

**Community Action Southwark and Healthwatch Southwark's response to
Improving health services in Dulwich and the surrounding areas
A consultation about local services**

This is a joint response from Community Action Southwark (CAS) and Healthwatch Southwark (HWS).

Both organisations have used our mailing lists to promote the consultation as did the previous Local Involvement Network (LINK Southwark). HWS has also valued the seat that it has on the Dulwich Programme Board (occupied by LINK Southwark pre April 2013). We were pleased to co-host a consultation session for the voluntary and community sector organisations and due to this we have kept this written response concise and used to provide a summary of the issues raised at that session and additional comments we have received from members of the public during the 3 month consultation period.

We have attempted to place our feedback in under one of each of the four Groups given in the consultation document.

Group 1: Healthcare for everyone- if you're feeling unwell or need advice and reassurance

Physical capacity and other resources- For residents responding to the consultation more information on the space available in GP surgeries and the staffing situations would have resulted in a more informed response. It is difficult to have a complete picture without this information.

GP Appointments- It is hoped that whatever option is chosen that the appointment system will improve for example reduced waiting time for appointment with own GP.

Group 2: Healthcare for everyone- helping you to stay well and prevent ill health developing

Care in Hospitals- There needs to be some consideration as to how the changes would affect care provided in hospitals. Some feedback we have received suggests that there is an inconsistency in quality of care between GPs/ GP surgeries when people are referred to hospital or when they are receiving care within hospitals. For example patient records not being transferred or updated between GP and Hospital Healthcare staff.

Group 3: Women who are pregnant and families with very young children-

We have consistently heard that location should be convenient, local and accessible, especially for those with very young children. Where possible, continuity of care i.e. through midwife, GP or other professional should be the norm throughout the pregnancy.

Additionally the former LINK Maternity & New Born Task Group also found physical capacity to be an issue during midwifery care at some GP practices. Physical capacity for midwife and health visitors to operate in and to accommodate buggy space during postnatal care should be considered.

Group 4: People with long- term conditions (including mental health) and older people

Mental Health- we are aware that South London and Maudsley are currently transferring patients from Community Mental Health Teams. Local and simple access to mental health support and to look at ensuring any 'reception desk/front house' has privacy considerations for patients and users when speaking to the reception, as well as a more user friendly entrance.

Dementia- Again, regardless of the options chosen, there needs to be more support for people with dementia (more than just Memory Clinics) e.g support groups at each Health Centre/ GP surgery as well as very strong links to the planned Centre of Excellence being put in place by Southwark Council.

District Nurses – concern about implications of the upcoming changes upon district nurses e.g. the care that people receive at home when they are at the end of their lives. Clarity needs to be given as to the effect that Option A. B or any other option will have on the district nurse provision in south Southwark and the borough as a whole.

Integrating voluntary sector service provision

According to the latest Charity Commission data, there are 1,111 registered charities in Southwark. These organisations provide a vast range of flexible and high quality health and social care services such as home care support for the elderly and day services for people with learning disabilities as well as services tackling social issues such as employment, debt advice and social housing. They work with people of varying age, background and need, including those who don't typically engage with statutory services.

There are benefits to be reaped through a more integrated working relationship between voluntary sector providers and the health sector that include reducing health inequalities, improving health outcomes and reducing hospital admissions. Arising from a series of cross-sector partnership working improvement events that Community Action Southwark held between senior colleagues across the local public sector (including Council and CCG) and voluntary sector, I propose that the health services in Dulwich and the surrounding areas would benefit from the development an **e-marketplace** would that would be a single, central resource to provide access and information regarding health and social care services in Southwark. It should have the following characteristics:

- Listings of statutory, private and voluntary sector health and social care services
- Information regarding services and the ability to purchase services

- 'Trip Advisor'-style rating system of services
- A website and telephone line
- Be accessible to the general public, people with personal budgets & professionals across sectors (including GPs)
- Partners should upload/update their own information but the marketplace should centrally managed
- User search data and information on services purchased through the system should be used to shape market.

Acknowledging that health is affected by wider social determinants such as housing, employment, mental health and connectedness - all areas where the voluntary sector typically provide professional support – this system would allow GPs and other health professional to refer patients who require specialist/social/ongoing support into the necessary services. In relation to the themes of this consultation, the e-marketplace would be particularly useful in relation to Priority 2 - Healthcare for everyone - helping you to stay well and prevent ill health developing and Priority 4 - People with long- term conditions (including mental health) and older people.

For more information regarding the e-marketplace and its potential application in Dulwich and the surrounding areas, contact Andy Boaden, CAS andy@casouthwark.org.uk 020 7358 7017.

Consultation process

We would like to highlight the impressive amount of outreach that the Programme Manager and Communications and Engagement Manager undertook in meeting with numerous community groups, projects, forums and voluntary organisations. We are also aware that there were some members of the public who were dissatisfied with the level at which they participated in the development of the consultation and the level of discussion at the May public meeting. It is hoped that these views and that of others will improve the levels of engagement in future consultations. We would like to state that the time spent answering questions and responding to residents comments by the Clinical Commissioning Group Chief Officer and other staff members is valued.

Post- consultation

Messages about the changes and stages of the consultation will need to be publicised to ensure that the people living within the area are informed.

Improving health services in Dulwich and the surrounding area

Consultation response from Southwark Council

We support developments that seek to improve the quality and effectiveness of primary and community care services for local children and families. Addressing health inequalities, integrating care and improving outcomes in the borough in the context of growing demand and highly stretched resources is a priority shared by council and its partners across the Health and Wellbeing Board. These principles will underpin our shared vision and strategy for local integrated care.

We welcome the overall direction of change set out in the consultation document, with both options seeking to increase the use of community-based care and reduce the reliance on acute care. Supporting people to live healthily and remain independent, preventing illness and the need for more intensive services, including social care, is a central tenet of our local strategy. The council also welcomes the potential opportunity to consider different and innovative ways of commissioning and delivering effective health improvement services.

We offer the following points for consideration as an option is chosen and taken forward:

- Exploring opportunities for integration, for example co-locating children's centres and adult social care services, or in developing stronger joint working through the Southwark and Lambeth Integrated Care programme, and with local beacons, such as the centre of excellence for people with dementia, as well as wider earlier intervention services such as the early help locality teams
- Providing more opportunities for prevention and self care, such as through support groups, as well as the promotion of wellbeing around the 'five ways to wellbeing'
- Ensuring new or refurbished buildings provide sufficient accommodation to support integrated working practices, such as community multi-disciplinary team meetings and multi-agency advice-giving
- Ensuring that a detailed understanding of residents' needs underpins decisions on where services are sited (be it a GP practice or health centre)
- Ensuring the primary care strategy continues to support and ensure improvements across all practices, including workforce developments, and meets any potential longer-term capacity issues
- The impact of changing services at GP practices on their capacity and ability to maintain and improve standards, in particular in reducing variation between practices, and financial sustainability
- Considering the distance patients will be required to travel for treatment, especially for those with mobility difficulties, young children or financial hardship
- Implementation will be key to ensure that the principles of high-quality care described in both options are achieved
- Ensuring arrangements are future-proofed to ensure they can develop and adapt in response to changing community needs going forward

We think either model has the potential to be applied elsewhere in the borough, and should be considered alongside other local developments to improve service user experience and outcomes, and meet local need. We believe the final choice should be based on these considerations as well as an evaluation of which configuration best serves patients' needs, taking into account cost and clinical effectiveness and equity of access and residents' views.



Lambeth
Clinical Commissioning Group

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Dear Sir/Madam,

Re: Development of Health Services in the Dulwich area

Thank you for the opportunity to comment on NHS Southwark consultation document 'Development of Health Services in the Dulwich area'. The proposals directly affect patients from Member Practices in the South East Locality of Lambeth and the Locality has been asked to contribute to the overall response from NHS Lambeth CCG.

NHS Lambeth CCG fully supports Southwark CCGs stated aims of delivering improvement in patient outcomes and in patient experience of healthcare services. We welcome the approach aimed at enhancing the range and quality of primary and community health services and to explore how they can be improved through greater integration. We trust you have considered equalities as part of your proposals and look forward to the outcomes of the Equality Impact Assessment that is currently underway.

The proposals described fit well with our own commissioning intentions and those set out within South East London CCGs Community Based Care Strategy. These all focus on making sure that high quality primary and community services are provided in the most appropriate settings, closer to where the patients live and are enabled to best support patients in managing their health conditions.

NHS Lambeth CCG has worked closely with Southwark colleagues in developing our proposals for West Norwood Neighbourhood Resource Centre. We remain keen that the outpatient provision and services to support long term condition management, as described in your proposals, link to the service strategy for West Norwood Neighbourhood Resource Centre, which is due to open in spring 2014.

NHS Lambeth CCG would be in favour of exploring the possibilities of relocating primary care OOH alongside our Urgent Care Centres and A&E departments to improve overall patient access to urgent care. This approach fits with the exploratory

Clinical Commissioning Group

discussions that have been taking place within the Unplanned Care Programme Board across Lambeth and Southwark.

We welcome the investment Southwark has made to enhance intermediate care services for the population of Southwark and would be keen to ensure that community rehabilitation services complement each other across the two boroughs.

A number of Lambeth patients access the current renal dialysis unit at Dulwich Community Hospital and we would continue to support approaches whereby access to renal dialysis remains accessible and convenient to patients.

NHS Lambeth CCG is keen to remain closely involved in the development of the proposals for Dulwich going forward. We would wish to work together with Southwark CCG so that we can maximise the opportunities to link the future of Dulwich Community Hospital, complementary with the Lambeth West Norwood scheme, to address improved community-based care.

We welcome regular updates on progress so that we can ensure our Member Practices in particular in the South East Locality are kept fully informed.

We wish you every success in progressing this important development work. Please do not hesitate to contact Therese Fletcher at therese.fletcher@nhs.net should you have any queries on this response.

Yours sincerely,

Adrian McLachlan
Chair
Lambeth CCG



Andrew Eyres
Chief Officer
Lambeth CCG





**Lewisham
Clinical Commissioning Group**

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21st May 2013

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Dr Amr Zeineldine
Chair
Southwark CCG
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Dear Amr

Improving Services in Dulwich and surrounding areas – Response to Consultation

Thank you for providing copies of your consultation document to Lewisham CCG. We have reviewed the documentation and raised it with members through our representative Membership Forum.

Lewisham CCG is pleased to be able to support Southwark CCG's proposals in broad terms as they are in line with our collaborative vision and strategy for community based services. We look forward to continued work between us as you implement the outcome following consultation to ensure our approaches to community based services are aligned for the benefit of both our populations living around the Dulwich area.

Yours sincerely

Dr Helen Tattersfield
Chair

Response to consultation: “Improving health services in Dulwich and the surrounding areas”

Guy's and St Thomas' NHS Foundation Trust welcomes this consultation and the opportunity to comment on the development of health services in and around Dulwich. We recognise the specific needs of this population which are identified in the consultation, such as increasing numbers of older people, very young children and those with long term conditions. The consultation identifies a number of challenges to providing appropriate and responsive healthcare services that improve population health. We believe this consultation presents a real opportunity to ensure that health services in Dulwich can meet the needs of patients and through better healthcare provision help people in Dulwich to stay healthier and live longer.

We welcome the extensive engagement with our staff and patients that has taken place over many months to consider different options, develop these proposals and consider the effect they would have on our acute and community services in Lambeth and Southwark. As providers of community health services in Lambeth and Southwark, we are aware just how critical the provision of high quality services in the community is to maintaining and improving the health of those in the area. It is a long standing aim that those patients who can safely be treated in the community are supported to do so, preventing unnecessary hospital admissions. We see the further development of appropriate community facilities in Dulwich as a key part of delivering this community based healthcare strategy.

The consideration of the impact of these proposals on different groups in the population is a useful way of outlining the effects of the different options. In particular we note the focus on the needs of older people and those with long-term conditions. This is something that we agree is vital, and as part of Southwark and Lambeth Integrated Care (SLIC), we are working as part of a federation across social and health care and yourselves as commissioners. We aim to transform how the community works together to provide integrated care, delivering better quality care with increased value ourselves, and empowering people to look after themselves better. Having the right facilities in the community is an essential part of this vision, and SLIC are submitting their own response to the consultation to allow them to explore this relationship in full. The development of health services in Dulwich should fully consider the opportunities to realise ambitions around integrated care and ensure there is scope for further development as the potential of integrated care continues to grow in the coming years.

We appreciate the need for efficiency in the delivery of healthcare services and fully endorse the need to make best use of the resources we have available, ensuring they are used to treat patients in the environment most appropriate for their needs. Guy's and St Thomas' is currently working with yourselves as commissioners and NHS Property Services to conduct a review of the utilisation of community services estates to ensure it is used effectively. In light of this review, we would welcome further conversations with Southwark CCG about ensuring plans for the Dulwich site complement our own proposals for the use of community sites in the surrounding area. There is always a need to balance clinical and administrative space in NHS properties, and we would support a mixed use of the site to most appropriately reflect the staff and services the building will contain.

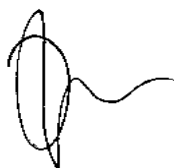
Guy's and St Thomas' has a specific interest in the Dulwich hospital site with respect to the community staff that are currently located there. We have been in discussion with Southwark CCG about the future location of staff under these proposals, and are content that appropriate provision has been made for this.

In coming to a decision on the use of the Dulwich site, we believe it is vital that the health services available in Dulwich are clearly linked to other healthcare developments in the local area. As providers of community services across Lambeth and Southwark, we are acutely aware of the need for a comprehensive network of community services that work together across the boroughs. As well as the health services highlighted in this consultation, there are significant developments at West Norwood (where there has been a large investment in a medical, dental and leisure centre), as well as the recently opened Ackerman health centre at Patmos Road and Gracefield Gardens in Streatham. While the proposals in this consultation are entirely compatible with these developments (and indeed they may provide relevant learning for the new health centre), it is important that these proposals fully take account of services on offer close to Clinical Commissioning Group or Local Authority boundaries. We recognise, however, that the consultation has worked to take into account NHS plans across south east London.

We consider that options A and B for the provision of healthcare services in Dulwich are finely balanced, with opportunities presented by both approaches. Having reviewed both proposals, it is our view that there may be greater benefits realised by implementing option A, in which more services are located in a larger health centre which would be likely to be based on the Dulwich Hospital site (accepting this might mean less services in individual GP practices). We have seen in other similar community developments the advantages that come from co-location of services and provision of a central healthcare community hub. We believe this is a successful and proven model that would be likely to create a focal point within Dulwich where a range of different services could be provided. It is possible that some of these benefits would be lost by providing the services across a wide range of GP practices, and this might lead to greater fragmentation and variation in care across the borough, as well as increased travel for patients with multiple appointments. Equally, it will be important to learn from other health centre developments in the surrounding area and across London to ensure that improvements on previous models are made and that full consideration is given to the need for innovation in areas such as workforce development.

We note that the consultation suggests that a disadvantage of a larger centre might be that it would cost more to build and run on an ongoing basis. While the initial costs of the development may be greater, it is our view that more value might be gained in the longer term through the larger health centre. It will be important to understand the detail of this during the production of a full business case for the development.

