li> <li>Nurses and AHPs with managerial responsibilities must have protected time to cover this.</li> <li>Specialist nurses must have job plans that enable them to maintain their competencies.</li> <li>The RCN recommends a “commitment to prepare all ward sisters adequately in non-clinical skills development as a pre-requisite to taking up their role. The RCN considers that this investment should focus on leadership and management training...”<sup>34</sup></li> </ul>

<sup>32</sup> BMA. Junior doctors’ handbook – study and professional leave (2015)

<sup>33</sup> <https://www.nice.org.uk/guidance/service-delivery--organisation-and-staffing>

<sup>34</sup> Royal College of Nursing submission to the Prime Minister’s Commission on Nursing and Midwifery



			<ul style="list-style-type: none"> <li>Trusts should consider their relationships with the local nursing, midwifery and AHP schools so that sufficient acute training placements are available.</li> </ul>
<b>ED</b>	<ul style="list-style-type: none"> <li>To maintain their competencies, consultants must have sufficient time scheduled for adult and paediatric ED.</li> <li>Every ED that treats children must have at least one consultant with a sub-specialty in paediatric EM.</li> </ul>	<ul style="list-style-type: none"> <li>"All training rotations must allow experience in at least one teaching centre and one DGH ED. Trainees should spend approximately 25% of their total time in years ST4-6 caring for children."<sup>35</sup></li> <li>All trainees must achieve CT3/ST3 competences in Paediatric EM. The RCEM's "preferred model comprises at least 6m experience in EM with a paediatric focus, plus some focused additional training in acute general paediatrics/neonates. At least 3m of this training should ideally be in a department recognised for paediatric EM sub-specialty training."</li> </ul>	<ul style="list-style-type: none"> <li>There must be adequate supervision of staff working in standalone units</li> <li>The ED must be of sufficient scale to justify a full rota of paediatric nurses.</li> </ul>
<b>Obstetrics</b>	<ul style="list-style-type: none"> <li>To maintain their competencies, obstetricians must have sufficient time scheduled for elective procedures.</li> <li>"The majority of consultants will be expected to contribute to delivery suite care and this must include subspecialists where relevant. However, ...to function [as] a gynaecological subspecialist, with</li> </ul>	<ul style="list-style-type: none"> <li>Trainees must achieve the RCOG curriculum competencies.</li> <li>"Training via the Advanced Training Skills Module (ATSM) route must deliver the consultant the service demands and must fulfil the requirements to cover emergency gynaecology and delivery suite as a minimum. The ATSMs must also provide the range of</li> </ul>	<ul style="list-style-type: none"> <li>The safe midwifery staffing guidance should be adhered to.<sup>37</sup></li> <li>"Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings."<sup>38</sup></li> </ul>

<sup>35</sup> The Royal College of Emergency Medicine. A trainee's guide to Specialty Training in Emergency Medicine (2015)

<sup>37</sup> NICE guideline. Safe midwifery staffing for maternity settings (2015)

<sup>38</sup> London quality standards. Quality and Safety Programme Maternity services (2015)

	<p>the restrictions of EWTD, delivery suite out-of-hours care will lead to such levels of compensatory rest that the primary clinical focus will be diminished considerably.”<sup>36</sup></p> <ul style="list-style-type: none"> <li>• If the consultant on call does not have competencies in acute gynaecology, a second consultant with these competencies must be rostered as a second on call.</li> <li>• “The on-call consultant should attend in person, whatever the level of the trainee, in a number of high-risk situations, including, for instance, eclampsia, maternal collapse, C-section for major placenta praevia, major postpartum haemorrhage and return to theatre for laparotomy.”</li> </ul>	<p>experience necessary to function as a consultant with a relevant specialist interest.”</p> <ul style="list-style-type: none"> <li>• “It is anticipated that trainees will undertake at least 2 ATSMs in ST 6&amp;7 but probably more.”</li> </ul>	
<b>Emergency surgery</b>	<ul style="list-style-type: none"> <li>• To maintain their competencies, surgeons must have sufficient time scheduled for elective procedures (this could be on an alternative site through a network arrangement).</li> <li>• “It is [RCS policy] that consultant surgeons should be free of elective commitments (NHS and private) during emergency on calls.”</li> </ul>	<ul style="list-style-type: none"> <li>• Trainees must achieve the RCS curriculum competencies.<sup>39</sup></li> <li>• “Separating emergency and elective services can help to achieve WTD 2009 compliance.”<sup>40</sup></li> <li>• Trainees must not work so many on call shifts that their elective training is compromised. The RCS recommends that “trainees at ST3–4 should, wherever possible, be precluded from working full shifts at night in order to consolidate their learning and maximise</li> </ul>	<ul style="list-style-type: none"> <li>• The safe staffing guidance for nursing in adult inpatient wards should be adhered to<sup>41</sup></li> </ul>

<sup>36</sup> The Royal College of Obstetricians and Gynaecologists. The Future Workforce in Obstetrics and Gynaecology (2009)

<sup>39</sup> Intercollegiate Surgical Curriculum Programme. <https://www.iscp.ac.uk/>

<sup>40</sup> The Royal College of Surgeons of England: Separating emergency and elective surgical care: recommendations for practice (2007)

<sup>41</sup> NICE guideline. Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)

		daytime training opportunities on the more complex elective cases.”	
<b>Paediatrics</b>	<ul style="list-style-type: none"> <li>To maintain their competencies, paediatricians with a craft specialty must have sufficient time scheduled for elective procedures. The current paediatric model supports this (the DGHs are staffed with general paediatricians with a specialist interest and the specialist paediatricians are based at SGH).</li> </ul>	<ul style="list-style-type: none"> <li>Trainees must achieve the RCPCH curriculum competencies.<sup>42</sup></li> <li>For many of the sub-specialties, this means that they must have sufficient time scheduled for elective procedures.</li> </ul>	<ul style="list-style-type: none"> <li>The RCN safe staffing guidance for children and young people’s services must be adhered to<sup>43</sup></li> </ul>
<b>Acute medicine</b>	<ul style="list-style-type: none"> <li>To maintain their competencies, physicians with a craft specialty must have sufficient time scheduled for elective procedures.</li> </ul>	<ul style="list-style-type: none"> <li>Trainees must achieve the RCP curriculum competencies.</li> <li>To maintain their competencies, trainees in a craft specialty must have sufficient time scheduled for elective procedures.</li> </ul>	<ul style="list-style-type: none"> <li>The safe staffing guidance for nursing in adult inpatient wards should be adhered to<sup>44</sup></li> </ul>
<b>Intensive care</b>	<ul style="list-style-type: none"> <li>To maintain their competencies, intensivists who are also anaesthetists must have sufficient time scheduled for elective anaesthesia.</li> <li>To maintain their competencies, dual-accredited intensivists must have sufficient time scheduled for elective activity relating to a dual accredited specialty.</li> </ul>	<ul style="list-style-type: none"> <li>Trainees must achieve the ICM curriculum competencies.<sup>45</sup></li> <li>“During the blocks of ICM training in both [core and enhanced training], the trainee’s duties [must] be exclusively dedicated to the practice of ICM throughout the hospital.”</li> <li>For Joint CCT Programmes, minimum durations of the ICM and other specialty components have been set</li> </ul>	<ul style="list-style-type: none"> <li>The BACCN guidance for nurse staffing in critical care should be adhered to<sup>46</sup></li> <li>“There are to be clearly defined nurse: patient ratios for each level of critical care, which as a minimum will be:</li> <li>Level 3 patients have 1:1 nursing ratios</li> <li>Level 2 patients have 1:2 nursing ratios”</li> </ul>

<sup>42</sup> The Royal College Paediatrics and Child Health. Curriculum for Paediatric Training (2010)

<sup>43</sup> Royal College of Nursing. Defining staffing levels for children and young people’s services (2013)

<sup>44</sup> NICE guideline. Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)

<sup>45</sup> The Intercollegiate Board for Training in Intensive Care Medicine. The Curriculum for CCT in Intensive Care Medicine

<sup>46</sup> British Association of Critical Care Nurses. Standards for Nurse Staffing in Critical Care (2009)

- “A minimum of 70% of nursing staff to have post-graduate qualification in intensive care equivalent to CC3N.”<sup>47</sup>

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<sup>47</sup> London quality standards: Quality and Safety Programme Critical care (2015)

# Clinical quality standards for acute services provided in South West London or operated by a South West London Trust: current position and gap analysis

November 2017



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# 1 Introduction

This document supports the evaluation of clinical sustainability of acute Trusts in South West London within a set of core acute services. It refers to the standards set out in '*Clinical quality standards for acute services provided in SW London or operated by a SW London Trust*' (henceforth 'the clinical standards'), and evaluates the current and likely future position of each Trust's consultant staffing levels against these standards. Section 2 describes the methodology used to assess staffing sustainability. Section 3 covers the current activity levels and consultant staffing levels within each of the six services (emergency department, acute medicine, paediatrics, emergency general surgery, obstetrics and intensive care). Section 4 then presents an analysis of the extent to which each Trust is currently able to meet the consultant staffing requirements set out in the standards, the gap (if any), along with the projected availability of new consultants in SWL between now and 2021.

We recognise that the acute standards set out here represent just one part of a wider clinical model for SW London. Moreover, consultant staffing is one element of staffing, alongside middle-grades, nursing, and other key health professionals. In addition, demographic change means increasing demand resulting from more complex health needs and this requires all health and care providers, including the voluntary sector and local communities, to work together in different ways.

***Please note that this document was compiled based upon discussions between Oct 2016 – October 2017 led by the Medical Directors of the 4 SWL-based Acute Trusts and data submissions sourced from the Acute Trusts and other NHS record keeping systems during this timeframe.***

## 2 Methodology

We gathered evidence around the activity levels and staffing levels for the six acute services, setting out the following questions for each service:

- What is the current activity level at each site, and what Royal College size category would the service fit into (where these size categorisations are available)?
- What is the current consultant staffing level at each site?
- Are acute sites in SW London / services operated by SW London Trusts able to meet relevant clinical standards given their current consultant workforce?
- To what extent might growth in the consultant workforce over the next five years support each site's ability to meet the relevant clinical standards?
  - Estimated from Health Education England ("HEE") data (using the number of trainee consultants projected to gain Certificate of Completion of Training ("CCT") in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions). We have also factored in the projected number of retirements (assuming a consultant retirement rate of 3.1% p.a. – see Appendix 1 for details).
  - Two methodologies have been used to estimate the likely proportion of the London consultant workforce who might be expected to work in South West London: the first is a proportion based on the population in SW London (16.4%), the second is based on the proportion of attendances/inpatient spells within the SW London trusts, relative to London as a whole (varies by specialty).



## 3 Current position

### 3.1 Current activity levels

The following table shows the activity levels, by Trust, for each core acute service, and the categorisation according to Royal College size categorisations (where these are available). This data is presented because unit activity determines the minimum consultant staffing requirement. The view of the Medical Directors is that it could also impact the availability of opportunities for consultants to maintain their skills, and on the number of trainees that a unit could support.

Acute service		St George's	Kingston	Croydon	Epsom <sup>1</sup>	St Helier	Source <sup>2</sup> / comments
<b>ED</b>	16/17 attendances	169,825	105,045	119,967	58,557	87,853	NHSE - Unify2 data collection – MsitAE <sup>3</sup> (figures include Type 1 & 3 data; Type 2 data is excluded)
	CEM category <sup>4</sup>	4	4	4	2	3	1: <50k p.a. 2: 50k-80k p.a. 3: 80k-100k p.a. 4: >100k p.a.
<b>Obstetrics</b>	15/16 births	5,153	5,670	3,833	1,927	2,891	NHS Digital – HES
	RCOG category <sup>5</sup>	Specialist Centre	C2	B	A	B	A: <2.5k p.a. B: 2.5k-4k p.a. C1: 4k-5k p.a. C2: 5k-6k p.a. C3: >6k p.a.

<sup>1</sup> For ED, obstetrics, acute medicine and paediatrics, the Epsom and St Helier figures are approximate – it is assumed that 40% of the ESUH activity takes place at Epsom and 60% takes place at St Helier.

<sup>2</sup> For obstetrics and intensive care, HES data was thought to be more accurate than SUS data. 15/16 data is quoted since 16/17 HES data has not yet been published.

<sup>3</sup> <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/08/Quarterly-time-series-2004-05-onwards-with-Annual-updated-06-05-2016-Q4-2016.xls>. Type 1 Departments – Major A&E; Type 2 Departments – Single Specialty (e.g. Ophthalmology); Type 3 Departments – Other A&E/Minor Injury Unit

<sup>4</sup> CEM, 2011. Emergency Medicine Operational Handbook: The Way Ahead. [https://www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead\\_Final%20Dec%202011.pdf](https://www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead_Final%20Dec%202011.pdf)

<sup>5</sup> RCOG, RCM, RCA, RCPCH, 2007. Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.

<https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf>

Acute service		St George's	Kingston	Croydon	Epsom	St Helier	Source/ comments
<b>Acute medicine</b>	16/17 non-elective admissions	16,244	14,909	20,334	13,505	17,165	Non-elective admissions under medical specialties for patients aged 18+
	RCP category <sup>6</sup>	3	2	3	2	3	RCP categories based on estimated number of spells / 24h 1: <25 2: 25-44 3: 45-60 4: >60
<b>Emergency general surgery</b>	16/17 non-elective admissions	3,922	2,489	3,655	98	2,211	Non-elective admissions under selected surgical specialties for patients aged 18+ (includes: general, colorectal, breast, upper gastrointestinal and vascular surgery)
<b>Paediatrics</b>	16/17 non-elective admissions, excluding PAU	5,425	3,727	6,176	2,126	2,435	Non-elective admissions for patients aged 0-17, excluding Paediatric Assessment Unit admissions
	16/17 non-elective admissions, including PAU	9,315	6,841	6,176	2,126	2,684	Non-elective admissions for patients aged 0-17, including Paediatric Assessment Unit admissions
	RCPCH category <sup>7</sup>	L	L	L	S	S	S: <2.5k p.a. L: >=2.5k- p.a.
<b>Intensive care</b>	16/17 critical care days Level 3	16,513	1,742	2,816	90 <sup>8</sup>	2,530	
	Levels 1 - 2	6,627	1,561	2,454	4,053	1,682	

<sup>6</sup> RCP, 2012. Delivering a 12-hour, 7-day consultant presence on the AMU. <https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit>

<sup>7</sup> RCPCH, 2013. Back to Facing the Future. <http://www.rcpch.ac.uk/sites/default/files/page/Back%20to%20Facing%20the%20Future%20FINAL.pdf>

<sup>8</sup> Epsom ICU activity includes SWLEOC (South West London Elective Orthopaedic Centre) for both Levels 2 and 3

### 3.2 Current consultant staffing levels

The following data was obtained directly from each Trust.

Acute service		St George's	Kingston	Croydon	Epsom and St Helier
<b>ED</b>	Current consultant WTE	26.8	10.25	10	14
<b>Obstetrics</b>	Current consultant headcount (consultants with the competencies to cover acute obstetrics on calls <sup>9</sup> )	19	16	12	26
<b>Emergency general surgery</b>	Current consultant headcount (consultants who contribute to the emergency general surgery rota)	9	9	10.1	10
<b>Paediatrics</b>	Current consultant headcount (consultants with the competencies to cover acute paediatrics on calls; for SGH, acute general paediatricians only)	9	14	12	26 <sup>10</sup>
<b>Acute medicine</b>	Current consultant headcount – dedicated acute care physicians	9	9	8	11
	Current consultant headcount – total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians <sup>11</sup> )	17	21	25	30
<b>Intensive care</b>	Current consultant headcount (consultants who contribute to the critical care rota(s))	24	8	8	7

<sup>9</sup> Note that gynaecology work may also be a significant part of some of these consultants' job plans.

<sup>10</sup> This includes 8WTE acute paediatric consultants who manage the paediatric ED service on both sites

<sup>11</sup> Given the complexity of the acute medical rota, we have included the figures for dedicated acute care physicians and for the total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians). The requirement is met by a combination of dedicated acute care physicians and non-acute care physicians.

## 4 The consultant workforce - ability to meet the clinical standards now and by 2021

The following analyses are *not* adjusted for changes to activity between now and 2021. Local Transformation Boards (LTBs) are currently modelling future activity projections. Following this work, each LTB will need to re-confirm their expectations and plans to meet the agreed quality standards. This will depend upon local variations in the difficulty of recruiting, and local recruitment plans, as well as the national shortage of consultants in certain specialties.

### 4.1 Ability to meet ED standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant WTE</b>	24	12-16	12-16	24 (12 for each site)	72-80
<b>Current consultant WTE</b>	26.8	10.25	10	14	61.25
<b>Current WTE gap</b>	No gap	1.75 – 5.75	2-6	10	13.75-21.75
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					7.3
<b>Projected WTE gap in SWL in 2021 assuming no new consultants are hired</b>					21.05 – 29.05
<b>Total projected availability of new consultants in SWL between now and 2021 (to cover <u>all</u> new ED posts in SWL)<sup>12</sup></b>					18-21

The range presented in the clinical standards (12-16) reflects the fact that consultant staffing in busy emergency departments<sup>13</sup> is dependent upon the robustness of middle-grade staffing levels (i.e. lower levels of consultant staffing would require a strong middle-grade presence).

<sup>12</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions. The banding reflects two methodologies to calculate the proportion of London consultants likely to work within the SW London Trusts (one according to the SW London patient population; the other based on the proportional attendances by specialty within SW London, relative to London as a whole)

<sup>13</sup> Defined in the clinical standards as having activity levels exceeding 100,000 attendances per annum

The WTE calculation above was extrapolated using the number of PAs in the job plan of the ED consultants at each Trust. The analysis suggests that both Croydon and Kingston are facing gaps in their ED staffing, which the Trusts are currently managing; however this challenge is exacerbated by difficulties with middle-grade staffing. Although St George's has no consultant-level gap, the ED is currently short of 7 middle-grades, a substantial challenge for the Trust. Epsom & St Helier has a gap of 10 consultants which is being managed through a continued, dedicated recruitment and retention programme, supported by a CESR training programme.

When considering the combination of retirements and anticipated future availability of consultants within south-west London, the maximum likely availability of new consultants matches the minimum anticipated requirement for consultants, suggesting that ED consultant availability will present a challenge for the region into the future. The challenge will be particularly felt by Epsom & St Helier, given the size of its gap. For the region, this suggests that focused efforts on managing middle-grade recruitment will be key to a sustainable ED position.

## 4.2 Ability to meet obstetrics standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant headcount</b>	21 (specialist centre)	16 (category C2)	12 (category B)	22 (Epsom – category A, St Helier – category B)	71
<b>Current consultant headcount (consultants with the competencies to cover acute obstetrics on calls<sup>14</sup>)</b>	19	16	12	26	73
<b>Current headcount gap</b>	2	No gap	No gap	No gap	2
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					9.0
<b>Projected headcount gap in SWL in 2021 assuming no new consultants are hired</b>					11.0

<sup>14</sup> Note that gynaecology work may also be a significant part of some of these consultants' job plans.

<b>Total expected availability of new consultants in SWL between now and 2021 (to cover all new obstetrics and gynaecology posts in SWL)<sup>15</sup></b>		<b>41-44</b>
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Obstetrics in South West London appears to be sustainable, currently as well as in the future. It is important to note that the apparent surplus of obstetricians, relative to clinical standards, does not mean the service is over-staffed, since obstetricians also cover gynaecology as well as some elective and outpatient services. There is also a shortage of middle grade doctors, particularly at Epsom & St Helier, and hence a requirement for additional consultants to cover this shortage. Importantly, the availability of new consultants covers both obstetrics and gynaecology.

### 4.3 Ability to meet emergency general surgery standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant headcount</b>	10	10	10	10	39
<b>Current consultant headcount (consultants who contribute to the emergency surgery rota)</b>	9	9	10.1	10	38.1
<b>Current headcount gap</b>	1	1	No gap	No gap	2
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					4.5
<b>Projected headcount gap in SWL in 2021 assuming no new consultants are hired</b>					6.5
<b>Total expected availability of new consultants in SWL between now and 2021 (to cover all new general surgery posts in SWL)<sup>16</sup></b>					15-16

The gap in emergency general surgery is minimal across all sites, and it appears to be a sustainable service currently and going into the future. St George's faces a gap of 1 consultant. Kingston, although

<sup>15</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions

<sup>16</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions

appearing to have a gap of 1, employs a staffing model which completely splits elective and emergency care. As a result, the service operates effectively with 9 consultants.

#### 4.4 Ability to meet paediatrics standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant headcount<sup>17</sup></b>	10 <sup>18</sup>	16	12-16	24 (12 at each site, as activity levels are lower)	66
<b>Current consultant headcount (consultants with the competencies to cover acute paediatrics on calls)</b>	9	14	12	26 <sup>19</sup>	53
<b>Current headcount gap</b>	1	2	0-4	No gap	3-7
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					9.2
<b>Projected headcount gap in SWL in 2021 assuming no new consultants are hired</b>					12.2-16.2
<b>Total expected availability of new consultants in SWL between now and 2021 (to cover <u>all</u> new paediatrics posts in SWL, including specialist paediatrics posts)<sup>20</sup></b>					45-46
<b>Total expected availability of new general paediatric consultants in SWL between now and 2021<sup>21</sup></b>					30-31

The sustainability of consultant staffing in paediatrics is complicated at the non-tertiary centres by the fact that these consultants also support the neonatal rota. Both St George's and Kingston face small but manageable gaps in paediatrics. Croydon's high activity figures for non-elective admissions reflect local health needs and the fact that they do not currently have a PAU. Its level of neonatal

<sup>17</sup> The required headcount is based on non-elective inpatient paediatric activity *excluding Paediatric Assessment Unit (PAU) activity*, which was agreed by Medical Directors to be more directly related to staffing requirements

<sup>18</sup> For large hospitals where rotas for general paediatrics are entirely separate from specialist paediatrics (including NICU), the requirement is 10.0 WTEs

<sup>19</sup> This includes 8WTE acute paediatric consultants who manage the paediatric ED service on both sites

<sup>20</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions

<sup>21</sup> Based on an expected 70% of the total number of paediatric consultants

activity is also lower than the equivalent figure at Kingston. Current staffing levels are interpreted in the context of the development of a PAU and optimised out of hospital programmes. Longer term review of staffing with respect to activity levels will be maintained.

## 4.5 Ability to meet acute medicine standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant headcount</b>	12	12	12	24 (on two sites)	60
<b>Total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians)<sup>22</sup></b>	17	21	25	30	93
<b>Current consultant headcount – dedicated acute care physicians</b>	9	9	8	11	37
<b>Current headcount gap if only acute care physicians are taken into account</b>	3	3	4	13	23
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					6
<b>Projected headcount gap in SWL in 2021 assuming no new consultants are hired</b>					29
<b>Total anticipated availability of new consultants in SWL between now and 2021 (acute care physicians only)<sup>23</sup></b>					9

Acute medicine is a significant challenge across South West London. Staffing the acute medical rota is not a problem, given that the acute care physicians are supported by large numbers of non-acute care physicians (the “ologists”). A much bigger challenge, however, is the provision of high quality care to the acute medical wards, where the small numbers of acute care physicians is exacerbated by the shortage of middle grade doctors. This will become more challenging as the service moves to

<sup>22</sup> Given the complexity of the acute medical rota, we have included the figures for dedicated acute care physicians and for the total number of consultants who contribute to the acute medical rota (includes acute care physicians and non-acute care physicians). The requirement is met by a combination of dedicated acute care physicians and non-acute care physicians.

<sup>23</sup> An estimated net growth rate of 2% p.a. was agreed by the Medical Directors. It was not practicable to use HEE data for acute medicine due to the range of specialty training programmes that equip doctors with the competencies to cover the acute medical rota.



fully deliver a 7 day model of care. The problem is most pressing at Epsom & St Helier, which has the fewest number of dedicated acute care physicians per acute inpatient site.

#### 4.6 Ability to meet intensive care standards

	St George's	Kingston	Croydon	Epsom and St Helier	Sum
<b>Required consultant headcount</b>	27 (for three units – general, neuro & cardiothoracic)	9	9	9 (for HDU at Epsom and ICU at St Helier) <sup>24</sup>	63
<b>Current consultant headcount (consultants who contribute to the critical care rota(s))</b>	24	8	8	7	45
<b>Current headcount gap</b>	3	1	1	2	7
<b>Expected retirements in SWL between now and 2021 (assumes a consultant retirement rate of 3.1% p.a. – see appendix 1)</b>					5.6
<b>Projected headcount gap in SWL in 2021 assuming no new consultants are hired</b>					12.6
<b>Total expected availability of new consultants in SWL between now and 2021 (to cover <u>all</u> new ICU posts in SWL)<sup>25</sup></b>					9

For St. George's, Kingston and Croydon, the gap in ICU does not pose a substantial challenge and is being managed by the specialties. Epsom and St. Helier currently operates a service whereby Level 1/2 critical care is provided within Epsom's HDU, and Level 3 patients are stabilised overnight and transferred to St. Helier, which has a Level 3 ICU. As such, the staffing requirement at Epsom is managed by staff from St Helier and visiting staff from the other three acute Trusts who contribute to the staffing for SWELEOC. The gap, therefore, is manageable within the context of the lesser requirement of the site and plans to appoint a further two consultants at St Helier.

<sup>24</sup> Epsom Hospital has an adult critical care facility that has the ability to treat and stabilise level 3 patients overnight. There is an expectation that such patients will either step down or be transferred to the intensive care unit at St Helier if they require ongoing level 3 care. In addition, there is a PACU, staffed 24/7 by consultant intensivists, on the Epsom site (within SWELEOC).

<sup>25</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions

The small number of consultants projected to come through the training programme should also be noted and may mean that Trusts will need to look further afield to recruit additional consultants.

## 4.7 Summary table

Acute service	Current consultant WTE / headcount gap <sup>26</sup>					Projected WTE / headcount gap in SWL in 2021 assuming no new consultants are hired <sup>27</sup>	Projected availability of new consultants in SWL between now and 2021 <sup>28</sup>
	St George's	Kingston	Croydon	Epsom and St Helier	Sum		
<b>ED</b>	No gap	1.75 – 5.75	2-6	10	13.75-21.75	21.05 – 29.05	18-21
<b>Obstetrics</b>	2	No gap	No gap	No gap	2	11.0	41-44
<b>Emergency surgery</b>	1	1	No gap	No gap	2	6.5	15-16
<b>Paediatrics</b>	1	2	0-4	No gap	3-7	12.2-16.2	30-31
<b>Acute medicine (<i>if only acute care physicians are taken into account</i>)</b>	3	3	4	13	23	29	9
<b>Acute medicine (all consultants who contribute to acute medicine rota)</b>	No gap	No gap	No gap	No gap	0	N/A	N/A
<b>Intensive care</b>	3	1	1	2 <sup>29</sup>	7	12.6	9

<sup>26</sup> ED figures are WTE (as ED doctors seldom work in areas outside of emergency medicine, Medical Directors felt that WTE was the most appropriate measure of availability). The figures for all the other acute services are headcount

<sup>27</sup> Assumes a consultant retirement rate of 3.1% p.a. – see appendix 1 for details. Note: we have modelled various consultant retirement rate scenarios, ranging from 2% p.a. to 6% p.a. In the best-case scenario (rate of 2%), the projected WTE / headcount gap in SWL in 2021, assuming no new consultants are hired, is still greater than the projected availability of new consultants in SWL between now and 2021

<sup>28</sup> Calculated from HEE data on the number of trainees projected to gain CCT in London between 2017-2021, adjusted for i) expected attrition during training, and ii) migration into and out of London following CCT for consultant positions

<sup>29</sup> See footnote 29 on page 14

## 5 Conclusion

This document has provided an assessment of current consultant staffing against the clinical standards for the agreed six core acute services described in '*Clinical quality standards for acute services provided in SW London or operated by a SW London Trust*'. It should be noted that this assessment is part of a wider evaluation of overall clinical sustainability. Consultant staffing is one component of overall staffing for these services, which includes middle-grades, nurses and other health professionals. These six core services are also a subset of services provided on each site and further work will need to be undertaken to assess the sustainability of this wider set of services.

The assessment suggests that, with the exception of Epsom & St Helier, acute Trusts in SW London are broadly clinically sustainable in the six core services with respect to consultant staffing. It is also unlikely that future activity projections will change that broad conclusion. There are existing gaps in a number of the six core services, but they are relatively small and are being managed by the Trusts through a dedicated commitment to ongoing recruitment and retention efforts, and supported through the use of locum staffing. Medical Directors of these Trusts have confirmed, with their Boards, that they believe they can recruit the necessary additional consultants and are therefore clinically sustainable in the six core acute services.

The most challenging service is probably acute medicine, where the move to fully deliver a 7 day model of care will be particularly challenging in respect of medical cover for the acute medical wards. There is a national shortage of dedicated acute care physicians and this is exacerbated by a shortage of middle grade doctors. Equally, additional consultants are required to ensure that both emergency department services and intensive care services are able to comply with the agreed standards.

As far as Epsom & St Helier is concerned, it has already centralised all of emergency general surgery and Level 3 intensive care on one site. In addition, the figures presented in this document demonstrate that, as currently configured, it meets the standards for obstetrics and paediatrics. However, the figures also demonstrate that it does not meet the standards for its ED services and faces particular pressures in acute medicine.

For ED, Epsom & St Helier currently has a gap of 10 consultants between its current staffing and the agreed quality standards, which represents between 46% and 73% of the total gap for SW London. For acute medicine, Epsom & St Helier has a gap of 13 consultants between its current staffing and the agreed quality standards (if only acute care physicians are taken into account), which represents 57% of the total gap for SW London.

The size of these two gaps for Epsom & St Helier is considerable and the challenges for Epsom & St Helier will increase as the move to fully deliver a 7 day service model intensifies. The projected shortage in the availability of new consultants for SW London as a whole for these two services is also an important factor. Therefore, in the longer term, it is unlikely that Epsom and St Helier will be able to deliver all of these acute inpatient services without a level of change to their clinical model.

## Appendix 1: Retirement rate model

Table 1. Input data – consultant age profile data from NHS Employers

Age	% of consultant population (raw)	% of consultant population (cleaned)
<34	2%	2.0%
35 - 44	37%	36.6%
45 - 54	40%	39.6%
55 - 64	19%	18.8%
65+	3%	3.0%
<b>Total</b>	<b>101%</b>	<b>100%</b>

Table 2. Assumptions

Assumptions	
Proportion of aged 55 - 64 who are 55 - 59	66.67%
Annual retirement rate: age <34	0%
Annual retirement rate: age 35 - 44	0%
Annual retirement rate: age 45 - 54	0%
Annual retirement rate: age 55-59	10%
Annual retirement rate: age 60-64	20%
Annual retirement rate: age 65+	20%

Table 3. Mini model

Age	% of consultant population	Annual retirement rate	Annual % of total consultant body retiring
<34	2.0%	0%	0.0%
35 - 44	36.6%	0%	0.0%
45 - 54	39.6%	0%	0.0%
55 - 59	12.5%	10%	1.3%
60 - 64	6.3%	20%	1.3%
65+	3.0%	20%	0.6%
<b>Total</b>	<b>100.0%</b>	<b>N/A</b>	<b>3.1%</b>

# **Public engagement on the South West London Sustainability and Transformation Plan**

By work stream theme

05 September 2017





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## 1. Executive Summary

The NHS in south west London, working with local councils, is in the process of developing a long-term plan for local health services, called the Five Year Forward Plan, or a Sustainability and Transformation Plan (STP). This work is being carried out by six local Clinical Commissioning Groups (CCGs), local authorities, four hospitals trusts, clinicians, community health services and mental health trusts and patients and members of the public. The six south west London boroughs are Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

Since March 2016, the NHS has been undertaking a grassroots outreach engagement programme, funded by NHS England, to reach out to seldom heard communities. The NHS provided funding to local grassroots organisations to run events that were enjoyable to their populations, and then attended to listen to views on local health issues. The funding was allocated via local healthwatch organisations that promoted the opportunity, evaluated the bids and administered the funding. In addition, OPM Group was commissioned to design, facilitate and report on six open access health and care forums, one in each of the six south west London Boroughs.

This report provides a summary of the feedback from the all this engagement activity, organised by work stream theme. It has been independently compiled by OPM Group.

### 1.1. Overarching themes

Overall, **people were supportive of the proposals and the direction of travel** indicated in the draft plan. This meant they wanted to know the practical details of the proposals which would help them understand how these changes would be achieved and what it would mean from a patient perspective. They shared ideas, concerns and questions which the NHS in south west London can use to shape implementation plans.

Several common issues emerged in the discussions about the different work streams:

- Concerns about a perceived lack of funding and resources to invest in service changes, particularly in the light of local services already being changed or cut.
- Capacity concerns for local NHS services, as people believed community services, local NHS hospitals and GPs would not be able to cope with potential changes in demand caused by some of the proposals. People also noted the current difficulty in accessing GP appointments.
- Improving and increasing signposting to services to make the public aware of services in the area, as well as educating people about health care choices.
- Concerns over quality of services and of equality in accessing these services.
- Difficulty in changing behaviour of the public and staff which would be required to successfully deliver the proposals.
- The need to improve staff communication skills so that patients and carers are treated with empathy and respect, especially those with complex or additional needs.



- The need for more joined up IT systems to aid communication between services and avoid patients having to repeat themselves.

## 1.2. Seven day acute services and urgent & emergency care

Overall, there were mixed views about the **ability to implement and deliver the quality of healthcare** service desired, and there was concern from people regarding the **capacity of the services** under the proposed seven day acute services plan. While people agreed with the aim to **reduce the number of patients using A&E**, there were concerns about what alternatives would be available, particularly as some potential alternatives are also closing. There was **low awareness of NHS 111**, and those who were familiar with it were **not confident it would reduce demand** on A&E. In discussing alternative services, several events discussed how **limited access to GPs** puts strain on acute services.

**Transportation needs** and geographical implications of new service proposals were raised as considerations for the implementation of the STP.

Some felt existing urgent and emergency care and acute **services need to be improved** to ensure they are inclusive and meet the needs of diverse users and provide **person-centred care**, and **waiting times are reduced**. There were concerns about **mental health crisis care**, and lack of mental health awareness in A&E.

A critical success factor identified in carrying out the changes identified was the ability of the NHS to communicate and signpost to the services available to patients

## 1.3. More care closer to home

Overall, while the idea of having more care closer to home was supported, there were concerns that the local NHS did not have the **capacity and resources** to manage the change towards a more local care model. In order for the plans to be effective, people believed significant **training and development** would be needed **for pharmacists** to be able to deliver appropriate healthcare, especially for vulnerable people, and that investment would be needed to improve pharmacist facilities.

