Open Agenda

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

Monday 27 January 2014
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Reports have been requested following up from a previous presentation on emergency & urgent care. Evidence is being taking to inform both reviews:

- Review : Access to Health Services in Southwark
- Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark

Papers and presentation from:

1. Guy's & St Thomas' - Presentation by James Hill, Head of Nursing and Nicola Wise, General Manager - paper circulated with main

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Date: 24 June 2014

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2. King's - Briony Sloper, Deputy Divisional Manager, Trauma, Emergency and Urgent Care - paper attached

3. SLaM - Steve Davidson, Service Director, Mood Anxiety and Personality Clinical Academic Group - paper attached.

Gwen Kennedy, Director of Client Group Commissioning (CCG), will also contribute to the item.

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This is the news report:
http://www.standard.co.uk/news/health/great-ormond-street-hospital-food-among-uk-worst-8838572.html

SLaM were asked:

1) To provide a copy or link to the report referred to in the article.

2) The article talks about an action plan to tackle these issues; please supply a copy of this.

3) How are SLaM currently holding Aramark to account?

4) Can you confirm that SLaM are intending to extend the contract with Aramark? If this is the case, and there are already concerns about catering and cleaning, on what grounds are SLaM doing this?

5) In what circumstances would SLaM retender the contract with Aramark?

Tamsin Hooton, Director of Service Redesign, NHS Southwark Clinical Commissioning Group will present.

A paper is attached.

This is a late and urgent item.

HEALTH, ADULT SOCIAL CARE, COMMUNITIES AND CITIZENSHIP SCRUTINY SUB-COMMITTEE

MINUTES of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Monday 9 December 2013 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Rebecca Lury (Chair) Councillor David Noakes (Vice-Chair) Councillor Rowenna Davis Councillor Jonathan Mitchell Councillor Michael Situ
OTHER MEMBERS PRESENT:	Councillor Catherine McDonald
OFFICER SUPPORT:	Sarah McClinton, Director of Adult Care Adrian Ward, Head of Performance, Adult Care Ray Boyce, Head of Older People's Services Julie Timbrell, Scrutiny Project Manager Kevin Brown, Assistant Director Operations for South London Keith Miller, Ambulance Operations Manager at Waterloo.

1. APOLOGIES

11.1 Apologies for absence were received from Councillors Capstick, Garfield and Coyle, who was going to substitute. Councillors Mitchell gave apologies for lateness.

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

2.1 The chair informed the committee that that a recent statement had announced that KHP are delaying merger plans. She also

reported that local residents, Tom White and Elizabeth Rylance – Watson, had raised a concern about a Continuing Care decision highlighted at a recent Southwark Pensioners Forum meeting.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the meeting held on 15 November were agreed as an accurate record.

5. LOCAL ACCOUNT

5.1 The chair invited Sarah McClinton, Director of Adult Social Care, and Adrian Ward, Head of Performance (Adult Social Care) to present the draft Local Account and the chair invited questions.

5.2 A member asked about the impact of the Dilnot review and officers said this affects charging at 18 and that social care is moving towards a universal system. Officers were asked if there was more bureaucracy and they agreed this could be more onerous.

5.3 A member commented that although the aim is to reduce admissions to care homes the numbers of older people and younger people in residential care is actually going up. Sarah McClinton agreed that reductions in the use of care homes are a council target and said that the overall trajectory is actually down, but she agree the recent figures are going up. She said that the service is unsure why, but there is deeper look being conducted looking at the reasons, in partnership with hospital - they are looking at possibilities such as dementia. She added at the moment there is a lack of alternatives, however Extra Care and Integrated Care could prevent admission into residential care.

5.4 Officers were asked about supported discharge and the 91 days target. Officers explained that the re-enablement team used to work with a smaller group, but this team now work with a larger cohort – this is an expansion of the offer. This expansion has had an impact, with the proportion of people still at home 91 days after discharge moving from 99% to 77.2 %, with 85% being the London Average. Officers said in future they would expect to stay closer to the London Average . They reported that a detailed analysis revealed that some people had died – so the service is considering patient needs and the appropriateness of the offer more closely.

5.5 A member asked about the telephone service and the extent that people are signposted or transferred to someone who can help. Officers said that this varies and where possible the call would be transferred. The member asked if this was monitored and officers reported the council does collect a variety of process measures; data can be supplied.

5.6 A member commented that the report refers to the Lay Inspectors only being in operation for 2 years; however they have been in place for longer than this.

5.7 A member referred to the outcome measures 1b and 3a, that are going down. These measure on 'feeling in control' and overall 'satisfaction'. Officers said that they are improving the support planning and shifting control to individuals so it is hard to know the cause. The member asked if it is possible to ask extra questions but the officers said that this can not be done as it is a national survey.

5.8 Officers were then asked how the council intends to make savings and Sarah McClinton said that the council will be a retendering for Supporting People in search for better value. There will also be more investment in community based services, as residential care is expensive. The move to personal budgets had made saving. The council will also have to make some as universal savings by reducing staff and management. Social Care will be receiving some NHS funds for re-enablement and there will be a move to invest more in home-wards.

6. CABINET MEMBER INTERVIEW

6.1 The chair welcomed the cabinet member for health and adult social care, Councillor Catherine McDonald, to her annual interview. She was then invited to comment on the first theme: Access to Health Services in Southwark, which is the subject of one of the committee's reviews. The chair started by remarking that the committee has heard evidence that one of the main drivers for rising demand at A & E is an increase in older people attending who are acutely unwell. She asked the cabinet member to explain what the council is doing to address this trend. The cabinet member responded that she understands that A & E is a barometer for the hospital and the health system as a whole. She explained that the council is helping to people to live at home longer with-out a hospital admission. GPs have been invited to look at this cohort of older people and to do an assessment to prevent later demand - for example grab rails to prevent falls. The council is also looking at housing policy - for example the

administration re-introduced wardens and will be expanding the provision of extra -care, which provides nursing on site. She ended by noting that Southwark is one of the top performers in enabling people to be discharged and providing re-enablement to support recovery.

6.2 A member commented that the LMC report said that education on using A & E appropriately is needed; how can the council help with this. The cabinet member referred to the poster campaign out that advises people to go to the doctors or pharmacy for more minor complaints. She commented that the Health & Well – Being Board is well placed to look at system problems.

6.3 A member commented that there are massive changes in the NHS arrangements and real term cuts, and asked how the cabinet member thought this was affecting the health system. The cabinet member agreed with the members comments on the scale of the change and commented that lots of organizations are bedding down. She added that 'integration' is a very important , and referenced the Southwark and Lambeth Integrated Care Programme which is making the best use of resources in times of constraint and frozen budgets, by bringing partners together to create a more integrated patient journey.

6.4 The chair then asked the cabinet member to comment on the second review theme: Prevalence of Psychosis and access to mental health services for the BME Community in Southwark'. The cabinet member responded that she is keen to promote resilience and that a Mental Health Strategy is being developed, and that this recognizes the diversity of different communities. There has been consultation work to inform the development of the strategy. A member commented that it would be useful to see the results of this and that the committee had heard some excellent evidence from church leaders on the effectiveness of a recent capacity building programme.

6.5 The committee then moved on to third them on 'Older Persons Day Care, including voluntary older people's day centers'. A member commented that he had been in touch with a number of old people day centers and he reported that while some are still functioning many are very much struggling - for example a significant number no longer offer transport. He said that many people were not assessed as eligible for care, and so were not in a position to use personal budgets to fund their use of day centers. He commented that some day centers are very low in numbers while others have a bigger attendance, and he is worried about their ability to survive. The cabinet member commented that there is a movement is towards individualized care rather than block contracts, and this was the direction of travel for both the last government and the present one. She said that many people are moving toward

individual funding - and choosing different options.

6.6 The cabinet member continued by explaining the council gave support and transitional funding - something like half a million pounds for providers to move to a new business model and the council also started up an innovation fund, so there is extra services for older people to choose. The member responded that he had been contacted by a day centre who said that they were contacted out of the blue to apply for some additional funding. The cabinet member inquired who this was and the member said that he did not feel comfortable naming the organization as he wanted to protect their position; he was more interested in the general approach.

6.7 The committee then moved on to discuss Personalization; the seventh theme. The cabinet member was asked how the council was doing and she explained that around 94% of eligible service users of have personal budgets. There are four groups of clients with different rates: older people have 97% take-up; learning difficulties 80%; mental health 98%; and physical disabilities 99%. She explained that the council is doing development work with individuals and is in the top quartile of councils. Sarah McClinton, Director of Adult Social care, said that there will be a 100 % take up by the end of the year.

6.8 A member commented that there was cross party agreement on the principle of Personalization; however he was concerned about patchy practice and had heard cases where people had to wait two years to complete the assessment process. The cabinet member agreed that two years did sound ridiculous and encouraged the member to contact her with concerns. She went on to remark that there is a balance to be struck on the pace of take-up, as the council does not want to rush people through. The council is also doing what it can to stimulate the market , so there are services available for people to exercise choice and control, but some people may struggle with this as Personalization means more decisions need to be made .The expectation that individuals do more for themselves can be scary , which is why support is important . She added that young people are more familiar with Personalization. Sarah McClinton explained that some personal budgets are still managed by council or by an independent provider. She added that a quick process is not necessarily most optimal or imaginative; a longer process can achieve a better result.

6.9 A member asked if there is an opportunity for people to change their minds about the plan and Personalization. The cabinet member explained that plans are regularly reviewed, and this underlines the importance of a good process which is designed to find ways to meets people's needs - within available funds. She

assured members that the council does not let go; there is ongoing support.

6.10 The chair invited questions on the forth theme of 'Intermediate care' and a member asked how many intermediate beds are available; on behalf of Councillor Capstick , who was unable to attend the meeting. The cabinet member explained that the council do not have intermediate beds; however there is re-enablement and said that she would be happy to correspond with Councillor Capstick on this.

6.11 A member then referred to the fifth theme on Public Health asked the cabinet member about the council pensions fund's investment in tobacco and how compatible this was with the Public Health priority to cut smoking. The cabinet member commented that she agreed the council is doing everything possible to reduce smoking and this would impact on reducing health inequalities. She referred to the council assembly question on this issue and the advice given to the pension's advisory board that pension funds had a duty to put the financial interests of its beneficiaries first. She noted that that there is equal representation from Labour, Liberal Democrat and Conservatives members on the panel, so it is odd to defend a policy when Labour is in a minority. She reported that there will be a review into the adoption of ethical investment principles and a staff poll will be conducted. She added that she is certainly not of the view that responsible investment reduces returns; but there is a balance to be found between the two poles.

6.12 A member reported that he understands that two major sexual health contracts are up for renewal and he is concerned that this could lead to cuts - particularly given high levels of STDs, HIV and drug use amongst the Southwark population. The cabinet member commented Public Health is one of the opportunities that came to the council with the change to NHS arrangements. The funding that is coming over is about 22million and this has been ring-fenced to achieve the outcomes. She said contracts should not just be rolled forward, the council needs to scrutinize every arrangement. She referred to evidence generated by the Joint Strategic Needs Assessment and the importance of the Health and Well-being strategy, and the focus on the priority of reducing health inequalities. She agreed that high levels of STDs, HIV and drug use are a huge area of concern and assured members that they will continue to see large investment.

6.13 The chair referred to the sixth theme, 'Meals on Wheels', and the cabinet member said the council reduced the meal charge to £2.52 , and are committed to a further reduction to £1.71 ; a 50% reduction since 2010 . She reported that this is significantly lower than most London Boroughs. Older people are one of the most deprived groups and a hot meal is a basic minimum. The Meals on

Wheels service is also an important moment of social contact.

6.14 A member refereed to the theme on Substance Misuse and asked the cabinet member, on behalf of Councillor Capstick, how closely the council is working with offenders to address health issues. The cabinet member reported that the 12 week Radar programme works to reduce and deter offending. This provides intense support and the programme will be adding a nurse as the council knows that offenders are at risk of drug and health problems. A member commented that 12 weeks does not sound long enough and asked if this was related to funding constraints. The cabinet member commented that Radar is a nationally recognized programme.

6.15 Lastly the chair invited questions on the Adult Safeguarding theme and the cabinet member commented that there is a new Independent chair of the Safeguarding panel. She was asked about the priorities and the cabinet member responded that one significant priority is to reduce the number of safeguarding alerts at Care Homes through the Care Home Strategy. The chair ended the interview by thanking the cabinet member.

7. CARE HOME QUALITY IMPROVEMENT STRATEGY

7.1 Sarah McClinton, Director of Social Care, and Ray Boyce, Head of Older People's Services, showed a video and spoke about the council's emphasis on relationships and care homes being part of the community.

7.2 A member asked how closely the council work with homes which are not compliant, and what penalties are imposed. Sarah McClinton said that there can be daily visits, including at night and Out of Hours. The emphasis is on developing a quality improvement programme working alongside care home providers; rather than saying what is wrong. The council's role is different to CQC, which is regulatory and can impose penalties. The officers said that the council also works with individuals. A member asked if officers looked at developing good practice across Southwark care homes and officers said that they did do this , including developing leadership across the piece, as well as good practice from other local authorities.

7.3 A member commented that he is concerned that CQC is not always right and asked about other measures. He added that he is pleased that GP's are being commissioned to work in homes. Sarah McClinton responded that the council is not reliant just on CQC; there is the care home support team, which the council is expanding and strengthening by adding a social work, pharmacy,

and mental health capacity.

7.4 Officers were asked how information is shared and they explained that on a day to day basis CQC inform the council and vice versa. There are also safeguarding and quality processes to raise concerns and a group t meets regularly; this includes key people such as the CCG & CQC.

7.5 A member asked officers if the Lay Inspectors go to all homes or only some. Officers responded that Lay Inspectors are funded by Age Concern and only focus on older people and that the learning difficulties service is exploring peer support. She added that that Mental Health has quite a lot of peer support, but she was less sure about arrangements here as the council does not commission mental health care homes.

7.6 Officers were asked why Cherry Croft home was closed. Officers reported that the council's social workers, CQC, and nursing staff worked on an improvement plan for sometime, however was insufficient progress, with the home requiring considerable capital and social investment. Ultimately the council and the care home owners came to a mutual agreement to close. There were four southwark residents there. A member voiced concerns that the care home had not conveyed the extent of the problems, nor had officers. Sarah McClinton said that she recalled that the council was clear. The member stressed the importance of open and honest communication and officers responded that it was a complicated and sensitive situation, with a meeting being held because many relatives were unhappy and didn't want the home to close; the council had a group of older people with dementia and who were frail to look after. The member responded that he appreciated the difficulties; however this is not the first case, there was another care home in a similar situation when he was an executive member, where concerns about closer were raised by relatives. He suggested better communication, particularly with ward councilors.

7.7 Members asked how CQC alerts and concerns generally with homes could be conveyed to members. Julie Timbrell, the Scrutiny project manager, commented that the scrutiny team will be working to alert ward councilors and the committee to CQC concerns. Sarah McClinton emphasized the importance of ward councilor's involvement to take action by visiting and also celebrating the positive.

7.8 A member asked about people placed out of the borough. Sarah McClinton commented that there is not a lack of supply for older people - but some older people might be exercising a choice. However she added that there is a cohort of people with learning difficulties that the council is looking to move back, including

people at Winterbourne View.

7.9 Officers were asked about the training provided to care homes and staff. Officers explained that the council did provide 'my home life' training and social care is also working with the council's Organizational Development department– however there is a balance: these are private providers. Member asked if basic standards were adhered; and officers said yes, for example training around Safeguarding, furthermore nursing homes are required to ensure a proportion is qualified nurses.

RESOLVED

Officers will provide more information on any peer support/ lay inspection quality improvement measures for homes for people with mental health needs.

8. LONDON AMBULANCE SERVICES

8.1 The chair invited representatives from the London Ambulance Service (LAS) to introduce themselves; Kevin Brown, Assistant Director Operations for South London and Keith Miller, Ambulance Operations Manager at Waterloo.

8.2 The LAS representatives referred to the report circulated and gave a brief overview of the service. They explained that calls have been increasing by about 3 %, year on year. LAS have a business target for 75% of category A call outs to be met within 8 minutes, and 95% in 19 minutes. In Southwark 76% of category A calls outs were met in November.

8.3 The chair invited questions and a member asked LAC about the different categories and the response times and the Director explained that Category A is reserved for the most serious critical life threatening incidents; there are also categories C1, C2, C3 & C4 . The service has a fast responder pathfinder which is about safely leaving people at home.

8.4 LAS were then asked about the calls out for older people, particularly given the evidence that there is an increase in acutely unwell older people arriving at A & E. LAS responded that demand is going up across the board by between 3-5%, and the service is seeing a greater number of older people. Members asked why; but LAS did not feel able to explain the reasons of the increase in the number of older people, but they did comment that the festive season added to the rise in the number of younger people seen. A member asked if this was linked to drug and alcohol and

commented that she had spent time on a shift with an ambulance crew and observed that this was a huge pressure. LAS reported it was a pressure and that previously the service was funded for an additional service in Soho over the festive period, but not this year.

8.5 A member asked about the general rise in demand. LAS commented it was difficult to know why; around half of patients are not being taken to A & E. Sometimes people are dialing 999 because they don't know what to do and don't know how to access help and support; and this could be related to increased social isolation and lack of community and family support. There is also a cultural change, whereas people used to ensure their drunk friends got home safely - now people get abandoned by their companions. LAS also added that unfortunately 999 campaigns to increase appropriate use actually increase demand, rather than decrease. There is a centrally based communication team which goes out schools to promote awareness of the service.

8.6 A member commented that theses are cash strapped times, and suggested that the service might ask patients to make a financial contribution to their care, for example if they needed to receive rehydration treatment for alcohol poisoning. LAS responded that the NHS guiding principle is that care is free at the point of access. A member asked if institutions could be asked to pay.

8.7 LAS were then asked about reports of ambulances queuing at hospitals. They explained that LAS monitor ambulance queue times; there is a system to look at timings. There are also new penalties for handover breaches. For example the chief executive has to be involved and a serious incident declared if there are serious delays. LAS have a new flow business tool to manage the system, which is improving performance.

8.8 A member asked if there had been an increase in category A calls out and LAS said that these are up by 20%, but the service does not know why. A member suggested this might be caused by drug and alcohol abuse, however LAS representatives said these incidents are not showing an increase, and most incidents on the increase are coding ‘unknown’. LAS said it would be possible to analyze this trend, and that they are able to provide data at a postcode level for Southwark & Lambeth.

8.9 A member asked about the modernization and collaboration improvement process and the Director said that LAS has to become more efficient given increased demand and constrained resources. The service is now sending cars and motorbikes out to incidents and there have been changes to shift times and annual leave to increase capacity. He reported that there is a shift of demand towards later activity in afternoons, and even the middle of the night , - the service is adapting capacity to meet this need.

LAS are also working with firefighters, who are able to respond to cardiac arrests.

9. PATIENT SURVEYS

9.1 The chair explained that this item will be deferred until January, when the scrutiny survey results will be ready.

10. LOCAL MEDICAL COMMITTEE LMC - SOUTHWARK

10.1 The chair reported that the LMC had provided a report and that invited members to comment and put further questions by the end of the week.

10.2 A member commented that further information on the changed to the Walk –in centers would be useful.

10.3 There was a discussion about the Blue Badge assessment arrangements. Councillor Noakes explained that there were separate arrangements to deal with the bulk assessments that took place every 5 years; however he was unsure about the day to day arrangements. Julie Timbrell, the scrutiny project manager reported that a briefing had been requested on this from relevant officers

11. WORK-PLAN

11.1 The chair recommended that the Access to Health Services in Southwark review take evidence from Public Health and Adult Social Care, particularly given the evidence about the increasing number of older people presenting at A & E with acute needs. She advised that the update on the Alcohol Strategy and Drugs Joint Needs Assessment, and the update on the Health & Well-being Strategy therefore need to be delayed until the following meeting.

RESOLVED

A briefing on Access to Health Services in Southwark will be requested from Public Health and Adult Social Care. The work-plan will be updated

12. PAPERS TO NOTE

Agenda Item 5

King's College Hospital NHS
NHS Foundation Trust

January 2014

Emergency management of Mental Health patients

The Emergency Department at King's College Hospital treats what we believe to be the largest number of mental health patients in the UK. This paper outlines the key operational processes, challenges and innovations at KCH associated with the emergency pathway for patients presenting with mental health conditions.

There are multiple drivers for the exceptionally high volumes of patients attending the ED with mental health issues. These include

- Local demographics and deprivation
- Proximity to SLaM and reputational drivers
- Proximity to specialist Child and Adolescent services
- Major Trauma Centre activity

KCH and SLaM have a strong history of partnership working, underlined by the formation of both the Academic Health Science Centre (AHSC) and Kings Health Partners (KHP). Together KCH and SLaM are actively engaged in the provision of care to patients presenting to the Emergency Department at Denmark Hill, continually reviewing, assessing and improving pathways to meet the needs of this particularly complex and vulnerable group of patients.

It is important to note that many patients present with both a physical and a mental health problem and these require assessment concurrently.

We have an agreed service aim for all patients to be seen by the specialist psychiatric team within 30 mins from referral and this is monitored as a key performance indicator alongside other pathway measures such as time to first clinician.

We have clear clinical and operational pathways in place that support the rapid assessment and referral of patients at the point of initial assessment.

All ED staff undertake specialist training, delivered as a rolling programme of events throughout the year, from the Psychiatric Liaison team to ensure they are able to identify signs of mental illness and distress, how to risk assess and are aware of how best to manage patients presenting in crisis.

We have a dedicated assessment room for patients with mental health needs to meet with members of the psychiatric team that is separate from the main clinical area and provides a quiet space to minimise any additional stressors the busy ED environment can place on an individual.

Staffing

In Q3 of 2013 KCH advertised and appointed 3 WTE Registered Mental Health Nurses (RMNs) in addition to the current ED nursing establishment.
This allows us to have 1 x RMN in the department 10:00 – 22:00 7 days a week. These specialist staff are able to provide 1:1 support, supervision and therapeutic intervention for patients presenting in mental health crisis. They are also able to support transfers, giving the patients a consistent member of staff and ensuring the Psychiatric Liaison Nurse (PLNs) pool is not depleted.

The PLN team are based in the ED 24/7, employed by SLaM and working in partnership with KCH. The team consists of
1 x band 7 and 10 x band 6 nurses. They are supported by a team of psychiatric doctors

In Q4 a successful pilot was completed demonstrating the effectiveness of having an additional PLN working in the evening (16:00 – 00:00) as well as a consultant psychiatrist (17:00 – 00:00). The increased staffing levels have subsequently been supported and the pilot extended by the CCG.
The benefits include timely assessment, rapid decision making and a reduction in the number of formal mental health act assessments and admissions undertaken.

Governance

We have an established joint governance meeting that takes place monthly and has done so for several years, with multidisciplinary, multi agency and cross organisational representation. The meeting reviews activity from the preceding month, identifies trends, reviews any adverse incidents, extended length of stays, frequent attenders as well as staffing, training and pathway developments.

We maintain a live action tracker to review developments and ensure there is a cohesive improvement plan with delegated responsibilities across the teams.

Future developments

- PLAN accreditation of the psychiatric liaison service at KCH
- Development and recruitment of a hospital wide team of specialist nurses and healthcare support workers to provide greater consistency of 1:1 supervision and support to patients with mental health and behavioural problems
- Organisational reconfiguration of KCH out patients to support the final phase of the mental health assessment suite and new main entrance opening

Challenges

- Increasing volumes and acuity of attendances to KCH ED
- Capacity – staffing (inpatients and ED), assessment space
- Social services, response times specifically out of hours
- MH bed provision/access
- Child and adolescent pathways
- Drugs and alcohol and the impact on the assessment process
- 136 suite provision
- Physical health support to the Mental Health inpatient environment to support collocated management
- Metropolitan Police and LAS relationships, training and pathways specifically for metal capacity assessments, documentation and the section 136 process

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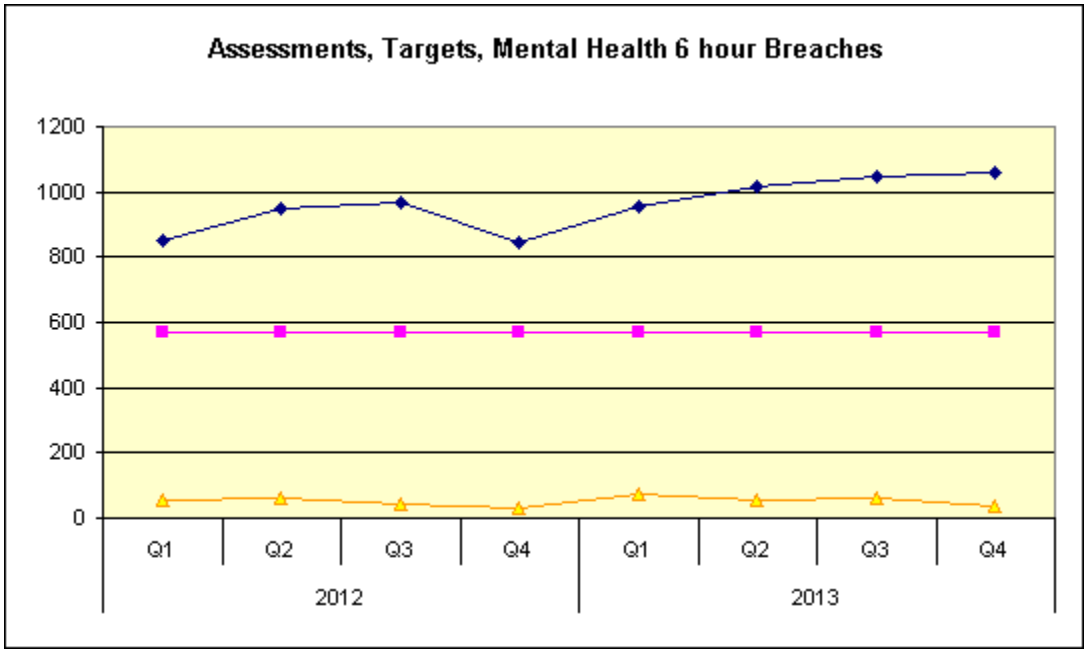
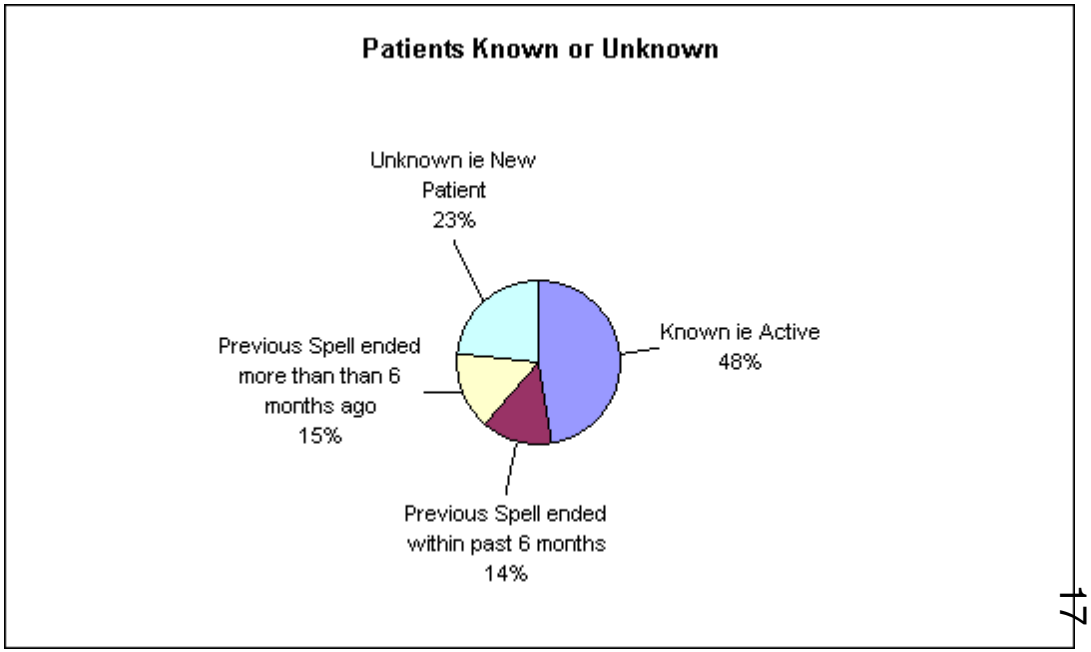
Southwark Mental Health Liaison Team Activity at Kings College Hospital Emergency Department 2012 - 2013





	2012				2013			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Assmnts	854	948	968	847	954	1019	1044	1058
Target	567	567	567	567	567	567	567	567
MH 6 Hour Breaches	57	64	41	32	72	53	63	35
Breaches as %	6.7%	6.7%	4.2%	3.8%	7.5%	5.2%	6.0%	3.3%

South London and Maudsley NHS Foundation Trust

Supplementary information

Mental health presentations at Kings College Hospital and St Thomas Hospital Emergency Departments

Those presenting at Kings and St Thomas' Emergency Departments, who are referred to the mental health liaison teams, typically fall into the following categories:

- Actual deliberate self-harm
- Intoxicated and suicidal
- Psychotic
- Hypomanic
- Depressed
- Depressed & Suicidal
- Anxious
- Requesting to see a Mental Health Professional
- Strange behaviour - often due to drug intoxicated

Self harm accounts for approximately 1/3 rd of all presentations.

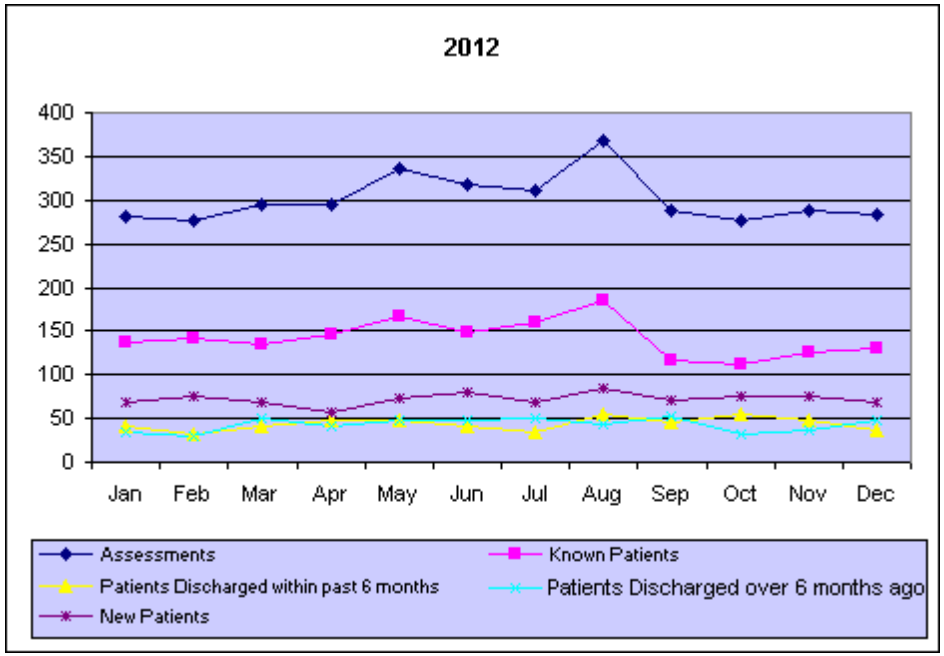
Of those presenting to the department, some are 'first presentation' patients (not known to SLaM) but from the local area, some are patients already under the care of SLaM and some are out of area patients. The latter group is particularly represented in those presenting at St Thomas' ED due to its proximity to major transport hubs and London's West End.

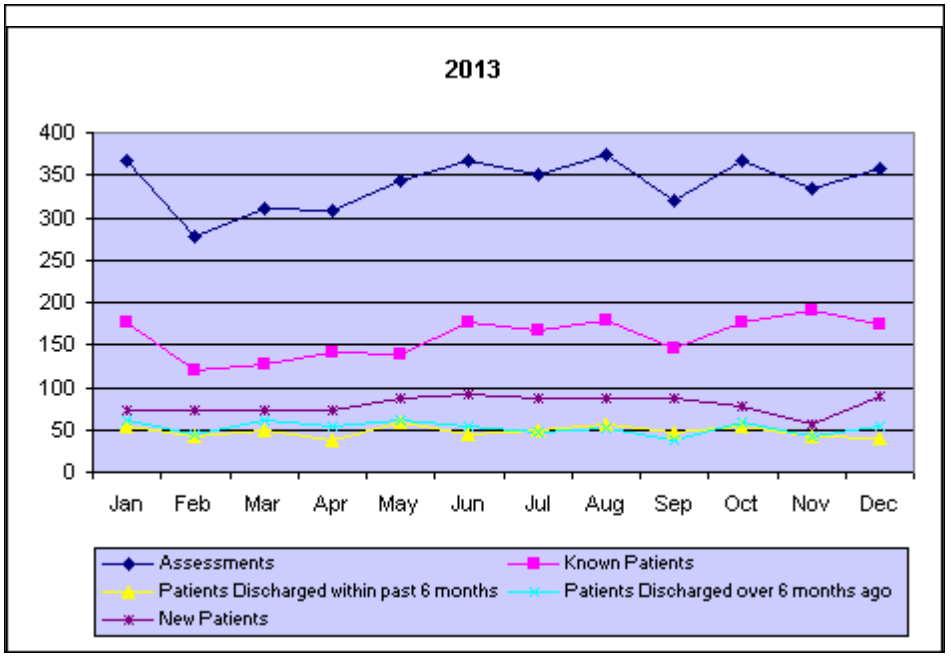
SLaM have not, to date, kept detailed records of the numbers of different classifications of presentations to the EDs but are now in the process of doing so as part of current initiatives, particularly at Kings, aimed at understanding the increased activity and identifying alternative pathways.

The following tables describe mental health activity over 2 years in the two emergency departments and illustrates the breakdown between presentations of people currently or recently know to mental health services and new presentations.