While supporting option A overall, we believe that both of the options being considered have the potential to deliver improvements in health services in the Dulwich area. It is vital that after the appropriately extensive deliberations that have taken place we now move decisively towards action. The focus must shift to implementation and delivery under whichever model is chosen, to ensure we are making use of the assets that exist in the local community to improve the experience for patients. We look forward to working with Southwark Clinical Commissioning Group to further develop the model for the site and discuss the role that Guy's and St Thomas' Foundation Trust can play as they progress their plans for the development of healthcare services in Dulwich.



Ron Kerr
Chief Executive

King's College Hospital NHS Foundation Trust

Response to the Southwark Clinical Commissioning Group consultation entitled 'Improving Health Services in the Dulwich and surrounding areas'

1. Introduction

King's College Hospital is one of the UK's largest and busiest teaching hospitals, we employ over 7,000 staff and provide around 1,000,000 patient contacts a year. King's primarily serves people in the London boroughs of Lambeth and Southwark as well as providing specialist services to patients from further afield.

The Trust is recognised internationally for our work in liver disease and transplantation, neurosciences, cardiac, stroke and major trauma.

King's are part of King's Health Partners (KHP) Academic Health Sciences Centre (AHSC), a pioneering collaboration between King's College London, and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts. The partners are currently looking into options for more formalised integration options in order to build on the existing partnership between the organisations to deliver benefits for patients, staff and students.

2. Consultation response

The Trust is pleased to be working in partnership with Southwark Clinical Commissioning Group (CCG) to identify the future health and wellbeing needs for the local people we serve in Dulwich and the surrounding areas and welcome the opportunity to provide a stakeholder response to the CCG consultation.

We will continue to develop local integrated care services in partnership with KHP, primary care and social care providers. A major initiative is Southwark and Lambeth Integrated Care (SLIC) in which King's is a partner. Our aim through SLIC is to build healthier, happier and longer lives through a radical transformation of how healthcare professionals, citizens and communities work together. This requires systemic change in health and social care in Lambeth and Southwark. It requires paradigm shifts in behaviours from service users and service providers.

We would like to explore opportunities with our primary care and community partners for providing more locally based care in the Dulwich area especially for people living with Long Term Conditions (LTC's). We believe that people with

LTC's need an array of services available to them and as much as possible in one place.

King's is capacity constrained and plans to manage emergency demand through admission avoidance pathways and managing care outside of hospital. We do not have plans to develop bed-based services within the proposed health centre but our specialist clinical teams could provide planned care in a community health centre to prevent the need for people to attend an acute hospital site. GP practices are known to be variable in terms of space, capacity and skills so it is desirable to have a number of services under one roof.

3. Community Based Care

Where appropriate, we support proposals to move access to planned services from an acute setting closer to local need. For example, there are high number of patients from the Dulwich area currently being treated at King's in the Diabetic eye screening service. This service would be better provided in a Dulwich health centre

4. Midwifery led Birthing Unit (MLBU)

King's would like to develop a MLBU in the future but after careful consideration with midwives, obstetricians and neonatologists about the feasibility of a Dulwich based MBLU we have opted to provide this service co-located with the hospital obstetric unit.

5. Renal Dialysis

King's will continue to provide a renal dialysis service in the Dulwich locality. Due to the increasing incidence of renal disease we will require a bigger unit than we currently have. We are now developing a business case to provide a larger renal dialysis unit either within or co-located on the Dulwich health centre campus.

6. Conclusion

In the context of the commentary set out above the Trust supports option A set out in the consultation. We believe option A would provide a longer term and more sustainable option for the provision of integrated health care services in the Community that are accessible and meet local need.

King's Health Partners Academic Health Sciences Centre
Headquarters, Ground Floor, Counting House
Guy's Campus, St. Thomas Street, London SE1 9RT

May 2013

Dear Andrew,

Re: 'Improving Health Services in Dulwich and the surrounding areas'

King's Health Partners recognises the importance of the collaborative work Southwark CCG is undertaking to improve health services in the Dulwich and surrounding area. I know that you fully appreciate that King's Health Partners is deeply committed to developing integrated care, collaborating with social and primary care, through the Southwark and Lambeth Integrated Care programme. We see successful integration of care as an important means of improving patient and population outcomes, reducing costs and thereby increasing value for the local health and social care economy.

Your proposals for Dulwich will support integrated care and particularly strengthen the care of people with long-term conditions. If successful, the proposals will move the care of many patients out of hospitals. Not only will this reduce costs, it will also improve the effectiveness of our hospitals and free up space to better care for increasing numbers of tertiary patients. The growth in tertiary activity will further strengthen the health economy.

King's Health Partners believes that the care of patients with long-term conditions and the successful move of care from hospitals to the community setting is more likely to be achieved by option A as set out in the consultation. We believe that in the longer term this option would be much more sustainable, better able to deliver high quality outcomes, make better use of resources, and add greater value.

There is one area of the consultation that causes us concern. We have doubts that a stand-alone midwifery-led birthing unit is appropriate and would express some concerns about the impact this could have on clinical outcomes.

Finally, we would welcome further discussion about the optimal way that mental health services can be incorporated into your proposal.

Yours sincerely,



Professor John Moxham

Director, Clinical Strategy King's Health Partners



SOUTHWARK & LAMBETH INTEGRATED CARE

On behalf of Southwark and Lambeth Integrated Care (SLIC), we welcome the opportunity to respond to the consultation re future health and wellbeing needs for local people living in Dulwich and the surrounding areas.

The SLIC vision aims to achieve:

'healthier, happier and longer lives through a radical transformation of how professionals and communities work together to provide integrated care and better value, with empowered citizens who are better able to look after themselves through supported self care'

The integrated care mission states we will:

1. Build community assets
2. Ensure that people in Southwark and Lambeth reliably receive the right care in the right place at the right time
3. Ensure that we are treating the whole person with care centred around the empowered individual
4. Ensure professionals are best able to deliver this new approach
5. Ensure better professional lives for the staff we are working with

Where possible, we aim to reduce hospital admissions, reduce hospital length of stay, reduce residential social care and improve people's experience of health and social care by improving the co-ordination and management of care.

Integrated Care is focused on care of older people and people living with long term conditions (often with multiple conditions) who need a range of services available to them as much as possible in one place. We believe there are greater longer term benefits realised by option A where more people can access care in one place and recognising the value of multi agencies working together. As we change service models we will build on assets in the community e.g. peer support, the voluntary sector and volunteers and the Dulwich facility would be a place for people to come together.

We look forward to working closely with the Southwark Clinical Commissioning Group and community services to progress plans for development of health and social care services in Dulwich which will be set out in the full business case.

Merav Dover, Chief Officer, Southwark and Lambeth Integrated Care

**South London and Maudsley NHS Foundation Trust
response to the Dulwich hospital consultation**

Initial discussions have taken place as to whether adult mental health services could be co-located in the Dulwich Hospital development as there could be real advantages if enough GP practices are located there. However, more detail on how SLaM can interact with primary care and work in the proposed health centre would be helpful.

The consultation does acknowledge the need to provide co-ordinated services to support long term conditions – which include mental health and the need to support the elderly population. There is an expectation that memory assessment will be part of the new model. It also acknowledges the plans to develop integrated care models possibly as part of the wider Southwark and Lambeth Integrated Care (SLIC) initiative.

SLaM's Mental Health Promotion Team have been commissioned by the people organising and running the consultation for the Clinical Commissioning Group to support them to consult with BME communities in South Southwark about this. As a result two focus groups to engage BME communities will be held by the end of the month.

Overall the FT strongly supports Option A as listed in the document.

Paul Mitchell
Trust Secretary
May 2013

Our Ref:
Your Ref:

Email address – jane.fryer@nhs.net
Telephone Number – 0207 932 3862

Andrew Bland
Chief Officer
NHS Southwark CCG

31st May 2013

Dear Andrew

Response to the consultation- 'Improving health services in Dulwich and the surrounding area'

Thank you for your letter of the 20th May inviting us to respond to the above consultation.

NHS England is pleased to support the proposed model of care set out in the consultation document. We see it as being based on a sound analysis of the issues facing the CCG, in particular the need to address population changes and to improve access to good quality primary and community services.

We note that it is consistent with the strategies set out by both commissioners and providers in the area, and recognise that these proposals will contribute in the medium-long term to the delivery of the Community-Based Care Strategy and your future QIPP. It will also, as part of that, support the implementation of the Southwark and Lambeth Integrated Care Programme.

We recognise that the detail of the service delivery is yet to be worked through, but would want to note that any services – in particular those relating to urgent and emergency care and maternity care will need to meet London standards.

We know you are already in discussions with colleagues here about the potential opportunities to improve the quality of primary care provision, and I am sure those discussions will continue.

Yours sincerely

Dr Jane Fryer

Cc Jacqui Harvey NHS England
David Sturgeon NHS England

**Response by Rt Hon Dame Tessa Jowell MP to the Southwark Clinical Commissioning Group consultation:
'Improving health services in Dulwich and the surrounding areas'**

The key principles in evaluating the changes proposed in this consultation are: Do they add value, quality and capacity and will they lead to the best possible services for service users?

My response can be characterised by reference to my contribution during the recent Queen's Speech debate in the House of Commons. The key to all the changes proposed is to build services around the needs of individuals rather than service providers:

"It is very hard to find those families who would not prefer their elderly relatives to be loved and looked after in their own homes. Therefore, that should not just be the rhetorical aim of the policy; it should be the organisational and administrative means by which that hope is realised. Again, that is not difficult, but we must start with the individual and their needs and build the structure and organisation of the service around them, rather than, as so many elderly people find is their lot, making their needs conform to predetermined rules that have little to do with their circumstances". This principle should extend to all services. I provide some more detailed comment below.

Section 2 - Part 1 - Proposed services

The four principles set out in Section 2, Part 1, of the consultation are beyond controversy, namely:

- Ensuring that individuals have access to healthcare advice and diagnostic services at a number of local sites including GP surgeries, pharmacies or at a health centre. This would reduce the length of time people have to wait for treatment and mean that, in many cases they do not need to go to hospital for treatment or advice.
- Detecting health problems early by improving the availability of screening, immunisation and prevention services in pharmacies, GP surgeries or a health centre, making it more convenient for people to use these services.
- Providing health services that are closer to home for expectant mothers and young children by providing more services in local community facilities so that care is personalised and tailored to people's needs.
- Helping older people and people with on-going health conditions to manage them and remain independent by ensuring care is provided in the community and is more joined up.

Comment

Specifically, in relation to services for expectant mothers and young children, it would certainly be ideal to provide individually tailored services closer to home. These must be planned however, and integrated with services provided by King's and other local organisations who may favour alternative ways of delivering services - by linking to their

obstetric services for example. As outlined above, services should be built around the needs of individuals using them.

The focus on helping older people and those with on-going conditions, to give them the opportunity of staying in their homes and prevent them from going into care or an acute setting is welcome.

The availability of individualised care, tailored to people's needs, is extremely important but it will require an intensification of community support in relationship intensive services by suitably trained staff. This is particularly the case in ante-natal and midwifery services and in services for older people and those with on-going conditions. There is no point in talking about developing such personalised services if the reality facing service organisation is, for example, a shortage of midwives or other suitably trained staff.

Section 2 - Part 2 - Organisation of services

Option A - more services from a health centre likely to be located on the Dulwich Community Hospital site with core services from GPs

Option B - more services from own or nearby GPs with other services from a more limited health centre located on the Dulwich Community Hospital site.

Comment

I strongly support the Option A plans for a multi-service health centre. This must not be a mere shell for GP services but offer a distinctive range of services that will, in practice, greatly reduce the need for patients to go to King's or other acute or remote settings.

The health centre should provide services above and beyond what a GP service could provide on its own. The new centre would provide the certainty of a well-planned, wide range of services, rather than the risk of fragmentation that relying on the hope of service development at GP practices will create. It will also provide for wider opportunities for the integration of health care services with other healthcare providers - the continuation of renal dialysis services by King's on the Dulwich site for example. The health centre should also operate at times that reflect modern expectations of those wishing to access services.

As the consultation notes, the quality of service and facilities at GP practices is variable locally. The Option A model should also ensure that all local GP practices are providing a high standard of core services in appropriate modern premises with increased capacity to deal with patients at times that suit them.

My concern with Option B is that it would create more confusion for patients with various services being provided through different GP practices with no clear logic as to where these services are provided. It may also mean that, for those with complex conditions for example, people may need to attend different GP practices for different elements of their care. The simplicity of Option A will ensure a simple, easily understood organisation of services for all patients who will access care locally either at their GP or the new health centre.

Option A is also more likely to allow a greater ability to successfully implement the growing areas of telecare and telemedicine which are likely to play a big part in the future in helping people to manage their conditions and stay in their own homes.

Conclusion

I support the principles outlined in the consultation document of bringing services closer to those who use them and individually tailored to people's needs.

I support Option A for the organisation of services as it is clear and simple for patients to understand and access. It provides the opportunity of bringing access to many services into the local community and away from an acute setting like King's. It also allows for clear planning and for the development of integrated services across a range of healthcare providers.

I would also make the point that the governance of these arrangements will be important in ensuring that the expressed objectives of bringing personalised care to people is fully realised.

Lambeth, Southwark and Lewisham Local Pharmaceutical Committee



Supporting Pharmacy Contractors

Chairman: Dilip Joshi MRPharmS
Chief Executive Officer: Jayesh Patel MRPharmS

C/O Business Services Bromley Ltd
Provident House
Burrell Row
Beckenham
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31st May 2013

Rebecca Scott
Programme Director - Dulwich
NHS Southwark Clinical Commissioning Group
1st floor, Hub 5
PO Box 64529
London,
SE1P 5LX

Dear Rebecca,

Re: Consultation - Improving health services in Dulwich and the surrounding area

Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognised by local NHS Primary Care Organisations and are consulted on local matters affecting pharmacy contractors.

Further to Dilip's initial reply, Lambeth, Southwark and Lewisham Local Pharmaceutical Committee (LSL LPC) wish to respond to the consultation on Improving Health services in Dulwich and the surrounding area as follows:

We suggest a full impact assessment study is carried out due to surgeries being relocated. Instead of improving access, as intended, it is possible that access is reduced for patient groups such as young mothers, the frail and elderly and those reliant on public transport. In fact, in the recent consultation event on 10th April at 6 Avonmouth Street, transport links were mentioned as one of the biggest barriers to accessing healthcare services. For those using personal vehicular transport, environmental factors such as adequacy of parking and traffic congestion need to be considered.

Furthermore, if the present local access to healthcare services, at relatively short distances, is compromised, there may be greater call on hospital emergency services by vulnerable, elderly and frail patients with a likely impact on the 999 service as this may be considered to be an easier option for some.

Previous consultations have shown that there is adequate provision of pharmaceutical services in Dulwich and the surrounding area. If a new pharmacy opens at the site or one pharmacy in the neighbourhood is relocated into the new site, existing level of pharmacy services may be jeopardised

due to loss of NHS income, resulting in possible closures. This is likely to have a wider impact in terms of services no longer being easily accessible to less mobile residents and loss of jobs in the local community. The British Retail Consortium reported that 11.3 per cent of stores on the High Street and in shopping centres were vacant in October 2012; pharmacy closures or relocation is likely to have a further negative impact on the viability of other local shops and businesses.