There were mixed responses regarding the impact of this plan on quality, as people felt it may reduce waiting times, but there were **concerns about information sharing and workload management** which, if not addressed, could diminish quality.

Detailed feedback was provided on **primary care services**, relating to **concerns about appointment availability, accessibility, referrals, and holistic and person-centred care**. In addition, several specific areas of **feedback relating to variable out of hospital care** were provided for consideration and improvement.

The introduction of **new roles** such as care navigators were positively received but many wanted more detail about how these teams would support local patient care in practice. Finally, **awareness of appropriate services** is low and people suggested additional communication from the NHS to

both professionals and directly to the public would help ensure patients used the available local options.

## 1.4. Prevention and early intervention

Overall, people **supported the inclusion of prevention approaches** in the STP, and a desire for **more personalised and holistic care**. However, there were concerns about whether the STP would be able to **change people's behaviours**. There were also concerns over the introduction of prevention services that may lead to **privatisation or service cuts** in other areas that would compromise care.

Some people had questions regarding the **role of different community groups** and how the **resources would be managed to ensure high quality care**. In addition, more **detailed information was requested regarding locality teams**, their role in healthcare and how these would operate in practice.

People emphasised that **communication is key to ensuring change in behaviour** for prevention, and people agreed the NHS must improve its outreach for this to be successful.

Finally, while **some people supported the use of technology to monitor health**, they did not see it as a universal tool and wanted more information about which contexts it would be used in.

## 1.5. Mental health services

Overall, there was **low confidence in current mental health services** due to perceptions of poor quality, closures, long waiting times, underfunding and inability to cope. Therefore, there were concerns that the STP will not be successful in this area.

People supported a **holistic approach, incorporating physical conditions** and coordinating with multiple organisations, but questioned how this would work in practice. It was felt that significant investment in training and **additional skills would be needed for GPs** and others to deliver higher quality mental health services and reduce stigma. People also wanted more information about where proposed mental health treatment would take place. They emphasised **the need for high quality out of hospital mental health care**, and more support in transitions into the community.

An **inclusive approach** to mental health was desired with the needs of marginalised and vulnerable groups, such as children, LGBT and ethnic minorities highlighted as an important consideration for the STP.

People want more mental health awareness and **education in schools**, as well more integration with mental health services and schools to support children and families. Finally, it was felt that the NHS should **improve its communication about available services** for mental health, as well as signposting people to care in more informal settings such as drop-in cafes.

## 1.6. Learning disabilities

People were concerned about **long waiting times** to see a GP and requested that GP **appointments for people with learning disabilities should be longer** to allow more time to explain information

clearly. It was strongly felt that **staff need to communicate more clearly** with those with learning disabilities, and involve them in their care (not just their carers). People also emphasised that more **support for carers** is needed.

People also highlighted a **need for improved accessibility** for those with disabilities (physical access and accessible communications). Finally, it was noted that there should be **more awareness of annual health checks** for children with learning disabilities, including reminders from the GP surgery.

## 1.7. Children's services

Overall, while people **agreed with the principle of reducing unnecessary A&E visits from children and parents**, they felt it would be challenging in practice. People believed that to reduce the burden on acute services, **more flexible GP services are needed**.

It was strongly felt that the STP should **address children's diverse health needs**, including giving support for mental health services and families with different cultural backgrounds. In particular, people emphasised the **need for improved standards of care for children and young people with a learning disability, a long-term condition, or autism**. It was suggested that **doctors should involve children more actively** in discussing their symptoms, conditions and treatments.

People believe **increased awareness is needed about what services are available for children's health** as well as when it is appropriate to use each service. There was also a desire for more education and information to support **healthy lifestyles** for children and families.

## 1.8. Maternity services

Overall, when discussing maternity services, people discussed the **lack of access to quality care due to midwifery staff shortages** which needed to be addressed. **Continuity and consistency** of maternity care were believed to be areas for improvement with specific issues due to the shortage of midwives. Many people would like to see **increased personalisation and patient-led approaches to care**, however emphasise the importance of **prioritising patient safety**.

**Post-natal care was highlighted as a service that required improvement** and people would like to see this addressed in the STP.

**Communication and attitudes of staff** involved in maternity care was seen as variable and in need of improvement in order to adequately support women giving birth and their families. Finally, people suggested communications and outreach should be carried out to **raise awareness of services** and cater to differing and diverse needs in the community.

## 1.9. Cancer

People discussed cancer care at all stages, from screening and prevention, through to supporting patients to live with and after cancer.

People felt more work could be done to **increase uptake of screening**, and to increase preventative care and guidance to those at higher risk of cancer. People emphasised the need for **early diagnosis**

and suggested GPs could receive additional training from hospital specialists. Furthermore, it was noted that delivering news of a diagnosis should be delivered with **empathy and sensitivity**.

People suggested additional **follow up support** could be provided after diagnosis and after treatment, both by NHS staff and through **signposting to support in the community**. Additional support could also be provided to help patients deal with **side effects and long term damage** caused by cancer treatments.

Finally, there was a desire for **NHS SWL to set the 'gold standard' for cancer** diagnosis, treatment and care, including being proactively involved in trials and new treatments.

### 1.10. Planned care

In relation to planned care, people felt **specialist hospitals or elective centres could produce better outcomes** but there were concerns about the feasibility of plans and whether they would lead to necessary cost savings. Concerns were raised about **whether there are sufficient staff** to deliver planned care effectively and efficiently, and some thought current staff are overworked and overstretched which impacts on patients. People noted that they were more **prepared to travel for non-urgent elective care**, but highlighted that ensuring **appropriate transportation will be important**.

It was felt that there is scope for current practices around **discharge and aftercare to be improved**, while a proposal that reduces the wasted time as a result of **cancellations of operations and outpatient appointments** would also be welcomed. Finally, people felt there should be **improved internal and external communication between services**, including GPs, hospitals and social care providers.

## 2. Introduction

### 2.1 Background

#### *Why is a forward plan being developed?*

The NHS in south west London, working with local councils, is in the process of developing a long-term plan for local health services, called the Five Year Forward Plan, or a Sustainability and Transformation Plan (STP)<sup>1</sup>. The draft plan is available [here](#).

This work is being carried out by six local Clinical Commissioning Groups (CCGs), local authorities, four hospitals trusts, clinicians, community health services and mental health trusts and patients and members of the public. It covers all aspects of local health services including hospitals, primary care, mental health and community services.

The local NHS has identified four key challenges – money, workforce, estates and consistent quality of care – which the Five Year Forward Plan will aim to address by setting out plans to:

- use money and staff differently to build services around the needs of patients
- invest in more services in local communities to improve outcomes for patients, including preventative care
- invest in estates (buildings) to make them fit for purpose
- try to bring all services up to the standard of the best.

#### *What has been done so far?*

An outline strategy was published in June 2014, setting out a plan for the local NHS and detailing the standards of care that people in south west London should expect.

An [issues paper](#) was published in June 2015 setting out the challenges for local services and initial ideas about how to tackle them. In September 2015, The NHS commissioned a series of deliberative events to gain the views of members of the public and local stakeholders on the Issues Paper (the events were delivered by OPM Group; see the report [here](#)).

Since March 2016, the NHS has been undertaking a grassroots outreach engagement programme, funded by NHS England, to reach out to seldom heard communities. The NHS provided funding to local grassroots organisations to run enjoyable events for their populations, to listen to views on local health issues. The funding was allocated via local healthwatch organisations that promoted the opportunity, evaluated the bids and administered the funding. In



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<sup>1</sup> All NHS regions are required to develop a Sustainability and Transformation Plan (STP).

addition, OPM Group was commissioned to design, facilitate and report on six open access health and care forums, one in each of the six south west London Boroughs.

## 2.2 Methodology

### 2.2.1 Health and care forums

People for the health and care forums were recruited by NHS South West London. They were invited to attend events via:

- emails to those who had attended previous events
- engagement with local community and voluntary groups and local Healthwatch groups
- advertising via local press, radio and social media.

Each event had capacity for up to 100 participants.

The six events were held in the evenings and lasted 3 hours (6-9pm). The format of the events encouraged an in-depth dialogue with people about the key issues and questions raised in the draft Five Year Forward Plan. People had the opportunity to join two rounds of table discussions, with each round including at least 6 tables, each table focusing on one of 6 topics. Most events had 6 tables for each round of discussion, but for some rounds there were fewer tables (if no people chose a particular topic), and for others there were two tables for the more popular topics (so that people could focus on the topic of their choice).

Each event was independently run by OPM Group's facilitation team, made up of one lead facilitator and table facilitators to manage the table discussions.

NHS representatives (including CCG Chief Officers and Chairs, hospital medical directors and chief executives and other NHS staff) attended the events, to set the scene, present the draft Five Year Forward Plan and answer questions from participants. At each event, the local NHS representatives:

- Provided background information on the Five Year Forward Plan, explaining what it is
- Outlined the challenges facing healthcare in south west London
- Described how the Five Year Forward Plan is proposing to address these challenges

This information formed the basis for the table discussions amongst participants, to elicit their responses to and concerns around the Plan.

### 2.2.2 Grassroots engagement activities

The aim of the grassroots engagement activities was to develop meaningful conversations with seldom heard communities. NHS South West London recognised that these communities would differ across boroughs, however, in general they focused on those people from groups with protected characteristics, as defined by the Equality Act (2010). They also enabled local Healthwatch organisations to suggest other local communities that were harder to reach in each borough.

To successfully deliver this programme, NHS South West London worked collaboratively with local Healthwatch organisations and grassroots groups. Each Healthwatch organisation was invited to manage a pot of funding that local grassroots groups could apply for to run events/activities enjoyable to their population. Each Healthwatch was able to set their own application guidelines with a request that groups applying for the funding should be from seldom heard groups and there would be an opportunity at each event for NHS staff to attend and speak with individuals.

Healthwatch organisations used their connections and communication channels to promote this opportunity to local groups, particularly those groups with protected characteristics/seldom heard voices. They advertised the opportunity through their websites and via social media. Some Healthwatches used a more targeted approach by making direct contact with those organisations that they thought would benefit from the funding. Each organisation was able to apply for the funding and Healthwatch would check the application and then let the organisation know if they were successful in receiving the funding.

Once this process was completed, the information was passed onto the programme team for contact to be made with the local organisation; congratulating them on being successful in the application process. Arrangements were then made for attendance at the event, including discussions around what the most appropriate way to speak to people on the day.

At each session, the programme team, local CCG and Healthwatch were invited to attend. Where sessions had a specific focus towards a work stream, the assistant directors, or other work stream people, were also invited to attend or send questions that would be relevant for the engagement team to ask – this helped to ensure that the conversations were relevant to local priorities within each area of the STP.

The programme and local CCG attended each session and spoke to attendees about their experience of local services. During the events, the engagement team had a dedicated slot/opportunity to discuss local health issues and to listen to the views of those participating. This was through a variety of mechanisms such as one-to-one conversations, focus groups or group discussions. The questions asked at each session were tailored to the audience.

## 2.3 Participants

The table below summarises the number of people who attended each of the events and engagement activities across the six London Boroughs.

Borough	Date	Number of participants
<b>Croydon health and care forum</b>	7 <sup>th</sup> February, 2017	33
<b>Croydon grassroots engagement events</b>	May – November 2016	11 events speaking to over 222 people
<b>Merton health and care forum</b>	29 <sup>th</sup> June, 2017	33

<b>Wandsworth health and care forum</b>	14 <sup>th</sup> March, 2017	44
<b>Merton grassroots engagement activities</b>	May – December 2016	10 events speaking to over 250 people
<b>Wandsworth grassroots engagement activities</b>	June 2016 – Feb 2017	10 events speaking to over 200 people
<b>Kingston health and care forum</b>	8 <sup>th</sup> February 2017	35
<b>Richmond health and care forum</b>	2 <sup>nd</sup> March 2017	55
<b>Kingston grassroots engagement activities</b>	March 2016 – March 2017	15 events speaking to over 302 people
<b>Richmond grassroots engagement activities</b>	June 2016 – March 2017	18 events speaking to over 378 people
<b>Sutton health and care forum</b>	1 <sup>st</sup> February, 2017	30
<b>Sutton grassroots engagement activities</b>	July – December 2016	13 events speaking to over 284 people

## 2.4 About the report

This report provides a summary of the feedback from the six health and care forums and the grassroots engagement activities, capturing the key themes discussed by the people in the following sections:

- Key overarching themes emerging across the events and activities
- A summary of the discussions around each of nine topics

A separate report has been produced organising the information by each of the four main geographical areas (each overseen by a Local Transformation Board). These four areas are: Croydon, Kingston & Richmond; Merton & Wandsworth; and Sutton.

The local NHS will use the feedback from these events to further inform the development and implementation of the Five Year Forward Plan, working with their local authorities and local people.



## 3. Overarching themes

Overall, people were broadly supportive of the ideas presented to them. They broadly endorsed the direction of travel if it was achievable. However, a number of common issues emerged in the discussions about the different work streams which largely related to the feasibility of implementing the plans. The following is a summary of these overarching themes.

### 3.1 Funding and finance

Many of the conversations at the six health and care forums were underpinned by concerns about the scarcity of funding and whether the plans would be affordable. While many of the ambitions in the forward plan resonated, most believed that in reality these would not be achieved without a significant increase in spending, which they did not believe would be possible. Some were worried that funding pressures may lead to privatisation of services.

At the grassroots engagement activities, this topic featured less prominently, however there were several questions about how changes and improvements would be funded and worries that money would be wasted on unnecessary changes.

### 3.2 Capacity of services

Many people at the six health and care forums, and the grassroots engagement activities, raised concerns that the current strain on services would mean that the NHS would be unable to deliver the proposed changes in the plan. It was observed that the current local services did not have the capacity to take on additional work in order to reduce the burden on acute services. While the integration of community and voluntary sector was generally welcome, there were questions as to how this would be managed to ensure quality care. The perceptions of current poor quality of, and limited access to, mental health services gave low confidence in the STP proposal for managing mental health. Perceived severe staff shortages also give cause for concern, especially for GP access, midwife services, and in-hospital care. In addition, people thought that training and new skills would be needed for the delivery of local care services including pharmacist training and mental health training for GPs.

### 3.3 Access to GPs

As noted in concerns over capacity, limited access to GPs was a common theme across the six health and care forums, and the grassroots engagement activities. Many people believe that they will not be able to reduce the number of A&E visits or acute services strain without adequate access to GPs. Currently, people discussed how they struggle to get an appointment with their GP and the lack of flexible access. They believed enhanced GP access could reduce A&E visits with children as they thought parents require flexible access to health services.

### 3.4 Education and awareness of services

Improved and more signposting to services was often suggested to ensure patients can access the most appropriate care. Many people suggested that current communication from the NHS was lacking, and did not adequately inform the public of local services available to them. There were several suggestions that GPs and other professionals should be more aware of local services that they can direct patients to. Raising awareness through more informal settings and schools were suggested as important tools for children's services and mental health.

### 3.5 Quality

The impact on quality of services and care was a key concern for many participants. Overall, there were mixed feelings about what the impact on quality might be, as some changes would improve access and quality of treatments. However, several raised concerns about how reductions in acute care, moving care more locally and increasing prevention services could negatively impact quality as resources were spread more thinly.

### 3.6 Changing behaviour

Changing behaviour was necessary for several aspects of the STP to be successful, and this was raised as a concern at several of the health and care forums. Many believed the STP underestimated how challenging it could be to change people's behaviour, in both where they receive care and in their lifestyles. In addition to patient behaviour change, some suggested that healthcare practitioners may need to change behaviour to deliver different services. For example, people suggested there should be a more patient led and personalised approach to service delivery.

### 3.7 Practical delivery of proposals

There were multiple discussions at the six health and care forums of how the operational changes would be implemented and managed practically. Many would like more detail regarding how and where health services would be provided, for example where alternative mental health services would be located. The transportation and travel implications of changing healthcare locations were raised as a concern in multiple events. For some ideas, such as the holistic approach to mental health and the use of locality teams, many people requested more information about what this would mean in practice for patients. To introduce new ways of receiving care, such as using technology or pharmacists, people would like additional information about how this would impact different patients and when these services are most appropriate to use.

### 3.8 Equality of access to health services

People supported equal access to services for all individuals in their community, and highlighted ways in which the STP could make this more inclusive. For mental health and children's services, the needs of those with limited English or lacking in local support networks were raised. Giving medical information in multiple languages and an awareness of cultural differences were suggested as important considerations. There was considerable feedback about making services more accessible

and inclusive for people with learning disabilities and for those with Autism Spectrum Disorders. People felt that mental health services should carry out more outreach of services for many marginalised or minority groups including lesbian, gay, bisexual, and transgender (LGBT) individuals, homeless, and black and minority ethnicity (BME) individuals. There was broad support for ensuring that services are fit to provide for the diverse needs within each of their communities.

### 3.9 Staff communication skills

During the grassroots engagement activities in particular, people provided mixed feedback about their experience of staff attitudes in both clinical and administrative roles. They felt additional training should be provided to staff on how to communicate with and support those with particular needs, including learning disabilities, mental health issues, autism spectrum disorders, physical disabilities, and children and young people.

### 3.10 Information management and technology

There were several comments at the six health and care forums and at the grassroots engagement activities, regarding information management and technology. The most common theme was around joining up IT systems so that there could be more efficient communication between services, avoiding patients having to repeat themselves.

At the grassroots engagement activities, there were some concerns about an increased reliance on technology, such as online repeat prescriptions and online GP consultations, because of worries that those without internet access might miss out. Others welcomed an increased use of technology, particularly working parents and carers.

## 4. Seven day acute services and urgent & emergency care

This section summarises the discussions across the six health and care forums and the grassroots engagement activities about seven day acute services. It highlights the emerging themes and key messages about the case for change and the ideas developed so far.

The suggestions outlined in the STP relating to seven day acute services include:

- Making sure that people are admitted into hospital only when it is the best place for them, and stay for the right length of time.
- Improving quality, with the right staff in place 7 days a week

### 4.1 Key messages

- Overall, there was concern from people regarding the **capacity of the services** under the proposed seven day acute services plan
- While people agreed with the aim to **reduce the number of patients using A&E**, there were concerns about what alternatives would be available, particularly as some potential alternatives are also closing
- There was **low awareness of NHS 111**, and those who were familiar with it were **not confident it would reduce demand** on A&E
- In discussing alternative services, several events discussed how **limited access to GPs** puts strain on acute services
- Some felt existing urgent and emergency care and acute **services need to be improved** to ensure they are inclusive and meet the needs of diverse users and provide **person-centred** care, and **waiting times are reduced**
- There were concerns about **mental health crisis care**, and lack of MH awareness in A&E
- **Transportation needs** and geographical implications of new service proposals were raised as considerations for the implementation of the STP
- There were mixed views about the **ability to implement and deliver the quality of healthcare** service desired
- A critical success factor identified in carrying out the changes identified was the ability of the NHS to communicate the services available to patients

### 4.2 Feasibility

### 4.2.1 Capacity of available services

Concerns were raised across several of the health and care forums regarding the capacity of existing NHS services and how they would cope with this proposed change.

While many people agreed with the principles and aim to manage resources more efficiently and deliver effective care, people were sceptical about how this would be delivered. People in Sutton believed that all five **A&E services were already operating above capacity**, suggesting that they would not be able to consolidate these without impacting patients. Similarly, people in Kingston had concerns that the proposals for seven day services would spread resources more thinly and therefore would not improve healthcare in their borough. They **suggested that the STP had contradictory aims to both provide more local level care and concentrate resources into fewer hospitals**, which they believe will put increased pressure on the waiting lists, specialists and A&E services currently offered. Other people from Wandsworth and Merton were **not confident in the NHS's ability to manage this change** and believed that there would not be sufficient funding to deliver the proposal. Some people believed that the motivation for this change was political rather than evidence-based.

Regarding specific services, although one participant in Wandsworth shared a negative experience about **St. George's Hospital A&E**, two other people said that the hospital's tiered approach to A&E care (i.e. different areas depending on the severity of need) was efficient. In Croydon, while it was noted that **Croydon University Hospital** had improved and is now a much better service, they were concerned that bed capacity at acute services could be an issue that would cause challenges if acute services were rationalised. In Kingston, they also questioned how the STP considers the use of services in neighbouring areas such as Tooting or Surrey.

Additionally, some people believed these changes were being proposed too late, as conditions had already significantly deteriorated at their services, and believed **the timescale of changes may be overly optimistic** and would take longer than 5 years to implement.

### 4.2.2 Directing patients to alternative services

Across all six health and care forums, there was a discussion of alternative services being utilised rather than relying on acute services such as A&E. Overall, there was **support for idea that there should be a reduction in the use of A&E** and agreement about re-directing patients to appropriate alternative services.

In Croydon and Merton, people believed there is **currently misuse of A&E services** due to an inaccurate understanding of where is the most appropriate place to access different care (e.g. using A&E for treating coughs and colds). People also questioned why patients who do not need to be in A&E are not sent to other locations upon arrival. People in Wandsworth also believed there was misuse of A&E services that could be reduced, and suggested charging patients to help reduce the number of unnecessary visits. They also highlighted that changing behaviour about where to go would only work if service levels were the same in non-A&E settings as they are in A&E (i.e. being seen within 4 hours).

While the other health and care forums also highlighted the need to reduce unnecessary use of A&E, they also questioned the **potential closure of A&E facilities** suggested in the STP. In Richmond, people asked what criteria would be used to decide which facility to close, and where people would be directed to instead. Similarly, in Kingston and Merton, while there was agreement that it would be best to reduce the number of individuals in A&E inappropriately, there was **concern about what alternative services are available** to patients. For example, an alternative suggested was to utilise pharmacists, however, funding to these services had also been cut. The people therefore requested more details of how the model for local services would relieve the stress on acute services. In Sutton, it was suggested that the **alternatives to A&E were also being closed**, leaving people with very limited options regarding their healthcare. Some believed the lack of social care funding made it difficult to effectively support patients outside of the hospital.

Many people at the grassroots engagement activities discussed where they might go for urgent care if they were not able to get a GP appointment, as an alternative to attending A&E. Many said that they would use an urgent care centre; walk-in centre; or call 111 in these cases. A small number of people felt that A&E was their only option if they were unable to get a GP appointment.

There was a feeling that **urgent care centres and walk-in centres** have made a positive difference to A&E departments, by delivering urgent care to patients so that they do not have to attend A&E. Several people said they would use their local walk in centre or urgent care centre rather than A&E, as the waiting times were often shorter and it is a less stressful place to wait. However, some people highlighted that there is a lack of awareness of what Urgent Care Centres should be used for, and a general lack of awareness about what services are available in the community for urgent and emergency care.

Several specific comments were made about **Teddington Memorial Hospital (walk-in centre)**, with many saying they had positive experiences there, and some expressing concerns that it could be under threat of closure. Some mentioned long waiting times but they felt this was offset by it being local and familiar. On the other hand, some people felt disappointed that in some cases they had been referred back to their GP for an emergency appointment after visiting this walk-in centre.

**Not all people had heard of the NHS 111 service.** Among those who knew of the service, people **shared mixed feedback**. Several people had positive experiences of using the 111 service, including friendly and helpful call operators; arranging an ambulance in an emergency; being able to access a same-day appointment; and being able to access repeat prescriptions. In contrast, **some people were not confident in the quality of the 111 service**, expressing concerns that the call operators were not necessarily medically trained and therefore that they may not be triaged appropriately. Some felt they would not use 111 because they had heard it has a bad reputation. It was felt that there should be more awareness of the 111 service, to ensure people know it exists and to help people understand when to use the service. There was a suggestion that the 111 service would be improved if it came under the London Ambulance Service, due to having greater connection, eliminating unnecessary calls, and having a unified approach to training and standards.

There was a general openness to using **NHS websites or apps** (such as Health Help Now) for help and advice, although there were some reservations for certain symptoms, or in the case of a child's health.

### 4.2.3 Access to GPs

People in most of the six health and care forums raised questions and concerns regarding **limited or delayed access to local GPs, which they felt was increasing reliance on A&E services**. Kingston people talked about the difficulty in getting an appointment locally. In Croydon, people discussed the difficult and often inconsistent access to a GP in their borough. It was recognised that this was being driven by difficulties in recruiting and retaining GPs. Wandsworth people also raised the shortage of GPs as a concern for the STP, and people in Merton said while online appointment booking was useful, they still struggled to get short notice appointments. Several people were concerned that while the STP proposed an increase in the use of community services to relieve the pressure on acute services, there was no additional funding for such services and GPs are already struggling with capacity (see Chapter 5 on Care Closer to Home for more details).

## 4.3 Desirability

### 4.3.1 Impact on quality

Some people in the health and care forums **did not have confidence in the NHS's ability to carry out changes to acute services** and **did not believe that this plan would have adequate funding** needed to achieve its goals. While some people in Wandsworth were supportive of the need for changes, they voiced their concern over how this would work in practice. The **closure of an A&E in the area was believed to have a negative impact on the NHS's ability to deliver healthcare**. In Richmond, some people were concerned this could mean a reduction in current health standards, for example due to increased travel time and having fewer sites to choose from.

There was **disagreement about the consolidation of services** as **some felt it was not necessary to have all specialist services available all seven days a week** while others believed quality service meant the same mix and level of staff at all times. People in Wandsworth had positive experiences with local services, and believed that the proposed changes would have little impact on them (either positive nor negative). In Croydon, some also believed that there may be better care offered in fewer sites, for example if there were hubs to triage non-urgent care. Additionally, people liked the prospect of quicker access to elective and rehabilitation services outside of the acute service location.

Some people felt that **intermediate care is not addressed in the STP** and they requested information about what the plans would be for those who are well enough to leave hospital, but not yet well enough to be at home.

### 4.3.2 Transport

People at the six health and care forums raised questions regarding the transportation and accessibility of proposed future acute services.

**Travel time** was important to many people and most believed that travelling short distances to care is preferred. In Sutton, people questioned whether the removal of one A&E service would mean

having to travel further for emergency care, and emphasised the high quality of care available to them from St Helier. **When pressed, some explained that quality was a greater priority** for them – for example, although services at Croydon University Hospital were closer, some people travelled to the further away St George’s Hospital due to perceived lower standards of care at the former hospital. Similarly, people at Merton and at other events accepted that traveling further for specialist care might be necessary to improve the quality of care overall. **However, few could see how reducing the number of A&Es would lead to an improvement in care quality for patients needing a ‘generalist’.** People at the grassroots engagement activities also raised travel and transport as issues to consider in relation to both urgent and emergency care, and acute services. It was highlighted that in any reorganisation of acute services in London, **travel time to reach a hospital** (and traffic congestion) should be carefully considered.

People at both Croydon and Kingston events discussed how **travelling at the weekends and out of working hours** is more difficult, especially for the elderly or vulnerable groups, due to their reliance on public transport. In Richmond, people discussed the implications of the seven day acute service and STP proposals given their geographical placement. Because they do not have a hospital in this borough, they questioned how the different areas of the borough would be impacted.

Some also raised practical considerations, such as

- whether acute cases needing admission would remain in the same hospital or would be transferred.
- where follow-up appointments, and physiotherapy if required, would be delivered.

Several people in the grassroots engagement activities commented on the provision of **patient transport** whereby vulnerable patients are transported to and from their homes when they need to visit hospital. It was noted that patient transport is not always suitable for those with physical disabilities and should be made more accessible. It was also noted that visits to hospital using patient transport can take a whole day, which can be very tiring for some patients. It was suggested that drivers should take patients to their front door, as some are discharged very late in the day and can be confused or disorientated.

**Parking facilities** at hospitals were also raised during the grassroots engagement activities. There was a general feeling that parking at **Epsom and St Helier** and at **St George’s** is extremely expensive and should be reviewed so that it does not stop friends and family from visiting relatives or needing to cut their visit short. Some felt that hospital parking should be free or that any income generated should be reinvested in patient care. It was also noted that parking can be difficult for people with disabilities, particularly if there are complex payment systems.

### 4.3.3 Urgent and Emergency Care

People also had specific feedback relating to the current urgent and emergency care services in the region.



### *Inclusive access to urgent and emergency care*

At the grassroots engagement activities, several people discussed how to ensure inclusive access to urgent and emergency care, for different groups of people.

In relation to those who are **deaf**, some people shared negative experiences at A&E at St Helier Hospital. A number of individuals had informed the receptionist that they were deaf, however due to a breakdown in communication or a change in reception staff during the waiting period, this information was not passed on. As a result, patients do not hear their name being called and missed their appointed time slot. They felt it would be beneficial if a screen with name was available in the waiting area, so that people who are deaf know when they are being called.

In relation to people with **learning disabilities**, people shared several negative experiences and made some suggestions for how the A&E experience could be improved. Some people highlighted that long waiting times with a child with a learning disability are particularly difficult. There was a suggestion that patients with a learning disability should be seen first, and that there should be clearer information for both carers and patients about what to expect at A&E when you have a learning disability. People also noted that there was no learning disability specialist on site when they had attended A&E. When they asked to see the learning disability nurse, A&E staff did not know if there was such a role (at Croydon University Hospital and at Kingston Hospital). Not all patients with a learning disability had Hospital Passports.

Access to translation services for those who speak **languages other than English** was seen as patchy and unpredictable. Some patients had to rely on family and friends to translate, which may not always be appropriate.

A number of cases were noted where, at St Helier Hospital, **transgender** people had been put on the same ward as their birth gender, rather than the gender in which they were living their lives, which made them feel very uncomfortable.

In relation to **carers**, several people highlighted that navigating the A&E system as a carer is very difficult, with a lack of information about what to expect. It was suggested that, because carers often have to attend A&E on a regular basis, there should be improved signposting to other services where applicable, and more support for carers to stay well.

Finally, it was highlighted that doctors and nurses do not always relate to **young people** very well. It was suggested there could be peer support available for young people. For more information, please see Chapter 9 on Children's Services.

### *Mental health support in A&E departments*

The following section summarises feedback relating to A&E services for people with mental health conditions, from the grassroots engagement activities. For detailed feedback on mental health services more broadly, and crisis care for people with mental health issues, see Chapter 7 on Mental health.

People felt that basic **mental health awareness training** should be provided for reception staff in A&E departments, and perhaps also for security staff. They also felt that there should be better

signposting from staff in A&E to further support for mental health issues. Some shared negative experiences where they felt A&E staff showed a lack of understanding of mental health. Several people noted that if they arrive in A&E in need of mental health support, but they are dressed well, that it is assumed they are not in crisis and are not taken seriously.

People wanted to see the following changes to MH services alongside any other plans within the STP:

- the NHS should also consider investing more in **peer support** alongside clinically trained staff.
- seeing A&E consultants without a background in mental health was very unhelpful. **Mental health nurses present in all A&Es would help** ensure people in crisis are treated appropriately.
- if you go to accident and emergency in a MH crisis, you **should be given a private room** away from other people to help keep you calm.
- when in A&E you should be given **a numbered ticket** that shows your place in the queue on a screen. They felt that this would help with people's anxieties to know how long they would need to wait.
- people in crisis or with a mental health condition could be given **a separate entrance** and area to A&E. This would stop any anxieties around other patients looking at the individual and judging them.

### ***Waiting times in A&E departments***

There was consistent feedback that **waiting times at A&E are too long**. People also felt that there was a **lack of communication from staff** when waiting times are long, **which adds to people feeling frustrated** and unsure of when they will be seen.

The waiting times at **Kingston Hospital** and **St George's** were both specifically referred to as being too long, by several participants. At St George's, people also commented that the waiting area is very poor and inadequate for the number of patients who attend. It was also noted that, for parents of children with additional learning needs, St George's is inappropriate for their needs due to the long waiting times and the lack of a sensory room. In contrast, both Kingston and St George's A&E departments were praised by a small number of participants, including that waiting times and staff communication were good.

People noted that when they are not seen for several hours after arrival at A&E they get very worried because they do not know what is wrong with them. Some noted that the triage system should be improved to ensure that more urgent cases are seen more quickly.

Some also noted that they are seen faster at A&E when they were taken there by ambulance or referred there by their GP, compared with if they attended by themselves.

## *London Ambulance Service*

Concerns were raised that paramedics could refuse to transport a patient to hospital. People felt that if they had called 999, an ambulance should respond appropriately. There were also concerns raised around the triaging by the 999 call handlers. It felt that if someone was unable to fully describe their condition due to pain, they would be dealt with inappropriately.

### **4.3.4 Acute Services**

In addition to feedback on urgent and emergency services, some people also made comments about the current acute inpatient services provided in SWL.

#### *Inclusive and person-centred care*

At the grassroots engagement activities, there were several comments regarding care provided to people with specific needs, and how this could be improved.

In relation to **elderly patients** or those with **dementia**, it was highlighted that patients on Mary Moore Ward at St Helier Hospital were not looked after well, and that nurses were discouraged from keeping the patients mobile. It was also suggested that the standards of care for the elderly at Kingston Hospital are very poor, and that there is a lack of management around elderly patients' long term healthcare. It was suggested that

- physiotherapy should be provided during the hospital stay to elderly patients who have had falls, in order to maintain their confidence and mobility once they are discharged.
- older people are not always helped to feed themselves when in hospital, leading in some cases to the patient not being able to eat. Similarly, several people noted that water is not always provided at patients' bedsides.
- the "blue band" scheme for those with dementia was highly praised. It was noted to be an excellent tool to help staff be more aware of patients' mental health and take more time when explaining a procedure. There was also a suggestion that the "dementia friend" model should be rolled out across all hospitals to support better care for the elderly.
- there were several examples of people feeling that they needed a cataract operation but that surgeons took the choice away from them saying that they did not think the patient should take the risk. These people would have preferred to be able to make their own **informed choice**, weighing up the risks and benefits.

It was also felt that there needs to be more **activities for patients** to participate in during the day while they are in acute care. They felt this would help with isolation, mental health and general wellbeing.

In relation to those with **learning disabilities**, it was felt that hospital staff are not always aware, and therefore did not take additional time to help them understand what was happening. It was felt that everyone with a learning disability or autism should be provided with a health passport to help staff know and understand each person's individual needs, likes and dislikes.

It was highlighted that St Helier Hospital is very good at providing access to **interpreting services**, including being able to book interpreters with little to no delay.

In relation to **Gypsy, Roma and Traveller (GRT) communities**, it was noted that since they live in a very tight community, they do not like family members to be in hospital alone. As a result, family members often sleep in communal areas (such as canteens) in order to be close to their loved ones, so providing alternative waiting areas would be helpful.

