

**NHS Sutton and Merton – Strategic Plan Discussion Document****Introduction**

Just over a year ago, we published our Strategic Plan, setting out our priorities over the next five years for improving the health of the nearly 400,000 people living in Sutton and Merton. Our plan centred on two strategic goals and eight health priorities, which were based on evidence of the greatest need and agreed in consultation with local people. We focused on **maximising quality of life** by providing the most appropriate care in the right place, at the right time, with a major focus on **stroke, diabetes, end of life care, and mental health** services. And we set out plans to **target health inequalities**, in particular increasing screening for **cancer**, helping people to give up **smoking**, supporting people with **coronary heart disease** to stay healthy, and preventing **falls in older people**.

We are now in the process of reviewing and refreshing that strategic plan, ensuring we are still on track to achieving our goals. The key change in the last twelve months, which is affecting all of our lives, is the downturn in the economy and the resulting expectation of reduced future growth in investment in the National Health Service. We need to prepare to **do more within existing resources, and to do it even better**. That is not a contradiction. It is achievable. In an organisation as large, as complex, as cherished and as science and technology-driven as the NHS, there is a high risk that what is held up by one interest or another as “the way to do things” may reflect the way to have done things three, five or ten years ago, but not the best way to do things now or for the future. That means there is a challenge to ourselves, to our partners and to the patients and public we serve to make best practice standard practice, to innovate, and to increase the pace at which successful innovation is adopted across the local NHS.

This document sets out our key ideas for ensuring NHS Sutton and Merton continues to improve health and reduce health inequalities whilst delivering even greater value for money in the years to come. Complementing these ideas, *Healthcare for South West London*, a programme sponsored by all the NHS organisations in Croydon, Kingston, Richmond, Sutton, Merton and Wandsworth, is looking at the case for improving the quality, sustainability and affordability of services across south west London. *Healthcare for London*, the strategy for London’s NHS published and consulted upon in 2007/08, sets the framework for the Sutton and Merton and south west London work.

Your views are important in making sure we have all the information to take the tough decisions needed to improve our local NHS. We need to accelerate the service change we began last year. We have a vision of high quality of life and low health inequalities with an excellent local NHS serving the needs of the population in Sutton and Merton. This document sets out how we can arrive there faster.

We would be grateful for your views by 27 November. Please email [PPI@smpct.nhs.uk](mailto:PPI@smpct.nhs.uk) with your comments. The strategic plan will then go to our Board in December for approval.

**Bill Gillespie**

**Chief Executive, NHS Sutton and Merton**

**Foreword from the Chairs of the Professional Executive Committee and Joint Medical Directors**

**As joint chairs of NHS Sutton and Merton's Professional Executive Committee, the key source of clinical advice to the Primary Care Trust's Board, we welcome the opportunity to share with you proposals for maintaining and sustaining improvements in service quality in the challenging financial circumstances that the NHS, in common with other sectors, is likely to face.**

*Healthcare for London*, the strategy for London's NHS published in 2007, set out a vision for radical changes in the capital's health services, centralising specialist services where necessary to improve quality and safety and localising other services to improve quality and access.

Three years on, those key themes in *Healthcare for London* are becoming a reality in south west London. In 2010, a new major trauma centre and hyper-acute stroke unit will come into being at St George's Hospital, Tooting with strong links into local hospitals in south west London. Such specialist centres, consulted on and commissioned by London's 31 Primary Care Trusts, reflect the "centralise where necessary" key theme of the *Healthcare for London* strategy. They will save lives and reduce disability for trauma and stroke victims.

The key complementary theme – "localise where possible" – has been taken forward by NHS Sutton and Merton in our local strategy, *Better Healthcare Closer to Home*. This will deliver faster, safer, fairer and nearer care:

- Faster, because some 75 per cent of diagnostic tests will take place in one of our four local care centres in Wallington, St Helier, the Wilson (Mitcham) and the Nelson (Wimbledon) enabling GPs to ensure that patients move along the right care pathway as soon as possible.
- Safer, because the pathways of care for patients will reflect evidence of best practice drawn from the *Healthcare for London* work and local clinical dialogue.
- Fairer, because we are shifting more care out of hospital and closer to our communities with greater health needs (for example, in Mitcham) and because some of our key priorities – cutting the number of smokers further and tackling diabetes – involve focusing most effort on those in our population with greatest health need.
- And nearer, because a whole range of procedures currently undertaken in hospital – diagnostics, outpatient appointments, early expert mental health advice and support - will move into our local care centres.