We believe that pharmaceutical service provision should be based on a needs assessment (PNA) and investment in the existing pharmacy network through commissioned services such as the Minor Ailments scheme that currently operates in Lambeth and Lewisham would be a better use of resources – this can be integrated with the new 111 service to alleviate pressure on hospital emergency services.

Local pharmacies provide triage and referrals to GPs and other healthcare providers and there is an opportunity to develop this further to improve cost-effective healthcare. Patients attending the new site already have an adequate network of existing pharmacies and space at the new site is perhaps better utilised for performing minor operative procedures and providing treatment that patients currently access through secondary care.

If you would like to discuss any of the points raised or consider alternative solutions, please do not hesitate to contact the LPC. We are also happy to attend a meeting if this is helpful.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J. S. Patel', written in a cursive style.

Jayesh Patel
CEO
LSL LPC

Southwark CCG

Evidence submitted to the Southwark CCG Consultation on Improving Health Services in Dulwich and the surrounding area

To: Sarah Mulcahy, Opinion Leader
By email: smulcahy@opinionleader.co.uk

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 51,000 qualified physiotherapists, physiotherapy students and support workers. 97 per cent of qualified physiotherapists are CSP members.

The CSP welcomes the opportunity to provide evidence to the Southwark consultation on *Improving Health Services in Dulwich and the surrounding area*.

Physiotherapy has an important contribution to make in meeting key outcomes that the consultation focuses on. These include treatment of a range of conditions within the community, reducing the need for hospital care, early diagnosis of health conditions, rehabilitation and reablement, supporting older people and people with long term conditions to manage their health and remain independent. Physiotherapy staff are involved in all areas of health care, public health, and in social care settings, and have useful insight into achieving integration and continuity of care from one setting to another, prevention and early treatment.

This evidence is submitted by the London Regional Network, a membership group in the CSP, in collaboration with the London Physiotherapy Managers Forum, and draws on the experience of clinical experts working in Southwark and other London areas from these networks, as well as national evidence collected by the CSP.

1. Existing services

- 1.1 Physiotherapy plays an important role in cardiac rehabilitation for people in Dulwich and the surrounding area. This includes clinical expertise to tailor exercises, deliver public health messages and support individuals to make lifestyle changes. National evidence shows that cardiac rehabilitation, which has physiotherapy as a core component of this, can reduce the risk of cardiac mortality by 26 per cent over five years and is second only to aspirin and betablockers in terms of cost-effectiveness, and reduces the number of hospital readmissions¹. There is also evidence that such programmes demonstrate an average 25 per cent improvement in fitness levels, enables people to return to work, and supports people to self manage their condition².
- 1.2 Physiotherapy also plays an important role in pulmonary rehabilitation for people with in the local community with chronic obstructive pulmonary disease (COPD), including pulmonary rehabilitation exercise, as well as exercise classes for renal patients. There

¹ *Physiotherapy works Cardiac rehab*

² *Department of Health. Coronary heart disease and the need for cardiac rehabilitation*. London DH 2010
<http://www.dh.gov.uk/en/Publicationsandstatistics/>

is a wealth of evidence, including NICE guidelines³ to support exercise classes for these patient cohorts.

- 1.3 Physiotherapy is also an essential part of the early supported discharge services for stroke survivors in Southwark. Approximately one third of stroke survivors are left with disabilities and rehabilitation needs. Physiotherapy professionals have a critical role to play in supporting stroke survivors in the weeks following discharge, and in supporting stroke survivors to maintain rehabilitation progress, prevent further strokes and the development of co-morbidities, and self-manage the condition. The contribution that physiotherapy makes is supported by National Clinical Guidelines for Strokes⁴.
- 1.4 Physiotherapy is effective in the management and treatment of musculoskeletal disorders, one of the most common problems that physiotherapists treat. Services are currently provided at Dulwich Community Hospital for the management of musculoskeletal disorders (MSDs). This includes assessment, treatment and management of a variety of orthopaedic, rheumatology, soft tissue and occupational health conditions. This also includes the use of acupuncture for pain management. Additionally, a range of exercise classes are also provided for these patients. Access to physiotherapy services for people with MSDs, and other long term conditions would be improved by the adoption of a self-referral model of delivery for Southwark communities (see 2.2).
- 1.5 Additionally, there is a role for physiotherapy as part of a multi-disciplinary team in the community with the management of patients with chronic pain, such as supporting patients using Cognitive Behavioural Therapy.

2. Where should services be provided and what additional services are needed that are not currently provided

- 2.1 Although there are some benefits to providing care for patients in GP practices, a move away from a model of illness towards a model of health and well being might be better supported in a larger health centre with access to a group room. Here, a variety of exercise classes can be run which in turn a number of patients can attend simultaneously which in turn may lead to better patient outcomes. Provision of physiotherapy at a local health centre would provide patients with the opportunity to interact socially with people in their area, whilst providing quality assurance and access to other services. This model also has greater potential for access to a larger number of staff from each professional group, so ensuring access to a range of sub-specialist skills and increased possibility of grade mixing and development of junior staff
- 2.2 Self-referral to physiotherapy is currently not available to communities in Southwark and would be an enormously valuable addition to community services in Dulwich, putting patients in control of their care and their health. Self-referral to physiotherapy has been found to be a cost and clinically effective way to enable people to manage a whole range of long term conditions, including people with MSD, neurological conditions, and stroke survivors following the end of treatment through Early Supported Discharge Programmes.

³ *Chronic obstructive pulmonary disease* (updated) (CG101) NICE Clinical Guidelines. Nice January 2010 <http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101>

⁴ Royal College of Physicians Intercollegiate Stroke Working Party, *National Clinical Guidelines for Stroke*. 3rd ed. London. Royal College of Physicians 2008

- 2.3 Evidence from the self referral pilots that took place across six NHS England Sites between 2006 and 2008 were found to reduce the number of associated NHS costs⁵. Since then many areas have adopted the self-referral model successfully. For example, in Cambridge the introduction of self referral for MSD outpatient services has reduced costs of GP use of prescribing and diagnostic tests, and 75 per cent of patients who self-referred did not require a prescription for medicines, giving an average saving of £12, 000 per GP practice.
- 2.4 The evaluation of the pilots looked at whether there as a risk of self-referral increasing demand for physiotherapy services beyond capacity. The findings were that as long as the service is not historically under-referred to (referral rate of less than 50 per 1000) self-referral does not lead to increased long term demand. The pilots showed that during the first three months there may be some increase in demand as patients access the service more quickly, levels revert to normal within that timeframe. These observations have been repeated in other Department of Health studies.⁶ We would strongly recommend that commissioners consider introducing such a service as it reconfigures community services in Dulwich

3. Detecting problems early by improving screening, immunisation and prevention services and making them more accessible

- 3.1 Exercise classes are an important tool in preventing illnesses and managing long term conditions. Physiotherapy staff have an important role to play in delivery of these for many different patient groups. (see 1.1, 1.2, 1.4, 2.1, 4.2, 5.2, 5.4, 5.7). In addition to the examples already referred to, physiotherapy staff can deliver effective exercise programmes as part of support to manage diabetes and obesity.
- 3.2 Early intervention with physiotherapy can prevent acute musculoskeletal disorders from becoming chronic, and improve recovery from injury, and reduce the length of time lost through sickness absence from work. This last point is a particularly important issue within the NHS where half of sickness absence is caused by MSDs. NHS trusts who have been proactive in getting staff access to physiotherapy at an early stage have substantially reduced sickness levels. For example, West Suffolk hospital in Bury St Edmonds achieved savings of £170 000 through a system of priority referrals to a local physiotherapist for injured health staff. For a cost of £21, 000 It has achieved a 40 per cent reduction in lost days through sickness absence, and savings of £170 000 in the cost of MSDs⁷.

4. Providing health services closer to home for expectant mothers and young children by providing more services in community facilities

- 4.1 There is an important role for physiotherapy provision in managing women's health conditions, including continence management and musculoskeletal disorders resulting from pregnancy and delivery (see 2.3 on MSD services).
- 4.2 Urinary incontinence is a common health problem, estimated to affect 20.4 per cent of people aged 40 and over, a figure that is substantially higher among women and is

⁵ NICE Quality and Productivity: Proven Case Study, NICE August 2012
<https://www.evidence.nhs.uk/search?q=PHYSIOTHERAPY&pa=8>

⁶ Holdsworth 2007, Department of Health 2008b

⁷ *Physiotherapy works: Musculoskeletal disorders*. January 2012. CSP

estimated to cost the NHS £117 million each year⁸. NICE guidance recommends physiotherapy training and strengthening the pelvic floor muscles as the first line management for women with urinary incontinence, and that this should be offered to all women in their first pregnancy as a preventative strategy for urinary incontinence⁹.

5. Helping older people and people with ongoing health conditions to manage them and remain independent by ensuring that care is provided in the community and is more joined up.

- 5.1 Physiotherapy, as part of a multi-disciplinary care pathway, has been shown to be clinically and cost effective in treating patients with a wide range of long term conditions in the community setting. It is particularly key to promotion of self-management and patient education.
- 5.2 Many musculoskeletal disorders (MSDs) are long term conditions, and can be both a causal factor and caused by other long term conditions. Early intervention with physiotherapy is clinically and cost effective. In particular, self-referral to physiotherapy has been demonstrated to save money and improve access and we would recommend that commissioners consider this model of delivery¹⁰ (see 2.2-2.4)
- 5.3 In addition to rapid and early access to physiotherapy intervention it is also important to ensure the 'exit routes' from physiotherapy are in place. Such routes may include referral to exercise programme in local gyms or referral to the Expert Patient programme or other strategies to encourage self-management. This is of particular relevance for patients with long term conditions.
- 5.4 Physiotherapy is also a key component of effective services for pain management for people with chronic MSD pain.
- 5.5 Physiotherapy rehabilitation in communities has a crucial role in keeping older people independent and restoring their independence, reducing the numbers of people requiring social care support or residential care, or delaying the need for such support. This includes physiotherapy provided as part of community-based falls prevention schemes. Each year 35 per cent of over 65's, and around 45 per cent of people over 80 fall in the community. Among the over 75's injury from falls is the leading cause of mortality. Half of all people who have a fall will fall again in the next 12 months, increasing mortality, rates of hospitalisation and institutionalisation¹¹. Falls prevention schemes have been proven to be a cost effective way to reduce falls.¹²
- 5.6 Cancer and its various treatments are associated with a wide range of distressing physical and psychological symptom, which can affect patients for many years following the end of treatment. Exercise can improve quality of life for cancer patients, regardless of the type and stage of their disease. Inclusion on physiotherapy led exercise within cancer pathways can reduce and prevent disability.

⁸ *Physiotherapy works. Urinary Incontinence.* CSP. 2012

⁹ NICE. *Urinary incontinence: the management of urinary incontinence in women.* CG40. London: NICE 2006 <http://guidance.nice.org.uk/CG40>

¹⁰ *Musculoskeletal Physiotherapy: Patient self-referral. Quality and Productivity Proven Casestudy (QIPP),* NHS Evidence, NICE February 2012 (first published February 2011)

¹¹ *Physiotherapy works. Fragility fractures and falls.* CSP January 2012

¹² *Physiotherapy works: Fragility, fractures and falls.* CSP January 2012

Specialist physiotherapy can also alleviate distressing symptoms such as lymphedema and fatigue, which debilitates 75-95% of all cancer patients. Excessive weight gain and loss can be a problem for many patients, dependent on their treatment, stage and type of cancer. Specialist physiotherapists within the community can help patients to maintain health weight and prevent muscle-wasting in cancer patients. Evidence also shows that exercise reduces the risk of cancer re-occurrence and mortality. Mortality can be reduced by 50 per cent, 40 per cent and 30 per cent in bowel, breast and prostate cancer respectively¹³. Guy and St Thomas' NHS Foundation Trust is currently undertaking a project across 6 boroughs, including in Southwark, investigating signposting to appropriate exercise provision at the end of treatment for this cohort of patients.

- 5.7 Physiotherapy has a significant role to play in reducing disability that arise from long term-conditions. With neurological conditions, for example, the greatest potential for central nervous system adaptation and recovery occurs in the early stages of multiple sclerosis (MS) where early access to physiotherapy can reduce disability. Physiotherapy, as part of a specialist neurorehabilitative service, has a key role in managing specific symptoms of MS including pain, spasticity and the prevention of secondary complications. Results from clinical trials of MS exercise programmes have demonstrated benefits in muscle strength, cardiovascular fitness, aerobic thresholds and activity levels and functional ability¹⁴.

6. The overall approach of focussing on the needs of people with long term illnesses, cardiovascular disease and cancer, older people, expectant mothers and young children.

- 6.1 The CSP agrees with the overall approach of targeting resources to meet local priorities as evidenced by population health data. We feel that there is significant scope for varying the current mix of services available, requiring sustained resource reallocation towards community-based services, prevention, early intervention and reablement/ rehabilitation. There is also scope to make better use of the skills and knowledge within the healthcare workforce and labour substitution. Physiotherapists have a detailed understanding of the biological, social, physical and environmental causes of ill-health within people and populations and a high level clinical reasoning. Working across a variety of settings, they can co-ordinate and lead effective and integrated services for people with long-term conditions. It is essential to maintain access to patient services during this transition. Where reallocation takes place, existing services must be continued until community-based alternatives are made available.

7. Proposals for the different ways that healthcare services could be delivered across Dulwich and the surrounding area – Option A versus Option B

- 7.1 See 2.1

8. The case for change

- 8.1 Physiotherapists have long been recognised as the integrators of care, with excellent communication and clinical reasoning skills. The skill mix and patient –centred focus

¹³ *Physiotherapy works. Cancer Survivorship.* CSP 2011

¹⁴ *Physiotherapy works. Multiple Sclerosis* CSP January 2012

of physiotherapy lends itself to physiotherapists working in extended roles. This results in specific competencies such as injection skills and highly tuned diagnostic skills. Recent legislation relating to independent prescribing for physiotherapists is also beneficial for these professionals where role substitution may be considered to support a more efficient skill- mix. Therefore, physiotherapists as first contact practitioners, can make a large contribution to local QIPP plans by providing more efficient and cost-effective services.

- 8.2 The CSP has serious concerns about the Any Qualified Provider (AQP) model for services and patients. By creating a proliferation of providers, it risks being confusing for patients and poses real problems in terms of managing contracts and costs. Furthermore, if tariffs are set too low it may make it impossible for quality providers to compete, and it may bring in a level of uncertainty that makes it difficult to plan and integrate services, particularly those with chronic conditions, and destabilise the existing workforce. We would therefore urge commissioners in Southwark not to use the AQP model for physiotherapy, but if commissioners in Southwark are considering this, CSP members would welcome an opportunity to work with them to try to ensure that the quality and impact of physiotherapy intervention is not compromised, and to examine how AQP could work in tandem with patient self-referral.
- 8.3 With the changes in the way that health services are delivered in the borough it is important to maintain the ability to provide educational placements and ensure a staffing system that supports the development of junior staff in providers (from all sectors).