In order for families and friends to support patients while they are in hospital, it was suggested that **visiting times** on wards should be more flexible and allow relatives to come in earlier. For example, they felt visiting hours of 12-8pm would be ideal as some visitors could help with feeding the patients their lunch which would reduce the burden on the nursing and care staff.

Some patients shared experiences of being regularly moved to different wards without being informed of the reason. It was also noted that **some patients are placed on inappropriate wards**, such as a younger person being placed on a dementia ward, causing distress.

### *Waiting times*

The **queues and waiting times at the pharmacies** at St George's and St Helier Hospitals were commented on specifically as being very long. For example, some people had waited two hours before receiving their prescription.

### *Buildings and signage*

People felt that often the **directions around hospitals are not very clear**, particularly at **Kingston** and **Croydon University Hospital**. It made people confused and anxious when directions stopped or when wording for departments were very long. There was a suggestion that a map should be provided in an easy to read format to help with navigating hospitals.

It was also highlighted that **the standard of the building at St Helier is very poor**, including plaster falling off the walls, wet floors in the toilets, and no locks on toilet doors.

## **4.3.5 Discharge**

There were several comments about discharge at the grassroots engagement activities.

A common theme was that patients were **discharged from hospital late at night** but were not provided with any transport to get home, nor did they have any care available at home. In contrast, one patient said they were taken home in an ambulance even though they could have taken a taxi, which way thought was a waste of money. It was noted that **being discharged with no care at home** often leads to being readmitted within a short space of time, especially if they had experienced a fall in the first place. Being discharged late at night was also raised a specific issue for homeless people, since shelters and other services are closed and they therefore have nowhere else to go.

Some felt they were **discharged too quickly or too slowly**. Several people noted that their discharge had been delayed from acute care, sometimes waiting several hours for medication and/or transport

to be arranged. Others noted that they were discharged too quickly, before they were medically fit to leave, which they felt was driven by a lack of bed spaces.

It was felt that there should be **closer working between NHS and social care services** in relation to discharge from acute care. People highlighted that if hospital staff know what services are available in the community, they could refer patients there for support and therefore be able to discharge them sooner but more safely. They felt that a care plan should be put in place before someone is discharged from hospital.

It was suggested that hospitals should write more **detailed notes about a patient's health and wellbeing** before they are discharged into their homes or care homes, so that appropriate support can be put in place.

Another suggestion was that when patients attend A&E for something like a fall, they should be checked over at outpatients upon discharge to check if there are any other issues - it was felt this could save time and money by reducing the risk of readmittance to A&E.

## 4.4 Advice on delivery

### 4.4.1 Communication

To deliver the changes proposed, some people at the six health and care forums believed **communication about NHS services would be a critical success factor**.

Overall, many suggestions were made about how to reach out to the public about the use of acute services. Some people believed there was a **lack of information and knowledge about where patients can access care outside of hospitals**. In Croydon and Merton, people discussed how to reduce the misuse of A&E acute services and suggested better communication of alternative services is needed to address this. For example, informing groups of different cultural backgrounds of which services other than A&E offer high quality medical advice.

People in Sutton suggested current **reliance on the NHS 111 line to signpost patients to the appropriate care would be ineffective due to the frequency of callers being directed to A&E**. It was recognised that a change in communication approach is needed for signposting patients to the best care options.

Some suggested that it would be **difficult to change behaviour, and that it would be more straightforward to change the service**. Specifically, having GP services alongside A&E, with the same service commitments as A&E (i.e. seen without and appointment, within four hours) could be a cost-effective way to ensure only those who needed A&E used it.

### 4.4.2 Staff attitudes and communication skills

#### *Sensitivity, empathy and responsiveness*

A common theme at the grassroots engagement events was that hospital **staff sometimes lacked sensitivity and empathy** in their communication with patients and their relatives. Hospitals

mentioned in this context include Kingston, St Helier, St George's, Moorfields, and Croydon University Hospital. People felt that **staff should be trained in how to communicate more sensitively** with their patients, **as well as in cultural awareness, respect and compassion**. In some cases, staff were observed to be unresponsive when patients rang their buzzer for help. Some people noted that a lack of empathy also means that care is not personalised because staff do not always try to get to know their patients.

It was suggested that Health Care Assistants should stay on the same ward and with the same patient, so as to provide emotional care and support for the patient as well as ensure they are eating and drinking enough.

### *Communicating with patients with specific conditions*

People highlighted that staff in urgent and emergency care, and in acute services, should be trained to be able to communicate more effectively with patients who have specific conditions, specifically:

- Adults with mental health conditions
- Children with mental health conditions
- People in a mental health crisis
- Children with learning disabilities
- Children with Autism Spectrum Disorders
- People with physical disabilities

### *Communication with patients and family members*

Several people noted that lines of **communication between hospital staff and patients and their relatives could be improved**. Several examples were given of when patient notes were not thoroughly read by medical staff, in some cases leading to inappropriate treatment. Examples were also given of when relatives were not listened to, causing delays in diagnosis. Several people also noted that relatives were not informed of what was happening with a patient's treatment, including not informing them of the patient being transferred to another hospital for treatment, nor when a patient was ready to be discharged.

In contrast, a few people noted that they felt listened to, well looked after, and that every step in their treatment was explained clearly to them.

Finally, people **wanted to see better communication between hospital consultants and GPs** and felt that they should be able to talk to each other about a patient's diagnosis/results rather than the patient being the "go-between".

## **4.4.3 Staffing**

People at the grassroots engagement activities felt that in order for the plans in the STP to be delivered, there **needed to be more expert staff available**, including specialist nurses, and

psychiatrists in addition to senior doctors. Some felt there was an over-reliance on bank staff and that more staff should be fully employed in order to reduce the pressure on over-stretched staff.

## 5. More care closer to home

This section summarises the discussions across the six health and care forums and grassroots engagement activities about more care options closer to home. It highlights the emerging themes and key messages about the case for change and the ideas developed so far.

The suggestions outlined in the STP relating to more care closer to home include:

- Setting up area based 'locality teams' to support patients in areas including prevention and early intervention
- Greater availability of treatment in local health centres
- Joined up services in the community to provide more intensive support to people at home
- Additional advice and support via an improved 111 telephone helpline, 'care navigators' signposting people to the right services, greater use of smartphone apps and Skype etc. for those people that want to use them
- Clinical pharmacists in GP practices to help people with long term conditions manage their medication
- Encouraging people to visit their local pharmacist for advice and support for minor conditions

### 5.1 Key messages

- While the idea was supported, there were concerns that the local NHS did not have the **capacity and resources** to manage the change towards a more local care model
- People believed significant **training and development** would be needed **for pharmacists** to be able to deliver appropriate healthcare, especially for vulnerable people, and that investment would be needed to improve pharmacist facilities
- Mixed responses regarding the impact of this plan on quality, as it may reduce waiting times, but there were **concerns about information sharing and workload management** which, if not addressed, could diminish quality. Some wanted reassurance on the security of online patient records
- Detailed feedback was provided on **primary care services**, relating to **concerns about appointment availability, accessibility, referrals, and holistic and person-centred care**
- Several specific areas of **feedback relating to variable out of hospital care** were provided for consideration and improvement
- **New roles** were positively received but many wanted more detail about how these teams would support local patient care in practice
- **Awareness** of appropriate services is low and people suggested additional communication from the NHS to both professionals and directly to the public would help ensure patients used the available local options



## 5.2 Feasibility

### 5.2.1 Resources to implement plan

Overall, at the six health and care forums, many people were **positive about having more care services closer to home**. However, they had **several concerns about the execution** of this proposal. Some felt that there were major challenges to overcome and questioned whether adequate resources were available.

People raised concerns regarding **how sustainable the proposed changes would be**, and questioned how this would fit into the context of current funding cuts. Further, people **wondered how longer GP surgery hours would be possible with the GP shortages** and worried that this budget shift would negatively impact on acute care. The impact on hospital care was discussed in Richmond, where they were **concerned that shifting funding back and forth between the health and social care budgets was negatively affecting both services**. There were more general concerns in Richmond and Wandsworth that there would be difficulty integrating health and social care (e.g. supporting carers after early discharge of patients), coordinating the health administration, and improving IT systems in order facilitate outreach such as being able to Skype with patients. People in Merton highlighted the need for integration with voluntary sector such as hospices as well as the local authority.

Some **people with positive experiences of pharmacists** liked the idea and **were supportive of using them where appropriate**. However, **they thought facilities would need to be improved** to ensure high quality care - for example by providing a private room to discuss health concerns. There were many concerns that pharmacists did not have the funding necessary to cope with additional patients and these new demands.

### 5.2.2 Skills and training

At the six health and care forums, people discussed the use of nurses and pharmacists as an alternative to GPs. People expressed concerns over the **training needed for pharmacists to deliver quality healthcare advice**.

Many believed that the plan does not account for the training required to service patients with a different range of needs. Some people raised that they would like to know that the pharmacist is knowledgeable enough to treat their medical needs. People suggested **training was necessary to ensure they can communicate well with patients** as pharmacists don't have experience giving this advice. A minority of people were concerned that the personal views or beliefs of pharmacists might influence the treatment and advice they provide. They would therefore need to be assured they would receive equal treatment, before they would consider approaching a pharmacist instead of a doctor. There were several suggestions that **pharmacists may need extra support or training to give services to vulnerable groups** and people with protected characteristics.

At the grassroots engagement activities, people emphasised that GPs should talk to patients in plain English, including clear explanations of what medication is being prescribed, why, and any known side effects; and provide more clarity about referral processes.

People suggested that **further training was needed for both GPs and reception staff**, relating to **communicating with those with learning disabilities; and communicating with sensitivity**. There were also suggestions for further training for GPs, around specific conditions such as ME (Chronic Fatigue Syndrome), ADHD/Autism, mental health, and support for carers.

There was a suggestion that receptionists could play a different role and help sign post people to services. This would help reduce isolation and improve health and wellbeing.

## 5.3 Desirability

### 5.3.1 Quality of care from health professionals other than GPs

At the six health and care forums, there were **mixed views on how the quality of care would be impacted** by the proposed change. While it **may result in faster treatment** to seek out pharmacists, visiting GPs would remain difficult and without this option people were **concerned about the quality of medical advice** they would receive.

Several people suggested that the proposed changes **could help to reduce waiting times** to see a trained professional and receive necessary medication. This was highlighted in Kingston as being useful for long-term conditions management, as well as at Merton where people raised the success of the Live Well group in managing chronic illness locally. Many people felt comfortable using their pharmacist and requested additional signposting to when this was appropriate (e.g. when you have a high temperature). Some people in Wandsworth said they felt comfortable once the question of privacy had been addressed. Some people praised their local nurses as source of local care, for example a specialist diabetic nurse and Parkinson's nurse in Richmond.

However, there were **concerns over how information would be shared with the GP** where necessary and how the information would be stored. In addition, Croydon and Wandsworth people questioned how pharmacies would cope with an increase in workload without additional funding to ensure the pharmacists would be able to cope with these changes.

At the grassroots engagement activities, people also discussed the potential for pharmacists to play a greater role in care closer to home. There was mixed feedback, due to variation in people's experiences of pharmacists. Some were very supportive of the idea of using pharmacists more frequently, since they have found them to be helpful and accessible. However, others were concerned due to experiences of poor communication from their pharmacists, insufficient instruction as to how to take a medication, or being given the wrong medication.

People suggested that in order for the proposal to be successful, **more education was needed for the general public around using local pharmacies** and going to see them for advice. Other suggestions included pharmacies having longer opening hours, and shorter waiting times to collect medication.

### 5.3.2 New roles for supporting care

At the six health and care forums, some people were **positive about care navigators and locality teams' new roles** in delivery service closer to home. However, questions were raised about how this service would be carried out.

People in Kingston were positive about the idea, however suggested that **the STP should outline more how this would work in practice**. For example, it was not clear what the remit for these roles was, how they would be accessed and how they would interact with other services. There was positivity about the possible collaborative and joined up approach these roles could facilitate, however the need for adequate training was emphasised in Richmond. Some in Wandsworth felt that the teams could be used more strategically to support families and carers as well as patients.

At the grassroots engagement events, some people noted that they found it difficult to navigate the care system for certain conditions or issues. Carers, in particular, found it difficult to navigate through the care system and felt that they had not received helpful advice or guidance from GPs. In light of these experiences, people **welcomed the idea of care navigators, particularly if their job includes patient liaison and support for both patients and carers**. There was a suggestion that if local practice networks were set up, in each area one or two GPs could take the lead on learning disability, and share their knowledge more widely amongst other practitioners. They also welcomed the idea of more coordinated care, but emphasised that this requires everyone knowing what services are available.

### 5.3.3 Primary Care

At the grassroots engagement activities, there were many discussions about primary care, which are summarised below.

#### *Appointments*

At the grassroots engagement activities, **many people had experienced problems with getting GP appointments at suitable times**. Several people emphasised the importance of appointments being available after 6pm and at weekends to accommodate those who find it difficult to visit during the day. For some individuals, **not being able to obtain a GP appointment had led to them attending A&E** in order to be seen. Others would attend a walk-in clinic, as not all had heard of the 111 service. In contrast, **several people said they had positive experiences of going to the GP and found it quite easy to get a GP appointment**, although it was not always with their named GP.

When making appointments, some people said they were happy for receptionists to ask the reason for their call, however **they did not like reception staff acting as 'gatekeepers'** in terms of how quickly you can see a GP. Some argued that reception staff are unqualified to ask medical questions and they should respect people's confidentiality by not asking personal questions in an open plan waiting room. It was suggested that receptionists should be trained in confidentiality and made more aware of their surroundings.

Several people felt that **GP appointments were too short**. They felt that 10 minutes was not long enough to learn about an individual's health problem and find a solution. This is particularly the case when discussing complex cases including mental health concerns. People were generally unaware that you can book two appointments if you need to discuss multiple or complex issues.

Some people mentioned that the **Patient Online system has made it easier to book** an appointment the night before, and that it has made it a lot easier to collect prescriptions from their pharmacy of choice at a time convenient to them.

There were mixed views about the idea of online appointments with a GP via Skype or email, and some would prefer to see the GP in person, although many are comfortable with telephone consultations.

### **Referrals**

Several people discussed that there were **very long waiting times for referrals** from primary care into secondary care or specialist services such as physiotherapists or mental health professionals. Many had waited several months for an appointment to come through, at which point their conditions may have escalated (see Chapter 6 on early intervention for more details).

Others felt that GPs were reluctant to make referrals at all, perhaps due to being under pressure to reduce the burden on other NHS services.

There was a suggestion that GPs should allow self-referral to certain services, or to repeat services, in order to save GP appointments for concurrent referrals.

### **Access**

There were several conversations relating to improving access to primary care for different groups of people.

In relation to **those who speak languages other than English**, several people had difficulties booking an appointment, as well as problems during consultations with GPs because of not having interpreters available. There were several experiences of GPs being reluctant to use Language Line in order to access interpreters. In contrast, some GPs offer excellent interpretation services either by arranging an interpreter in advance, or by having GPs who can speak specific languages available to those patients who need them.

Similarly, **for those who are deaf**, people raised concerns about GPs not booking interpreters for routine appointments. They had the impression that GP surgeries felt that it was the responsibility of the patient and were not aware of the process for booking an interpreter for a deaf patient's appointment. Several individuals noted that they had been asked to bring family members in to appointments to interpret for them, however most felt that this was not appropriate as they may wish to discuss confidential matters. Although online appointment bookings have made making an appointment easier for deaf patients, it is only possible to arrange an interpreter by calling the surgery. Several individuals stated that they would like to book appointments via email or text.

While online bookings and appointments have improved access for some people (e.g. people who are deaf; or working carers), there were concerns that those who are elderly or **who do not have**

**access to the internet** might miss out on appointments. People suggested that telephone appointments should continue for those who do not have internet access.

There were a few comments about **waiting areas not being suitable for those with disabilities**. For example, if you are visually impaired it can be difficult to register using automated systems and there can be difficulties with the boards that scroll through and tell people when the doctor is ready for their appointment. People emphasised that all GP surgeries should be wheelchair accessible.

**Access for carers** was raised as an issue. Working carers can find it especially difficult to get a GP appointment, and people felt that both GPs and pharmacists should play a bigger role in identifying / supporting the health and wellbeing of carers.

Some people felt that GP surgeries need to be more **LGBT** inclusive and this would include having more publications and visible posters available in the reception area, and more proactive promotion of HIV testing among this community.

It was noted that it can be particularly difficult for people from **travelling communities** and for **homeless** people to register with a GP, although walk-in services help with this.

### *Holistic treatment and person-centred care*

There were several discussions at the grassroots engagement activities about primary care services that were more holistic and person-centred. People felt that **GPs should recognise that people are experts in their own care** and should pay more attention to what they think is wrong with them. They also felt that carers should receive more support from GPs, including prescribed respite care.

Continuity of care was seen as being linked to a personalised approach. Some **people were concerned that they were not always able to see the same GP**, or that they often have to see locums, so there is no relationship development between patient and GP. This was particularly **important for those with long-term conditions, serious illness, or children with additional needs**. In contrast, others said they did not mind if they did not see the same GP, as long as they got an appointment when needed.

### **5.3.4 Out of hospital care**

At the grassroots engagement activities, people discussed out of hospital services, with varying feedback based on their experience to date. For example:

- In relation to **long-term conditions**, some people were disappointed in the support they had received, slow diagnosis, or lack of help to enable self-management. People wanted more support taking control of their own health. For example, one patient noted that they had diabetes and had to have injections twice a day. They would like to be taught how to give themselves injections so that they could go away for the night, but haven't been taught how to do it.
- There was a suggestion that **community nurses** could attend sheltered accommodation to pick up issues early on – this would prevent conditions from escalating and reduce the reliance on GPs.

- Finally, there was a lot of praise for the newly built **Nelson Health Centre** and many people appreciated that they can get lots of things done in one place rather than travelling to different hospitals.

A key theme about out of hospital care was the **inconsistency people experienced**. For example, those who had received home help appreciated the service and found it helped them to stay healthy and out of hospital. However, others did not know who to contact for this kind of support.

Some people found it very difficult to get an appointment with a **community chiropodist**, and were only entitled to one appointment every six months, which was not enough for older people or those with learning disabilities. This meant people had to either had to live in discomfort or pay for support privately.

## 5.4 Advice on delivery

### 5.4.1 Communication and signposting

At the six health and care forums, the current **lack of knowledge about local services was highlighted as a barrier** for rolling out the plan. Many people thought that people do not feel confident about where to go to seek appropriate care, and that there is an opportunity for the NHS to communicate this more clearly. Several people suggested that raising awareness of the different services and what professionals can offer through improved communications would be important. In particular, some felt that people don't know where to go as an alternative to A&E. In Kingston and Richmond, people suggested that more could be done by GP receptionists to signpost to appropriate care, as well as improving services such as the 111 phone line.

To support people using care closer to home, many agreed that **the 111 service needs to be improved**. In Croydon, some suggested the 111 service is not able to provide necessary advice and signposting to services. People believed there is low trust in the service and suggested it should be improved and re-launched. People in Wandsworth believed that the current state of 111 is potentially increasing use of acute services rather than reducing it, as they often direct callers to A&E. In addition, they felt the 111 operators do not communicate well – specifically they felt the operators ask too many questions, rather than listening to the callers more fully.

At the grassroots engagement activities, people raised several **issues relating to communication from primary care services**.

It was felt there should be better signposting and advertising of available services, such as community groups and the new GP Hubs, as well as how to navigate the health and social care system.

A few people felt very concerned around data protection with the Patient Online system. People felt unsettled that their personal medical notes could potentially be looked at or hacked into. Improved information about this would be helpful.

Several people wanted clearer information about how to complain about the service they had received from GP surgeries.

### 5.4.2 Joined-up services

Many people at the grassroots engagement activities **emphasised the need for more joined-up services**. This includes GP surgeries and hospitals **communicating better with each other to ensure the best outcomes for patients**, and NHS services working more closely with social services.

There was some discussion about the new GP Hubs. People **were broadly supportive of the idea of having several health professionals in the same place**, and noted that the waiting time for appointments is shorter. However, they highlighted that **the service can be more impersonal** due to seeing different GPs, and the **hubs can involve travelling further distances which can be difficult for those with mobility problems**. There were some positive experiences of the Leatherhead Hub, where it is possible to get evening appointments, however they felt that the hub system would benefit from more awareness raising.

One person had a positive experience of 'GP Pooling' services, whereby if their GP surgery is closed or they cannot get an appointment they are then referred to another nearby.

## 6. Prevention and early intervention

This section summarises the discussions across the six health and care forums and grassroots engagement activities about prevention and early intervention services. It highlights the emerging themes and key messages about the case for change and the ideas developed so far.

The suggestions outlined in the STP relating to mental health services include:

- Better prevention and early intervention supported by ‘locality’ teams of health professionals dedicated to supporting at least 50,000 strong communities. Locality teams would bring together health professionals from across the NHS who would work alongside GP surgeries and other partners
- Locality teams will:
  - Help people to stay well by placing a greater emphasis on prevention and early intervention
  - Take action early by working to identify people at high risk of hospital admission and support them before their condition deteriorates and they need to go into hospital
- It will be easier to receive treatment in your local health centre, at a local clinic or at home, as we will be putting more resources into your local communities.
- We will work with public health to encourage people to live healthier lives. For example
  - Rolling out the “London Healthy Workplace” and “making every contact count” schemes
  - Developing better tools to help people make positive changes – such as smoking cessation and weight loss referral services
  - Using modern technology (such as smart phone apps for people who want it) to encourage more self-care.

### 6.1 Key messages

- People **supported the inclusion of prevention approaches**. However, there were concerns about whether the STP would be able to **change people’s behaviours**
- Some people had questions regarding the **role of different community groups** and how the **resources would be managed to ensure high quality care**
- There was a desire for **more personalised and holistic care**, which people felt to be linked to improved prevention and early intervention.
- There were concerns over the introduction of prevention services that may lead to **privatisation or service cuts** in other areas that would compromise care
- **More detailed information was requested regarding locality teams**, their role in healthcare and how these would operate in practice



- **Communication is key to ensuring change in behaviour** for prevention, and people agreed the NHS must improve its outreach for this to be successful
- **Some people supported the use of technology to monitor health**, however not as a universal tool and wanted more information about which contexts it would be used in

## 6.2 Feasibility

### 6.2.1 Changing patient behaviour

While there was **support for prevention approaches to healthcare**, many had **concerns over the feasibility** of changing people's behaviour in practice.

Many people across events believed **changing behaviour is challenging** and that the effort required may be underestimated in the STP. In Richmond, the people liked the focus on promoting healthier living and reducing obesity, which they felt could improve outcomes and alleviate demand for resources. However, they observed **this would be a long-term effect while the planned changes required short term benefits** to support the healthcare system. In addition, they had concerns that prevention is typically the first programme to be affected by budget tightening.

Some people made **suggestions of how change could be better supported** in the plan. In Sutton, people suggested the NHS 111 service could focus on prevention, or that targeting specific groups such as elderly people in care homes would be more efficient than targeting the whole population. This was echoed by people who supported more education for the public on prevention as well ensuring that health care professionals see the value of early intervention. Some people did warn that being too focused on prevention could be risky as someone might underestimate a health issue and not seek treatment.

### 6.2.2 Support from community

There were some **questions about the role of different community organisations** in the goals for prevention and early intervention. Some felt that the STP was overly optimistic about the resources that were available as more would be needed to support this. In addition, there was concern that voluntary sources could be replacing medical professionals which people did not want. In Merton, people suggested lack of funding and communication between services would be a challenge for partnerships. Further, if resources were not available people at some health and care forums worried that this could lead to privatisation of the services.

Overall, people believed that support from families, friends and communities would be needed to support behaviour change. People suggested a **cultural change was needed**, shifting towards personal responsibility and collaboration between healthcare professionals with families.

## 6.3 Desirability

### 6.3.1 Holistic treatment and person-centred care

There were several discussions at the grassroots engagement activities about **making primary care services more holistic and person-centred**. In relation to lifestyle and prevention, several people said that GPs do not routinely provide information on diet, wellbeing and mental health. When this information or advice is provided, they felt it was lacking in detail or signposting to further support. They felt more should be done to support healthy lifestyles and prevent ill-health.

People also felt that the NHS should **invest more in social prescribing** and local initiatives, as these approaches support both mental and physical wellbeing by helping people remain active and reducing social isolation.

In relation to person-centred care, many people **felt that their conditions were looked at one by one** rather than being considered as a whole person. They felt that the primary care system still operates a very medicalised model of care rather than a holistic one. However, they also acknowledged that at the moment GPs do not have time to support people to live healthier lives, or support carers in their role.

### 6.3.2 Quality of services

Some people raised **concerns that a move towards prevention and early intervention would lead to further loss of services**, while doing little to relieve the NHS burden. There were some who believed it was realistic to move towards prevention to reduce demands on the NHS, however others were concerned that the plan was not transparent as they believed that the level of service would not continue. In Sutton, people worried the changes would compromise care and did not believe there was enough evidence that prevention was reducing NHS demand. In Croydon, people were concerned that further cuts would follow this change and were frustrated that previous prevention services had been lost such as the Croydon POP bus.

### 6.3.3 Locality teams

While some people at the six health and care forums **expressed their interest in the locality health teams**, there were **widespread questions about how these would operate in practice**. For example, in Richmond, people felt locality teams might be a good idea to enable practitioners to address local problems. However, they did not have sufficient information to know if this would be possible.

Many people wanted more information about how these would operate, such as how the teams would be run or coordinated, who would they work with, where they would be accommodated and which professionals would be included. In Kingston, some were concerned that this would add another layer to an already complex health administration system.

## 6.4 Advice on delivery

### 6.4.1 Communication

To deliver this prevention and early intervention programme, many people **believed the NHS would need to improve its communication with the public and ensure that practitioners were aware** of all the relevant services.

People at the health and care forums Kingston, Richmond and Croydon believed that **the ability to communicate information about health would need to be improved** to effect change in behaviour. It was suggested that **posters, advertisements and information on screens** in GPs offices could be used to communicate and detail the services available. Additionally, **online information and GP knowledge** about local services was thought to be important. Some people suggested that GPs need to know more about community-based early intervention services that they can signpost patients to as appropriate. Some people believed that the inability of practitioners to communicate with each other is preventing some early intervention. In Merton, people suggested more realistic healthy living advocates and role models to promote changing behaviour.

### 6.4.2 Use of technology

There were **mixed responses to the idea of using technology** to manage health and encourage preventative activities. Some in Kingston were positive about the idea of health-related apps such as a blood pressure monitor. However, others did have concerns about how the health information would be used, for example if there was cause for concern would this be sent to the GP. Many people pointed out the issues of accessibility as not all will be able to use technology in this way for example the elderly, homeless or vulnerable groups. For these groups, it was suggested that more community-based health or social prescribing options could be more useful. At the grassroots engagement activities, people were worried about confidentiality of information held in online systems.

## 7. Mental health services

This section summarises the discussions across the six health and care forums and grassroots engagement activities about mental health services. It highlights the emerging themes and key messages about the case for change and the ideas developed so far.

The suggestions outlined in the STP relating to mental health services include:

- Early prevention and intervention for people with mental health issues to avoid their condition worsening and reaching crisis point. By doing this we will help to avoid patients needing to be admitted urgently into hospital.
- Developing perinatal mental health services in the community.
- Supporting community based recovery - this includes embedding mental health into primary care.
- Mental and physical health services working better with one another - recognising that poor mental and physical health are often related.
- A psychiatric decision unit will assess and develop treatment plans for people with serious/enduring long term mental health conditions in crisis.

### 7.1 Key messages

- There was **low confidence in current services** due to perceptions of poor quality, closures, long waiting times, underfunding and inability to cope; therefore, there are concerns that the STP will not be successful
- People felt that significant investment in training and **additional skills may be needed for GPs** and others to deliver higher quality mental health services and reduce stigma
- People wanted more information about where proposed mental health treatment would take place and **promoted the need for out of hospital mental health care**, and more support in transitions into the community
- People supported a **holistic approach, incorporating physical conditions** and coordinating with multiple organisations, but questioned how this would work in practice
- An **inclusive approach** to mental health was desired with the needs of marginalised and vulnerable groups, such as children, LGBT and ethnic minorities highlighted as an important consideration for the STP
- People want more mental health awareness and **education in schools**, as well more integration with mental health services and schools to support children and families
- The NHS should **improve its communication about available services** for mental health, as well as signposting people to care in more informal settings such as drop in cafes

### 7.2 Feasibility

### 7.2.1 Funding

Across the six health and care forums, there were concerns that the **current lack of NHS funding resources available to support mental health services would lead to difficulties implementing the plan**. Some people highlighted the misalignment between the demand for mental health services (for example, that 1 in 4 people will experience mental health condition) and the level of funding allocated. A few people in Kingston suggested budgets could be pooled from NHS, local authorities and the police.

At the grassroots engagement activities, one participant noted that Springfield Hospital used to use an in-house team for talking therapies, but this has now been contracted out which seems a much more expensive way to deliver the service.

### 7.2.2 Capacity of services

Many people at the six health and care forums expressed **concerns about the current provision of mental health services in their community** and were therefore **pessimistic about the success of the planned changes**. In Merton, people felt current services were not adequate with too few sessions of treatment like talk therapy.

#### *Local services closing*

In the Sutton event, there were concerns that **while a need for more holistic treatment of mental health had been identified, several local services had been closed** (e.g. 'Memory Lane' mental health drop-in centre) and they currently do not have a mental health crisis centre. Many voiced concerns that when funding is reduced, patients will need to travel further or receive help in non-specialist facilities such as A&E. One participant questioned if there are enough NHS staff to implement a preventative approach to mental health, particularly for children. In Richmond however, people felt that mental health provision was very good due to strong local volunteer support for mental health care which reduces pressure on NHS services.

People at the grassroots engagement activities were also **concerned about the capacity of existing and future services**, noting that many mental health services seem to be closing down despite the high levels of need.

#### *Long waiting times*

People often noted that there **are currently extensive waiting times to receive treatment**, which is leaving patients without adequate support. In Sutton, people were concerned that long waiting times to access mental health services, combined with limited support for patients and carers after initial treatment, would continue under the new proposals. People in Croydon felt that there was a long wait to get on IAPT services, and that difficulties in accessing GPs are leading to even longer waiting periods.

Many people in the grassroots engagement activities shared their experiences of long waiting times to access mental health services, including 6-12 month waits for talking therapy; an 18-month wait to see a psychiatrist (for someone who was suicidal); a five year wait to see a therapist for Post-

Traumatic Stress Disorder; an 11-month wait for an ADHD assessment at Springfield Hospital; up to 12 weeks for IAPT services or Cognitive Behavioural Therapy (CBT); and a four-week wait to have a telephone conversation for the Sutton Uplift Service. People highlighted that long waiting times can put people off seeking treatment, and can lead to conditions escalating, ending up in crisis which could have been averted.

### *Lack of local beds and staff*

A lack of bed spaces was also highlighted by participants, particularly at Epsom, Springfield, and Queen Mary's. Some noted that even if a bed is allocated it is often only temporary and patients are regularly moved between wards. Due to a lack of bed spaces, some also highlighted that they **have to travel further to be admitted to hospital, which can be challenging**.

Others echoed this concern about being treated somewhere further from home. Support outside borough. Some had only been able to receive the treatment they needed outside their own borough, making it very difficult for family members to travel to visit them and provide them with support, leaving them feeling vulnerable and isolated.

People at the grassroots engagement activities also shared concerns about a lack of resources to deliver the plans for mental health services. Some questioned **whether there would be enough qualified staff, especially to provide early interventions**. Others highlighted a current lack of beds for mental health patients, particularly within Richmond, while some were concerned that mental health wards in Epsom and Leatherhead were closing. These people felt that this leads to people being transferred out of their local area for emergency mental health care, and having **fewer options available for people in crisis**. Similarly, people felt that drop-in services for Mental Health are lacking and as a result people's mental and physical health is declining.

## **7.2.3 Training and skills**

People at the six health and care forums were concerned that the **mental health plans rely on GPs to carry out more services** or see more patients. In addition to the capacity issues raised above, people felt GPs **may not have the appropriate knowledge and training** to recognise and treat a range of mental health conditions.

Others felt there was a tendency for GPs to **prescribe medications rather than talking therapies** or social prescribing. People suggested the plan should address this by making GPs more aware of the IAPT programme and other services giving access to talk therapy.

Similarly, at the grassroots engagement activities, several examples were provided of GPs prescribing antidepressants without looking at alternative treatment options. People felt GPs were too quick to hand out pills – and more should be done to treat the cause not just the symptoms. In many cases the antidepressants had a negative impact on people's quality of life. In most cases GPs didn't refer people on for specialist support or treatment before prescribing pills, but people felt that you should be seen by a mental health specialist before being prescribed anything. Some also noted that GPs sometimes simply give lifestyle advice to patients exhibiting symptoms of mental health issues, rather than referring them for further support.

Several people felt that it would **help if each GP practice had a mental healthcare specialist to provide more tailored support.**

People also agreed that **nurses and doctors should have regular training** on how to deal with challenging people, how to communicate with someone with a mental health condition, and how to not take things personally. Some also felt that psychiatrists should be trained to spend more time talking to the person rather than just focusing on medication and changing prescriptions.

## 7.3 Desirability

### 7.3.1 Crisis care

At the grassroots engagement activities, there was a consistent view that **there needs to be 24/7 crisis support for people with mental health conditions and their families.** People felt that very little support was provided at the weekends, which can be the most difficult times for people with mental health issues. They felt there needs to be an increase in walk-in services and out of hours services to support individuals when they need it most. Some people felt it would be helpful if there was a safe house to go to in times of crisis.

#### *Avoiding A&E if possible*

Often both individuals with mental health issues and their carers, **resort to going to A&E in a crisis, although people recognised that this is not the best place to treat them** or their loved ones. There was a strong feeling that specialist mental health nurses should be present in Hospitals, especially in A&E. If someone presented at A&E and was experiencing a mental health crisis, it was felt that a dedicated safe space would work well. It was also noted that there needs to be faster assessments at A&E.

Many people at the six health and care forums felt there was **not enough detail about how the mental health proposals would operate in practice**, and particularly about where patients would be directed for treatment. People agreed that A&E should not be the first port of call for someone with a mental health crisis as this can be an overwhelming environment, but felt there were few alternative options. At the Croydon event, there were questions about how to keep patients out of hospital, because the recent closure of the local Foxley Hill women's mental health service means patients are now sent directly to the hospital instead.

#### *Experiences of current services*

Some people at the grassroots engagement activities reported **specific concerns about current crisis services.** For example

- There were significant levels of feedback that the crisis support line is often out of action or unavailable. People shared their experiences of being told to leave a message but then not getting a call back.