Steve Davidson Service Director 23rd January 2014

Kings College Hospital Mental Health Liaison Team 2012 - 2013





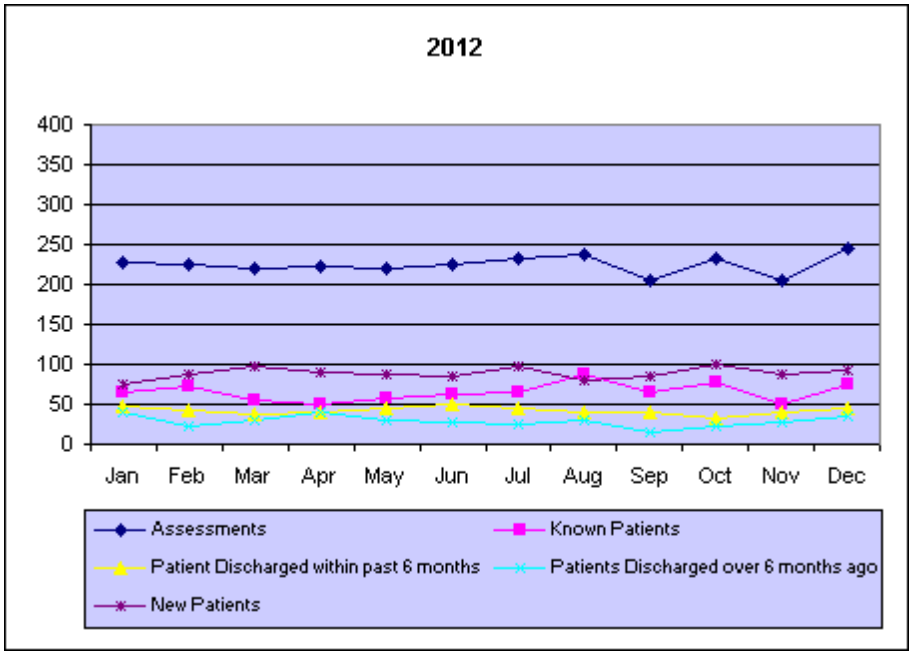
2012

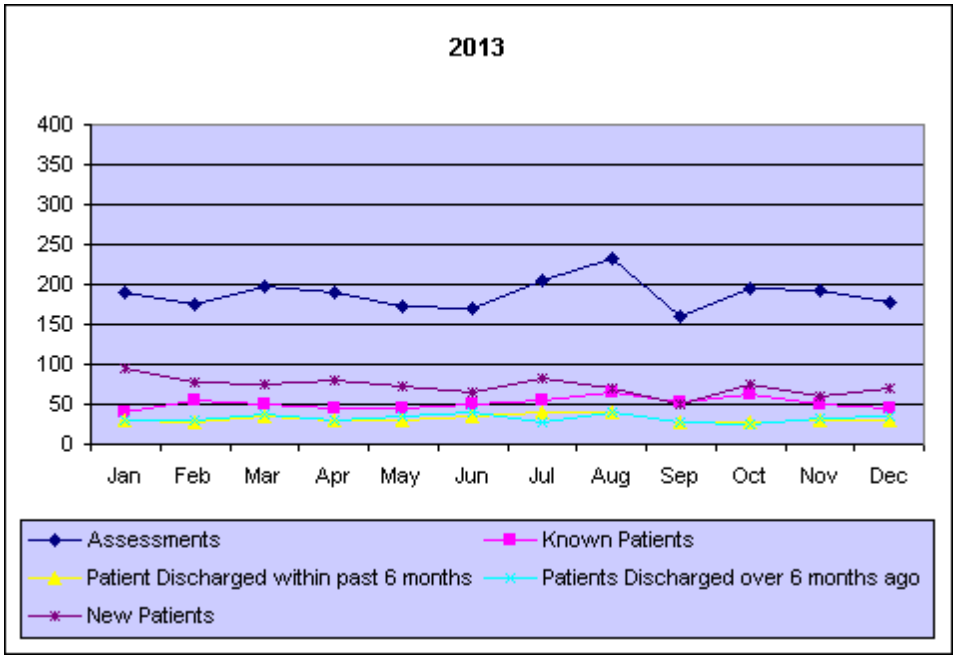
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessments	282	277	295	294	336	318	312	369	287	276	287	284
Known Patients	138	141	136	147	168	149	159	185	117	113	126	131
Patients Discharged within past 6 months	42	31	41	47	47	41	34	55	46	55	49	37
Patients Discharged over 6 months ago	34	30	50	42	47	48	50	44	52	33	37	48
New Patients	68	75	68	58	74	80	69	85	72	75	75	68

2013

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
366	277	311	308	344	367	351	374	319	368	333	357
176	119	127	142	138	176	168	180	147	177	190	175
55	42	50	37	58	44	49	56	48	55	43	39
62	44	62	55	62	55	46	52	38	59	43	54
73	72	72	74	86	92	88	86	86	77	57	89

St Thomas' Hospital Mental Health Liaison Team 2012 - 2013





2012

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessments	227	225	220	222	220	225	232	238	205	232	205	245
Known Patients	66	72	55	51	57	63	65	88	64	77	49	74
Patient Discharged within past 6 months	48	43	37	40	44	50	44	40	39	32	41	44
Patients Discharged over 6 months ago	39	22	31	40	31	27	26	31	16	23	27	34
New Patients	74	88	97	91	88	85	97	79	86	100	88	93

2013

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
189	174	198	189	172	170	205	232	161	195	192	178
39	55	50	45	45	50	54	64	53	63	50	44
30	28	34	31	31	35	41	39	27	27	30	31
29	31	38	31	35	40	27	39	27	26	32	34
94	77	75	80	73	64	83	69	50	76	60	69

HASCCC Review: Access to Health Services

Background

As part of the Health & Social Care Act 2012, Healthwatch Southwark (HWS) was established in April 2013, delivered through the contract won by Community Action Southwark (CAS). Supported by a National Healthwatch England, HWS is intended to bring the local consumer **voice** and **champion patient and public involvement** to influence, shape and ultimately improve health and social care services in Southwark.

HWS is currently guided by a sub-committee of CAS consisting nine organisational representatives affiliated with a range of community and user groups. For more information visit www.healthwatchsouthwark.co.uk

Why are we carrying out our Community Focus Groups?

For Healthwatch to be as representative of the local community's voice (and needs), we have started a programme of engagement with a wider and more diverse part of the population, in particularly the *seldom heard-those not typically involved in consultations or statutory engagement structures*. Thus, we will be holding an ongoing programme of Community Focus Groups.

Programme aim:[1]

- Increase our knowledge, and insight into a range of issues across different groups
- Build ongoing relationships with individuals, groups and organisations and fulfilling our role as the n*etwork of networks*.
- Inform our Strategic Priorities and Activities
- Influence specific services and longer term planning and delivery of local services.

Focus Group aim: To explore the key issues within these communities, specifically:

- Highlight particular health and care behaviours,
- Gain insight into the challenges they face, both specific and general faced by members of the community

What will we do with it?

- Develop ways to address them working in partnership with those bodies responsible for health and care services, including using our statutory powers

Healthwatch Priorities

[1]*Note*: Findings are not intended to be represented of a whole community, there is diversity within all communities, nor quantifiable.

Based on a combination of engagement at our June launch, a stakeholder's day, and LINk Southwark's recommendations, the HWS board agreed on 4 strategic priorities which HWS could influence:

- Access to GP Services
- Access to Mental Health Services
- Sexual Health Services (specifically HIV)
- Social Care provision, for those outside of the Fair Access to Care (FACs)criteria

Focus Group findings

Two focus groups have been held with LAWRS (Latin American Women's Rights Service) and a Deaf Support Group run by SDA (Southwark Disablement Association) in August 13 and November 13. The focus group focused on:

1. **Key challenges or barriers in accessing health & social care services**
2. **Needs specific to the community**
3. **Ways to offer ''good quality services''**
4. **Best way to get and obtain information HWS next steps**

A total of 38 surveys were completed from the two sessions with attendance from approximately 45 individuals. Interpreters were provided at both sessions and conducted in an informal setting with lunch provided.

Similar issues and challenges around access to health services rose at both focus groups. A summary is provided below, with further detail in the appendices.

- **Language issues**-verbal and written communication
- **Interpreters** – the ease to book interpreters, the availability and the awareness of the service at both primary and secondary level, and the potential safety implications
- Awareness of the **complaints process**, and the support required to enable using this route to complain and feed back to services.

- **Cultural and diversity training** of front line staff in dealing with communities with particular needs. A huge aspect involved the 'soft skills' of staff around patience, dignity, respect and empathy.
- **Workshops** – information about services, communication, confidence to empower communities. There is a lot of support for this and Healthwatch is exploring this.
- **Accessible information and support provision** - Both groups showed a distinct lack of awareness of services outside of A&E and GP practices.

Other feedback received through our online forums, engagement activities, info & signposting function included:

Relating to access to GP services…

- **New booking appointment system** at some GP practices – without prior or sufficient notification and/or engagement
- **Current appointment booking system**- not suited to people's lifestyle particularly Older and Working people,i.e. ringing on the day or advance booking available in 2weeks
- **GPs not responsive to calls**, or perceived inappropriate usage of service
- GP catchment areas / right to choose misinterpretation

Hospital& Community Services…

- Information and communication relating to appointments after being referred from GP practice

Information

- Complaints – knowing where, how and being able to (supported)

Awareness / confusion relating to the status of NHS 111 in Southwark

- At a previous HASCCC meeting, HWS submitted patient feedback on 111 and we highlighted issues and questions it raised. Whilst we are still involved in the NHS 111 Patient Involvement Sub-Group for South East London, the group agrees that a lack of a 111 website or communication surrounding 111

Next steps

- **H&WB Engagement – 1000 lives and gathering feedback on HW's four priorities**

HWS is working with the Health and Wellbeing Board and its partners to collect the stories of local residents around there health. More info here http://www.healthwatchsouthwark.co.uk/get-involved/tell-us-your-story-to-improve-health-services-1000-lives

- **Our HW priorities**: Access to GP services, Access to Mental Health, Sexual health services (HIV) and Social Care provision – those outside of the eligibility criteria (Fair Access to Care). This will involve taking forward our focus group findings and working with voluntary and community groupsandour partners.

- **HWS Public Forum – March 2014.** Feedback from our last Public Forum: 'Building our Network' in December 2013 can be found on or website.

Community Focus Group with:

Latin American Women's Rights Service (LAWRS)

Findings & Recommendations

CONTENTS:

Healthwatch Southwark

As part of the Health & Social Care Act 2012, Healthwatch Southwark (HWS) was established in April 2013, delivered through the contract won by Community Action Southwark (CAS). Supported by a National Healthwatch England, HWS is intended to bring the local consumer **voice** and **champion patient and public involvement** to influence, shape and ultimately improve health and social care services in Southwark.

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1. Why are we carrying out our Community Focus Groups?

For Healthwatch to be as representative of the local community's voice (and needs), we havestarted a programme of engagement with a wider and more diverse part of the population, in particularly the *seldom heard-those not typically involved in consultations or statutory engagement structures*. Thus, we will be holding an ongoing programme of Community Focus Groups. As part of our engagement strategy we will engage and involve both community and user groups, and the wider population.

Programme aim:[1]

- Increase our knowledge, and insight into a range of issues across different groups
- Build ongoing relationships with individuals, groups and organisations and fulfilling our role as the n*etwork of networks*.
- Inform our Strategic Prioritiesand Activities (see Appendix)
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What will we do with it?

- Develop ways to address them working in partnership with those bodies responsible for health and care services, including using our statutory powers

2. Profile of the Latin American Community

[1]*Note*: Findings are not intended to be represented of a whole community, there is diversity within all communities, nor quantifiable.

Based on the recent comprehensive research project in the Latin Community (''*No longer Invisible, 2011''*), over 1000people were surveyed through a mix of long, short questionnaires, focus groups and in-depth interviews.

- There is an estimated 113, 500 (61%) living in London (2008)[2]
- Could be referred to as a new migrant group, with 2/3 arriving since 2000 and more than 1/3 arriving since 2005.
- There is no official national statistics/monitoring data for the Latin American communities, with mixed identities of nationalities within the Latin American countries.
- There is national low take up of health and welfare public services. 1 in 5 are not **registered with** a GP and 4 in 10 have not seen a dentist[3]
- Many use **private health services**[4]**,** sometimes alongside a GP
- Many use **migrant organisations** for a variety of advice and support needs.
- **Limited or lack of information**due to language and awareness issues
- **Language difficulties** hindered their integration into economy and society.

***Specifically in Southwark*,**

- Southwark Council has officially recognised the Latin American Community has a separate ethnic group (2012). More recently, Lambeth Council has also officially recognised the group (2013)
- Southwark & Lambeth hold the largest concentrations, with high numbers of Bolivians and Colombians.[5]
- The LatinAmerican groups include: Bolivians, Peruvians, Ecuadorians, Brazilians, Columbians, although this is not exhaustive

Relating to Health…

- Feedback on the difficulties in registering with a GP practice
- **Private services**are an issue, including unofficial over-the-counter medicines. (Southwark Council's *Healthwatch Outreach Report(Oct 2012*)

3. What we did

The session was conducted in Spanish, led by LAWRS with staff support from CLAUK and Healthwatch. The approach was a mixed method approach, comprising a short survey with key topics explored in focus group discussions, case studies and detail into the '*whys and how's'*.

Approximately 29 people were present, including those arriving late and leaving early. A total of 25 surveys were returned.The session was split into two:**Part 1: Survey,** and **Part 2: Discussion**

Accompanying documents were translated and provided at the session:

- **A signposting document** providing information on how to access health services, outside of GP Out of Hours, and social care services including how to leave feedback / complain about services was translated.
- **Survey**

[2]Mcllwaine. C, Camilo Cock. J and Linneker. B, Supported by Queen Mary University of London, LAWRS, Trust for London, ''*No Longer Invisible People''*, 2011

[3] Ibid. Survey

[4] 40% of those surveyed used private services and 1/3 access community organisations for support and advice

[5]Survey respondents 15% Southwark and 14% from Lambeth.

4. Findings

Findings from both parts of the session will be themed into the key aims, following the topic guide.

1. **Key challenges or barriers in accessing health & social care services**
2. **Needs specific to the community**
3. **Ways to offer ‘‘good quality services’’**
4. **Best way to get and obtain information**

1. Key challenges or barriers in accessing health & social care services

A lot of discussion and experiences centred on GP access and hospital care services. What came through strongly were the perceived barriers regarding ***non-clinical care***, ***specialist*** **services** and cases of ***clinical consequences***. **Language** and**Information** on services and the health care system seemed to be the underlying issues in creating challenges to access.

Quotes from participants are included in the text below. Case studies referred to are included in the appendices.

A) Language

Most attendees could not speak or read English and this hindered their ability to both *access* services, and get a *'good quality 'experience*.

i. Access(Process)

Through the Focus Group, it came out strongly the difficulties in **registering** with a GP arising from **a language barrier**was strongly emphasised**.** They could notcommunicate and/or understand the 'dos and don'ts' and 'can and cannot'. Experiences ranged from being ''de*nied the right to register until they could bring someone who could speak English*''with some resulting in using the Accident & Emergency departments to*finding it difficult to know what document was needed.*

Many experiences expressed that the actual process of **entering** a Practice to register was very unwelcoming and felt *''humiliated and disrespected''* or *''way they speak to you…''*

The **availability of an interpreteraffected how long** it would take to book an appointment *''the same appointment is delayed 2-3 weeks when having an interpreter''*or if the appointment took place or not. *''…got there… there wasn't an interpreter, the appointment was cancelled. I am still waiting…''.*

ii. Quality (of Service)

In the discussions, *quality*highlighted two dimensions; the **availability of interpreter** to facilitate communication, and the **quality of the interpretation** in a health context.

Survey results showed 4/5 (20) people did not have **an interpreter** at GP service level, with ¾ felt that it affected the *quality* of their GP appointment *''a lot'*.Some referred to the role of the receptionist facilitating interpreting services. "Receptionists are negligent to **arrange** for interpreting services"

Follow up appointment and letters received were in English and then missed or not understood which affected the follow up care.One person shared her experience relating to her child's care who had had asthma *''She couldn't argue due to the language barrier...she now takes him to the hospital with a paper that explains his condition in English''* (Case Study 7). Another lady shared her experience ''She *broke down into tears as her pain was unbearable, but couldn't argue with the doctor, as her English language knowledge was very limited…' (Case Study 5)*

Children and/or relatives have also acted as an informal interpreter.

*''When they don't have the **phone line we depend on our children** to understand what the doctors say'' 'I usually call my friends over the phone and they translate for me with the doctors…' (Case 8)*

Booking an interpreter did not always mean the appointment would take place. Delays, cancellations and interpreter availability were common. *"The same appointment is **delayed** 2 or 3 weeks when having an interpreter".*

Where an interpreter was made available, the quality of the translation was questioned with the patient not always satisfied. *"You can never know whether they are translating correctly and sometimes they seem very insecure of knowing **medical language**".*

When using informal interpreters (family, friends), it is more likely for miscommunications and misunderstanding between the GP and the patient to take place, resulting in negative experiences of care. Case 8 highlighted *''I usually call my friends over the phone and they translate for me with the doctors. They have told me my baby has not developed as expected, but my friends did not understand exactly what that meant, since they do not know about medicine. I do not know exactly what or why my baby hasn't developed. …nobody has offered me an interpreter to explain what happens with my baby...'*

B) Information

i. No place to go to get information– Where or how to get info?

On the whole, many attendees did not know *where or how* to get information relating to NHS and social care. Survey results showed **friends and associates**through word of mouth were their main source of information and advice (Case 9) *and*/or how to access services. The same number of people also said that they did not know where to get information *''friends because I don't know where else to go''*. 4 people cited community **groups or associations**. 2stated**newspapers** with one referring to the Southwark primary school service and anothersaid GP/hospital.

*"It is very difficult to find **information** about services and treatments"*

In the survey, we asked if a) they had a long term condition and what it was and b) if they felt supported to manage their long term condition. Interestingly, many respondents responded (X) to part b) they *''didnot feel they could support their condition''*, even when they stated they did not have a long term condition. In response to the follow up question of *what would help them*, most said *''more information''*.

Where information was provided, it was **not given in Spanish**. This applied to both general service information (i.e. alternatives to Accident &Emergency) and specific services (i.e. specialists, sexual health clinics or other social and community services) not known to them.

"We don't know who is entitled to what.'' (In relation to Patient Transport)

ii. Pathways:Treatments, services provided/not provided, entitlement to what(PROCESS)

Through discussions there were many experiences whereby lack of information and/ awareness of services prevented or delayed their access or treatment.

- The majority **did not know how** to access the different services listed (GPs, emergency room, specialists, sexual health clinics, or other social or community services). This survey result showed that aside from a couple of responses, most did not know where to go outside of GP hours, aside from the A&E. (although this is common across the general population as well). Only 28% knew a little about the services offered at GP level, 56% did not know.
- If they could not access a service for whatever reason, they had **no way of knowing if that was accurate or not** *''…if a service is denied I am unsure if that can be reported...''*. Most people did not know about the complaints process, *''…other women and their babies should not go through this…but I couldn't because I did know'' (Case 6)*but those who did *''it does not have any way to support a person who does not speak English''*
- This included **what other services** were available relating to their care, i.e. patient transport. *''We don't know who is entitled to what.. .'*
- There was a strong sense of a **barrier by GPs to access specialist** services or tests.

'' ….started having problems walking and urine leakage. As her GP was reluctant to run any kind of colon test, she went to visit another GP and then paid £600 in x-rays. She was the referred to a neurologist, had a series of MRI tests …'' (Case study 5)

*''GPs are very reluctant to **refer patients to specialists**; they only send you when the condition is extremely bad"*

2. Needs specific to the Latin community

A lot of discussion centred around the limited understanding from health staff on Latin cultural characteristics in terms of female sexual health and health habits, and in terms of social care around family dynamics.

In order to understand, the following issues, you will need to understand the context (in italics)

In marriages and relationships, a healthy sexual life is encouraged and considered a part of Latin culture. However, as a generally considered patriarchal society, women seldom openly discuss this part publicly due to sigma issues attached. (LAWRS)

Many felt it could be **difficult to speak** about certain topics ranging from sexual health, sex life, birth control to period situations. One described themselves as a *''patriarchal society''* and it was *embarrassing* to speak to men about sexual health particularly*''lack of understanding on issues to female sexual among males''*,or a female from *''traditional cultures'* 'where they felt 'under scrutiny'.

What came out through discussions was that **sensitivity and support**was needed when interacting with the migrant community, especially as many will have limited knowledge on NHS and social care services.

A lot of attendees felt their **needs were ignored** which they felt resulted from a lack of support/channels to express their need.

3. Ways to offer a good quality services.

First what is meant by a 'good quality service?' This section centred on what attendees thought a good quality service should be, some of which was drawn out from case studies…

- **Representative staff** that reflects the diversity of the population, especially related to pockets of GP practices where Latin communities are concentrated. A Latin American receptionist could expedite some of these cultural awareness and access issues.

- **Education** about the new and unknown UK system, understanding the health structures and pathwaysas distinct fromLatin American countries.Latin staff could support the information dissemination. (Medication, drug prescribing, access to specialists tests)

- A place to getting **information and signposting** service in Spanish.

- Easier**access to specialist services and tests**.

- The role of staff/receptionists to be aware and assess **if the person requires language** line or an interpreter with the willingness to facilitate this.

> *"Receptionists are negligent to **arrange** for interpreting services" Receptionists should understand why people ask for interpreters and should not be reluctant to do so when needed."*

- Clinical staff and support staff, especially receptionists,should have **cultural and diversity awareness training** in terms of understanding and communicating with particular groups

- Compassion, patience and sensitivity and empathetic approach.

4. Best way to get information to the Latin American community, and obtain information from them

We asked *where* individuals currently receive their information and *how* they would like to receive it.

Currently[6]1/3 of attendees go to their friends or people they know for information and advice, 1/ 3 did not know where to get information, 1/6 people said community groups and associations, a couple referred to newspapers with individual cases relating to children services, GP/hospitals.

''friends because I don't know where else to go''

What is the best way to receive information?

- Website and by post
- Workshops for migrants
- Easier access to information, signposting or advocacy in Spanish

[6] 2 people did not answer this question.

How can bodies/we (statutory bodies, Providers, Commissioners) obtaininformation from you?

- By making it easier to complain and/ or get advice
- By making it easier to leave feedback on services *(i.e. a place they could give feedback which could be at their GP or in a specific location after they have received a medical / social care service)*
- Include Latin American ethnicity into their data monitoring

Other areas that could be explored…

Other issues that were mentioned but not explored in detail included:

Social Care

- Similar issues arose relating to little understanding of how the social care system operates, who is entitled to what, and how to get information about support and other services. This included the 'soft side of care' and patient experience, sensitivity, support and compassion. Examples included:
    - Child with disabilities. ''I *feel the social worker wanted me to go back to Spain, so he did not have to deal with my case." (Case 10) - 'Keyworker spoke English…tried best.*
    - Applying for disability allowance*hasn't been able to contact adult social care services to get information…since all info is in English….''*
    - *Case study 9 about patient transport relating to social care.*

Discharge and communication between hospital doctors and GPs

- Consequences relating to **differentmedication, prescription and diagnoses**, between GPs and Hospital Doctors. (Case 1, 3, 4)
- Some cases clearly referenced that not being able to communicate in English either exacerbated the situation or indirectly affected the outcome of the situation. (See case studies: Case 7

Other primary care services

- Are similar issues arising in different primary care services, outside of GP services?

"My child had an appointment with the **optometrist**, I waited for 3 week for that appointment, I requested an interpreter, when I got there, there wasn't an interpreter, and the appointment was cancelled. I am still waiting for the appointment"

Complaints process

- Not understanding how and who to complain to, and sometimes not being able to complain due to language or other issues.

*After this extremely traumatic experience, she wanted to make a complaint - "other women and their babies should not go through this" - but couldn't do so due to lack of knowledge of the complaint procedures.(*Case Study *6)*

The effect of eating habits on health

"Our eating habits are completely different than the British or Asian ones. We come here and, because the water has a lot of scale, our digestive system struggles"

GP specialism in paediatrics (child health)

- Acknowledging that LAWRS is a women's organisation and will understandably have higher proportion of mothers, it's not unexpected that **paediatric services** was highlighted. Experiences relating to the GP role not possessing the knowledge required to treat young

children with one attendee stating ‘‘*Children should not be seen by a GP who doesn’t know anything about children’*

5. Conclusions/Summary

- Some issues seem to be more prevalent in the Latin community as well as **specific issues** around language and information and cultural characteristics, however there are other issues that also **reflect broader issues from the ‘general population’**.
- Not being able to speak English, especially when the **means to support or facilitate communication is not there,**hugely affected both access to services, and the quality of care experienced. If support is not provided, it cannot be expected that people will speak up.
- Complementary to language, **useful information was not easy to find**. There is a huge knowledge gap on where to go to findinformation led to antedoctal and word of mouth as an unofficial source. This created uncertainty on what the experience should be or if the professional information/advice given was credible. In some cases they did not know if they were within their rights to ask questions, challenge or they were worried about repercussions.
- The Group showed minimal awareness and understanding of the different services available, if the GP practice was closed and as an alternative to A&E. Coupled with the knowledge gap, this has implications on current local and national NHS campaigns particularly around the ‘‘Choose Well’’, the review into the urgent care system and the policy and cultural drive towards ‘empowering people to self-manage their conditions’.
- Communication and informationwere not in **accessible format**, i.e. translated documents, services, as appropriate.
- There is a strong sense of wanting and needing to be informed, with a **keenness to access this information** whether that is in workshops, or from a central source.
- A lot of unhappiness about how staff, particularly receptionists, communicated and engaged with patients, particularly those not confident in their knowledge of the system, and in their English ability.
- **By understanding thecultural context, particularly aroundsexual health**, could help to address their issues around the difficulties in speaking to males and females from conservative backgrounds.
- **A lot of bad experienceshave led to a breakdown of trust with GPs,** and between GPs and Hospitals. Some implications included reverting to private services (accredited or not is another issue), and/or using the A&E as their ‘go-to’ place for care treatment.
- By not being able to access the complaints process, and knowing where to leave feedback, could mean that **Service Providers and Commissioners may miss the opportunity to obtain user intelligence**, which could be incorporated into service/systems improvement.

6. Recommendations / Actions / Who

For service providers to include Latin American ethnicity their data monitoring

- To help identify the population, what services and where they are accessing them. This will provide the start of dialogue towards understanding needs and supporting access.

Breaking down access barriers to local services *through support and information:*

- **GP Practices to make their registration process clear**

What we have done?

- *HWS has produced a statement outlining the process for registering with a GP Practice, including what is allowed and what isn't. LAWRS has translated and circulated the statement.*

Immediate work…

- *HWS to produce a log for LAWRS and other Latin groups, to record experiences at specific GP practices.*

- **Clear information on how to access Interpretation at both GP's and Hospitals**

Immediate work…

- *HWS will produce a summary sheet on access to interpretation services at primary care services and at hospitals (Future: NHS 111 sheet to follow)*
- *Understand the current process, and the relationship between language line and an interpreter.*

Building awareness of local health & social care services

Immediate work…

- *HWS produced a signposting document outlining how to access different health and social care services and how to complaint.*
- *LAWRShas translated and cascaded this. We will further build links with other local Latin groups to circulate this information widely.*

Receiving Information

- **Understanding key patient pathways(i**.e. how to access, or know where to)

- **Information workshops**, **service updates** through HW to community hotspots and networks
- Simple place to get info & signposting

Making it easier to leave feedback, and complain

- GP Practices and Hospital Wards should make clear, advertised and physical means of encouraging feedback, and those wanted to complain. (Mapping of the Latin Population within GP surgeries could inform the extent of reasonable adjustments).

- Take the complaints section from Healthwatch Signposting document, and transform into a leaflet.

This includes the organisation, Voiceability, commissioned to provide complaints support (Independent Complaints Advocacy Service) regarding NHS services. (Social Care is different)

Cultural& diversity awareness

- For frontline staff to undertake cultural and diversity training, particularly around sensitively, support, patienceetc. to migrants who may not have information.

Other work…

Shorter specific pieces of work, as indicated,will be actioned. However, wider pieces of recommendations will be incorporated when formulating our action & monitoring plan for our priority: *Access to GP services*. This will also include focus group findings from our recent deaf support group. **DATE: JAN/ early FEB 2014**

Further exploration on the practicalities and approach, the role of statutory body or other body/group required and the monitoring side is needed. HoweverPart of the Priority Action Plan will include,

- Mapping staff population
- For GP practices in particularly, to understand their local patient population in terms of additional needs.
- Partnerships with LAWRS and other statutory bodies (LBS, CCG) to facilitate community feedback, & distribute information
  - Short term – be informed
  - Longer term – get involved in decision making at local level
- Support to complain and/or feedback

Strategies these findings will feed into

- Primary and Community-based Care Strategy (NHS Southwark CCG)
- NHS Southwark CCG Commissioning intentions2014/15
- Joint Health &Well Being Strategy 2014 onwards
- Joint Strategic Needs Assessment

APPENDIX A:

Latin American Women's Right Service

LAWRS is a charity established in 1983 directly engaging with other 4,000 Latin American migrant women in the UK every year. It delivers programmes which focus on promoting economic security, tackling violence against women and girls, and on improving opportunities for successful integration.www.lawrs.org.uk

Coalition of Latin Americans in the UK (CLAUK)

CLAUK is a coalition of 11 Latin American organisations that have come together to raise awareness and understanding of the issues facing the Latin American community in the UK and to provide a collective voice for, and represent the collective interests of the Latin American community in the UK.

www.clauk.org.uk

APPENDIX B: CASE STUDIES

Note: All names have been changed.

Case 1

4-year-old girl with heart problems and diabetes had to be taken to the hospital due to a crisis. She was given a prescription. When her mother took her to the GP, the GP said that the medication was not appropriate for her case and that it would actually harm her. The girl wasn´t given the prescription, had a new crisis and had to be taken to the hospital where the mother was questioned for not giving the child the medication.

Case 2

As an informal community worker, Sandra normally accompanies people to the hospital to help them with the English. She frequently finds that patients are referred from the GP to a hospital, and from one hospital to another without providing a clear treatment plan.

Case 3

An older Latin American with Diabetes type 2 (56 y.o.) was given a prescription in the hospital after an emergency episode, when she went back to her GP, he told her that prescription wasn't for her and

stopped the prescription. She had to go back to the emergency room, where she was called negligent for stopping the previous prescribed medications. She stated she does not know trust any of the doctors' opinions anymore.

Case 4

Marta (Colombian, 43) went to the GP with pains in her stomach. She was told it could be a premature sign of menopause. As the symptoms were persistent she was told that she could be pregnant. After a check-up and no responses, Marta went to the hospital where she had a meeting with a team of 10, which included nurses and doctors. Her condition was getting worse, she started bleeding a lot, but she had no diagnosis. After 6 months, she decided to go back to her home country to seek medical advice, having to face a 12-hour flight with severe blood loss. The doctors in her home country found that she had fibroids. She had to go through surgery and she was informed that her life was at risk.

Case 5

Mabel (Ecuadorian, 45) was feeling pain in her back. She went to see the GP and was given anti-inflammatory tablets. After a few months, the problem persisted and she started having problems walking and urine leakage. As her GP was reluctant to run any kind of column test, she went to visit another GP and then paid £600 in X-rays. She was then referred to a neurologist, had a series of MRI tests and was then told, "You have absolutely no problem". She broke into tears as her pain was unbearable, but couldn't argue with the doctor, as her English language knowledge was very limited. She decided to pay for private services. Her private doctor explained that she had 3 worn discs in her spine. She spent £2,800 over 8 months to receive treatment. She now feels a lot better but continues to pay for private services periodically.

Case 6

Laura (Peruvian, 35) was about to deliver her baby in St. Thomas Hospital. Her water broke, but she didn't have enough dilation. She was told that although her water broke the labour could still wait up to 72 hours and was sent home. She asked to give birth by caesarean, but the doctors did not agree to it. She had an induced dry labour, which resulted in the baby having to stay in intensive care for 5 days due to the severe wounds (burnt from lack of liquid and had to be pulled out). Her husband was present, begging for a caesarean to be performed, but the doctors did not agree. The baby was born with a very low pulse and currently has respiratory problems. After this extremely traumatic experience, she wanted to make a complaint - "other women and their babies should not go through this" – but couldn't do so due to lack of knowledge of the complaint procedures.

Case 7

Manuela (Bolivia, 32) has a 3-year-old boy with asthma. He once had a crisis and was making a whistling noise when breathing, so she took him to the GP who told her that it was "normal" and that there was nothing to worry about. He provided no treatment, but she couldn't argue due to the language barrier. She took the child to the St. Thomas Hospital, the child had an infection in his right lung, had to be intubated, was given oxygen and had a very low pulse. She went back to the GP, but she was told that they had no records of the boy having asthma as they had lost his clinical history. Since then, and as she is unable to speak English, every time the boy has an asthma problem, she takes him to the hospital with a paper that explains his condition in English.

Case 8

Violeta (Ecuador, 34). "I am pregnant; I have worked for the entire 7 months of my pregnancy. I have never given an interpreter to talk about my baby's situation. I usually call my friends over the phone and they translate for me with the doctors. They have told me my baby has not developed as expected, but my friends did not understand exactly what that meant, since they do not have knowledge about medicine. Therefore, I do not know exactly what or why my baby hasn't developed. I have been hospitalised twice, and no body has offered me an interpreter to explain what happens with my baby. I am also homeless and live one day in one house, and one day in another one, but I am afraid to contact social services because they might take my baby away. I know they know I speak Spanish, but they act as if I can understand everything".

Social Services

Case 9

"We don't know who is entitled to what. I have my mother in law and my 2-year-old daughter to take care of every day while my husband works. My mother in law uses a wheelchair and whenever I need to take her to the hospital; it is very difficult for me to get her into the car while keeping an eye on my daughter. I always end up paying for a mini cab, although we have a low income. I feel very guilty because, although we have a park across the road, my daughter is in the house all day because I have to take care of her granny. We don't even know what kind of help we can receive in terms of transport or help in the house."

Case 10

Luz, (Ecuador, 40), "I have 2 children with disabilities, and I had to work to feed them, for a while I left them in the place where we used to live by themselves, so I can work. Then, I had social services to visit me, they stated I had to stop doing that; otherwise they will take my children away. I stopped going to work because I did not have anyone to take care of my children. I was evicted from the place I rented, and I did not have any money. The social worker contacted the Spanish embassy to see if they can take me back to Spain, they responded that was not possible. Social services allocated one room in a hostel to me and my 2 children with special needs, without a school or any income. I have also to pay the hostel, and I did not have any income. I have a key worker for the children, but he only speaks English, however, he has tried his best and he is trying to help. However, the social worker is not very involved in the case, and despite all the complications with older child aggressive behaviour towards my younger child, I am still living in one room accommodation. The psychiatrist and doctors have written letters stating the distress that my children are living by living in one room accommodation. The social worker was worried about my children when I left them alone for work, but he is not worry about my children who have especial needs becoming emotional distress of being in one room. I feel the social worker wanted me to go back to Spain, so he did not have to deal with my case."

Case 11

Mari (Colombia, 36). "My husband has been diagnosed with a chronic illness in his back, which will only degenerate from now on, and this does not allow him to work. We do not have any income coming into the house, since I have to take care of him and my daughter most of the time. I am applying for disability allowance; however, I haven't been able to contact adult social services to obtain information on how I can get help, since all the information is in English."

APPENDIX C: SURVEY RESULTS

1. Summary of Focus Group Findings

The second focus group as part of the HWS engagement took place. The session included a short survey and discussion. Findings from both parts of the session will be themed into the key aims, following the topic guide.

1. **Key challenges or barriers in accessing health & social care services**
2. **Needs specific to the community**
3. **Ways to offer ''good quality services''**
4. **Best way to get and obtain information**

The session was guided by Healthwatch Southwark Staff, with interpretation provided by a freelance BSL who was already familiar with the group, a British deaf association (BDA) staff member and the Deaf Support Group Co-ordinator who scribed.

1. Key challenges or barriers in accessing health & social care services

Communication is a key obstacle which the Group felt hindered their ability to both *access* services and get a good *quality* experience.

Language
The group emphasised language as the first challenge in accessing services. Most of the attendees were from a mix of ethnic backgrounds and generally communicated with each other through British Sign Language. Unfortunately one attendee could neither sign nor lip read. A lot of the attendees could no lip read, and so depended on the Interpreter.

In addition, the content of written communication also required translation in terms of grammar changes and simplistic English. Some received support from the Club Co-ordinator relating to letters. It was noted that the role of the Club Co-ordinator had changed because of limited capacity and also to avoid duplicating services as some required providing interpreting services.

''our language is not English, we rely on Ann to change it to BSL…''

Interpreting Services
The Group highlighted the difficulties in booking an interpreter, the long waiting time for an interpreter to be available, and the alternative ways they had to deal with services when an interpreter was not available. Some highlighted safety implications around adequate communication and understanding between health professionals and patients.

- *Most attendees mentioned that their ''English is not good'. Some took an active approach and went to a ''discussion meeting about the doctors services'' and they did not know ''how to treat a deaf person''*

- *O*thers explained that booking a GP appointment required weeks ''*ages''* of waiting. *''When I need to book appointment at the doctors I need to wait 6 weeks for an interpreter.''*

HWSouthwark Summary of findings with a deaf support group:

- Possible safety issues as a consequence of not being able to have an interpreter. ‘‘*The majority of people will go to their GP without an interpreter which is not a safe thing to do…’*

- *Others have used pen and paper as means to communicate in GP, hospital and other settings.*

Information and support
Many wanted or went through the process of filing a complaint about a service. However, many also did not know how to go through the process, including the support which the individual required to enable them to do so.

Cultural and diversity Training: Staff/Health professionals
A key issue highlighted was around front line staff, particularly support and receptionist staff, who did not always know who to deal and communicate with deaf people.

‘’Receptionist should know how to deal with deaf people. ..’’
‘’If they do not have any training why are they are front desk?’’

Some expressed frustration that during follow up appointments or when booking appointments, staff would call instead of text.

‘’W*hen I have an appointment they seem to ring my home and not text me. Why do they do that? Considering they know that I am deaf.’’*

Some shared experiences on how other public services ‘*instead of booking for an interpreter they forced me to learn to lip read the conversation..’’*

When probed about how they find the experience of GPs and if they felt they were being understood by professionals, some responded with *‘’no they don’t, I feel they talk down to me…’*

Needs / good experiences

Individuals valued services where staff considered and remember the needs of patients and took the patients advice as to how to communicate with them.

