Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (BLMK STP)

Feedback on the October 2016 submission to NHS England

3 March 2017

1. Introduction

This paper summarises the feedback that has been provided on the BLMK STP October 2016 submission to NHS England.

We are extremely grateful to local people for taking the time to share their thoughts and opinions, which will help to shape our plans as the STP progresses.

2. Approach

In November 2016, a public summary of the BLMK STP submission was prepared and placed on the www.blmkstp.co.uk website along with a copy of the technical submission and an online questionnaire. This questionnaire was open for responses from 15 November 2016 to 10 February 2017 and received **184 responses**.

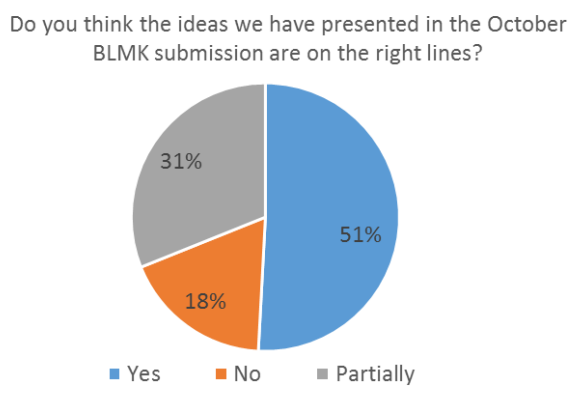
From 26 January to 1 February 2017, the STP team worked with the four Healthwatch organisations in the BLMK area to host four public engagement events which were attended by **174** people. At these events the public summary was shared and feedback invited through a general Q&A and round table discussion sessions.

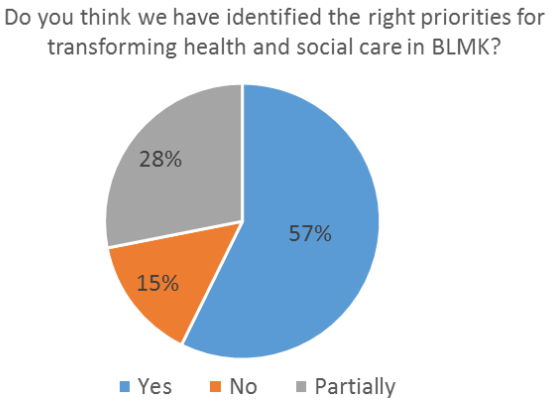
To ensure people had as many ways as possible to provide their feedback, responses were also invited by email, telephone and in writing. Five comprehensive email responses were received.

More detail is provided below.

Method	**Number of attendees / respondents**			
Audience	Patients /public	Clinicians /providers	Democratic	Total
Stakeholder events in Luton (26 Jan 2017), Milton Keynes (30 Jan 2017), Central Bedfordshire (31 Jan 2017) and Bedford Borough (1 Feb 2017)	174			174
Questionnaires completed (available online with the public summary from 15 Nov 2016 to 10 Feb 2017)	147	37		184
Emailed responses	2		3	5

3. Feedback – headline summary and key themes





The key themes emerging from the feedback were as follows.

- **General support but lacking detail:** People were pleased to see health and social care being reviewed together and that none of the hospitals were facing closure. *"This is the first time everything is being put under an umbrella trying to do something constructive in the NHS – it's wonderful!"* With the exception of P3, respondents were largely supportive of the proposals in the document, but many felt the plan was not detailed enough for them to comment. *"The document reads like a plan for a plan."*
- **Nothing new:** Some of the clinicians who responded felt that the plan was not radical enough and that the STP seems to be thinking along the lines of what already exists. *"Feels like we are re-arranging the deckchairs on the Titanic."* Some felt that there was nothing new in the plan and that "*it has all been said before and nothing has materialised*". There is concern about the uncertainty that the continuing review is causing for staff and patients.
- **Timescales and funding:** Many felt the timescales were unrealistic, especially given the number of organisations involved, and urged the STP not to *"rush change"* and to look at more long-term savings. People felt that, across all priorities, implementation will be the key and there were questions about how the proposed changes, especially P1, P2 and P4, would be funded. Some felt that the only way to sustain the NHS is with proper funding and there were concerns as to how the same levels of care could be provided with Council cuts, lack of social care funding and the sustainability requirements of the STP. *"I can see the cuts but can't see the investment."*
- **Cuts / privatisation:** There is some concern that the plans, and especially P1 and P2, are a route to cuts in services and staffing levels, which may lead people to be resistant and cynical about change. There are also concerns that changes would be a precursor to privatisation.
- **Care closer to home (P2):** There was general support for moving some services out of hospital and closer to home. Specific services mentioned were blood tests, scanning, X-rays, diagnostic imaging, audiology, neurology, non-acute operatives, physiotherapy, spectrophotometry, recovery and treatment for minor illness and injury, and hospital consultants coming out to the community to run clinics. *"Having more services in the community is excellent, local people need local access."*