9. Other comments

- 9.1 We suggest that it might be helpful for enabling community input to include a definition of physiotherapy in jargon busters/glossaries of future public consultation documents.

Submitted by:

Carole McCarthy, Therapy Services Manager, The Hillingdon Hospital, on behalf of the London Regional Network, Charter Society of Physiotherapy (Chair)

Susan Evans, Planning and Healthy Living Clinical Group Services Manager, Teddington Memorial Hospital, on behalf of the London Physiotherapy Managers Forum (Chair)

Date: 31st May 2013

- ends -

For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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The Rylance-Watson family response to the Southwark Clinical Commissioning Group's Consultation on the 'Future of Health Services in Dulwich' - 28th February 2013 -31st May 2013

Preamble: Please read this text before reading our completed entries on your printed 'feedback' section. What follows below corresponds to, and should be read as, your Section 4 (section 4) Page 52. Please also take the attached list of Appendices as an integral part of this feedback. Some of the items in these appendices have previously been tabled with the Southwark PCT (now the Southwark Clinical Commissioning Board).

1) Introduction:

Our family is making the case here for a comprehensive, future proofed and integrated health and care set of services on the Dulwich Community Hospital site which:

Addresses the needs of the 65+ patient populations: their carers and their families. It is one which recognises the impact of this group on a wider population, on the NHS and on the wider British economy

Hard data analysis of push and pull factors together with a far more realistic picture of your planning assumptions should have been in your consultation document. Instead these are either absent, 'ostentatiously absent', or well buried.

So, here is our offer of how we might assist and inform you in addressing the health and care needs with specific regard to the over 65's, their carers and families:

- We give you feedback on the money side and on how financing may be strategically commissioned and sought to fund the model (A++) we propose
- We give you feedback on the populations and geographic areas to reflect demand accurately and to sustain the model A++) we propose
- We examine how robust and ready GP capacity and the community capacity is to take on your A and B models. How "Future Proof" (Robert Park SCCG 9th May 2013) are models A&B?
- We propose our model: a 24/7 A++ "with the lights on." We describe our model and we argue our case
- We reiterate why our model must be on the Dulwich Community Hospital site

Finally, we leave you with reminders of powerful policy and legislative contexts which you should not ignore and which your consultation document, just as it has sought to 'airbrush' Dulwich Hospital out of your plans, has woefully failed to capture.

2) Let us start by looking at the money side:

Question:

What % of total GP commissioning into the acute sector (particularly King's) is represented by 65 + population? (ERW to SCCG (then PCT) February 2013)

Answer:

"The figure you require is (that) 43% of acute activity was spent on over 65's in 2012/13... (Exclusions go on to be listed) but I would consider it to be a representative enough figure for the purposes of your report." (Tamsin Hooton, Director of Service Re-design SCCG email to ERW 15.05.13)
(Appendix 1 and 2 TH email to ERW 15.05.13)

2.1:

SCCG total acute expenditure for 2012/13 was £310,187 million out of a total budget of £572,217 million. This is 54.2% of your total budget. The 65+ patient populations consume 40+% of £310,187 million which means that **right now** over 65's consume over £124 million pounds of expenditure on acute activity and that is itself over 57+% of your total budget. (Appendix, Page 63 (Enclosure.D) CCG Year End Finance Report 2012/13 Pre-audit) And pressure on that budget is rising.

2.2:

Therefore, a strategic commissioning priority for the SCCG must surely be to divert some of this £124 million away from expenditure on acute hospitals and stream it into, we argue, a dedicated medical health and care facility on the Dulwich Hospital site with the dual objectives of both guaranteeing needs AND of making savings over time by reducing presentations and re-admissions into the acute sector.

2.3:

On 21st May 2013, Mike Farrar, (Chief Executive of the NHS Confederation) in front of the House of Commons Select Committee for Health on the question of Emergency Services and Care, made the case for more Strategic Commissioning which gets all those who control budgets together with each other. Farrar then described how the deployment of fragmented budgets (secondary, primary, specialist etc.) has meant that system leadership is detrimentally missing. The Health Committee also heard from Dr Patrick Cadigan, representing the Royal College of Physicians, and from Dr Mike Clancy, representing the College of Emergency Medicine, who were at pains to make direct linkages between Primary Care and the Acute sector.

2.4:

Their powerful testimony blows a horse and coaches through the artificial separation between primary care and hospitals that SCCG have sought to embed in your consultation document, one designed to divert the public's attention away from considerations of 'hospital' and toward 'primary care' and even the more cosy, slim-line sanctuary, 'home.' Ever since the SCCG approved the business case and launched this consultation document, barely a day passes without yet another 'crisis', 'enquiry', or 'event'. Such ructions call ever more loudly for the false separation between 'health' and 'care' to end. Yet, when I asked Colin Beesting to put the word 'Care' on the face of your consultation brochure, his reply was that that would not be allowed. You have continued wilfully to work within your entrenched finance driven silos.

2.5

Well, the crisis in Emergency Medicine might just spur the SCCG and Southwark Council into some creative thinking on the 'affordability' question, so often repeated by Andrew Bland, Chief Officer of the SCCG. This year, the NHS in England saw the numbers admitted to A&E rise by a whopping 250,000. If you go ahead with a plan based on Options A & B only, then maybe the 'future proofing' that the Dulwich Project Board now says it is looking for (Robert Park SCCG Meeting 09.05.13) will prove all too fragile as you all contemplate another set of rounds of the A&E experiences of this year.

2.6

The Parliamentary Select Committee on Health mentioned above has just shone a small light on how finances are allocated and who is incentivised by which payment. What we learned on the 21st May was that for Emergency Medicine, hospitals receive 30% of the cost of treating the patient and NHS England keeps 70%. Discussion followed about how alternative models could be designed with NHS England incentivised to integrate social care and health.

2.7 Therefore, here is our suggestion for how you approach the: "Where's the money coming from?" question:

Rebecca Scott has told me that the cost of running Dulwich Hospital is £1.7 million per annum. You would need to set an entirely new and higher budget based on the final specification of services on the site and on the site cost. **This is how we recommend you approach bringing together the sources of funding to create a new national model for the comprehensive and integrated health and care of the 65+ population and their carers:**

- Diversion of a small proportion of the £124 million currently spent on the acute sector by SCCG to the Dulwich Community Hospital
- "Robust" discussion with NHS England about pooling together some of their 'top slicing' in the direction of proper integration and a clear message to them that their finances must be a strategic and holistic response to this population and their carers. In short, for NHS England to commit to a new national experiment for South East London, one which stops wringing its hands about older people and faces their true impact on us all with a guarantee to them of

dignity and respect, whilst reminding ourselves of the cast iron certainty that we are all destined to join them.

- Seek £2 million from Southwark Council whose £2 million plan to use their Cator Street site as a health/care centre recognises the problem, but lacks the needed ambition and scale to solve it. Cator Street is a site looking for a solution, not the other way round. Cator Street would better meet the problem of school over-crowding. It was after all a training centre and development hub for all Southwark Teachers!

See Southwark Council's Consultation Southwark Council's Consultation Document: 'Our Future vision for a Centre of Excellence for older adults with dementia and complex needs' (Pages 7 and 8 reproduced showing initial £2m allocated through its capital programme (p7) and (p8) and its comments on Dulwich Hospital land

- Appeal at the highest level to Guys and St Thomas's Charitable Trust who have taken the strategic decision to resume purchases of properties in London. Ask them to "Buy" the Dulwich Hospital Estate from NHS Property Services Ltd.
- Appeal at the highest level to Charitable Donors, particularly those with an interest in Medical and Social Science research. One example here is Lord David Sainsbury and his Gatsby Foundation which invests in medical research, especially neurology (Appendix Page 2 of ERW email to Andrew Bland of 03.03.13)
- Contact all South London Charities with direct interests in the older populations' health conditions, such as Alzheimer's UK, the Hospice Movement, Diabetes UK, Care UK etc. Ask them for supporting funds by launching special appeals.

3. Populations, Geographic Areas and Sustainability

But, you may say, our Dulwich population, the age differential of which you have sought not to specify in your consultation document, really does not have that many old people. In fact, I have even heard in your presentations your making a virtue of how young the population of Southwark is. And your population graph on page 10 directs our gaze to draw that conclusion. Instead, here are some actual population statistics so 'ostentatiously absent' from your consultation document. Let us use them to estimate demand by looking at our population and their carers:

What does the 2011 Census say?

3.1

The 2011 census gives the Southwark 60-90+ population as 31,401
It gives its 45-59 population as 47,275. Total 78,676

When we look at these two sets of figures, we also need to factor in:

- The average age of all Southwark Carers is over 55 (source: Rob Danavell, Operations Manager, Southwark Carers)

- These carer populations therefore will be or are already entering this older age group. Analysis shows that carers are associated with 'not good' general health among all age groups. (*Appendix ONS The Gender Gap in unpaid care provision: Is there an impact on health and economic position? Key Points 16.05.13*) They will need to have their health and care needs and appointments met in co-ordination with the appointments of those they care for in order to protect and maintain their own health. This is an overlooked problem, but one I have experienced in my practice as a carer. A centralised, integrated health care centre such as that we propose for Dulwich Community Hospital is an ideal solution to this problem.
- With regard to the inequalities impact assessment, the Office of National Statistics May 16th 2013 has published an analysis of the gender gap impact in unpaid care provision showing that females rather than males take on a higher share of the unpaid care burden with that share falling most heavily on women aged 50-64. But among retired people this gender inequality diminishes.

So, your plan must cater for a significant proportion (not all) of those 78,676 older people and carers who do use King's and GSTT sites when 'home' is not enough

3.2

But, you will say, running such a facility in Dulwich Hospital requires a sufficiently large number of patients to be affordable and sustainable. Yes indeed. Please keep firmly in mind how much this age group population is already costing. (See 2.1 and 2.2 above). Is the 'do nothing option' affordable? Will continuing to respond to the crisis in the acute sector not sink the budget faster than diverting funds towards Dulwich Community Hospital? You are of course hoping that the primary/community sector may be robust enough to take the strain. We look at that later in this paper. But let us first take a more detailed look at the demographics and how the boundaries of patient populations are drawn.

3.3

This brings us to how wide you have drawn your map of Dulwich in your consultation document. When you first wrote your business plan you drew Dulwich very tightly indeed. Then you published your consultation document and, 'yes', Herne Hill, South Peckham, Nunhead and South Camberwell appear at the very bottom of the front cover. How visible is that? We can tell you that when a well educated local Dulwich resident we know first looked at the brochure, he immediately said: "But, my GP is in Herne Hill and that is in Lambeth, so does this affect me?" Why not clearly acknowledge and communicate this expanded catchment clearly and up-front in any future publications?

3.4

You should have broadened your population catchment area and made explicit, (at the very least) those Southwark residents registered with Lambeth and Lewisham Practices and those Southwark GPs who have patients on their books who are resident in Lambeth and Lewisham. You have the resources to do the research and it is research you should have completed before you launched this consultation (as we asked).

Here are just two examples of what you should have captured and made explicit:

- In Forest Hill Group Practice 1/3 of its 14,000 registered patients, are resident in Lewisham. Of those 14,000, between 700-800 are over 65.
- A large Lambeth residential care home with GP services provided on site has residents and staff registered with a Southwark GP

3.5

Some of what we know about the 60-90+ populations of Lambeth and Lewisham and their carers from the 2011 census is that the census gives the 60-90+ populations of Lambeth as 32,199 and the 45-59 populations as 47,870 (Total 80,069). And Lewisham records the 60-90+ group as 35,924 and Lewisham 45-59 as 47,754 (Total 83,678). The 45-90+ total for both boroughs is therefore 163,747.

3.5.1

When we add the Southwark population figures (45-90+) to the Lewisham and Lambeth figures (45-90+), the total of the three boroughs is 242,423. You have statisticians who know what proportions of populations make demands on the acute sector and on the primary and community services. **The figures which should have been in your consultation documents are those proportions and they should have been expressed clearly as demand on services.**

The work your statisticians then need to complete is a calculation which arrives at a target population of demand which embraces all of South Southwark and neighbouring Lambeth and Lewisham within proximity or ease of travel to King's, Guys and St Thomas's and Dulwich Community Hospital.

Your statisticians will look at the King's (KOPAU) referrals, which in the model we go on to describe in Section 5 below, would be substantially expanded. However, they merit reproduction in full here. *(Please also see King's own full statistical table in Appendix.)*

KOPAU -BAS REFERRALS				
	GP (03)	A&E (04)	Consultant (05)	Other referral methods
Lambeth PCT	877	48	1360	255
Southwark PCT	1046	66	1833	493
Lewisham PCT	88	14	208	33

The KOPAU numbers do not of course equate with the total number of over 65's accounting for the 43% of total SCCG expenditure in the acute sector. The numbers of patients above are the evidence of King's level of activity with regard to specialist older person's outpatient services. They are a useful starting point. My suspicion is that KOPAU service is under-used by GPs. For example, my mother's care home in Lambeth is run by an order of nuns who have homes throughout England. The Reverend Mother tells me that in the Greater Manchester area there is a permanent link between the University Departments of Gerontology and the care home and that

she is stunned by the fragmentation of the provider landscape here in South London. It is only through the records of my mother's on-going care by KOPAU (pre-dating her entering this care home) that the Rev. Mother has even learned of KOPAU and that is in spite of constant contact with a Southwark GP providing services to all residents on the residential care home site! Not one mention of KOPAU.

3.5.2

If on the order of 40% of total expenditure in the acute sector is on these older populations as the SCCG has confirmed above, then your planning assumptions are deeply flawed. You cannot argue that just because Southwark also has a young population, that the older populations and their carers are not major factors in your models. They are. They are because they consume so much of the money! That is the flaw you have embedded in pages 10-11 of your consultation document. We consider this to be a serious distortion of reality.

3.6

In Mr Parks' 'Future Proofed' plans, we would also like to see (up there in lights) the fact that the pension age will rise to 68 and if society seriously expects carers to cope and continue to be employed, then the question of simplifying and unifying the siting and setting of your 'provider landscape' and your systems with a one-stop-shop (i.e. Dulwich Community Hospital) will become ever more important. So, we are asking you to design a delivery model to collocate a lot of the medical and care needs of these combined populations (not to fragment them) in order to give everyone the best chance of providing care.

3.6.1

But no, you will say, that is why we are putting all the emphasis on 'home' and on 'community care.' Care must be close to where people live is your message. This is to dissemble a complex reality. A lot more hard questions need to be put and faced. Our response below addresses them.

4. GP and Community Capacity –how robust are they and how ready are they really to take the load?

(We hope all who read this paper will also have been watching TV, listening to the radio and hearing the repeated message that Primary and Community Care is already over stretched and does not have the capacity to take this strain.)

4.1

Therefore, since 'home' and 'community care' are the main attractive options you present in your consultation brochure, why are such 'affordable' and 'efficient' attractive options continuing to produce inexorable, massive and expensive rises in presentations by older populations into the acute sector?