- It was felt that mental health crisis was not dealt with very well at Epsom hospital and a few individuals felt let down by the NHS. They noted that there is a lack of beds available to treat individuals when they experience a mental health crisis.

Others had better experiences. For example, people **welcomed the introduction of street triage** in Merton, whereby a qualified nurse would be based in police stations to support police when they attend to members of the public exhibiting behaviours that indicate they have a mental health condition. People felt this would improve the skills of the police force and the relationship between them and service users.

It was also noted that the NHS are developing **the 'Lotus Suite' in the psychiatric decision unit**, and people **hoped that this would provide a better experience for people**.

Some people had positive experiences of crisis support outside SW London. For example, one person recently used the Safe Haven Service provided by NHS Surrey & Borders Partnership. She felt that this service was very good when she was in crisis and felt that more of these services should be across south west London. Reference was also made to the single point of access service provided by SLAM and it was noted to be a positive service for individuals experiencing a mental health crisis. It was suggested that SW London should operate a similar service, as they provide an experience that is less medical and perceived to be more cost effective.

### 7.3.2 Diagnosis and early intervention

At the grassroots engagement activities, there were several comments relating to the **difficulty in getting a diagnosis** for a mental health problem. There was consistent feedback that people are more likely to get treatment if they have a supportive family who campaign for better care.

People noted that **late diagnosis can have a significant impact on later life**, increasing the risk of early death. Several people emphasised that when people seek help, support should be immediate. They noted that it takes a lot to make the decision to seek help for mental health, so not receiving it immediately may put people off and their condition could escalate. There were several examples of late diagnosis of conditions, and the impact this has on people:

- Some people felt that it was very difficult for adults to receive a diagnosis of **Autism**. They felt that GPs block these diagnoses, for example if the individual has a stable job and family, even though a diagnosis can often help people to develop self-awareness so that they can maintain positive relationships with colleagues and family members. They felt that there needs to be much greater awareness and understanding of Asperger's and High Functioning Autism in adults.
- Several adults with **ADHD** (aged between 35 – 52) had only recently been diagnosed. They noted that they had gone through the majority of their adult lives being told they had a range of mental health conditions such as personality disorders, depression and anxiety.

It was noted that **diagnosis for mental health conditions sits between different organisations**, which leads to a disjointed system. For example, Tolworth will diagnose some mental health



conditions, but Your Healthcare are responsible for diagnosing ADHD. It was felt communication between these two providers is poor.

There was a view that **some groups of people needed enhanced support**. For example, in relation to early intervention, people felt that there should be earlier and more visible support for mental health, particularly for men who might not seek help due to the stigma around mental health. It was also felt that there should be more support for people with high level needs e.g. personality disorders.

### 7.3.3 Inpatient mental health services

At the grassroots engagement activities, several people shared their experiences of inpatient mental health services, which they felt needed to be improved.

At both Roehampton and Epsom mental health units, individuals were placed on mixed wards which they did not feel comfortable with.

There were **several comments about negative staff attitudes towards patients** at Roehampton, Epsom, Springfield, Queen Mary's, Richmond Royal and Bethlem inpatient services, including staff not taking patients seriously, not being available, over-medicating and using controlling behaviour, poor organisation, and a lack of personalised care.

People noted that the environment within NHS mental health services needs to be more informal and personalised so that it promotes recovery.

### 7.3.4 Out of hospital mental health care

People at the six health and care forums had **questions about the use of specialist mental health units**. In Kingston, there were some concerns that the psychiatric decision making unit **could mean that patients would not get specialist care until they were classified as 'severe' or 'enduring'**. In Richmond and Merton, people asked whether the Psychiatric Unit at Springfield Hospital would be changed. Some people were frustrated that there was not information about how this unit had performed (for example, had it reduced the use of A&E? Did it have successful patient outcomes?). They pointed out that residential care is very expensive and often lacks therapeutic treatments, instead only offering psychiatric drugs. In line with concerns about inpatient care outlined above, **further concerns were raised by people about the quality of existing outpatient services** which would be used in the plan. In Kingston, one participant described Tolworth Hospital (a mental health service) as being stressful for people experiencing mental health issues, especially due to long waits while at the service to see a specialist.

#### *Transitional support*

At the grassroots engagement activities, many people cited **examples of people being discharged from mental health care too early** without having addressed the underlying problem, and without support in place at home or in the community. This led to conditions escalating and causing relapse

and meant that people end up having to go back to their GP for a referral to get ‘back into the system’.

It was felt that **patients needed more transitional support** after being discharged from hospital care to help prevent relapse and support the transition to living independently. They expressed concern that this kind of support is being closed down, such as Foxy Lane Halfway House. Several people agreed that there should be long term support provided for people once they’ve been discharged from care (whether this is as an inpatient or community patient). They emphasised that people will often fall into a crisis again if no further support is given to help them maintain their health and wellbeing. People also said that changes in care coordinators happen frequently, and that people need to have consistent care.

### *Experience of services*

There was a suggestion that the existing 9-5pm mental health helpline should be rolled out to a 24hour local line rather than being referred to Crisis Line after 5pm.

At the grassroots engagement activities, several people also commented on outpatient mental health services.

Some had **experience of receiving outpatient care that was lacking in empathy or compassion** for the individual. For example, one participant described that staff were aware that a side effect of his medication is memory loss, yet did not provide any support for him to find his way home after going in to take the medication.

There was varied feedback about psychiatric care. Some people felt that **Community Psychiatric Nurses (CPN) are generally good, but the appointments that they offer are too short** and time is mainly spent filling in forms for assessments and not talking through the current issues. Some noted that psychiatric care continuously changes with little or no notification or consultation.

### **7.3.5 Holistic approach and personalised care**

People at the six health and care forums **agreed with the proposal for a holistic approach to mental health that integrated mental and physical health**, and would generally like to see a more well-rounded approach to patient care.

In Croydon, people believed that a holistic approach was needed that accounted for how mental health issues interacted with various conditions and illnesses. People in Richmond questioned if treatment and care would be joined up in practice and what this would mean for patients. In Sutton, people suggested linking mental health services with other physical health services such having mental health provision within a vision rehabilitation clinic to improve care. In Merton, people supported this integration as seen in a local hospital giving cancer patients psychological support. In Richmond, there was support for the idea of working more coherently with a range of voluntary organisations to give a more integrated patient experience - for example between GPs and IAPT.

A holistic approach to mental health care was also discussed at the grassroots engagement activities. Many people felt that **currently there is a lack of parity between the treatment of physical illness**

**and mental health illness** by the NHS, with physical health conditions treated before mental health, or with the conditions being treated completely separately. They agreed that there should be a more holistic approach, citing several examples of how mental and physical health conditions impact each other. For example, they noted that long-term conditions (e.g. diabetes) are often linked to a low mood if patients do not feel able to manage their condition well. Some also noted that fibromyalgia is a life changing condition and that people can take some time to come to terms with their body changing so much. They felt that they could fall into depression as they have no further support to help them with their mental wellbeing following this diagnosis.

People felt that staff should provide individual care specific to their needs rather than a generic package, taking into account that everyone is different.

### 7.3.6 Inclusive outreach and issues affecting specific communities

People at the six health and care forums believed **additional support is needed within the mental health services offered for individuals with a diverse range of needs**. They also thought it was important to ensure that all services are inclusive to all patients.

People highlighted the importance of services for a minority of vulnerable patients, including **BME patients and those with cultural barriers** to understanding or identifying mental health issues. Others suggested the plan should recognise and accommodate the needs of specific groups including **Lesbian, Gay, Bisexual and Transsexual (LGBT)** people, **adolescents** and **perinatal patients**. In Wandsworth, people were concerned that care for vulnerable populations was currently inconsistent and should be improved as part of these proposals.

At the grassroots engagement activities, there were several discussions about the need to address issues that affect specific communities.

With relation to the **homeless community**, people expressed a lot of frustration at the lack of services for homeless people until they are in a crisis. They felt that there was stigma attached mental health issues within this community and they felt people needed to be made aware that mental health issues are very common. Many said that they struggle with day to day living because they cannot manage the very little money they have. They may end up spending their money on alcohol to deal with how they are feeling emotionally, and often have to rely on food bank services. People shared some suggestions to help address these issues, including practical support to show them how to budget; and more training for front line staff in primary and secondary care (including receptionists) to help remove the stigma. It was also noted that 'dual diagnosis' was an issue experienced by many homeless people (having both a physical issue, mental health and alcohol and substance misuse). Furthermore, homeless people often struggle to access prescription medication because of not being able to register with a GP, yet they cannot afford to buy medication themselves.

With relation to the **LGBT community**, people highlighted that poor mental health and self-loathing can be quite prevalent, and some people cope by turning to drugs and alcohol. Some noted that there is an excellent Merton Drug and Alcohol team at the Wilson, however they felt this needs to be better promoted.

It was noted that many **Tamil women** stay at home while their husbands are at work. This can lead to loneliness and depression. People were not aware of where they could go if they needed treatment and they felt the best idea was to find out about services through GPs.

It was also noted that people from the **Gypsy, Romany, and Traveller (GRT)** community sometimes don't seek treatment for mental health conditions as they are fearful that if they do, their children will be taken away from them. More needs to be done to reassure people so that they feel more comfortable seeking support. People highlighted that there is quite a high rate of anxiety and depression within the GRT community and too much reliance on prescribing medication to treat these conditions.

People also noted that **loneliness** can have a huge impact on a person's mental wellbeing, especially following the death of a loved one. They felt that more needs to be done to support the mental health of people who are lonely or recently bereaved.

There were concerns that there was not much support for families who are supporting relatives with mental health problems. An individual stated that they felt that, due to the shortfall in the NHS funding, families were often left to pick up the job without any support. Several people echoed this need to provide better support to carers.

Finally, some people noted that Sutton CCG has been unable to provide British Sign Language (BSL) Counselling for deaf people and emphasised that this needs to change.

### **7.3.7 Mental health care for children and adolescents**

At the grassroots engagement activities, there were several discussions about mental health services for children and adolescents.

#### ***Diagnosis***

Many parents had experienced a struggle to get a diagnosis for their child, including feeling that their concerns were dismissed by health professionals. Often it had taken several years before a diagnosis was provided, which affected the children's educational and personal development. They also found that once a diagnosis was given, there was a lack of further support and also no pathway in place to check for other health conditions. In relation to this, they noted that, for example, children who have autism spectrum disorders (ASD) will often have vitamin deficiencies, epileptic episodes, and G.I and heart problems, which should be checked for. Parents emphasised that they would like to see a specialist following a diagnosis, to understand more about the condition and what treatment or support options are available.

#### ***Navigating the system***

A consistent theme was that parents were unsure of how to navigate the system and where to go to get more information on their child's health and mental health needs.

Many of the young people said they had experienced anxiety and depression, but they did not feel that they got the help that they needed when they needed it. None of them were routinely informed about the IAPT services and what treatment options are open to them for their mental health needs.

## *Children and Adolescent Mental Health Services and transitions*

There was varied feedback about Children and Adolescent Mental Health Services (CAMHS). Several people noted that they were only able to access CAMHS when things got really bad, and that there was limited support for them at tier 1. Once they had accessed CAMHS, many people found the support to be good, with excellent therapists. However, others felt they had not received enough support, (for example to help parents manage their child's behaviour, and to help them maintain their own wellbeing) and that communication was very poor. Some noted that staff within CAMHS seem over-stretched and they felt this is leading to children not being given full assessments. In relation to a more holistic approach to mental and physical health, some noted that there should be more awareness within the NHS of the link between hearing loss and behavioural issues and provide access to appropriate CAMHS services for this.

People noted that there needs to be clearer links between different services, for example acute trusts linking up properly with community services when the child is in the care of both of them. Some parents noted that once a child transitions from CAMHS to adult services, the pathway is very difficult to navigate and people get lost in the system. They felt that the transition between child and adult mental health services need to be more streamlined and supportive.

### *Crisis support*

It was highlighted that there is no crisis support available for children whom are experiencing mental health difficulties.

It was also felt that there is a lack of specific support for children who are transgender. Despite there being research to suggest that autistic children have a higher rate of becoming transgender than other individuals, there are no specific services in place to support them.

## 7.4 Advice on delivery

### 7.4.1 Working with schools

People at several of the six health and care forums discussed the importance of education about mental health and the role of schools could play in promoting services and raising awareness.

There was agreement among people about the **importance of mental health support within the education system**, to holistically tackle mental illness. In Kingston and Sutton, people believed there should be a more complete approach to supporting mental health in children by working to join resources in schools, families and local health services. Some people believed that more sustained and consistent support is needed from an early stage, rather than leaving caregivers alone to manage a condition.

There were also suggestions that **schools and education services should know more about mental health conditions and what support is available**. Additionally, in Sutton people believed that there should be more information about early mental health interventions in the school curriculum.

People at other events similarly suggested that mental health education should be developed, and that work was needed to alleviate stigma and encourage more people to seek support.

Similarly, at the grassroots engagement activities, there were several comments about mental health support in schools, and **improved links between schools and CAMHS**. Some felt that mental health, physical health and education should all be joined up and treated together rather than separately. For example, one young person received good support from CAMHS but when that ended and she started receiving the Health Educational Support Plan, the support became less effective because it only concentrated on school life and did not address the mental health issues.

Parents and young people alike emphasised that **schools need to provide more mental health support**. Young people who had a counsellor in their school had mixed feedback, with some feeling anxiety about being seen going for an appointment. It was suggested that a more informal approach, rather than an appointment-based system could help address this issue. **Young people also found that the school nurse was often either unavailable, or unapproachable**, which put them off going for support. Some young people had confided in their school tutor, however they felt they received mixed messages about whether conversations would be confidential or not, and a lack of transparency about this. Some young people said they would rather seek support outside school so that their peers did not find out that they needed help. However, they felt that there is a lack of awareness of youth centres that could provide support outside of school, and that schools should help raise awareness of where they could get help.

#### 7.4.2 Raising awareness of mental health services and support

People across the six health and care forums believed that **communication from the NHS needs to be improved to increase the use of mental health services** and suggestions were offered about how to communicate with the community better.

In Sutton, people believed that the NHS could **better inform the public and local medical professionals about what services are available from across the medical, community and voluntary sectors**. In addition, some in Wandsworth suggested that increased **signposting in GP surgeries, awareness campaigns and additional training for 111 phone line operators** could help support those with mental health issues. People suggested **raising awareness and training non-medical staff** (e.g. GP receptionist) to support people with mental health conditions and to signpost to treatment options earlier. In Wandsworth, people discussed **The Crisis Café in Merton as an example of a providing support in a community setting**, where signposting to care was available in a more informal space. In Kingston, people suggested care navigators could help with communication throughout the delivery of mental health services, as it reduces the need for patients to repeat themselves which can be distressing.

At the grassroots engagement activities, a suggestion made was to **ensure posters in hospitals and GP surgeries were up to date** to make sure people are aware of what other services for mental health are available.

### 7.4.3 Mental health awareness and stigma

People at the grassroots engagement activities felt that the **stigma towards mental health issues is slowly changing** and more people are speaking out about how they feel. However, they felt this is not the case for everyone, and **many people still do not access the support they need because of stigma**. It was mentioned that peer support and community groups are vital to people who have a mental health condition, however some people are still too scared to speak out about how they are feeling and **a targeted approach should be taken to reach those people**. It was also suggested that more training is available for front line staff in primary and secondary care (including receptionists etc.) to remove the stigma.

People felt strongly that **there should be someone in the community to talk to about preventing crisis**. They suggested that private drop in cafes should be available in each borough to provide independent advice around ways in which a person could keep themselves well mentally, to help reduce the stigma around using mental health services.

### 7.4.4 Improvements to crisis care

People at the grassroots engagement activities also had some suggestions for service improvements. **People were supportive of the 'crisis cafe' concept** but felt that this model assumes that people understand their own triggers and know when to seek support. They emphasised that **people need more training and support to enable them to understand their condition** and when it might escalate. They also emphasised that these services should be well advertised to raise awareness that they are available.

Several people noted that **they would have liked a medical review once their MH crisis was over**. They would like to be given the opportunity to reduce the amount of medication they were prescribed during crisis.

**Community Centre staff asked if they would be able to access the local directory of services** so that they could signpost individuals to the most appropriate services before they go into crisis. Centre staff all also asked if they could have access to the Crisis Response Service, as they often recognise when their more frequent visitors are moving into crisis.

### 7.4.5 Joined-up working

At the grassroots engagement activities, people emphasised that **all aspects of the health service need to work together more**, and that at the moment it feels very disjointed.

There were also some suggestions about how the **NHS could work more closely with other agencies** with a view to enabling a more holistic approach that includes both mental and physical health. For example, one participant suggested there should be a health advisor at the job centre, particularly for when people are sanctioned by the job centre, as this can have a detrimental effect on mental health.



People felt that there needs to be more **joining up with the voluntary sector and community groups** who can offer excellent support and activities for people suffering from mental health issues. One participant noted that co-production and asset-based community development are important approaches, and that the NHS should take this approach when commissioning mental health services and developing mental health strategies.

It was felt that **currently, signposting to the voluntary sector is a problem**, and many people had to do their own research or be lucky enough to receive recommendations from people they met. It was felt that people need a safe environment where people know them and can tell if they are on the edge of a crisis, and that the voluntary sector plays a vital role in this. However, people felt that there needs to be more investment in community groups and the voluntary sector to enable this support.

## 8. Learning Disabilities

The topic of learning disabilities was not discussed at the six health and care forums however there was some discussion during the grassroots engagement activities. The discussions focused predominantly on advice for delivery of services that are suitable for people with learning disabilities. These discussions are summarised below.

### 8.1 Key messages

- People were concerned about **long waiting times** to see a GP and requested that GP **appointments for people with learning disabilities should be longer** to allow more time to explain information clearly.
- **Staff need to communicate more clearly** with those with learning disabilities, and involve them in their care (not just their carers).
- There is a **need for improved accessibility** for those with disabilities (physical access and accessible communications).
- There should be **more awareness of annual health checks** for children with learning disabilities, including reminders from the GP surgery.
- More **support for carers** is needed.

### 8.2 Desirability

#### 8.2.1 Primary care

People **found it difficult when they couldn't get an appointment with their doctor** and noted that sometimes they had to book 6-8 weeks in advance before they could get an appointment with their GP. It was also strongly felt that people who attended their GP surgery should be informed of any delays to their appointments in advance as it can cause anxiety and stress.



It was felt that **GPs should allow a longer appointment slot** for patients whom have a learning disability so that the patient can ask questions if needed and the GP has enough time to explain things properly. Many felt that it is important for the carer to be invited to the appointment to help support the patient.

People highlighted that problems for people with learning disabilities when accessing primary care are well documented, including diagnosis and delays in treatment.

### 8.2.2 Communication from healthcare professionals

There were **several references to GP receptionists** and many individuals had negative experiences; **particularly in relation to how they deal with people with learning disabilities**, and particularly children with learning disabilities.

Some people felt that the **doctor would either talk to their support worker or just look at the computer** and type. This made them feel ignored and sad and felt it was important that GPs talk directly to the patient as well.

People noted that when **letters are sent out to patients**, they **are not written in 'easy read' formats** and sometimes contain complicated language. This means patients have to rely on others in order to understand the contents. It was suggested that GPs could phone patients with learning disabilities after letters are sent to explain and answer any questions.

However, some people felt that **even in person, GPs sometimes speak in jargon** and that this can be difficult for someone with a learning disability to understand.

People had **similar feedback in relation to communication with pharmacists**. They suggested that when people are given their medication, the pharmacist should take the patient into a room and explain how to take it. Sometimes people are given many different pills and only written instructions which can be difficult to understand for those with learning disabilities.

In order to facilitate appropriate communication, people felt that individuals with a learning disability should have this noted on their files so that staff (both receptionists and clinical staff) are aware and additional provisions can be made.

### 8.2.3 Accessibility

Some people felt that their **GP surgeries were not very accessible** and noted that all GP practices must be wheelchair accessible, including having wide enough lifts. Specific mention was made of Surbiton Health Centre which people noted needs more access ramps to be installed.

People noted that **Patient Online has made it easier for people to pick up prescriptions**. However, some were frustrated that they were still unable to book online appointments or see their medical records online.

### 8.2.4 Annual Health Checks

There were several comments relating to annual health checks for people with a learning disability.

It was noted that **not all GP surgeries invite people with a learning disability for their annual health check**. It was strongly felt that the GPs should write to the patient in advance to organise and remind them to book an annual health check. Many felt that the annual health check is an extremely important appointment and GPs should take the time to discuss and explain what they are doing. The majority of people spoken to had never heard or been offered a yearly health check for themselves or their children, indicating a lack of awareness of this service for children with a disability. People also noted that when they are offered an annual health check, they were seen for 20 minutes rather than an hour, which they felt was not long enough. One person mentioned that his particular GP surgery didn't know about annual health checks when they asked at reception.

### 8.2.5 Specialist services

Several comments and suggestions were made in relation to specialist services for people with a learning disability.

Some said that the **specialist care for children with disabilities is poor** and that it is not often tailored to an individual's needs. People felt there should be specialist clinics especially for patients with complex needs to help address this.

Some people also noted that **no support or information is offered to parents on how to obtain clinical samples** such as urine, when a child wears a nappy.

Finally, in relation to dental care for people with learning disabilities, some people were concerned that the **special needs dentistry service at St John's Health Centre, Twickenham has "vanished"** with no information provided to those that regularly accessed the service.

### 8.2.6 Diagnosis

There were several references to the delay in diagnosis for child with learning disabilities.

Parents described that it could take several years before a diagnosis is made, with some describing a two-year wait to see CAMHS in Croydon.

This is discussed further in the 'Care for children and adolescents' section within the 'Mental Health' chapter.

### 8.2.7 Communication between services

People felt there is a lack of communication between services and this has an impact of care that is being delivered. When seeing a new professional, they described having to explain everything again and they highlighted that this is difficult when you have a child with a disability.

## 8.3 Feasibility & Advice for delivery

No specific plans were presented at the health and care forums and therefore feasibility was not discussed. Equally, feasibility was not specifically discussed at the grassroots engagement activities.

## 9. Children's services

This section summarises the discussions across the six health and care forums and grassroots engagement activities events about children's services. It highlights the emerging themes and key messages about the case for change and the ideas developed so far. Across the health and care forums, there were fewer attendees at this topic group than at others and in some cases, there were no people to discuss the proposed changes to children's services.

The suggestions outlined in the STP relating to children's services include:

- Parents with young children will have improved access to GPs or another community based service
- Children requiring short term hospital treatment will be treated in specialist units linked to A&E
- Children needing extended hospital stays will see specialists more quickly.

### 9.1 Key messages

- Some people expressed concerns that there were **currently not enough NHS resources to carry out the proposals for children's services**.
- While people **agreed with the principle of reducing unnecessary A&E visits from children and parents**, they felt it would be challenging due to a perceived absence of alternatives
- People believed that to reduce the burden on acute services, **more flexible GP services are needed**
- There were concerns about **long waiting lists for referrals** to specialist clinics, and long waits at clinics, sometimes with inappropriate waiting areas
- The STP should **address children's diverse health needs**, including improving mental health services, services for learning disabilities and provision for families with different cultural backgrounds
- People believe **increased awareness is needed about what services are available for children's health** as well as when it is appropriate to use each service
- It was suggested that **children should be more involved in actively discussing their symptoms** and conditions with doctors directly
- There was a desire for more education and information to support **healthy lifestyles** for children and families

## 9.2 Feasibility

### 9.2.1 Resources to deliver services

Some people expressed concerns that there were **currently not enough NHS resources to carry out the proposals for children's services**. At the Richmond health and care forum, people were concerned that the lack of staff across the healthcare service (from GPs to midwives), combined with insufficient funding of services, would lead to an inability to deliver the STP. One participant suggested the consolidation of health and social care budgets to achieve better health outcomes with greater resources.

In Richmond, people liked the use of a **community paediatric nurse** and would like to see this service more often.

At one of the grassroots engagement activities, it was raised that **the way funding is organised is perceived to cause problems for delivering children's services**. In particular, it was noted that funding for hearing screening for newborn babies is included in the "postnatal maternity payment". However, because of this allocation, the maternity leads in each of the acute trusts do not have money for all babies, and therefore time and resources are spent chasing payment. It was hoped that a more collaborative approach to commissioning and more joined-up working would help alleviate this kind of issue. It was suggested that newborn hearing screening should be included in the five-year strategy for local health services to facilitate continuity and uniformity across the sector.

It was felt that generally children and young people are often seen by trainees who regularly rotate, therefore there is little continuation in care and a lack of experienced specialist staff.

### 9.2.2 Alternatives to A&E

Most people at **supported the idea of reducing the number of unnecessary visits to A&E** by parents with children. However, they believed that it would be challenging to do this. At both the health and care forums and the grassroots engagement activities, many agreed that A&E can be an unsuitable environment for treating children, but believed that **anxious parents often do not think there is an alternative**. People in Kingston highlighted that existing services such as the NHS 111 phone line are not always effective for parents, as if they are worried about their child they are likely to prefer in-person diagnosis and treatment. Also, other services can be slower to access as they do not have a target to see all patients within four hours, or have services which are perceived to be of variable quality. In Croydon, people believed that parents would take their children to A&E if GPs were not accessible as they did not trust pharmacy or community services.

**Improving access to GPs** was therefore considered to be fundamental to reducing the number of children unnecessarily in A&E. Access to appointments and advice was raised as an issue at most events. People suggested that, if parents have confidence that the care their children are receiving out of hospital is appropriate, then they will stop relying on A&E as their first choice. It was

emphasised, however, that GPs are currently under great pressure, therefore actions should be taken to increase their capacity.

**When young people were asked where they would go if they needed urgent care, most said they would call 999 or go to A&E** because they knew where A&E was and because they knew that doctors would be there. A few said they would go to their local walk-in centre because they thought it would not be such a long wait as A&E. A few also said they would ask their parents to make a GP appointment.

Some young people in the grassroots engagement activities were also **aware of several other services they could access for support**, including Child Line; Talk bus; the local substance misuse team; and police. If they needed support for drug or alcohol problems, young people felt it was important to have somewhere to go where they would not be judged, somewhere that was safe and secure, and that support groups and counselling would be valuable.

## 9.3 Desirability

### 9.3.1 Flexible services for parents

To achieve the proposed aims for children's healthcare, people at the health and care forums raised the issue of **flexible access to services for parents** as while they agreed A&E was not the optimal solution, it was viewed as flexible. There were common concerns that a 'one size fits all' approach would not be suitable for parents. In a couple of events, people discussed that parents may need access to GPs after normal working hours and that they should be accessible seven days a week.

### 9.3.2 Appointments and referrals

At the grassroots engagement activities, people noted that there are **often long wait times for referrals into specialist clinics or support services for children and young people**. It was suggested that improved systems should be introduced to help manage this.

People also said that **appointment times at specialist clinics rarely run on time** and this can be difficult to manage, especially when you have an autistic child. As such, it was felt that **waiting rooms need to be more autism-friendly** and have a sensory area for children.

### 9.3.3 Inclusive support for diverse needs

To address the diverse range of needs in each community, people across the health and care forums suggested some specific areas of improvement to be addressed in the plan.

At the Croydon health and care forum, the **additional needs of immigrant families** were discussed and it was suggested extra support may be needed as extended family members may not be available. A similar concern for **parents with limited social networks** was raised in Kingston, as they may be less confident in managing their child's care. Both events believed those with English as a second language would need tailored support, such as **information available in multiple languages**.

More nervous parents were believed to be more likely to take their child to the hospital as the first port of call, therefore there should be additional efforts to support these groups.

In addition, people in Kingston discussed **provision of care for children with mental health conditions** and additional needs. They believed more needs to be done to address this within the STP proposals, including clarity of what qualifies as a mental health issue in a child, and information about what services specialising in paediatric mental health are available for children and their parents. For parents with children with special educational needs and disabilities, people suggested that direct routes to services could reduce the burden on GPs.

At the grassroots engagement activities, people emphasised the **need for improved standards of care for children and young people with a learning disability, a long-term condition, or autism**. This includes further training for staff on how to care for these children effectively and communicate sensitively. It was suggested that staff working within the healthcare system, need to be friendlier and have an **improved ability to relate to young people**, especially those with complex needs, learning disabilities or autism. It was also felt that there should be **quicker access to specialist advice** and support for people with learning disabilities, in order to avoid any detrimental impacts on children from delayed diagnosis or support.

There was a suggestion that more **specialist care could be provided within schools** so that children did not have to attend hospital regularly for their appointments and have to miss school as a result.

The **transition stage as children with long-term conditions become adults** was felt to be very challenging, and there were calls for commissioners to address this issue and ensure long-term or lifetime care is planned from the point at which a condition is diagnosed. People felt that more joined up working between GPs, specialist clinics, schools, hospitals and other forms of care would be needed as children with long-term conditions become adults.

### 9.3.4 Out of hospital care

There were specific concerns from parents of children with **unilateral hearing loss**, that their children are not given the same treatment or consideration as those with bilateral hearing loss. They were disappointed by the lack of support they received.

Access to **speech and language therapy** service is seen to be patchy and inconsistent. It was felt that speech and language therapists need specialist training in how to work with and support children who have hearing loss as they do not appear to be experienced in this area.

People also voiced concerns that there was **insufficient support provided through out of hospital care**, both by the NHS and the Local Authority. For example, people highlighted a lack of continuity of care in terms of speech and language therapy for children. There was a suggestion that having speech and language therapy and/or occupational therapy funded as part of the Education and Health and Care Plan (EHCP) from the local authority does not work well, as there are either not enough sessions, no sessions, or inconsistent and different therapists.

### 9.3.5 Communication

People at the grassroots engagement activities emphasised that **communication both within and between children's services should be improved**. For example, it was felt that care is not well coordinated between the NHS and local authority for children who have an education health plan.

It was also felt that there should be improved communication with parents about what to expect in terms of waiting times for appointments. It was suggested that when a long-term condition is diagnosed in a child, their parents should be provided with a **designated support worker who can provide advice, support and guidance as parents get to grips with their child's condition**. They felt that this kind of support would lead to less stress among parents and potentially fewer trips to the GP or to A&E.

### 9.3.6 Mental Health

Detailed feedback about mental health care for children and young people, can be found in section 7.4.7.

People at the grassroots engagement activities **questioned how Child and Adolescent Mental Health Services (CAMHS) are involved in the plans for children's services**. There was a feeling that mental health for children and young people needed particular consideration and improvement. It was felt that the **waiting times to receive support through CAMHS was too long**, the process is confusing, and the thresholds for support are too high, leaving young people with no support and at risk of self-harming.

## 9.4 Advice on delivery

### 9.4.1 Raise awareness of services

People at the health and care forums believed that more should be done to **promote services for children's health available in the community**, as well as when you use each one. Many people thought the NHS could do more to communicate with the public about children's health services. They gave several suggestions for how to improve this communication, including

- providing better signposting to other services when parents and caregivers arrive at A&E;
- GPs explaining to parents about when to use different services during appointments (e.g. discussing when to go to the pharmacist rather than GP)
- GP surgeries signposting to appropriate services when booking appointments;
- developing partnerships with schools and community based services to advertise where parents should seek medical advice;
- having a nurse available within schools who can discuss children's health with parents.

In addition to raising awareness of services, some believed there was a need to **clarify what services should be used when**. For example, when to speak to a GP on the phone, when to see them in



person and when to go to A&E. In Wandsworth, people suggested that these standards should be adhered to in GP surgeries to ensure consistent and appropriate treatment is given. In Merton, people emphasised the importance of giving parents confidence in which service they should use, and suggested reaching out to local parent groups.

At the grassroots engagement activities, it was noted that the Hounslow & Richmond Asthma service brought great improvements by taking the programme into schools, and that this model could be used for other conditions too.

### 9.4.2 Use of technology

At the health and care forums, **some people liked the idea of using technology to have more flexible services** for parents and children. In addition to traditional GP appointments, some people in Kingston and Merton suggested using technology such as Skype to provide remote appointments and in Wandsworth they suggested telephone consultations. However, they suggested that remote appointments may not be reliable for advice and diagnosis in all cases, as parents would need to be able to accurately describe or assess symptoms. Other suggested approaches were to have walk-in clinics for first stage diagnosis from which appropriate follow up could be signposted, or having a GP available in a hospital setting.

Young people at the grassroots engagement activities suggested that an app could be helpful for people to find their nearest surgery and give health information such as showing what healthy and unhealthy foods are.

### 9.4.3 Children's role in treatment

At the Wandsworth health and care forum, it was highlighted that in administering children's health services, there should be a **cultural change in how young patients are communicated with**. This would include asking children about their symptoms directly rather than through the parents as intermediaries. They felt this would encourage a culture of confidence among young people accessing healthcare. In Merton, people also suggested that better understanding the needs of children and parents through local parent groups would help give better care.

Similarly, at the grassroots engagement activities, people felt that children could be communicated with more effectively to **help them manage their own conditions**, such as explaining why they are prescribed medication, how it will help them, and when or how to take it.

### 9.4.4 Prevention (promoting healthy lifestyles)

At the grassroots engagement activities, **education and promotion around healthy lifestyles** was discussed with children and young people.

People showed a good awareness of the distinction between healthy food and less healthy options, as well as more detailed understanding of what makes food health or unhealthy. There was also awareness of the "five a day" and "eat a rainbow" campaigns and what they mean, and there was

positive feedback about the “Eat Well Plate”. Most children said they exercise regularly, however some wanted more advice about what is considered to be good exercise.

In discussing mental health, some children talked about stress associated with school and daily life, with some citing exams and homework as causes of anxiety.

It was noted that information on personal topics such as sex, relationships, and eating well usually only comes through outside organisations rather than being discussed at schools. The majority of the children who took part wanted **more support from school about healthy lifestyles**, including classes such as food technology, lessons on what is healthy and unhealthy, and lessons on healthy body image and eating disorders. Some children also wanted healthier choices for school lunches. In contrast, some young people felt that when they are given too much information, it could have the opposite effect and could put people off from listening.

**Among parents**, some noted that they have received support through their child’s school to **help with budgeting and healthy eating**. In contrast, others said they had not received any support on healthy eating habits in relation to their children or themselves.

Parents made several **suggestions about how to support families to be healthier**, including having more free fitness activities for children; more education around health and exercise; vouchers for healthier food for single parents; gyms and swimming pools at reasonable prices for families; and quicker and better treatment of ailments that prevent people from exercising.

## 10. Maternity services

This section summarises the discussions across the six health and care forums and grassroots engagement activities about maternity services. It highlights the emerging themes and key messages about the case for change and the ideas developed so far.

Across the six health and care forums, the maternity services tables were attended by lower numbers of people than for other topics, and due to the high representation of older participants, most people had not used maternity services in recent years.