Our vision for the future – outlined in *Better Healthcare Closer to Home* and the priorities identified in last year's strategic plan – is based on public engagement following a comprehensive analysis of the health needs of our local communities, undertaken jointly with our local authority partners. This process takes into account the main causes of ill

## **Sutton and Merton**

health, disease and premature death locally. A range of factors, such as health inequality, employment and other social issues, are also considered.

However, strategic plans, even those developed with strong clinical and patient involvement, do not deliver themselves. That is why NHS Sutton and Merton has spent much of the past year in dialogue with local clinicians about the establishment of Integrated Care Organisations (ICOs). These GP-led organisations will take responsibility for bringing together primary, community and certain parts of hospital care and working more closely with social care. They will ensure that there is strong clinical buy-in to the pathways of care that connect general practice, local care centres and hospital care. They will ensure that there is strong, ICO-led review of clinician compliance with those pathways and, where necessary, performance management of clinical practice which varies from best practice without good reason. They will be key to translating *Healthcare for London* and *Better Healthcare Closer to Home* from impressive plans to real changes in services on the ground and real improvements in patient experience.

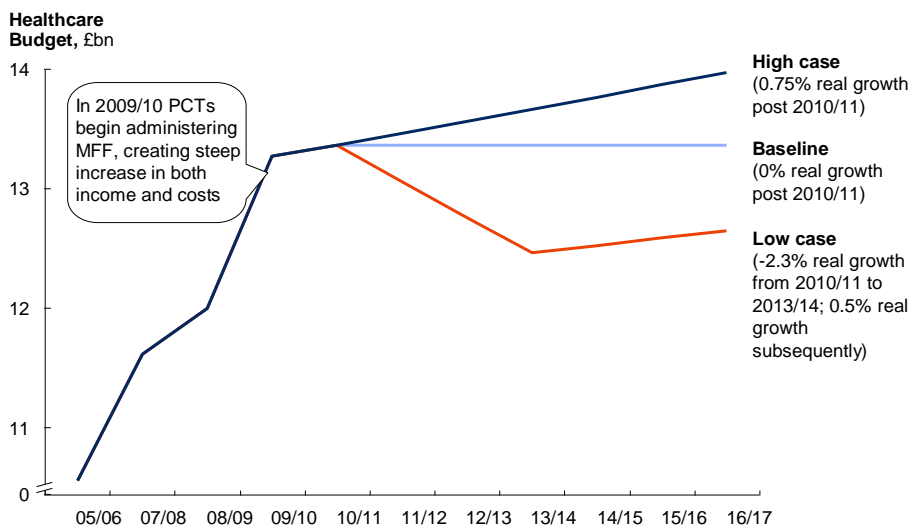
**Dr Howard Freeman**  
**Dr Martyn Wake**

## ENGAGEMENT AROUND EMERGING FINDINGS

This paper has been produced following workshops with NHS clinical experts, staff and managers. This has included looking at the needs of the local population, how much we spend on services (benchmarking against other PCTs) and the health outcomes for our local population. Where major change needs to be taken forward, then there will be further exploration of the impacts and benefits, and engagement with the public – as well as full public consultation if necessary - before implementation.

We are working on three future funding scenarios. These scenarios vary in terms of the level of future growth the NHS can expect between 2010/11 and 2016/17. The three scenarios are set out in the table below. The graph represents London PCT allocations.

### Three scenarios for future funding allocations



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At this stage, these are planning scenarios. We believe that it is responsible to plan for all three. If the most challenging scenario does not materialise then our plans can be reviewed and rephased. To plan only for the best or even the intermediate scenario would leave us with no robust plan in the event that the most challenging scenario materialises. That would not put us in a position to sustain the drive for delivering on our strategic priorities.

We have looked at the scope for improvements and value for money in nationally defined programme areas such as mental health and respiratory disease. These enable us to make comparisons between our spend in this programme area and the spend of other Primary Care Trusts serving populations with similar health needs<sup>1</sup>.

As part of last year's strategic plan, we have invested £12 million in agreed priority areas over 2009/10. Our ability to sustain investment in these priority areas will be dependent on delivery of value for money from other areas other our expenditure.