‘’I was waiting to see my doctor I ask receptionist to tap me when my name is called and she did not forget, she tapped me..’’

Although there were more negative experiences shared, where staff seemed to ‘forget’ about their *need* after being informed by the patient, and in some cases resulted in no health or care service being provided, or a bad experience of care.

‘’I was having problems with my back, went to the doctor and the nurse said take your clothes off and said doctor will see me in an hour, an hour went pass and no doctor…2 hours nothing. By the time I put my clothes back on the nurse said where had I been and I said nowhere. I made a complaint.’’

Some shared negative experiences at unplanned urgent care service settings where professionals would forget their disability and need, e.g. A&E. It remains to be seen how prevalent this issue is.

''I broke my arm I told receptionist I was deaf I waited and waited. I waited for 10 hours and no one came for me. Obviously they had called my name out but I am deaf!''

However, interestingly one attendee perceived that their needs in relation to other individuals with language needs were met through alternative ways more so than the deaf community, and questioned this.

''I feel as a deaf person it is so much harder because our needs are not met. Other disabled people get their needs met, why don't we? If a person needs a Spanish translator – no problem but when we need a BSL interpreter big problems. I have never heard of a non-speaking English person having to communicate via pen and paper.

Ways to offer a good quality service

This question was intentionally open-ended to allow for constructive suggestions and ideas what would help alleviate the obstacles and challenge their faced. This will be taken forward in the recommendation and Healthwatch role section later.

- General agreement around the need to be more confident, especially around communication. Some suggested workshops to enable this.
- That health professionals and clinician should take a BSL course
- That health professionals, particularly frontline staff should undergo a cultural and diversity training
- GPs and hospitals should have an interpreter on call

''I don't see why we have this meeting because this has been going on for years.''

Agenda Item 8

Trends in Acute Care Usage in Lambeth and Southwark: Public Health Analysis

- Produced by Lambeth and Southwark Public Health Department (Dr Grace Howarth/Dr Alison Furey)
- July 2013

Contents

Executive Summary

Shifts in demand and in the pressures on A&E departments have multifactorial causes, and it is hard to identify such complexities without consistent collection of the *right* data across the whole system. It is also difficult to tease out the influence of changes in coding and tariffs. This report has identified a number of features of local urgent care usage in Lambeth and Southwark:

- Population growth is a contributor to demand for urgent care. The populations of Lambeth & Southwark are expected to grow by 11% and 15% respectively to 2025. Deprivation, which is higher in both boroughs compared to the England average is also a factor. Other factors include access to alternatives to A&E, preventive interventions such as influenza immunisation, social support etc.
- Standardised A & E attendance rates were lower in Lambeth & Southwark compared to England during 2010/11 -2012/13.
- The crude numbers of A&E attendances increased by 2.1% in Lambeth and 2.9% in Southwark from 2010/11 - 2012/13 while attendance rates overall stablilised (decreasing by <1% in both Lambeth & Southwark) during the same period.
- Crude Emergency admission rates *reduced* by 4.6% in Southwark and <1% in Lambeth from 2010/11 -2012/13.
- A&E attendance and admission rates increased amongst 65-84 year olds , but fell amongst younger groups. The greater proportion of older patients being seen in A&E and urgent care may be one explanation for the increased 'acuity' experienced by clinicians since they are more likely to present with co-morbidities.
- The proportion of long stays amongst older patients has not increased however, which is not in keeping with the idea of increased severity of illness, although it may be explained by reductions in delayed discharges.

- The proportion of short (1-2 day) admissions increased in both Lambeth and Southwark, while the proportion of long stay admissions decreased. Possible explanations include a lower number of delayed discharges, or changes in admission or coding practice.
- The pattern of attendances and admissions amongst children is more variable, but there is some indication that rates per 1,000 population are falling.
- There is little evidence of a seasonal trend in attendance or admission rates
- There is some evidence of increasing admissions in Southwark for preventable conditions, compared to London & England, after adjustment for age and sex differences.
- Among co-morbid conditions, alcohol-related admission rates increases in Lambeth since 2010/11, but fell in Southwark over the same period. Substance misuse-related emergency admissions have remained broadly stable since 2010/11. Mental health co-morbidity amongst emergency admissions has increased since 2010/11.

1. Scope/Aims

- Analysis of unplanned care in Lambeth and Southwark boroughs to the year end of 2012/12 with the aim of identifying patterns of change and interpreting possible reasons for trends.
- Based on comparison of 3 years of SUS data for the years 2010/11 to 2012/13
- Includes breakdown of A&E attendances and emergency admissions by:
  - Age
  - Length of stay
  - Proportion of A&E patients admitted to the hospital
  - Primary and secondary diagnoses
  - Further breakdown of groups for whom notable increases are observed compared to previous years

2. Background/Data Issues

There is always interest in analysing unplanned care, representing as it does such a significant cost to the healthcare system. Avoidable emergency admissions are also very costly to patients in terms of distress, and avoidable admissions may represent problems with long-term management. It is however important to recognise that unplanned care is not a negative outcome in itself, and that there is a balance to be struck between controlling its use, but still ensuring that patients access emergency care when appropriate.In a recent BMJ paper[1], Roland and Abel discuss some of the problems with interpreting acute care data:

- *Random variation* – numbers can vary quite widely by chance e.g. if the expected number of admissions is 200, then results would fall outside the range of 173-228 by chance 5% of the time. This means that detecting genuine changes in activity amongst statistical "noise" is difficult, particularly with only a few years year of data.
- *Regression to mean* – individuals who have had frequent admissions in one year often return to the same admission rates as the rest of the population their age without any outside interventions.

They also critique some popular admission strategies:

- *Targeting high risk/ frequent attenders*: targeting the highest risk people (0.5% of the population) is not necessarily the most effective way to reduce admissions. An alternative theory is that it would be more effective to reduce risk in the 80% of the population who account for 40% of admissions.
- *Intensive interventions:* these can create supply-induced demand. For example, community matrons for high risk patients can actually increase admissions (but may reduce length of stay).
- *Assuming that reducing admissions is always beneficial* - under referral can be dangerous just as over referral is wasteful.

A&E attendances have been rising over the past decade, although nationally this increase is noted to have levelled off over the past 30 months.[2] The picture has been complicated by changes in urgent care provision. Since 2004, GPs have not had to provide out of hours care, and the last decade has seen the growth of urgent care centres, walk-in clinics and more recently the 111 telephone service starting to take over from NHS Direct. There have also been changes in data collection, with a broadening of the services coded as urgent care. The increased number of providers, and changes in how they are coded, makes analysis of the long-term trends in urgent care difficult. A&E

data remains far from ideal, providing patient numbers and broad payment codes rather than the actual diagnoses. Activity data from primary care is also missing from the picture, and it is therefore difficult to identify whether increases in one part of the system, such as A&E, reflect a real change in need or rather a shift in the location care has been accessed.

There have been local and national reports of increased 'acuity' in the A&E and emergency caseload, with clinicians noting that even when numbers have remained stable, the workload has increased. This 'acuity', which could be described as increased severity or complexity, is a difficult characteristic to identify within the data. In A&E particularly, diagnostic data collection is limited, and there is a limit to the insights that can be gleaned from HRG codes. There are currently local trials of an acuity score in A&Es, to try and capture shifts in the complexity of the case mix. A&E and emergency admission numbers are based on episodes of care, and can therefore be skewed by small numbers of users requiring frequent attendances and admissions, for example cancer patients or patients who misuse alcohol. Finally, much of the data has been compared over the time period 2010/11 to 2012/13, and ideally trends would be analysed over a longer time period to avoid drawing conclusions from what could be normal variation.

Over the past few months there has been an increased national focus on the pressures faced by A&Es, both from NHS England, and the media. CCGs have been asked to "facilitate the development of local recovery and improvement plans centred around each A&E department."[3] Lambeth and Southwark CCGs have now formed an Urgent Care Board, and this paper contributes to the extensive range of metrics analysed in the annual review of winter pressures.

3. Lambeth and Southwark Demographics

Where possible this report presents attendance and admission figures as rates per 1,000 population so that increases in the population or its age structure are accounted for. Rates are produced using population estimates produced by the GLA based on the 2011 Census.[4]

[1] Roland M, Abel G, Reducing Emergency Admissions – are we on the right track? BMJ 2012;345:e6017
[2] Appleby, Are Accident and Emergency Attendances Increasing? BMJ 2013;346:f3677
[3] Letter re Delivery of the A&E 4 Hour Operational Standard, Dame Barbara Hakin. Chief Operating Officer/Deputy Chief Executive, NHS England, 09/05/13
[4] http://data.london.gov.uk/datastore/applications/custom-age-tool-gla-population-projections-ward

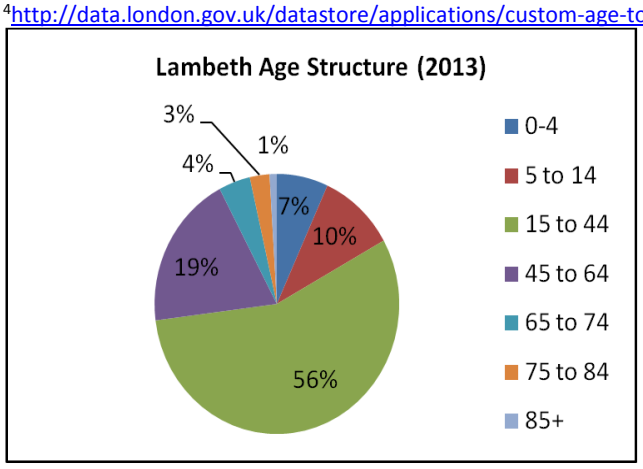


Figure 1. (Source: GLA mid-year estimates)

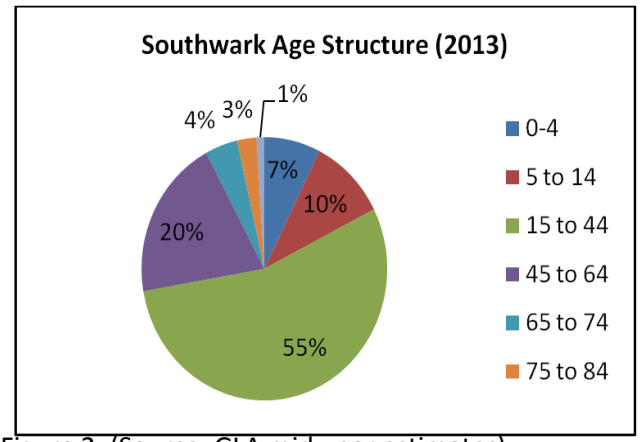


Figure 2. (Source: GLA mid-year estimates)

Lambeth and Southwark have very similar age structures. They are typical of London, where compared to the rest of England there is a higher than average working age population. Migration into the capital has led to a 13.5% increase in the number of residents aged 15-64 since the 2001 census. GLA projections indicate that the populations of Lambeth and Southwark will grow by 11% and 15% respectively by 2025, but that the age structure will remain broadly similar, in contrast to the national picture of an ageing population. There is also a higher level of population turnover, or churn, with around 10% of the population arriving, and around 10% leaving each year in both boroughs. This can cause issues with data collection, and with continuity of care, which could impact on emergency care usage.

Lambeth and Southwark also have ethnically diverse populations in common and in particular a high proportion of African/Caribbean/Black British groups, which account for around a quarter of the population in both boroughs. The ethnic composition of the boroughs could impact on emergency care usage both in terms of the conditions experienced by the population, but also in patterns of healthcare access.

Deprivation is higher in both boroughs than the English average, although as is the case in most of London there are pockets of affluence alongside extremely deprived localities. Higher deprivation is generally associated with a higher level of emergency admissions, due to a combination of factors including higher levels of morbidity and barriers to community management.

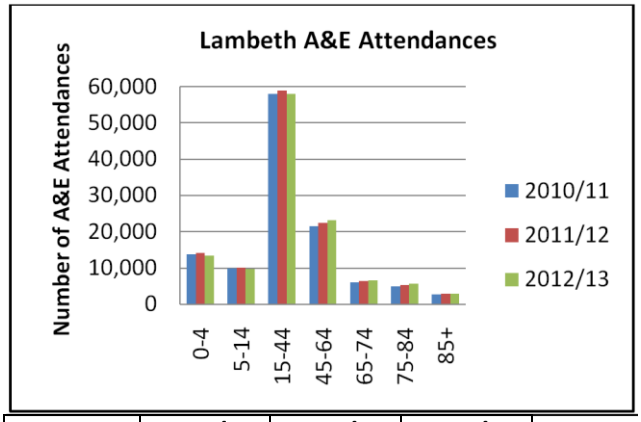
Figure 3. (Source: Local SUS data, 2010/11 – 2012/13)

Figure 4. (Source: Local SUS data, 2010/11 – 2012/13)

Figures 3 and 4 show that Lambeth and Southwark residents also make similar use of emergency providers. The majority of Lambeth and Southwark residents receiving emergency care during the period 2010/11 to 2012/13 did so at either Guy's and St Thomas' NHS Foundation Trust (GSTT) or Kings College Hospital NHS Foundation Trust (KCH). In both boroughs, care is split fairly evenly between these two providers, although a greater proportion of Lambeth residents seek emergency care at alternative providers, chiefly St George's Healthcare and Croydon Health Services (whereas Southwark residents are more likely to use Lewisham Healthcare). The similarities in provider landscape in the two boroughs means differences between the emergency care data for the two boroughs are less likely to be due to coding differences, as a shift in the coding practice of either GSTT or KCH would impact on both boroughs.

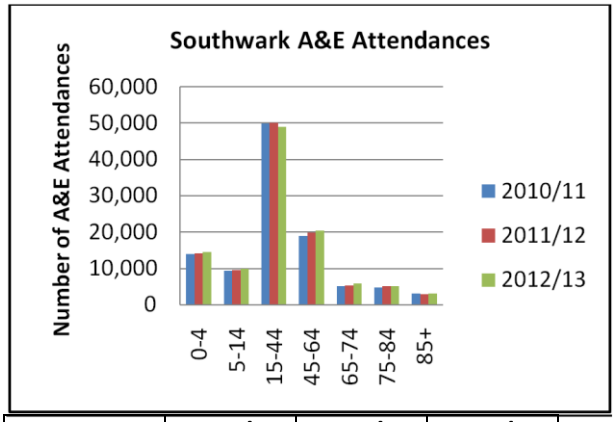
However, since 15% more patients in Lambeth received their care in 'other' hospitals, differences between GSTT/KCH and these other providers may be more strongly reflected in Lambeth's data.

4. A&E Attendance



Lambeth	2010/11	2011/12	2012/13
0-4	13,851	14,067	13,471
5-14	9,931	10,079	9,798
15-44	58,020	58,952	58,041
45-64	21,505	22,336	23,101
65-74	6,028	6,389	6,501
75-84	5,003	5,246	5,710
85+	2,749	2,890	2,972
Total	**117,087**	**119,959**	**119,594**

Figure 5. (Source: Local SUS data)

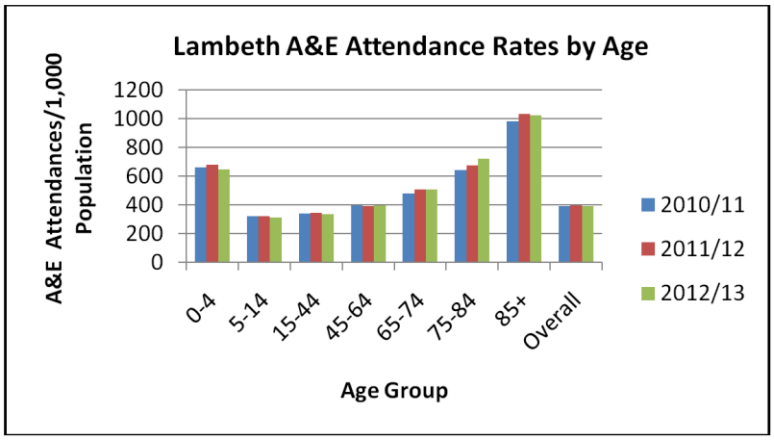


Southwark	2010/11	2011/12	2012/13
0-4	13,945	14,238	14,607
5-14	9,307	9,576	9,887
15-44	49,949	49,993	49,029
45-64	18,904	19,846	20,474
65-74	5,194	5,379	5,877
75-84	4,789	5,073	5,205
85+	3,047	2,975	3,130
Total	**105,135**	**107,080**	**108,209**

Figure 6. (Source: Local SUS data)

The number of A&E attendances by Lambeth residents has increased by 2.1% since 2010/11, but actually fell by 0.3% last year. The greatest increase was in the 75-84 age group, where attendances increased by 707, or 14.1%. There were 2.9% more A&E attendances by Southwark residents in 2012/13 compared to 2010/11, with a 1.1% increase in 2012/13. In contrast to Lambeth, the greatest increase was seen in the 65-74 year old age group where attendances increased by 13.1% over the 3 years.

Figures 5 and 6 show clearly that 15-64 year olds make up the majority of A&E attendees in both Lambeth and Southwark. They accounted for 68% of attendances in the Lambeth population and 64% of Southwark attendances in 2012/13. However, this age group accounts for 75% of the population in both boroughs, indicating that they are proportionally lower users of A&E services.



Age group	% change 2010/11-2011/12	% change 2011/12-2012/13	% change 2010/11-2012/13
0-4	3.03%	-5.15%	-2.28%
5-14	0.51%	-3.41%	-2.91%
15-44	1.37%	-2.34%	-1.00%
45-64	-1.20%	1.13%	-0.08%
65-74	5.99%	0.16%	6.16%
75-84	4.86%	7.47%	12.69%
85+	5.13%	-0.71%	4.38%
Overall	1.37%	-1.44%	-0.08%

Figure 7. (Source: Local SUS data)

Converting attendance numbers to rates allows comparison of usage levels between age groups, across years and between the boroughs. For example, the population in Lambeth has increased by an estimated 2.2% since mid-2010, during which time the number of A&E attendances has risen by 2.1%; this is reflected in the A&E attendance rate, which has remained very stable at 388 per 1,000 population. As with the crude numbers, 75-84 year olds account for the greatest increase in A&E attendance rate, with a 12.69% increase since 2010/11.

The picture amongst younger age groups is far more variable, and it is difficult to discern a pattern in these variations. Both 0-4 and 5-14 age groups have shown a decrease in attendance rate over the past year, with the attendance rate amongst under 4s falling by 5.15% since 2011/12. In isolation, in the context of the variability in attendance rates, this may not be significant, but figures should be monitored over the coming year to identify whether this is part of a longer term trend. A fall in the A&E attendance rate amongst children could reflect a decrease in actual need, parents taking children to other settings such as GPs, or more home management of illness, but it is important that parents can access emergency care for their young children, and a lower rate of attendance is not necessarily desirable.

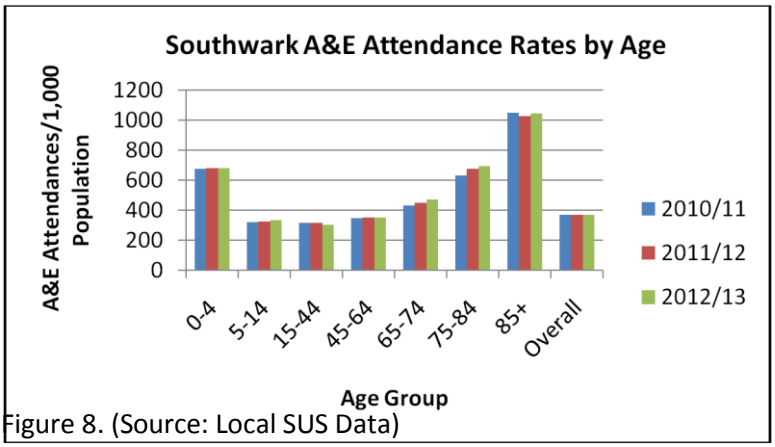


Figure 8. (Source: Local SUS Data)

Age group	% change 2010/11-2011/12	% change 2011/12-2012/13	% change 2010/11-2012/13
0-4	0.64%	-0.27%	0.36%
5-14	1.50%	2.56%	4.09%
15-44	-0.79%	-3.27%	-4.03%
45-64	0.36%	0.68%	1.04%
65-74	4.42%	4.89%	9.53%
75-84	7.34%	2.60%	10.14%
85+	-2.36%	1.70%	-0.70%
Overall	0.30%	-0.67%	-0.37%

In Southwark, A&E attendance numbers increased by 2.9% between 2010/11 and 2012/13, but taking into account the estimated population growth of 3.3% over this period, the attendance rate/1,000 population has remained very stable. Within this stable picture, there were significant increases of 9.53% and 10.14% in the attendance rate/1,000 population amongst 65-74 year olds and 75-84 year olds respectively. This was balanced out by a 4.03% fall in the attendance rate/1,000 population amongst the large 15-44 age group.

Amongst children in Southwark, the attendance rate in the 0-4 age group has remained stable, whereas the rate amongst 5-14 year olds has increased by 4.09%. This is contrast to the picture in Lambeth where both age groups showed reduced rates of A&E attendance/1,000 population last year.

Figure 9. (Source: NHS Comparators, 2013. * 2012/13 figures are rolling year figures based only on Q1/2 data)

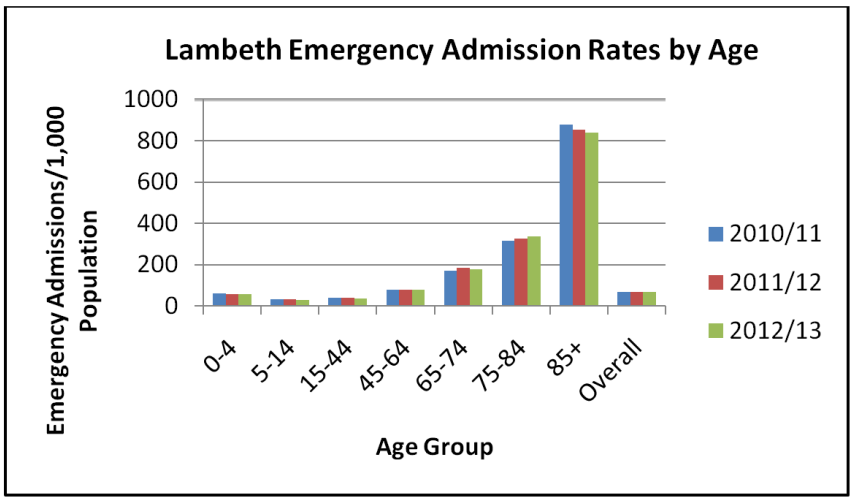
The above figure is based on NHS Comparators data, which standardises crude rates per 1,000 population to allow comparison between areas and over time. The standardisation involves producing an expected number of A&E attendances for the characteristics of the population (e.g. age, deprivation, ethnicity), and then comparing this to the actual number observed. The validity of the standardised rate therefore relies on the completeness, consistency and quality of population and A&E data (which has had particularly issues in terms of completeness), but also on the standardisation methodology itself. This can make standardised rates controversial, but they do allow cautious comparison across geographical areas, and over time.

The figure for 2012/13 is a preliminary rolling year rate based on Q1/2 data, and as such should be treated with particular caution. Population estimates for Lambeth and Southwark used by NHS comparators are notably different from the GLA figures used to calculate rates for local SUS data elsewhere in this paper, with all NHS comparators estimates being higher. This is particularly the case for the Lambeth population estimate used by NHS comparators, which may go some way towards explaining the consistently lower standardised rates observed in Lambeth when compared with Southwark.

Based on NHS Comparators data, both Lambeth and Southwark have had standardised A&E attendance rates per 1,000 population that are consistently lower than the England-wide rate since 2009/10. Lambeth's standardised A&E attendance rate has been significantly lower than that of both Southwark and London over this period, although it too showed an increase between 2010/11 and 2011/12. Southwark's standardised A&E attendance rate has tracked the England-wide rate fairly closely but has stayed more stable than the continually increasing London-wide rate, and Q1/2 data suggests that it may actually be lower than London for 2012/13.

5. Emergency Admission Rates

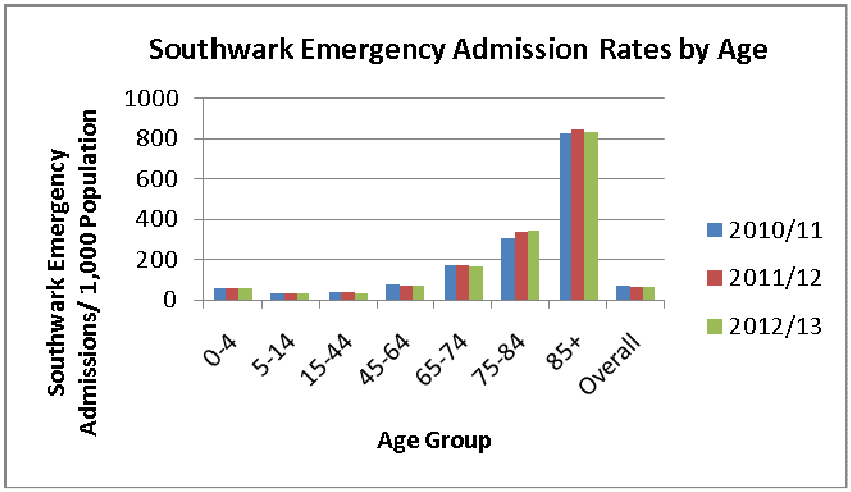
Emergency admissions analysis excludes maternity, mental health and A&E admissions, for example to a Clinical Decision Unit (CDU).



Age group	% change 2010/11-2011/12	% change 2011/12-2012/13	% change 2010/11-2012/13
0-4	-4.97%	0.25%	-4.73%
5-14	0.73%	-5.40%	-4.72%
15-44	3.20%	-8.34%	-5.41%
45-64	-0.43%	1.19%	0.75%
65-74	8.90%	-4.26%	4.25%
75-84	3.07%	3.18%	6.35%
85+	-2.84%	-1.76%	-4.55%
Overall	2.15%	-2.52%	-0.42%

Figure 10. (Source: Local SUS Data)

Whereas the crude number of emergency admissions in Lambeth increased by 1.8% between 2010/11 and 2012/13, the emergency admission rate/1,000 population remained very stable, with a 2.15% increase in 2011/12 followed by a slightly larger decrease in 2012/13. The increase in emergency admissions in older age groups is lower than the increase in A&E attendances, but 75-84 year olds again showed the greatest increase.



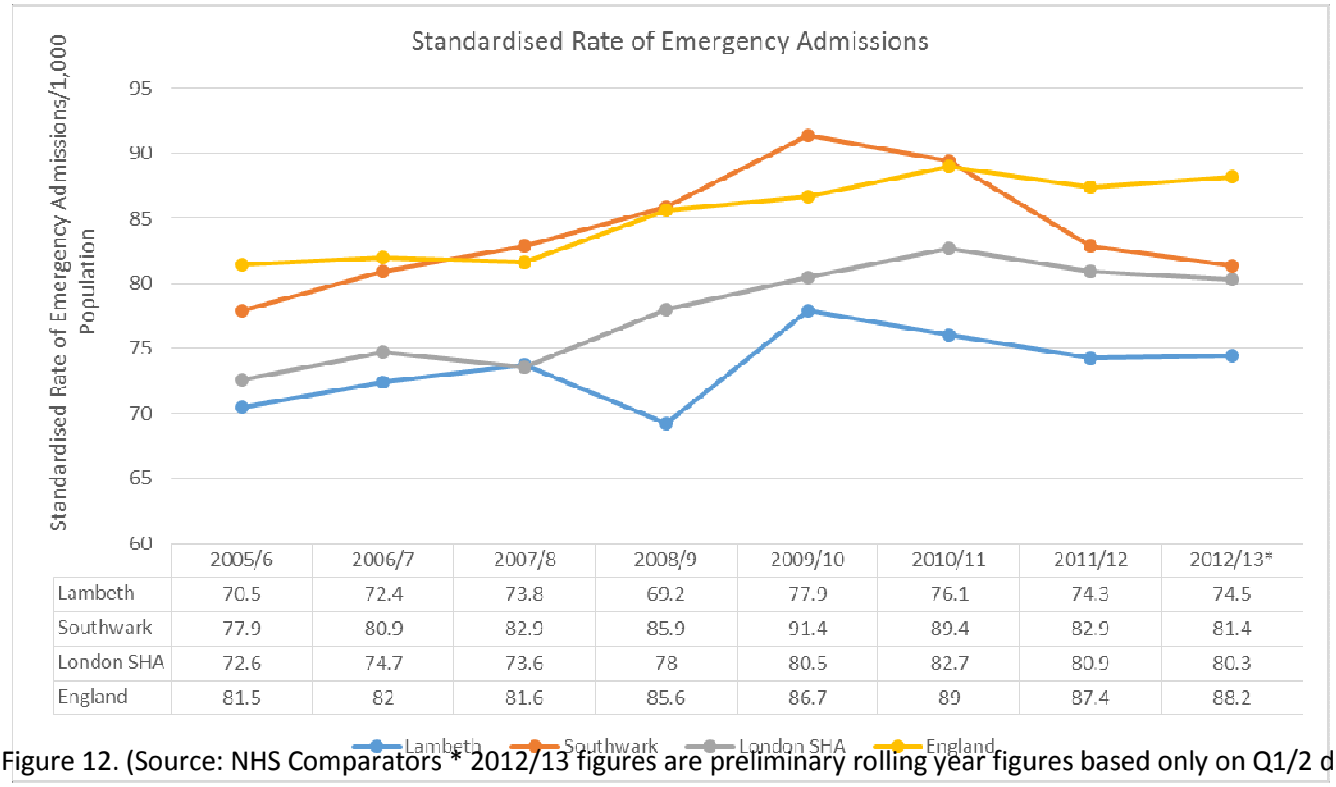
Age group	% change 2010/11-2011/12	% change 2011/12-2012/13	% change 2010/11-2012/13
0-4	-4.92%	0.18%	-4.74%
5-14	-3.45%	-0.31%	-3.75%
15-44	-3.39%	-6.58%	-9.74%
45-64	-4.79%	-5.36%	-9.90%
65-74	-1.37%	-1.15%	-2.50%
75-84	11.25%	0.28%	11.56%
85+	2.43%	-2.03%	0.35%
Overall	-1.47%	-3.24%	-4.66%

Figure 11. (Source: Local SUS Data)

In Southwark, the number of emergency admissions in 2012/13 was 1.5% lower than in 2010/11, but the rate per 1,000 population fell by a more significant 4.66%. A&E attendance rate per 1,000 population (see fig.8) had risen by around 10% in both 65-74 and 75-84 age groups since 2010/11, but the emergency admission rate per 1,000 population actually fell by 2.50% in the 65-74 age group, whilst rising 11.56% in the 75-84 age group. This may indicate that the increase in attendances by 65-74 year olds is predominantly amongst less seriously ill individuals, whereas the increase in the older 75-84 year old age group consists of more seriously ill individuals who then require admission, but ideally a longer time trend is needed.

The decrease in the rate of emergency admissions/1,000 population amongst younger age groups is greater in Southwark than in Lambeth. The rate of admissions amongst 15-44 year olds in Southwark was 9.74% lower in

2012/13 compared to 2010/11, whereas this figure was 5.41% in Lambeth. Whereas the emergency admission rate/1,000 population in the 45-64 age group in Southwark remained stable, it fell by 9.90% in Lambeth.



	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13*
Lambeth	70.5	72.4	73.8	69.2	77.9	76.1	74.3	74.5
Southwark	77.9	80.9	82.9	85.9	91.4	89.4	82.9	81.4
London SHA	72.6	74.7	73.6	78	80.5	82.7	80.9	80.3
England	81.5	82	81.6	85.6	86.7	89	87.4	88.2

Figure 12. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

Figure 12 compares the NHS comparators standardised emergency admission rates for Lambeth and Southwark to London and England figures. A time series such as this going back to 2005/6 is vulnerable to changes in coding of emergency admissions over time. As with the standardisation of A&E attendance rate, comparison relies on the validity of the algorithm used to standardise crude rates.

NHS comparators data indicates that since 2005/6 Lambeth has consistently had a lower standardised emergency admission rate than England overall, and lower than the overall London standardised rate for the past 5 years. It has also been consistently lower than the Southwark standardised emergency admission rate.

The Southwark standardised emergency admission rate has been consistently higher than the Lambeth and London standardised rates, but has shown more fluctuation when compared with the England figure. For the past 2 years it appears to be falling below the England-wide standardised emergency admission rate after a number of years of exceeding this figure.

6. Admittance Rate From A&E

The 'conversion rate' of an A&E department refers to the percentage of patients attending the A&E who are then admitted to the hospital. Again, emergency admissions are defined as excluding maternity, mental health and A&E admissions, whereas the A&E attendances include all patients. The ratio of admittances to attendances is therefore lower than if these groups of patients were included.

The proportion of patients admitted could reflect the 'acuity' of the patient mix attending A&E. However, the decision to admit can also be influenced by pressures on the system. Patients requiring high levels of observation may be kept in A&E rather than being transferred to a ward. Since it is a proportion, this figure is also influenced by fluctuations in A&E attendances by individuals who do not require A&E care. A low proportion of patients admitted could indicate inappropriate attendances, although it is important to note that even if a patient only receives advice rather than treatment, this is not necessarily an inappropriate use of A&E.

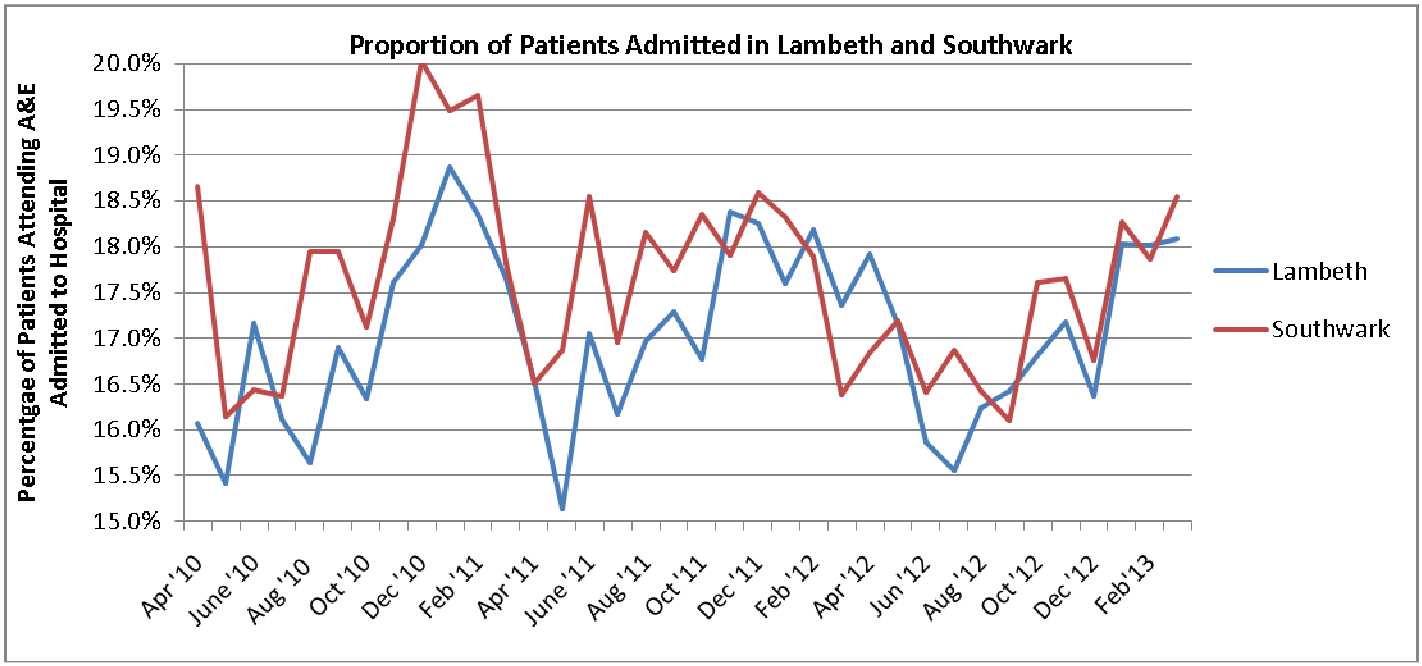


Figure 13. (Source: Local SUS Data)

The proportion of patients admitted is slightly lower in Lambeth compared to Southwark, but the two boroughs have followed a very similar pattern since April 2010, peaking at 18.9% and 20.0% respectively in December and January 2010, followed by a low of 15.1% and 16.5% respectively in April and May 2011.