- **Secondary care (P3):** While most people were supportive of closer working between the hospitals and reducing duplication, there were major concerns over the potential removal of services and people wanted clarity on which services would be affected.
- **Transport and travel:** The main issues raised in connection with P3 were the difficulties of transport and travel getting to another hospital (especially for the elderly, infirm, vulnerable groups and those living in deprived areas), the strain on patients and how this would impact their treatment and recovery, and the cost and availability of parking for patients and visitors. Clinicians also felt that, if services were amalgamated onto one site, the selected hospital would not be able to cope or be future-proofed to meet the demands of the growing population.
- **Surrounding areas:** There were questions about how the plans would affect people going out of the area for treatment, and questions as to whether populations in the surrounding areas who use the BLMK services have been taken into account.
- **Priorities:** Those that felt we didn't have the right priorities felt that the integration of health and social care was the key priority and that there needed to be more focus on mental health issues / dementia, learning disabilities and continuing care. There was a suggestion that priority areas should be activities that are critical, either because they are essential or because there are particular problems, and that they should therefore be health education, GP services, maternity services, A&E, and social care. It was mentioned that the ACS (Accountable Care System) is far reaching and must have more prominence and that there needed to be more reference to family carers, out-of-hours dental provision and the future of MSK. *"The only priority we should be focussing on is the patient and their needs."*
- **Communication and consultation.** It was felt that the summary document was well presented but that the language in places needed to be more 'Plain English' / less corporate. Many felt that consultation and public and patient involvement in the STP had been lacking and said that there was little mention of consultation in the submission documents. People felt that more publicity was needed, as many people were not aware that the submission documents and questionnaire were online. Concern was also expressed that people who were not computer literate would be left out of the consultation and it was felt more engagement was needed with the Black, Asian and Minority Ethnic (BAME) communities, with documents available in different languages. The public would like patients, carers, GPs, pharmacists and front line staff to be listened to and involved in the design of services and said that strong communication would be imperative to support any change. Respondents requested regular updates on the progress of the STP.

4. Feedback – detailed summary

A more detailed summary of the feedback on each priority, along with some general comments, are provided below.

P1 – Prevention

- **Overview:** Respondents were generally supportive of the proposals for prevention *"Unless the balance between prevention and cure is addressed no amount of organising is sustainable"* but felt more detail was needed and that implementation would be the key.

One respondent felt that a universal approach could not be applied across the whole area, saying that Luton and Milton Keynes have a much more deprived demographic.

- **Funding:** There were questions over how funding would be protected to make this happen, especially given that *"local authorities seem to be moving away from funding prevention services".*
- **Voluntary sector:** Respondents said that a joined up approach would be essential and that a thriving local voluntary and community sector would be key to that.
- **Education:** It was felt that cultural change would be needed and many people mentioned the need for more health education, starting at school, especially around healthy eating and what constitutes an emergency, as well as partnering with schools and parenting organisations to tackle the issues which lead to depression and anxiety. *"People don't know how small a unit of alcohol is."*
- **Communication:** People mentioned that widespread communication would be necessary through multiple channels (not just electronic) and that the right tone was needed. *"Don't preach – that 'one you' initiative recently hit the right note."*
- **Solutions**: In terms of specific solutions, a number of respondents felt that a fracture liaison service and social prescribing hub were good ideas, but one person said that a physical hub may not be practical for the BLMK area given the wide geography. Other suggestions were regular GP health checks to flag up issues / promote early diagnosis and focus on healthy lifestyle choices, more input from psychologists, enjoyable ways to keep fit and accessible low-level preventive services, e.g. chiropody, podiatry and hydrotherapy. One person asked if there should be some sort of penalty, e.g. refusal of treatment if you are overweight.