The suggestions outlined in the STP relating to maternity services include:

- More personalised care before, during and after birth with women seeing the same midwife/team of midwives throughout their pregnancy
- Better mental health support for mothers struggling to cope.
- Greater provision of consistent and unbiased information around the options available to ensure women give birth in the place of their preference (i.e. midwife-led unit, home birth).
- Ensuring women receive high quality care which supports them to have a normal, health experience whilst also caring for higher risk, more complex births (such as mothers with diabetes or obesity).

### 10.1 Key messages

- When discussing maternity services, people discussed the **lack of access to quality care due to midwifery staff shortages** which needed to be addressed
- **Post-natal care was highlighted as a service that required improvement** and people would like to see this addressed in the STP
- **Continuity and consistency** of maternity care were believed to be areas for improvement with specific issues in midwifery care due to the shortage of midwives
- Many people would like to see **increased personalisation and patient-led approaches to care**, however emphasise the importance of **prioritising patient safety**
- **Communication and attitude from staff** involved in maternity care was seen as variable and in need of improvement in order to adequately support women giving birth
- People suggested communications and outreach should be carried out to **raise awareness of services** and cater to differing and diverse needs in the community

## 10.2 Feasibility

### 10.2.1 Access to quality midwifery care

People at the six health and care forums believed there is insufficient access to midwives currently, and **had questions about where additional staff proposed would be sourced** from given the current shortages. In Kingston, some people believed there was a current lack of trained midwives to deliver the necessary maternity services. This was echoed by some people in Richmond, whom also believed that recruitment was a challenge which would increase due to the impact of Brexit.

There was further **discussion of how the difficulties in recruiting midwives would impact care provision**. In Richmond, people suggested that the challenges in recruiting and retaining midwives could reduce quality, as high staff turnover and pressure to fill positions with less qualified staff was believed to impact patient trust. One participant also suggested that midwives have a high workload and this could be relieved with the support of a labour assistant to coach patients through birth. Similarly, concerns about the midwives' workload were discussed in Wandsworth where several people believed overwork was leading to poorer outcomes for patients. They believed that the emphasis on productivity was leading to midwives not being able to effectively offer emotional support to the women they work with. People suggested **training for midwives should include helping them to take care of themselves** so they are able to deliver the best quality care.

Discussions at the grassroots engagement activities also reflected these **concerns about the quality of midwifery care**. St George's maternity services were described as "appalling". For example, one individual described that when delivering her third child, she was left for long periods of time with no midwife available and believes she did not receive proper care from staff. In contrast, several other people were more positive about their experiences of St George's and felt care was attentive and appropriate, suggesting there is a lack of consistency around the quality of care. Others felt that there are too many locum midwives at Kingston Hospital and that they do not seem to care about mothers and their children. In contrast, the maternity services at Epsom were praised due to good standards of care from the staff.

It was also highlighted that both hours and pay for midwives need to be reviewed in order to help with staff retention.

## 10.3 Desirability

### 10.3.1 Post-natal care

People at the six health and care forums were **broadly supportive of the STP proposals for pre- and post-natal care**. However, there were also some concerns and **questions regarding the post-natal care proposals** and how these would work in practice.

Many people discussed the kind of **support they felt was needed post-partum and across the pregnancy**. In Richmond, while pre-natal and birthing care were agreed to be high quality, post-natal care did not match this and was considered surprisingly poor. A participant believed that

personalised care was most important after the birth, offering more flexible services post-partum. Others believed that there was a **need for post-natal classes** for women after they have given birth. Additionally, at least one participant felt more should be done to encourage new fathers to learn to help care for infants and mothers. They believed this was particularly important for vulnerable mothers such as those suffering from post-partum depression.

**Support for mental health across pregnancy was also an important need** people felt needed to be addressed in the STP. Similarly, in Wandsworth people discussed how to support women who are struggling to cope particularly after the pregnancy. While the STP aims were supported, **they questioned how professionals would be able to identify those who are not coping** in practice, particularly when there is a stigma about disclosing information. People believed having strong trust and communication between women and their care professionals was vital before, during and after birth.

People at the grassroots engagement activities also felt that post-natal support was lacking. Several mothers felt that not enough support was given after their babies were born. Of note, people **didn't feel they received enough support around feeding** and were put under too much pressure to breast feed. The emphasis on breast feeding (rather than feeding) meant that their babies ended up being dehydrated. Some noted that they were given only very generic information after the birth of their child through St George's Hospital, rather than advice that was specific to their situation.

Others noted that **the quick turn around after birth causes some concern to new mothers**. They highlighted a need in Maternity units to accommodate a longer hospital stay after birth, and that this should be considered when new premises and rebuilds are planned.

There was a **suggestion to have a helpline number** to call after having a home-birth. People described that after a home-birth, their notes were taken away and they were not given any contact numbers.

### 10.3.2 Continuity and consistency in care

Many people at the six health and care forums **agreed with the STP that maternity services should be delivered differently**. Specifically, there were several comments regarding the **need for increased consistency in the care received** as well as **more continuity before and after birth**.

A few people discussed standardisation of midwifery to give greater consistency in the treatment and approach of midwives. In Richmond, people supported having more consistency, including post-natal visits to provide additional support to mothers. People in Wandsworth believed midwives should have a shared mindset about how they work with women in their care and a similar patient led approach to offering choice.

In Kingston, some people had experienced a lack of continuity in care delivered across the pregnancy from check-ups to post-natal care. In Wandsworth, a participant recommended managing expectations about what the NHS can deliver, including letting women know they may not see the same midwife throughout their pregnancy or birth, to be more transparent about what is possible.

The need for improved continuity and consistency of maternity care was also discussed at the grassroots engagement activities. People felt very strongly that their **care would be improved if they had the same midwife throughout their maternity journey**. They felt this would enable them to build a bond between the mother and midwife, and would help the midwife to pick up on softer signs of concern.

Some people **would also prefer to have more ‘check points’**, especially for older mothers or those likely to experience complications with their pregnancy.

Several people described having very **inconsistent care from one pregnancy to the next**, or from different midwives or different hospitals, or that the standard of care had dropped significantly from first pregnancies to more recent pregnancies within the same hospital.

### 10.3.3 Personalised and safe care

Across several of the health and care forums, people discussed the provision of personalisation in maternity care, however **there were concerns about what personalisation would mean in practice**. People believed it would be **important to balance the patient led approach with patient safety**.

Many people were **supportive of a more holistic approach** to maternity care, allowing women to have choice in pregnancy and labour as suggested in the STP. A participant in Kingston highlighted the need for women to feel listened to rather than a bureaucratic, ‘box-ticking’ service. In Wandsworth, people supported the idea of empowering women to have more choice in their maternity care. However, **some questioned what the real choices offered to mothers are**, and how choice would extend beyond which hospital to give birth in.

Many people at the six health and care forums agreed that **providing accurate medical advice was more important than personal choice** in supporting women’s maternity care. In Sutton, some people believed that without the necessary information, allowing patients to make maternity care choices could harm their health rather than empower them. This concern was shared in Richmond where people were concerned women would not make safe or healthy choices without advice from a practitioner. In bringing together these concerns, people in Wandsworth believed that while choice for women must always be balanced by medical decisions about what is safe, where there is scope for choice there should be a shift towards woman led approaches.

Discussions about personalised maternity care, holistic care, and increased choice also took place at the grassroots engagement activities. Several people were **supportive of home-births where appropriate**, however they **emphasised that sufficient staff are needed** in order to both promote and deliver this. The dedicated home birth team at Kingston Hospital was praised in particular as a good model of care. In contrast, **other people felt that a hospital is best place to give birth**, particularly for the birth of a first child, and they felt **the hospital needed to be local**. Some people described maternity services at St George’s as really good. One couple noted that the team were open-minded to the use of acupuncture and complementary therapies, which they valued.

It was highlighted that sometimes mothers do not get a birth plan until very late, and that there was a lack of support for women to develop a plan that was tailored to what they wanted.

There were also **some concerns relating to high-risk pregnancies not being identified**, for example not being identified as high-risk following the birth of a premature baby, with very negative consequences for two subsequent pregnancies.

### 10.3.4 Staff communication and attitudes

At the grassroots engagement activities, several additional comments were made regarding to communication from staff. Several people described **poor experiences of communication when in hospital**, and a lack of empathy from staff during an anxious time for mothers and their partners. This was particularly the case at Kingston and Croydon University Hospital. Others described that a **lack of clarity in communication** led to them being kept in hospital longer than necessary.

Several examples were given of **insensitive attitudes and treatment**, including pregnant women not being taken seriously when they have concerns about the health of their baby, and especially during and after still births. For example, one person noted that they had to give birth in the same ward as other women having live births and found this very traumatic (at Epsom Hospital). It was also noted that not only was the birth traumatic, but there was **no support or aftercare**.

## 10.4 Advice on delivery

### 10.4.1 Inclusive outreach

People at the six health and care forums made several suggestions regarding how the STP would be delivered to the community. One common topic was how outreach and communications for services would be addressed in the STP.

People believed that it was **important to promote the maternity services available** as well as **making these accessible to individuals with a diverse range of needs**. Some saw it as important to have maternity **care closer to the home and more personal** rather than in a large GP surgery which is busy with high numbers of patients. People in Sutton believed that it was important to tailor information based on a person's needs, such as GPs and midwives giving more information to patients, and giving information sources in multiple languages. Several also spoke about the **need for consideration of cultural differences** in how women and their support networks prefer to receive care.

People in Sutton and Kingston both highlighted the need to support at-risk patients. Some felt that the **need for personalisation was linked to outreach and safeguarding**, as for example, if done well this could help to identify women who are experiencing or at risk of domestic violence. They believed that the medicalisation of maternity care is a barrier to safeguarding outreach and conversations.

### 10.4.2 Improved waiting areas

People at the grassroots engagement activities felt that the **waiting area within the Emergency Gynaecology Unit (EGU) needs to be improved** to appropriately accommodate those attending

(many of which are experiencing a loss of a child). Some noted that there was also a long waiting time and nowhere for children to keep themselves occupied. It was felt that the area was not child friendly and the room that you have to wait in was very small and not appropriate.



## 11. Cancer

The topic of cancer care was not discussed specifically at the six health and care forums, however there was detailed discussion during the grassroots engagement activities. These discussions are summarised below.

### 11.1 Key messages

- People felt more work could be done to **increase uptake of screening**, and to increase preventative care and guidance to those at higher risk of cancer.
- People emphasised the need for **early diagnosis** and suggested GPs could receive additional training from hospital specialists.
- Delivering news of a diagnosis should be delivered with **empathy and sensitivity**.
- People suggested additional **follow up support** could be provided after diagnosis and after treatment, both by NHS staff and through **signposting to support in the community**.
- Additional support could be provided to help patients deal with **side effects and long term damage** caused by cancer treatments.
- There was a desire for **NHS SWL to set the ‘gold standard’ for cancer** diagnosis, treatment and care, including being proactively involved in trials and new treatments.

### 11.2 Desirability

#### 11.2.1 Screening and prevention

There were a few comments about screening for cancer. People had **positive feedback about screening programmes** which had successfully picked up on early signs of cancer. They valued the service and felt that it led to early diagnosis and successful treatment.

However, it was noted that there is very **poor uptake of cancer screening among the Gypsy Roma and Traveller community**. Feedback suggested people from this community do not feel comfortable discussing personal issues with strangers. Some suggested solutions included taking public health messages through churches (where many of this community attend), or having a mobile screening unit that goes to their sites to screen women during the day.

It was felt that there **should be more emphasis on preventative care** to those that at risk of certain cancers. People thought this should include increased activity and weight management and encouraging patients to manage their health through lifestyle choices.

#### 11.2.2 Diagnosis

People at the grassroots engagement activities emphasised **the importance of early diagnosis**, in order to avoid the need for more aggressive forms of treatment and to improve clinical outcomes.

Overall it was noted that **once diagnosed, the NHS provides excellent care**. However, there were some experiences where receiving the wrong diagnosis had serious repercussions. For example, one person had been diagnosed with cancer of the womb, and had surgery which involved a hysterectomy. After this procedure, a biopsy was taken and it was identified that there was no cancer present.

There were some concerns that **GPs might need more support and guidance** about spotting symptoms of cancer that are less obvious, and to not dismiss symptoms because a patient is younger. There were also concerns that GPs may not always identify symptoms of recurrence. There was a suggestion that increased communication between GPs and specialists at the hospital might help. One participant noted that this was starting to happen at Croydon University Hospital.

People emphasised the importance of the **diagnoses being delivered with sensitivity and support**. Several people shared experiences where there was a lack of empathy, including where there was a terminal diagnosis. Some had also received no signposting to sources of support, while others had to chase follow-up referrals themselves.

People also noted the importance of having someone with them when receiving a diagnosis of cancer as patients are unlikely to be able to take in everything that has been said. It was noted that Macmillan play an important role in this, accompanying people to their appointments.

It was suggested that more could be done **to identify people at risk of recurring cancer or secondary cancers**. For individuals diagnosed with **metastatic cancer**, people emphasised the need for joining up health and social care services to provide better care, and working towards more effective treatment and symptom management.

There was a question about what the NHS in South West London is doing to implement the recent Metastatic Breast Cancer Specification from The London Cancer Alliance.

### 11.2.3 Support following diagnosis

It was suggested that it would be helpful if patients could have a **follow up appointment**, possibly with a nurse, shortly after the appointment with a consultant where the diagnosis is confirmed, so that they have time to absorb the news and then be able to ask further questions.

People also felt that there should be **more counselling services** for people affected by cancer (both patients and carers), to help reduce strain on GP services due to patients experiencing stress and anxiety following a diagnosis of cancer.

It was suggested that more support should be given to people who are diagnosed with **terminal cancer**, to help them accept the diagnosis and cope with their life. Concerns were raised particularly for people who live on their own, who can feel very isolated following a diagnosis.

People also felt that more support groups were needed, including investment in survivorship schemes.

### 11.2.4 Treatment

People emphasised the importance of prompt treatment in improving outcomes for cancer.

In relation to where patients receive treatment, there was some support for the idea of **using community settings** as long as this could be done safely. There was a suggestion that the first few sessions of chemotherapy could be done in hospital to watch for any adverse reactions, followed by subsequent sessions in the community. Whilst people valued the specialist treatment they received (for example at the Royal Marsden) many felt that they would **prefer having all of their treatment in one place** – rather than going between sites (local and specialist).

In terms of follow-up soon after treatment, people noted that there was a **lack of clarity about who would provide follow-up care**, especially when treatment takes place at several different hospitals. It was suggested that a guide could be produced so that patients were clear on the follow-up they should receive. Similarly, people felt that there could be **more signposting after treatment to other sources of support** available to them in the community, such as the Mulberry Centre and Pauls Cancer Support. It was suggested that GPs could play a role in informing patients about these sources of support.

There were several comments about the need to provide **more support to patients to help them deal with the side effects of cancer treatment, and the longer-term damage it can cause**. There was a suggestion that there could be a physical check-up once a year for cancer survivors, or heart checks at a minimum. Several people felt that GPs should be calling people in for cancer reviews, and that it shouldn't be up to the patient to initiate these. People felt strongly that that GPs could have a greater role post diagnosis, including following up after surgery regularly and checking in on their patient's wellbeing.

In order to reduce delays in treatment, it was suggested that there could be a system where if one trust or area has the capacity, they could take on treatment from another hospital that was over capacity.

It was noted that West Middlesex operate free parking spaces for those attending appointments relating to their cancer and it was suggested that other hospitals should do the same, due to the number of appointments cancer patients have to attend.

### 11.2.5 Support following treatment

It was suggested that more could be done to **support patients in the transition from receiving aggressive cancer treatments to follow-up treatments as part of their recovery**. People noted that this need not involve additional NHS resources, but that it could be achieved by joining up primary and secondary care with sources of support in the community.

There was also a suggestion that **physical therapy, lymphedema services and mental or emotional support could all be provided locally** rather than in a hospital, for example through –local health centres, GP services and walk in centres. It was felt that this would help with the transition and could also be combined with support for patients to start self-managing their health and wellbeing following cancer treatment.

### 11.2.6 Quality of care / treatment

There were several comments about the **high standards of care received at the Royal Marsden Hospital**. However, it was noted that **quality of care can vary depending on the time of year** a patient is diagnosed. For example, hospitals change their staff at the end of July, which can interrupt treatment, including a loss of knowledge about the patient and their condition.

There was a call for the NHS in South West London to **set a “gold standard” for London regarding cancer diagnosis, treatment and care**. It was suggested that this should include better data collection on patients so that they can be followed from early diagnosis to end of treatment and beyond, to help identify and manage any cases of metastatic cancer that arise following initial treatment.

It was suggested that **additional training should be provided to district nurses** to support patients' cancer care, to help ease the burden on GPs.

There were also concerns that the NHS in South West London were trying to persuade people to support the idea of specialist hospitals, in order to justify closing local hospitals.

### 11.2.7 New treatments and trials

There were several comments about new cancer treatments and offering the opportunity for patients to take part in trials.

There was a suggestion that primary cancer and metastatic cancer **patients should be offered appropriate trials at the point of diagnosis**.

It was noted that emerging research is showing the effectiveness of a “once and done” dose of radiotherapy, and that **shorter emerging treatments such as this would help the NHS make further savings**.

It was also suggested that the Oncotype DX Test (which can identify whether a person diagnosed with early breast cancer would benefit from chemotherapy) could be used in a pilot to determine whether costs of administering this test would be offset by costs saved through unnecessary chemotherapy treatments that would be avoided. It was suggested that **initiating pilots** such as these would help the NHS in South West London raise the bar in terms of pioneering and high quality treatments.

## 12 Planned Care

The topic of planned care was not discussed at the six health and care forums, however there was some discussion during the grassroots engagement activities. These discussions are summarised below.

### 12.1 Key messages

- People felt **specialist hospitals or elective centres could produce better outcomes** but there were concerns about the feasibility of plans and whether they would lead to necessary cost savings.
- Concerns were raised about **whether there are sufficient staff** to deliver planned care effectively and efficiently, and some thought current staff are overworked and overstretched which impacts on patients.
- People are more **prepared to travel for non-urgent elective care**, but ensuring there is **appropriate transportation will be important**.
- There is scope for current practices around **discharge and aftercare to be improved**.
- A proposal that reduces the wasted time as a result of **cancellations of operations and outpatient appointments** would be welcomed.
- There is scope for **improving internal and external communication between services**, including GPs, hospitals and social care providers.

### 12.2 Feasibility

#### 12.2.1 Funding

People broadly felt that **providing specialist hospitals or elective centres could produce better outcomes** due to having specialists available 24 hours a day. However, there were **concerns about the feasibility** of this plan, in terms of **how it would be funded**, and **how it would contribute to cost savings** across the NHS. For example, the Epsom Orthopaedic unit proved a great success until financial issues threatened closure, and as a result many specialists left and essential experienced surgeons are no longer available to train and develop future consultants. The pain clinic at Kingston was praised, however, staff were unable to provide home appointments for patients due to how they are funded which was seen to be a limitation.

#### 12.2.2 Staffing and resources

Several concerns were raised about **whether there was sufficient staff to deliver planned care effectively and efficiently**, and how this would be addressed. In order to reduce waiting lists and increase patient turnover, **people noted that more staff would be needed**, and a combination of

different specialisms is necessary to treat patients effectively. It was also noted that administration services need to be improved to support more efficient delivery and link hospitals together.

People shared **concerns that hospital staff are currently overworked** and overstretched, leading to negative experiences for patients including some feeling that they were being treated by junior staff lacking in the necessary experience.

There was a suggestion that new specialist staff members should be employed rather than relying on locums, since locums are often more expensive.

There was general consensus around the need to pay nursing staff more, in order to improve patient care.

There was a concern that **equipment is not always managed in the most efficient way**, for example ordering operating equipment as needed rather than having a supply available means operations are delayed due to lack of equipment. Some felt that having specialist elective hospitals would help with managing resources as expensive specialist equipment could be concentrated on one hospital.

## 12.3 Desirability

### 12.3.1 Accessibility and transport

People felt that **when elective surgery is essential but not urgent, they would be willing to travel further** distances to receive specialist care. However, they felt that having a **dedicated ambulance service to help with transportation would help** provide a better experience for patients but also help to make beds available more quickly by enabling them to travel home straight after being discharged.

Some highlighted that there is a **need to ensure that the correct transportation is allocated** when booked for individuals to attend planned appointments at hospital. As a general rule, seated ambulances are booked however ME suffers at times struggle to sit for long periods of time.

Although Kingston Hospital is very accessible in terms of public transport, some individuals need to drive and they thought the car parking charges should be free or at a reduce cost, to accommodate this.

### 12.3.2 Aftercare and discharge

Some people were **concerned about the quality of aftercare following an elective operation** and felt this needs to be improved. For example, there were some concerns about infection control protocols, and also experiences where pain post-operation was not managed well enough.

People were also **concerned about their experiences of support following discharge**. Some said there was not enough information provided on enablement care and support that was available to them. Some found that physiotherapists were not available soon enough after an operation for the therapy to be effective, and others found that the physiotherapy they received was very minimal.

They felt that more physiotherapy would be needed for more vulnerable patients such as those who are elderly.

Others had experiences of being discharged too quickly, while they were still feeling the effects of a general anaesthetic.

For those in pain following an operation, some felt clinics should be made available in their community to help with pain management if they are unable to get a GP appointment.

There was a suggestion that more should be done to **support people to remain independent when they are receiving inpatient rehabilitation**, for example being able to wash and dress themselves whenever possible rather than someone else doing so for them.

### 12.3.3 Appointments and waiting lists

Several people shared experiences of **operations and follow-up appointments being cancelled**, or having **long waiting lists**.

In relation to cancelled operations, this sometimes happened at very short notice, such as the day before, causing significant disruption to people's lives when they have made arrangements based on the appointment.

Outpatient appointments were also cancelled at short notice, while others had long waiting lists, for example waiting five to six months for an outpatient appointment. When an outpatient appointment was made, some people found they had to wait for several hours past the designated appointment time before they were actually seen.

Similarly, some were concerned that waiting times for test results were too long, causing anxiety for some patients.

Several people at the grassroots engagement activities shared experiences of long waiting times once they arrived at hospital for a scheduled appointment and expressed frustration at a lack of communication about any delays on their arrival. Some also had experiences of appointments being changed at short notice without explanation, or cancelled without a new appointment being issued. There was a suggestion that the introduction of new "missed appointment fees" was unfair considering the common experience of long waiting times or cancelled appointments.

## 12.4 Advice on delivery

### 12.4.1 Communication between and within services

Some people emphasised that there **needs to be better communication between services** that are involved in an individual's care, for example, patients had experienced referral letters being lost between services. In one example, a patient had to stay in hospital much longer because of a lack of communication with social care that meant there was no support available to change their pressure socks in the community.

**Internal communication within services could also be improved**, for example patients had experienced different nurses coming to take blood pressure readings in quick succession, while one deaf patient did not have the support of an interpreter because staff kept forgetting to arrange one.

There was a lot of praise for SWLEOC however some people felt concerned that the pre-operation assessment questionnaire was insensitive and very impersonal.

**Interpretation services are found to be better in hospital settings than in primary care.** However, there were suggestions that wifi should be provided in all settings so deaf patients can use online interpreting services when there is no interpreter available for appointments; and that more health settings should sign up to the 'Interpreter Now' system as a backup in case interpreters are unavailable.

## 13. Next steps

The Sustainability and Transformation Plan in south west London is currently undergoing a refresh in order to ensure that the work moves towards local planning and delivery to keep people out of hospital and ensure that delivery is centred around the Local Transformation Boards (LTB). It is expected that a refreshed plan will be published in November 2017. All of the outputs from the engagement activities (health and care forums and grassroots engagement activities) will feed into this refresh. In addition, the area feedback will be taken to each Local Transformation Board for their consideration. It will be saved as a repository of information which can be drawn upon when community intelligence is needed about a local service. The grassroots engagement programme has continued into 2017/18 – and the feedback will be considered at a LTB level.



Client	NHS SWL
Company	OPM Group
Title	Public engagement on the South West London Sustainability and Transformation Plan
Subtitle	By work stream theme
Dates	last published 05/09/2017 last revised 30/11/2017
Status	Draft
Classification	Restricted External
Project Code	10799
Author(s)	Bethan Peach Perla Rembiszewski Anna Beckett
Quality Assurance by	Anna Beckett
Main point of contact	Anna Beckett
Telephone	0207 239 7800
Email	<a href="mailto:info@opm.co.uk">info@opm.co.uk</a>

# **Public engagement on the Sustainability and Transformation Plan**

**By Local Transformation Board (LTB) area**

05 September 2017

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## 1. Executive Summary

The NHS in south west London, working with local councils, is in the process of developing a long-term plan for local health services, called the Five Year Forward Plan, or a Sustainability and Transformation Plan (STP). This work is being carried out by six local Clinical Commissioning Groups (CCGs), local authorities, four hospitals trusts, clinicians, community health services and mental health trusts and patients and members of the public. The six south west London boroughs are Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

Since March 2016, the NHS has been undertaking a grassroots outreach engagement programme, funded by NHS England, to reach out to seldom heard communities. The NHS provided funding to local grassroots organisations to run events for their populations, to listen to views on local health issues. The funding was allocated via local healthwatch organisations that promoted the opportunity, evaluated the bids and administered the funding. In addition, OPM Group was commissioned to design, facilitate and report on six open access health and care forums, one in each of the six south west London Boroughs.

This report provides a summary of the feedback from the all this engagement activity, organised by Local Transformation Board Area. It has been independently compiled by OPM Group.

Due to the wide-reaching nature of the engagement, not every issue was covered in every event/activity. Therefore, comparisons between areas should be treated with caution. To understand if the differences highlighted below are 'real' or a result of who participated, a more focussed and structured exercise would be necessary.

### 1.1.1. Seven day acute services

People in all Local Transformation Board Areas had mixed views about the ability to implement and deliver the quality of healthcare services anticipated in the plan. They believed that limited GP access was likely to be a significant barrier to delivering the proposals for seven day acute services and that many people attend A&E as they are unable to access an alternative.

In Sutton, people recommended instead of aiming for behaviour change, the service offering should be changed so that that GPs and social care services were provided alongside A&E so that people can be directed easily to the appropriate service.

People in Kingston and Richmond requested further information on the criteria for choosing which A&E site would close, and people in all areas expressed concern that any closure would increase pressure on the remaining services.

People in all areas also commented on the creation of more specialist centres, with some supporting this proposal, but others expressing concern about travel times and the impact this could have on patient outcomes. In Kingston and Richmond, some thought that centralising services contradicted plans to take care closer to home. They also raised questions about how decisions made in SW London would be coordinated with other STPs.

People in Sutton emphasised the strengths of St Helier's hospital, while people in Croydon noted the improvements they had seen in Croydon University Hospital.

People in all areas also felt that it was unclear that NHS 111 could reduce A&E use, as people commented that they were often directed to A&E by the NHS 111 service. All areas agreed more needs to be done to educate people about alternatives to A&E. In Wandsworth and Merton, it was suggested that patients should be charged for service misuse.

### **1.1.2. More care closer to home**

People in all Local Transformation Board Areas supported the ideas about more care closer to home, but expressed uncertainty as to how it could be delivered in practice. In Kingston and Richmond people were particularly concerned about how to hire and train staff to deliver this level of local care.

People in all areas commented on the proposals for an increased role of pharmacists. People in Croydon and Sutton felt that they needed to be better trained and gave specific examples of mistakes pharmacists have made, undermining confidence for pharmacists to deliver local care. In Kingston and Richmond and Merton and Wandsworth, people were more confident in pharmacists. However, people in all areas commented that pharmacists would need to adapt their services, suggesting special rooms to ensure confidentiality, and identified a need to support pharmacists to improve their communication skills.

People in all areas commented on the issues accessing GP appointments, and many commented on the difficulty to make same-day appointments. It was also mentioned in all areas that reception staff acting as 'gate-keepers' to appointments made patients feel uncomfortable. People commented that GPs, hospital staff and nurses needed more training to communicate with patients with additional needs, such as learning disabilities, autism and mental health issues.

People in all areas also commented that GPs often lack information to signpost to alternative services and all commented that GPs were too quick to prescribe medication in the case of mental health issues, rather than considering alternative treatments.

### **1.1.3. Prevention and early intervention**

People across all Local Transformation Board areas were supportive of plans for prevention, but felt that they would be challenging to deliver. People expressed concerns about whether there would be the budget to deliver both treatment services and prevention. People in Croydon and Sutton expressed concerns that the proposals may not deliver the anticipated benefits and others felt they would take a long time to realise.

In Kingston and Richmond people expressed support for the use of technology such as smart phones, so long as services remain for those who are uncomfortable using these technologies. Other areas mentioned the use of technology but had mixed views.

People in all areas wanted more information about how locality teams will work in practice. In Kingston and Richmond people commented on the need to work with friends, family and communities, as well as the voluntary sector to deliver the proposals around prevention. In Merton

and Wandsworth people expressed concerns that this proposal could lead to an overreliance on the voluntary sector.

#### **1.1.4. Mental health**

People all supported more integrated mental health services, suggesting that physical and mental health should be better linked. People agreed that A&E should not be the first port of call for a patient suffering from a mental health crisis, but expressed concerns about whether GPs are sufficiently knowledgeable to support mental health patients. In Merton some highlighted the importance of early intervention so that the need for crisis care was reduced.

In Croydon and Sutton, people felt that they are not getting enough funding for mental health services and in Sutton they were particularly concerned given recent closures and the lack of a local crisis centre.

Overall there was concern about current mental health services, and while people in Richmond felt their services were good, all other areas felt significant improvements were needed. People raised specific concerns about the long waiting times for referrals, the needs to educate staff and patients to overcome the stigma attached to mental health and the delivery of Children and Adolescent Mental Health Services. In Merton and Wandsworth, people commented on the difficulty in transferring from CAMHS to adult mental health services.

#### **1.1.5. Learning Disabilities**

There was little variation across the areas on views surrounding learning disability services. In all areas people felt that services providers, including nurses and reception staff, needed more training in how to deliver care to patients with learning disabilities and autism. There was emphasis on tailoring services to individual needs, with a patient-centred approach as opposed to treating each condition separately. People felt that more should be done to promote the annual health check for children with learning disabilities as many were unaware of it.

#### **1.1.6. Children's services**

People agreed with the proposals to reduce parent's reliance on A&E, but all thought that there was a need to provide more detail about viable alternatives and agreed that more flexible access to GPs was required. In Kingston and Richmond, people emphasised the importance of supporting parents who might feel isolated as they felt these would be most likely to be nervous and therefore over-use services.

In Croydon, people noted that high staff turnover (for example in occupational therapy) could be detrimental to children using these services. This was echoed across the other Local Transformation Board Areas where people felt that continuity in care was particularly important for children with learning disabilities.

In Croydon people commented that there was more scope to encourage healthier lifestyles for children both in and out of school.

### **1.1.7. Maternity services**

In Kingston and Richmond, people were positive about the pre-natal services. Despite this, all Local Transformation Board Areas agreed that changes to maternity services were required.

In Merton and Wandsworth, people said that they agree with the proposed inclusion of perinatal and mental health services in the plan, and commented that there should be more support for patients who have experience miscarriage.

Most areas commented on the national shortage of midwives and that there should be better training to ensure consistency in care.

People in all areas supported the idea for a more personalised maternity service, but wanted to ensure that safety was maintained as a priority. Kingston and Richmond and Merton and Wandsworth were particularly positive about offering choice where it could be delivered (although people in Merton felt the plans were not ambitious). In contrast, in Sutton there was some concern that people might not be equipped to make good choices.

### **1.1.8. Cancer services**

In Croydon people commented that GPs needed more support to spot cancer earlier. People in Croydon also specified that there should be more access to drug trials and they felt that data collection could be improved.

In Kingston and Richmond, people commented that there should be increased support for cancer patients following diagnosis and treatment and that GPs should be more involved with treatment, following up with patients while treatment is underway.

People across all areas commented that the communication of a cancer diagnosis should be delivered with more sensitivity.

### **1.1.9. Planned Care**

In Kingston and Richmond people discussed adequate transport options for planned care. In Merton and Wandsworth few people mentioned planned care other to comment on the length of waiting lists. In Sutton, people commented on follow-up care such as physiotherapy which they thought could be improved.

## 2. Introduction

### 2.1 Background

#### *Why is a forward plan being developed?*

The NHS in south west London, working with local councils, is in the process of developing a long-term plan for local health services, called the Five Year Forward Plan, or a Sustainability and Transformation Plan (STP)<sup>1</sup>. The draft plan is available [here](#).

This work is being carried out by six local Clinical Commissioning Groups (CCGs), local authorities, four hospitals trusts, clinicians, community health services and mental health trusts and patients and members of the public. It covers all aspects of local health services including hospitals, primary care, mental health and community services.

The local NHS has identified four key challenges – money, workforce, estates and consistent quality of care – which the Five Year Forward Plan will aim to address by setting out plans to:

- use money and staff differently to build services around the needs of patients
- invest in more services in local communities to improve outcomes for patients, including preventative care
- invest in estates (buildings) to make them fit for purpose
- try to bring all services up to the standard of the best.



#### *What has been done so far?*

An outline strategy was published in June 2014, setting out a plan for the local NHS and detailing the standards of care that people in south west London should expect.

An [issues paper](#) was published in June 2015 setting out the challenges for local services and initial ideas about how to tackle them. In September 2015, The NHS commissioned a series of deliberative events to gain the views of members of the public and local stakeholders on the Issues Paper (the events were delivered by OPM Group; see the report [here](#)).

Since March 2016, the NHS has been undertaking a grassroots outreach engagement programme, funded by NHS England, to reach out to seldom heard communities. The NHS provided funding to local grassroots organisations to run events for their populations, to listen to views on local health issues. The funding was allocated via local healthwatch organisations that promoted the opportunity, evaluated the bids and administered the funding. In addition, OPM Group was

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<sup>1</sup> All NHS regions are required to develop a Sustainability and Transformation Plan (STP).



commissioned to design, facilitate and report on six open access health and care forums, one in each of the six south west London Boroughs.

## 2.2 Methodology

### 2.2.1 Health and care forums

People for the health and care forums were recruited by NHS South West London. They were invited to attend events via:

- emails to those who had attended previous events
- engagement with local community and voluntary groups and local Healthwatch groups
- advertising via local press, radio and social media.

Each event had capacity for up to 100 people.

