Healthwatch Croydon Forum

Thursday 3 November 2016, Mind in Croydon

The Healthwatch Croydon Forum, meeting quarterly, advises on our priorities and associated work programmes.

Attended by around 40 people, the focus of this meeting was the Sustainability and Transformation Plan (STP).

As part of its 'Five Year Forward View' the NHS has drafted a range of proposals to make services more efficient and integrated, while at the same time, increasing quality. They say that the health service in its current format is unsustainable, and 'doing nothing is not an option', therefore the STP is essential if services are to meet future demand.

At the table discussions, delegates considered how we can maximise treatment, care and support in the community and reduce hospital admissions, and how we can pool services regionally, and make best use of clinicians?

As lay people, delegates also considered what they need, in order to make a meaningful contribution to the STP going forward. Appendix one shows the detailed comments on which this report was produced.

Workshop 1 – Primary Care

How can we maximise treatment, care and support in the community, and reduce hospital admissions?

- Raising awareness of alternative and self-care options may reduce footfall at primary care and mental health services, for example signposting to a befriending group. Pharmacies could be given a broader role around advice, prevention and treatment. The worried-well need to be educated – could information be integrated into community hubs?

- There is a narrow focus on medication – alternative treatments and options could be more effective. GPs should receive more training and development on mental health.

- Greater use could be made of existing community health services, for example the facilities at Purley War Memorial Hospital are not being fully utilised.

- GPs or health centres could become centres of excellence in areas including mental health, dementia and diabetes, with specialist clinicians and nurses. A greater focus on prevention generally would pay dividends - could GPs or nurses visit high risk groups to deliver talks on prevention, for example on prostate cancer?

- Further integration of health, social care, housing and voluntary organisations is required, with better access for carers. Pathways need to be clearer and more robust, with communication improved all-round.

- Sharing of expertise, successes and best practice across the region could drive up standards. Currently, quality and accessibility of services is variable.

- Increasing provision of community midwives and raising capacity of home births would reduce demand on maternity.

- We've heard a lot about continuing care and care in the community – increasing provision of community nurses with assessment skills and knowledge, and operating from community health clinics or GPs, may reduce hospital admissions. However, how productive are home visits – as much time is spent travelling from client-to-client'?

- Clinicians and nurses need to be more pro-active in follow-up for older people.

- Clinicians and other staff could maximise and make better use of technology to monitor and review. Increased online access to GPs is effective in parts of London.

- Outsourcing of administrative tasks could save costs, for example call centres to handle appointment booking and general enquiries, and send text reminders.

- We should give people, including the vulnerable, more control over their own health and wellbeing, with the neighbourhood, as well as family and friends, playing a greater role and held to account in failing cases. Care plans should involve all stakeholders from the start.

- Many older people could be looked after in their own homes, while home monitoring of blood pressure, for example, could save visits to the GP.

Workshop 2 – Acute Care

Every hospital does not have to provide every service. How can we pool services regionally, and make best use of clinicians?

- Smaller smarter units could be one solution with workforce flexibility to operate across sites. Incentives for cross-unit work could be financial, or also career building, such as an attachment to a university or research project.

- In London, people expect things to be close so increasing distance may be hard to sell. Not everyone can travel long distances and cost (including parking) is an issue - those with long term conditions may not be able to afford a regular commute. Coming home afterwards could be a problem for the vulnerable, especially those who are alone and those without assistance, not least as patients are still being discharged at unsociable hours.

- Travelling for specialist day surgery, such as Moorfields, would be reasonable.

- We can only pool resources effectively if medical records are shared between primary, acute and mental health services. Otherwise we are silo working.

- Hospitals could specialise in elective surgery (such as hip replacements), with follow up treatment (such as physiotherapy) delivered closer to home at community health centres. Every hospital could have some speciality.

- Mobile units could be centrally located.

- Emergency options need to be local to cater for unusual circumstances – a road traffic accident may require several specialisms in short order. Cardiology and neurology also need to be readily accessible.

- Ambulances can take too long for transfer – all hospitals should be equipped with helipads, however there are few places in Croydon you can land an air ambulance.

Workshop 3 – What residents need

What do we, as lay people, need in order to make the STP a success?

