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). 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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1 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.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Date</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon health and care forum</td>
<td>7th February, 2017</td>
<td>33</td>
</tr>
<tr>
<td>Croydon grassroots engagement events</td>
<td>May – November 2016</td>
<td>11 events speaking to over 222 people</td>
</tr>
<tr>
<td>Merton health and care forum</td>
<td>29th June, 2017</td>
<td>33</td>
</tr>
<tr>
<td>Location</td>
<td>Date</td>
<td>Total Events</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Wandsworth health and care forum</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; March, 2017</td>
<td>44</td>
</tr>
<tr>
<td>Merton grassroots engagement activities</td>
<td>May – December 2016</td>
<td>10 events</td>
</tr>
<tr>
<td>Wandsworth grassroots engagement activities</td>
<td>June 2016 – Feb 2017</td>
<td>10 events</td>
</tr>
<tr>
<td>Kingston health and care forum</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; February 2017</td>
<td>35</td>
</tr>
<tr>
<td>Richmond health and care forum</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; March 2017</td>
<td>55</td>
</tr>
<tr>
<td>Kingston grassroots engagement activities</td>
<td>March 2016 – March 2017</td>
<td>15 events</td>
</tr>
<tr>
<td>Richmond grassroots engagement activities</td>
<td>June 2016 – March 2017</td>
<td>18 events</td>
</tr>
<tr>
<td>Sutton health and care forum</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; February, 2017</td>
<td>30</td>
</tr>
<tr>
<td>Sutton grassroots engagement activities</td>
<td>July – December 2016</td>
<td>13 events</td>
</tr>
</tbody>
</table>

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 signpost 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 have 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 24-hour 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 reply 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 hospitals 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 as 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, healthy 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 breastfeed. 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.
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