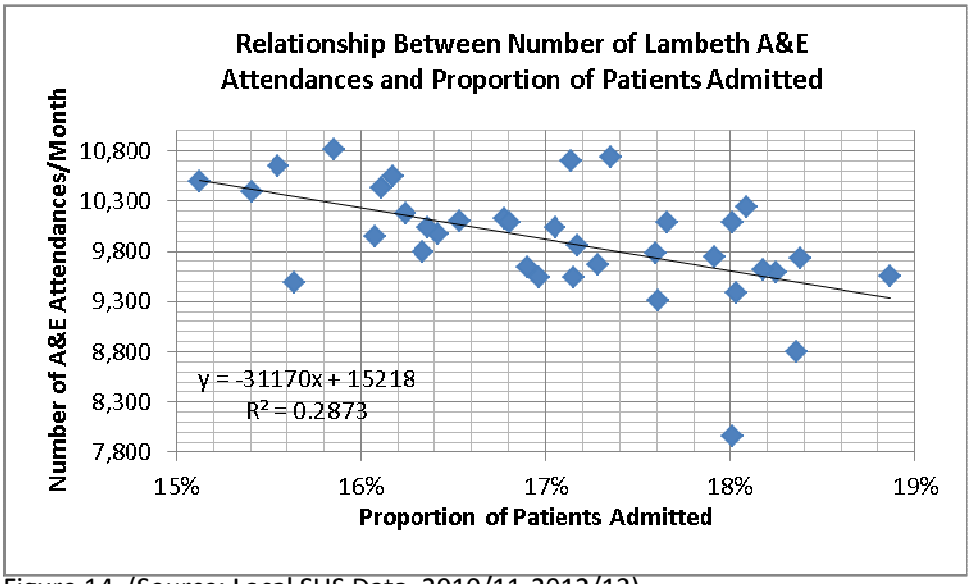


Figure 14. (Source: Local SUS Data, 2010/11-2012/13)

Despite an apparent relationship between how 'busy' a month is, and the proportion of patients admitted, the correlation co-efficient is only 0.536. This indicates a moderate negative linear relationship between the number of A&E attendances per month and the proportion of patients admitted, but is not significant enough to draw conclusions without further analysis.

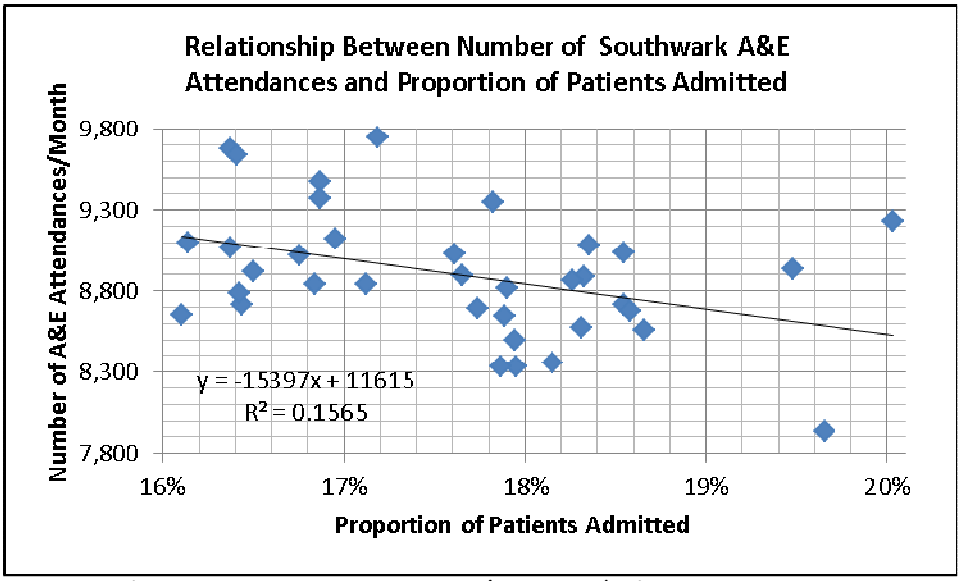


Figure 15. (Source: Local SUS Data, 2010/11 -2012/13)

In Southwark, the correlation is 0.396 which again only represents a moderate linear correlation. In Southwark the correlation is weaker than in Lambeth, so should be treated with even greater caution.

The variation in the proportion of patients admitted is relatively low, and falls in the middle of the UK-wide range (3-38%)[5]. The data presented in figures 14 and 15 is at a borough level, and without looking at daily or weekly provider-level data it is difficult to draw definite conclusions.

7. Length of Stay

Average length of stay can be a marker of the severity of case mix being admitted through a hospital, and therefore reflect actual need. For an individual patient, length of stay can also be influenced by quality of care affecting speed of recovery, or issues with discharge. Shifts in trends of length of stay can however also reflect changes in discharge protocols or coding practices.

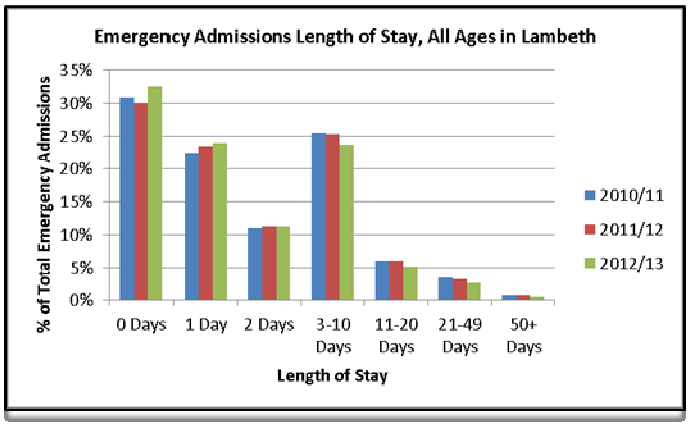
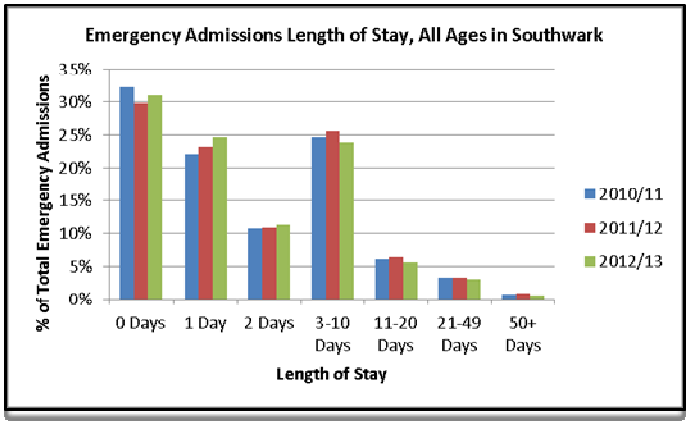


Figure 16. (Source: Local SUS Data)

Length of Stay	% change 2010/11-2011/12	%change 2011/12-2012/13	% change 2010/11-2012/13
0 Days	-2.80%	14.31%	11.12%
1 Day	3.86%	8.49%	12.68%
2 Days	1.81%	5.94%	7.86%
3-10 Days	-0.60%	-0.75%	-1.34%
11-20 Days	1.31%	-8.20%	-7.00%
21-49 Days	-6.02%	-12.01%	-17.31%
50+ Days	-6.57%	-36.02%	-40.22%

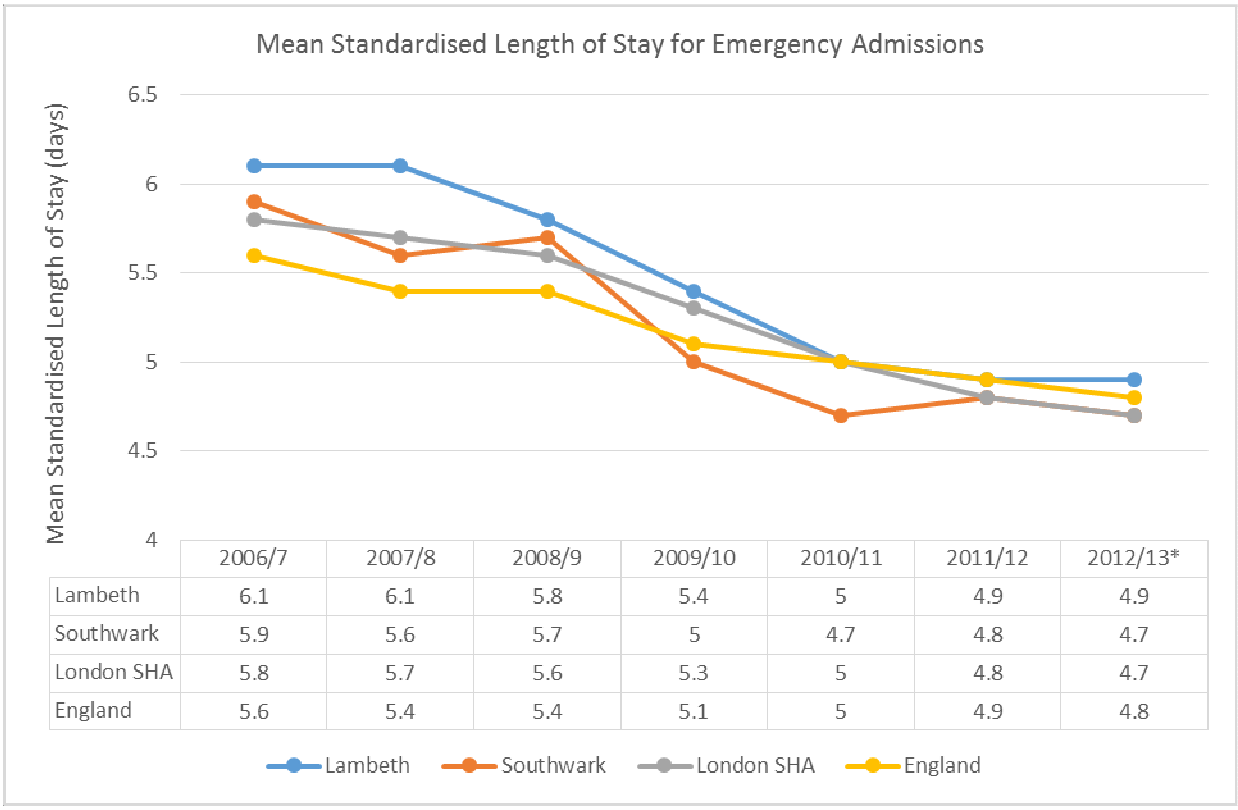
[5] Purdy et al. (2012) Interventions to reduce unplanned hospital admission: a series of systematic reviews. http://www.apcrc.nhs.uk/library/research_reports/documents/9.pdf



Length of Stay	% change 2010/11 - 2011/12	% change 2011/12 - 2012/13	% change 2010/11 - 2012/13
0 Days	-13.51%	10.38%	-4.53%
1 Day	-1.74%	12.86%	10.90%
2 Days	-5.99%	11.05%	4.40%
3-10 Days	-2.65%	-1.23%	-3.84%
11-20 Days	-2.44%	-7.90%	-10.15%
21-49 Days	-6.68%	-4.20%	-10.60%
50+ Days	15.32%	-25.94%	-14.59%

Figure 17. (Source: Local SUS Data)

Both Lambeth and Southwark have shown an increase in 1-2 day admissions in the last year, and a decrease in the proportion of longer admissions. Hospital data indicates that delayed discharges have reduced over this time period, which could be one explanation for this trend. However it is important to ensure that pressures in the system do not lead to premature discharges. Another possible explanation is variation in coding practice.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13*
Lambeth	6.1	6.1	5.8	5.4	5	4.9	4.9
Southwark	5.9	5.6	5.7	5	4.7	4.8	4.7
London SHA	5.8	5.7	5.6	5.3	5	4.8	4.7
England	5.6	5.4	5.4	5.1	5	4.9	4.8

Figure 18. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

The mean length of stay is another way of expressing trends in length of stay. NHS comparators standardised figures indicate there has been a downwards trend in the mean length of emergency admissions since 2006/7 across Lambeth, Southwark, London and England. The variation between these geographical areas is low, and the figures have become more similar over time, although Lambeth has consistently had a slightly higher mean standardised length of stay since 2006/7.

8. Emergency Care for the Elderly

The 65-84 year old group in particular have had increased A&E attendance rates/1,000 population, and also increased rates/1,000 population of emergency admittance (Southwark 65-74 year olds being the exception).

The proportional increase in attendance of patients of older age may mean a greater proportion of patients with co-morbidities as elderly patients are more likely to present with a number of conditions. Managing chronic conditions during an acute illness presents challenges, and this could be part of the explanation for the increased 'acuity' noted by local clinicians.

Length of Stay:

One way of measuring whether the elderly patients presenting to A&E in 2012/13 have been more seriously ill than in previous years is to look at their length of stay. The caveat is that a long stay in hospital can also reflect delayed discharge, and over 65s often require more complex packages of care on discharge than their younger counterparts. Recent initiatives to help shift care to the community as part of an integrated care programme (ICP) across Lambeth and Southwark include home wards and intermediate care.

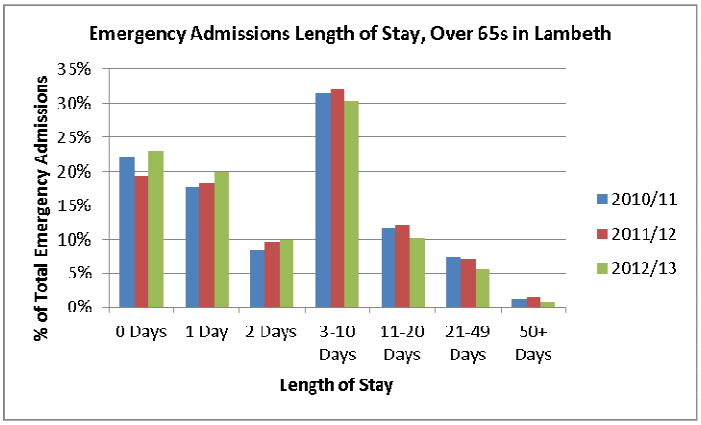


Figure 19. (Source: Local SUS Data)

	% change 2010/11 - 2011/12	% change 2011/12 - 2012/13	% change 2010/11 - 2012/13
0 Days	-8.91%	25.97%	14.74%
1 Day	8.62%	15.73%	25.70%
2 Days	20.29%	9.61%	31.86%
3-10 Days	6.79%	0.13%	6.92%
11-20 Days	8.62%	-11.61%	-3.99%
21-49 Days	1.10%	-16.70%	-15.79%
50+ Days	22.85%	-37.92%	-23.74%

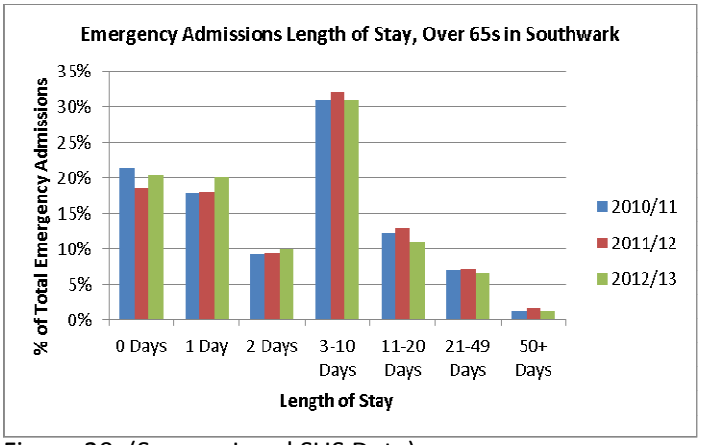


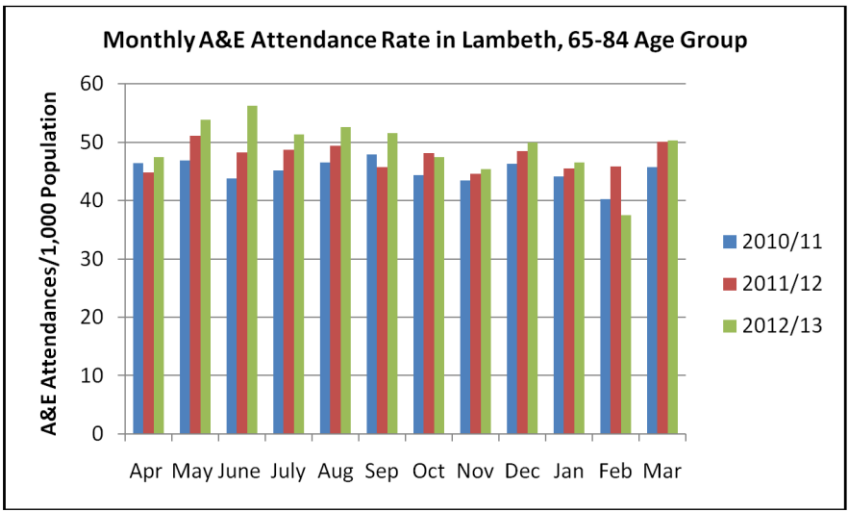
Figure 20. (Source: Local SUS Data)

	% change 2010/11 - 2011/12	% change 2011/12 - 2012/13	% change 2010/11 - 2012/13
0 Days	-13.77%	14.18%	-1.55%
1 Day	-0.41%	15.70%	15.23%
2 Days	1.80%	8.99%	10.95%
3-10 Days	3.29%	-0.23%	3.06%
11-20 Days	4.76%	-11.13%	-6.90%
21-49 Days	2.07%	-6.35%	-4.41%
50+ Days	41.40%	-27.70%	2.23%

In both Lambeth and Southwark, there has been an increase in the proportion of emergency admissions discharged after 1-10 days, and particularly 1 and 2 day admissions each year since 2010/11. This was more marked in Lambeth than Southwark. The proportion of longer stays has shown a corresponding fall, largely over the last year. Stays over 50+ days have shown a particularly significant fall in both boroughs, although the numbers involved are very small. More significant in terms of overall bed-days are the falls in the number of 11-20 day and 21-49 day admissions in both boroughs. This could be due to lower illness severity amongst admissions, which would contradict theories of higher acuity. However, other possible explanations include better treatment with faster recovery, or, more likely, changes in discharge practices or coding. Hospital analysis does indicate a reduced incidence of delayed discharges; this could be due to the support offered by ICP initiatives described above across Lambeth and Southwark. Ideally, data would be compared to years prior to 2010/11 to allow analysis of longer term trends.

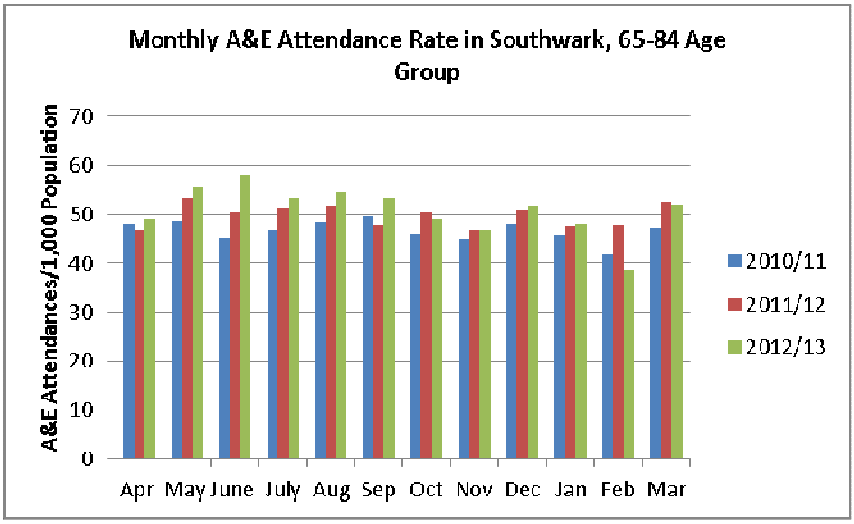
Attendances and Admissions by Month:

Analysing attendances and admissions by month can give some indication of the seasonality of pressures on the urgent care system.



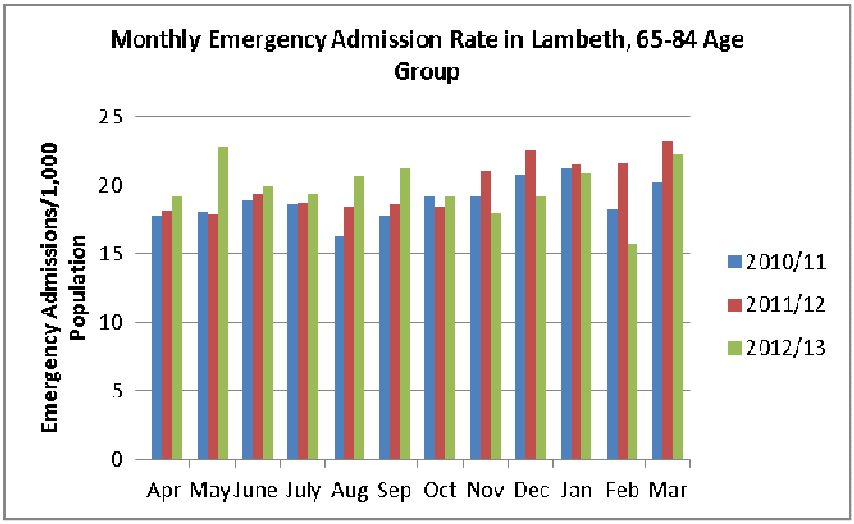
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11-2011/12	-3.48%	8.89%	10.20%	8.04%	6.11%	-4.70%	8.63%	2.71%	4.66%	3.00%	13.76%	9.54%
2011/12-2012/13	5.88%	5.46%	16.60%	5.29%	6.47%	12.93%	-1.45%	1.80%	2.94%	2.27%	-18.23%	0.48%
2010/11-2012/13	2.19%	14.84%	28.49%	13.76%	12.97%	7.62%	7.05%	4.56%	7.73%	5.34%	-6.97%	10.06%

Figure 21. (Source: Local SUS data)



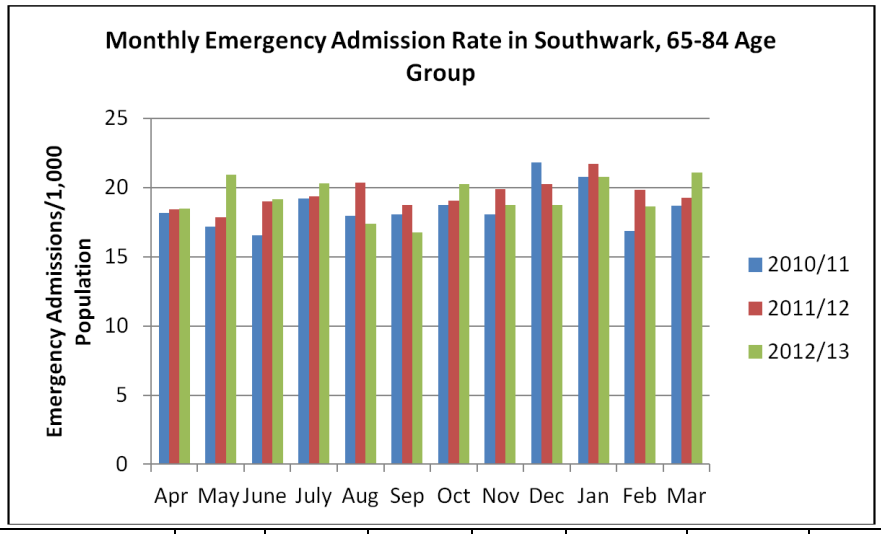
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11-2011/12	-2.49%	10.01%	11.33%	9.15%	7.19%	-3.73%	9.74%	3.77%	5.73%	4.06%	14.93%	10.66%
2011/12-2012/13	4.75%	4.34%	15.35%	4.17%	5.33%	11.73%	-2.50%	0.72%	1.84%	1.18%	-19.10%	-0.59%
2010/11-2012/13	2.14%	14.78%	28.43%	13.70%	12.91%	7.56%	7.00%	4.51%	7.67%	5.29%	-7.02%	10.01%

Figure 22. (Source: Local SUS Data)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	1.65%	-0.82%	2.60%	0.52%	13.21%	4.68%	-4.58%	9.16%	8.73%	1.15%	18.55%	15.05%
2011/12	6.27%	27.71%	2.79%	3.44%	11.88%	13.85%	4.07%	-14.31%	-14.92%	-2.80%	-27.15%	-4.15%
2012/13	8.03%	26.67%	5.46%	3.98%	26.67%	19.18%	-0.70%	-6.46%	-7.49%	-1.68%	-13.64%	10.27%

Figure 23. (Source: Local SUS Data)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11-2011/12	1.31%	4.01%	14.66%	0.76%	13.30%	3.58%	1.57%	10.11%	-6.98%	4.48%	17.46%	2.95%
2011/12-2012/13	0.22%	17.11%	0.93%	5.00%	-14.78%	-10.51%	6.44%	-5.77%	-7.44%	-4.34%	-6.04%	9.46%
2010/11-2012/13	1.53%	21.81%	15.72%	5.80%	-3.45%	-7.31%	8.11%	3.76%	-13.90%	-0.06%	10.37%	12.69%

Figure 24. (Source: Local SUS Data)

The monthly analysis of figures illustrates that there is no particular trend of seasonality in terms of the rate of A&E attendances and emergency admissions. The most significant increase in 2012/13 for 65-84 year olds was in May 2012, when rates of attendance and admission increased by between around 15-25%. This counters the widely held perception that pressure on A&Es and acute care due to excess morbidity amongst the elderly is a winter problem, although numbers alone do not capture the workload created by a varying case mix.

9. Emergency Admission Diagnoses

Lambeth Top 25 ICD 10 Diagnoses in 2012/13 by Emergency Admission Rate Per 1,000 Population	2010/11	2011/12	2012/13	Southwark Top 25 ICD 10 Diagnoses in 2012/13 by Emergency Admission Rate Per 1,000 Population	2010/11	2011/12	2012/13
R074 - Chest pain, unspecified	8.07	8.34	8.56	N390 - Urinary tract infection, site not specified	7.87	8.08	8.34
N390 - Urinary tract infection, site not specified	7.96	8.43	7.96	R074 - Chest pain, unspecified	8.60	7.47	7.16
R104 - Other and unspecified abdominal pain	5.77	4.74	5.08	R104 - Other and unspecified abdominal pain	5.75	4.52	5.37
J181 - Lobar pneumonia, unspecified	3.14	3.64	4.62	J181 - Lobar pneumonia, unspecified	3.42	3.49	4.58
J459 - Asthma, unspecified	3.90	3.86	4.20	R55X - Syncope and collapse	4.01	2.90	4.16
R55X - Syncope and collapse	3.80	3.46	4.06	B349 - Viral infection, unspecified	2.84	2.47	3.88
J22X - Unspecified acute lower respiratory infection	4.22	3.67	4.04	J22X - Unspecified acute lower respiratory infection	4.40	3.73	3.69
D570 - Sickle-cell anaemia with crisis	3.26	3.74	3.83	D570 - Sickle-cell anaemia with crisis	3.43	3.34	3.61
B349 - Viral infection, unspecified	2.81	3.37	3.51	J459 - Asthma, unspecified	3.14	2.89	3.36
R51X - Headache	3.69	3.62	3.25	R51X - Headache	3.51	3.21	3.05
J440 – COPD with acute lower respiratory infection	2.37	2.42	2.81	J440 - COPD with acute lower respiratory infection	3.47	3.12	2.98
R103 - Pain localized to other parts of lower abdomen	2.29	2.17	2.77	R103 - Pain localized to other parts of lower abdomen	2.22	2.15	2.94
R073 - Other chest pain	2.46	2.63	2.72	J189 - Pneumonia, unspecified	3.39	3.35	2.77
F100 - Mental and behavioural disorders due to use of alcohol	2.06	2.14	2.71	R073 - Other chest pain	2.38	2.97	2.62
J189 - Pneumonia, unspecified	2.76	2.88	2.45	J441 – COPD with acute exacerbation,unspecified	2.93	2.74	2.58
K590 - Constipation	2.32	2.18	2.40	L031 - Cellulitis of other parts of limb	2.62	2.31	2.54
J441 – COPD with acute exacerbation,unspecified	2.08	2.46	2.38	K590 - Constipation	2.48	1.93	2.29
L031 - Cellulitis of other parts of limb	2.04	2.69	2.36	I48X - Atrial fibrillation and flutter	2.14	2.11	2.00
R101 - Pain localized to upper abdomen	1.61	1.73	2.18	R101 - Pain localized to upper abdomen	1.63	1.36	1.92
I500 - Congestive heart failure	1.87	1.73	1.96	R060 - Dyspnoea	1.91	1.54	1.91
I48X - Atrial fibrillation and flutter	2.70	2.14	1.95	I500 - Congestive heart failure	1.67	1.79	1.89
R11X - Nausea and [illegible]	2.05	1.62	1.94	N12X - Tubulo-interstitial nephritis, not specified as acute or chronic	0.98	1.32	1.82

Figure 25. (Source: Local SUS data)

R060 - Dyspnoea	1.68	1.14	1.90	R11X - Nausea and vomiting	2.09	1.65	1.79
G409 - Epilepsy, unspecified	1.91	1.74	1.88	J039 - Acute tonsillitis, unspecified	1.30	1.43	1.68
R568 - Other and unspecified convulsions	1.84	1.58	1.87	R072 - Precordial pain	0.80	0.56	1.68

Figure 25. (Source: Local SUS data)

The above table illustrates a high degree of crossover between the ICD 10 codes accounting for the highest rate of emergency admissions in both boroughs. The most notable variation is the 2012/13 Lambeth admission rate of 2.71 per 1,000 population for mental and behavioural disorders due to use of alcohol, whereas in Southwark this is the 28th most common diagnosis, with an admission rate of 1.57 per 1,000 population.

For the purposes of analysis, a list based on individual ICD 10 codes gives little insight into patterns of admission by condition or category of condition. For example, pneumonia can be classified as lobar, unspecified, or categorised more precisely by causative organism. Grouping these ICD 10 codes gives the following emergency admission rates:

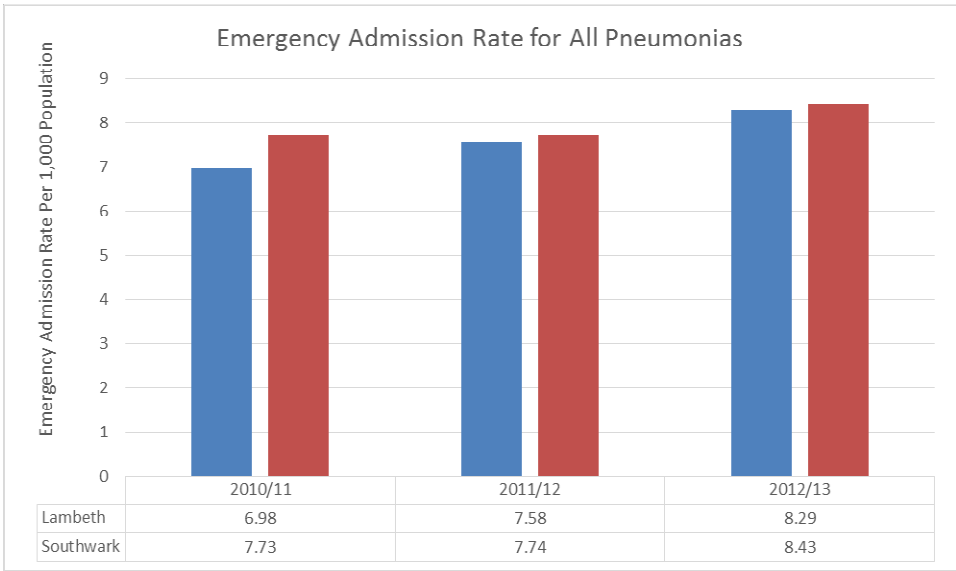


Figure 26. (Source: Local SUS data)

Figure 26 gives a greater insight into admission patterns for pneumonia. The admission rate per 1,000 has increased in both boroughs since 2010/11 but whereas Lambeth did have a lower admission rate than Southwark, it has increased by twice as much in the past 2 years (the emergency admission rate has increased by 9.1% in Southwark and 18.8% in Lambeth) so that Lambeth and Southwark now have very similar rates of admission.

This increase could be due to an increase in susceptible individuals in the community, an increase in the circulation of pneumonia-causing organisms over the past 2 years, or issues with managing patients with pneumonia in the community to avoid an emergency admission.

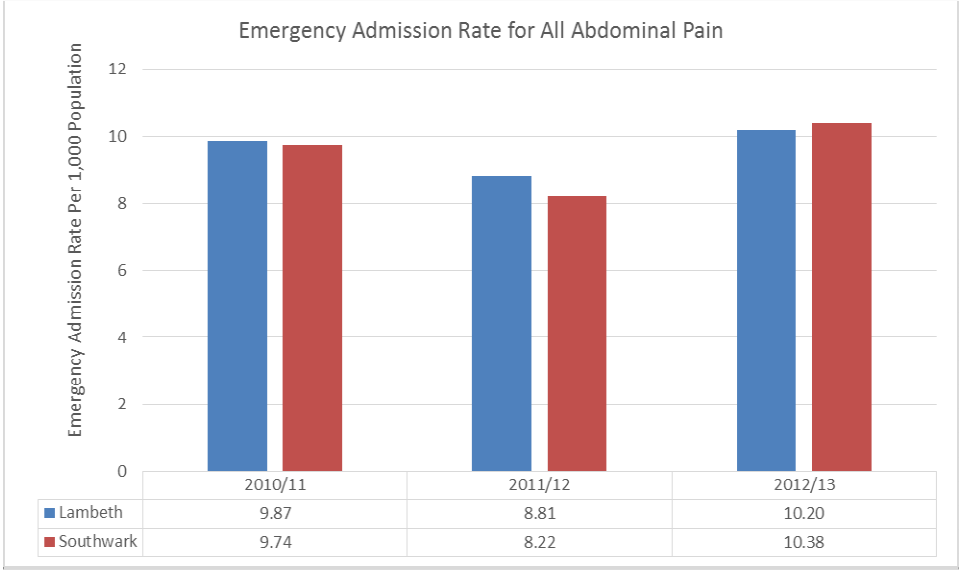


Figure 27. (Source: Local SUS data)

Combining ICD 10 codes for upper, lower and other abdominal pain gives a broader perspective on the emergency admission rate for abdominal pain. There was a downwards fluctuation in the admission rate in 2011/12, but overall emergency admissions have risen slightly (3.3% in Lambeth, 6.5% in Southwark) since 2010/11.

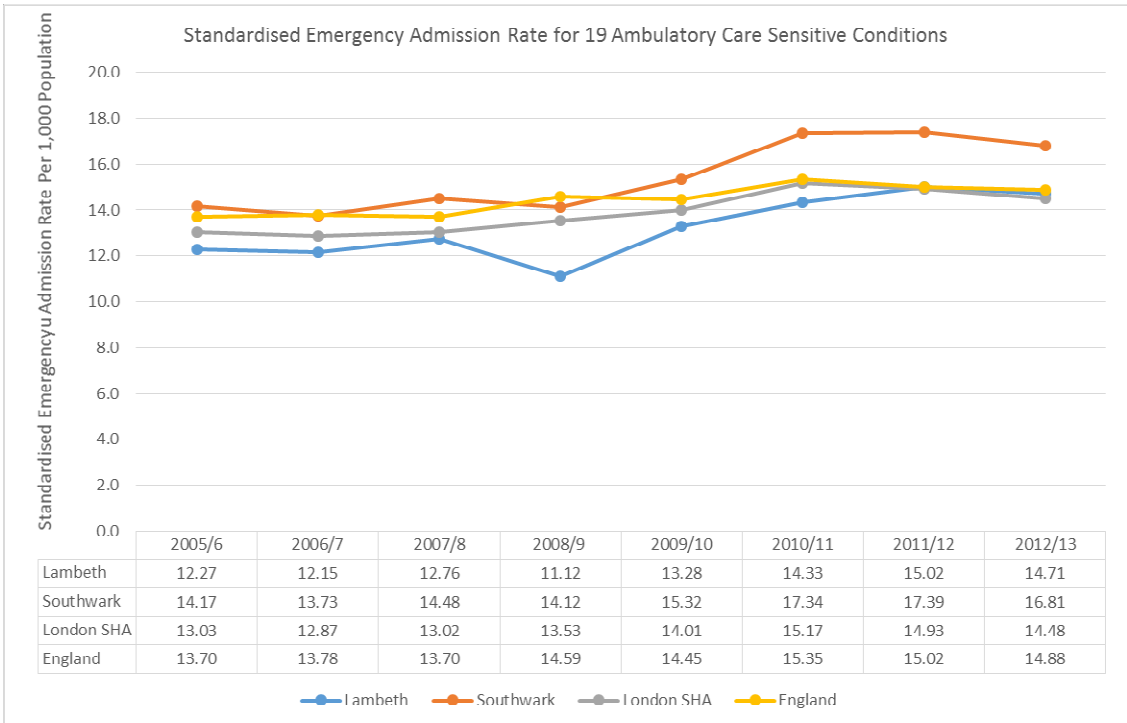
The same approach of grouping ICD 10 codes is used for diagnostic analysis through the rest of the paper.