The six events were held in the evenings and lasted 3 hours (6-9pm). The format of the events encouraged an in-depth dialogue with people about the key issues and questions raised in the draft Five Year Forward Plan. People had the opportunity to join two rounds of table discussions, with each round including at least 6 tables, each table focusing on one of 6 topics. Most events had 6 tables for each round of discussion, but for some rounds there were fewer tables (if no people chose a particular topic), and for others there were two tables for the more popular topics (so that people could focus on the topic of their choice).

Each event was independently run by OPM Group's facilitation team, made up of one lead facilitator and table facilitators to manage the table discussions.

NHS representatives (including CCG Chief Officers and Chairs, hospital medical directors and chief executives and other NHS staff) attended the events, to set the scene, present the draft Five Year Forward Plan and answer questions from people. At each event, the local NHS representatives:

- Provided background information on the Five Year Forward Plan, explaining what it is
- Outlined the challenges facing healthcare in south west London
- Described how the Five Year Forward Plan is proposing to address these challenges

This information formed the basis for the table discussions amongst people, to elicit their responses to and concerns around the Plan.

### 2.2.2 Grassroots engagement activities

The aim of the grassroots engagement activities was to develop meaningful conversations with seldom heard communities. NHS South West London recognised that these communities would differ across boroughs, however, in general they focused on those people from groups with protected characteristics, as defined by the Equality Act (2010). They also enabled local Healthwatch organisations to suggest other local communities that were harder to reach in each borough.

To successfully deliver this programme, NHS South West London worked collaboratively with local Healthwatch organisations and grassroots groups. Each Healthwatch organisation was invited to manage a pot of funding that local grassroots groups could apply for to run events/activities enjoyable to their population. Each Healthwatch was able to set their own application guidelines with a request that groups applying for the funding should be from seldom heard groups and there would be an opportunity at each event for NHS staff to attend and speak with individuals.

Healthwatch organisations used their connections and communication channels to promote this opportunity to local groups, particularly those groups with protected characteristics/seldom heard voices. They advertised the opportunity through their websites and via social media. Some Healthwatches used a more targeted approach by making direct contact with those organisations that they thought would benefit from the funding. Each organisation was able to apply for the funding and Healthwatch would check the application and then let the organisation know if they were successful in receiving the funding.

Once this process was completed, the information was passed onto the programme team for contact to be made with the local organisation; congratulating them on being successful in the application process. Arrangements were then made for attendance at the event, including discussions around what the most appropriate way to speak to people on the day.

At each session, the programme team, local CCG and Healthwatch were invited to attend. Where sessions had a specific focus towards a work stream, the assistant directors, or other work stream people, were also invited to attend or send questions that would be relevant for the engagement team to ask – this helped to ensure that the conversations were relevant to local priorities within each area of the STP.

The programme and local CCG attended each session and spoke to attendees about their experience of local services. During the events, the engagement team had a dedicated slot/opportunity to discuss local health issues and to listen to the views of those participating. This was through a variety of mechanisms such as one-to-one conversations, focus groups or group discussions. The questions asked at each session were tailored to the audience.

### 2.2.3 People

The table below summarises the number of people who attended each of the events and engagement activities across the six London Boroughs.

Borough	Date	Number of people
Croydon health and care forum	7 <sup>th</sup> February, 2017	33
Croydon grassroots engagement events	May – November 2016	11 events speaking to over 222 people
Merton health and care forum	29 <sup>th</sup> June, 2017	33

Wandsworth health and care forum	14 <sup>th</sup> March, 2017	44
Merton grassroots engagement activities	May – December 2016	10 events speaking to over 250 people
Wandsworth grassroots engagement activities	June 2016 – Feb 2017	10 events speaking to over 200 people
Kingston health and care forum	8 <sup>th</sup> February 2017	35
Richmond health and care forum	2 <sup>nd</sup> March 2017	55
Kingston grassroots engagement activities	March 2016 – March 2017	15 events speaking to over 302 people
Richmond grassroots engagement activities	June 2016 – March 2017	18 events speaking to over 378 people
Sutton health and care forum	1 <sup>st</sup> February, 2017	30
Sutton grassroots engagement activities	July – December 2016	13 events speaking to over 284 people

#### 2.2.4 About the report

This report provides a summary of the feedback from the six health and care forums and the grassroots engagement activities, capturing the feedback by Local Transformation Board area. It includes an executive summary which pulls out similarities and differences from across the areas; a summary table per LTB which pulls out key themes and then a more detailed analysis of the feedback per work stream.

A separate report has been produced organising the information by each work stream (across boroughs).

## 3. Findings by borough

### 3.1 Croydon

Borough	Date	Number of people
<b>Croydon health and care forum</b>	7 <sup>th</sup> February, 2017	33
<b>Grassroots Engagement Events</b>	May – November 2016	11 events speaking to over 222 people

#### 3.1.1 Overarching themes

Many people agreed that there is a need for change in the NHS nationally. Several people felt **local circumstances exacerbate a need for changes to the health service** (e.g. Croydon has a large and diverse population; the Home Office near Croydon means many asylum seekers move to the borough).

**Some people felt the plans laid out in the STP had been discussed before and hospital closures were off the table.** Some felt that the STP was not realistic in the context of the resources available and that there was **not enough detail in the plan.**

Seven day acute services	<p>GP access was a significant issue, impacting on the perceived feasibility of changes, and potentially driving perceived misuse of A&amp;E.</p> <p>There were also concerns about whether the existing capacity of acute services was sufficient.</p> <p>Although some could see a case for fewer, more specialist centres, others had concerns about the implications for travel times.</p>
More care closer to home	<p>People were generally supportive of the plan to have more care closer to home, but there were different opinions about how it could work in practice.</p> <p>Some concerns about whether NHS 111 would meet expectations and whether nurses/pharmacists would be suitable alternatives to GPs.</p> <p>Some specific concerns about privacy of a pharmacist consultation, and specific examples of mistakes made which would undermine their confidence in pharmacists.</p> <p>Some questions about the feasibility of extending out of hospital services, when there are already insufficient staff to cover the current provision (especially GPs).</p> <p>Examples of difficulties getting appointments and with the accessibility of GP services. Also, frustration with receptionists acting as gate-keepers.</p>

	Identified room for improvement as currently feel post-diagnosis support and signposting can be lacking.
Prevention and early intervention	<p>Most people thought there were challenges to achieving the plans for prevention and early intervention.</p> <p>Specifically, they felt it would be under-resourced and changes would not lead to the anticipated benefits and some felt there was a risk this could lead to privatisation of health services. Although some felt that ‘fun’ activities could lead to behaviour change, others thought this would be difficult.</p> <p>People were unclear about how locality teams would work, and were concerned that using budgets to support at-risk patients could compromise care for others.</p> <p>Some identified preventative or early intervention opportunities missed due to long waiting lists currently.</p>
Mental health	<p>People want to know which services could be discontinued and how, if at all, physical and mental health will be linked.</p> <p>Perception that there is not sufficient capacity in IAPT currently which leads to long waiting times.</p> <p>There is a need for services to be better tailored to the needs of minority or vulnerable patients.</p> <p>People want to be treated with more compassion as inpatients, and were concerned that reductions in community services would lead to more cases ending up in hospital.</p> <p>Experiences of community hubs after discharge are mixed – some prefer them, but travel times can make regular visits difficult.</p> <p>Some felt that Croydon is not getting a ‘fair share’ of funding for MH services.</p> <p>There were particular concerns about CAMHS, and mental health education in schools.</p>
Learning Disabilities	People raised particular issues including the need for GPs to ensure all staff are aware which patients have learning disabilities. Additionally, they wanted GPs to have more knowledge of LD and related issues.
Children’s services	<p>The NHS needs to promote awareness and signposting to available services.</p> <p>However, if no GP is available, most believed parents would continue to use A&amp;E as an alternative, rather than a community based service.</p> <p>High staff turnover (for example in occupational therapy) was seen to have a detrimental impact on children using these services.</p>

	More scope to encourage children to have healthier lifestyles both in and out of school.
Maternity services	People valued having a local hospital to give birth in.
Cancer services	<p>GPs need more support to spot cancer earlier, and waiting lists need to be reduced.</p> <p>People would like more access to drug trials, and felt data collection could be improved.</p> <p>Most were open to idea of treatment in community settings, as long as it was safe.</p>

### 3.1.2 Seven day acute services

Overall, people felt there were many challenges to achieving the proposed plans for seven day acute services in the STP. **For example, GP access was a significant issue for many people.** People were concerned that access to a GP can be patchy depending on the practice you attend and felt that inconsistent access to GPs can increase demand for A&E. At the grassroots engagement events, people commented that at Croydon Hospital they ‘never serve people on time.’ Most understood that access to GPs is strained because of difficulties in recruiting sufficient numbers of clinicians, and thought this should be addressed.

Some people from the health and care forum were **concerned about a current lack of capacity in acute services**, and thought this could be exacerbated by having fewer acute services. This was echoed by people at the grassroots engagement events who commented on the long waiting times in A&E, which put some people off going to A&E especially at peak times. Some people also felt that short travel times were important, and were worried about travelling further if there were fewer acute services. However, others thought there might be better care if there were fewer sites, for example if there were hubs to triage non-urgent care and ensure people go to the right place. At grassroots engagement events, people raised concerns about walk-in centres being too driven by efficiency and seeing patients in five minute slots, rather than by patient needs. Some health and care forum people liked the idea that patients might receive elective surgery and rehabilitation quicker if it took place outside of an acute service.

**There was a belief that Croydon University Hospital has improved and is now somewhere they would be happy to go** (it had not been, historically), although at the health and care forum they did not explain why. However, at the grassroots engagement events, some people commented on areas for improvement, such as the current lack of signage and communication issues at A&E, where people have been left feeling anxious and frustrated when they are not given regular updates. A few people at the grassroots engagement events also mentioned communication issues within the hospital, for example due to a lack of learning disability specialist nurses or peer support available for young people, which are both needed to cater services and communication accordingly.

Several people at the health and care forum thought **communication from the NHS is critical to ensuring people go to the appropriate place for care**. At the grassroots engagement events only a minority of people had heard of NHS 111 (but some who had used this service had positive reviews). A few people commented that they would not know where to go in a mental health crisis, with a few giving examples of being rejected at A&E and having nowhere else to turn to. They suggested that there be mental health nurses present at A&E. For more information about mental health services in Croydon please see section 3.1.5.

People thought changing behaviour about where to go would only work if service levels were the same in non-A&E settings as they are in A&E (i.e. being seen within 4 hours). **There was a concern about perceived misuse of A&E currently**, and confusion in the grassroots events about the difference between A&E and Urgent Care. Across the events in Croydon, some people thought cultural differences meant migrants prefer hospitals over non-A&E care, and some thought people wrongly rely on A&E for minor illnesses such as coughs and colds. Some people felt communication from the NHS to encourage people to use services appropriately was necessary to ensure patients accessed appropriate care.

### 3.1.3 More care closer to home

Although people were **generally supportive of the plan to have more care closer to home, there were different opinions about how it could work in practice**.

Some people broadly liked the idea that **services would be more joined up**. Many people said that the plan could work if prevention was prioritised and if services like NHS 111 were improved. However, some were sceptical of the quality of service NHS 111 provides and thought that this could hamper quality care as proposed in the STP.

People had **divided views about whether seeing a nurse or pharmacist instead of a GP would work in practice**. Some said it could be a positive change (e.g. could be quicker way to receive care/advice). However, even if they were supportive of the concept, some people felt there would be barriers to uptake (e.g. people not knowing that pharmacists are skilled, and a current lack of promotion of pharmacist services).

At the grassroots engagement events, several people commented about communication breakdowns with pharmacists, leading to unknown changes made to medication, lack of advice about how to take medication, or wrong medication being given. Several health and care forum people were sceptical of using a pharmacist or nurse instead of a GP or other specialist. Concerns about pharmacists included a lack of privacy in locations that pharmacists operate, a perception that pharmacists are too overworked already, a perception that pharmacists cannot prescribe, and a belief that pharmacists are not skilled enough. At the grassroots engagement events, some people commented that 'Patient Online' has made it easier to pick up prescriptions.

At the grassroots engagement events, **some people also highlighted communication issues surrounding GP prescriptions**, such as GPs as changing medication without notifying the individual, not discussing side effects with patients, and not writing prescriptions for over-the-counter medicine for their children.

Several people at the health and care forum had concerns about the plans for more care closer to home including **how longer opening hours could be sustained** if the NHS was already short of GPs and **how the NHS could shift budgets without negatively affecting acute care**. Some people also highlight current challenges that could affect the success of the proposed changes. For example, they thought that there was a current **lack of patient knowledge about what services are available** in the area and a high number of patients who do not show up for appointments with their GP. These people felt these problems should be addressed in order for the plans to work.

At the grassroots engagement events, **people discussed the difficulty surrounding booking GP appointments**, some said that they had issues getting a same day appointment and others commented that they had to wait several weeks to be seen. Other people commented that they were happy that they could book a telephone appointment if a face-to-face one was not possible. People expressed concerns about issues with referrals to hospitals, where hospital appointments were cancelled due to incorrect information being provided by the GP surgery and some commented on long waiting times for referrals from GPs. A few mentioned weekend appointments were available, which they really valued.

These people also expressed the need for more interpreters in GPs and hospitals. They commented that GPs have a general lack of understanding about autism and that it can be very hard to get a diagnosis, particularly for those who do not speak English. For more information about learning disability services in Croydon see section 3.1.6. A few spoke more generally about **accessibility issues with GPs**, commenting that letters were often written in a way that was difficult to understand, and that some building layouts were confusing or inaccessible with dangerous stairs.

Some people at grassroots engagement events commented on issues regarding reception staff at GP surgeries. A few commented that receptionists were too loud when discussing confidential patient matters which meant that other people could hear personal information. **People also expressed frustrations that reception staff are acting as practice ‘gatekeepers’** triaging patients for appointments and making decisions on whether their cases are emergencies. Some people in the grassroots events who did not speak much English highlighted that they can find receptionists particularly intimidating due to the language barrier.

People at the grassroots engagement events emphasised issues with post-diagnosis support, where they commented that they **did not know where to turn to for follow-up support**, with many relying on voluntary organisations. They said that they would like more support, advice and signposting to understand treatment and support options for them and their children. They also noted that when they were referred for specialist follow up care there could often be a long wait.

### **3.1.4 Prevention and early intervention**

Most people thought there were **challenges to achieving the plans for prevention and early intervention in the STP**. For example, people felt that the STP was overly optimistic about the resources available to deliver the proposed changes. Others felt that the changes would mean current levels of care will not be met in the future. Additionally, many people were **worried that the lack of resources could lead to privatisation of health services**.



Several questions were raised, mainly around the quality of service and how changes to prevention and early intervention would be coordinated. People **wanted to know if further cuts would follow the changes proposed in the STP and what services would be lost**. When asked about locality teams, **people had questions on how a locality team would be run, and who would find who** (e.g. would specialists reach out to patients or vice versa). There was also a concern that locality teams would only work with at-risk or vulnerable patients, compromising care of others.

Many people felt that **the quality of communication** between the NHS and the public is low but that the success of prevention and early intervention would rely on good communication from practitioners to patients. Specifically, they felt there is a current lack of communication about the services available in the area, and a lack of confidence that CCGs and GPs know enough about services to share useful information. People said that posters, advertisements in mainstream media and information on screens in GP offices would be useful ways to disseminate knowledge about local services.

People had **mixed views about whether changing people's behaviour would be a successful approach to improving prevention and early intervention**. Some people felt that behaviour changes could be introduced and encouraged in schools or in community groups (e.g. Croydon Weight Watchers, Croydon Nordic Walking or groups at the Asian Resource Centre) where the focus is on having fun rather than telling people what to do, and where people already trust the people they interact with in those settings. Other people thought it would be challenging to change peoples' behaviour if they did not want to change.

A discussion took place on the Croydon POP (Partnership for Old People) bus. Broadly, people said that this intervention (e.g. parking in pedestrianised area and providing advice on variety of topics) was useful. Some people were frustrated that funding for the service had stopped.

There was limited discussion of this topic in the grassroots events. However, a few people mentioned examples of preventative opportunities missed, leading to problems escalating. For example, one person found the cost of dentists prohibitive so would wait until they definitely needed attention. Others mentioned waiting lists for psychological support (see section 3.1.5 below).

### 3.1.5 Mental health

Discussions about mental health at the health and care forum centred on challenges and questions about proposed changes to mental health services in the STP. Broadly, many people wanted to know **which services would be discontinued and how, if at all, physical and mental health might be linked**. One participant said they were not sure what the NHS is proposing because they felt the plan sounds like what should currently be offered.

Some people said **additional IAPT (Improving Access to Psychological Therapies) services are needed to reduce waiting times for psychological treatment**. At least one participant said that a lack of GPs in the north of the borough meant long waiting times for care.

Some people said there was a **need for services to be better tailored to the needs of minority or vulnerable patients** including BME patients, those who might experience cultural barriers to

understanding mental health, and those struggling with alcohol dependency. This was echoed at the grassroots engagement events, where people commented on cultural barriers to seeking help, not knowing where to turn for mental health issues, and anxiety caused by their communication with The Home Office.

People at the grassroots engagement events expressed concern that **staff that work in Mental Health Trusts sometimes were not able to show compassion** to the individual when they were an inpatient. Many of these people said that they wanted psychiatrists to spend more time talking to patients rather than making assumptions that they need medication or a change of prescription.

Some people at the grassroots engagement events had been discharged from hospital (Bethlam/Springfield) and referred to community hubs such as Tamworth Resource Centre to receive their medication. There were **mixed views about community hubs**, with some feeling positive not to have to make appointments with their GPs and others expressing frustration about having to make regular visits to Tamworth Resource Centre to collect medication. Some expressed concern about the change of care coordinators and commented that care needed to be kept consistent.

People in the health and care forum felt they have seen the funding to community services being reduced and **questioned how it would be possible to keep non-urgent care needs out of hospital in this context**. For example, one participant said that because mental health services were cut at Foxley Hill, patients now go to the hospital for care. At least one participant felt that Croydon is not getting a “fair share” of funding for mental health services.

People also asked specific questions on a variety of mental health topics during the discussion. These questions included how mental health education for schools would be developed, what type of support home carers would get, and what would be different about coordinating hospital and community mental health resources.

Overall, people **agreed with the need for a holistic approach to mental health issues, that accounts for how they interact with other illnesses and physical conditions**.

At the grassroots engagement events, some people discussed concerns regarding **mental health support for children**. They raised issues with confidentiality when seeing a school councillor or a tutor, and many said that they would prefer to seek help outside of school, but that they did not know where to go to receive help. To read more about children’s services in Croydon, see section 3.1.7.

### **3.1.6 Learning disabilities**

Many people at the grassroots engagement events commented on the treatment of patients with learning disabilities, suggesting that people with a learning disability should be noted on the GP system so that **all staff are aware**. Parents also commented that they wanted more support surrounding diet and nutrition for children with autism, who can often fixate on certain foods to the detriment of a varied diet. Some also noted the lack of Easy Read or accessible materials.

Several people commented that they struggled to get a diagnosis for their child and felt that this could take several years, commenting that CAMHS in Croydon are overrun.

### 3.1.7 Children's services

Most people at the health and care forum who discussed children's services attended because there was a lack of interest among other people and they felt it was important that the topic was discussed. Generally, people had suggestions and concerns about the proposed approach to children's services in the STP.

Concerns and suggestions centred around how **the NHS needed to promote better awareness and signposting of available services**. People recommended developing partnerships with schools and community-based services to advertise services or to have nurses available in schools for parents to speak to if they have concerns about their child's health.

However, several people agreed that changing behaviour in order to reduce the number of visits to A&E for non-urgent care may be difficult. Since many parents can be anxious when their child is ill, people felt it was likely **parents would still take their child to A&E in a non-emergency if a GP was not available (rather than a pharmacy or community-based service)**.

There was a recognition that immigrant families might need extra support because their extended family members might not be around to provide advice or care. Additionally, many people agreed that information and services should be provided in different languages.

At the grassroots engagement events, some people commented on the turnover of staff for occupational therapists which has a big impact on children and their treatment and suggest that more occupational therapists are needed.

There was some emphasis of **supporting healthier lifestyles for children** at the grassroots engagement events, where children and young people were asked about their relationship to healthcare and their understanding of diet and nutrition. Most said that they would call 999 to seek medical help, or use the walk-in clinic and some were unsure where to go for alcohol or drug problems. When discussing healthy eating and exercise, the children participating were generally aware of which foods were healthy and which were not, and some wanted more nutrition education and healthier choices at school. Others commented that more lifestyle help was available outside of school and wanted there to be more information in school about these services. For more information on prevention in Croydon, see section 3.1.4.

### 3.1.8 Maternity services

No people attended the maternity sessions at the Croydon health and care forum or commented on the service in the grassroots engagement events.

### 3.1.9 Cancer services

Cancer services were not discussed separately at the health and care forum, but were discussed at the grassroots engagement events. People mentioned that GPs need the right support and guidance from hospitals to spot **early stages of cancer with less obvious symptoms**. They also discussed the need to better manage the health requirements of the metastatic cancer population, suggesting that

GPs learn how to spot the possible symptoms of recurrence (be it a local one or advanced stage) and get these patients seen as quickly as those who might have a primary cancer.

There was some **concern about waiting lists**, and one participant made the suggestion that patients could be directed to hospitals with shorter waiting lists if the local service had a long wait. Equally, people were **open to some treatment being provided in community settings**, as long as they were assured that it would be safely managed. Equally, they were supportive of the service helping people with cancer to self-manage where appropriate – for example, by encouraging them to manage their weight.

Some people commented on cancer treatment received at the Royal Marsden, asking for **more treatment trials and new testing methods to be offered**. People also requested that the data collection of cancer patients be improved. Several mentioned that the suggested proactive approach is particularly relevant as the Royal Marsden is part of a cancer vanguard.

Some people commented on the importance of post-treatment care, such as physical therapy and emotional support. They suggested that this could be done locally using community centres and local services.

## 3.2 Kingston and Richmond

Borough	Date	Number of people
Kingston health and care forum	8 <sup>th</sup> February 2017	35
Richmond health and care forum	2 <sup>nd</sup> March 2017	55
Kingston grassroots engagement activities	March 2016 – March 2017	15 events speaking to over 302 people
Richmond grassroots engagement activities	June 2016 – March 2017	18 events speaking to over 378 people

### 3.2.1 Overarching themes

In both Kingston and Richmond one of the most frequent comments at the health and care forums was that **more detail is needed in the STP**. People felt that the STP as it stands is too aspirational and high-level, and they would like to see more detailed plans, figures, modelling and timelines about **how the proposals will work in practice**. There was also a suggestion in Kingston that the STP mirrored what was in the 2008 “High Quality Care for All” report, i.e. that there was not anything new in the STP.

People in both Kingston and Richmond questioned how the proposed improvements would be possible to make given the **lack of funding available to support these changes**. Some people **felt that the STP lacks realism** and people were **concerned about how the NHS would balance funds between health and social care** and suggested that more funding needed to be directed to social care, especially if the NHS wanted patients to leave hospital sooner, but also to better support patients over the long term.

In Richmond, some people felt that **one individual or small group should champion and lead the changes** outlined in the STP, so there would be accountability for coordination and delivery and to avoid inconsistency or duplication of services. They did not believe that a collaborative approach to leading the implementation would be effective.

People at the health and care forums in Kingston emphasised the **importance of public health, and of educating and informing the public** as part of the prevention and early intervention agenda, as well as more broadly so that patients understand the changes and who they should see for support in different situations.

Many people in both areas raised concerns about the NHS and healthcare generally, including:

- their experience of poor communication within NHS and with patients;
- a perceived lack of resources and staff;

- concerns about funding cuts;
- questions about the cost of administration;
- concerns about privatisation of NHS services; and
- concerns about the provision of quality care for older people.

Seven day acute services	<p>Support for plan to direct people to alternatives services, but lack of clarity on what these might be.</p> <p>Wanted more information on criteria for choosing which A&amp;E to close, and had concerns about the additional pressure on remaining A&amp;E services.</p> <p>Mixed views on impact of proposals on quality, and concerns that centralising the service was contrary to plans to take care closer to home. And diverse views on whether seven day service was desirable.</p> <p>Questions about how good access would be ensured, especially for people living on the borders of the STP, and the level of co-ordination with other STPs.</p> <p>Concerns about existing acute service including communication and problems with discharge.</p>
More care closer to home	<p>Some concerns and questions about these plans, particularly relating to the staffing and training required.</p> <p>Supportive of idea of locality teams and potential for better joined-up working if it can be achieved.</p> <p>Current lack of confidence in alternative service provision including NHS 111 and potentially pharmacists.</p> <p>Need for more information about when different services are appropriate to use, encouraged by staff working in different care settings.</p> <p>Support for the idea of working more closely with voluntary sector, but concerns about how it would work in practice.</p> <p>Significant concerns about current GP services including access to appointments, accessibility of services, problems with referrals and GPs not being patient centred.</p>
Prevention and early intervention	<p>Broadly supportive of plans but concerned that it will be challenging to deliver.</p> <p>Think locality teams are a good idea but have questions about how they will function and want to see enhanced communication within and between NHS services.</p> <p>Support for use of technology, such as smartphones, as long as services remain in place for those who are not comfortable with these services.</p>

	Encouragement to work with friends/families/communities as well as the voluntary sector to deliver the ambitious around prevention.
Mental health	<p>Some concerns about existing mental health services, although Richmond people felt that services were currently good.</p> <p>Particular concerns related to parity of esteem, knowledge of frontline staff, and gaps including for mental health crisis. Additionally, regular changes and the range of organisations involved could make navigation difficult.</p> <p>Support for plan to ensure A&amp;E is not the first port of call, and for the idea of care navigators, but some questions about the overall ambition and likely impact on existing services.</p> <p>Need for more education for frontline and public to understand mental health conditions, and to address stigma.</p> <p>Additional support required for people with diverse needs.</p>
Leading Disabilities	<p>Some particular challenges faced by parents of children with LD – they asked for more support and also help in booking suitable appointments.</p> <p>Low awareness of annual health check, and expectation GP should do more to promote this service.</p>
Children's services	<p>Concerns that lack of funding would make it difficult to provide services envisaged in the STP.</p> <p>Agreed in principal with reducing reliance on A&amp;E but were not clear parents know, or trust, the alternatives.</p> <p>Also, felt that increased access to GPs would be particularly important.</p> <p>Want more information about CAMHS in the STP.</p> <p>Important to ensure care is flexible and tailored to individual needs of the young person and their parents.</p>
Maternity services	<p>Agreement with the case for change, although pre-natal care in both boroughs received positive feedback.</p> <p>Support for a more personalised service, but not at the expense of safety. View that while there are insufficient midwives, choice should be a lower priority, although important that diverse needs are met.</p> <p>View that maternity services should not be too medicalised, so that they also support safeguarding and post-partum care.</p> <p>Support for the idea of greater consistency in care for midwives.</p>

Cancer services	Some services receive positive feedback but need for increased support for patients following diagnosis and treatment.  Request that GPs are more involved in treatment, and follow up on both mental and physical wellbeing while treatment is underway, and following treatment.
Planned Care	Discussion related to the need for adequate transport options and the importance of avoiding last minute cancellations and long delays.

### 3.2.2 Seven day acute services

There was some confusion about the term ‘acute’. At the Kingston health and care forum people queried whether this meant emergency services or specialist facilities and in Richmond, people generally took “acute care” to mean A&E. Once this was clarified, some people **supported the idea of directing people to places other than A&E, in principle**. However, **in practice, they questioned where else people can go**.

#### *Response to plans to consolidate acute services*

This raised several issues and queries. In Richmond people wondered **what criteria would be used to decide which A&E sites would close**. Several people also commented that it is already difficult to get a GP appointment and, although the STP suggests people could visit pharmacists more often, people thought that funding for pharmacists had also been cut. Some people commented that there were cultural reasons for some groups, (for example refugee groups) for going to A&E with minor needs, and that this would be difficult to change.

In Kingston, people requested details and modelling to show how local services can relieve the burden on acute services. Some people thought providing **improved support to patients in hospital** so they can leave sooner might alleviate the perceived pressure closing A&E sites might cause.

While many people thought that **Richmond was generally well-served** for health care, **some worried the changes could mean a reduction in health care standards** such as increased travel time, and fewer acute sites to choose from. Other people thought **the principle of seven day acute services was a good idea** (i.e. to have fewer sites but provide improved care; and to become better managing staff and services), but felt **sceptical about whether the STP could deliver as proposed**.

During one discussion at the Richmond health and care forum, some people thought it was not necessary for acute services to have a full range of specialists seven days a week (e.g. physiotherapists), while others thought a quality acute service does require the same level and mix of staffing on every day of the week.

In Kingston, people identified what they believe to be **two incompatible aims within the STP: to provide care at a more local level, and to concentrate resources** into a smaller number of acute hospitals.

There were **concerns that concentrating resources into a smaller number of acute hospitals could:**



- exacerbate waiting lists;
- make accessing the right specialist more difficult;
- increase pressure on A&E;
- mean hospitals only treat the most severe emergencies or conditions; and
- mean that the right hospital is much further away.

There was a view that **providing seven day acute services is likely to mean resources are spread more thinly**, rather than an improvement to services. Some people suggested the motivation to have seven day acute services is political rather than based on evidence. In contrast, some people at the Richmond grassroots engagement activities said that there was **fear among the older population around getting ill on Friday**, as they were concerned about the level of treatment that they would get over the weekend.

Most people said that if they were ill over the weekend or they could not get an appointment with their GP, they would either go to Teddington Memorial, or call NHS 111. Yet, some people were worried that they would not be adequately triaged by the NHS 111 service. Others said that if they were not able to get a GP appointment they would go to A&E. People commented on the **long waiting times at A&E** (particularly at Kingston Hospital) where some said that they would avoid going.

### *Access to services*

There were also several questions relating to the access to acute services. People at the Richmond health and care forum discussed how the plan for seven day acute services could work geographically. One participant noted patients do not fit neatly within boroughs and because there is no hospital in Richmond, it wasn't clear how the changes would apply in the borough. Another participant wondered what coordination between regions and boroughs was being planned.

At the Kingston health and care forum, people felt that transport for elderly people or those with disabilities could be more difficult at weekends (they said there is no hospital transport at weekends at the moment), and that this should be taken into account in changing to seven day services. They also questioned how the STP considers the use of services in neighbouring areas such as Tooting or Surrey.

Some people commented on transport issues at Kingston hospital, for example that **parking can be difficult for people with disabilities** and should be free. Others commented that patient transport was not always adequate for people with physical disabilities and a few said that Kingston Hospital was very confusing to navigate around as the signposting is not clear.

### *Tailoring acute services to different needs*

A few people at the Kingston and Richmond grassroots engagement activities shared negative **experiences about communication issues in hospital**. People mentioned a lack of translation services, having to rely on friends or family. Others commented that A&E staff do not know how to effectively communicate with children or adults with mental health conditions or learning

disabilities. Several people said that staff at Kingston Hospital were rude. A few people praised the ‘blue band scheme’ which let staff know if a patient was suffering from dementia.

Some people commented on the **provisions for those who arrive at A&E in a mental health crisis**, and suggested that these patients be given a room away from others to help them keep calm, where they should then be attended to by someone with experience working in mental health. For more details about mental health services in Kingston and Richmond, see section 3.2.5.

At the Kingston grassroots engagement activities people commented that **discharge from A&E was always delayed**. Others mentioned that some homeless people were discharged in the early hours of the morning when shelters and other services are closed.

People made several negative observations about **how older patients were being treated** at Kingston Hospital. For example, one commented that older people were seen as not being helped to feed themselves when in hospital and another commented that the staff were more focussed on freeing up bed space, than providing care.

People at the health and care forums **felt that intermediate care is not addressed in the STP** and they requested information about what the plans would be for those who are well enough to leave hospital, but not yet well enough to be at home.

### 3.2.3 More care closer to home

People at the Kingston and Richmond health and care forums had **concerns about the plans for health care closer to home**. These concerns were broadly about:

- A lack of staff or adequate training for staff to serve patients currently and in the future;
- The role of care navigators in the STP;
- Challenges with communication and information sharing by the NHS internally and externally; and
- The role the voluntary sector would play in the STP.

People in the health and care forums **liked the idea of locality teams** providing services that are usually accessed via a GP or Outpatients. However, they wanted to know more about what a locality team would look like in practice, and what role they would play beyond information sharing. Similarly, they wanted to know **what the remit of a local health centre would be**, how patients would access such a service, and what the waiting times would be.

In both Kingston and Richmond, people were **positive about the focus on local care, joined-up working between health and social care, and increased collaboration in communities** to improve health care. For example, some people felt the approach would facilitate the prevention of health problems.

A few people had questions, including whether care and health services would be joined up across the boroughs. At the Richmond health and care forum they asked how Queen Mary’s Hospital would function and be funded under the STP.

### *Staffing and training*

Some people in the health and care forums **expressed concerns about staffing and training**. They questioned whether the plan would be viable since they felt GPs are already too busy to manage their current caseload. Further, some people felt that the plan did not account for how much training would be needed to prepare practitioners to deliver care to patients with a different range of needs.

Closely related to staffing and training were **questions about the role and training of care navigators**. For example, some people wanted to know how patients would be informed of the remit of the care navigator role and how they would be trained.

### *Views of alternative services*

People at the Kingston health and care forum felt that the **NHS 111 service needs re-launching** if it to be a key part of the new way of working; they felt that people do not trust the service as it is now and wanted to know more about how it would be improved. This was echoed by people at the grassroots engagement activities where some commented that they had never heard of the NHS 111 service and others thought it had a poor reputation.

At the health and care forums in Kingston and Richmond, there was **support for the idea of long-term conditions being managed by pharmacists, and using pharmacists as a first port of call instead of GPs** because they felt there would be less waiting time to receive advice. However, people wanted to be reassured that pharmacists would be able to provide consistent, reliable, and accurate advice. Some people at the grassroots engagement activities commented that pharmacists needed to improve their communication skills, as some said that they were given medication without being given advice on how to take, and others commented that their medication had been changed without being informed.

People felt comfortable in principle with seeing other health professionals instead of going to A&E in a non-emergency. However, they felt that communication needs to be improved to support this shift, including **providing information about what different health professionals can do, and raising awareness about different services, including the NHS 111 service, pharmacists and other out of house services** and when to see these rather than a GP.

Some people in Kingston suggested that receptionists at GP surgeries should play a bigger role in signposting to clinical nurses or pharmacists when appropriate. Others noted that local services need to offer a more convenient alternative to visiting the hospital. Some also thought there **needed to be increased collaboration and communication between different health and social care practitioners**. For example, at least one participant felt health and social care practitioners work in silos, which can limit the exchange of information across services and different areas of care.