<sup>1</sup> For more information on Programme Budgeting, please go to:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_073055](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073055)

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The emerging findings from our review of programme expenditure are outlined below in the following areas:

- Mental health
- Older people
- Hearing
- Primary care
- Dental care
- Eyes/vision
- Respiratory
- Diabetes and Endocrinology (hormones)
- Circulatory (e.g. blood supply)
- Long term conditions and complex health needs (includes stroke, CHD and neurological conditions)
- End of life care, cancer and tumours
- Maternity and reproductive care
- Children and young people
- Healthy living and partnership working
- Learning disabilities
- Other initiatives

Under each heading, we have listed a range of initiatives. These are informed by best practice – working smarter and better. This is an opportunity for everything to be considered, although our expectation is that not all of these initiatives will be implemented in their current form. We welcome your feedback and views; please email [PPI@smpct.nhs.uk](mailto:PPI@smpct.nhs.uk) by midday on Friday 27 November.

### **Mental health**

In line with national guidelines (*New Horizons*<sup>2</sup>), early treatment of mental health problems can help people to keep their jobs, stay in education and remain independent – preventing the onset of more serious mental health problems. We plan to develop more support in the community and in primary care in order to reduce dependence on medication and inpatient facilities. This will also support people recovering from mental illness and regaining their independence.

This would enable us to provide care which is right for the 21<sup>st</sup> century, and to reduce the need for beds for working age, adults and older people – as well as specialist CAMHs (Child and Adolescent Mental Health Services) beds. Service users, carers and partners are already involved in a review of mental health services for adults and older people. The findings from the review will be considered by NHS Sutton and Merton's Board in January 2010.

At present, we commission some forensic services (e.g. specialist services for people with mental health problems who have been in contact with the criminal justice system) for people with mental health problems from a mixture of NHS and private providers. However, there is a high cost for this, so we propose re-tendering for forensic services to ensure that local people get the best services and that we get the best value for money.

<sup>2</sup> To see *New Directions*, go go: <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/index.htm>

Traditionally in the UK there have been long waiting lists for psychological therapies after referral from a GP, with many not accessing this service. As part of our strategic plan, we have already invested in improving access to psychological therapies in primary care. By increasing investment in primary care, there is a reduction in the need for medication. However, the commitment to maintaining investment in psychological therapies may need to be reviewed if other PCT initiatives do not deliver the cost savings required.

### **Older people (trauma and injury)**

We need to continue to develop work around falls to help older people to continue to live independently. At present, the PCT commissions services to help prevent falls – including exercise classes specifically designed to improve balance and strength, assessments to help identify risks associated with falls and services in the accident and emergency which identify people at risk of falling. There is national evidence that exercise classes are the most effective way to aid recovery and prevent people from falling in the future, and from January 2010 we will be improving the exercise classes offered locally – ensuring they are delivered to the highest standard and to that there are no waiting lists for these important classes.

The provision of intermediate care can help aid recovery and reduces the need for hospital treatment. Under *Better Healthcare Closer to Home*, our long-term strategy for the future, we are planning to develop an intermediate care centre at the Wilson as well as expanding intermediate care places in the community. We are proposing looking at further expanding intermediate care services – on top of *Better Healthcare Closer to Home* – to make a real difference in helping older people avoid going to hospital.

We are proposing to develop clinical and cost effective pathways in both primary and secondary care, ensuring that we are meeting *South West London Effective Commissioning Guidelines*.

These are NHS guidelines for ensuring that patients are not given treatment when there are no clinical benefits.

We commission services from the South West London Elective Orthopaedic Centre (SWLEOC), which provides elective treatment for ankle, foot, hip, knee, shoulder or spine operations. It has demonstrated good results in helping patients to return home from hospital quickly, providing best value for tax payers' money. However, in other areas services may not be following best practice or helping patients to stay out of hospital. We are planning on asking SWLEOC, or other accredited/reputable providers, to help us review and refine other elective pathways where this is the case. This could include reviewing services for patients requiring treatment for musculoskeletal disorders (e.g. low back pain, joint injuries and repetitive strain injuries of various sorts).

At present, the PCT funds the provision of incontinence pads. We are considering reviewing whether our eligibility criteria are as rigorous as other PCTs.

### **Hearing**

We believe that we may be able to get better value for money in purchasing hearing aids for local people, so we propose reviewing how we do this. One approach could be to

consider purchasing hearing aids in partnership with other South West London PCTs to drive down costs.