10. Preventable Admissions

Ambulatory care sensitive conditions are defined as conditions where management in primary care or the community can prevent emergency admission. They are of particular interest since there is scope to reduce overall emergency admissions by targeting care at these conditions. As well as reducing pressures on acute care, this also has obvious benefits for individual patients who are supported to stay at home, and to avoid a stressful emergency admission.

NHS Comparators produces a 'Managing Emergency Care' metric, using a compound standardised admission rate for 19 ambulatory care sensitive conditions. It defines the 'Managing Variation in Emergency Admissions' comparator as: "The rate per 1000 practice population of emergency admissions for 19 conditions. These conditions have been identified as ones where community care can avoid the need for hospitalisation. The purpose of the comparator is to help monitor potentially avoidable emergency hospital admissions for certain acute illnesses that are amenable to management in a primary care setting." The conditions are:

- Vaccine-preventable: including Influenza and pneumonia
- Chronic: Diabetes complications; Nutritional deficiencies; Iron deficiency anaemia; Hypertension; Congestive heart failure; Angina; Chronic obstructive pulmonary disease; Asthma
- Acute: Dehydration and gastroenteritis; Convulsions and epilepsy; Ear, nose and throat infections; Dental conditions; Perforated/bleeding ulcer; Ruptured appendix; Pyelonephritis; Pelvic inflammatory disease; Cellulitis; Gangrene



	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Lambeth	12.27	12.15	12.76	11.12	13.28	14.33	15.02	14.71
Southwark	14.17	13.73	14.48	14.12	15.32	17.34	17.39	16.81
London SHA	13.03	12.87	13.02	13.53	14.01	15.17	14.93	14.48
England	13.70	13.78	13.70	14.59	14.45	15.35	15.02	14.88

Figure 28. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

The standardised emergency admission rate for the 19 ambulatory care conditions follows a similar pattern to the overall standardised emergency admission rate over the same period. There was a notable rise in all geographical areas in 2010/11, and a levelling off over the past 2 years. Southwark has had consistently higher standardised

admission rates for these conditions than Lambeth, London and England, although as for other NHS comparators categories this may raise questions about the standardisation methodology. If accurate, it would suggest that more Southwark patients with the 19 listed ambulatory care sensitive conditions are being admitted as emergencies, which could reflect issues with how their care is managed in the community.

11. COPD Admissions

COPD is of particularly interest because patients often have repeated emergency admissions, and it is viewed as an ambulatory care sensitive condition, meaning admissions can be prevented through care in the community. The admission rate is calculated based on prevalence estimates using the APHO COPD model which adjusts the number of patients on GP disease registers to include an estimate of the number of undetected individuals. This gives an estimate of 8,145 individuals in Lambeth (APHO modelling of 2011 figures) 9,029 in Southwark (using March 2013 figures). It is also possible that the 'undetected' patients are also less likely to present to A&E either due to milder illness or barriers to healthcare access. COPD admissions were defined as all occasions when COPD ICD-10 codes were listed as the primary diagnosis (as opposed to occasions when a patient with COPD was admitted with another problem, such as a fracture).

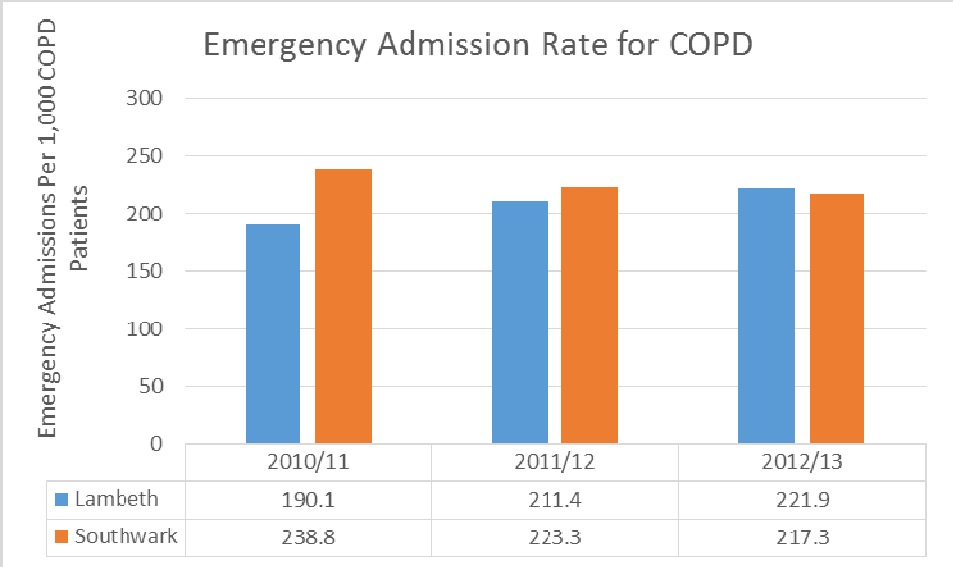
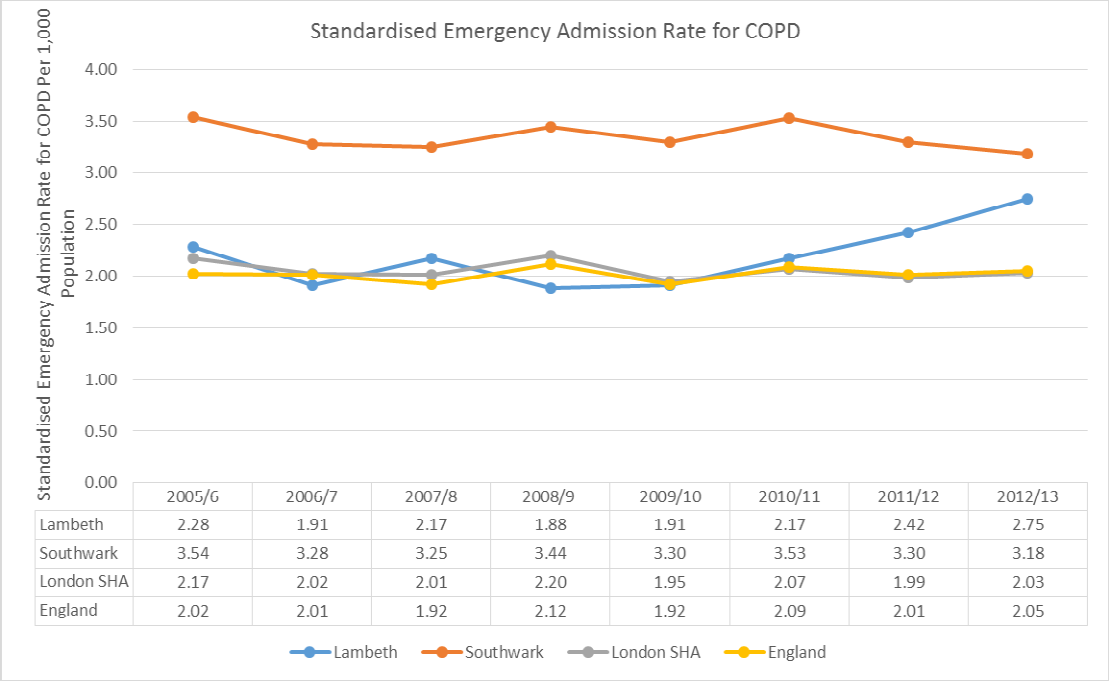


Figure 29. (Source: Local SUS Data and APHO COPD Model)

Lambeth and Southwark have broadly similar admission rates per 1,000 COPD patients, but whereas the admission rate has increased by 16.7% from a lower starting point in Lambeth since 2010/11, in Southwark it has fallen by 9.0%. The admission rate in the two boroughs has therefore become more similar over time. An increase in emergency admissions could reflect issues with primary care management, or access to ambulatory services to prevent such admissions. The differences could also be explained by normal variation, or the severity of illness of the patient group.



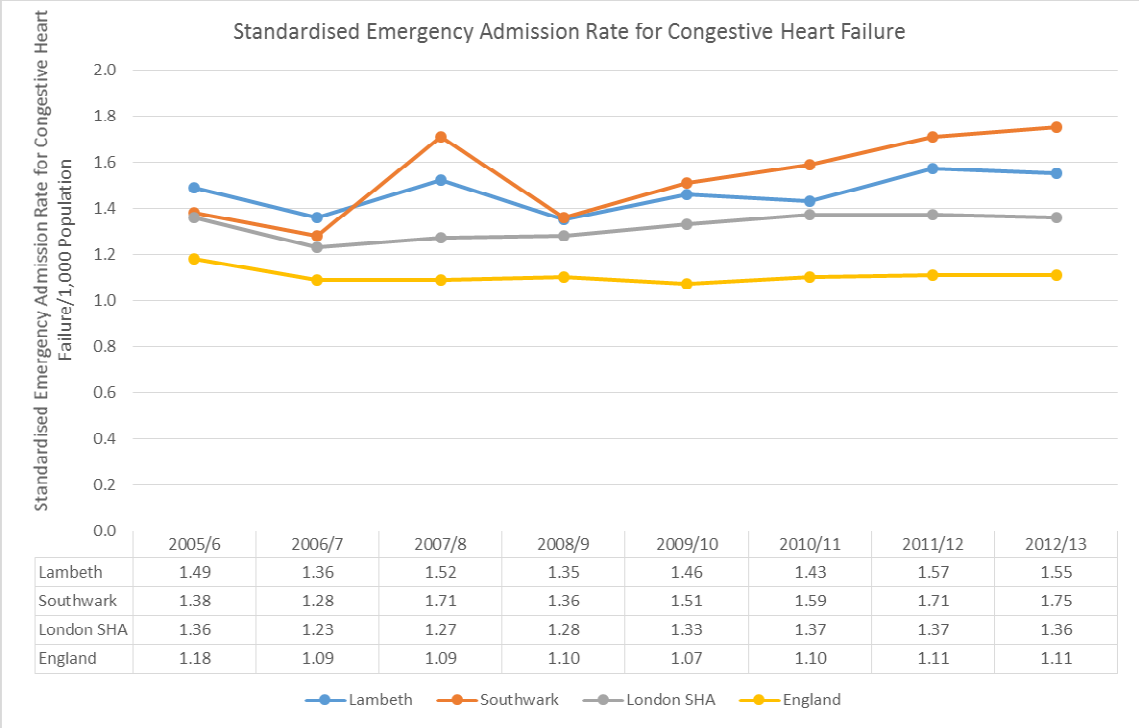
	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Lambeth	2.28	1.91	2.17	1.88	1.91	2.17	2.42	2.75
Southwark	3.54	3.28	3.25	3.44	3.30	3.53	3.30	3.18
London SHA	2.17	2.02	2.01	2.20	1.95	2.07	1.99	2.03
England	2.02	2.01	1.92	2.12	1.92	2.09	2.01	2.05

Figure 30. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

NHS Comparators have produced a standardised emergency admission rate for COPD per 1,000 population. In common with the local crude rates, the Lambeth standardised rate has increased since 2009/10, whereas the Southwark standardised rate has fallen, and London and England rates have remained broadly stable. This strengthens the case for examining differences between Lambeth and Southwark in terms of community management of COPD.

12. Congestive Heart Failure Admissions

Congestive heart failure is another ambulatory care sensitive condition, where community management can help control symptoms and prevent admissions.



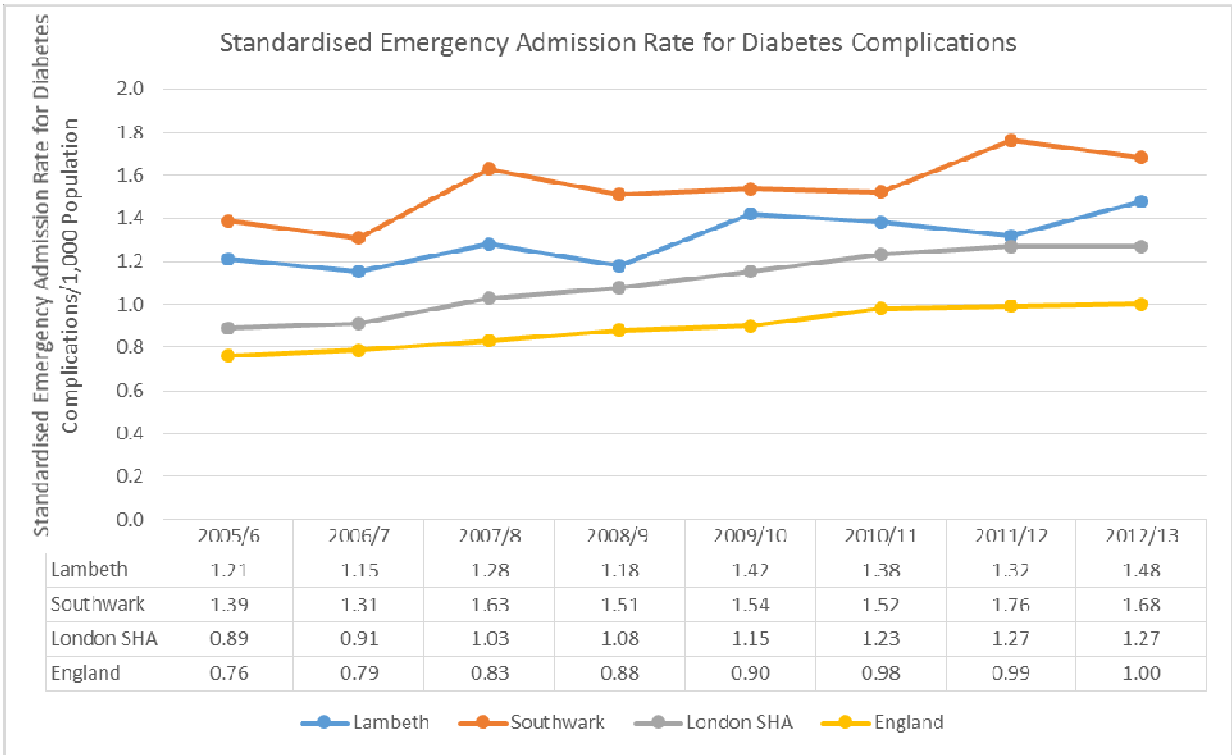
	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Lambeth	1.49	1.36	1.52	1.35	1.46	1.43	1.57	1.55
Southwark	1.38	1.28	1.71	1.36	1.51	1.59	1.71	1.75
London SHA	1.36	1.23	1.27	1.28	1.33	1.37	1.37	1.36
England	1.18	1.09	1.09	1.10	1.07	1.10	1.11	1.11

Figure 31. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

Figure 31 shows the NHS comparators standardised emergency admission rates for congestive heart failure. The England-wide rate has remained very stable, whereas Lambeth and Southwark have both shown greater fluctuations. Southwark shows a trend for increasing emergency admissions for congestive heart failure over time, with the standardised rate increasing from 1.36 per 1,000 population in 2008/9 to 1.75 per 1,000 population in 2012/13. Lambeth standardised emergency admission rates for congestive heart failure have risen slightly, but have been lower than Southwark since 2009/10. This could be due to variation in diagnosis rates, differences in community management, or variation in actual need.

13. Diabetes Admissions

A proportion of admissions for the complications of diabetes are also preventable through good management of blood glucose in the community, and prompt treatment of complications. Complications such as ulcers can also be managed at home with packages of nursing care to avoid admitting a patient to hospital.



	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Lambeth	1.21	1.15	1.28	1.18	1.42	1.38	1.32	1.48
Southwark	1.39	1.31	1.63	1.51	1.54	1.52	1.76	1.68
London SHA	0.89	0.91	1.03	1.08	1.15	1.23	1.27	1.27
England	0.76	0.79	0.83	0.88	0.90	0.98	0.99	1.00

Figure 32. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

NHS Comparators standardised emergency admission rates for complications of diabetes have risen steadily in all geographical areas. Both Southwark and Lambeth have had consistently higher rates than London and England. This could reflect differences in the population not allowed for in the standardisation algorithm, or issues with community management of diabetes in the boroughs.

14. Preventing Admissions Through Vaccination

Influenza:

Influenza is of interest as a potentially preventable condition, with the seasonal influenza vaccine programme aiming to protect the patients most at risk of serious complications. Local GPs had also commented that they felt that they were still seeing patients later than in previous influenza seasons.

Influenza-Like Illness, Current and Recent Seasons

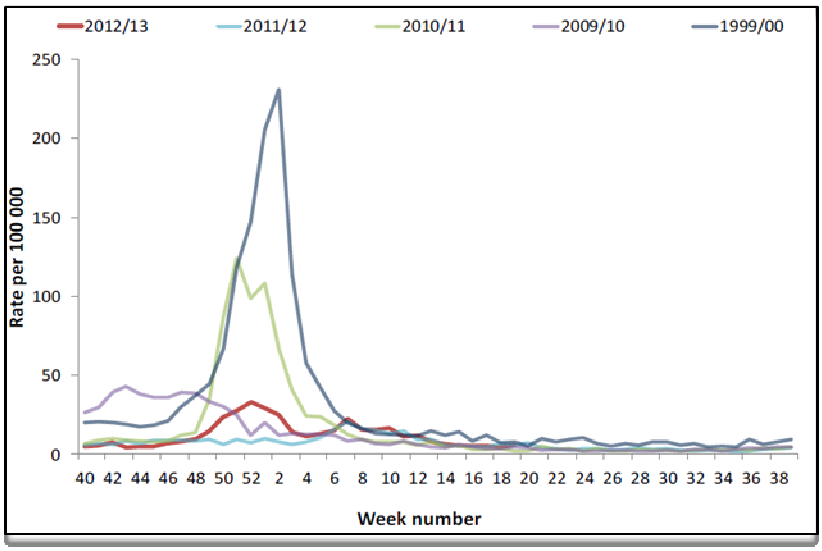


Figure 33. (Source: HPA – RCGP Sentinel GP System)

Figure 33 illustrates the national picture for influenza this year. It is based on a sentinel system of GPs who report all cases of influenza-like illness. These figures are then extrapolated out nationally to give a case rate per 100,000. The graph shows that whilst there were more cases nationally in 2012/13 than in 2011/12, levels were in line with recent non-pandemic years, although the season may have taken longer to tail off than usual in line with local observations.

Influenza emergency admissions to hospital are defined below using the primary or secondary diagnosis ICD 10 codes J10 (where the virus has been identified) and J11 (where it was not). Avian influenza was excluded.

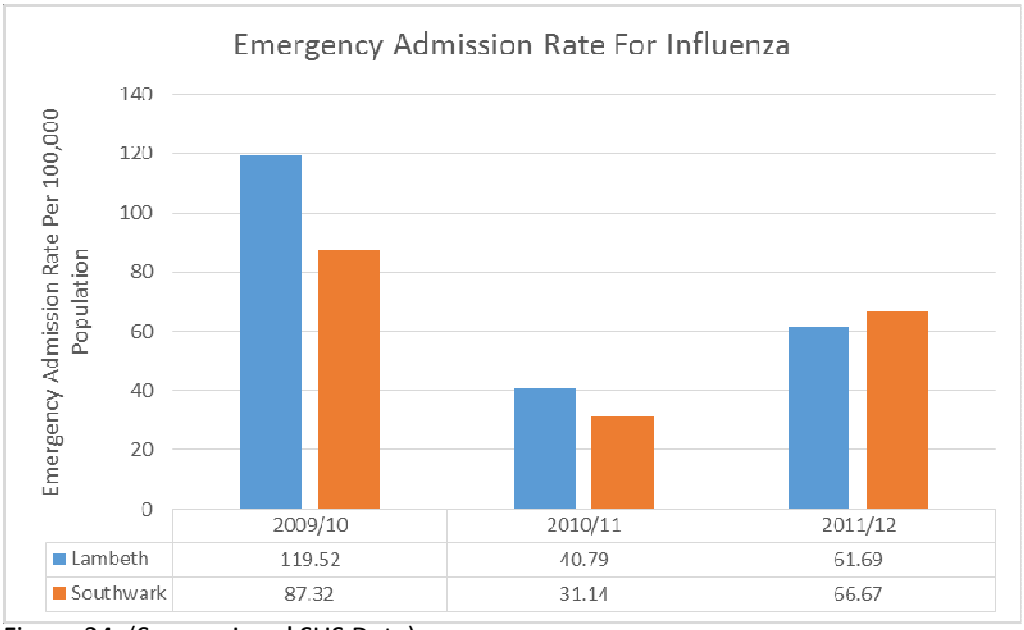


Figure 34. (Source: Local SUS Data)

The number of admissions with influenza listed as the diagnosis is small for all years, and this makes interpretation difficult. The emergency admission rate per 100,000 population was very similar in Lambeth and Southwark in 2012/13, and although higher than in 2010/11 was well below the admission rate during the 2009/10 pandemic. Influenza vaccination can prevent cases in the elderly and vulnerable, who would be the most likely groups to require admission during an episode of influenza.

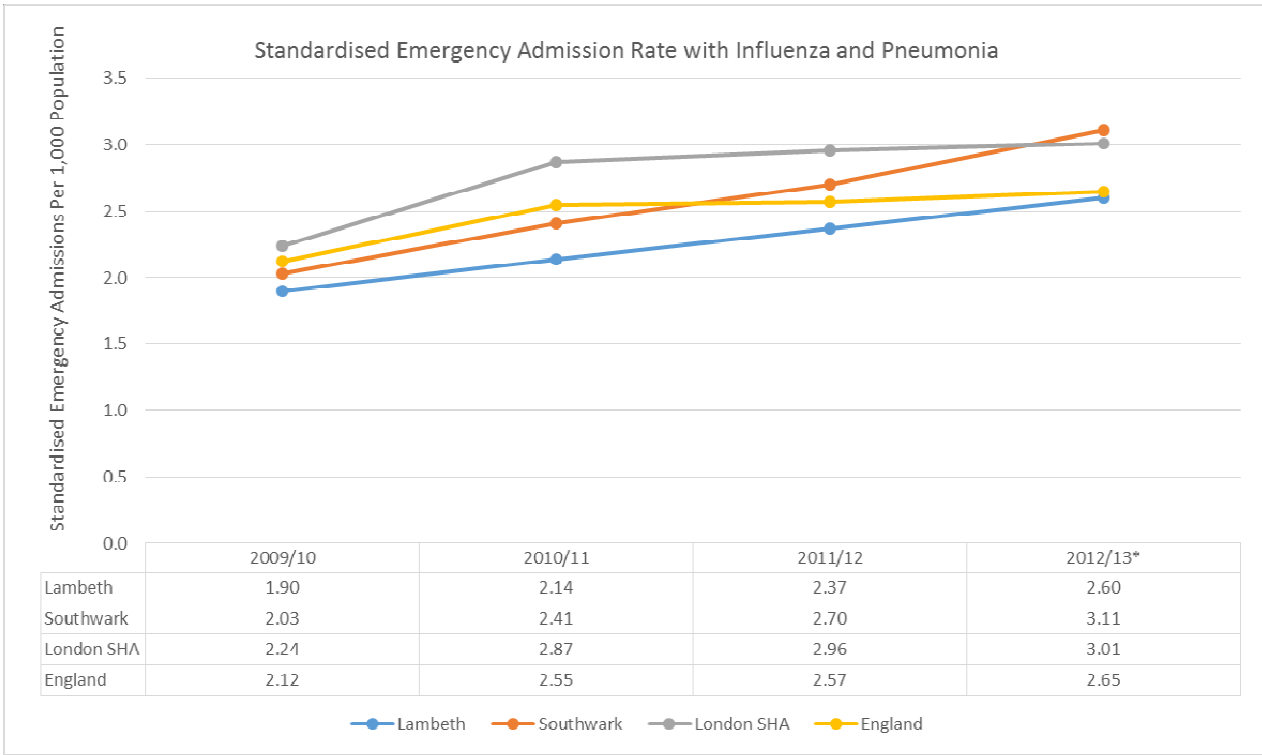
Seasonal Influenza Vaccine Uptake 2011/12-2012/13

Group	Lambeth		Southwark	
	2011/12	2012/13*	2011/12	2012/13*
Over 65s (target 75%)	68.9%	66.5% (-2.4%)	71.9%	70.4% (-1.5%)
Under 65s in at-risk groups (target 70%)	48.6%	47.1% (-1.5%)	47.5%	49.0% (+1.5%)

Figure 35. (Source: South-East London Health Protection Unit) * 2013 data is provisional and to end January only

Vaccine uptake rates have dropped slightly in all groups apart from the at-risk under 65s in Southwark. This is in keeping with an England-wide picture of slightly lower uptake rates in 2012/13. The target for 2013/14 is 75% for both groups, and there is clearly significant work required to bring local figures closer to that figure, particularly amongst younger vulnerable groups. As an infectious disease, influenza rates are expected to vary from year to year, and the variation illustrated in fig.31 is more likely to reflect seasonal variation than variation in flu vaccine uptake.

Influenza and Pneumonia:



	2009/10	2010/11	2011/12	2012/13*
Lambeth	1.90	2.14	2.37	2.60
Southwark	2.03	2.41	2.70	3.11
London SHA	2.24	2.87	2.96	3.01
England	2.12	2.55	2.57	2.65

Figure 36. (Source: NHS Comparators * 2012/13 figures are preliminary rolling year figures based only on Q1/2 data)

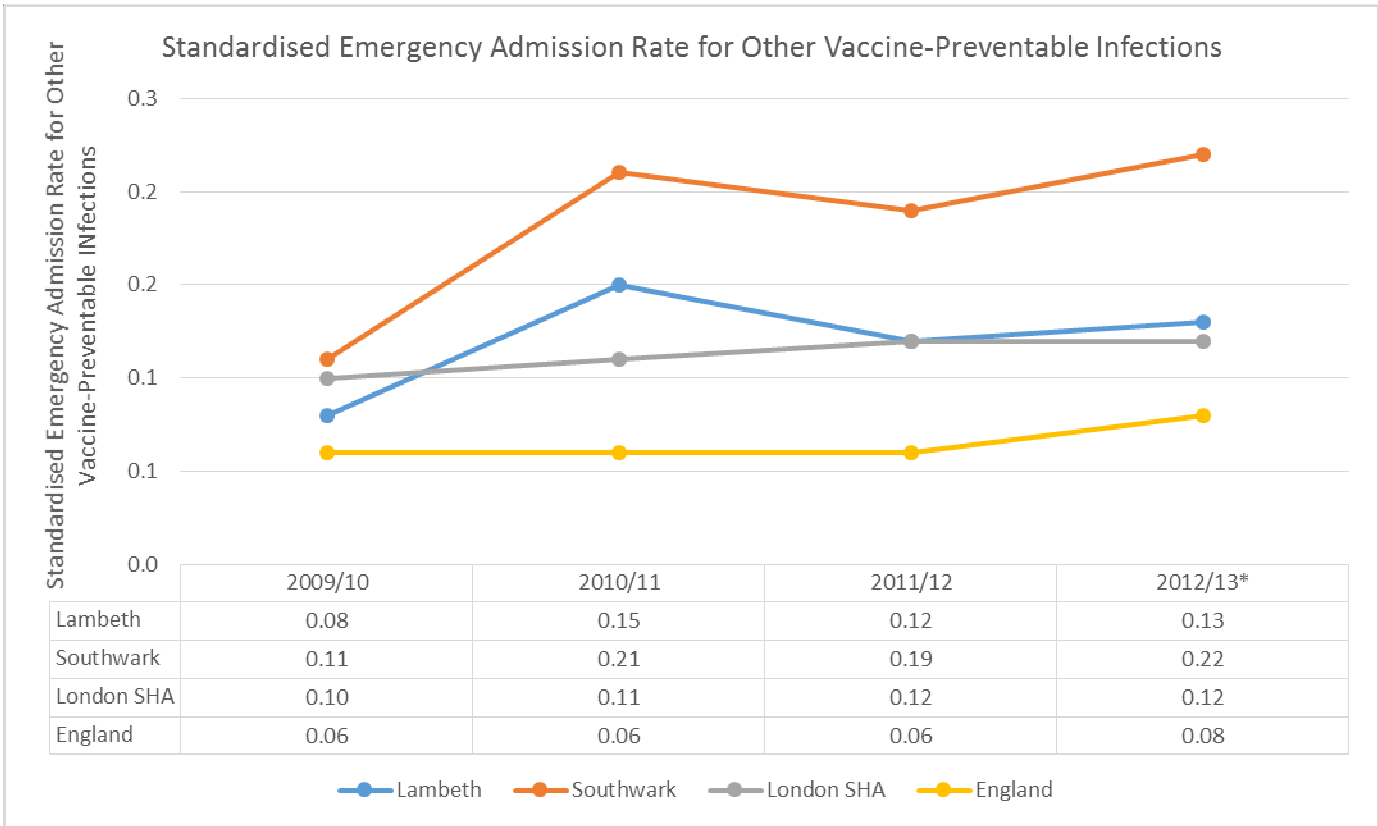
Figure 36 combines emergency admissions for both influenza and pneumonia in individuals aged over 2 months. The 2012/13 figures need to be viewed with particular caution as they are only based on Q1/2, therefore not capturing the peak influenza/pneumonia season. The emergency admission rate is based on admissions with the following ICD 10 codes:

J10	Influenza due to identified influenza virus	J11	Influenza, virus not identified
J13	Pneumonia due to Streptococcus pneumonia	J14	Pneumonia due to Haemophilus influenzae
J15.3	Pneumonia due to streptococcus, group B	J15.4	Pneumonia due to other streptococci
J15.7	Pneumonia due to Mycoplasma pneumonia	J15.9	Bacterial pneumonia, unspecified
J16.8	Pneumonia due to other specified infectious organisms	J18.1	Lobar pneumonia, unspecified
J18.8	Other pneumonia, organism unspecified		

It is not possible to tell from this data what proportion of emergency admissions for vaccine-preventable influenzas or pneumonias were individuals who would have been eligible for such vaccines. In addition, not all pneumonias and

strains of influenza are protected for by vaccine. It is therefore not a performance indicator for vaccine programmes, but does provide an insight into the relative burden experienced by Lambeth and Southwark compared to London and England.

Lambeth has had a lower standardised rate of emergency admission for influenza and pneumonia than London and England-wide since 2009/10. The Southwark standardised rate was broadly in line with the England-wide figure (and lower than London overall) until this year when the rate seems to have increased. However, since this figure is a rolling rate based on Q1/2 it may be misleading.



	2009/10	2010/11	2011/12	2012/13*
Lambeth	0.08	0.15	0.12	0.13
Southwark	0.11	0.21	0.19	0.22
London SHA	0.10	0.11	0.12	0.12
England	0.06	0.06	0.06	0.08

Figure 37. (Source: Local SUS Data)

The NHS comparator for other vaccine preventable conditions is based on emergency admissions with the following ICD 10 diagnosis codes:

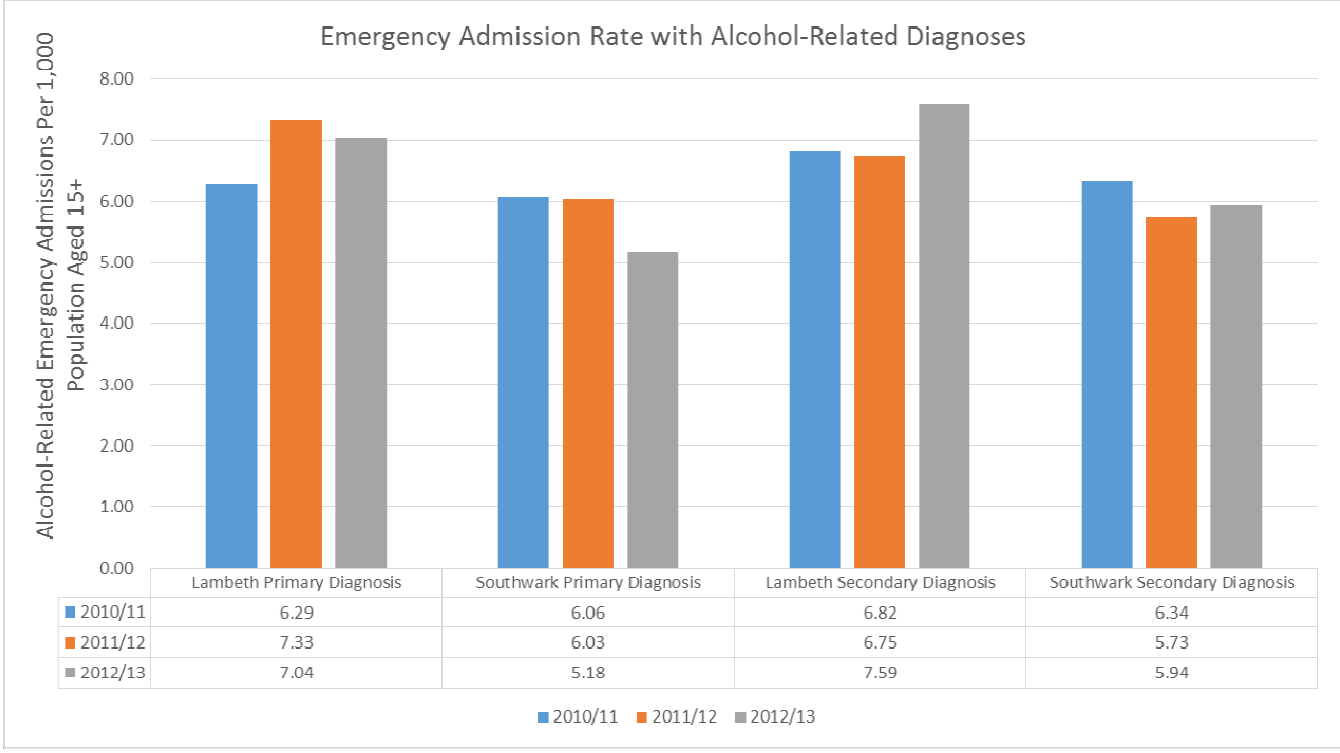
A35	Other tetanus
A37	Whooping cough
B05	Measles
B16.1	Acute hep B with delta-agent (co-infection) without hep coma
B16.9	Acute hep B without delta-agent and without hep coma
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent
A36	Diphtheria
A80	Acute poliomyelitis
B06	Rubella [German measles]
B26	Mumps
M01.4	Rubella arthritis
G00.0	Haemophilus meningitis

It is not possible to distinguish from the data whether an individual had received vaccination, or whether they were eligible for such vaccination. London has particular issues with vaccine-preventable diseases. It has a more transient population than the rest of the country, making it difficult to identify and vaccinate individuals. It also has a high proportion of individuals born outside the UK, or with family in countries where such diseases are endemic. The above graph illustrates this, but also seems to indicate that Southwark has a notably higher standardised emergency admission rate than Lambeth. Since the majority of NHS comparators indicate higher standardised rates for Southwark this should be treated with caution as a possible consequence of flawed standardisation.

15. Alcohol Misuse

The burden on A&E departments due to alcohol-related problems has been well-publicised over the past decade. There have been national and local initiatives to try and address levels of harmful drinking such as controlling the density of outlets, but there have also been local efforts to cope with the consequences of that drinking. Examples include units which supervise intoxicated patients until they are safe to go home, hopefully avoiding an admission.

Alcohol-related admissions in the below figure are defined as all primary or secondary diagnoses with ICD-10 codes related to alcohol. This includes both the short and long-term consequences of drinking, ranging from intoxication to dependence to liver disease, and a range of other complications where the known cause is alcohol. The rate is based on the estimated 15 and over population. Primary diagnoses are when the patient has been admitted for their alcohol-related problem, secondary diagnoses are where a patient has been admitted for another reason but complicated by their alcohol-related problem.