There is no single answer, but please do pay attention to Dr Patrick Cadigan again, on the 21st May 2013, in his evidence to the Health Select Committee:

- **"Patients will go where the lights are on.... in many of the 'alternatives,' the lights are not on...and that is a problem for all of us."**

- Listen also to Dr Mike Clancy who says that the alternative setting to A&E has to be **“equally visible and equally attractive”**.

Clearly here in South East London, amongst the alternatives, the ‘lights are not on.’ The alternatives are neither “equally visible” nor are they “equally attractive.”

4.2

To illustrate this, I would like to offer a case study of a Dulwich man, one which is on going. I had planned to attend the final public event of the consultation in Dulwich on the 22nd May and I was at the time writing this response to this consultation, needing to meet the submission deadline.

I had a call on the morning of 21st May from a respected health campaigner about a man aged 93 and problems getting a doctor to come and see him at home. The campaigner dictated the details to me and I volunteered to immediately write up a case note of what is happening to the elderly man. I decided that this was more important than attending the Dulwich consultation event. This case note is now being used to help the patient’s friend write a complaint to NHS England. I am enclosing this case note entitled *“Weak and unreliable ‘care in the community’: A live case study of how a patient falls between the cracks and is at risk”* as part of our response to this consultation. We do this so that you can have a ‘live example’ (‘un-spun’) of what is happening at this moment. **This case note exposes what the primary/community “alternative” can become without the ‘lights on’ and without ‘visibility’ and illustrates the problems of accountability regarding proper medical care if it is not delivered in a public setting with the eyes of society able to scrutinise those who should be held to account.**

4.3

No wonder people go to where the lights are on, where the computers are switched on and kept working, where there are staff and where they are working 24 hours a day and 7 days a week. We are also public creatures. Too much isolation in the home is as bad as being stuck in a hospital surrounded by equipment. We need a model that will change our behaviours, relieve pressures, save money AND deliver the health and care benefits we need.

- I am afraid your Option B (GP + a tiny centre) or A (GP + a bigger centre) does not cut the mustard. These offers do not reflect the reality of the needs of frail older people, their multiple conditions and the realities that their carers manage every day and often every night.

We need a far more ambitious model and we have highlighted at the start of this paper how you would set about gaining support for such a model and seeking the funding:

4.4

What we need is a model with a Publicly Visible Health and Care Setting for this population, which is neither an 'Acute' Hospital nor a 'home', but which bridges both. This is what we will outline now.

It is an A++ solution which adds an important additional safety junction to the map of provision. It draws a new map in the landscape of the care of a growing population which, in previous decades, would not have survived. The sheer size of this population is new and requires a 'fit for purpose' solution. To quote Mr Park again, one which is 'future proof'.

5. DESCRIPTION OF OUR A++MODEL

5.1: A 24 hour, 7 days a week, dedicated National Centre of Excellence for the medical treatment, care and social care of over 65's and their older carers resident in Southwark, and accessible parts of Lambeth and Lewisham and other South East London

5.2

Para-Medic Ambulance crews supported and trained divert (after telephone consultation with A&E consultant at King's/GSTT) those patients requiring investigation but not A&E admission. Dulwich Hospital is the non-A&E visible 'with the lights on' alternative to A&E. This would expand the 24/7 Telephone TALK – telephone assessment and liaison started by King's

5.3

Staffed by a consultant and medical team from King's/GSTT, the National Centre conducts assessments and interventions at a deeper level than available in the community and makes the clinical decisions for the few who might need to go onto A&E. Research shows that early clinician led intervention reduces unnecessary admission, re-admission (Please see Dr Cadigan's and Dr Clancy's evidence to The Health Select Committee on 21st May 2013)

5.4

There are a number of admission beds for short-term stays available to relieve pressure on A&E/acute wards preparing for discharge back home or into residential care. The number of red alert signs in your integrated performance reports show that the pressures on King's and GSTT are growing and that is without adding what may happen after Lewisham Hospital changes.

5.5

GP's and community staff access the consultant geriatricians and take their advice on the appropriate settings of care, facilitate urgent appointments booked either in the King's/GSTT sites or the Dulwich Community Hospital site depending on the probability of requiring acute admission. Most acute admissions would in fact not be required as King's own information shows. (Only a small number of those seen in King's Older Person's Assessment Unit (KOPAU) actually do have to be admitted and it is not clear how much the access to an extended range of diagnostics is used.) (See SCCG's meeting of 7th February 2013- report on the Betty Alexander Unit (now known as

KOPAU) extract from Page 2 in appendix. However please log the whole report available on the SCCG's emails and on its website and the PCT archived website as part of our response to this consultation.)

5.6

A **multi- disciplinary service** has as its core mission the raising of **clinical** and **research** practice in Gerontology to a new international standard because it adds the full dimension of integrated care performed within an appropriate setting.

5.7

The centre demonstrates how integrated disease management and long-term conditions through to end of life can **support and educate** patients, their carers and families in the latter years

5.8

The multi-disciplinary service breaks up the divide between physical and mental health. It is a ground breaking co-run and managed facility between the Maudsley and King's/GSTT for complex and interdependent needs. It has a particular role in medication and pain management, their impacts and their reduction, and the dual benefit of medication and non-medicated therapies. It produces 'how not to fall between the cracks' care plans and strategies which educate and even train both patients and carers indirectly, preparing carers to better face what may happen to them.

5.9

The Centre of Excellence runs clinics in Gerontology, Falls, Memory, Psychological Therapies, Alcohol, Anti Smoking and Substance Misuse for older people, Osteoporosis, Bladder and Bowel Specialist Nursing and Incontinence, Parkinson's, Hypertension, Phlebotomy, X-Ray, Diabetic Retinal Screening, Phlebotomy, Diabetes, Dietetic/ Nutrition Advice and help with keeping hydrated and with digestion. It also provides Physiotherapy and help with maintaining mobility, Artificial Limbs, Leg ulcers and pressure sores. The occupational therapists will return to the visible role that they had when the Betty Alexander Unit was on the Dulwich site, and they will be joined by the un-sung heroes of Southwark Council's help in the home facility, The Southwark Council's Handyperson's Service.

(The Centre of Excellence has included all the Suite 2 Clinical Gerontology services provided on KOPAU –See King's table of its suite of rooms allocation in the Appendices

5.10

The Centre of Excellence leads in bringing together Charities working in these fields so that transformational and joined up work drives more education, inspires us to take on the responsibilities we all need in order to help keep us as well as possible for as long as possible. This is about consistent and relentless work to change behaviours towards Prevention and Wellbeing. This Centre of Excellence gives Public Health the setting for the high profile it requires to gain recognition and standing.

5.11

Above, we have talked of care plans and education. The Centre of Excellence is transformational in its information, advice, guidance, and follow up. It is the trusted

source of guidance. It works consistently to educate and empower whole families. As a nation, we have become almost infantilised as our poor standards of health education continue to generate failures of individual responsibility. **The consequence is that we inadvertently or otherwise pile more pressure and demand on NHS resources.** We have to be educated about how preventative health measures can reduce demand, re-admissions, time wasting and so on. In our family's recent experiences of various specialists at King's (all good) the only doctors who give us serious dietary advice came from countries other than the UK. That advice has relieved symptoms, has reduced the need for pain killing medication and has speeded patient being discharged from the acute sector! We really must move beyond 'leaflets in surgeries' and 'take a look at the web site'. Surely, we can do better. Outcomes from enhanced information, advice and guidance would include reductions in admissions and re-admissions, relief of pressure on GP surgeries, and the emergence of a next generation of an older population better prepared to take care of their own health needs. That next generation if our model is created, is found among today's carers.

5.12

The multi-disciplinary service currently provided by King's in its inadequate KOPAU small suite of rooms returns to Dulwich Hospital and regains the honoured name of Betty Alexander, showing some respect for a pioneer campaigner in the setting of care.

(Please see a report from King's titled: "Services Provision at King's Older Person's Assessment Unit." giving the details of the clinics they run in KOPAU and how the services are delivered- Appendix)

5.13

There is a dedicated transport shuttle service between Dulwich Hospital and King's/GSTT with timed services. Transport for London has been persuaded/embarrassed into lengthening the route of the No 42 bus to ensure it stops outside Dulwich Hospital as well as passing King's. Dulwich Hospital Transport has a dedicated home facility and carers have parking bays to bring patients for appointments.

5.14

We have noticed that, with fragmented care, fragmented budgets and fragmented services, every opportunity to pass the buck is seized whilst waiting for yet another enquiry to recommend improved communications and better IT systems. I repeat that we are public creatures and, if we physically feel part of a single service, then we begin to behave as though we are part of a national effort and we respond to the positive examples of others. This Centre of Excellence is the first to co-locate under a single leadership and management Adult Social Care for the older population

5.15

Southwark Council rightly identifies the need to provide respite care/day centres. The Centre of Excellence provides this on the site.

5.16

Residential care facilities continue to be of variable quality and the greatest challenge is to provide residential care for those at the advanced stages of dementia with

multiple conditions not requiring acute hospital stays. If the whole Dulwich site can be preserved for health and care, then the Centre of Excellence also provides a residential care facility. It is run separately on a not-for-profit charitable basis. However the Centre of Excellence guides its practice on the highest standards of clinical and nursing care. It is the training centre hub for dissemination of best practice across all residential care homes in South East London. It is linked closely into the programmes run by St Christopher's Hospice for end of life palliative care.

5.17

The Centre of Excellence has a small conference/meeting facility to allow for training and development across all combinations of teams

5.18

There is a crèche/play area/garden and café for people who accompany family members. There are even some tables and chairs for anyone needing to make calls or work on a tablet/laptop whilst the patient/carers are being seen to. There is thought given to the time spent by others. The setting allows them to feel relaxed. There is an alert system to advise them when to return to the patient.

5.19

The Centre of Excellence draws on and pioneers new forms of integrated treatment and care. It is firmly anchored in academic rigour and research and that is why it is lead by our teaching hospitals and why it feeds into and from the facts of GP practices. It helps GP practices by lifting some of the pressure on simply managing the treatments and most of the monitoring once the older person's condition has become sufficiently complex. For example, it reduces unnecessary repeat blood tests on the frail elderly. It checks on and reduces medication management, saving money at the same time. GPs can send patients to the Centre of Excellence for education events to help them manage their conditions better.

5.20

The Centre of Excellence has a specially drawn up protocol of care between it and the patient's GP to clarify **at all times** who carries the clinical lead and legal responsibility for the continuity of care of the patient.

5.21

Together with the main provider hospitals and GP practices, the Centre of Excellence plays an important role in the 'informatics' improvement so much talked about in your documents. A good place to start is to have a system whereby the GP, the laboratory and the multi-disciplinary team can all read the same blood test results on a screen and spare frail elderly veins repeated and painful blood tests. (My mother's arms have looked as though she has been assaulted and her residential care home recounts the pain and discomfort caused to residents by unnecessary repeat 'community' blood tests caused simply because the systems do not 'talk to one another.').

5.22

In addition to the Centre of Excellence the Dulwich Community Hospital site has:

- SELDOC out of hours GP service
- A GP practice on the site and a pharmacy

That concludes our model for the Centre of Excellence and for the use of the Dulwich site.

6.

Why do we so insist on the site of **Dulwich Community Hospital**? Because, as your own analysis has shown, this is the only 2.83 hectares of land originally built for health that is strategically located at the crossroads of several boroughs and on the transportation routes towards and from our two major hospitals. There is huge pressure for other uses for such prime real estate. **Once lost to health, this land will never again be reclaimed for health.**

Put effort into estimating what a 'more expensive than in the home' but 'less expensive than at King's' strategic option would cost. That figure is the cost of Dulwich Community Hospital. Go on to make the tight and clear connection between your costs and your key outcomes indicators (Your CCG 2013/2014) and then make a plan, just like the government has to do, to **both** cut expenditure **and** invest at the same time. In my non-NHS background, we used to call that 'explicit planning for transitions'.

6.1

We are certain that you would achieve more of your key outcomes indicators by investing in a **secure medical setting** protected from too many of the 'cracks' present in so many examples of 'scare in the community.' The risks are those associated with diffuse and dispersed medical delivery. The older and more frail we are the more complexity exists and the greater the risk and the fear these risks engender in the 'community.' In short, you need an alternative 'with lights on' for our older population and their carers. Why do I keep banging on about carers? Because the more you involve and prepare them in the care that they give, the more they prepare for their own situation and the more efficiently they can support others.

7.

Before we conclude our feedback on the consultation and on the future of the Dulwich Community Hospital site, there are huge policy, legislative and legal contexts which you are duty bound to take into account. These are singularly absent. They are, again, ostentatiously absent or so well hidden in your consultation documents that we cannot find them. Mr Park's 'Future Proofing' would be well advised to pay attention to them and to air them at SCCG public meetings in order that the public may follow developing problems and progresses.

They are about:

- The settings and sitings of care and protection of the patient
- Hearing the patient voice responsively and placing it at the centre
- The integration of care beyond warm and often empty words

7.1

On the settings of care: I have made submissions to the SCCG about how inappropriate and unwelcome has been the transfer of the outpatient service of Clinical Gerontology and associated clinics of King's College Hospital from Dulwich Community Hospital to King's. (See references in Section 5.5) I have shown in public meetings at which you were present that mine is no isolated voice. In fact King's itself conveys this voice beautifully in its own Annual report 2004-05

King's College Hospital's own Annual Report of 2004-5:

"SOS service for the elderly reduces pressure on A&E: King's has developed a SOS service for elderly patients as an alternative to visiting A&E. The Betty Alexander Suite at Dulwich Hospital is a medical day unit focused on emergency assessment, treatment and rehabilitation of acute and chronic conditions. It accepts referral for urgent cases that require immediate investigations or treatment"... "Elderly patients benefit from the suite's 'one stop shop' approach: x-rays, blood tests and ECGs can be carried out on the same day. The service is multi-disciplinary and links to social services, occupational therapists, physiotherapists, chiropodists, tissue viability nurses and the pain team. Of the 213 referrals seen in 2004, 93% were successfully managed in community settings. Only 4 patients were transferred to A&E and 10 were admitted to hospital."

7.2

Over the last months, I have pressed SCCG on the matter of the transfer back to King's. In response to an information request from Tamsin Hooten, Kings has described the services now provided. Please read the Appendix "Services Provision at King's Older Person's Assessment Unit." When we look closely, the only small group within the patient population, who would indeed need to be on the Denmark Hill site, are those who immediately require further high-tech diagnostics and maybe those requiring blood transfusions and other intravenous therapies." That group represents a small proportion of the clinics. All the other clinics are located for the convenience of King's administration and King's finances, not for the convenience of patients.