### **Primary and community care**

We plan to review the capacity and productivity of primary care, looking at:

- Whether all local enhanced services (additional services provided by GPs outside of their core contract with the PCT) are funded by the PCT
- Value for money from the Personal Medical Services contracts the PCT has with GPs, using national benchmarking information to identify areas for potential productivity gain, taking into account GP practices overall use of NHS resources. For example, we are looking at patient access to general practice both “in-hours” and in separately funded “extended hours”. Internal systems and processes within general practice can make a big difference to patient access. On extended hours, we need to look at the return on PCT investment in terms of patient utilisation of extended access.
- We plan to review the productivity of the PCT’s own community services, using benchmarking information where available to identify areas for detailed scrutiny, and ensure we are getting best value for money
- The possibility of ceasing to fund localised pilot services for patients which are operated by practice-based commissioning groups (groups of local GPs working across practices). There are concerns that these pilots have not successfully shifted care from hospitals to the community.

### **Dental**

At present, NHS Sutton and Merton commissions community dental services from NHS, Wandsworth Community Services. We plan to review whether we are getting the best value for money, and if necessary, consider other providers for this service.

At present, some dental services – for example restorative surgery and periodontal (dental infection of the gums) - are provided in secondary care (e.g. in hospitals). Anecdotal evidence suggests that some of these services are being referred to inappropriately, which means that patients are not getting the treatment they need. We are planning to review this, and see if more services can be provided in the community where patients need them.

We are considering maintaining investment in NHS dentistry at 2009/10 levels, and reviewing whether we can meet the demand for NHS dentistry within existing resources.

### **Eyes/vision**

We plan to look at developing ‘gate-keeping’ arrangements in primary care, to review patient referrals and ensure that only appropriate referrals are made to secondary care (e.g. hospital treatment). This is about making sure people get referred for appropriate treatment in the right setting – which could be in a community setting, closer to home.

Over, 2009/10, we have been working with the National Screening Programme to make improvement to the PCT’s diabetic retinal screening programme. We may be able to make long-term savings by procuring diabetic retinopathy screening service jointly with other PCTs in South West London.

### **Long term conditions and complex health needs (includes stroke, CHD and neurological conditions)**

We have been talking to the PCT's six practice-based commissioning groups (PBCs) – groups of GPs who work together to develop and commission pathways of care – about moving beyond practice-based commissioning. Ultimately, this would involve PBCs moving from having “indicative” budgets to “hard” budgets for which they take responsibility. It is likely that some of our PBC groups will begin the journey to taking on this responsibility and becoming what we have called an “Integrated Care Organisation” in 2010/11. These groups will focus on improving the care, treatment and support for people with long-term conditions.

There is strong evidence that people who have a stroke are more likely to survive and recover more function if admitted promptly to a specialist stroke unit, and receive specialist rehabilitation. Through *Healthcare for London*, St George's is being developed as a hyper acute stroke unit – providing specialist treatment - and St Helier is being developed as a stroke unit –providing rehabilitation services.

Within the context of preventing and managing conditions in primary care, we are also considering:

- Introduction of NHS Health Checks to targeted population of increased risk - including improved identification and management of Atrial Fibrillation (a condition which means you are more likely to have a stroke)
- A co-ordinated programme of personalised advice and support services to help people make healthy lifestyle choices
- Improved support in the community e.g. specialist nursing for Parkinson's disease to reduce the need for hospital treatment
- Identifying more cost effective solutions for managing chronic pain and thereby reducing emergency admissions.
- Investing in a system to analyse GP data and identify patients at risk so support can be provided in the community.
- Increasing use of telehealth and telecare
- Provide intermediate care services - applying the *Better Healthcare Closer to Home* model around intermediate and domiciliary care more extensively. e.g virtual wards.
- Improved case management and integrated multi-disciplinary teams for long term conditions. This could stop people with long-term conditions from being admitted to hospital for other complications, e.g. chest infections.
- Provide personalised care plans
- Support people to take appropriate and effective self directed care and greater responsibility to manage their own health
- Work with the Community Matrons/ Pharmacists to reduce waste of medication and medication not being used in the right way.

### **Respiratory**

We believe that a co-ordinated programme of personalised advice and support to help people make healthy lifestyle choices could improve health and wellbeing, and the take up of smoking cessation services. As part of this, maternal smoking has been identified as a

priority area, and is being addressed by Epsom and St Helier University Hospitals NHS Trust, who are focusing on this area.