	Lambeth Primary Diagnosis	Southwark Primary Diagnosis	Lambeth Secondary Diagnosis	Southwark Secondary Diagnosis
2010/11	6.29	6.06	6.82	6.34
2011/12	7.33	6.03	6.75	5.73
2012/13	7.04	5.18	7.59	5.94

Figure 38. (Source: Local SUS Data)

The Lambeth emergency admission rate (per 1,000 population aged 15+) with an alcohol-related primary diagnosis increased by 11.90% between 2010/11 and 2012/13, whereas in Southwark it fell by 14.62%. The same pattern is evident in the emergency admission rate where the secondary diagnosis is alcohol-related: in Lambeth the emergency admission rate per 1,000 population aged 15 + increased by 11.30% between 2010/11 and 2012/13 whereas in Southwark it fell by 6.25%. This increase means that in 2012/13 Lambeth had approximately 2 more admissions per 1,000 population aged 15 and over for both primary and secondary diagnoses related to alcohol. Even if the two categories are combined, the trend is the same. Since the majority of emergency admissions for Lambeth and Southwark residents are to the same 2 hospitals, and in similar proportions, this is unlikely to be due to differences in coding between the populations.

It could be due to differences in the actual levels of alcohol-related harm in the two boroughs, differences in ascertainment of cases of alcohol misuse, differences in the community support available for these individuals, or differences in how people seek help when unwell.

16. Substance Misuse

Local concern had been expressed that an increasing number of patients presenting to A&E had concomitant substance misuse diagnoses, complicating their care and increasing 'acuity'. Patients with substance misuse issues can require greater supervision, and whilst in hospital their withdrawal from the substance has to be carefully managed. In the below graph, substance misuse-related diagnoses include all admissions under the influence of a substance of misuse (excluding alcohol) or due to complications from substance misuse. The term includes misuse of substances such as opioids, cocaine and cannabis. Admissions are classified according to whether the substance misuse was the main reason for the admission (primary diagnosis) or a co-morbidity (secondary diagnosis).

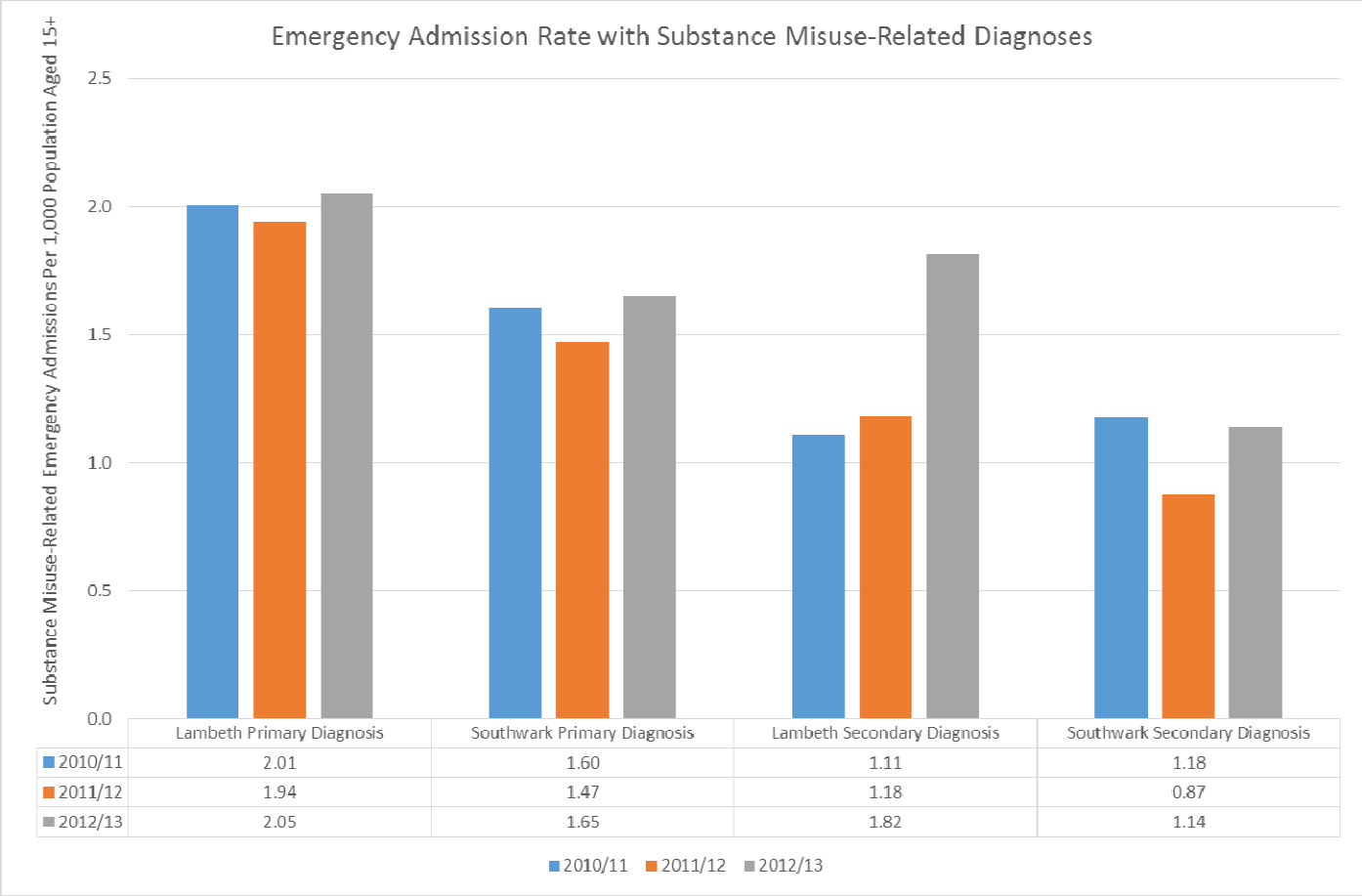


Figure 39. (Source: Local SUS Data)

Rates of admission for substance misuse are higher in Lambeth than in Southwark for both categories. This could be due to demographic differences between the boroughs. The admission rate had remained broadly stable between 2010/11 and 2012/13. The most striking shift is in the Lambeth rate of emergency admissions where substance misuse was noted as a secondary diagnosis: this increased by 64% between 2010/11 and 2012/13, with the majority of that increase occurring in the past year. This could reflect an actual increase or could be due to increased awareness leading to better recognition of substance misuse as a co-morbidity.

17. Mental Health Co-Morbidity

There has been national concern about the ability of hospitals to cope with mental health co-morbidities. Primary diagnosis was not examined in this case as full data for mental health emergency admissions across the system was not available. In the graph below, mental health ICD 10 codes as the secondary diagnosis were compared, hopefully capturing the level of mental health co-morbidity seen in Lambeth and Southwark emergency admissions. Alcohol and substance misuse diagnoses were excluded as these have been explored above.

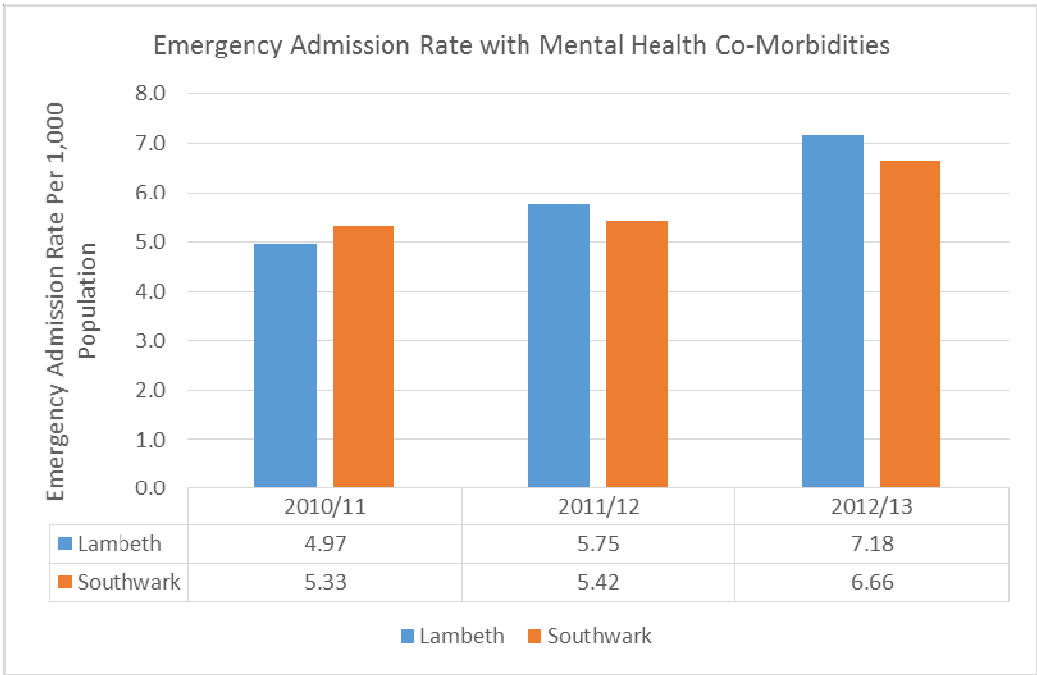


Figure 40. (Source: Local SUS Data)

Figure 40 illustrates that there has indeed been an increase in the rate of emergency admissions with mental health co-morbidities. This is particularly the case in Lambeth, where there has been a 44.5% increase in admissions with mental health co-morbidities since 2010/11. In Southwark the corresponding increase is a less marked 25.0%, but again shows an increasing trend across all 3 years. This could be due to an actual increase in the rate of mental health co-morbidity, increased emergency presentations by patients with mental health conditions perhaps due to difficulty accessing primary and community care, or could in fact represent a change in coding practice. Secondary diagnoses are particularly vulnerable to shifts in coding, for example better recording of mental health co-morbidities due to increased staff awareness of the issue. A mental health secondary diagnosis could be a co-morbidity for a primary mental health diagnosis, so that increases could reflect more patients presenting as emergencies with their mental health conditions to A&E rather than being managed in the community, or being admitted to alternative providers.

This data was broken down further into the main categories contributing to mental health co-morbidity in emergency admissions in both Lambeth and Southwark.

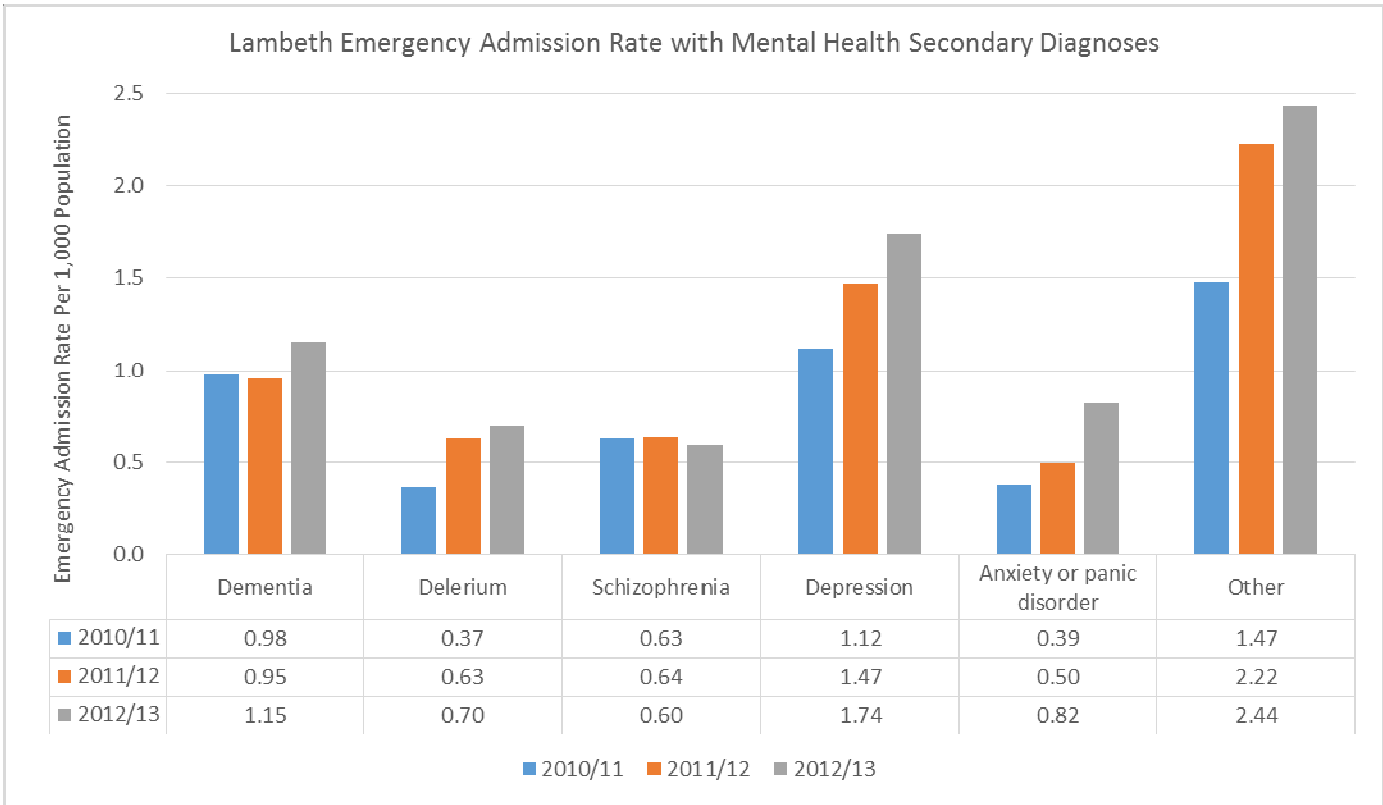


Figure 41. (Source: Local SUS Data)

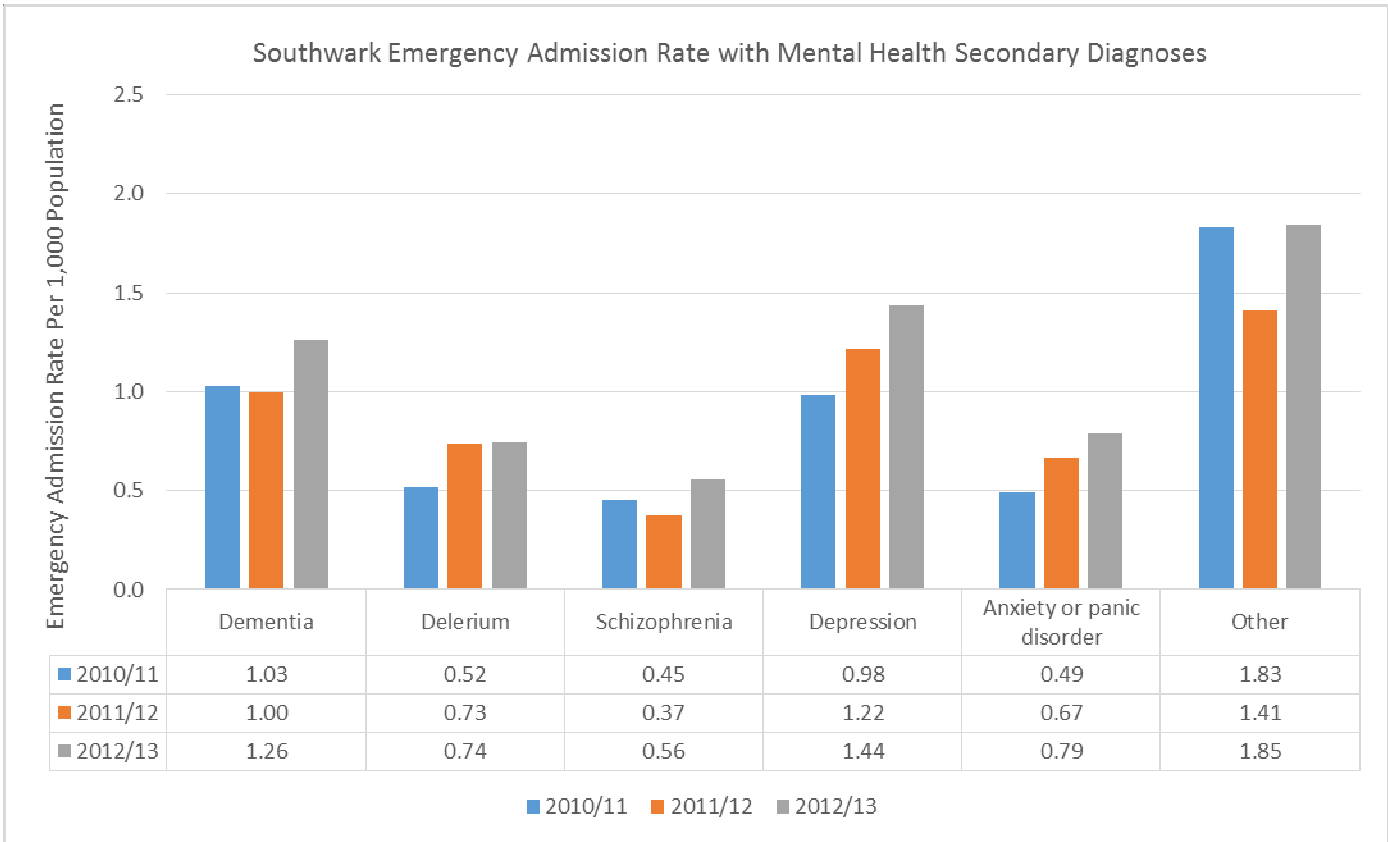


Figure 42. (Source: Local SUS Data)

The mental health diagnoses most commonly listed as a secondary diagnosis are similar across the two boroughs, although Lambeth has had an increasing proportion of 'other' diagnoses which include bipolar affective disorder, eating disorders and developmental and learning difficulties. All the common co-morbidities have seen significantly increased rates of emergency admission since 2010/11 except for schizophrenia in Lambeth.

The ageing population has led to particular concerns about the proportion of elderly patients who will require dementia care during admissions for other illnesses of old age. The emergency admission rate with dementia as a co-morbidity has increased since 2010/11, but not actually as sharply as some other diagnoses. The increase has been 17.3% in Lambeth and 22.3% in Southwark. As previously discussed, the elderly population in Lambeth and Southwark is not growing to the same degree as the national picture, but if this trend for increased dementia co-morbidity continues hospitals will need to develop increased capacity to cope with patients with dementia.

Although the actual numbers involved are lower, there is a marked increase in the rate of emergency admissions with an anxiety or panic disorder as a co-morbidity. The emergency admission rate per 1,000 population has increased by 110.3% in Lambeth and 61.2% in Southwark. This may have less repercussions in terms of care needs for a hospital, but could reflect difficulties in accessing timely primary care amongst this group. Again, this could be a coding issue due to increased awareness, diagnosis or recording of anxiety disorders.

Delerium can be part of the natural history of a mental disorder such as dementia, or can complicate a physical illness such as sepsis. The significance for hospitals is that patients with delirium may require significant supervision by staff, and managing the delirium is a significant management challenge in itself. The emergency admission rate with delirium as a secondary diagnosis has increased by 89.2% in Lambeth since 2010/11 and by 42.3% in Southwark over the same period. Elderly patients are more susceptible to delirium during physical illness, and this could be one cause for the increase, but it could also be a change in coding practices.
There are similar, although less marked increases in emergency admission rates with depression as a co-morbidity.

18. Preliminary Conclusions

The recent King's Fund report "Urgent and Emergency Care: A Review for NHS South of England (March 2013)" noted that "the data do not explain the problem". This is despite the numerous analyses undertaken annually within health economies across the country. Shifts in demand and in the pressures on A&E departments have multifactorial causes, and it is hard to identify such complexities without consistent collection of the *right* data across the whole system. It is also difficult to tease out the influence of changes in coding and tariffs.
This report has identified a number of features of local urgent care usage in Lambeth and Southwark:

- Whilst crude A&E attendance numbers and emergency admissions have risen slightly over the past 3 years, the rate per 1,000 population for attendance and admission has levelled out.
- Within this picture of stability, there has been an increase in the rate of attendance and admission amongst patients aged 65-84, whilst these rates have fallen amongst younger groups.
- The greater proportion of older patients being seen in A&E and urgent care may be one explanation for the increased 'acuity' experienced by clinicians since they are more likely to present with co-morbidities.
- The proportion of long stays amongst older patients has not increased however, which is not in keeping with the idea of increased severity of illness, although it may be explained by reductions in delayed discharges.
- There has been an increase in the proportion of short (1-2 day) admissions in both Lambeth and Southwark, and a decrease in the proportion of long admissions. Possible explanations include a lower number of delayed discharges, or changes in admission or coding practice.
- The pattern of attendances and admissions amongst children is more variable, but there is some indication that rates per 1,000 population are falling.
- Monthly analysis of the attendances and admissions amongst older people indicate that there is limited seasonality to demand, and that in fact recent periods of high attendance have been in the summer months.
- There has been an increase in the alcohol-related admission rate in Lambeth since 2010/11, whereas it has fallen in Southwark over the same period.
- Substance misuse-related emergency admissions have remained broadly stable since 2010/11.
- Mental health co-morbidity amongst emergency admissions has increased since 2010/11.

Item No.	Classification: Open	Date: 27th January 2014	Meeting Name: Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Report title:		Access to Health Services in Southwark – call for evidence - submission from Director of Adult Care	
Ward(s) or groups affected:		All	
From:		Sarah McClinton, Director of Adult Care, Children's and Adults Department	

RECOMMENDATION(S)

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

BACKGROUND INFORMATION

2. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee is undertaking a review on the subject of Access to Health Services. This is covering issues around out of hours services (especially the 111 service), GP access, implications of the TSA and KHP merger, and understanding the reasons for increased pressures on A&E over winter and how this may be reduced where appropriate.

3. The Director of Adult Care has been invited to provide evidence for the review with a focus on the pressure on A&E arising from the following groups that have been identified as key sources of pressure:

   - older people with high needs
   - people with mental health problems

4. This report sets out the issues from an adult care perspective, with a focus on how social care plays a role in preventing avoidable A&E attendance, and assists in reducing pressure on the overall urgent care system by assisting discharge from hospital.

FACTORS FOR CONSIDERATION

Social Services Users at risk of A&E admission

5. People who are eligible for adult social care services have substantial social care needs, and also frequently have health problems such as long term conditions, dementia or mental health issues and/or may be highly frail older people. Risk of hospital admission is a key factor in assessing eligibility for social care, and services are put in place to minimise the risk. As such social care users are a population at high risk of needing to use urgent care services, including A&E.

This is particularly so in the winter when there are additional risk factors associated with the cold, and the prevalence of viral infections.

6. Our experience of demand pressure confirms that with the ageing population there are increasingly high levels of need, in particular arising from people with dementia. With a 38.5% increase in the over 90's age group forecast between 2014 and 2020 in Southwark this pressure will continue to grow. Dementia is now a key factor in most care home admissions for older people.

Increases in A&E attendances by Southwark residents at Kings

7. Data provided by the CCG indicates that whilst there was an overall increase in A&E attendances of 6% at Kings between Quarter 3 (i.e. Oct-Dec) 2012/13 and 2013/14, there was actually a reduction of 6% in the numbers of Southwark residents attending A&E over the same period. This is important context, and is encouraging insofar as it indicates that the system wide efforts to prevent avoidable A&E attendances are having an impact in Southwark. There is a similar picture with regards to emergency admissions to hospital which have decreased 4% over the same period.

8. It is also important to note that for the Southwark Mental Health Liaison Team, which supports people presenting at Kings A&E with mental health problems, only 37% of the cases are Southwark residents (December 2013).

Social Services objectives and A&E demand reduction – integrated approach

9. A key objective of all our social services is to provide support that prevents, delays or avoids the need for people to access more intensive health and care services including A&E, by helping people to live safely and independently in the community. Also, when people are admitted to hospital our services have a key role in supporting the hospital discharge process and providing appropriate community support such as intermediate care and reablement to reduce the risk of re-admission through attendance at A&E or other routes.

10. To work effectively with people with health and social care needs at risk of hospital admission we recognise that integrated working with health and other agencies (including housing) is essential, hence the integration agenda we have with health, including through Southwark and Lambeth Integrated Care and through integrated community mental health teams with SLAM. This is particularly so given the reduction in resources available to health and social services, which means services need to be targeted and well co-ordinated.

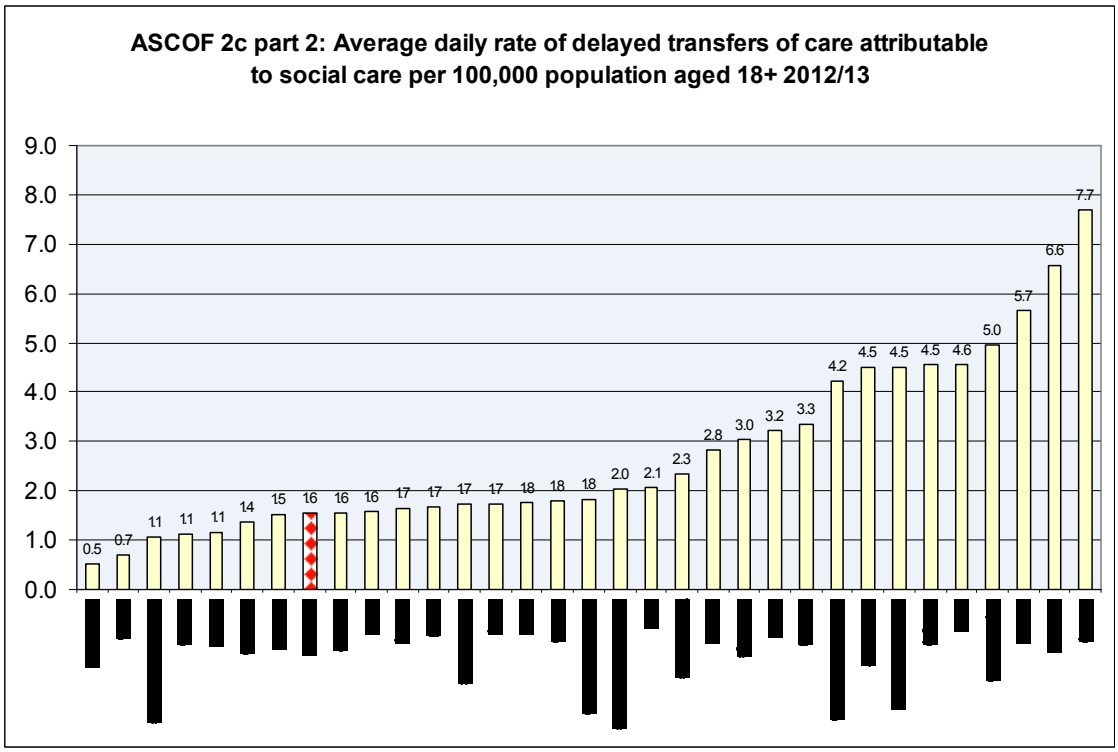
11. For older people identified as at risk of admission we take a multi-disciplinary team approach with a single lead professional co-ordinating support from different agencies that should help prevent avoidable admissions through A&E. This priority is recognised nationally and will be taken forward in 2014/15 onwards through the Better Care Fund which necessitates pooled funding and joint working in areas that will reduce pressure on health and care services, in particular non-elective care. This approach will build upon the existing arrangements where services are part funded by NHS funding transfers specifically to reduce pressure on health (e.g. re-ablement, discharges services, intermediate care).

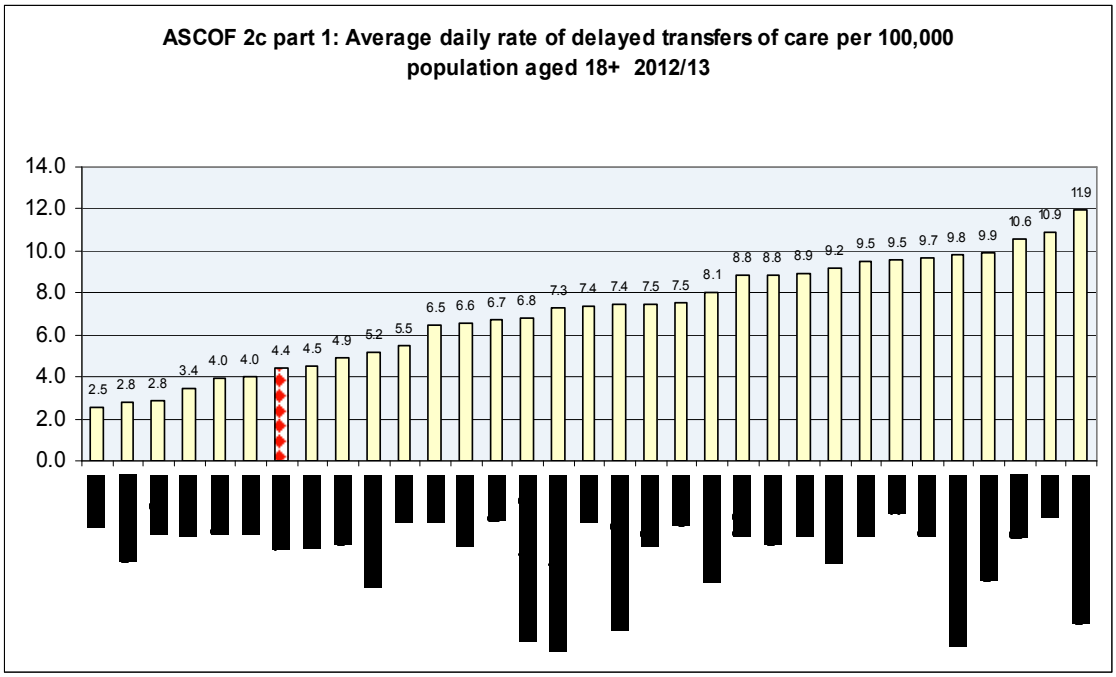
12. Health services lead on the overall admissions avoidance plan, and social care contributes where appropriate through the multi-disciplinary team approach. This includes the provision of the "Night Owls" enhanced homecare service operating between 10.00pm and 7.00am providing higher levels of care that reduce deterioration and avoid re-admission. The enhanced rapid response team and home ward services have enhanced social work input. Southwark social services are active members of the Urgent Care Board which leads on the development of health plans that cover A&E pressures.

13. Re-ablement is a key area that has been expanded in line with our strategy, with 1,400 people benefitting from short term services that restore people's independence after a period of disablement in 2012/13. Recent figures show that around 85% of people discharged from hospital into a re-ablement service were found to be still at home, without a hospital re-admission, 3 months later.

Minimising Delayed Transfers of Care

14. A key measure of the success of local systems in facilitating smooth hospital discharge is the national Delayed Transfers of Care (Adult Social Care Outcome Framework measure). This differentiates between all delayed transfers of care and those delays attributable to social care. On both measures Southwark is a strong performer, in the top quartile as the charts below show. This is a key measure that impacts on A&E because it reduces the risk of there being a shortage of acute beds in which to admit people from A&E, and so reduces the risk of lengthy waits in A&E which in turn block up the A&E system for new arrivals.





Further relevant issues re social care and reducing A&E pressure

- Southwark operates a 24 hour 7 day social care service. The emergency duty team system operates out of hours, reducing risk of avoidable A&E attendance or admission by people requiring social care support.

- The Carers Strategy will enhance the focus on supporting people in looking after the people they care for. The breakdown of informal care arrangements is frequently a factor in A&E attendance.

- Telecare is a resource that can help people live independently at home, for example sensors that detect wandering by people with dementia. Around 3,000 people benefit from alarm systems that can connect them to family or sheltered housing support services rather than escalating this to emergency services.

- As set out previously to the committee in our report on Care Home quality (My Home Life), homes are supported to manage the health of residents in a way that reduces unnecessary ambulance call outs, which place a particular pressure on the A&E system. Quality home care provision is a vital resource for keeping people safe and well, and subject to similar quality improvement initiatives.

- People who are not eligible for a full social care package can still benefit from contacting services in other ways. For example, our information line provides advice on how to access a range of appropriate universally accessible services, including health services and our council funded community support services which provide advice and support including to services such as befriending support for people who are suffering due to social isolation.

- Occupational Therapy Services and Community Equipment Services work specifically with people to reduce the risk of household accidents in older people, making a key contribution to the falls prevention strategy.

- For people requiring dementia care, day services provide a range of support, and through the proposed centre of excellence in Peckham due to open in 2015 we wish to further develop and improve this offer, reducing the risk of hospital attendance.

- Social Services play an active role in promoting the flu immunisation programme, in particular for front line staff.

- Southwark Council also promotes the winter "Keep Warm" campaigns.

Focus 1: Hospital Social Work Teams

At an operational level, work undertaken by the Hospital Discharge Teams to maintain patient flow through the hospital includes;

- Close partnership working with the ward Multidisciplinary teams and discharge coordinators to facilitate safe and timely discharges for patients.

- Close linking with Kings A&E social worker for early identification of most complex patients being admitted to the hospital.

- Southwark have recently implemented a new operating system in which all cases which are referred from the wards are allocated on the same day with the aim of providing a more proactive response to assessment.

- Priority and integrated referral to the Re-ablement and Intermediate Care teams for hospital inpatients.

- Implementation of a new care package restart pathway which accelerates discharge for patients who do not require a change in existing services to go home Wards are able to restart care packages directly with our brokerage services rather than having to complete the existing 3 day referral process via the social work teams.

This has contributed to the strong performance referred to above.

Focus 2: Mental Health Services

Features of our mental services relevant to preventing and responding to A&E attendance are set out below:

- Mental health services in Southwark are provided by integrated health and social care teams – under the auspices of SLaM. Integration enables there to be a seamless service between health and social care that uses an MDT approach (multi-disciplinary team approach – social workers, nurses, OT's, Doctors, psychologists, therapists etc) that is holistic and enables teams to support all health and social care needs under one service (holistic assessments and care plans – which are recovery orientated with good crisis

and contingency plans). These teams also "in-reach" on to wards to enable earlier discharges. Over the past year in particular rates of delayed transfers from mental health setting have reduced and are now significantly below many neighbouring boroughs.

- HTT (Home Treatment Teams) provide 24/7 care to service users in a crisis in their own homes rather than them having to either be admitted to hospital or attend A&E. The teams are multi-disciplinary and provide a range of treatments and care to enable residents to stay in their own homes when unwell. They also provide 'early intervention' to enable residents to leave wards earlier (earlier discharge) with daily support from the HTT.

- HTT accept out of hours referrals from GP's – rather than GP's having to refer residents to A&E

- Peer support is also provided for people in leaving HTT and / or in the community. A randomised control trial is to be set up soon to research the effectiveness of peer support for those that have been in crisis.

- PLN (Psychiatric Liaison Nurses) – are based in A&E and provide a 24/7 mental health triage in A&E to enable a rapid assessment and care planning for those that come to A&E. They also assess for HTT – so a speedy discharge can be accommodated.

- Reablement is a social care team that provides up to 13 weeks support to enable residents to be supported in any social care needs – i.e. feeling isolated, money management, housing etc. This is a new team, and relatively rare in mental health services. After re-ablement is completed people are subject to a Recovery and Support Plan aimed at avoiding any future mental ill-health episode leading to a crisis situation.

- Maudsley's "place of safety" (sometimes known as the 136 suite) – a dedicated unit open 24/7. Residents who may have an mental illness and who are picked up by the police are taken to this unit rather than A&E.

- AMHP service – a dedicated team who are able to respond immediately to undertake assessment under the Mental Health Act – these assessments may take place in A&E or the Maudsley's place of safety.

- Social care provides an EDT (emergency duty worker – social worker/AMHP) for out of hours. They provide rapid assessment (including AMHP work – Mental Health Act assessments) as well as care planning. EDT and HTT work closely together. There is no evidence that significant numbers of A&E breaches are created by lack of – or response time of – EDT/AMHP.