7.2

There is research to show that where and under what circumstances older patients are treated actually matters. I quote from Guy's/KHP integrated care pilot report to Lambeth and Southwark Scrutiny Committees: ***What do older people think?***

- "They like the older age-specific environments as the staff understand and sort out their problems."
- They want support for psychological, not just physical wellbeing and to be helped to have an active fulfilling life
- They value continuity of care with the same professionals, people who know them (so they don't have to keep repeating themselves), and people they trust
- Older carers often don't know their entitlements and need more support e.g. respite

(See Slides 5&6 Appendices)

7.3

After the Francis report, after mid-Staffordshire, after the countless horror stories of the neglected older population, you have policy contexts and considerations which are now raising the bar over the duty of care, the settings of care, the patient voices and the integration of health and care. And this older population is affecting the pressure

on settings of care available for the younger age group for whom acute hospitals are more appropriate. On top of those pressures, the settings of the acute hospitals are becoming less (not more) safe for all. Large acute hospitals are less safe particularly for the frail and for those with weakened immune systems. We should turn our attention to the Chief Medical Officer, Professor Dame Sally Davies, who has recently published her first report as Chief Medical Officer. (I quote from my email of 8th May to Tamsin Hooten):

“(King’s Annual Report 2004/5)... perfectly makes the case for an integrated medical day unit which keeps the frail older population away from a site which all the experts agree is not in most cases suitable for this population. Professor Dame Sally Davies has recently published Volume 2 of her first report as Chief Medical Officer. In it she has warned in the most unambiguous and powerful terms of the dangers of antibiotic/antimicrobial resistance. She talks of the dangers being greater than those of global terrorism. She says: “Infection is an important cause of illness and premature mortality in older adults and can hasten the decline in health of an otherwise active older person.”(p 118). Her recommendation (4) is that “infection control policies of organisations responsible for the care of individuals should explicitly address the setting of care, including a focus on the home and the community.”

Therefore, in addition to the increasing danger of exposing the frail elderly population to an already over-populated hospital, (Professor John Moxham at the Health Scrutiny Committee meeting which you and Andrew Bland attended on the 1st May talked of the pressures on King’s of patients with multiple diagnoses) why do you (SCCG) and King’s insist on the co-habitation benefits of adding yet more frail older patients onto an already over-crowded Denmark Hill hospital site?”

7.4

Quite frankly, given such strong and unambiguous warnings from Professor Dame Sally Davies, the most authoritative and official voice in our country, your persistence and insistence on squeezing yet more frail elderly into a setting in which they are exposed to the rich assortment of bugs donated by the entire transient and global population of South London comes close to a failure of responsibility. We do **absolutely expect to see** that your policy documents and your plans for Dulwich Community Hospital after this consultation properly reflect just **how you do intend to protect the frail elderly and those with weaker immune systems**. Frankly, some return to old fashioned practices on infection control with **space** for isolation (isolation wards) must surely enter the planning radar. But we are not seeing that. What we are seeing are more plans for more ways of cramming more temporary structures on to the King’s site and more ways of weaving the frail and disabled around frighteningly over crowded entrances, exposing them to all the infectious diseases of the general public as they are navigated to their appointments. So, Professor Dame Sally Davies and her recommendation no 4 should be high on your list when you plan for services after this consultation. We suggest a lot more ‘Future Proofing’ (Robert Park) by implementing Professor Dame Sally Davies’ recommendations.

7.5

Your SCCG Meetings and reports to the Southwark Council Health Scrutiny Sub-

Committee have been signaling major changes in the provider landscape which, amongst others, will take into account what may happen over Lewisham etc. We are not alone in voicing concern over what may be the impact on King's. **More pressure on King's argues even more strongly for Dulwich Community Hospital** to become a safe setting for the treatment and care of this older population, if only to allow King's enough space to respond both to the 'infection' environment and to take on more of the wider population.

7.6

Our feedback has so far focused extensively on the medical and other benefits of integrated and joined up care and has pointed up the risks when there is too much fragmentation and therefore too many cracks opening up through which the frail, older patient falls. We shall end with a brief word on what looks like the coming legislative landscape. We have no idea who will form the next government. But, whoever does, the issues remain for us all and we are reading that the government may be planning to embed integration through changes to the financing landscape.

7.7

Therefore we shall end with a little of Andy Burnham's speech to the King's Fund this January 2013. I sense that across all parties there will be no appetite for yet more structural re-organisations (or re-disorganisations), but there may indeed be an appetite for what Mike Farrar has called "Strategic Commissioning." Strategic Commissioning will change the financial structures that have created the silos which, as Andy Burnham says below, produce a "One Person-Three care services" health structure. That structure is experienced by the exhausted carer as an endless round of 'battles' on the phone (on and on and on) and experienced by the poor frontline NHS and Care staff as a round of endless complaints and irritated voices.

7.8 Please end by rereading my case study (Section 4.2 Page 8) And as you read it, please do relate it to the policies, systems and structures both criticised and proposed in Andy Burnham's speech:

The exclusion of the social side of care from the NHS settlement explains why it has never been able to break out of a 'treatment service' mentality and truly embrace prevention. It is a medical model; patient-centred, not person-centred.

But, in reality, it's even worse than that.

For 65 years, England has tried to meet one person's needs not through two but three services: physical, through the mainstream NHS; mental, through a detached system on the fringes of the NHS; and social, through a means-tested and charged-for council service, that varies greatly from one area to the next.

One person. Three care services.

For most of the 20th century, we just about managed to make it work for most people.

When people had chronic or terminal illness at a younger age, they could still cope with daily living even towards the end of life. Families lived closer to each other and, with a bit of council support, could cope.

Now, in the century of the ageing society, the gaps between our three services are getting dangerous.

The 21st century is asking questions of our 20th century health and care system that, in its current position, will never be able to answer to the public's satisfaction.

As we live longer, people's needs become a complex blur of the physical, mental and social.

It is just not possible to disaggregate them and meet them through our three separate services.

But that's what we're still trying to do.

So, wherever people are in this disjointed system, some or all of one person's needs will be left unmet.

In the acute hospital ward, social and mental needs can be neglected. This explains why older people often go downhill quickly on admission to hospital.

In mental health care settings, people can have their physical health overlooked, in part explaining why those with serious mental health problems die 15 years younger than the rest of the population.

And, in places, such is the low standard of social care provision in both the home and care homes, barely any needs are properly met.

What, realistically, can be achieved from a home care service based around ten-minute slots per person?

On a practical level, families are looking for things from the current system that it just isn't able to provide.

They desperately want co-ordination of care – a single point of contact for all of mum or dad's needs – but it's unlikely to be on offer in a three-service world.

So people continue to face the frustration of telling the same story over again to all of the different council and NHS professionals who come through the door.

Carers get ground down by the battle to get support, spending days on the phone being passed from pillar to post. “

Your task is to change our experiences for the better. Please know that you will always have our support and our efforts when you work to do so.

Elizabeth Rylance-Watson, M.B.E

Jim Watson and Alice Rylance-Watson

Also on behalf of Maria Yolanda Rylance (grateful patient of Professor Stephen Jackson, Department of Clinical Gerontology, King's College Hospital)

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Appendices mentioned in the Rylance-Watson family response to the 'Future of Health services in Dulwich' consultation: 28.02.13-31.05.13

Section 2, page 2 RW Family response:

Q: % of total GP commissioning into the acute sector (particularly King's) represented by the 65+ population? (Segment of email string ERW to SCCG, repeated to Tamsin Hooten (page 4/13 reproduced)

A: "The figure you require is 43% of acute activity was spent on over 65's in 2012/13." (TH to ERW email 15.05.13 pages 1 & 2)

Section 2.1, page 2: CCG Year End Finance Report 2012/2013 Pre-audit. (Page 63 Enc.D)

Section 2.7 Bullet 3 Page 3:

Southwark Council's Consultation Document: 'Our Future vision for a Centre of Excellence for older adults with dementia and complex needs' (Pages 7 and 8 reproduced showing initial £2m allocated through its capital programme (p7) and (p8) and its comments on Dulwich Hospital land)

Section 2.7, Bullet 5 page 4: "Lord David Sainsbury and his Gatsby Foundation which invests in medical research, especially neurology: Appeal to charitable donors - page 2 of ERW email to Andrew Bland of 03.03.13

Section 3.1 pages 4 and 5 Bullet 3: Office for National Statistics: The Gender Gap in unpaid care provision: Is there an impact on health and economic position? (Key Points:16.05.13 pages1 & 2)

Section 3.5.1 Page 6: King's own full statistical table of KOPAU referrals

Section 4.2 Page 8 "Weak and unreliable "care in the community" Live case study of how a patient falls between the cracks and is at risk."

Section 5.5 page 9: Page 2 of SCCG Meeting of 7th February report on the Betty Alexander Unit (now known as KOPAU) extract from Page 2, however the whole suite of exchanges between SSCG and ERW on Betty Alexander Unit, available on email and on the SCCG website should be taken as part of this report.

Section 5.9 Page 10:Table of all the Suite 2 Clinical Gerontology services provided on KOPAU (KCH)

Section 5.12 Page 11 Report from King's Section 5.12 "Services Provision at King's Older Person's Assessment Unit."

Section 7.2: Slides 5 &6 of the GSTT/KHP integrated care report to Lambeth Scrutiny Committee

Subject: Re: Information request re Betty Alexander Unti/KOPAU
Date: Wednesday, 15 May 2013 10:20:16 United Kingdom Time
From: Elizabeth Rylance-Watson
To: Hooton Tamsin (NHS SOUTHWARK CCG)

Tamsin
Thank you very much indeed
Best Wishes
Elizabeth

From: "Hooton Tamsin (NHS SOUTHWARK CCG)" <tamsin.hooton@nhs.net>
Date: Wed, 15 May 2013 10:10:39 +0100
To: Elizabeth Rylance-Watson <eliz@rylancewatson.plus.com>
Subject: RE: Information request re Betty Alexander Unti/KOPAU

Elizabeth

We did not have this piece of information so I had to ask our analyst to calculate a figure and he has just sent this through to me. The figure you require is 43% of acute activity spent on over 65's in 12/13. This is based on SUS data only (i.e. excludes any service that is not funded via Payment by Results or another agreed local tariff) but I would consider it to be a representative enough figure for the purposes of your report.

Tamsin

From: Elizabeth Rylance-Watson [<mailto:eliz@rylancewatson.plus.com>]
Sent: 15 May 2013 10:00
To: Hooton Tamsin (NHS SOUTHWARK CCG)
Subject: FW: Information request re Betty Alexander Unti/KOPAU
Importance: High

Tamsin
Please see my email below and the highlighted bullet point outstanding.
I hope to finalise my response to the consultation in the next few days .
Thank you
Elizabeth
Rylance-Watson

From: Elizabeth Rylance-Watson <eliz@rylancewatson.plus.com>
Date: Sat, 11 May 2013 13:22:30 +0100
To: "Hooton Tamsin (NHS SOUTHWARK CCG)" <tamsin.hooton@nhs.net>
Subject: Re: Information request re Betty Alexander Unti/KOPAU

Tamsin:
I am very grateful indeed for the information. I shall now work this week on completing our response to the consultation.
My final request is your bullet below. Please would you send me this information. Also, would you have a view about whether Lambeth and Lewisham are likely to have very different patterns of commissioning into the Acute Sector represented by their post- 65 populations? I am increasingly conscious of the overlaps and over-spills between Boroughs. I learned that my GP practice (one of the largest in South Southwark with 14,000+patients) has 1/3 of their registered patients who are Lewisham residents. Of their 14,000 patients, between 700-800 are over 65.
Here is the final question copied from your email of 15th April to KCH for ease of reference.

SECTION 2

- Also, what % of total GP commissioning into the Acute Sector (particularly King's) is represented by the post 65 population? (I think the CCG may be best placed to answer this one)

Thank you again
Elizabeth
(Rylance-Watson)

From: "Hooton Tamsin (NHS SOUTHWARK CCG)" <tamsin.hooton@nhs.net>
Date: Fri, 10 May 2013 08:47:43 +0100
To: Elizabeth Rylance-Watson <eliz@rylancewatson.plus.com>
Subject: FW: Information request re Betty Alexander Unti/KOPAU

Hope this works for you

From: Bowler Sue (KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST)
Sent: 08 May 2013 17:24
To: Hooton Tamsin (NHS SOUTHWARK CCG)
Subject: FW: Information request re Betty Alexander Unti/KOPAU

Sorry this is late and you had to chase. Mixed messages on this side. Others have had direct conversations with Elizabeth and therefore felt the request was redundant (but didn't discuss this decision with me)!

Hope this is sufficient for now. Please let me know if you need anything else.

Best wishes

Sue

Sue Bowler
Divisional Manager, Trauma, Emergency and Acute Medicine, KCH
Joint CAG Lead, Medicine CAG, KHP
direct line: 020 3299 4668
mobile: 07841 834097
PA: Rachel Keeley, 020 3299 3541

From: Greir Donna (KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST)
Sent: 08 May 2013 16:38
To: Bowler Sue (KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: Information request re Betty Alexander Unti/KOPAU

Please find attached report plus data file for breakdown of referrals and the unit clinic timetable

Kind regards
Donna

Donna Greir | Service Manager, Clinical Gerontology, Allergy & Immunology, Respiratory Medicine,
Trauma, Emergency & Acute Medicine
King's College Hospital NHS Foundation Trust | Denmark Hill, 4th Floor Hambleton Wing London, SE5 9NY
Secure Email: donna.greir@nhs.net | Direct Dial: 020 3299 4171

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From: Bowler Sue (KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST)

SECTION 2

difficult to access and which the Chief Medical Officer warns will be increasingly unsuitable for the older population.

I am really saddened that after all the effort I have put in, I still have not heard a word from Dr. Roger Durston himself on where he thinks such an integrated service for the post 65 population should be sited.

I would like a reflective and substantive response to this email in time for the June SCCG. And when the SCCG is looking at its draft 2013-14 Annual Operating Plan tomorrow, perhaps it could point me to where and to how it will be configuring its plan to take account of the most powerful call to action from the Chief Medical Officer? Have I missed it, or is there no reference at all to Professor Dame Sally Davies's report and her recommendations? Where is the planning for isolation wards?

Also, I would like a response to my observations above about the Draft Operating Plan.

And, I do please need the data information which I asked for in February and again in March. (See below for ease of reference)

With Best Regards

Elizabeth Rylance-Watson

This is what I requested in February and again in March:

Also, please, would the committee request a short report from Professor Moxham to provide a list of all the clinics and services run in the Betty Alexander Unit (KOPAU) per week and per month in the last recorded year? It would be helpful to have in the public domain a breakdown of numbers attending with the age profiles as compiled by the 2011 census (65-74, 74-79, 80-89, 90+). Please ask for the numbers referred to King's by the Southwark, Lambeth and Lewisham GPs directly to KOPAU – Betty Alexander broken down by Local Authority GP Practices. It would also be most helpful to know what data is available to GP practices overall, by Local Authority on numbers who might first enter King's via another route such as A&E or GP referrals into another specialism which are transferred internally to the specialist care of Gerontology. If there are existing reports for me to look at, I would be most grateful to be pointed in the right direction. Also, what % of total GP commissioning into the Acute Sector (particularly King's) is represented by the post 65 population?

CCG Budget Summary Month 12
(a negative sign indicates overspent)

Budget	Annual Budget (£k)	End of Year (£k)
Total Acute	310,187	-2,935
Client Groups	98,784	1,672
Primary Care	71,124	-718
Prescribing	32,897	2,009
Community and other Services	38,069	-225
Corporate Costs	17,403	393
Earmarked Budgets and reserves	896	13
Planned Surplus	5,857	5,857
Total	575,217	6,066
Month 11 (for comparison)	571,877	5,857

SECTION 2.7 *Bullet 3*

complex needs when structured day activity is not taking place.