- Who is responsible for delivering a contract – we need details of lead people and organisations.
- Outcome measures are a good idea, but who is doing the measuring and how can lay people observe or understand the process? We need sight of parameters, quality standards, action plans and timeframes.
- We need to look at mechanisms for collaboration and consulting – how effective is the Health and Wellbeing Board and what is its role, if any, in the STP?
- Should we be questioning Councillors on their level of involvement in STP related meetings and matters? Do they need to communicate with their constituents?
- Which meetings can the public attend and are those meetings advertised in the right places?
- In Birmingham, it's the council fielding questions on STP, not the NHS – should our local authorities be doing more also?
- Croydon would be a good candidate for health service devolution – is this being considered?
- It's not helpful, and a waste of resources to relabel large scale projects and initiatives such as the STP – please let's keep the name this time.

Appendix 1 – Workshop Notes

Workshop 1

Primary Care - How can we maximise treatment, care and support in the community, and reduce hospital admissions?

- Training of professionals.
- Needs of the community.
- Health Education for the community/public.
- What's provided in the new hubs?
- How is the public going to be informed of new health developments?
- All GP surgeries must have doctors specialised in different areas of health ie; Mental Health and dementia (named GPs).
- Open day to re-recruit all professionals and retrain them to access the housebound.
- More links and integration between health, social services (voluntary and carers).
- Sharing expertise /successes/best practice across the region.
- Pharmacy – broaden role (advice, prevention, treatment).
- Community nurses – operate from clinics, GPs.
- Community midwives, homebirths, more drop-in clinics, walk in centres delivering specific/varied specialities.
- Travelling clinicians delivering services to high risk groups in variety of locations in the Borough (outreach).
- Maximise technology, clinicians making use of, monitoring, reviewing etc. Outsource, admin, more Health Centres carrying out minor work.
- More Community Nurses with assessment skills and knowledge.
- More Walk-In Centres/ GP surgeries. Open longer hours.
- Effective transport.
- GPs – more focus on prevention.
- Better pathways – social care/ NHS integration and housing.
- GP practices need to be welcoming.
- GP practices need to include other services e.g. CAB.
- Links to befriending services (need to be more of these).
- Pro - active follow up by GPs especially for old people.
- Pro -active involvement by pharmacists. Prevention/advice/quick response, better manner than some GPs. But Government too narrow focus on prescriptions.
- Personal responsibility and for others (vulnerable people).
- Neighbourhood responsibility, but friends and family spread.
- Where people present.
- On line to GP.
- Awareness.
- GP training and development e.g. mental health.
- Relationship GP/sec care.
- Patient notes.
- Skype.
- Email.
- Appointment management technology – texts.
- Home monitoring e.g. BP.

- Teach chronic patients to self-manage.
- Teaching people how to manage their own health.
- Care support.
- Community service for minor issues e.g. around care.
- Addressing the worried-well information and community centres.
- Integration of information.
- Info hub appropriate information.
- Integration of services (working together).
- NHS local authority integration/vol. sector.
- Fractured responsibilities (social care).
- Care plan to involve all stake holders from the start.
- Families should be held to account, and those not taking responsibility – highlighted.
- Transparency of Mental Health Services – what money on what services – how is it spent.
- GPs paid less for refunds/prescriptions.
- Better diagnostics at GP level.
- When GPs refer elderly/Alzheimer's/people with mental health issues to specialist services in hospital who cannot manage their post or make the journey – so miss numbers of appointments.
- How close to death do you need to be for continuing care?
- Look after elderly people in their homes much better.
- Invest in better 'hands on' services, less signposting.
- GP not consistent. Some good/some bad.
- Better communication between hospitals and Social Workers.
- Establish better system for continuous care – who will pay.
- Proper care packages.
- Better befriending services.
- Shopping services/ post/ cleaning.

Workshop 2

Acute Care - Every hospital does not have to provide every service. How can we pool services regionally, and make best use of clinicians?

- Constraints – accessibility; estates; transport; staff – specialists versus need; viability; perception; availability of related services; local demography; disease incidence; value for money; health outcomes.
- Solutions – Smaller smarter units; workforce (clinician) flexibility; work across sites; mobile units centrally located; long term thinking; large specialist units; financial incentives for cross-unit work; staff incentives (ie; attach to university or research project).
- Transport – not everyone can travel and parking is an issue - £7 per hour at Kings. But the care is 'second to none'!
- May daughter chooses to go to Kings for everything, as her medical records are there. She feels more comfortable getting all of her needs 'under one roof'.
- It's in people's best interests if their medical records are shared. SLaM has different systems, this presents some challenges.
- For elective surgery like hip replacements – a couple of days in hospital, followed up with physiotherapy closer to home sounds sensible.
- We've heard a lot about 'continuing care', and 'care in the community' but home visits are not productive.