Lead Officer	Sarah McClinton, Director of Adult Care, Children's and Adults Department
Report Author	Adrian Ward, Head of Performance (Adult Social Care), Children's and Adults Department

Health scrutiny overview 13/14 work-plan

Wednesday 5 March	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (6)
	King's – update on acquisition of PRUH and impact of TSA **Annual Safeguarding** **Update on Health and Wellbeing** **Drug Joint Strategic Needs Assessment & Alcohol Strategy** **CCG Performance report** **Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark** Agree report on **Review : Access to Health Services in Southwark**
Monday 24 March	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (7)
	DRAFT Quality Accounts Agree report on : **Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark**

	Items to be slotted in as appropriate 1. Adult Mental Health review (part of Psychosis CAG – so linked to review) 2. Possibilities: Integrated Care – Frail & elderly and new long term conditions

NHS
Southwark
Clinical Commissioning Group

CCG Performance Highlight Report

Month 8, 2013/14

Southwark Council

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

January 2014

Urgent Care (1 of 3)

NHS Southwark Clinical Commissioning Group

A&E waits all types (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3
KCH									89.7%	90.4%	87.9%	**89.4%**
KCH (Denmark Hill Site)	96.3%	96.4%	96.3%	**96.3%**	94.5%	95.2%	95.4%	**95.0%**	94.5%	94.5%	93.4%	**94.2%**
GSTT	94.6%	96.4%	96.7%	**95.9%**	94.5%	95.8%	96.9%	**95.7%**	96.9%	96.8%	96.6%	**96.8%**

With effect from 1 October, Princess Royal University Hospital became part of the King's College Hospital NHS Foundation Trust (KCH), the figures for KCH above reflect this.

Cause of Reported Performance Position

•One of the drivers behind KCH A&E performance at the Denmark Hill site is critical care availability. Additional critical care capacity is planned to come online at the site and is expected to be operational in January.

•There are a number of schemes within the trust winter plan and expansion plans which are still due to start. One of these, additional Emergency Department Clinical Decision Unit (CDU) capacity , began at the end of December. This should help improve January's position.

•Additional funding to support A & E was announced by NHS England for winter. Some of this funding is now available for investment at KCH Denmark Hill.

Urgent Care (2 of 3)

NHS Southwark Clinical Commissioning Group

Actions Taken by Trust to Address Emergency Pressures

1.Denmark Hill site capacity – Additional capacity is now open, including Infill block 4; CDU; majors and Brunel Ward. CDU opening was slightly delayed and Infill block 4 was delayed more significantly from the original Q3 plan. Additional critical care capacity is also available and flexed as required.

2.Staffing – Increased nursing levels on acute medicine, sickle cell and neurosurgery wards to support increased acuity of patients and secure optimal staffing levels, underpinned by an acute medical nursing shift review. Increased medical and nursing support for paediatric A&E. Enhanced medical and Emergency Nurse Practitioner staffing for twilight shifts. Additional nursing and administrative support to facilitate London Ambulance Service handover and performance.

3.Winter Monies – There were delays in implementing the Trust's planned winter investments due to delays in confirming national winter monies and the trust's internal financial position. This meant the trust did not go at risk with all schemes included in the their winter plan. The CCG assessment of this indicates a delay of between 6 and 8 weeks in winter schemes having the planned impact. This would mean a shift in outcomes being achieved from Q3 to Q4.

4.Monitoring – The trust are holding internal site specific weekly Emergency Care Board meetings, which Southwark CCG are now attending. There are daily breach meetings in order to rapidly identify and address issues. Weekly teleconferences will also be held with the Southwark CCG Chief Officer and the Chief Operating Officer of KCH to monitor and address any performance issues. Monthly clinical summits will also be held for senior leadership review of the performance position and action planning.

Urgent Care (3 of 3)

NHS Southwark Clinical Commissioning Group

Out of Hospital Actions to Address Emergency Pressures

***1.GSTT@home* roll out** – Across the whole of Southwark & Lambeth, with the additional 25 beds to be in place in Q4. This will release bed capacity, improve patient flow and reduce length of stay and early readmissions.

2.Southwark & Lambeth Integrated Care (SLiC) Programme Simplified discharge workstream – testing of senior multidisciplinary assessment at admission and rapid transition back to home once ready for discharge, with a trajectory to upscale this in quarter 4. This includes piloting of seven day working within health and social care elements of model.

3.Mental health – increased consultant cover and out-of-hours psychiatric liaison nurse cover to support more timely assessments, reduce A&E breaches and reduce emergency admissions. Agreed South London & Maudsley (SLaM) overspill capacity and enhancement of Home Treatment Teams.

4.Nursing home support – coordinated approach to improving the quality of care within nursing homes involving consultant gerontologists; Southwark and Lambeth multi-disciplinary teams and General Practice.

5.A&E attendance rates – Analysis of Southwark A&E activity has shown a 4% decrease in presentations at King's College Hospital at M7, relative to 2012/13

6.Primary care access – On-going work with general practice to review A&E activity, develop improvement plans including identification of high risk patients.

7.Winter communications campaign – Across south east London, including website aligned to local service directory to support patients to access the most appropriate service.

Cancer Waits: 62 days pathway

NHS Southwark Clinical Commissioning Group

62 days treatment (85%) - % patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Target = 85%									
Month	Apr	May	Jun	**Q1**	Jul	Aug	Sep	**Q2**	**Oct**
SCCG	83.3	90.2	82.4	**85.9**	100	83.3	81.1	**86.3**	**78.4**
KCH	93.3	87.9	76.7	**86.7**	97.2	83.1	92.5	**88.1**	**86.2**
GSTT	68.6	80.5	79.7	**75.5**	77.9	80.0	70.1	**70.8**	**71.0**

Cause of Reported Performance Position

•Southwark and KCH have met the 2 week GP referral, 31 days and 62 days target for Q1 and Q2.

•Underperformance in October was driven by Guy's & St. Thomas' (GSTT) as 29 breaches were recorded against a total of 100 pathways.

Actions Agreed to Meet Performance Standard

•62 day pathway performance at GSTT associated with receipt of tertiary referrals, although also for some patients with pathways within the trust.

•Intensive Support Team (IST) have reviewed processes at GSTT for patients on pathways within GSTT.

•The IST has also recently separately reviewed all old South London Healthcare Trust (SLHT) providers focussing on pathway access issues for 62 day patients who start their journey at the old SLHT and are referred to GSTT.

•The final report was received by trusts in December 2013 and the SLCSU is now organising a review group to ensure recommendations from the report are taken forward. This will be held in mid-January.

•GSTT does not expect to meet this target before the end of the year.

Referral to Treatment (RTT) – 18 weeks

NHS Southwark Clinical Commissioning Group

RTT admitted (target 90%) - The percentage of admitted pathways completed within 18 weeks

RTT Admitted	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Southwark CCG	90.6%	88.0%	90.7%	89.3%	88.4%	87.3%	86.0%	87.3%
KCH	88.8%	88.2%	89.7%	88.1%	87.1%	88.7%	88.1%	87.8%
GSTT	92.1%	92.0%	92.7%	92.4%	92.8%	90.7%	90.7%	90.4%

Cause of Reported Performance Position

- Admitted performance for Southwark CCG patients below the 90% target for the last five months.
- KCH are below the performance threshold. They are however within the planned improvement trajectory of 87% agreed with the trust and therefore amber rated.
- This trajectory was agreed to allow the trust to focus on reducing the backlog of patients currently waiting over 18 weeks.

Actions Agreed to Meet Performance Standard

- Admitted RTT Performance at KCH will continue to be below the threshold while the trust address their backlog of admitted patients. This has been agreed by the CCG, King's and NHS England.
- KCH have a combination of increased internal capacity and outsourcing to private providers in place. King's has also transferred some orthopaedic patients to GSTT.
- Acquisition of the PRUH site along with Orpington and development of the Centenary Wing at Denmark Hill has given further capacity from October and November respectively.
- The trust will not achieve the RTT target until April 2014.

Referral-to-Treatment(RTT) – 52 + week waits

NHS Southwark Clinical Commissioning Group

52 + Week Waits	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Southwark CCG	3	5	7	3	8	8	10	6
KCH	49	44	31	24	28	29	33	27
GSTT	9	5	0	1	0	0	0	0

Cause of Reported Performance Position

•All Southwark long waiters are patients at KCH. In November the specialities with long waits for Southwark patients at King's were 4 in gastroenterology for benign Hepato-pancreatic-Biliary (HpB) surgery and 2 general surgery/bariatric surgery.

Actions Agreed to Meet Performance Standard

•KCH has used a combination of additional in house capacity and outsourcing to reduce long waiters.

•For bariatrics, some activity continues to be outsourced to private providers and additional ring-fenced beds are now also available in the Centenary Wing.

•A cohort HpB of patients are being outsourced to private providers and ring-fenced beds are available in the Centenary Wing. Weekend lists occurred to the end of December with more planned in January.

•Additional critical care capacity will open by the end of January in the modified Christine Brown Ward on the Denmark Hill site.

•The trust keeps long waiters under regular clinical review to ensure there is no clinical risk to patients.

•The CCG applies a contractual financial penalty each month for patients still waiting over 52 weeks. This has been implemented since April 2013 in line with national arrangements.

Diagnostic Waits

NHS Southwark Clinical Commissioning Group

Diagnostic wait less than 6 weeks (target <1%) - The % of patients waiting 6 weeks or more for a diagnostic test

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Southwark CCG	1.86%	1.95%	1.85%	2.63%	2.41%	2.48%	1.52%	1.71%
KCH (Denmark Hill)	3.00%	4.20%	2.77%	2.57%	1.23%	0.94%	0.87%	1.40%
GSTT	2.00%	2.10%	3.08%	3.83%	5.13%	4.44%	2.17%	2.46%

Cause of Reported Performance Position

- The main driver for under-performance in October and November is endoscopy at GSTT.
- Although GSTT has opened a new larger endoscopy suite, poor staffing levels has resulted in an increased number of plus 6 week waiters in these months.
- KCH Denmark Hill had an issue with sleep studies in November due to the loss of a staff member. Activity has now restarted with additional sessions arranged to clear the backlog, this is expected to be cleared by late January 2014.

Actions Agreed to Meet Performance Standard

- GSTT has put additional sessions in place to increase staffing capacity using clinical fellows. The trust expects to come near to the 1% target for December 2013.
- GSTT is however likely to show a further increase in performance in January 2014. Patient choice over the Christmas period has caused an additional temporary pressure effecting the first week after the Christmas period. The trust expects to clear the backlog by early February 2014.

Mixed Sex Accommodation

NHS Southwark Clinical Commissioning Group

Mixed-sex accommodation breaches (target 0) –
All providers of NHS funded care are expected to eliminate mixed-sex accommodation

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Southwark CCG	12	6	7	11	1	0	25	35	32
KCH	49	19	29	40	16	0	27	99	85

Cause of Reported Performance Position

•All Southwark breaches in November and December occurred at KCH Denmark Hill.

•All of the October, November and December breaches were in the Clinical Decision Unit (CDU) at Denmark Hill.

Actions Agreed to Meet Performance Standard

•KCH opened a new 8 bedded CDU at the end of December, and now has 16 CDU beds in total. Although this is a net increase of 2 beds, the new configuration will allow males and females to be more easily separated.

•Contractual penalties being applied to breaches.

•A clinically-led assurance visit is scheduled to take place on the morning of 23 January 2014.

Improving Access to Psychological Therapies (IAPT)

NHS Southwark Clinical Commissioning Group

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Monthly 1st contacts to equal 12.5% trajectory	389	389	431	436	431	447	454	454
Number of first contacts	330	335	326	383	322	403	438	465
Recovery Rate (target 50%)	42.1	47.8	42.7	40.2	40.4	37.0	31.3	40.7

Cause of Reported Performance Position

- Growth in demand for IAPT services in Southwark and capacity limits in IAPT provision from SLaM
- Identified variation from practice-based counsellors completing psychological therapy interventions.

Actions Agreed to Meet Performance Standard

- Audit and review of all practice-based counselling completed.
- Additional temporary low intensity support by Psychological Well-being Practitioners (PWPs) have been in place at SLaM since the end of August.
- Case management support role recruited and started in September to support counsellors deliver stepped care within the IAPT model.
- Additional administrative staff funded within SLaM to register referrals to counsellors and remove administration tasks from counsellors.
- Programme to increase IAPT-accredited activity being completed by practice-based counsellors.
- The actions above were planned to impact performance by the end of Quarter 3 2013/14. This improvement is evident in November 2013 data.

Healthcare Acquired Infections (1 of 2)

NHS Southwark Clinical Commissioning Group

Number of cases of MRSA (target 0) and ***clostridium difficile (CCG annual target 48)***

MRSA

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	YTD
Southwark CCG	0	1	0	**1**	0	0	0	**0**	0	1	**2**

- This table now only shows cases assigned to the CCG following Post Infection Review.
- All MRSA bacteraemia cases reported via the HCAI Data Capture System (DCS) are assigned to either an acute Trust or a CCG through the completion of a Post Infection Review (PIR). A case is deemed to be CCG assigned where the completed PIR indicates that a CCG is the organisation best placed to ensure that any lessons learned are completed.

c. difficile

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	YTD
Southwark CCG	2	0	0	**2**	7	3	5	**15**	5	4	**26**
Breakdown:											
Non - Acute	0	0	0	**0**	5	3	2	**10**	1	3	**14**
GSTT	1	0	0	**1**	2	0	0	**2**	3	1	**7**
KCH	1	0	0	**1**	0	0	3	**3**	1	0	**5**

Healthcare Acquired Infections (2 of 2)

NHS Southwark Clinical Commissioning Group

Actions Agreed with Providers to Meet Performance Standard

•Infection Control including MRSA and *Clostridium difficile* (CDI) cases are discussed at the monthly Clinical Quality Review meetings at King's and GSTT. These meetings are chaired by CCG Clinical Leads in Southwark and Lambeth. KCH and GSTT undertake a Root Cause Analysis (RCA) on all MRSA cases and all *CDI* cases attributed in their organisation.

•Following the transfer of community services, GSTT provide community infection control support to primary care through training and *CDI* surveillance (currently based on GSTT lab data). It is planned that King's lab data will also soon be included for the purpose of enhanced surveillance.

•The Lambeth and Southwark Public Health Team review local HCAI data regularly. Following a local *CDI* summit, a multiagency *CDI* Task and Finish Group is addressing surveillance, raising awareness, antibiotic prescribing and care pathway development. Post Infection Reviews of MRSA bacteraemias are producing information on the detail of local cases and learning. Most cases are very complex with numerous healthcare contacts.

•Southwark CCG is undertaking a Deep Dive Review of Infection Control within its local acute and community providers. It will include recommendations on how to improve local infection control arrangements.

Questions raised by Julie Timbrell, Project Manager

A copy or link to the report referred to

Referred to the PLACE results (Patient Led Assessments of Care Environments)as published on the 18th September 2013 by the Department of Health

The process

- 42 Wards and sites were assessed between April and June 2013
- The team comprised of 2 services users recruited from the SLaM Service Users involvement register and Heathwatch and a member of the Hotel Services team.
- 18 Service users took part in the assessment
- 4 SLaM staff members attended as observers to the process
- All service users undertook a training session on the PLACE assessment requirements
- The Department of Health decided which dates the sites should be assessed
- Service users were only told 1 week in advance which sites r=they were to assess

Please see attached an Introduction to PLACE as issued by the Department of Health

Also attached are the PLACE Assessment Scores

The article talks about an action plan to tackle these issues. Could you please supply a copy of this?

Every ward across all site have an action plan to address the issues within their area ;42 Wards/Sites were audited (Sample Plan attached – Please let me know if you require to see further copies)

ARAMARK completed an Action Plan for all Catering and Cleaning Issues – Copy of Plan attached

How are SLaM currently holding Aramark to account?

Action Plan has been developed as previously mentioned

As the scores were disappointing against several of the sites for Cleaning and Catering Jane Sayer, Acting Director of Nursing and Paul Winter Head of Hotel Services meet with the ARAMARK Regional Manager and the Operations Director to ensure actions required from the assessments are implemented

PLACE type assessments have been carried out during late and November with Hotel Services team and ARAMARK Management.

The Cleaning scores have improved across the Trust on every site ranging from 43% to 3% an average of 13% which matches the benchmark average set with all London Mental Health Trusts in April to June this year.

During the Mock Audits meals were sampled on a selection wards across the Trust and were much improved.

As part of the spotlight audits carried out regularly, meal tasting will be part of the assessment process similar to the PLACE methodology.

A Trustwide Food Operational Review Group (FROG) has been formed in July to review the Service Users menus and discuss and rectify issues relating to food that are raised. There has been Nursing representation at these meetings and service users from the involvement register have been are invited.

Chefs are also visiting wards to view the service of meals produced and receive comments from nursing staff and Service Users to amend and adjust recipes where appropriate

An Additional Monitoring officer is to be appointed in the coming weeks under the direction of the Head of Hotel Services to monitor contracted Hotel services; Catering, Cleaning and Laundry Services

Can you confirm that SLaM is intending to extend the contract with Aramark? . If this is the case, and there are already concerns about catering and cleaning, on what grounds are SLaM doing this?

The contract with ARAMARK was agreed by the SLaM Board in January to be extended by 2 years, therefore it will continue until Jan 2017

The Performance Measurement System (PMS) which monitors the Key Performance Indicators (KPI's) is currently being reviewed and modified where appropriate to ensure a robust system to give assurances that the KPI's are met in line with the requirements of the contract.

In what circumstances would SLaM retender the contract with Aramark?

The contract would be retendered to commence February 2017 and would be open competition in line with European Legislation.

The next round of Place assessments will carried out in Feb/March 2014 as required by the Department of Health Information Centre

NHS
Commissioning Board

Patient-led assessments of the care environment Guidance and information for patient assessors

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

Foreword

Good environments matter. A clean hospital is the foundation for lower infection rates, whilst good food promotes recovery and improves the patient experience. High standards of privacy promote patient dignity, whilst good maintenance and décor support a safe and comfortable stay.

But good environments don't just happen. Without the efforts of all staff, the benefits of cleanliness, good food, privacy and proper maintenance may be lost.

Patient-led assessments of the care environment (PLACE) help organisations understand how well they are meeting the needs of their patients, and identify where improvements can be made. They take place across all hospitals, hospices and independent treatment centres providing NHS-funded care and use information gleaned directly from patient assessors to report how well a hospital is performing – in terms of national standards and against other similar hospitals.

This guidance document explains how patients are involved in the assessments and offers advice and guidance to those who choose to become patient assessors.

The role of patient assessor is an important one. It needs people who can be objective and unbiased, and who do not let themselves get sidetracked. It needs a clear commitment to quality and to viewing the hospital environment in its widest sense. Most of all, it needs people who are determined to help providers of NHS-funded care to improve, and who are prepared to make their voices heard in a constructive and supportive way.

Your NHS needs you. If we do not listen to patients, we will not be able to deliver the best experience possible of NHS care. By providing a patient's-eye view of the buildings and food your hospital offers, you are helping to make it better for yourself, your family and all other patients.

Introduction

The Department of Health and the NHS Commissioning Board recommend that all hospitals, hospices and independent treatment centres providing NHS-funded care undertake an annual assessment of the quality of non-clinical services and condition of their buildings. These assessments are referred to as patient-led assessments of the care environment (PLACE). They look at:

- how clean the environments are;
- the condition – inside and outside – of the building(s), fixtures and fittings;
- how well the building meets the needs of those who use it, for example through signs and car parking facilities;
- the quality and availability of food and drinks; and
- how well the environment protects people's privacy and dignity.

The assessments apply to all hospitals of all types. This includes acute, specialist, children's, mental health, learning disabilities, community hospitals, and independent hospitals that provide NHS-funded care. The assessments also apply to hospices and independent treatment centres.

Assessments are carried out every year by people who use the hospital – patients, relatives, carers, friends, patient advocates, volunteers or trust membership and trust Governors – supported by hospital staff. The assessment will be organised by a member of the hospital staff known as the assessment manager, but the patients' voice is the one that matters most.

The purpose of this document is to set out in clear and simple terms what qualities and experience are required to be a patient assessor, what carrying out PLACE assessments means, why you might want to join in, and how to get involved. Further guidance specific to your hospital will be provided locally.

PLACE is an annual snapshot that gives hospitals a clear picture of how their environment is seen by those using it, and how they can improve it.

PLACE assessments only look at the buildings and related non-clinical services like catering. The quality of care and all the other things that go to make up a good experience are dealt with elsewhere, for example local Healthwatch's "enter and view" assessments, or the Care Quality Commission's surveys and monitoring processes.

Experience, knowledge and skills

You do not need any specific knowledge of healthcare to take part in a PLACE assessment. However, there are a few things to think about before becoming a patient assessor, and these are set out below. This is to make sure that the process works as well as it can do for all concerned – the assessor, the patients, the staff and the hospital management.

Experience

- Some recent personal experience of hospital in-patient care is useful, although it is not essential. This could be as a patient, relative, carers, friend, patient advocate, volunteer or trust membership and trust Governor. You will be called a patient assessor even if you are not a patient yourself.
- You should not act as a patient assessor if you are employed (or have been employed within the last two years) by the organisation you are assessing. In this case you may be on the team as a staff assessor, or you may be a patient assessor for other organisations.
- Age is no barrier to being a patient assessor. It can be particularly helpful to have input from children and young people for paediatric areas. Older people make up the majority of the adult in-patient population, so should ideally be well-represented in the PLACE team.

Knowledge

- Patient assessors do not require any particular technical expertise or knowledge. What you need is the ability to understand and apply simple guidance, together with a common-sense, unbiased and practical approach.

Skills

- Patient assessors need to be able to gather information in a variety of ways, following a clearly defined checklist. You will need to be able to:
  - communicate clearly with people;
  - listen actively and encourage people to talk about the hospital building and its services;
  - be objective when assessing or gathering evidence;
  - participate in discussions;
  - present a point of view clearly but reasonably;
  - be open to the views of others; and
  - contribute to a brief summary statement of what you saw.

Physical abilities

- Assessing a hospital can be very tiring. If you are not physically fit, the hospital should be able to make adjustments for this – perhaps by involving you in just a part of the assessment, or by providing a wheelchair.
- If you have a disability, there may be parts of the assessment you cannot contribute to, but this does not mean you cannot be involved. If you are partially-sighted, for instance, your input will be particularly helpful in assessing how easy it is to find your way around the hospital.
- You will also need to be able to manage time and travel in getting to hospitals in the local area (the hospital may provide help with this).

Involvement

How does it work?

PLACE patient assessors are volunteers who are appointed by local Healthwatch or approached directly by the hospital.

You may be asked to participate in one or more assessments. Assessments can last from two to six hours on any day, depending on the size of the hospital. In very large hospitals, an assessment might run over more than one day. You may be asked to carry out just part of an assessment.

You will help the team to agree a score for a number of things including cleanliness, décor, the quality and taste of food, and how the privacy and dignity of patients is provided for. You will not be asked to make any judgements about how well clinical staff are doing their job, although if you see something that causes you concern you will be expected to draw attention to it either straight away or at the end of the assessment. You will reach your own views about the scores to be applied, and these will contribute to overall judgements that the team will make.

You will be able to talk to the assessment manager, who will explain how your work will fit into the wider assessment of the performance of the hospital.

The key stages of an assessment are:

- **planning** for the assessment;
- **agreeing on the day** who will do what;
- **undertaking** the assessment;
- **discussing** your findings with other team members;
- **preparing or contributing to** a short summary statement of what you have seen;
- **completing** the patient summary assessment sheet.

The hospital will then send the results to the Health and Social Care Information Centre (HSCIC). You will not be involved in this step.

As a patient assessor, you will always be accompanied by a staff assessor whilst you are in the patient areas. You will have the chance to talk to other patient assessors on your own at the end of the assessment.

The table below shows how patient assessors are usually involved:

When?	What?	Where?	How long?
Before the assessment	• Reading through the assessment form and guidance so you know what you will be looking at and how the scoring system works • Undertaking training the hospital or local Healthwatch provides	At home or in a training session At the hospital or local Healthwatch	1–2 hours (you only need to do this once, no matter how many assessments you do) Time to be determined by the hospital or local Healthwatch
On the day (before the assessment begins)	• Meeting with the rest of the team • Receiving a short briefing from the assessment manager and agreeing who will do what. Some hospitals are very big, and responsibility for specific areas is shared between separate teams	At the hospital	30 minutes
During the assessment	• Carrying out the assessment • Noting down things you want to remember as you go • Agreeing a score for each area with the rest of the team	At the hospital	2–6 hours approx
After the assessment	• Meeting with other patient assessors to answer some patient only questions • Completing the patient summary assessment sheet • Meeting with the full team to resolve any difficulties and agree scores that require joint input • Agreeing a short summary statement	At the hospital	30 minutes to one hour – usually included in the times above

Joining the assessment team

Once you have agreed to be a patient assessor, the hospital will contact you approximately six weeks before the planned date of the assessment. If you are not able to take part on that day you can say so, but once you have agreed to join the assessment you should make every effort to do so. Late withdrawal will cause inconvenience to others and may result in the assessment being postponed. Of course, if you have any symptoms that might suggest an infectious illness (especially with vomiting and diarrhoea), you should not attend. Please inform the hospital as soon as possible in this situation.

Things to do before the assessment

The hospital or support organisation will provide you with a copy of the assessment form and the guidance that goes with it. If you wish to, you can get these documents for yourself from the Health and Social Care Information Centre website. You can read these papers at home – this should not take more than two hours. If you have any questions, you should contact your assessment manager.

The papers tell you what you will be looking at and how the scoring system works. In general, you will work with other members of the team to decide on such things as whether something (for example a floor or toilet) is clean, or whether something is in good condition (such as furniture, decorations). Extra guidance will be provided to help you make these judgements.

The hospital or local Healthwatch will provide training for all patient assessors, either on a date before the assessment, or on the actual day of the assessment. It is recommended that you attend the training, as it will give you the opportunity to meet the other staff and patient assessors, and learn about the process and what is expected of you on the day.

Things to do on the day

Your first task will be to agree a lead assessor, who will co-ordinate the production of the final report. This may be a staff or patient assessor. You will then agree amongst yourselves which areas of the hospital you will be looking at. The assessment manager will be able to help you, but where there is a choice (for example if just a sample of wards is being assessed), the final decision should be discussed with you.

For most hospitals, the team will split up into smaller teams to make sure everything is covered. One person in each team will be appointed as team leader, and they will record the final agreed scores for each area. You will have a staff assessor with you at all times.

You will then visit the designated ward, department or other area of the hospital, looking at each relevant item. You should make sure you see enough of each to get a clear picture, but you do not need to check every single item. You should take care not to disrupt the normal activity of the ward, although you should be able to speak to staff and patients if you wish.

Remember that the hospital is looking for your opinion. This is not a patient survey, so when you talk to patients, you should do so in order to form your own opinion. As a general rule, you should only ask patients about those things that you cannot judge for yourself. So, for instance, you might ask: Do you always get the food you ordered?, rather than Do you think this locker is clean? Take care not to disrupt the care of patients. Do not enter bedrooms or bathrooms without permission (unless they are empty) and do not ask patients personal questions about their medical condition or care.

When speaking to patients always introduce yourself as part of an assessment team, stressing that you are there to represent the interests of current and future patients.

Have your ID badge issued by the hospital with you at all times.

You will need to follow the hospital's instructions about what to do in an emergency, for instance if there is a fire, or a cardiac arrest. Sometimes, the team may need to break off an assessment and come back later, if there is a clinical emergency.

Before you leave the ward, the team will spend a few minutes agreeing the score(s) to be awarded before moving on to the next part of the hospital. This means that if there are any disagreements you can return to the area or item and have another look. The team leader should then complete just one form per ward or department on behalf of you all.

This 'score as you go' approach means you should not need to write much down, but you may take notes if you wish. This will be especially useful if you see something that is not part of the assessment but which you want to mention at the end.

You do not need to assess every single item to make a judgement. Just make sure you assess a reasonable amount.

Ask yourself; **"Have I seen enough to be sure it's clean enough?"**

Assessing the food services

You may be asked to taste the food and judge its quality. Every dish must be tasted by several people, but you do not need to taste each one yourself. For instance, if you are vegetarian, you would not want to taste the meat dishes, but it would be wrong to say they do not taste good. In this case, you would base your judgement solely on the vegetarian options. You should take care not to let any personal preferences overrule the general quality – for example, you may prefer white bread, but you would still be able to say whether a brown bread sandwich was fresh and well-prepared.

What to do if you see a problem

During the assessment, you may see something that is not covered by PLACE, but that you want to draw attention to. Usually this is best done direct with the ward staff or assessment manager. Although unlikely, it is possible that during a PLACE assessment you may see something which is of very serious concern. This may be something that should be acted on very quickly. For example, you may hear about or observe abuse. If this happens and if you feel that this is something that should be reported beyond the hospital management, you can contact the Care Quality Commission (CQC).

To do this you should call the Care Quality Commission 03000 616161 number and select Option 2 for safeguarding. This will put you through to the safety escalation team. The National Care Standards Commission will record your information and notify the relevant member of staff to deal with this, who may then contact you.

The role of the Care Quality Commission

The Care Quality Commission is the independent regulator of all health and social care services in England. Their job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets essential standards of quality and safety. They put the views, experiences, health and wellbeing of people who use services at the centre of their work, and have a range of powers they can use to take action if people are receiving poor care.

After the assessment

Some questions are specifically written for patient assessors only to answer. This is to make sure that the patient voice is strong and clear.

At the end of the assessment, patient assessors will meet alone to answer the questions that relate only to you and complete one patient assessment summary sheet. You will need to discuss your answers, resolve any difficulties, and agree the wording of a short summary statement. It is very unusual to find serious disagreements. You will need to agree amongst you which patient assessor will sign the patient assessment summary sheet on behalf of you all.

Your name will never appear in any published document or information.

The patient assessors will also make recommendations for improvement. Clearly, these must be reasonable and achievable – it would be unrealistic, for example, to suggest that the hospital needs to be completely rebuilt before the next assessment. Recommendations work best when they are specific and measurable – for example:

- Provide a hot option with the evening meal;
- Replace bed curtains with longer ones;
- Replace worn-out flooring in out-patients corridor.

After the assessment, you should hand your patient assessment summary sheet to the assessment manager. They will submit your comments along with the final results of the assessment through an online system.

The patient assessment summary sheet also asks you to confirm that you feel the visit has

been handled properly and your views have been listened to. If you have any concerns, you should say so here. However, you can also contact the Health and Social Care Information Centre. If you find you do need to get in touch, please state clearly the hospital where the assessment took place and be as clear as possible about what happened to make you need to write about it.

Publication of results

Once the results are submitted, they are analysed and weighted according to a standard procedure. This is done by the Health and Social Care Information Centre. The hospital will receive their final results and will have a chance to plan their response to your suggestions. They will then publish the results and their improvement plan on their website. The hospital will contact you when they are publishing their results and improvement plan.

The national results are published by the Health and Social Care Information Centre on their website later in the year.

How the information is used

PLACE information is used by a range of public bodies such as the Care Quality Commission, the NHS Commissioning Board, the Department of Health, local clinical commissioning groups and local Healthwatch. All the results will be published by the Health and Social Care Information Centre and will be publicly available.

How to get involved

Each hospital recruits its own patient assessors. They will start with local Healthwatch, but they will also use patients from other sources. If you want to be involved, you should contact your local Healthwatch or patient involvement team at your local hospital. Alternatively, the hospital's volunteer co-ordinator should be able to help.

Conclusion

The role of patient assessor is an important one.

It needs people who can be objective and unbiased, and who do not let themselves get sidetracked. It needs a clear commitment to quality and to viewing the hospital environment in its widest sense. Most of all, it needs people who are determined to help the NHS to improve, and who are prepared to make their voices heard in a constructive and supportive way.

If, at the end of the assessment, there are still any issues that you did not feel were properly dealt with or that you were unable to reach an agreement on, you can report this by sending an email to **place@ic.nhs.uk** or by writing to
PLACE TEAM
HEALTH AND SOCIAL CARE
INFORMATION CENTRE
TREVELYAN SQUARE
LEEDS LS1 6AE

Q&A

Will I get paid?

Hospitals will normally cover travel expenses and/or provide free parking, and provide refreshments. This may be just tea and coffee for a short assessment, but if the assessment is a long one you would normally be offered a light meal. Depending on their policy, some trusts pay a small honorarium.

Will I have to have a Disclosure and Barring System (DBS) check?

The Government stated its intention in May 2010 to scale back the Vetting and Barring Scheme and the criminal records regime to more proportionate and 'common sense' levels. Whilst some patient assessors may already have DBS checks (for example local Healthwatch members who undertake 'enter and view' activities), it is unlikely that DBS checks will be needed for the majority of patient assessors. However, the final decision on this rests with the hospital, who may choose to seek a standard DBS check. Patient assessors are not eligible for enhanced DBS checks.

What if I see something that is clearly wrong, but that is not part of the PLACE assessment?

You should report any concerns immediately to the assessment manager and to the person in charge of the ward or department you are assessing. Usually, this will be sufficient, but if you are concerned that this will not be enough, there is a place on the form for you to make a written report. If you see something that is of great concern, you may wish to contact the Care Quality Commission.

What if I disagree with the Staff Assessors?

Most times, the assessors all agree, because the questions are mainly factual (for example a toilet either looks clean or it doesn't). There is detailed guidance to help you understand the questions so that everyone judges things in the same way.

Generally speaking, at least 50 per cent of the assessors on the team will be patients. You will have a chance to talk to the other patient assessors without the staff assessors there, so you can check whether you all feel the same.

Most importantly, at the end of the assessment you will be asked to confirm that you agree with the overall summary result. If you do not agree, you should make it clear at that stage.

PLACE ACTION PLAN

Please complete the Action Plan and return to: Paul.Winter@slam.nhs.uk by no later than **31st August, 2013.**
Detail any actions taken and the person responsible and an action completion date.

• Cleanliness	• ARAMARK have been informed of the issues and they will be addressed. This will be monitored by the Hotel Services Managers and Team Leaders. • Any cleaning issues should be emailed to slamhelpdesk@aramark.co.uk or call Ext: 84548
AAU	
• Debris in radiators. • External glazing failed in all areas.	Rectified by daily clean but Estates need to remove covers to enable deep clean. Rectified
Chaffinch – MOH	
• Cleaning schedule should be displayed • All bedrooms and en-suites that were observed were dirty. Dust, grime, scale and stains. • The corridor to the garden needs a thorough clean	This now available at the ward All bedrooms and bathrooms deep cleaned. This is now cleaned as part of the ward schedule
NDS 1	
• Scuff marks and dirty walls. • Lime scale on laundry machines. • Dust and grime on low surfaces throughout the unit. • Floors • Stains in toilet pans.	These have now been removed by domestic This has been removed and is now checked by the supervisor Surfaces dusted following floor work Floors scrubbed and buffed Toilet deep cleaned
Ward in the Community	
• Dirty Walls. • Dirty doors and frames. • Chewing gum under table in dining room. • Dirty ventilation grills. • Floors dirty in all bedrooms and bathrooms. • Dusty linen room. • Dirty floors under beds.	Rectified on daily clean Rectified on daily clean Gum removed by Hostess Rectified on daily clean Floors to be scrubbed and stripped Rectified on daily clean Rectified on daily clean

Snowsfield • Fabric chairs dirty in multi purpose room. • Dirty public toilets outside ward area.	These have been clean and are part of the domestic duties Toilets raised during weekly meetings with hotel services Manager as not fit for purpose.
B.A.U. – TE1 • Internal glass was smeary, needs attention. • Art room needs a good clean.	Glass cleaned by both domestic staff plus window cleaners Room deep cleaned
TE2 – Acorn Lodge • Food area and dining room need to be cleaned after each meal service.	Rectified by domestic
Woodland House – CAMHS • Dirty cleaning trolley • High level dusting in OT kitchen required • Dirty window sills in bedrooms	Rectified by domestic Rectified by domestic Rectified by domestic
Alex 1 • Sticky residue on the fronts of some doors & wardrobes • Beverage bay – water machine, fridge and pipe work were dirty.	Rectified by domestic Rectified by domestic
Aubrey Lewis 2 • Dirty furniture in Activity Room • Dirty tables in dining room.	Rectified on daily clean Rectified on daily clean
Woodlands Nursing Home • Edges and corners of floors are dirty • Lots of cobwebs and dusty floor in the laundry room • External surfaces of basin were dirty	Additional work schedule in place following CQC visit. All actions rectified. Additional work schedule in place following CQC visit. All actions rectified. Additional work schedule in place following CQC visit. All actions rectified.
Lishman Unit – DB1 • Internal and external glazing very dirty • Corners and edges of floors need attention – build up • Floors in sanitary areas need scrubbing • Most of the doors need cleaning • Toilets dirty and need descaling	Rectified in daily clean Floors scrubbed by floorman Floors scrubbed by floorman Rectified in daily clean Rectified in daily clean

• Activity room needs a good clean	Rectified in daily clean
• Dining room needs a thorough clean	Rectified in daily clean
• Settees / chairs have debris under the cushions.	Rectified in daily clean
EDU	
• Lime scale on shower room floors	Showers have been descaled by Supervisor
• Drawer of washing machine dirty	Rectified by domestic
• Seats of chairs dirty and debris under cushions	Rectified by domestic
Aubrey Lewis 3	
• Lime scale in sinks	Descaling completed
• Stains in toilets	Stains cannot be removed
• Internal windows need cleaning	Rectified by domestic and will be cleaned by window cleaners
• Paintwork grubby	Rectified by domestic
Clare Ward	
• Bathrooms and toilets dirty and unhygienic.	Floors thoroughly scrubbed and cleaned
• Internal glazing, doors and door frames in need of a good clean.	Rectified by domestic
• Floors need more attention when being cleaned.	Floors machine scrubbed
Eden Ward	
• Finger marks	Rectified by domestic
• Rusty radiators with rubbish inside them.	Radiators cleared of rubbish
Ellen Skellern 1	
• Bedrooms – poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• Sanitary areas - poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• Lounge – poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• TV lounge - poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• ADL kitchen - poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• Activity room - poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• Dining room - poor standard of cleaning observed.	Additional hours put in. All issues now rectified
• Internal glazing is very dirty.	Additional hours put in. All issues now rectified
Ellen Skellern 2	
• Dirty floors throughout the ward. – floors need replacing	Rectified in daily clean. Supervisors monitoring area.
• Dirty chairs in foyer.	Rectified in daily clean. Supervisors monitoring area.