By helping people with a chronic obstructive pulmonary disease (e.g. chronic bronchitis and emphysema) to live independently and manage their condition, we can reduce hospital attendances and give people a better quality of life. We are considering rolling-out a pilot which was run in Merton last year by the Integrated Pathway Care Consortium (IPCC) practice-based commissioning group, comprising GPs in Merton. Under the pilot, patients were given support and advice from healthcare professionals at clinics, reducing the need for hospital treatment and increasing health and wellbeing.

### **Diabetes and Endocrinology (hormones)**

We are considering ways of ensuring that all patients who are at risk are identified through regular health checks in primary care. This will help us to ensure that people with conditions like diabetes and cardiovascular disease manage their conditions as effectively as possible.

We are also considering implementing the *Healthcare for London* diabetes guidance - providing more personalised advice and support. This is about providing more support and treatment in primary care (e.g. drug treatments and insulin initiation which traditionally only took place in hospitals) for prevention and self-care, and minimising the need for secondary (hospital) care for the majority diabetics.

### **Circulatory (e.g. blood supply)**

Coronary heart disease (CHD) is the single biggest cause of mortality in people over 65 years and the biggest cause of emergency admissions in people over 50. Sutton and Merton has admission to hospital rates above the national average for cerebrovascular disease (e.g. brain dysfunctions related to disease of the blood vessels supplying the brain) and problems of heart rhythms. We also have the highest rates in London for cardiology first outpatient attendance. This indicates that there are more referrals in Sutton and Merton cardiology in other areas, which needs to be examined.

With this in mind, we plan to review admission rates and outpatient rates to scope the opportunity for re-provision and bring in line with best performing PCTs. We will also consider:

- Placing more emphasis on prevention in primary and secondary care
- Introducing NHS Health Checks to targeted population of increased risk
- Co-ordinating a programme of personalised advice and support services to help people make healthy lifestyle choices
- Improving the management of cholesterol – giving more people regular health checks in primary care
- Improving the cardiac rehabilitation pathway, ensuring patients receive the best treatment which helps them to recover from cardiac surgery as quickly as possible
- Improving the proactive management of patients with heart failure, offering specialist support seven days a week

**End of life care, cancer and tumours**

The PCT is working with the South West London Cancer Network and provider organisations (e.g. Royal Marsden and St George's Hospitals) to reduce waiting times for patients. For example, we are working to ensure that patients with symptoms of breast cancer receive treatment within two weeks of referral.

We are considering investigating providing more support to patients by commissioning services from Oncology Day Centres where patients can receive care before going home to self-care, with the support of primary and community services. This would help people to live independently, and reduce the need for out-of-hours admissions to hospital.

We plan to look at the information patients are given when they are discharged from hospital. This could include ensuring they receive treatment plans with actions as to what to expect re: symptoms etc., packs to support their own symptom control e.g. thermometers and antibiotic starter packs, and links to support from integrated primary health care teams (community matrons and teams and the GP).

We are also looking at increasing patients' choice in where their end-of-life care is managed. The Royal Marsden's Hospital to Home (H2H) pilot is already giving cancer patients more choice towards the end of their lives. We plan to look at extending this pilot for other disease groups and hospitals – e.g. so patients with heart and respiratory disease also have a choice in where they receive end-of-life care.

We also plan to review appropriate use of high cost drugs, including medication given at the end-of-life phase.

## **Maternity and reproductive health**

A brand new state-of-the-art birthing centre at St Helier Hospital was opened in November 2009 as part of a £2.8 million overhaul of the maternity unit. The centre has been designed so that women who have had problem-free pregnancies have the chance to give birth in a more relaxed environment, supported by midwives.

We plan to ensure that we are getting value for money and efficiencies in current investment. For example, to ensure that treatment is given to people who need it, we will look at the criteria around the Early Pregnancy Unit at St George's to avoid inappropriate use.

We are also considering reviewing the most clinically appropriate methods of termination of pregnancy, for example non-surgical methods.

At present, non medically indicated caesarean sections are provided on the NHS. We plan to review whether or not it is appropriate to fund these.

We also plan to consider giving more choice driven by need around the most appropriate setting for births.

## **Children and young people**

NHS Sutton and Merton is committed to improving the health and wellbeing for all children but in particular the increasing numbers of children and young people with disabilities and complex health needs. We have been working closely with local authority colleagues in both boroughs in line with national guidelines to improve services for this group including increasing support for their parents and carers.