P2 – Primary, community and social care

- **Overall support:** There was overall support for the proposed changes to primary, community and social care, but people said that these changes needed to be in place before making any changes to secondary care. It was felt that GPs would be at the heart of change in this area and that they needed to be on board,
- **Care closer to home:** There was overall support for providing more care closer to home, but concerns as to how this would be funded. There was support for smaller 'cottage hospitals' and satellite clinics in villages, but a concern that community hubs would only benefit those near to them *"more community care / nurse practitioner care may be the answer."* Some people would like to see minor injuries units in towns away from hospitals, whereas others favoured walk-in centres adjacent to A&E to make it easier to stream patients away from A&E back to the GP. *"Urgent care centre needs to be the 'king' of urgent care – not A&E."*
- **Enhanced GP services:** All respondents were in favour of strengthening GP services but there were concerns that this was optimistic, given the problems recruiting GPs and concerns that GPs would not be willing to work together. "*GPs are significantly over-stretched and this is having a significant impact on secondary care. If we can get this right we would have made a huge transformation!"* It was felt that cultural change would be needed and that this should be built it into GPs' training. One respondent mentioned making General Practice more attractive to training medics.

Some people were against merging / centralising GP practices as they felt this could result in a poorer service and that GPs could become more remote from patients.

In terms of enhancing GP services, a number of respondents mentioned extending GP opening hours and expanding the services they provide to include, for example, stronger links with mental health services and CAMHS, on-site psychiatric and specialist diabetes nurses, mental health clinics, health visitors and midwives – and that every GP practice should offer urgent care and treatment for minor injuries. Two respondents mentioned triage at GP surgeries "*Paramedics triaging at GP practices was excellent*" and one asked if there could be a more formal way for GPs to prescribe alternatives to medicine.

There was a suggestion that patients could self refer to physiotherapists, dieticians etc rather than putting additional pressure on GPs by making them 'gatekeepers'.

- **SPoA:** Views on the Single Point of Access (SPoA) were mixed, with some people feeling it was a good idea that would reduce present confusion, so long as staff are qualified and trained. However, one person expressed a concern that it could impede the serious and really urgent cases and one clinician felt it wouldn't work as a local service "*It should be national, otherwise 999 will take over*". Respondents noted that it would need to be widely communicated and one respondent mentioned giving callers a reference number to avoid the need for individuals to have to repeat the explanation of their condition. One clinician suggested including urgent and primary care in the SPoA, making it easier to 'get help today' across all services, which could reduce duplication and address the increasing demand.
- **Pharmacists:** Respondents felt that pharmacists should be more involved, e.g. promoted as the place to go for people with sore throats, and upskilled to deliver more services. However, there was concern that the reduction in pharmacy funding would take out a vital resource for prevention and supporting people to find non-hospital solutions.
- **Social and community care:** There were a number of individual comments in this area, but no clear themes:
  - Community services teams' knowledge and skills are important to support GP knowledge and skills.
  - There is duplication in the occupational and physiotherapy services commissioned by local authority and hospital social workers, meaning patients can get lost between the two.
  - Allied health professionals need funding and to have the capacity to assess patients in a timely manner, which has the potential to avoid certain hospital admissions.
  - 80 additional healthcare assistants equates to 1/110k residents in BLMK, is this enough?
  - Health representatives should attend meetings run by the local authority as their voice needs to be heard in shaping social services and offering support to children with additional needs.
  - There needs to be more multi-skilling, particularly in tertiary services, to prevent carers *"passing each other on the driveway".*
  - The role of the health visitor is greatly undervalued and underused
  - I don't get the huge value of therapies.
- **Hospital discharge / bed blocking**: There was support for a hospital discharge team but minor concerns that a rush to discharge people from hospital could lead to readmissions.