People also discussed the use of the voluntary sector. Some people **liked that the plans for care closer to home included working with voluntary organisations**. They felt this could improve access to and the quality of care, since voluntary organisations have expert local knowledge. Others thought there were **challenges to working with the voluntary sector that might hinder the proposed changes**. These challenges included how to ensure consistency and quality of care,

organisational and logistical challenges, and a perception that the voluntary sector is becoming “too commercial.”

Some people at the grassroots engagement activities commented that there should be **better sharing of patient records and information** and that this was particularly important for people with disabilities and long term complex conditions who use multiple branches of the NHS, and multiple services. They also commented that patients should be able to get access to their medical records free of charge.

### **GP practices**

Many people at the grassroots engagement activities commented on GP practices – specifically the difficulties they were currently experiencing, which could impact on the STP’s ability to deliver more care closer to home.

#### **Access to appointments**

A few said that they had no issues getting appointments with GPs and in particular, **some praised particular practices**, for example for their use of ‘Patient Online’ to book appointments in advance. Another said they liked that they could have a telephone GP consultation when they were unable to get a face-to-face appointment. Despite this, most people at the grassroots engagement activities had **difficulty getting a GP appointment when they needed one**. They suggested that this was due to a shortage of GPs, and thought more emphasis should be placed on recruitment and regulating registration to practices.

In most cases, to get a same-day appointment, people were required to call at 8am. In many instances, they had to wait on the line for up to an hour, and even then it could be several days until they got an appointment. Some commented that they felt they had to ‘jump through hoops’, justifying to reception staff why they needed an appointment. Several people also commented that they had **no choice over appointment days or times, even when booking in advance**, which was a concern for working parents.

A few people at the grassroots engagement activities said that it was particularly important that reception staff are friendly and helpful, rather than a barrier to care. Several were concerned that **reception staff act as ‘gatekeepers’ asking invasive questions**, which people felt should be confidential, and others commented that the mood of reception staff influence the service delivery. Some commented that receptionists should have training for how to speak to people with learning disabilities and how to deal with sensitive matters.

Many people felt that there **should be alternative ways to book appointments**, such as online, by text or in person at all practices. However, others expressed concerns about online bookings, or online GP appointments, as they were concerned that those who did not know how to use computers would be left out.

Several people at the Kingston and Richmond grassroots engagement activities **wanted more continuity with their GPs**. They were frustrated that they would see a different GP every time, which meant that they could not build relationships and trust with their GPs and had to explain their health concerns each time. They also commented that this meant that advice given was often inconsistent.

Others suggested that they did not mind seeing different GPs if it was a one-off, but not if their appointment was part of an ongoing condition.

### Referrals

Some people felt that although they had no issues getting an appointment with their GP, there are serious issues when it comes to referrals. Some commented that **referrals take a long time** and some told anecdotes of referrals being lost, either in the post or due to other administration errors, and that it was then left to the patient to follow up. Some people felt that there needed to be more information about the referral process, where a few commented that they had to wait several weeks for test results which made them anxious. A few people at the Richmond grassroots engagement activities suggested that some services should allow for self-referral.

### Accessibility

Several people commented on accessibility issues:

- A few people comment that GPs are more **reluctant to make home visits** which causes an issue with those who have accessibility needs.
- Some people felt that **calling appointments being via a screen** is not appropriate for those with bad vision.
- Others commented on the **lack of translation services** offered at GP practices, which leads to misdiagnosis, delayed or cancelled appointments, and issues making appointments. Specifically, a few people at the grassroots engagement activities in Kingston commented that there are limited staff of Korean descent and that this impacts access to services, given the large Korean population.

### Patient centred care

People commented on the need for patient centred care, treating the person holistically and emphasising health lifestyle and prevention. Some people welcomed the concept of a care navigator, especially for people with multiple complex conditions. For more details on the discussion surrounding prevention see section 3.2.4.

A few people at the grassroots engagement activities felt that their **illnesses were not being taken seriously**, or that due to a lack of GP knowledge their illness took a long time to diagnose. Some specifically commented that GPs need to have more sensitivity towards ME.

Some people at the Richmond and Kingston grass roots engagement activities felt that GPs were **unsupportive when discussing mental health concerns** such as autism, ADHD, anxiety and depression, and that appointments were too short to talk openly about such issues. Some said that GPs were dismissive of mental health issues and quick to prescribe medication as opposed to suggesting other services that may help. For more information on mental health, see section 3.2.5.

Some people commented that there was not enough information for carers that GPs should place more emphasis on the mental wellbeing of carers.

Some people commented on issues with prescriptions. People expressed frustration around the **delay in prescribing PrEP** medication to those at risk of HIV. Individuals need to be treated within 72

hours of exposure and there is confusion around prescribing this medication; which often comes down to who is funding it. Others commented that it was **difficult to get B12 injections** prescribed for patients suffering from ME.

### Other concerns

A few people commented that it was **difficult to register with a GP**, and some noted that the Kingston Churches Action on Homelessness was helping some register. Homeless people at the grassroots engagement activities felt that their personal circumstances restricted them from seeking medical help.

A few people at the grassroots engagement activities were **concerned about smaller practices closing** and merging into hubs. People believe that this means that patients will need to travel further to see a GP, which could be particularly difficult for older people, and may encourage more people going to A&E.

A few people at the Kingston and Richmond grassroots engagement activities commented on the **lack of appointments available with a chiropodist**, suggesting that there should be more frequent appointments, and more places that offer chiropody services.

### 3.2.4 Prevention and early intervention

While people were **broadly supportive of the focus on prevention and early intervention** in the STP, they also **cautioned against thinking it would be easy** to change people's behaviour. Some suggested that information and communication is an important first step so that people understand where they can go for what kind of support. Some people **liked elements of the plan**, such as the **focus on promoting healthier living and addressing obesity**.

#### *Locality teams and communication*

Several people said they **like the idea of locality teams, however there were questions and concerns about how these teams would function** in practice. One participant was concerned that introducing locality teams would mean another layer in an already complex healthcare system. Another was concerned about how to ensure locality teams would be in the places they are needed, with enough local provision for all. Others still queried how locality teams would work in practice given the shortage of GPs.

Most people felt **communication and information sharing by the NHS amongst practitioners and with patients was currently unsatisfactory**. Some people offered suggestions for how communication and information sharing could work better in the STP. Suggestions included:

- the need for GPs and other practitioners to be aware of all available services in an area and communicate this information to patients;
- improved online public information to signpost services; and
- provide enhanced communication between practitioners about patients to reduce the need for patients to tell the same story repeatedly.

### *Use of apps*

Some health and care forum people **liked the idea of using smartphone apps to help manage their health** and care. For example, they could see benefits such as being able to check their own blood pressure. However, they also questioned whether this information would only be available to the patient or whether it would be sent through to their GP or another health professional who could respond if there was something concerning.

Other people noted that **digital apps will not work for everyone** and there should be alternatives to support diverse needs and preferences. There was also a concern that patients might feel they have been ‘fobbed off’ by being directed to an app, rather than being able to see a health professional.

### *Working with non-NHS resources to support prevention*

People at the health and care forums, as well as the grassroots engagement activities considered the role of community support, and a perception that GPs may currently be dealing with a number of patients whose needs are social rather than medical. People felt that **if support from families, friends, communities and the voluntary sector was encouraged, this would support the prevention and early intervention agenda**. One participant described this as a cultural shift in how people think about their health and care.

There was **broad agreement that the voluntary sector could be more involved in prevention and early intervention**, as long as **they do not replace other more highly trained professionals**. One example of where volunteers could provide support in addition to clinician care was volunteers in the eye unit at Kingston Hospital, who are perceived to play a valuable role in providing information and support about sight loss. The participant who shared this example felt a similar model could be used for other conditions such as strokes, but they emphasised that the voluntary sector needs resources to be able to provide these services, and said that there was a high initial set-up cost for this service.

### **3.2.5 Mental health**

There were several **concerns about the quality of existing mental health services** in South West London, with specific reference to St. George’s Hospital and Tolworth Hospital. One participant described attending Tolworth Hospital as a stressful experience for someone with a mental health issue, with long waiting times, specialists not available and often only locum psychiatrists. Despite current and future concerns about mental health services and the NHS, several people felt **Richmond mental health services were very good**. This quality of care was attributed in part to having strong local volunteer support for mental health care.

**Praise was given** by people at the Kingston grassroots engagement activities for the Recovery College provided by South West London and St George’s Mental Health. One individual used the services and felt it really improved her wellbeing. Others commented that voluntary services were better than NHS support and some specifically mentioned Soundmind Battersea.



### *Improvements to current services*

At the grassroots engagement activities, several people commented that there is **little support for those suffering from mental health crises**. People mentioned that some carers turn to A&E in desperation and few commented early discharge, before the problem has been treated, contributes to this.

People at the grassroots engagement activities felt that there is a lack of parity between the treatment of physical illness and mental health illness by the NHS and believe that physical health conditions are treated before mental health. People also felt that there was stigma attached to mental health concerns. It was suggested that **more mental health education was needed for front line staff in primary and secondary care (including receptionists)** to learn how to be more sensitive to those with mental health needs.

People discussed funding for mental health services. Some highlighted that the budget allocated for mental health was unjustifiably low given the high prevalence of mental health issues, leading to **gaps in existing mental health provision**. There were a few **suggestions that budgets from different departments should be pooled to provide mental health services**, including budgets from the NHS, local authorities and police.

People at the grassroots engagement activities in Richmond commented that **psychiatric care is often changed without notifying patients**. Many also raised the issue of how long they had to wait to be referred to a specialist service and that it was difficult to get a diagnosis for mental health issues.

It was also noted that **diagnosis for mental health conditions sits between different organisations, which leads to a disjointed, inefficient system**. Many adults (aged between 35 – 52) spoken to at the grassroots engagement activities had only recently been diagnosed with ADHD. They noted that they had gone through the majority of their adult lives being told they a number of mental health conditions such as personality disorders, depression and anxiety instead of ADHD. Several people noted that late diagnosis can have a significant impact and leads to the wrong medication being prescribed.

### *Response to proposals*

People were in **broad agreement that A&E should not be the first port of call** because it is a disturbing place for someone who is in a mental health crisis. They felt it is particularly important for there to be out-of-hours mental health care somewhere other than A&E, so that people can be taken to a more appropriate place of safety.

People **supported the idea of having care navigators for mental health** because they felt it would help reduce the need to repeat yourself - which is particularly difficult due to the sensitivity often associated with mental health issues - and to signpost to the right places. One example of a service that was thought to offer valuable signposting to other mental health services was the 'Crisis Café' in Merton. Some people felt that providing **informal spaces for people to gain support for emerging or enduring mental health issues** were just as important as providing support during crises.



People raised **some concerns about the plans for mental health** in the STP. These ranged from: whether the right resources were available for GPs and other professionals to be trained to recognise and treat mental health issues, to whether smaller mental health charities would experience increased competition with larger mental health charities, which was not seen as ideal because it might limit the variety of services available in a local area. Although people liked the idea of a psychiatric decision unit, some were concerned this could mean patients would not get seen by a specialist until the condition has progressed to being classified as ‘severe or enduring’.

Many people also had **questions about the plans for mental health** in the STP. For example, one participant wanted to know if the proposals aimed to keep people with serious mental health issues out of residential care. Other people wondered how physical and mental health care would be joined up in practice. There were also a few Richmond-specific questions including what the outcomes would be for the Psychiatric Unit at Springfield Hospital.

### ***Making the proposals work***

Several people had suggestions for what could make the proposals work. These ideas included **recognising and accommodating diverse needs in mental health services** (i.e. LGBT patients, adolescent patients, perinatal patients), **working better with a range of voluntary sector organisations** to improve community collaboration, more **coordination between NHS practitioners** (i.e. between GPs and IAPT professionals), and **improving mental health education** to alleviate stigma so more people ask for mental health support sooner. People at the grassroots engagement activities in Kingston commented that there is a particular stigma surrounding mental health in the Korean community which needs to be overcome.

Mental health services for children and young people were discussed. Some people felt that **more sustained support should be provided for young people**, from an early stage in any mental health condition, and that a holistic approach should be taken to providing this support. They felt that parents and schools are currently left to manage by themselves for too long before any support is available.

Many people felt that **the NHS was not as good as it could be at working with a variety of services that promote mental health**. People discussed a desire for the NHS to prioritise collaboration between and signposting to mental health services, as well as other services such as schools, voluntary organisations, organisations that support homeless people or veterans, and the criminal justice system.

Some people at both the forums and grassroots engagement activities also felt that the **public should be better informed about how to support people presenting mental health issues** and that schools and community organisations could be sensible places to promote mental health awareness.

### **3.2.6 Learning disabilities**

Several people at the grassroots engagement activities commented on the provisions for patients with learning disabilities, and their parents. They thought that **parents of children with learning disabilities should have more support for their own health and wellbeing**.

People also commented on the **accessibility of GP practices** for patients in wheel chairs. For example, one participant mentioned that there needed to be more access ramps at the Surbiton health centre.

It was noted that **not all GP surgeries invite people with a learning disability to an annual health check**. People in the grassroots engagement activities felt strongly that the GPs should write to the patient in advance to remind them to book these annual checks. Everyone felt that the annual health check is an extremely important appointment and GPs should take the time to discuss and explain what they are doing. However, many people had never heard of this service.

People noted that there is a lack of communication between services and this has an impact on care that is being delivered for patients with complex issues.

### 3.2.7 Children's services

People who discussed the proposals for children's services agreed that there is a need for change in this area. People had **concerns about the perceived lack of NHS funding** and wondered how the NHS could make the proposals for children's services work in practice. For example, people worried about not having enough trained GPs and midwives. One participant felt that 24-hour care would not be possible because of insufficient staff availability and another suggested that amalgamating health budgets and social care budgets may alleviate pressure on services.

#### *Avoiding unnecessary A&E usage*

They agreed that **unnecessary visits to A&E should be discouraged, but felt that access to GPs is not working** for many parents. Some highlighted that existing alternative services, such as the NHS 111 service, are not always effective for parents if they are worried about their child as they feel more reassured by seeing someone in person.

Most people felt **the NHS does not communicate well with the public on options** for where parents can take ill children. People had a range of suggestions for how the NHS can deter parents from making A&E their first port of call. Suggestions included:

- signposting parents and carers to other services upon arrival at A&E,
- GPs and nurses being better informed to signpost parents to other services during regular appointments,
- targeting local schools with information about children's services, and
- providing community paediatric nurses in locality teams.

**Access to GPs was important for people** and they emphasised that parents need GP appointments to be available **after work hours and seven days a week**. Some suggested that there could be dedicated appointment times available for children; some were supportive of using technology such as Skype for remote appointments; and a walk-in clinic for first-stage diagnosis was also suggested. If children do need to go to hospital, specialist units such as the paediatric assessment unit at Kingston Hospital were referred to as good models of care, or a further suggestion was having access to a GP in a hospital setting.

**Isolation was raised as a significant barrier to the implementation of changes** to children's services. People said that when parents are isolated with few social networks, they are more fearful and less confident about their child's care, so they are more likely to go to a hospital as the first port of call. They felt this could particularly be the case for people with English as a second language and people suggested the STP could better address the needs of diverse or vulnerable parents

### *Child and Adolescent Mental Health Services*

People felt that **specialist support for children with mental health issues needs to be addressed more thoroughly in the proposals**. This should include clarity about what a mental health issue for children is; availability of practitioners who specialise in children's mental health; and support for parents with children who have mental health issues.

For parents with children with special educational needs and disabilities, people suggested that direct routes to services such as occupational therapy, speech therapy, and nurses could help the child get what they need and reduce the burden on GPs and hospitals.

### *Person-centred care*

Although in general, people were in support of out-of-hospital care for children, they emphasised the **importance of flexible services that meet different parents' needs**, instead of taking a 'one size fits all' approach.

At the grassroots engagement activities people commented that there is a **lack of specific support for children who are transgender**, and despite there being research to suggest that autistic children have a higher rate of becoming transgender than other individuals, there is no specific services in place to support them.

Some people commented that there needs to be more awareness in the NHS of the link between children with hearing loss and behavioural issues and provide access to CAMHS services specifically for these patients.

Some commented that the private services are better than NHS therapists for those with speech and hearing issues, as they are more tailored and consistent. A few mention that there is a difference in services offered to children with unilateral (hearing loss in one ear only) and bilateral hearing loss (both ears).

### **3.2.8 Maternity services**

People **agreed with the overall proposals for maternity services and that change is needed**. Their own experience was that there is currently a lack of continuity of care, and they were supportive of the aspiration to address this issue and to improve personalisation and choice.

Generally, people thought **pre-natal care in Richmond was good, birthing care was very good and post-natal care was poor**. Kingston was highly thought of both in terms of care and private rooms and staff were highly praised by several people. Conversely, **some people expressed criticism for the level of care at Kingston Hospital**, saying that locum nurses did not seem to care about the mother or children.

There was a feeling that **more personalised maternity care would enable a more holistic approach**, where women feel listened to and understood, rather than experiencing 'box-ticking' exercises. However, some people queried what choice really means in the context of maternity care and whether it extends beyond choosing which hospital to give birth in.

There were **concerns about a current lack of trained midwives**, and people questioned how this would be addressed as part of the STP. At least one participant felt that this would be exacerbated by Brexit. People generally thought that providing **adequate staff for maternity care should be prioritised over providing pregnant women with choices** about her care. For example, one participant was concerned that if women had more choice over their care during and after pregnancy, some would not make safe or healthy choices without advice or guidance from a practitioner. At least one participant thought personalised care was more important after the mother had given birth, rather than before.

People felt the STP proposals should give more consideration of **outreach to individuals with diverse needs**. This includes support not just for the pregnant patient, but to her partner, or to other family members who may be supporting her; as well as to pregnant women from communities with English as a second language and her family, or pregnant women who do not typically access healthcare.

People were **concerned about safeguarding pregnant patients** and some people thought a medicalised approach to maternity care is a barrier to having conversations where safeguarding risks and concerns could come to light. For example, some people felt personalised and holistic care and outreach could help identify women who are experiencing or are at risk of domestic violence, especially during pregnancy.

People also discussed the types of support they thought were most important to prioritise for pregnancy and post-partum care. People felt there was a **need for post-natal classes to be available to women after they have given birth**. At least one participant felt the NHS could do more to encourage new fathers to participate in post-natal learning to help care for new-born children or mothers, especially if the mother was suffering from post-partum depression. Another participant emphasised that mental health support for depression during pregnancy was important.

Overall, people **supported the idea of having greater consistency in care from midwives** and having post-natal health visitors for additional support, though they emphasised the need for recruiting and retaining more midwives as well.

### 3.2.9 Cancer

Several people at the grassroots engagement activities commented on cancer services. A few said that **support should be given to patients after a diagnosis**, with concerns specifically for people living alone who can feel isolated after a diagnosis.

People expressed the importance of an early diagnosis, and **many shared experiences where diagnoses were wrong, or the prognosis was delivered tactlessly**. People noted that it would be helpful to have a follow up appointment to discuss any questions that may not have been asked immediately upon diagnosis.

People said that the quality of care they received varied depending on what time of year they were diagnosed with cancer, due to the staff changeover in July, and were concerned that this could interrupt care. People also felt **that GPs should be more involved in their treatment**, finding out the results of surgeries and caring about the patient's wellbeing, as opposed to merely treating the condition.

Some people praised the West Middlesex Cancer services and the Royal Marsden for the treatment they received. A few people commented that they had used the **'one stop shop' centre in Kingston** and said it was efficient for testing and treatment, but it was not good at emotionally supporting patients. Several people commented that there was a big lack in support following cancer treatment.

### 3.2.10 Planned Care

Many people commented on the **need for adequate transport** for planned hospital appointments. Several said that there are usually delays with transportation. Some also commented that typically seated ambulances are booked, and that these are not always appropriate. For example, people with ME can struggle to sit for long periods of time.

Although Kingston Hospital is considered very accessible in terms of public transport, for the individuals who need to drive people felt that car parking charges should be free or at a reduced cost.

Several people commented **on a last minute cancellations**, or long delays for planned hospital appointments. In particular people commented on the long waiting times at Kingston Hospital eye clinic.

A few people commented that they had poor experiences of doctors within Kingston Hospital, not having a clear understanding of ME and how to diagnosis the condition.

### 3.3 Merton and Wandsworth

Borough	Date	Number of people
<b>Merton health and care forum</b>	29 <sup>th</sup> June, 2017	33
<b>Wandsworth health and care forum</b>	14 <sup>th</sup> March, 2017	44
<b>Merton grassroots engagement activities</b>	May – December 2016	10 events speaking to over 250 people
<b>Wandsworth grassroots engagement activities</b>	June 2016 – Feb 2017	10 events speaking to over 200 people

#### 3.3.1 Overarching themes

Across the health and care forums and grassroots engagement activities in Merton and Wandsworth, three discussion topics were very popular: **care closer to home, prevention and early intervention**, and **mental health**. Seven day acute services had a moderate level of interest, and the maternity services topic was slightly less popular.

Most people in Merton and Wandsworth were **very engaged with the STP plans**, and welcomed the proposals. However, there were concerns from people about the **ability to implement** these proposals due to a range of constraints, including funding and staffing pressures.

For many people, their primary concern was **uncertainty in NHS funding**. They felt that it was not clear where funding would come from and whether it would be sufficient to deliver on the transformation goals. **Some clarification or additional details** of the financial model supporting the plans were requested.

Others were concerned about **how staff would be attracted and retained** to deliver the plans, especially in light of upcoming changes such as Brexit and the rise of living costs in London.

The proposed new roles of **care coordinators and locality teams** were seen **positively** as helpful and appropriate additions to the care system. There were many questions regarding how these would work, and people asked for more detail and specific information about these proposed changes. There were also requests for more information about the **hospital bed reduction targets**. Some people expressed concern that these targets would not be met, and asked for assurances that there was provision for additional resources during the transition period. Others questioned how **access to GPs** would be improved, emphasising the importance of addressing this issue to support the other aspirations in the STP.

People supported the idea of encouraging individuals to take more responsibility for their own health and lifestyles but emphasised that a culture shift is required for this to be successful.

<p>Seven day acute services</p>	<p>Overall people supported the proposals for seven day services in theory, and liked the flexibility and opportunities for specialisation it would offer, but were concerned that they would be challenging to implement and that it might become over-centralised</p> <p>There is a need to educate people about which alternative services are most appropriate to use instead of A&amp;E, and potentially charge people for misuse of services</p> <p>Some concerns about alternatives as GPs are already very busy, and many were not aware of NHS 111.</p> <p>There was support for locality teams as long as they had sufficient time to care for patients.</p> <p>People described poor experiences in A&amp;E and acute services including inappropriate waiting areas, abrupt healthcare staff, communication issues and early discharge</p>
<p>More care closer to home</p>	<p>Most people supported the proposals for having more care closer to home and felt that success would be reliant on funding, training, good access to patient data, strong connection to local infrastructure and improved IT systems.</p> <p>People reported difficulties getting GP appointments and discomfort with receptionists acting as 'gate-keepers'. There are some concerns about communication with GPs, with some specific examples of cultural differences leading to problems</p> <p>Most were comfortable with asking pharmacists for advice as long as privacy could be maintained, although there were concerns about capacity</p> <p>There were concerns about NHS 111, and some felt it would direct more people to A&amp;E, rather than less.</p> <p>There was support for increased integration with the voluntary sector with examples of where this works well</p> <p>People want more information about care navigators and supported the idea of health champions on locality teams</p> <p>Some would welcome increased use of technology but had mixed experiences and raised concerns about the security of online services</p> <p>There were concerns that GPs are too quick to medicalise mental health conditions</p>
<p>Prevention and early intervention</p>	<p>While supporting the need for change people wanted more information about the details of the prevention</p>

	<p>People were concerned it would be difficult to fund prevention as well as treatment, although they recognised the need to invest</p> <p>They felt behaviour change would be needed in staff as well as patients in order to improve prevention outcomes</p> <p>They liked the ideas of locality teams in this context, although wanted to make sure this did not exclude the involvement of community based organisations</p> <p>There was some concern that the voluntary sector might be relied upon too heavily unless funding was available to support them</p>
Mental health	<p>General agreement that MH needs are not currently being met and a desire for more information about the plans in the STP</p> <p>View that there is not sufficient funding currently and questions about whether more would be available</p> <p>Some concern about increased emphasis on GPs, given difficulty in accessing appointments and tendency for GPs to medicalise MH</p> <p>Recognised a need for increased MH education in the community through a range of channels to demystify MH</p> <p>Encouragement to ensure early intervention as well as improving crisis care</p> <p>Support for plans to integrate mental and physical health</p> <p>Concerns about Children's MH services including long waiting times and difficulty transitioning to adult services.</p>
Learning Disabilities	<p>Limited people responded but emphasised importance of tailoring services to individual needs, balanced with a need for consistency in the services available.</p>
Children's services	<p>Fewer people commented on these services but those who did supported the proposals overall.</p> <p>They thought providing alternatives to A&amp;E is important, and highlighted the importance of more flexible access to GPs</p> <p>They were open to use of technology and telephone appointments to support flexible access</p> <p>The difficulty transporting unwell children was identified as an important consideration when making changes to services</p> <p>Communication of range of services is important, and should start during pregnancy</p> <p>It is important that the plans provide for holistic and patient centred care that is able to meet the additional needs of children – for example those with autism or leading disabilities.</p>



Maternity services	<p>Viewed the maternity plans as positive but unambitious</p> <p>Agreed with inclusion of perinatal and mental health services in the plan, and thought there are some good services e.g. in Wandsworth, that Merton can learn from</p> <p>Reflected on national shortage of midwives and importance of focussing on what the patient really needs, while also helping midwives take care of themselves</p> <p>Supportive of plans to increase choice, but also recommended managing expectations so that mothers are not disappointed later</p> <p>Some concern that current services are ‘hit and miss’ and that staff could benefit from more training to ensure consistent care levels</p> <p>Need for more support after miscarriage</p>
Cancer services	There were not many comments about cancer. Issues with referrals, support and the way diagnosis was delivered were the main points raised
Planned Care	Few people mentioned planned care except to say that waiting lists are too long for a range of services.

### 3.3.2 Seven day acute services

Overall, people **supported the proposals for seven day acute services** and believed they were going in a sensible direction. There were conflicting views in Wandsworth as to whether the plans would work in practice and Merton people felt **practical details were needed** to include more specifics about the savings and how much funding would be provided for the changes.

#### *Feasibility*

Many people in the Wandsworth health and care forum **thought the plan would not be successful**. The main reasons were a perception that the NHS does not have a track record of managing change well and that the NHS does not have sufficient funding to deliver the changes effectively. Many Wandsworth people felt **the changes were being proposed too late**. Several people were frustrated that waiting times were long and buildings were in poor condition and felt these issues should have been addressed sooner. One participant said the scale of changes could not be delivered in 5 years and the NHS would need more time for implementation.

People raised concerns about **practical constraints that could hinder the success of the proposals**. There were concerns about staff requirements, particularly when there is a shortage of GPs within the current model of care. Some people were concerned that community services would be asked to take a greater caseload without additional funding or capacity and one participant was concerned about a dip in service quality over weekends. There were also worries that larger hospitals **would lose the advantage of being a ‘one-stop-shop’ for services if departments had different timetables**.

Other challenges raised were a lack of social care funding to support patients once they left hospital; and a lack of information and knowledge about where patients can access care outside of hospitals

Some people shared **positive views about the proposals for seven day services in the STP**. For example, Merton people in the health and care forums viewed seven day acute services as **flexible to support different needs** and thought this approach would reduce congestion.

A few **Wandsworth people said** they had good experiences with care in the area (e.g. quick access to a variety of services; additional care locations across the river are easy to access), and felt that because there are options for care, that the **proposed changes would not significantly impact them** (negatively or positively).

### ***Alternatives to A&E***

Merton people **agreed with the proposal to reduce A&E visits**, but were concerned that there were few alternatives, for example most reported difficulty getting a GP appointment when they needed one, although online booking was seen as improving convenience. They felt that more **people would need education about which alternative service is most appropriate**, and it was suggested that this would particularly benefit those not familiar with the UK health system. People at the grassroots engagement activities noted that there were few alternative options for urgent health needs after 6pm.

A couple of people at the Wandsworth health and care forums said that the hospital's tiered approach to A&E care (i.e. different areas depending on the severity of need) was efficient. These people also suggested that patients could be charged for missing appointments or misuse of A&E to help reduce the instances of unnecessary visits to A&E. People also questioned why patients who do not need to be in A&E are not sent to other locations upon arrival.

People felt that **more education and promotion was needed around NHS 111** and when to use it. A few people shared positive experiences using NHS 111. One participant expressed that a child's health was too important to risk using NHS 111, and they would always go to A&E.

People at the Merton grassroots engagement activities commented that **if they were unable to get a GP appointment that they would try to go to a walk-in clinic**, such as Wilson Health Centre or the Croydon walk-in service. They commented that this was more pleasant than going to A&E. Some people at the grassroots engagement activities commented that although the service at the hubs is good, it is less personal than going to a local GP.

**Specialisation of larger sites was supported by Merton health and care forum people**, who believed the trade-off in travel would be needed to **concentrate medical expertise and high quality services**. Some people cautioned about over-centralisation, as they were concerned that this could lead to a reduction in the quality of community services. To support this, additional **resources for community services were suggested for the transition**.

### ***Locality teams***

People at the health and care forums expressed **support for the proposed locality teams**, and felt it would allow more care at home to reduce hospital usage. People would like health visitors to have

**more time to care for their patients**, rather than what some felt was overly computerised medicine management. They also expressed concerns about the current difficulty in recruiting and retaining nurses, and the impact this could have on implementation of the proposal for seven day acute services.

### *Experiences of A&E*

People at the Wandsworth grassroots engagement activities noted that **St George's A&E has a particularly poor waiting area** which is not fit for purpose. They said that staff were bad at keeping patients informed as to when they would be seen. Some people also noted the long waiting times to pick up prescriptions at St George's.

A number of people at the Merton and Wandsworth grassroots engagement activities commented that **nurses could be rude and abrupt**. Several people shared anecdotes where nurses were not accepting of children with learning needs. It was felt that hospital staff should undergo training in how to treat a patient with autism.

A few people commented that mental crisis is not taken seriously in A&E and that staff needed to better understand mental health conditions. They felt that there needed to be a quieter 'safe' space to wait to be seen. For more details on mental health services, see section 3.3.5.

### *Acute hospital services*

Several people noted **communication issues**, where doctors asked for embarrassing information without reading patients' files and some commented that hospital staff's bedside manner could be improved, particularly at Croydon University Hospital.

People at the grassroots engagement activities expressed the view that patients were being **discharged from hospital without being medically fit** and that little information is given about at-home care.

A number of people commented on the single sex wards at St Helier, and noted cases where transgender patients were put on the same ward as their birth gender which made them feel very uncomfortable. People also commented that they felt uncomfortable disclosing their gender which could impact care.

People felt frustrated that parking was so expensive at St George's, as this can accrue a big fare and also puts people off visiting relatives.

## **3.3.3 More care closer to home**

People at the Merton and Wandsworth health and care forums **supported proposals for having more care closer to home**. They identified several **key success factors including funding, training, access to patient data, strong connection to local infrastructure and improved IT systems** (for example to link different services or professionals involved in a patient's care, or to use Skype with patients).

## *Feasibility*

Despite high-level support, many people identified **challenges to achieving the plan** and there was some scepticism about how it could work in practice. These challenges included:

- A lack of integration between health and social care, including patients remaining in hospital longer than necessary because no support was available outside of hospital, and insufficient communication arrangements between services;
- Insufficient coordination of NHS services and staff internally;
- A lack of GPs;
- A lack of information and awareness on alternatives to A&E, meaning people often did not know where else to go.

## *Working with the voluntary sector*

Merton health and care forum people suggested that **integration with the voluntary sector was important and needed to be improved**. For example, in end of life care hospices would potentially be able to reduce NHS caseload. They also felt there should be better integration with the local authority, because they thought this could facilitate a quicker discharge from hospital. They referred to Wellbeing teams as good examples of a community based approach to care.

There were additional services Merton people wanted to be delivered closer to home, including **chronic illness management** through schemes such as Live Well (a local voluntary group) which matched people with professionals and volunteers.

## *Care navigators and locality teams*

People wanted more information about the locality teams, and whether there was additional funding for this model. Wandsworth health and care forum people supported the idea of **care navigators** but felt they should be used more strategically, making them available in public places where people go to anyway such as neighbourhood shopping areas.

People were **frustrated that GPs were unable to signpost people to different groups or services**. Some people **like the idea of care navigators** to help deliver joined up care. Many had to do their own research to find support groups and IAPT services. Some people felt that more should be done to encourage social prescribing.

People in the Merton health and care forum felt an expert in a patient's medical condition was needed on locality teams and they supported the idea of **Health champions** for this purpose.

People in Wandsworth also felt it was important to provide **more support for families and carers**, especially to manage the needs of ageing patients. One participant said having dieticians more readily available could help keep people out of A&E.

## *GP Services*

### **Appointments**

Many people at the Merton and several at the Wandsworth grassroots engagement activities disliked the current GP appointments system and expressed frustration that **they struggled to get same-day GP appointments**. Some said that they would be on hold for up to an hour when trying to make an appointment and others commented that they could never get through. Some commented that once they did get through after the long wait, all appointments would already be gone. A few said that **when they were unable to get an appointment they would go to A&E**.

Despite this, **some people at the Wandsworth grassroots engagement activities had not encountered any difficulty** getting a GP appointment. One participant commented that there are two walk-in clinics a week in her area and another said that they had a positive experience using the GP Pooling services where if their GP surgery is closed or they cannot get an appointment, they are referred to another one nearby.

Several people at the grassroots engagement activities noted that **GP appointments were not long enough** and expressed frustration that they had to book double appointments if they had more than one issue to discuss and a few people commented that they **did not like the lack of continuity** in terms of which GP they saw, which they felt disrupts care.

### **GP Capacity**

Some people noted that **there was a shortage of local GPs** and there was some concern that GPs were no longer doing home visits to the most sick and vulnerable, who would struggle to come into a surgery. A few felt that GP surgeries should do more to stop patients missing appointments, such as charge them.

### **Receptionists**

Many people commented that **reception staff are used as ‘gatekeepers’ and several felt uncomfortable disclosing confidential information to a non-clinician**. Receptionists ‘triaging’ patients seemed to be a cause of anxiety for older patients, and there were concerns about whether the receptionists were qualified to make these assessments. There was also some frustration surrounding reception staff giving patients test results, as they were unable to answer any follow-up questions.