- Expand on-site community health services, the facilities at Purley are not being fully utilised.
- Keep major surgery (knee/cardiac) at the local hospitals.
- Travelling for specialist day surgery (such as Moorfields) is fine.
- Brompton has a specialist cardiology unit, but if you have a heart attack you need to be seen very quickly indeed – distance and delays could mean life or death. Emergency options need to be local – one avoidable death is 'one too many'.
- Emergency brain surgery – should that also be local?
- In London 'people expect things to be close'.
- Yes it does make some sense to pool resources between hospitals but there have to be safeguards in place to cater for 'unusual circumstances' – if you have a serious road traffic accident you may need to see several specialisms in short order.
- Keep emergency services local (ie; heart surgery or brain injury). If you have multiple injuries, and local hospitals are not equipped, they may solve your head wound, but then you might lose some limbs?
- There are few places in Croydon you can land an air ambulance.
- Ambulances can take too long for transfer – all hospitals should be equipped with helipads.
- Coming home afterwards – long distances could be a problem, if you're vulnerable, alone, and don't have any assistance, and people are still being discharged at unsociable hours.
- Every hospital should have a speciality in treating disease and conditions-these can be share regionally.
- If the above treatments are stabilised-can be referred back to the GP e.g mental health, post-surgery, post cardiac episodes, diabetes, where specialist GPs and clinicians are.
- All parents discharged from rehab centres, hospitals or clinics require a discharge summary to the above.

Workshop 3 (General Discussion)

Computer Records

- IT systems in the NHS are not integrated and different areas and specialities may use different systems.
- Some of the administrative systems are reliant on paperwork, still.
- Systems can be faulty, the 'online booking' at my GP is down as much as it's up.
- A lot of money is (and has been) wasted on IT integration – it's 'fantastically expensive'.
- The amount of data generated by a hospital alone is 'vast'.
- Nurses have to spend time in front of computers – and they get hassled for it.
- What about outsourcing?
- Consultants now use 'speech to text' microphones and I've heard this transcribes directly into the medical record.
- Speech technology is in its infancy, but could eventually be rolled out to all kinds of specialisms.
- Patients don't want information shared as they don't trust that it's secure.
- Not everyone is IT literate.
- We spent a lot of money on Ethernet that is 'lying dormant now' as services are switching to wi-fi.
- Council departments need to work closer together internally (housing and social care). Where does the information go? Individuals are 'falling off lists' as 'information is going nowhere'. The services 'don't meet'.
- Closer sharing of information may require legislation.

Statutory and Scrutiny

- We need to look at mechanisms for collaboration and consulting – how effective is the Health and Wellbeing Board?
- We should be questioning Councillors on their level of involvement in health meetings and matters. They need to communicate with their constituents.
- Which meetings can the public attend and are those meetings advertised in the 'right places'?
- In Birmingham, it's the council fielding questions on STP, not the NHS.
- Croydon would be a good candidate for health service devolution.
- How many locality teams are there?
- It's not helpful to relabel initiatives such as STP – it's also a waste of resources.
- 'Outcome measures' are a good idea, but who is doing the 'measuring' and how can lay people observe or understand the process?

Statutory and Scrutiny (Questions for SWLCC).

- Who is responsible for delivering a contract? The NHS should publish details of contracts including timeframes, lead organisations and people.
- Lay people need to look at accountability, parameters, quality standards, action plans and timeframes.

Services

- We all want specialist services to be centralised but it 'will not happen'.
- People should be involved in their own care planning, I hear that over-65s now get a named GP, which is good.
- Primary care does not share good practice and we need to 'formalise it' – there is 'staggering variation' within clinical neighbourhoods/clusters alone.
- When moving between primary and social care there can be a 'gap in care and support'.
- Budget cuts and constant restructuring do not help – it creates a vortex – records disappear and can't be found, and the system comes to a 'juddering halt'.