Many people mentioned the need for more community convalescing and step up / step down beds provided locally (especially in South Central Bedfordshire), and that these needed internet access as not all elderly people *"live in the dark ages."* One respondent mentioned that the discharge process needs to be right so patients aren't left without medicines. *"Sorting out secondary care will only work if patients can be discharged back into the community in a timely manner."* One respondent (referring to the technical submission) mentioned that they could see how bed blocking would allow more people to be treated more quickly in hospital, but not how it would save money, as the beds would quickly be filled by other patients.

- **Care for older people / long term conditions**: Many people mentioned that more resources and funding were required for care home places and staff training. Others favoured older people's 'villages' with care and nursing available, and that housing for the elderly and frail (as well as disabled people and people with mental health issues and learning difficulties) should be considered alongside health. One person mentioned there needs to be more provision for care of the dying, including hospice facilities, and another asked if the local hospices have been involved in this process. One clinician said they felt chronic and long term conditions were not being managed properly in primary and community care, which added pressure on hospital services and was not always best for the patient. Another mentioned the need for rehab facilities for people with complex or multiple conditions.
- **Care at home:** Views on increasing care at home were mixed – some felt supporting people to receive care in their own home should be a priority *"Support the Hospital at Home project"*, one said they didn't want care in their home and some mentioned that home care is costly for the individual, so the cost would be shifted from NHS to patient.
- **Voluntary sector:** A number people suggested that there should be more community involvement, with more community volunteering to support services. *"Could the CSV help?"*
- **Self care:** Respondents were supportive of the need for more self care, but there were concerns that some people would fall through the cracks, for example due to mental illness, neglect or disability.

P3 – Sustainable secondary care

- **Closer working / removing duplication:** Most people were supportive of closer working between the hospitals and reducing duplication, if it can be achieved while maintaining access and quality / safety of services, but many respondents asked for clarity on what is meant by 'unnecessary duplication'. One respondent said they supported clinical teams working across hospitals and a few people mentioned merging of back office functions. One clinician said we should standardise some things across the three Trusts to make sure we are getting value for money and that staff can work safely.

  Some respondents also felt that this closer working should be extended to a wider range of hospitals. *"How does this co-ordination of the three hospitals affect existing co-ordination with other hospitals e.g. Addenbrooke's oncology with Bedford?"*
- **Removal of services:** There were major concerns over the potential removal of services and people want clarity on which services would be affected. Many felt that, to support the growing population, all hospitals needed to offer all services.

Consultant-led A&E, maternity and paediatrics were cited a number of times as services that must be maintained at all three sites. One clinician said that, if we must remove services from sites, then we should consider pre-booked services.

There were concerns that removal of services would lead to further closures, service inconsistency, longer waits, job losses and low staff morale. "*If you centralise services, how will that affect further recruitment? Who wants to work at a hospital which only does minimal work and posts patients off to other centres? This would reduce surgeons to 'mechanics' doing repetitive and often boring procedures day in day out".* One clinician mentioned that any proposed changes should be risk assessed, involving frontline staff and patient reps in all discussions, before decisions are made.

- **Transport and travel:** The main issues raised in connection with removal of services were the difficulties of transport and travel getting to another hospital (especially for the elderly, infirm and vulnerable groups), the strain on patients and how this would impact their treatment and recovery, the cost and availability of parking for patients and visitors. Many people mentioned that public transport is inadequate between the sites and that road congestion would be a problem. One respondent said that a detailed travel analysis was required, working with the local councils.
- **Premises:** There was mention that the current hospital premises were not fit for purpose and one respondent asked where the desired L&D rebuild would fit into these plans. A number of people mentioned the need for more facilities in the Southern part of Central Bedfordshire including suggestion of a 'super hospital' in Flitwick, at the centre of the triangle between the three hospital sites.
- **Aftercare:** One person said that patients could possibly be sent to their nearest hospital for nursing following surgery, but another said they didn't think it would work if aftercare was provided in a different Trust.
- **General comments on secondary care:**
  - Better triage is needed and GPs are needed in A&E to manage admissions.
  - At Milton Keynes Hospital, a complete cancer treatment is needed and there is a lack of nutritionists.
  - Make hospital machinery transportable and invest more in radiology equipment to avoid patients having to wait in Bedford Hospital.
  - Drastically cut the amount of money and human resources to secondary care and spread it equally across the five priorities.
  - The Circle MSK Enhanced Services Centre is not inspected by the Care Quality Commission and is a parasitic operation that bears no costs.