Minimising disruption for the current users

33. The council will proactively work with service users, their carers and stakeholders to minimise disruption for current users of the service.
34. Accessible transport would continue to be made available on a similar basis as is currently provided. This would be free, door-to-door transport for all users in receipt of a personal budget, including the current users of Fred Francis and Southwark Park Road. Transport arrangements would be more flexible and staggered throughout the day to meet individual service users' and their carers' needs. The use of taxi card and other transport schemes would be explored to facilitate maximum usage of the facility for the wider community of older people living with dementia and their carers.
35. These issues are addressed in more detail in the consultation section of this report.

Suitability of the current buildings

36. Fred Francis and Southwark Park Road are both purpose built day centres well over 30 years old. Their physical design was not intended for use by a very frail older population as they currently serve, and as a result the buildings are not best equipped at present to meet the needs of older people with dementia.
37. In preparation for the consultation exercise, council officers working in partnership with South London and Maudsley Older Adult services, the Business Support Unit of the local GP Clinical Commissioning Group and the Alzheimer's Society drew up a requirements guide of essential and desirable criteria for the physical space requirements of the Centre of Excellence.
38. This included characteristics such as sensory and memory rooms as well as other design features to promote safely supporting older people who may wander or express challenging behaviours in a more homely and less institutionalised environment. It also specified the requirements for more traditional features such as a dining space, kitchen and activity rooms. Alongside these essential specified requirements, there was also consideration of space for co-located staff, meeting rooms and interview rooms for surgeries and peripatetic visiting services, such as podiatry or hairdressing.
39. These requirements were then further developed by a firm of architects commissioned by the council, whose work was itself informed by visits to other sites and application of best practice in relation to design for dementia friendly buildings. The requirements brief was then developed following a stakeholder event involving family, NHS partners and community groups during the consultation period.
40. From this brief, the architects undertook feasibility studies on both existing sites as well as an alternative site at Cator Street.
41. The council also agreed at August 2012 cabinet to allocate an initial £2m through its capital programme to fund refurbishment of premises to host the Centre of Excellence.

SECTION 2.7 Bullet 3

The case for Cator Street

42. Following the conclusion of the consultation exercise and the outcomes of the initial feasibility studies, officers from the council, the architects commissioned to undertake the feasibility studies and partners from South London and Maudsley NHS Trust (SLAM) Older Adults Services and community groups working with older people living with dementia, assessed the potential for the three sites to accommodate the centre of excellence.
43. Following this workshop a Strength, Opportunities, Threats and Weakness exercise was undertaken on the three sites, as well as two other options that came up in the consultation process (Keep two sites and also to look into the possibility of proposing to build the centre on NHS-owned Dulwich hospital site) alongside a "do nothing" exercise.
44. Following this process, Cator Street was identified as the most appropriate location for the Centre of Excellence for the following reasons:
 - Site has most flexibility and potential use (including connected proposed extra care housing development adjacent)
 - The costs for Cator Street are closer aligned to the indicative allocation set by the council
 - No need to temporarily decant users from existing day care centres.
 - Central location in the borough
 - Most opportunity for co-location and partnership working.
45. Southwark Park Road and Fred Francis are thought not to be suitable options for the following reasons:
 - Both sites would need to be demolished and rebuilt as the buildings' fabric would not allow building upwards
 - Both sites would cost at least twice as much as Cator Street to develop
 - Both sites would need to be accommodated on two floors which are not recommended for this client group to be supported safely
 - Southwark Park Rd site is very small and Fred Francis is built on a steep slope which makes full use of the land space more problematic
 - Development on either side would mean decanting current users for 2 years plus, which will be both disruptive for the vulnerable client group and costly for the council
 - It will take longer to develop.
46. Likewise "do nothing" would not resolve the challenges facing the council highlighted earlier in this report. Dulwich hospital would cost more because it would be a new build and the land is not owned by the council. The proposal to locate at Dulwich hospital would also be subject to further NHS consultation (which itself is being delayed due to the financial challenges affecting acute trusts in South East London). No other suitable options were identified through the consultation process.
47. It is noted that currently the ground floor of Cator Street is used for office space and training rooms for local schools and other council departments, as well as accommodating one off core council responses (Emergency planning, electoral

SECTION 2.7 Bullet 5

because I could not believe what I was seeing. We are being sent to a document titled: East Dulwich Hospital and dated July 2005. Nearly eight years old! No context provided, no updated 2013 analysis, no link to the consultation, no mention of integration, no leadership. Councillors McDonald and Williams: Please catch up with "the facts on the ground" so rapidly and so brutally being created by this government through its use of Statutory Instruments (If you have not already done so, please all look at SI 257 on EU Procurement and read today's, 3rd March 2013, Observer front page lead article).

I did attend the Integrated Care Programme event on the 18th February. Important, hugely well attended, however it is very much work in development. The number of people there, on a dark February evening is proof indeed of the vital importance for me, not only of the importance of the topic, but also of the value of creating a visible public space for us all to see integration in action across health, care, social care and public health. Andrew, Jim and I are not confused about the wider use of any vacant part of the site. What we see is so little effort being put into setting Terms of Reference and parameters which would put front and centre the health, care, social care and public health needs and then, and only then, move on to plan for schools, etc. It is about emphasis and priority.

We thank you and do welcome your offer to form a panel of the project board to review and understand our views on what a model might look like during the consultation period. Please propose dates for this and also please let us know how you propose that we may hear about the workings of the Dulwich Project Board. You were going to give this further thought.

On a number of occasions, we have proposed that the site could be transformed into a **NATIONAL AND VISIBLE MODEL OF EXCELLENCE IN INTEGRATED CARE FOR THE ELDERLY, PIONEERING HOW TO MEET COMPLEX NEEDS IN A PEACEFUL AND NON-ACUTE SETTING; REDUCING DEMAND ON A&E AND ACUTE SERVICES**(details below).

We recognise that to move to such a model would require the seeking out of Health and Care Champions and Benefactors to develop the capacity for leadership and funding as the Arts, the Universities and Sports have had to do. But, please see where we are today, in, say, Universities. HEFCE's recent report on Philanthropy reports that 152 UK institutions received £693 million pounds of philanthropic giving in 2011/2012. Malcolm Hines has referred to 600 organisations/contacts as part of this consultation. I would like to propose [redacted] and Southwark Council together write, at leadership and board level, to Boards, CEO's and [redacted] ying out a vision, making a case, seeking financial support. Here are 6 examples of who I would

- Lord David Sainsbury – Connect to his Gatsby Foundation and links to his other medical research, especially in neurology.
- Dame Barbara Young – CEO Diabetes UK
- The Chair of the Guys and St Thomas's Charitable Trust – Connect to their funding of the Integration Pilot and to the fact that this very well funded Trust took a strategic decision last year to return to buying property closer to its core interests. Could it be persuaded to be interested in Dulwich?
- The King's Fund – Sir David Bell (Chair), Sir Cyril Chantler (Member of the Board) and Baroness Helena Kennedy of the Shaws, QC, FRSA – Connect to the King's Fund co-funding of the Integration Pilot and of course to the Fund's specific policy pronouncements and interests. Also, is this the same Sir Cyril Chantler who was previously involved with Dulwich Hospital?
- Baroness Joan Bakewell of Stockport – connect to her on-going interest in the elderly and seek out her advice on finding Champions and Benefactors
- Matthew Bowcock, Chairman of the Community Foundation Network, (and also Philanthropy UK) – connect to how philanthropy can be harnessed to co-sponsor the funding needed to develop a pioneering model without a corporate takeover being the only alternative to 100% state funding.

We can produce a longer list and would be happy to help, if there is the will to explore outside the box.

We await your response and we'll start the coming week by looking at your website for the Consultation Document.

With Best Regards

Elizabeth Rylance-Watson and Jim Watson



The gender gap in unpaid care provision: is there an impact on health and economic position?

Data in this release (1)

Released: **16 May 2013** Download PDF

Key Points

- In 2011, females were notably more likely to be unpaid carers than males; 57.7 per cent of unpaid carers were females and 42.3 per cent were males in England and Wales
- Across English regions and Wales, females took on a higher share of the unpaid care burden than males in a similar proportion, regardless of the amount of unpaid care the region's usually resident population provided
- The share of unpaid care provision fell most heavily on women aged 50-64; but the gender inequality diminished among retired people, with men slightly more likely to be providing care than women
- The general health of unpaid carers deteriorated incrementally with increasing levels of unpaid care provided, up to the age of 65; the burden of providing 50 hours or more unpaid care per week appears to have the greatest impact on the general health of young carers in the age group 0-24
- In 2011 in England, 116,801 men (1.0 per cent) and 81,812 women (1.2 per cent) were in full-time employment while providing 50 hours or more unpaid care; in Wales the equivalent numbers were 9,320 (1.6 per cent) and 5,068 (1.8 per cent) respectively
- Economically active women in both full-time and part-time employment provided a greater share of the unpaid care burden than men; in England 12.1 per cent of women working full-time provided unpaid care, and in Wales it was 15.3 per cent
- Approximately half of men who were 'Looking after the home or family' provided some extent of unpaid care, with the majority providing 50 hours or more
- A uniform pattern of deteriorating general health with rising levels of unpaid care provision was present across all economic positions; men and women working full-time in both England and in Wales and providing 50 hours or more unpaid care per week were between 2.4 and 3.2 times more likely to report their general health as 'Not Good' compared with those providing no unpaid care.

Animated YouTube video

A podcast explaining this story using audio commentary and graphical animations is available on the ONS YouTube channel.

SECTION 3.1

Source: Census - Office for National Statistics

Notes:

1. Includes economically active unemployed full-time students.

Notes for Unpaid care by economic position and health

1. The economic support ratio is the number of people aged 16 and over in employment divided by every other person of any other age, including children.
2. Dahlberg, L. and Bambra, C. and Demack, S. (2007) 'Age and gender of informal carers : a population-based study in the UK.', *Health and social care in the community.*, 15 (5). pp. 439-445.
3. The NHS Information Centre, Social Care Team (2010).
4. Dahlberg, L. and Bambra, C. and Demack, S. (2007) 'Age and gender of informal carers : a population-based study in the UK.', *Health and social care in the community.*, 15 (5). pp. 439-445.
5. King, D and Pickard, L. (2013). When is a carer's employment at risk? Longitudinal analysis of unpaid care and employment in midlife in England. *Health Soc Care Community.* 2013 May;21(3):303-14
6. The Census 2011 allowed the responder to identify with more than one economically inactive position. The reasons for inactive economic position were subject to some decision rules to determine the precise category. For those which selected both 'Looking after the home or family' and 'Retired', the default economic position was retired. This means the bulk of those designated an economic position of 'Looking after the Home or family' will be below the state pension age'
7. Carers Scotland (2011): Sick, tired and caring: The impact of unpaid caring on health and long term conditions

Conclusion

This story describes the provision of unpaid care in England and Wales in 2011, in order to understand how unpaid care, an important voluntary undertaking, varies across gender, age groups and by economic position, and how it might be impacting on the health of carers.

The analysis has shown that women take on a higher share of the unpaid care burden at ages below 65, and unpaid care is associated with higher likelihoods of 'Not Good' general health among all age groups.

Unpaid care is more common among part-time workers than full-time workers, suggesting part-time work provides a greater opportunity to balance work and care commitments, but gender inequalities are present in each with women contributing more unpaid care than men.

A marked health divide is also present between full-time workers providing 50 hours or more unpaid care and those providing no unpaid care, suggesting providing unpaid care to this extent is affecting the health related well-being of both men and women living under these circumstances.

Statistical contacts

SECTION 3.5.1

Reschid Appt Ind
 Financial Year
 NHS PP
 Division Hierarchy
 Location
 Attended DNA Hierarchy

Column Labels
 M01-Apr

Appts Row Labels	M02-May	M03-Jun	M04-Jul	M05-Aug	M06-Sep	M07-Oct	M08-Nov	M09-Dec	M10-Jan	M11-Feb	M12-Mar	Grand Total
Kent	1	1	2	2	3	2	2	1	1		2	15
05-05												14
08-08												1
Other London	3	3	3	3	3	1	3					10
05-05												10
Other PCT	2	12	6	2	4	3	4	10	8	1	1	55
03-03												18
05-05												36
08-08												1
SE London	512	591	454	559	498	544	627	407	582	552	465	6346
SAT - BROMLEY PCT	3	7	1	3	6	2	4	2	8	10	7	58
03-03												30
05-05												19
06 - Self Referral												2
08-08												7
SAB - GREENWICH TEACHING PCT	3	2	2	1	1	2	1	1	6	5	2	22
03-03												2
04-04												2
05-05												13
06 - Self Referral												6
08-08												1
SID - LAMBETH PCT	176	216	176	244	202	214	283	159	214	201	175	2490
03-03												827
04-04												48
05-05												1360
06 - Self Referral												1
08-08												218
13 - Nurse Specialist (CNS)												2
14 - Allied Health Professional (AHP)												3
97-97	4	2	2	4	1	1	3	1	1	1	1	19
99 - Not Specified	2	1	1	1	2	1	2	1	1	1	1	12
51E - SOUTHWARK PCT	293	335	262	289	265	281	301	218	323	318	265	3438
02-02												1
03-03												1046
04-04												66
05-05												1833
06 - Self Referral												4
08-08												451
14 - Allied Health Professional (AHP)												9
97-97												17
99 - Not Specified												11
SLF - LEWISHAM PCT ...	39	32	15	23	22	45	37	27	37	21	15	343
03-03												88
04-04												14
05-05												208
08-08												33
TAK - BEXLEY CARE TRUST	1											4
03-03												1
05-05												3
SW London	12	6	12	11	20	19	20	8	22	7	4	166
03-03												54
04-04												4
05-05												101
08-08												7
Grand Total	526	613	472	574	522	579	652	426	612	560	472	6592

SECTION 4.2

Weak and unreliable "care in the community":

Live case study of how a patient falls between the cracks and is at risk.

"Improving health services in Dulwich" ... We cannot trust a vision in a glossy consultation brochure, which contrasts so starkly with what follows below.

[Before the Francis report and the 2012 NHS Act, patients could be "funnelled away" down the PALS individual complaints route in the hope that each case could be treated as an isolated one.

No-longer

Now, it is the duty of politicians, of NHS England and of the Clinical Commissioning Group to build resilience into primary and community care by building proper NHS medical facilities which bridge the gap between the major acute hospitals and 'home care'. They cannot have a system reliant on fragmented complaints, unsafe 'communications,' + the benevolence of caring friends. This is not 'care in the 'community', it is indeed 'scare in the community']

Live Case Study:

The patient is 93. He lives alone. He has no close family. He has a history of depression. He was an in-patient at South London and Maudsley Trust and was discharged back into his home in 2012.