### **Referrals**

Several people at both Merton and Wandsworth grassroots engagement activities commented that **referrals to hospital appointments had been lost, and it had been up to the patient to chase them**. These administrative errors led to long waiting times for referrals. People felt that GPs and hospital consultants should be able to talk to each other directly without the patient being the middle man. Several commented that improvements needed to be made to the referrals system to improve these delays.

### **Communication**

People wanted to see **more interaction between GPs and patients**, for example giving reminders for blood tests and appointments. Some felt that GPs did not care about patients as they did not follow up. Others commented that GPs seemed disinterested during consultations.

A few people commented on cultural issues which they believed had impacted on the quality of care that they received from a GP. Several people in Merton commented that Merton GP surgeries no longer do HIV testing. It was felt that more should be done to promote HIV testing.

Many people commented on a lack of awareness of specific services. For example, a few said they were unaware of annual health checks.

Several people commented that GPs should be trained in how to communicate with children with learning disabilities and autism.

### *Pharmacy*

Almost all Wandsworth health and care forum people said they **would feel comfortable asking a pharmacist for advice** if issues of privacy, including having a private place to meet with the pharmacist, were addressed and well managed. Despite this support, various concerns were raised:

- pharmacies would not be able to manage all the community needs;
- pharmacies were being closed;
- there might be resistance to directing people to pharmacists from GP surgeries as it might be against the GP's business interests;
- personal views or beliefs of pharmacists might influence the treatment and advice they provide.

Some people had queries about operational details of using pharmacists instead of GPs, such as whether and how communication would be shared between pharmacists and GPs; how patient information gathered by pharmacists would be stored; and whether pharmacists would be financially compensated for having a larger workload.

### *NHS 111*

Wandsworth people were **concerned about the current NHS 111 service**. For example, they wondered how the service would fit into the plan since they felt NHS 111 often directs people to A&E, rather than non-A&E sites. Further, some people did not like the idea of using NHS 111 more because they preferred speaking to a practitioner in person, while some felt NHS 111 staff do not communicate well (e.g. staff ask too many questions during a call).

### *Use of technology*

A few people at the Merton and Wandsworth grassroots engagement activities commented that they would like **the ability to book non-urgent appointments in advance**, and some **welcomed the prospect of telephone consultations** but requested more information. Several people liked that they received a text from their GP to remind them of when their appointment was.

People had **mixed experiences with online services**. Some had used 'Patient Online' but most were unaware it was an option and said that they would not use the service as they did not use the internet. Others were more positive and said they would consider using it and felt that it should be

better promoted. A participant who had used the services commented that it was difficult to navigate the bookings system. A few people felt that their privacy would be compromised by using online services, and were concerned about data hacking and leaks. Some people liked the fact they could email their surgery.

### **Mental Health**

People at the Merton and Wandsworth grassroots engagement events felt that **GPs were too quick at prescribing medication, particularly for mental health conditions**, rather than seeking alternative options. People noted that these can often be addictive, are not explained properly, and tackle the symptoms instead of the causes of mental health issues.

Some felt that their GPs did not understand mental health conditions and people wanted more support for themselves and their families to understand their mental health condition in more detail. An example would be counselling from the community mental health team for families and carers so that they are able to understand what the individual is going through. For more details on mental health services in Merton and Wandsworth, see section 3.3.5

People at the Merton grassroots engagement activities felt that their conditions were being looked at one-by-one instead of as a whole person and that there was a **disconnect between physical and mental health issues**. They suggested that an integrated and coordinated approach to healthcare would particularly benefit patients with learning disabilities, who often have a variety of medical problems.

People also felt that **NHS services should work more closely with social care**. One participant commented that GPs should have better knowledge of existing services and that information should be easily relayed between these services for joint up care.

### **Other**

Some people at the Merton grassroots engagement events felt that there was a need for a new GP hub, as the current surgery is run down. There was much praise for the newly built Nelson Health centre, and people appreciated having several complimentary services under one roof.

People commented that the general environment in GP surgeries should be disability friendly.

Some people expressed frustration with the current complaints systems, and felt these should be updated to allow for face-to-face complaints.

### **3.3.4 Prevention and early intervention**

Overall, **while supporting the need for change**, people at the Merton and Wandsworth health and care forums **wanted more information about the details of the prevention services**. Merton people cautioned against continued consultation without a final plan, as well as suggesting the need to take learnings from previous transformations.

Merton people raised **concerns over lack of funding and resources**, as people believed public health funding had been cut and the NHS would **struggle to fund prevention as well as acute care**. Many felt that prevention was very important as an aging population would mean **more complex needs in**

**the future unless intervention was implemented** now. As they believed early intervention work has an impact on health outcomes 15 – 20 years later, they thought changes would not see a reduction in demand for services in the short term. One participant felt the focus should be on quality of years not just longevity.

People identified several **challenges relating to behaviour change and education**. Some felt there is a current **lack of interest in prevention** and early intervention **from many health professionals**, whilst other people thought encouraging prevention and early intervention could be dangerous (e.g. one participant felt individuals might underestimate a health issue and decide not to seek support). Merton health and care forum people supported **promoting healthy lifestyles to more people**, and thought **signposting to services in local areas would help support changing behaviour**. They believed the public did not know about all options, such as mental health services in the area, and suggested GPs have a list of services they could signpost to. **More realistic healthy living advocates and role models were suggested** to encourage people to seek more information.

### *Locality teams*

People at the Merton and Wandsworth health and care forums **liked the locality teams working to support people from different agencies together**, providing integrated health care in their community. However, some Wandsworth people were concerned that community-based organisations could be forgotten as a useful resource, and one participant felt locality teams presented a risk because they were an un-tested service.

People had questions about how locality teams would be implemented, who would coordinate them, which professionals would be included, what area they would cover, how to contact them, and the level of support that would be provided for patients. Other questions raised by people included:

- the role of **care navigators as they felt these roles were not clearly defined**, for example, how would this role differ from receptionists who direct to services;
- more details about **interventions for obesity and diabetes and how this would be managed by a GP**;
- how workplaces would be involved in meeting the objectives of the prevention and early intervention plans in the STP.

### *Voluntary organisations*

Merton health and care forum people also discussed the **role of voluntary and community services in this transformation plan**, which some felt might be relied upon too heavily. Some partnerships were working well, such as Live Well (a local voluntary group), as these groups understand the needs in community. However, a lack of funding and communication between services would be a challenge to these partnerships. A directory or forum to share ideas locally was suggested, which could help support the transformation plan.

People also made the following suggestions:

- there should be **additional services for recovery and reablement**, as well as prevention;



- making use of **technology**, including apps, could make health care more accessible (however, others thought technology would not be universally accessible);
- **social prescribing or using more community-based health care** options would improve health outcomes.

### 3.3.5 Mental health

Many attended the Merton mental health discussion, and agreed that change was needed. They felt there is a **serious need for mental health services in the area which is not being met**. For example, one participant said there were increasing numbers of people with mental health needs in statutory services or on the street, as well as inadequate support for carers.

Some people felt there was a **lack of information about how the STP proposals for mental health would be carried out**. They wanted to know more about

- what a mental health team might look like;
- the Psychiatric Decision Unit, whether it currently exists and how it would work in practise;
- whether GPs have sufficient capacity and training to work with a range of mental health practitioners in the community to improve care.

#### *Feasibility*

Concerns were raised about the feasibility of proposals, given the funding challenges in the NHS. Merton health and care forum people believed there was **not enough funding for mental health services**, such as talk therapy, meaning patients did not get the full treatment they needed. Understaffed and underpaid workers was also a concern, as the **national lack of nurses was made more difficult in London due to expensive living costs**. They questioned if **funding for changes would be taken from existing services**.

There were **concerns about the increased emphasis on use of GPs** in mental health provision. Many Wandsworth health and care forum people thought **current problems in accessing a GP**, including long waiting times and insufficient GP capacity, could hinder the mental health proposals in the STP. As outlined above (In Section 3.3.3), some Wandsworth people felt there was a **tendency for GPs to prescribe medications** rather than prescribing non-medical approaches such as talking therapy or social prescribing. Some people at the Merton grassroots engagement activities noted that loneliness can often cause or exacerbate mental health problems and that this required community support. Several people thought there that **GPs lacked an overall awareness of the IAPT programme**.

People also said care for different vulnerable populations (e.g. ageing, young, or parents) was currently inconsistent and should be improved as part of the proposals. Many people commented on the long waiting times for 'talking therapies', which for some has taken over a year.

### *Springfield University Hospital*

People at the Merton health and care forum and grassroots engagement activities commented on Springfield University Hospital. Some people expressed concerns that reducing the use of beds in Springfield Hospital would lead to longer travel times for patients. Others commented that the negative public opinion of Springfield was not good for their mental health if they were admitted there and some were irritated that when you call Springfield you need to provide a lot of personal information which made people feel nervous. People felt that it would be helpful if patients at Springfield were grouped by condition on the ward.

### *Education*

People felt there was a **need to engage with the community, to demystify and take action on mental health**. The Springfield Hospital of Recovery College was highlighted as a model **for peer support in recovery**. Wandsworth health and care forum people thought that the **voluntary sector could be more involved in providing mental health support in community settings** such as in public libraries, so people can find support in a more informal setting.

People made various suggestions for mental health awareness raising initiatives:

- schools should do more to **educate young people and children, supporting healthy habits particularly with technology** with direct discussion in classrooms;
- local further education colleges could be used to educate and fund courses for people in recovery moving into learning and employment;
- signposting in GP surgeries;
- running mental health awareness campaigns;
- more training for NHS 111 staff to signpost to mental health support and services;
- training for a wider range of professionals about how to support someone with a mental health issue.

### *Early intervention*

**Early intervention in mental wellbeing, not just crisis, was highlighted** with models in Wandsworth and Merton given as examples of what they felt was good practice. For example, faith-based community leaders were given Mental Health First Aid training, such as a group of 12 pastors of black majority-led churches learning about therapy and how to support families with mental health conditions, and a similar scheme was being implemented for Imams and mosques. At least one Wandsworth participant felt there were not currently enough staff in the NHS to implement a preventative approach to mental health, especially for children's mental health. At Wandsworth grassroots engagement activities people felt there should be more visible support for men who may not seek support due to the stigma around mental health issues.

## *Integration*

The plans for **integrating mental and physical health were supported**, and people gave the example of a pilot scheme at St George's Hospital giving mental health support during cancer treatments. Some Merton people felt it was important to explain the importance of healthy eating and exercise to mental health. Similarly, **perinatal mental health support before and after birth was needed**, for example having an assessment during home visits to identify signs when a mother is not coping.

## *Crisis support*

People at Merton and Wandsworth grassroots engagement activities commented that there was a **lack of support within the NHS for those experiencing a crisis** and suggested that there needed to be an increase in walk-in services and out of hour's services to support individuals when they need it most.

Many people at the Merton grassroots engagement activities commented that the **crisis line had been unavailable when required**. One participant commented that after he was discharged from hospital having had a mental health crisis, he was not offered any follow up support, but had to seek it himself and suggested that this support should be more readily available.

Some people noted that the NHS in SWL are setting up '**Crisis Cafes**' in partnership with the voluntary sector. People fed back that this model assumes that people understand their own triggers and know when to seek support. Some also commented that it was important these are promoted effectively.

## *Child and Adolescent Mental Health Services (CAMHS)*

Several people at the Wandsworth grassroots engagement activities commented on mental health treatment for children or adolescents. Several individuals criticised **the long waiting times for CAMHS**, but most found that once they were in the system, the service was good.

A few people commented that there was little support for parents after the diagnosis of their children and that it would be useful for parents to be given useful tips on how to manage difficult situations, especially if they have children with behavioural issues. A few people commented that the **transition from CAMHS to adult services was difficult to navigate** and patients got lost in the system.

For more information of children's services, see section 3.3.7

## **3.3.6 Learning disabilities**

People at the Wandsworth grassroots engagement activities discussed issues surrounding care for patients with learning disabilities. They felt that the specialist care for children with disabilities is poor and **not tailored to individual's needs**. Several people commented that there is a **lack of support for carers of disabled children**. A few people also commented on the **lack of consistency** received for speech and language therapy outside of school.

### 3.3.7 Children's services

Very few people participated in this discussion in the health and care forums, however they supported the children's service proposals overall. People had concerns about **reducing A&E visits**, as they felt this **would not be achieved without more flexible access to GPs for parents**.

#### Alternative services

Using a **specialist nurse at the local GP hub** was understood to be successful in Richmond. Another suggestion was that **technology could be better utilised to give advice to parents more quickly**, such as skype appointments to assess things like dermatological conditions.

Some people at the Wandsworth health and care forum felt that **telephone consultations could work well** for parents with children who are unwell, especially if this kind of service was available out of hours. However, others had concerns about how reliable advice and diagnoses could be if consultations are carried out over the phone. Some noted that telephone consultations rely on the parent being able to accurately describe the symptoms which might not always be appropriate.

People talked about **needing services in the right place for parents as transportation can be difficult** with a sick child or to visit them in hospital. In addition, there were questions about where the proposed specialist nurse unit would be located.

#### Raising awareness

People also talked about **providing education and raising awareness of services** with parents. They believed parents should be **empowered with knowledge of the choices available** to them and when it is appropriate to use them, giving them confidence. **People suggested more engagement about their needs at local parent groups** could be a good option for several reasons: engaging with parents in an environment they are comfortable in; an opportunity to both learn what they need; and raise awareness of existing or new services.

Another participant expanded on this, believing that this **communication should start during pregnancy**, to build a trust in the NHS and knowledge of services throughout the child's life. At the grassroots engagement activities in Merton, people felt that there should be greater access to advice and support from the start when a child is diagnosed with a long-term condition.

#### Holistic and patient centred care

One participant in Wandsworth health and care forum felt that there should be a **culture change in how children are communicated with as patients**. They emphasised that children should be asked about their symptoms so that the medical professional hears directly from them rather than second-hand through their parent. In their view, this approach could also foster a culture where young people feel more confident being people in their own care, helping to move society further towards a patient-centred approach.

Some of the Merton grassroots engagement activities were centred around prevention of health issues for children. Several commented that **GPs had not tried to solve health issues through healthy eating** and others commented that they were unaware that a child with a learning disability was eligible for an annual health check. For more details on prevention, see section 3.3.4.

### Children with additional needs

People at the Wandsworth grassroots engagement events commented on the importance of seeing the same professional when dealing with children with additional needs. Some also expressed concern that there were often long wait times and delays in the waiting rooms of specialists, which can be difficult to manage with an autistic child. Others mentioned that awaiting a referral to a specialist can take a long time which should be better managed.

Many commented that staff should have full training on how to manage patients with autism.

### 3.3.8 Maternity services

People at the Merton health and care forums felt the proposals were **positive but unambitious, as these things should previously have been in place** with one person saying these were proposed 25 years ago. There was a **lack of awareness about the plans**, with people from the local authority feeling there was not enough information for them or local counsellors.

People were **pleased to see that mental health and perinatal services were included** in the proposals, but felt staff at St George's Hospital could be doing more to support mental health. At the Wandsworth health and care forums, people were concerned that it **is not always easy to identify who is not coping**, especially if mothers feel stigma associated with disclosing this information. These people felt that more personalised care and good relationships between women and their maternity care professionals is vital to support this aim.

People in the Merton health and care forum believed there were several areas of London with **excellent perinatal services such as Wandsworth, Chelsea, and Westminster, which they felt Merton could learn from**. In addition, they felt that they could learn from transformations such as Basildon or Morecombe Bay, or from international leaders such as Sweden.

People noted the **national shortage of midwives**, which they felt needed to be addressed in the plans. They felt **quality care was more important than having one person consistently** throughout pregnancy. People believed good maternity care was less about complex procedures, instead **competent basic care with a good bedside manner was key**. They had concerns that midwives were being given too many 'tick box' procedures to carry out rather than **thinking about what a patient really needs**. For example, a participant noted that women who were refugees would have very different maternity needs to a same sex couple, or an older mother. Some disagreed about use of beds post birth proposals, as some felt that patients could be moved to a less urgent care ward, while others said mothers should be discharged to go home more quickly.

At the Wandsworth health and care forums, discussions centred around the proposals for personalised maternity care and choice. Some people felt that control and choice is sometimes taken away from women in pregnancy and labour and they **supported the aspirations in the STP to empower women to have more choice in their maternity care**. Some noted that choice for women must always be balanced with medical decisions about what is safest for mother and child, but that there is scope for the balance to shift more towards women compared to their experience of current practice.

One participant noted the importance of **managing expectations** and for the **NHS to be realistic about what it can provide**, rather than raising expectations and then not meeting them. For example, letting women know that they may not have the same midwife throughout their pregnancy but that there will be a team of midwives available. This participant felt that by being honest in this way women wouldn't feel so let down, for example if they see a different midwife when their usual one is not available.

At the Merton health and care forums people agreed that patient **experience varied and there was a 'hit-and-miss' element to the services**, suggesting that more training is needed to ensure more consistent care standards. For example, one participant said Kingston and St Helier hospital had excellent maternity units.

Some forum people and the Merton grassroots engagement events were generally positive about their experience of St George's. Whereas people at the Wandsworth grassroots engagement events were less positive, including one comment that the health visitor only gave very general advice and some comments that the services were 'disgusting'.

People said more support was needed **post-miscarriage and for fathers in supporting pregnant partners and their own needs**. A participant highlighted the **lack of prevention plans in the proposals** for maternity services, such as educating young people more about sexual health and pregnancy.

Finally, people raised **concerns about midwives being overworked**. Linked to this, they felt that training for midwives should include helping them to take care of themselves so that they are able to give the best care to women. People were worried that the emphasis on productivity could cause midwives to burn out and not be emotionally available to support women effectively.

### 3.3.9 Cancer

There were no comments on cancer services in Merton, however a few people commented on cancer services at the grassroots engagement activities in Wandsworth. One participant noted that their cancer diagnosis was delivered insensitively and that there was no signposting to additional support services. They also mentioned that they had issues with their referral. Another commented that they had to do their own research into community support. One participant mentioned that their treatment at the Marsden was excellent.

### 3.3.10 Planned Care

Few people at the Merton and Wandsworth grassroots engagement activities commented on planned care.

A few people at the Merton grassroots engagement activities commented that there were long waiting times at St George's for outpatient appointments.

Some people at the Wandsworth grassroots engagement activities commented that the aftercare was not good and that changes in staff were very disruptive. One participant commented that that waiting list for the pain clinic was too long.

### 3.4 Sutton

Borough	Date	Number of people
<b>Sutton health and care forum</b>	1 <sup>st</sup> February, 2017	30
<b>Grassroots Engagement Activities</b>	July – December 2016	13 events speaking to over 284 people

#### 3.4.1 Overarching themes

While people at the health and care forum were supportive of the aspirations laid out in the STP, many felt that **the plan lacked detail and they wanted more information including overall timelines and a chronological plan**. Some questioned whether the STP is any different from previous plans, expressing frustration that plans are constantly produced but little change appears to take place. Others felt that the plans are **unsustainable and are too ambitious in the current financial climate**.

People broadly supported the STP aspirations, but had questions about how it would be implemented including **how staff shortages would be managed and where services would be located**. People also felt the STP did not provide enough detail about how the changes would work in practice and wanted to know more and what decisions had already been made (e.g. which hospital would be closed).

Seven day acute services	<p>Concern that there is insufficient capacity in A&amp;E and that closing a department would exacerbate waiting times.</p> <p>Unclear whether NHS 111 will reduce A&amp;E use based on their past experience.</p> <p>Suggestion to change configuration of A&amp;E to have GPs / social care available there, rather than try to change behaviour.</p> <p>Strong support for St Helier Hospital and concern that reliance on alternative A&amp;E services would lead to increased travel times which they felt could put people at risk.</p> <p>Some concern about communication within St Heliers, and between St Heliers and other organisations.</p>
More Care Closer to Home	<p>Variable experience of GP services, with some great experiences and others reporting difficulty accessing appointments and a perception that receptionists were undertaking triage for appointments.</p> <p>A view that GPs need to improve the way they support and communicate with patients with additional needs (e.g. deaf, learning disabilities, mental health).</p>

	<p>Some concerns about increasing reliance on pharmacists as people were unsure whether they would have the right skills/training.</p> <p>Online booking works well for those who can use internet, but important to keep telephone option for those who cannot.</p>
Prevention & Early Intervention	<p>Broad support for idea of increasing the emphasis on prevention, but more evidence needed to convince people it will have the benefits anticipated in the STP.</p> <p>Will require changes to both NHS staff behaviour, and people's behaviour – both of which will be challenging.</p> <p>Specifically, people want more information about how locality teams will work and how they will interact with other local services in the public and voluntary sectors.</p>
Mental Health	<p>Concerned about a current lack of resources and funding for mental health, especially given recent closures, the lack of a local crisis centre and long waiting lists.</p> <p>Felt they would benefit from more long term mental-health support once patients have been discharged.</p> <p>Scope for the NHS to improve the information available to patients about mental health services including community and voluntary sector services.</p> <p>GPs sometimes too quick to prescribe medication and should involve specialists.</p> <p>Felt that some groups have specific needs that are not addressed, for example providing counselling in sign language, providing a clear route to getting mental health support for young people and supporting carers.</p>
Learning Disabilities	<p>Very few comments in Sutton.</p> <p>Suggestion more could be done to increase professional's understanding of LD and autism.</p>
Children's Services	<p>A few people felt frustrated with how long it took to be referred to CAMHS. There was a feeling that the local CAHMS service is overstretched. People were unsure where to find help.</p>
Maternity Care	<p>There were some concerns about access to maternity care, as people did not want it to be provided in a large GP surgery.</p> <p>The NHS should do more to raise awareness of maternity services, as well as tailor information about relevant services to individual needs.</p> <p>Some questions about personalised maternity care and providing more choice to patients and how to ensure this would be safe.</p>
Cancer	<p>Very few comments in Sutton.</p>



	View that follow-up care could be improved for patients and carers.
Planned Care	<p>Very few comments in Sutton.</p> <p>Some positive comments about the South West London Elective Orthopaedic Centre.</p> <p>A perception that follow-up care, including physio could be improved.</p> <p>Some mentioned poor communication in hospital leading to wasted time.</p>

### 3.4.2 Seven day Acute Services

Overall, there was **significant concern that all five existing A&E services are already operating above capacity**. People at the grassroots engagement activities believe that this will be exacerbated by the growing population in Sutton. As a result, people at all events were concerned about possible negative impacts of removing one or more acute services, including the potential for **waiting times to be even longer** than they are now, and about having to **travel further** for urgent care. These concerns were compounded by worries that A&E alternatives, such as walk-in centres, were closing. In contrast, a few people accepted that traveling further for specialist care might be necessary to improve the quality of care received.

Some people at the grassroots engagement activities commented that they did not know where to go other than A&E in an emergency; some had not heard of NHS 111, or did not wish to use it as they felt it had a poor reputation. Additionally, many people at the health and care forum were **concerned about an increased reliance on NHS 111 for signposting patients to care**. Some said NHS 111 had sent them to A&E in the past, so relying on the service could increase demand for A&E. They therefore suggested that the NHS 111 service would need to change if the plans were to be successful.

Similarly, people **questioned whether it is possible to change people's behaviour** to stop them going to A&E unnecessarily. Instead, there was a suggestion to move the location of some GPs and social care services to the same place as A&E.

**Short travel times to care were important** to people and many were concerned that getting to care quickly would get harder over time as traffic increases. Although technically closer, people told us that Croydon University Hospital does not have a good reputation and some thought their only option would be travelling further to St George's Hospital if St Helier A&E closed.

At the grassroots engagement activities, there was **strong support for St Helier Hospital**, where people have had mostly good experiences, although many said more could be done to speed up discharge. Several people noted the lengthy wait for patient transport to take patients home after they have finished their appointments in hospital. Some people shared their experiences of having been discharged at unsociable hours, without care being arranged at home and others said that they were disappointed at level of care post-discharge and suggested that there was no support outside of hospital. A few people also commented that the **NHS and social care services needed to work**

**together more closely**, to avoid patients staying in hospital longer than they needed to, when social care services could help.

Some people at the grassroots engagement activities shared anecdotes about **communication issues** at St Heliers hospital, giving mixed feedback about staff attitudes. People raised instances of rudeness, abruptness and being sent to the wrong wards. Others commented that hospital staff have not been trained to communicate with patients with autism. Some people commented that there is little support for mental health needs in A&E. For details about mental health services in Sutton, see section 3.4.5.

A few people also commented on the **lack of provision for deaf patients** at St Helier. Whilst there were varying views on the availability of interpreters (some felt there was no one on hand, whereas others said it was easy to book in advance) one commented on the lack of a free TV options for those hard of hearing and a few people commented that as there was no Wi-Fi in the hospital, they could not engage with online interpretation software, which would be useful in the absence of an interpreter.

Some people at the grassroots engagement activities noted that there is a **long waiting list to be referred across departments** at St Helier Hospital and one commented that there was an issue with referrals being lost from Epsom Hospital.

A few respondents at the grassroots engagement activities commented on the St Helier building, and maintenance needs, for example that the toilet doors do not lock.

### 3.4.3 More Care Closer to Home

Discussions about more care closer to home raised many questions among people. These often centred around how the plan could work and be sustainable in what was perceived as an environment of funding cuts. Some people were concerned that care closer to home could mean services would be more basic than tailored and specialised. For example, one participant asked, “what are we willing to lose by putting care into the community?”.

Most people **did not think they would go to a pharmacist as a first choice for care** and were sceptical about how this change would work in practice. Many people **believed that pharmacists were not skilled enough** to manage medical problems compared to a doctor and pharmacists and may not have appropriate communication skills to work with patients. At least one participant felt specialist doctors and nurses are best placed to serve patients and was frustrated about the shift away from this model of care. Some people felt a nurse would be better placed than a pharmacist to provide alternative care for patients to help make care closer to home feasible.

Some people had suggestions for what changes needed to be made for patients to feel more confident about going to a pharmacist. Suggestions included more effort by the NHS to change people’s tendency to go to A&E as a first resort, encouraging people to use the NHS 111 service more often, and investing in further training for pharmacists to communicate and offer advice regarding a range of health problems.

Many people at the grassroots engagement activities shared their positive experiences with GPs in the local area, particularly at Manor Surgery. Others commented that there should be a clearer complaints system, and several expressed concerns which are outlined below.

Many people at the grassroots engagement activities commented on the **difficulty of getting a GP appointment**, saying that it can take up to 2 weeks. People also expressed frustrations **that reception staff at practices are triaging patients** for appointments and making decisions on whether their concern should be treated as an emergency. Some people commented on **the length of time for referrals** and their frustrations when referrals got lost, which meant that they had to chase their GPs.

There were some specific concerns about **GP's responsiveness to different patient needs**. For example:

- A few people commented **GPs' lack of knowledge on the rights of deaf patients**. For example, people commented that many GPs were unaware that they should book interpreters, and that a double slot should be offered. People also commented it was particularly difficult for deaf people to phone up for an emergency appointment, so it was suggested that another method of appointment booking be introduced for more equality.
- A few people at grassroots engagement activities described the **lack of support for parents with children with learning disabilities**, and many people commented on the lack of support for carers, where some commented that GPs should play a bigger role in identifying the health and wellbeing needs of carers.
- Some people felt that GPs were unable to direct patients to mental health community groups and a few felt that GPs were quick to prescribe medication for mental health issues as opposed to talking.
- Some also felt that GPs do not provide information on diet, wellbeing and mental health.

Some people at the grassroots engagement activities commented on the **benefits of Patient Online**, saying it was somewhat easier to book an appointment the night before and that it has made it a lot easier to collect prescriptions from their pharmacy of choice at a time convenient to them. Others expressed concern that the NHS is moving towards booking online appointments and accessing medical notes online as they did not know how to connect to the internet. People suggested that telephone appointments continue for those who do not have internet access.

Several people at the grassroots engagement activities wanted **information at GP surgeries to be presented in a more readable format**, as some of the jargon used can be difficult to understand (and some especially asked for there to be more information around eye conditions.)

### 3.4.4 Prevention & Early Intervention

Some people at the health and care forum felt **the STP's focus on prevention and early intervention was logical**. However, most people raised challenges and questions around financial feasibility and how, if at all, social care resources would be included. A few people said they **did not think there was enough evidence in the plan to demonstrate how prevention and early intervention would make the NHS work better**, such as how the plan would reduce the number of patients in A&E in

practice. One participant was concerned that a focus on prevention and early intervention could compromise the care for conditions that cannot be prevented.

People felt there was **not enough information in the STP about how locality teams would function**. For example, many people wanted to know more about who would manage the locality teams, who would champion the linking of services and practitioners, and where the members of locality teams would be physically situated.

People said **changing peoples' behaviour would be challenging**; however, they agreed it was a key component to making prevention and early intervention work. Some people offered suggestions including changing NHS 111 to focus on prevention, using the voluntary sector (though not relying on the sector), and targeting specific groups for prevention and early interventions such as elderly via care homes, smokers, or pupils in school.

Some people felt **the NHS would need to change** its internal culture and approach to patients to make prevention and early intervention work. For example, many people perceived the NHS does not currently foster a culture of prevention and early intervention and that internal policies and staff would need to change to support patients' behaviour changes. At the grassroots engagement activities, some people commented that free gym membership would help people live healthier lives.

### 3.4.5 Mental Health

Many people at the health and care forum said they were **concerned about a current lack of resources and funding for mental health care**. Several people worried that despite an identified need to address mental health more holistically, several mental health centres in the Sutton area have closed (i.e. the 'Memory Lane' service and a mental health drop-in centre in Wallington). They also noted Sutton does not have a mental health crisis centre. Thus, people discussed the negative impact on patients of needing to travel long distances to access mental health care. Patients were also concerned about long waiting times to access mental health services and limited support for patients and carers once initial treatment is completed. For example, several people at the grassroots engagement activities commented specifically on the lack of mental health support after being diagnosed with fibromyalgia.

Some people at the grassroots engagement activities suggested that there should be more **long term mental-health support once patients have been discharged** from care to stop them going into crisis again. They also noted a need to connect mental health services with other physical health services to improve care in a more holistic way. Others commented that people needed more education into how physical and mental health are linked.

People also felt **the NHS could improve the information available to patients** about mental health services including community and voluntary sector services in their area. Some people felt there was a need for greater awareness about early mental health intervention, such as incorporating mental health education in the school curriculum.

A few people commented that GPs were quick to prescribe antidepressants without considering alternative treatment methods. They suggested that more should be done to treat the cause and not

just the symptoms, and that there should be **more emphasis on referrals to mental health specialists**.

Several people at the Sutton health and care forum were concerned that some groups were not represented at the discussion, noting that different groups would have different mental health needs (e.g. homeless, ex-offenders, migrants, LGBT, teenagers)<sup>2</sup>. Some people at the grassroots engagement activities said that they were **unsure how to navigate getting help for child mental health**, where several found getting referrals for their children difficult and others commented that the Sutton CCG currently **does not offer British Sign Language counselling for deaf people**. At the grassroots engagement activities, some people commented **that carers' mental health** should be specially considered,

### 3.4.6 Learning disabilities

A few people at the grassroots engagement activities commented that more training and awareness around learning disabilities and autism would be helpful.

### 3.4.7 Children's Services

No people attended the children's services sessions at the Sutton health and care forum. A few people felt frustrated with how long it took to be referred to CAMHS. There was a feeling that the local CAMHS service is overstretched. People were unsure where to find help.

### 3.4.8 Maternity

Three people at the health and care forums attended the discussion on maternity services. People expressed **concerns about access to maternity care**. Many felt it was important to have maternity support close to home and ideally not in a large GP surgery where people felt care would be comprised with high numbers of patients competing for appointments.

People said the NHS should do more to raise **awareness of maternity services**, as well as **tailor information shared during appointments** to individual needs. For example, people thought GPs and midwives could provide more information to patients about available support, provide information in different languages, account for cultural differences in how women prefer to receive care, and provide at-risk mothers and families with additional support.

Some people had questions about **personalised maternity care and providing more choice to patients**. One participant was unsure about what more personalised care would mean in practice. Another participant felt that by allowing patients to choose maternity care for themselves without the right information, women might make choices that could harm their health, rather than empower them.

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<sup>2</sup> Although not all these groups are necessarily represented in Sutton, the grassroots engagement activities were designed to ensure that people from seldom heard groups have a voice

### 3.4.9 Cancer

A few people who attended the grassroots engagement activities commented on cancer services in Sutton. Several mentioned that the **follow up support services were lacking**, for those who have gone through cancer treatment. People also felt that there should be more counselling services for those affected by cancer as well as their carers.

### 3.4.10 Planned Care

Several people at the grassroots engagement activates raised concerns about the cancellation and postponing of operations, as well as a **lack of communication** in hospital which led to events such as checking blood pressure twice in a row, and delayed discharge.

People gave a lot of **praise for the South West London Elective Orthopaedic Centre** although some were concerned that the pre-op assessment questionnaire could be feel insensitive and very impersonal.

Some people expressed concerns about recovery from operations, and **several felt that support with physiotherapy was lacking**. One said that they were given some physiotherapy sessions and these were abruptly stopped and a few others were expected to engage in physiotherapy on their own at home. Some people wanted to see more support in the community after an operation, including physiotherapy and community activities.

## 4. Next steps

The Sustainability and Transformation Plan in south west London is currently undergoing a refresh in order to ensure that the work moves towards local planning and delivery to keep people out of hospital and ensure that delivery is centred around the Local Transformation Boards (LTB). It is expected that a refreshed plan will be published in November 2017. All of the outputs from the engagement activities (health and care forums and grassroots engagement activities) will feed into this refresh. In addition, the area feedback will be taken to each Local Transformation Board for their consideration. It will be saved as a repository of information which can be drawn upon when community intelligence is needed about a local service. The grassroots engagement programme has continued into 2017/18 – and the feedback will be considered at a LTB level.

Client	NHS SWL
Company	OPM Group
Title	Public engagement on the Sustainability and Transformation Plan
Subtitle	By Local Transformation Board (LTB) area
Dates	last published 05/09/2017 last revised 30/11/2017
Status	Draft
Classification	
Project Code	10799
Author(s)	Bethan Peach Perla Rembiszewski Anna Beckett
Quality Assurance by	Anna Beckett
Main point of contact	Anna Beckett
Telephone	0207 239 7800
Email	<a href="mailto:info@opm.co.uk">info@opm.co.uk</a>

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Write to us: South West London Health and Care Partnership, 3<sup>rd</sup> Floor, 120 The Broadway, Wimbledon, SW19 1RH

Email us: [swlccgs@swlondon.nhs.uk](mailto:swlccgs@swlondon.nhs.uk)

Visit our website: [www.swlccgs.nhs.uk](http://www.swlccgs.nhs.uk)

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