P4 – Technology

- **Good idea, but can it be achieved?:** Most people felt that integrated patient information was an excellent idea, but there were concerns that the cost of a digitised system could be prohibitive and that the NHS IT system would prevent it happening. Several respondents mentioned previous failed NHS projects that have cost £millions. One respondent said that a national solution would be better, and another said that any technological solutions should be based on agreed national standards to avoid unnecessary duplication and excessive costs. One clinician said we shouldn't try to reinvent the wheel as there were good systems currently being used that had additional potential.

- **Sharing records:** A few people said they felt that hospitals should be able to view GP records; that it is more important to share hospital records with GPs, community and mental health providers than between hospitals; that shared records should include social care and that the records should also be able to be shared outside BLMK.
- **Information security:** The major concern with this approach was security of people's information and that too many people would be able to access records without consent. However, one clinician said that patients think their information is already shared across the healthcare system and that *"the inability to share for whatever reason holds us back*".
- **Patient access:** Views on allowing people to access their own health records were mixed. One clinician said it was *"an excellent opportunity to promote patient empowerment and involvement in their own healthcare",* linked in with patient information websites such as www.labtestsonline.org.uk. However, other respondents felt that great care needs be taken in letting people access their records, as *"too little knowledge could be a dangerous thing",* particularly with the NHS use of acronyms, medical jargon, etc.
- **Back up and training:** There were questions as to what alternatives there would be for people who didn't have internet access and what would happen if the system crashed. Training would also be needed *"remember that a system is only as clever as the people that use it."*
- **Other ways to use technology:** Several respondents mentioned the need to make more use of telephone, Skype, and Facetime consultations, more Telehealth and to have IT that enables people to remain independent at home, be examined at home or at a nearby community facility. One clinician mentioned that care needs to be taken with online laboratory results as different technologies and reference ranges could lead to patient safety issues.

P5 – System redesign

- **General support but low priority:** There is general support for a more patient-focused, joined up approach if this can save money, especially if this can be spent on frontline staff and services. *"Sounds promising – focus on the patient and clinical outcomes, not who pays for what…Health organisations should not need incentives beyond the health and wellbeing of patients - they are not dealing with commodities but people".* However, some feel this should be a low priority that should be *"saved for when there is money in the pot"* and have questioned how this would work across borders, especially given different needs in different parts of the wide SMTP footprint.
- **Organisation:** Some respondents said that the organisational structure needed to be simplified, suggesting merging the three Trusts into one organisation operating across three sites and questioning whether three CCGs were needed.
- **Staff costs:** Respondents mentioned that there needed to be less use of costly locum doctors, contracting and agency staff. *"The three Trusts need to agree payments for bank and agency staff so that they stop competing with each other"*. Some respondents favoured reduction of middle managers and administrative costs, but there was a comment that we need to be careful not to victimise administrative staff, secretaries, practice managers etc as they play a vital role in the smooth running of our health services.
- **Cultural change:** It was mentioned that cultural change is needed, from competitive to collaborative working, and that managers need to be trained to think like private sector business people.

- **General comments on system redesign:**
  - The ‘accountable care options’ need to be identified and published before the public is asked to comment on them.
  - You shouldn't be commissioning anything, you should providing services directly in a ‘not for profit’ model.
  - Reduce admin costs by bulk buying across hospitals.
  - Allowing the cheapest tender bid to win, then immediately giving in to demands for additional funding reduces your credibility considerably.

General comments

Below is a summary of general comments received, where they fall outside the specific priority areas.