Wednesday 15th May 2013: his neighbour opens his front door to allow in the carer (around 07.30). Finds him on the floor, conscious. He had fallen over 7 hours earlier (**night 14th/15th May**)

A carer returns him to bed. Decides not to call 999, as he was reasonably OK and to avoid more distress. Cleaner calls nominated friend (On the Maudsley list) who goes to patient's Southwark GP (within the Dulwich consultation list) to ask for a home visit to check out patient

Receptionist: "that is not how we do it ..." >>passes her phone to Doctor in surgery>> Doctor starts: "I should not speak to you." ... >>>... Doctor asks friend whether he thinks patient should go to hospital. Friend: "I do not have that medical knowledge". Doctor asks friend to return to the patient and to call the surgery with his findings. Friend does as asked, but decides he will return in person to the surgery to tell them what he found. He said that he found the patient was still groggy and that he was asking for a home visit from the GP.

The patient rings friend to say that he had a call from GP practice at 6.00 pm saying that the GP could not visit that day, but that if he was still feeling unwell, he should wait until 6.30pm and he should call SELDOC.

So, on behalf of patient, friend calls SELDOC and absolutely excellent SELDOC doctor comes, expressing surprise that GP surgery had not sent a doctor to examine this patient.

Doctor examines patient and decides that "because of his ordeal", the SELDOC doctor does not want to send the patient unnecessarily to King's A&E. SELDOC doctor also tells patient and friend that when someone elderly has been on the ground for over 7 hours, depending on what position they are in, there could be damage to the kidneys. SELDOC doctor decides to ask for blood tests and would send a message to GP to ask for GP home visit and to request that blood test be taken because of possible thyroid problem.

Thursday 16th May: Carer sits patient in chair>>might be safer position>> still no call from GP
Friend calls GP surgery to remind them that patient has still not received a home visit and that he has asked for one >>

Friday 17th May: Friend phones GP reception to tell them that GP had still not visited. Receptionist tells friend that no message from SELDOC had been received...>>"Oh >>just a moment...>>we had a problem with our system yesterday and we did not receive the message from SELDOC until late...> Doctor is going through his hundreds of letters right now...> receptionist will then be told whether doctor can visit patient.

Friday 17th May, now 4.30pm: Patient rings friend...>>still no Doctor and no call from GP. Friend calls GP receptionist...>> a different one answers. Patient is not on the Doctor's list for a home visit that day. Friend now complains of the outrageous treatment of a vulnerable 93 year old. Receptionist said she would make sure that Doctor knew what had happened.

Friday 17th May: Patient rings friend. GP surgery has just called and Doctor will be visiting after surgery. 6.30pm Friend goes to patient's house. The GP is there and gives excellent treatment. In addition to blood tests, high blood pressure will need to be treated and an enema administered and treatment for sores. Someone would be coming on Monday to take blood test

Monday 20th May: Patient is still waiting for the blood test, still waiting for the treatment for sores, still waiting for treatment over what may be a failed enema...>

Tuesday 21st May: pm. The patient is still waiting...

Wednesday 22nd May. The patient is still waiting...

This patient's case has not been completed, but there are some important judgements to be made already:

Judgements: In their own home old and vulnerable patients are clearly vulnerable. They are at risk, even when there are 'packages of care'. Home care and the medical side are **not** joined up.

The GP surgery and SELDOC certainly have computers...> but computers are no substitute for capacity to read and take action. If the GP surgery does not have the capacity to respond in working hours to HOME visits, then NHS medical

treatment in the home **is not working** and the 'default position' for all sorts of situations becomes to send the 93 year old patient to A&E (which actually he does not require.) What he does require is an integrated medical facility with some 'hospital' and some 'primary care together' until he is sufficiently able to return home or have to enter a residential care setting. This mind set of **either** acute hospital **or** 'home' must change.

Future proofing will need to take a long hard look at just how many friends and carers will be able to take on the vital role of plugging the gaps and bridging the failures of communication between the various parts of the system. (Pension age is rising) NHS Reforms structured further to fragment NHS budgets are NOT the answer. Building resilience and capacity into the gaps and deficiencies is where the focus should lie.

Proposal: Start by a proper 'stress test' of GP and SELDOC and patient group 'horror' stories, as well as a stress test of examples, which do work well. Abandon vague words and expensive brochures.

PS: To re-assure all those at the top of the NHS who rely on individual 'complaints,' these case study notes will be used to assist the patient's friend to file a 'complaint.' Does the patient want to "complain?" Of course not, what he really wants is good and timely treatment and care. We want responsibility to be exercised and we want communication. We know, and this case study shows it, that time and time again, when the Doctor is actually able to attend to the patient, then the treatment and care that the NHS provides is excellent.

This note has been written at the request of the friend and on behalf of the patient to give voice to those who cannot report.

Elizabeth Rylance-Watson, M.B.E
50 Dovercourt Road
East Dulwich
London SE22 8ST

Tel: 020 8693 1974
Email: eliz@rylancewatson.plus.com

SECTION 5.5

To one side there is a curtained off, staffed area, which the staff from the Betty Alexander Unit explained was a discharge lounge area for in-patients and patients for the Betty Alexander Unit. It was directly accessible from a door at the back of the clinic. Rather confusingly, these are labelled 'transport and discharge' and 'discharge'

Mrs Rylance-Watson noted that:

- She had never been told about the back door, so had always had to manoeuvre her mother round from the front door;
- She had never been told that they could use the discharge lounge area.
- Sitting with her mother in the main area, with the phlebotomy patients and customers of the café felt very cramped and un-restful, and that her mother found that very distressing.

This was discussed with the staff from the Betty Alexander Unit, who thanked Mrs Rylance-Watson for her feedback and said they would ensure that patients knew about both the discharge lounge area and the back door.

Transport Arrangements

Mrs Rylance-Watson explained that when the Betty Alexander Unit was based at Dulwich Hospital there was a dedicated team of drivers who transported patients to and from their homes. There were fewer waits, and the drivers knew the patients and their mobility issues so it was easier and less stressful for patients.

Changing ways of working

There was also a chance to discuss the way the clinic was working with the nurse in charge and the Deputy Director of Nursing. They explained that they were changing the way they worked with senior nursing staff going out to the wards and A&E to identify patients who might be more effectively managed by the Betty Alexander Unit. With focussed elderly care expertise they expected to be able to manage patients' health concerns more effectively and avoid unnecessary admissions. In order to support this they had, on secondment, a senior nurse with extensive ward-based experience. This senior nurse was, however, returning to her substantive position in January and it was not clear whether there were any long term arrangements being put into place.

Mrs Rylance-Watson agreed that this is an excellent strategy, but has since expressed concerns about whether, if this approach is successful, it will put more pressure on the already cramped space. She suggests it would support the argument for more, not less space for the Betty Alexander Unit and for more differentiation between categories of elderly patients, more of whom will need a community clinical setting as numbers of elderly patients increase.

Access to in-patient facilities and diagnostics

The staff at the clinic noted that they saw real clinical benefits to the unit being close to a wider range of diagnostics, clinical expertise and in-patient beds. However, the staff at the Unit reported that they had probably only had to admit 4 people in the past six months. It isn't clear how much the access to an extended range of diagnostics is used.

Further Visit by Mrs Rylance Watson on 8th January 2013

Waiting space

Report to: Tamsin Hooton (Southwark CCG)
By: Donna Greir, Service Manager Medical specialties
Subject: Information request KOPAU BAS

1. Services provision at King's Older Person's Assessment Unit

King's Older Persons Assessment Unit - Betty Alexander Suite is a multidisciplinary service that provides a variety of services within an outpatient/ambulatory setting.

The overall aim of the unit is to provide person centred care through a comprehensive multidisciplinary assessment and ongoing support to prevent unnecessary hospital admissions and early discharge; promoting best practice care for older people.

KOPAU offers an alternative to the ED (Emergency Department), for patients with functional decline or a medical need who require rapid assessment and intervention. It is equipped to manage patients with multiple health/physical problems who require intensive treatment and review, preventing acute hospital admissions. The unit aims to offer urgent appointments and review patients within 24-48 hours. The unit receives referrals from a variety of sources: General Practitioners, other healthcare professionals, community services, individuals & their carers. KOPAU now has direct access to the full range of diagnostic modalities available on the Denmark Hill site. These can be appropriately scheduled for individual patients to minimise the need for repeated hospital attendances.

The multidisciplinary team includes dedicated nurses who case manage patients, act as a patient advocate and co-ordinate care working alongside doctors and therapists. Occupational therapists assess a patient's functional ability with particular reference to independence and safety at home, providing any aids/minor adaptations that may be needed. Physiotherapists provide screening, assessment and management of patients at risk of falls and for those with mobility or balance problems. We provide group balance classes as well as individualised assessments. We also provide other forms of rehabilitation.

A patient can see the whole team or individual members of the team depending on their needs. The unit also offers a treatment service where patients can have blood transfusions and other intravenous therapies as prescribed by the medical team.

In addition to the daily MDT service provision, the unit offers a comprehensive range of specialist outpatient clinics for older patients. A copy of the unit timetable is attached for further information.

SECTION 5.12

List of clinics / services held in the Betty Alexander Unit in 2012/13

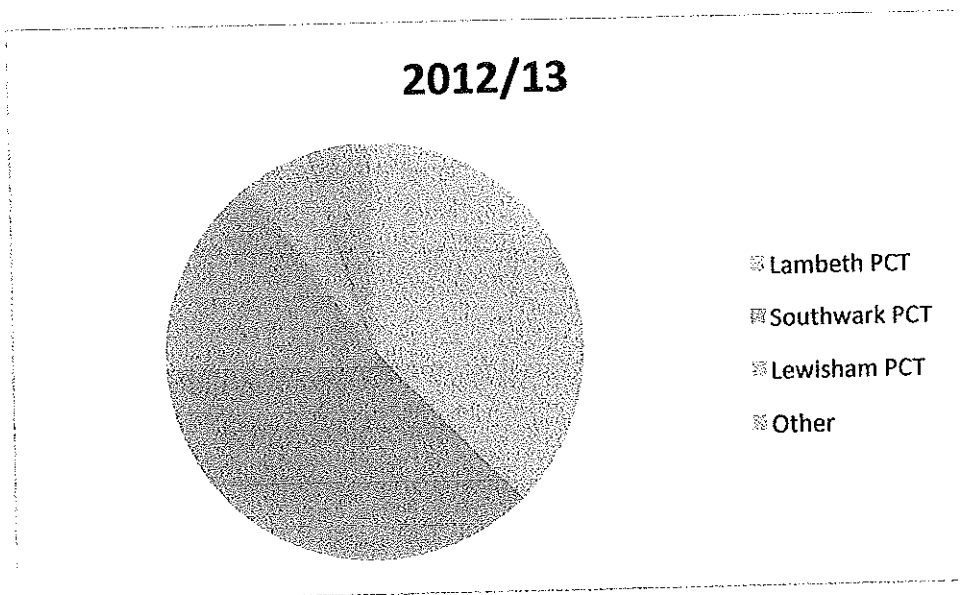
- Daily MDT clinics including OT and Physio clinics
- Clinical Gerontology Outpatient Clinics (Monday, Tuesday, Thursday & Friday)
- Falls (Wednesday)
- Memory (Wednesday, Thursday & Friday)
- Osteoporosis (Friday)
- Continence (Custom clinics)
- Parkinson's (Thursday)
- Hypertension (Tuesday)
- King's Older Person's pre-surgery assessment (Monday – new service in 2013)

Opening hours are generally 08.00- 18.00 but this is flexible. The unit opens Monday to Friday every week of the year excluding bank holidays.

New in 2012/13 is also a 24/7 telephone service TALK – Telephone Assessment and Liaison at King's. This is aimed at GPs and community staff supporting them in the management of older people across Lambeth & Southwark by providing 24 hours access to a consultant geriatrician for advice, to facilitate an urgent appointment at KOPAU or to facilitate access to other services at KCH including admission.

2. Referrals

95% of patients seen at King's Older Persons Assessment Unit are registered Lambeth, Southwark & Lewisham residents. In 2012/13, the unit had 6592 outpatient attendances of which 6271 were LSL patients.



SECTION 5.12

The unit accepts referrals from a variety of healthcare professionals, including self referrals, clinical nurse specialists and allied health professionals. A data file has been included to show this breakdown.

In summary the referral source for LSL only attendances in 2012/13 are shown below.

KOPAU - BAS referrals

	GP (03)	A&E (04)	Consultant (05)	Other referral methods
Lambeth PCT	827	48	1360	255
Southwark PCT	1046	66	1833	493
Lewisham PCT	88	14	208	33

Source: Reports by Guy's/KHP integrated care pilot to Lambeth & Southwark Council's Scrutiny Committee.

SECTION 7.2

What do older people think? (Local interviews & reference group)

The pilot's aims are 'excellent' – but there is scepticism about whether it will happen

People don't want to go to hospital or into a care home

- Older people are concerned and sometimes frightened about being admitted to hospital as they feel vulnerable and are worried about cleanliness, infections and dignity (eg requests for bedpans)

They want better support when they're discharged from hospital

- Want more communication and support after discharge – a single named contact, better GP access, temporary social or nursing care at home

They want better access to specialist health advice and more time to talk

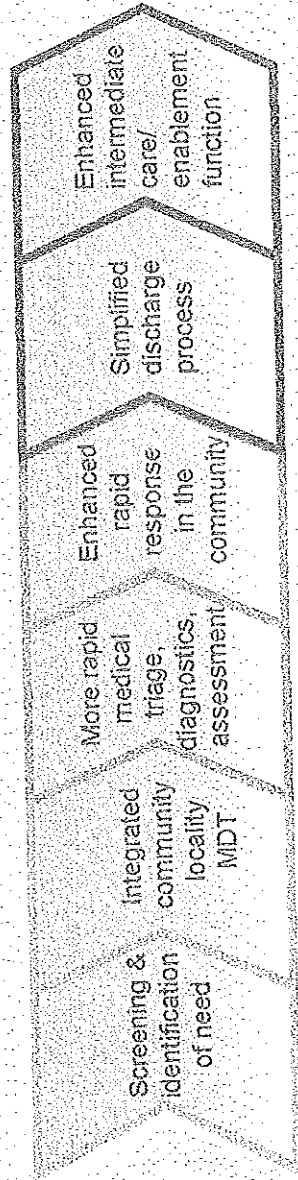
- They find it hard to get an appointment at the GP, and not enough time to talk about eg side-effects or concerns; want 6-monthly check-up on medicines, 6-monthly healthcheck
- Want to have access to an older person's specialist (specialist nurse or geriatrician). They like the older age-specific environments as the staff understand and sort out their problems

People want support for psychological, not just physical, wellbeing and to be helped to have an active, fulfilling life

They value continuity of care with the same professionals, people who know them (so they don't have to keep repeating themselves), and people they trust

Older carers often don't know their entitlements, and need more support e.g. respite

The whole system design group for older people has prioritised generic functions... combined with an across-function focus on certain conditions



Generic functions to promote the health and independence of older people.

Supported by:

- Information-sharing and IT requirements
- Ongoing monitoring of quality along the pathway

With a specific focus on preventing and managing:

- Falls
- Dementia
- Infections (UTIs, cellulitis, respiratory)