• Dirty kick plates.	Rectified in daily clean. Supervisors monitoring area.
• High and Low dust.	Rectified in daily clean. Supervisors monitoring area.
• Lime scale in toilets.	Rectified in daily clean. Supervisors monitoring area.
• Dirty ventilation grills.	Rectified in daily clean. Supervisors monitoring area.
• Drain away in a shower area was filthy.	Rectified in daily clean. Supervisors monitoring area.
Ellen Skellern 3	
• Dirty toilets and bathrooms.	Rectified in daily clean
• Dust on bedroom furniture – High and low level.	Rectified in daily clean
Fitzmary 2	
• Dining room area needs cleaning after breakfast	This is the role of the domestic to do this before any cleaning duties
• The sanitary areas need to be cleaned more frequently	The areas are cleaned & checked regularly by domestic
• Bedrooms floors need attention – need to be cleaned properly	This has been rectified by domestic & Supervisor
• All of the internal glazing needs to be cleaned	These have now been cleaned by the window cleaners
• The tiles in the bathrooms need to be cleaned at high level.	All bathrooms have been given a deep clean
Foxley Lane	
• High and low level dust.	Extra hours were put into Foxley Lane to rectify all of the issues. All of the issues have been rectified and monitored
• Ventilation grilles dusty.	
• Tops of wardrobes dusty.	
• Curtain tracks generally dusty.	
• Washing machine, dishwasher and oven dirty.	
Gresham 1	
• Dirty internal glazing	This has now been rectified and cleaned by the window cleaners.
• High level dust in bedrooms	All the bedrooms were given a thorough clean
• Dirty skirting	This was rectified by the domestic
• Dirty dining room furniture	This was scrubbed clean by domestic
Jim Birley Unit	
• All sanitary areas – very poor cleanliness standard observed.	Additional hours provided to ensure ward meets cleaning standards. All issues rectified and being monitored regularly.
• Bedrooms were dusty, under beds not cleaned, and the internal glass very dirty.	As above
• Family room – poor cleanliness standards observed.	
• Laundry room – poor cleanliness standards observed.	As above

• Activity room – poor cleanliness standards observed.	As above
• Dining room – poor cleanliness standards observed.	As above
• Glazing dirty.	As above
	As above
Johnson Unit	
• Sinks in bedrooms need cleaning.	
• Some surfaces are dusty.	Rectified by domestic
• Some areas had no hand towels or soap.	Rectified by domestic
• Lots of litter etc. in the enclosed garden.	Rectified by domestic
	Rectified by domestic
Leo Unit	
• Dirty doors and frames.	
• Dirty radiators.	Rectified in daily clean
• Dirty tables and chairs in the dining room.	Radiators cleaned externally. Estates to remove covers to enable internal clean.
• Dirty plug sockets.	Cleaned by hostess
	Rectified in daily clean
Luther King (in W. B Bridge House)	
• All en-suites need to have a thorough clean.	
• Toilet brush holders need a good clean.	Unit Closed – Refurbishment on-going
• Lots of fluff in the tumble drier.	As above
• Perspex on the TV cabinet is dirty.	As above
• En suites do not smell clean.	As above
	As above
Nelson	
• Bedrooms – poor standard of cleaning observed.	
• Sanitary areas - poor standard of cleaning observed.	All issues rectified by domestic and floorman.
• Lounge – poor standard of cleaning observed.	As above
• Dining room – poor standard of cleaning observed.	As above
• Family room – poor standard of cleaning observed.	As above
• Resource room – poor standard of cleaning observed.	As above
• De escalation room – poor standard of cleaning observed.	As above
• Poor standard of cleaning observed throughout the ward.	As above
• Some of the dispensers had no soap.	As above
• Sani bins are dirty.	As above
• All internal glass is dirty.	As above
	As above
Powell Ward	

• The glazing is dirty. • Radiators throughout the ward need a good clean. • All sanitary ware needs to be descaled as they are badly stained.	Rectified by domestic Radiators cleaned externally Rectified by domestic
Tony Hillis Unit • Bedrooms – poor standard of cleaning observed. • Sanitary areas - poor standard of cleaning observed. • Lounge – poor standard of cleaning observed. • Dining room – poor standard of cleaning observed. • Internal glazing throughout the ward needs to be cleaned. • De escalation room – poor standard of cleaning observed. • Gym – floor and high surfaces need attention. • Quiet room – doors and high surfaces need attention. • No soap in some of the dispensers.	Issues rectified by domestic and floorman Issues rectified by domestic and floorman Issues rectified by domestic and floorman Issues rectified by domestic and floorman Issues rectified by domestic Issues rectified by domestic and floorman Issues rectified by domestic and floorman Issues rectified by domestic Issues rectified by domestic
Triage • Bed bases need to be cleaned on a regular basis. • Tumble dryer is dirty. • Fan in laundry room is filthy. • Red mop and bucket full of dirty water was left in laundry room.	Rectified by domestic on daily clean. Domestic retrained. Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean. Domestic retrained on IC.
Triage – Lloyd Still • Bed bases need to be cleaned. • Doors throughout the ward need cleaning. • Chairs in the bedrooms and communal areas need cleaning. • Low surfaces generally need cleaning. • Toilets need to be descaled. • Floors in general need cleaning, particularly the bedroom floors. • Internal glazing throughout the ward needs cleaning. • High surfaces dusty in communal areas. • Some hand basins need cleaning. • Lots of the radiators need to be cleaned.	Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean Rectified by domestic on daily clean – outsides only. Estates to remove covers for internal cleaning
Wharton Ward • All internal glazing is dirty and furniture is not being cleaned to a good standard.	This has now been rectified and cleaned and standard maintained

• Shower heads should be descaled • IT Equipment in relaxation room and TV in art room dusty and dirty • Lots of dusty skirting • Chairs and under tops of tables dirty • Debris in laundry room • Clinic room needs thorough clean • Dirty floors in some areas Westways • Dirty internal and external windows. • High level dusting poor in bedrooms. • Dirty cooker in OT Kitchen. Ruskin Unit – DB2 • Bedrooms – poor standard of cleaning observed. • Sanitary areas - poor standard of cleaning observed. • Lounge – poor standard of cleaning observed. • Family room - poor standard of cleaning observed. • Meeting room - poor standard of cleaning observed. • Activity room - poor standard of cleaning observed. • Dining room - poor standard of cleaning observed. • Laundry room - poor standard of cleaning observed. • Clinic room - poor standard of cleaning observed. • Glazing very dirty.	Rectified by domestic Rectified by domestic Rectified by domestic Rectified by domestic Rectified by domestic Rectified by domestic Rectified. Coaching provided by Supervisor on floor cleaning process. These were cleaned by window cleaner Rectified by domestic This is now rectified by domestic Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated. Moved to Ruskin for refurbishment. Ward cleaned when vacated.
1. Condition & Appearance (Please ensure all failures on the audit are actioned and if need be that Estates & Facilities are notified via PLANET FM)	•
2. Hand Hygiene; Safety and Staff Appearance.	•
3. Privacy & Dignity; Wellbeing and Confidentiality	•

• Food Service, Food Presentation and Food Tasting	• ARAMARK have been informed of the issues and they will be addressed. This will be monitored by the Hotel Services Managers and Team Leaders. • Any catering issues should be emailed to slamhelpdesk@aramark.co.uk or call Ext: 84548
Chaffinch – MOH	
• The food at the end of the service was below a reasonable temperature.	• Burlodge to check trolley working correctly
• Pizza, rice and jacket potato was all that was on offer at lunch	• Ask Housekeeper to order more variety
Ward in the Community	
• Vegetable Soup – Cold and peppery.	• Burlodge to check trolley working correctly; recipe has been revised
• Macaroni Cheese – Strange spice taste – cold.	• Burlodge to check trolley working correctly; recipe has been revised
• Tuna Pasta Bake – dry and bland – over cooked pasta.	• recipe has been revised
• Chick pea and spinach - acceptable.	
• Cake and Custard – couldn't taste as too dry to cut – watery custard.	• recipe has been revised; host retrained
• Salad – had brown edges to lettuce.	• production times reviewed
• There were flavours in the food that we didn't expect to find like pepper in soup and fragrant spice in macaroni cheese.	• covered above
TE2 – Acorn Lodge	
• Not enough variety in the menu and the menu is not really appropriate for children.	• Autumn menu revision will incorporate School Food Trust recipes
Aubrey Lewis 2	
• Corned Beef Hash – Poor taste, texture and temp.	• Recipe confirmed correct for soft texture; Burlodge to check trolley working correctly
• Syrup Sponge and Custard – Poor taste, texture and temp.	• recipe has been revised; Burlodge to check trolley working correctly
• Special diet had been ordered – Scrambled egg sent but client refused to eat it – Steamed fish sent as replacement.	
• Stir fry veg was a strange choice to have with main dishes.	• Stirfry goes well with a dish the ward did not order
Woodlands Nursing Home	
• Apart from ginger pudding and custard the food was very bland and served at low temperature.	• Burlodge to check trolley working correctly
• General quality of food could be improved.	• Chefs given PLACE feedback

Lishman 1 – DB1 • Baked beans too hard • Cauliflower sloppy, overcooked	 • Chefs given PLACE feedback • Chefs given PLACE feedback
Aubrey Lewis 3 • Broccoli – over cooked and mushy. • Fruit cocktail was okay but no custard was offered. • No fresh fruit seen. • Waste food trolley was messy with no disposal system in place.	 • Chefs given PLACE feedback • hostess retrained • Ask Housekeeper to order • hostess retrained
Clare Ward • Soup so peppery we could not eat it. • Chicken bland. • Steamed rice undercooked and hard. • Croquette potatoes over cooked, dry and tasteless. • Lentil and apple savoury lacked apple but flavour was good. • Fresh fruit was very limited.	 • recipe has been revised • recipe checked • Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback • Ask Housekeeper to order
Croydon Triage • No coriander in the coriander rice	 • Ground coriander seed (not leaf) cannot be seen in rice
Eden Ward • Tofu Noodles and veg – bland taste and overcooked veg	 • Ask Housekeeper to order
Ellen Skellern 1 • Corned beef hash – awful and lukewarm. • Peanut vegetable satay – not nice , • Rice – very hard, • Stir fried mixed vegetables - overcooked. • Temperature of the food was lukewarm	 • Recipe confirmed correct for soft texture; Burlodge to check trolley working correctly • Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback • Burlodge to check trolley working correctly
Ellen Skellern 2 • Corn Beef Hash – Poor Taste and Texture. • Stir-fry Vegetables – Poor Taste Texture and Temperature. • Peanut Veg Satay – Poor Taste and Temperature. • Steamed Veg – Poor Taste Texture and Temperature. • Service started late by 15 minutes	 • Recipe confirmed correct for soft texture • Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback • Noted

• Menu displayed was out of date and hard to read. • No soup was available.	• Ask Housekeeper about this • Ask Housekeeper about this
Ellen Skellern 3	
• Chicken & Ham Stew – Poor temperature & Raw Potatoes. • Rice – Poor temperature – Stuck together. • Peas – Poor taste, texture and temperature. • Salad – Red cabbage served in big chunk.	• Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback • Kitchen Assistant given PLACE feedback
Fitzmary 2	
• Jollof rice – overcooked and very spicy • Boiled rice – overcooked very hard • Cauliflower – too soggy overcooked • Food temperatures – lukewarm/cold • All food temperatures were lukewarm/cold. • Culture specific recipes not up to standard; should be cooked properly.	• Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback • Burlodge to check trolley working correctly • Burlodge to check trolley working correctly • Chefs given PLACE feedback
Gresham 1	
• Spinach and broccoli – Overcooked and cold • Shepherds Pie – tasted nice but was cold • Cold fruit served in hot bowl • Menu board needs to be moved so it can be seen • Wider range of drinks to be available	• Chefs given PLACE feedback • Burlodge to check trolley working correctly • Ask Housekeeper to order more crockery • Ask Housekeeper to order • Ask Housekeeper to order
Jim Birley Unit	
• Tuna pasta bake - pasta hard, meal very bland. • Bean goulash – tasteless. • Boiled rice – very hard. • Broccoli – overcooked – very mushy. • Cajun spiced vegetable jambalaya – rice hard, no taste very bland – not on menu sent from the restaurant	• Chefs given PLACE feedback • Recipe checked • Chefs given PLACE feedback • Chefs given PLACE feedback • Chefs given PLACE feedback
Johnson Unit	
• Cauliflower Mornay – swimming in oil, looked dreadful but tasted quite nice. • Soup – very peppery - couldn't taste the soup.	• Chefs given PLACE feedback • recipe has been revised

• Lentil bake – very dry and bland.	• Chefs given PLACE feedback
• Potato croquettes – hard, bland and very dry.	• Chefs given PLACE feedback
• Jacket potato – overcooked.	• Chefs given PLACE feedback
Leo Unit	
• Chicken in white sauce and mushrooms – Poor taste and texture.	• Recipe revised
• Veg Stew & Rice – Bland – Carrots & Kidney Beans.	• Recipe revised
• Soup – Unknown – Thin, bland and cold .	• Recipe revised; Burlodge to check trolley working correctly
• Didn't look appealing at all.	• Chefs given PLACE feedback
Luther King (in W. B. Bridge House)	
• Soup very bland tasteless.	• Recipe revised
• Fish was grey in colour and the batter was soggy.	• Chefs given PLACE feedback
• Veg stew peas tasteless, chips very hard and cold, jacket potato very dry, steamed rice undercooked and very hard.	• Chefs given PLACE feedback • Chefs given PLACE feedback
• All food temperatures were lukewarm/cold.	• Burlodge to check trolley working correctly
• Very few condiments and no mayo.	• Ask Housekeeper to order
• Squash very watery.	• Noted
• No menu displayed.	• Ask Housekeeper
• Patients do not choose from the menu.	• Noted
McKenzie House / IRIS	
• Celery & Potato Soup – Bland and cold.	• Recipe revised
• Cauliflower & Peas – Over cooked.	• Chefs given PLACE feedback
• Cornbread was served as sponge with custard.	• hostess retrained
• Old Lambeth catering services menu displayed.	• Ask Housekeeper
Nelson	
• The soup was very bland.	• Recipe revised
• All 3 courses were served at the same time, so your main dish got cold if you had soup for a first course.	• hostess retrained
• Wrong menu displayed.	• Ask Housekeeper
• No disposable cups out for drinks.	• Disposables not eco-friendly - Ask Housekeeper to order more crockery
Powell Ward	
• Celery soup bland.	• Recipe revised
• Turkey bolognaise – couldn't taste meat too spicy.	• Recipe checked

Tony Hillis Unit	
• Soup – very bland.	• Recipe revised
• Chicken jollof rice – dry cold and far too spicy.	• Chefs given PLACE feedback
• Sweetcorn and bean stew – no sweetcorn.	• Recipe checked
• Temperatures of food lukewarm/cold.	• Burlodge to check trolley working correctly
• Hostess served cornbread with custard for dessert.	• hostess retrained
• No sultanas in the Spiced Apple and Sultanas.	• Recipe checked
• Wrong menu displayed.	• Ask Housekeeper
Triage	
• Soup was much too peppery but had body.	• Recipe revised
• Rice and vegetables under cooked.	• Chefs given PLACE feedback
• Minced meat greasy.	• Chefs given PLACE feedback
• Chicken dish lacked chicken.	• Recipe checked
• Lack of fresh fruit - only three bananas for the whole ward .	• Ask Housekeeper to order
• Lack of choice and no menus displayed.	• Ask Housekeeper
Triage – Lloyd Still	
• Tomato and chickpea soup – very bland.	• Recipe revised
• Spicy chicken & black eyed bean stew – hardly any chicken in this dish.	• Recipe checked
• Tofu, veg and noodles – tasteless.	• Recipe checked
• Minced beef – overcooked burnt but cold.	• Burlodge to check trolley working correctly
• Jacket potato – very dry.	• Chefs given PLACE feedback
• Boiled rice – very hard.	• Chefs given PLACE feedback
• Mixed veg – overcooked and soggy.	• Chefs given PLACE feedback
• The dessert was tinned fruit; this was left on the table in the dining room for the service users to help themselves.	• Ask Housekeeper to support hostess to serve
Wharton Ward	
• Tuna pasta very bland and greasy.	• Chefs given PLACE feedback
• Boiled rice was of poor quality and under cooked.	• Chefs given PLACE feedback
• Broccoli over cooked and soggy.	• Chefs given PLACE feedback
• Tinned oranges tasted of the tin.	• Taste checked
Westways	

• No choice offered. • Small portion. • No pudding only yogurt. Ruskin Unit – DB2 • Macaroni cheese – overcooked and tasteless. • Chicken sausage – didn't taste of chicken.	• Ask Housekeeper to order more variety • Ask Housekeeper to order more variety • Chefs given PLACE feedback • Taste checked
4. Nursing Issues and Others	•

PLACE ACTION PLAN – Hayworth Ward

Date	Unit Assessed	Hotel Services Lead	S.U.Assessors + Others
23rd May, 2013	Hayworth Ward	Karen Carpenter	Laura, Sherron and Sarah

1. Cleanliness • Cobwebs. • Dust on chairs. • Good standard of cleanliness elsewhere. • External glazing failed.	(ARAMARK to be informed of the issues and they will be addressed. This will be monitored by the Hotel Services Managers and Team Leaders. Any cleaning issues should be emailed to slamhelpdesk@aramark.co.uk or call Ext: 84548) • Ward manager has been regularly reviewing the cleaning standards with Arramark • External glazing reported through planet fm for repair. **– Spoken to Barry Leaf – He has informed us that the external cleaning of the windows is now Aramarks responsibility – We will contact Aramark to confirm this and to find out if there is a planned date for the windows to be cleaned.**
2. Condition & Appearance (Please ensure all failures on the audit are actioned and if need be that Estates & Facilities are notified via PLANET FM) • No curtains in Female lounge. No Dementia friendly signs.	• We will arrange for curtains to be put up in female lounge through speaking with Gemini – **All windows now have curtains** • This unit is not purely a unit for patient with dementia, but alos for patients with functional illness we are required to take into account the needs of all the patients and we will review the unit signage to consider both patient groups –**Signage is now up and visible for all patients**
3. Hand Hygiene; Safety and Staff Appearance.	
4. Privacy & Dignity; Wellbeing and Confidentiality	
5. Food Service, Food Presentation and Food Tasting • Spicy Chicken. • Mince and Onion noodles.	(ARAMARK to be informed of the issues and they will be addressed. This will be monitored by the Hotel Services Managers and Team Leaders. Any catering issues should be emailed to slamhelpdesk@aramark.co.uk or call Ext: 84548) • Problems with food was reported to Aramark - **Ongoing** • Ordering system has been revised to ensure there is enough food –**Adequate food**

• Rice and Peas. • Food was cold and the portion size was small. • No pudding offered.	**being provided**
6. Nursing Issues and Others • Friendly staff. • Tidy ward. All patient daily activities were displayed in each bedroom.	
Other Comments from Assessors: 7.	

Agenda Item 14

NHS
Southwark
Clinical Commissioning Group

Urgent Primary Care in Southwark and consideration of future models of service

1. Introduction

This paper considers the provision of Urgent Primary Care in Southwark. Local analysis and engagement has shown that the current model for urgent access to primary care across the borough is neither consistent nor optimal, with variation in service provision and quality of care in different parts of the borough. This leads to patients having difficulties navigating the system, contributing to A&E sometimes being used as a default. There are strong drivers supporting the need to change the way that urgent primary care is delivered, including the National Urgent and Emergency Care review and A Call to Action. There are real opportunities to deliver improvements in access and the productivity of services, which would support the broader Southwark Primary Care & Community Strategy.

The Lister Walk-in Centre in South Southwark which provides urgent access to primary care has been operating since May 2009. With the contract coming to an end in September 2014 it was agreed by the CCG to review the current service, but also to use this an opportunity to more broadly review the commissioning of urgent access to primary care services within both this locality and Southwark as a whole.

This paper sets out

- Engagement undertaken to date
- Findings of the service review
- Recommendations for commissioning of urgent primary care access
- Next steps, including plans for engagement

2. Engagement

In 2010, the Government introduced four tests that are intended to apply in all cases of NHS service change during normal stable operations.

The four tests – as set out in the 2014/15 Mandate from the Government to NHS England - are that proposed service changes should be able to demonstrate evidence of:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base; and
- support for proposals from clinical commissioners

This guidance relates only to major service changes, which would not be applicable in the case of the Lister Walk-in Centre. However, as good practice, we have applied these principles as part of this review and have set out below work to date

2.1 Patient Engagement

Over the past year NHS Southwark Clinical Commissioning Group (CCG) has carried out a range of patient and public engagement. The projects listed below are the areas of work which link to urgent primary care.

Improving Health Services in Dulwich and the Surrounding Areas

During February and May 2013, the CCG carried out a consultation exercise asking local people for their views on two models for the delivery of primary and community health services in the area. 863 were actively engaged in the consultation through a variety of methods including focus groups, deliberative events, responding to surveys and providing written responses. Key findings included:

1. 80% of respondents were in agreement with the overall model of delivering healthcare in the community
2. Respondents were supportive of more accessible settings for healthcare in the community rather than hospital
3. Having healthcare delivered locally was an important issue for many respondents
4. That health care should be joined up
5. That provision of out of hours care was a concern for many respondents with 92% of respondents rating access to evening and weekend primary care as an important issue

Primary and Community Care

Over the past year, the CCG has developed a Primary Care and Community Strategy which aims to deliver improvements in the quality, capacity and capability of primary and community care services across the borough. Improving access to a consistent range of high quality services, both routine and urgent, is integral to realisation of this vision. It is recognised that with increased demands upon services and the current financial challenges faced by the NHS, we need to consider different and more innovative ways of providing healthcare. The CCG has engaged with Southwark patients in a number of ways to get their views on what good primary and community care looks like, including: .

- An event was held on the 10 April 2013 by the CCG to seek input into developing the CCG's primary and community care strategy, attended by 70 stakeholders, the majority being local residents. The event sought to co-produce with stakeholders the CCG's priorities for improving primary and community care, and to develop some strategic options for delivering care out of hospital within Southwark. The key messages were:
  - patients very much valued primary care and the service offered by GP practices, but wanted consistent access to care wherever they were registered
  - patients wanted the interface with general practice to be easier and to have more signposting to other services as well as more continuity of care
  - patients wanted information shared between professionals to provide more seamless care
  - people supported the development of more services based in locality hubs
- Discussions with patients also took place at the CCG's Engagement and Patient Experience Committee in March and May 2013 and continued at locality Patient Participation Groups prior to the strategy being agreed in September.

Urgent Care Review

A patient engagement meeting was held on 29 May 2013. The purpose of this meeting was to provide information about the Guy's Urgent Care Centre Review and engage with the public about Urgent Care Services. The key messages from the group discussions included:

i. Patients who had used the Urgent Care Centre at Guy's Hospital reported a very good experience

ii. The vast majority of patients who used the UCC reported that they would have attended an A&E if they had not gone to the UCC
iii. It is complicated for patients to know where they should go for emergency and urgent services and there needs to be much clearer messaging to support patients to know where to go
iv. CCG should consider specific messages and targeting for parents of young children
v. The CCG should consider extending the opening hours until 10pm

Call to Action

As part of the national Call to Action, the CCG organised a meeting which took place on 22 October 2013, attended by approximately 70 local people. The focus of the discussions were on staying healthy, self-management and improving experience of services, but key messages that came out of the discussions that relate to the provision of access to urgent primary care include

- The need to reduce duplication in services
- There should be no postcode lottery of services
- Share common [GP] services across sites
- Pharmacists used more widely by public for a wider range of services
- Knowledge of what support exists to be made available as wide as possible
- Make sure there are a range of options available, GP, Pharmacist for people to use
- Suitable times of appointments to be available
- It can help make services flexible and convenient

Urgent Primary Care Access

As part of the review of the Lister Walk-in Centre and looking more broadly at the provision of access to urgent primary care, the CCG arranged a patient engagement discussion group which took place on 26 November 2013, attended by approximately 30 people.

The purpose of this meeting was to

- Engage with public about access and urgent care as part of the commissioning intentions process and build upon Primary and Community Care strategy
- Provide information about the planned review of the Lister Walk-in Centre
- Consider the key principles of a service model which delivers good primary care access and what this would look like in practice
- Consider how we can support patients to better manage their own health

The key messages from the group work

- Provision of urgent care: need to focus on both consistent diversion across the board and treating people at the point of access where appropriate.
- Importance of signposting and information provision – this should be consistent at all points of the healthcare system if there is to be an impact upon behaviours.
- Education: agreement that there should be a focus upon educating the public about both self-care and how to use services, in addition to general communication about what is available
- Community Pharmacy - there was a clear message about the importance and value of community pharmacy in signposting patients to appropriate services and providing advice for

more minor conditions. It was felt this needed to be more clearly communicated to the public, with pharmacists being more visible and seen as an alternative to general practice in certain circumstances. There was positive feedback on the Minor Ailments Scheme which has been recently approved by the CCG.

- Elements of urgent primary care service
    - Agreement upon the need for clear and responsive access to clinical advice and treatment in and out of core GP hours. Whilst the Walk-in Centre provides a means of deliver this, there was discussion about whether it was the solution to access issues or merely a 'sticking plaster'. If there is to be less reliance upon A&E, there is a need for more responsive capacity within primary care. A locality based model of urgent care providing weekend and evening appointments was discussed and supported as an option to explore, however there is a need to understand what factors will affect patients accessing this, with one report of inter-practice arrangements having not been successful.
    - Support for using different ways to provide care e.g. use of email and telephone consultations broadly supported but need to bear in mind different patient needs (e.g. autism/deafness) and preferences in addition to practicalities of service provision e.g. regular monitoring of email consultations would need to be so should be one of many options. Suggested that care plans include communication preference e.g. email/phone.
    - Extended hours – should be more consistent across the borough.

2.2 Clinical engagement

CCG engagement with member practices

The CCG has established a structure of meetings and forums to engage with its membership. These include monthly locality meetings for member practices organised on a North and South basis, a weekly electronic GP bulletin, monthly Protected Learning Time meetings for practice staff and a quarterly Council of Members meeting which is formal part of our governance structures as well as a 6monthly programme of individual practice visits undertaken by clinical leads and staff. This is in addition to having 9 clinical leads in place from members' practices on our Governing Body who attended monthly Clinical Strategy Committee meetings.

Improving Health Services in Dulwich and the Surrounding Areas and Primary and Community care Strategy development and implementation

There was significant engagement through locality meetings for the Dulwich programme of work and the development of the primary and community care strategy with both items being regularly agenda items at locality meetings and in the GP bulletin throughout the spring and summer, as well as being discussed at individual practice visits in this time period. (South Locality for the Dulwich work). In addition the CCG organised an additional meeting for all practices in early September on the primary and community care strategy prior to sign off later that month.

Lister Walk-in Centre Review

The review of the Lister Walk-in Service has involved consultation with practices. A practice questionnaire was circulated through the weekly GP bulletin. Practices were asked for their views on why their patients accessed the Walk-in Centre rather than their own practice. As expected the common themes were

- ease of access -both in terms of same day appointments and location
- convenience -opening times
- inability to book appointment with own GP or GP closed
- seeking a second opinion

Practices were asked for their thoughts on what interventions or support they felt would lead to more patients using their practice or other primary care /self-care option rather than urgent care services such as the Walk-in Centre. The importance of provision of information and effective signposting, re-direction from A&E and consideration of co-location of primary care and appropriate capacity in general practice were noted. Two additional points were providing access to practice nurse walk-in appointments at weekends and patient education, recognising the challenges associated with changing patient perceptions, particularly different cultural groups.

In terms of satisfaction with the clinical care provided by the WiC, over two thirds reported they were very or fairly satisfied. Practices were asked what they felt worked well in the current Walk-in Centre with the majority noting improved access. In terms of improvements, suggestions included better information sharing , patient education and opportunities to support seven day working.

Commissioning Intentions Focus groups

Lambeth and Southwark CCGs have committed to developing unified commissioning intentions across the CCGs and Local Authorities. Draft commissioning intentions were pulled together from existing programmes of work and redesign groups/programme boards and shared with stakeholders through localities and acute provider forums in October/November. In addition to this a series of focus groups were hosted across Lambeth and Southwark to take a multidisciplinary approach to reviewing and co-producing Commissioning Intentions for next 2-5 years across areas including Access & Urgent Care. The Access and Urgent Care focus group on November 20th involved attendance from secondary care, primary care, community services, mental health, LAS, out of hours providers and public health. There was agreement upon the need for local strategies to respond to both patients with complex needs and those with more minor conditions requiring convenient and accessible services. The commissioning intentions have been revised to incorporate the feedback from this discussion. The final document was considered and supported by the Lambeth & Southwark Urgent Care Working Group on 22nd January.

2.3 Patient Choice

Currently, there are a number of urgent care services operating across Southwark including the Urgent Care Service, Walk-in service and GP Out of Hours. As a result of issues that have arisen through our engagement as outlined above and through our structure of locality PPGs, concerns have been raised about the inequity of access to urgent primary care due to the geographical location of the current provision.

The model of urgent primary care access proposed (see below) would be implemented across the borough, representing an expansion of service from the current South Southwark location and hence enhance choice and access.

The service routinely record information during the patient registration process, including the reasons patients attended the Walk-in Centre. The reason cited by over half of patients was that their own GP had no appointment. However there was a shift in the nature of this response – during the initial review most patients indicated it was due to GP not having an appointment at a convenient time, whilst over the past two years, this has been replaced by GP not having an appointment that day which may be suggestive of increase in demand/expectation of same day care. Convenience was cited by only 13% of respondents.

2.4 Clinical effectiveness

The review of the Lister Walk-in Centre sought to assess the clinical effectiveness of the service. It found the majority of attendances were from Southwark registered patients, during surgery opening hours. Assessing the proportion of urgent versus routine presentations proved challenging however, the nature of conditions and anecdotal feedback suggested most presentations were not for urgent primary care conditions. This would suggest the service is being used as a substitute for general practice for factors including access issues and convenience, as reported in patient feedback.

The review also considered the impact of this service upon A&E. Whilst the data was inconclusive, a service providing access to urgent primary care can provide a useful alternative, alleviating pressure upon acute emergency services. The recent clinical streaming pilot at King's College Hospital Emergency Department (ED) demonstrated there was potential to strengthen this element and increase re-direction of patients from ED to the Walk-in Centre. Although it is not possible to assess direct impact on A&E, it is likely that a withdrawal of this service would lead to an increase in activity, representing significant risk, in terms of pressures upon A&E and achievement of the 4 hour target, in addition to financial costs if there were no alternative service put in place.

3 Options for provision of urgent primary care services

Four options for the provision of urgent primary care services were presented to the Southwark Commissioning Strategy Committee (CSC) for consideration in December 2013

i. Re-commission the Walk-in Centre service in line with the existing specification
ii. Commission limited Walk-in Centre service – unregistered patients and Kings re-directed patients only
iii. De-commission Lister Walk-in Centre and focus upon improvements in primary care access
iv. Commission alternative model of urgent primary care access based on extended access to GP practices on a locality basis

The Southwark CSC supported the fourth recommendation, and asked for the model to be further worked up with appropriate engagement and costings.

4 Proposed service model

- Locality based model delivering urgent access to primary care services, 8am – 8pm, 7 days a week provided in a way that responds to patient needs. This model is currently being developed further but could incorporate a number of elements including appointment based, walk-in, non-face to face contacts e.g. telephone and online advice and consultations
- Integrated with the service provided by each practice within the locality, and with out of hours services
- Is an extension of general primary care access rather than a separate service
- Information sharing between practices and the locality access clinic, to enable continuity of care
- Integration of access routes to urgent and core primary care services, to support triage and re-direction to services as appropriate
- Service coverage: the existing service is also open to non-Southwark patients, with a re-charge mechanism in place administered by the CCG. Our current proposal is that any re-commissioned service be commissioned by the CCG for Southwark patients only (registered and unregistered), however options to implement a cross borough re-charge arrangement will be explored to enable patients from other boroughs to be seen.

The proposed service model is in line with the current Walk-in Centre service in terms of opening hours. The number of access points across the borough will be subject to economies of scale, however, the intention is to use the Lister site as one service hub.

The new service will be implemented across the whole of Southwark, rather than in the South only, which supports the Primary Care & Community Strategy (PCCS) aim to reduce variation in service provision and responds to feedback from patients. As part of the implementation of the PCCS, practices have been asked to work collectively on Neighbourhood developments plans, which will include requirements to improve access for patients within each practice within the neighbourhood, as well as a requirement that practices work collaboratively to implement best practice across the neighbourhood and develop innovative solutions to patient access. The intention would be to use this framework to commission the proposed service.

The proposed model is an extension of current primary care provision across the borough with practices providing urgent and routine appointments to their registered patients. Close alignment with core primary care services and exploring opportunities to deliver care in a different way should improve accessibility, quality of service and patient satisfaction.

Our engagement with our local residents has clearly demonstrated the difficulties in navigating the current healthcare system, with multiple services providing urgent care and lack of a consistent message at all points of contact. The integration of urgent primary care with core general practice and GP Out of Hours Services will support a seamless service for routine and urgent care needs with one point of access. This will promote continuity of care, consistency of message and ensure more effective use of limited resources. The model will incentivise general practice to provide improved access to registered patients in collaboration with their locality practices, reducing the need to re-direct patients with primary care needs to services such as the Urgent Care Centre and A&E.

We wish to build upon the traditional Walk-in Centre model and consider innovative ways of delivering care in a way that responds more flexibly to patient need, including non-face contacts and more

effective use of technology. This approach supports the vision outlined within the Challenge Fund, which was announced by NHS England in December.

The importance of patient education in facilitating a shift in use of health services and promoting self-care, has been a consistent theme in our patient and public engagement. The proposed service will support patients to access the right care at the right time through triage and consistent re-direction where appropriate.

5 Next steps including engagement

As described, in December 2013 the Clinical Strategy Committee recommended that a locality model of provision or urgent primary care be developed. In working up this model, the CCG has proposed that further clinical and patient engagement include:

January	Locality commissioning meetings – discussion with general practice
	Overview and Scrutiny Committee
February	Locality commissioning meetings – discussion with general practice
	Locality Patient Participation group meetings - discussion regarding potential service models at the
	CCG Commissioning Strategy Committee – 18th February
	Patient engagement event – 26th February
	Discussion with King's College Hospital and SELDOC (GP Out of Hours service) regarding the implications of this proposal upon the wider health economy
March	Engagement and Patient Experience Committee EPEC: 19 March
April	CCG Commissioning Strategy Committee – 15th April
	Oversight and Scrutiny Committee
Ongoing	Views and on-going dialogue sought via the weekly GP bulletin
	Advertise this work via the website and ask for views via our social media work including twitter and posting on area forums

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2013-14**

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Dated: December 2013