- **Population growth:** One respondent urged the STP to ensure population growth is fully considered and to make sure we are using the most up to date figures.
- **NHS misuse and charging.** There were concerns about misuse of the NHS, e.g. drunks at A&E, and several people suggested charging for missed appointments, hospital food and those not entitled to NHS services. One respondent recommended an increase in the community charge to better fund the social care element, but another said that people have paid their taxes and National Insurance for decades to fund care and should not be expected to pay again.
- **Diversity.** A few respondents talked about diversity – that there needs to be more understanding of cultural, religious and caste issues within the BAME community, and that staff should be as diverse as the communities they serve.
- **Ambulance services:** There were questions as to whether the ambulance services in the wider BLMK footprint were sufficient, especially as they provided a critical link to provision in community and primary care, as well as taking people to hospital.
- **Staffing, training and education:** There was some concern that there were not enough health professionals to carry out the planned changes and that more doctors and nurses were needed. There were a number of comments about training and education including that nurse education needs to be reviewed, that trainee hospital nurses should have a stint in the community and spend some hours visiting older people and that there needed to be measures to improve the overall training, values and education of NHS staff. It was mentioned that there needed to be more focus on staff's wellbeing, as *“valued staff work more efficiently and will go over and above expectations.”*
- **Joined up care:** There were a few comments in this area, but no clear themes:
  - Multi-disciplinary meetings are a great way to co-ordinate treatment, but why does the patient still feel he/she is being passed from pillar to post with no idea why?
  - Every patient should have a project manager who ensures continuous transfer between services.
  - A person should have their treatment planned, co-ordinated and implemented from initial diagnosis to final discharge. This should be clear and defined with the patient, family and carer involvement at every stage.
  - There should be ownership clearly defined for making the patient journey progress as it should. How about a local patient ombudsman?

- **Miscellaneous comments:**
  - Sustainability should apply to all areas, not just secondary care.
  - Need to extend NHS control over dental practices.
  - Work to remove stigma around social care.
  - It is disappointing (in the technical submission) that there is no mention of all the extensive work that was carried out for the Healthier Together (particularly transport) Review and the Healthcare Review.

5. How this feedback is being used and shared

The feedback on the STP summary will be shared with the BLMK STP leadership team across the 16 partner organisations for review and consideration. Importantly it will also be shared with clinical teams to inform their thinking and further development of ideas for addressing the challenges facing our local health and care system, and opportunities for improvement. It will also be shared publicly via the BLMK website – www.blmkstp.co.uk

Further engagement is planned during March and a 'What we've heard so far..' document, capturing views from patient, public, staff and clinicians will be shared later that month. All of this initial feedback will then be considered and captured within the 'Case for Change' which will be the next step in the process towards developing possible solutions for service change.

6. Analysis of responses

The following organisations were represented within the responses received:

- Age UK
- Alzheimer's Society
- Aragon Housing
- Bedfordshire Clinical Commissioning Group
- Bedford Borough Council
- Bedford Hospital Charity
- Bedford Hospital NHS Trust
- Bedfordshire and Luton Fair Play
- Bedfordshire Rural Communities Charity
- Bhagwan Valmik Sabha (temple)
- Bionicare
- British Legion
- Brook
- Business in the Community
- Central Bedfordshire Council
- Clifton Residents Association
- Council for Voluntary Services
- Deaf Awareness Group
- Guru Nanak Gurdwara
- Hearts in Beds Cardiad Support Group
- InHealth

- Healthwatch Bedford Borough, Central Bedfordshire, Luton and Milton Keynes
- Labour Party
- Luton Clinical Commissioning Group
- Luton and Dunstable University Hospital NHS Foundation Trust
- Luton Irish Forum
- Millbrook Healthcare
- Milton Keynes Council
- Milton Keynes University Hospital NHS Foundation Trust
- Mind BLMK
- MK Pensioner's Association
- Multiple Sclerosis and Parkinson's
- MS Volunteer
- OPN
- Parish and Town Councils (Bletchley East, Campbell Park, Eversholt, Flitwick, Sandy, Stantonbury)
- Patient Council – Bedford Hospital
- Patient Participation Groups (including Bedford Locality Patient Group, Flitwick Surgery, Ivel Valley Medical Centre, Leighton Buzzard)
- POhWER
- Queen's Park Community Centre
- SEPT

Questionnaire respondent details (completed by around half of those who responded)