We plan to review the productivity of the PCT's own community services for children, using benchmarking information where available to identify areas for detailed scrutiny, and ensure we are getting best value for money. This would cover areas including health visiting and school nursing.

For example, over the last year we have increased investment in community occupational therapy to improve access and significantly reducing waiting times. Also in the last three years we have increased funding for providing short-breaks (respite for patients/ carers), and community palliative care (which includes healthcare support in specialist schools), and funding for community equipment for children. We believe we can improve these services by commissioning a more coordinated service to ensure we are getting best quality and value for money.

## **Healthy individuals and partnership working**

As the local leader of the NHS, we work closely with the local councils and other partner organisations to improve the health and wellbeing of local people. For example, in Sutton this includes running *Active Steps*, a pioneering physical activity programme, with Transport for London and the London Borough of Sutton. *Active Steps* encourages people to use their car less and get fit by walking or cycling, and has benefitted over 1,000 local people. In Merton, we have launched an innovative scheme to help the most vulnerable people called *New Directions* – a project run with Merton Council, South West London & St George's Mental Health Trust and the Metropolitan Police. Under the scheme, people

with a mental health trust problem who have traditionally not benefited from care are given support to get their lives on track.

The PCT recognises the Government's carers strategy that was published in June 2008, which included investment aspirations for all PCTs. From a baseline investment of £1 million, we have increased investment for carers by £150,000, although we recognise this was less than the 2009/10 aspiration of a £360,000 increase. Going forward, we will be looking at how we can best support carers, and what progress we can make towards the aspiration for increasing investment by £720,000 in 2010/11. Between 2008-9 and 2010-11, we are investing around £3million across Sutton and Merton in partnership working. Alongside mainstream funding this includes funding from other sources (e.g. lottery grants). We see promoting healthy living as a priority area as it keeps people out of hospital and increases health and wellbeing. There is a focus on smoking cessation and promoting exercise and healthy living. We want the views of our stakeholders to make sure we are prioritising the right areas. Going forward, we are considering:

- Commissioning a range of programmes, linked to the partnership based health alliances (e.g. partnerships between the NHS, local councils and voluntary agencies), that target preventable disease such as diabetes and obesity.
- Breaking the cycle of inequalities by working with local communities to achieve behavioural change
- Developing the key health improvement alliances and public health groups to support the above opportunities.

### Learning disabilities

In partnership with local authorities, we would seek to maximise opportunities to improve both the quality and value for money of services provided to people with learning disabilities within existing resources.

Our investment in learning disabilities is significantly higher than for other similar PCTs. We are planning to benchmark against other PCTs and ensure that local people are getting the right services and we are getting best value for money.

The care setting for people with learning disabilities has shifted from residential care to supported living. We believe that people should be given individualised care which helps them to play an active role in the community. Our work with both local councils has led to a major shift towards individualised care in supported living.

### Other initiatives

There are a range of other initiatives being explored which do not fit into analysis of expenditure by nationally defined programme. These are outlined below.

Most hospital care and treatment is covered by national price tariffs (for example, the national tariff for a hip joint replacement costs up to £9,300). Each year providers of NHS care are required to deliver efficiency through reductions in tariff prices. We are assuming that where tariffs apply, efficiencies of 3.5 per cent will be required in 2010/11 and 4 per cent thereafter. While this helps the PCT as a commissioner by increasing our spending power, we need to balance our responsibility to get value for money for our population (which puts pressure on our providers to be efficient) with our responsibility to have a

sustainable configuration of providers (we need providers who are efficient and sustainable).

Under *Better Healthcare Closer to Home*, we will be shifting care out of the acute sector into community settings, including the new Local Care Centres. We are aiming to achieve tariffs that are between 50 to 80 per cent of the tariffs currently charged for the same care in hospital settings.

Other initiatives include:

- Managing inflationary pressures and growth in demand by improving productivity and ensuring we get value for money in all areas.
- Reviewing investment in clinical engagement – practice based commissioning and integrated care organisations.
- De-commissioning low priority treatments and investing in prevention (e.g. services which keep people healthy and out of hospital).
- Reduce management costs at the PCT. This could be by sharing resources with other PCTs on purchasing services more effectively in partnership with other South West London PCTs
- Working with local authorities to ensure that value for money is achieved on partnership agreements.