NHS Sutton and Merton

Strategic planning update
Vision and commitment

The local case for change

Polysystems update
Our vision in Sutton and Merton emphasises partnership working to reduce health inequalities, prevent ill health and provide value for money.

NHS Sutton and Merton will improve the health and quality of life of its population through focusing on prevention of ill health and the commissioning of quality services that are clinically effective and provide value for money. People will be supported to manage their own health, and care will be provided in the most appropriate and accessible way. NHS Sutton and Merton will strive to reduce health inequalities, working with other public service and third sector partners.
We are committed to the South West London Whole Systems Development Programme

**Sector process**
- Understand the scale of service transformation needed to deliver the quality benefits and the financial bottom line
- Model potential acute activity shifts

**PCT process**
- Better Healthcare Closer to Home – long-running local initiative now aligning with Whole Systems Development e.g. through modelling
- Sutton and Merton will have four Local Care Centres to incorporate shift of activity from acute to non-acute brought about by WSD outcomes

### Timeline
1. **Understanding the challenge**
   - May 09
   - Understand the scale of service transformation needed to deliver the quality benefits and the financial bottom line
   - Model potential acute activity shifts

2. **Building our local response**
   - Aug 09
   - Develop solutions that address the needs of the local population for high quality, cost effective services
   - Involve clinicians and other key internal and external stakeholders

3. **Consultation**
   - TBC
   - Develop preferred options for wider consultation
   - Run pre-consultation engagement

4. **Implement our response**
   - TBC
   - Develop plans to deliver new care models
   - Decommission and re-commission services to implement new pathways

**Completed**
- Better Healthcare Closer to Home – long-running local initiative now aligning with Whole Systems Development e.g. through modelling

**This phase**
- Sutton and Merton will have four Local Care Centres to incorporate shift of activity from acute to non-acute brought about by WSD outcomes
- Local engagement laying the ground work for WSD consultation and engagement
- Local work on-going (e.g. Wallington LCC) but inextricably linked to decommissioning and re-commissioning at WSD level
Insights from our metrics

There are 23 indicators within the National Priorities and another 13 indicators that form part of the Existing Commitments to date the PCT summary of performance is:-

<table>
<thead>
<tr>
<th>Status</th>
<th>National Priorities</th>
<th>Existing Commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved</td>
<td>14 (60.9%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>Underachieved</td>
<td>4 (17.4%)</td>
<td>2 (15.4%)</td>
</tr>
<tr>
<td>Failing</td>
<td>5 (21.7%)</td>
<td>2 (15.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>23 (100%)</td>
<td>13 (100%)</td>
</tr>
</tbody>
</table>

Underachieving

<table>
<thead>
<tr>
<th>Underachieving</th>
<th>Failing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Primary Dental Services</td>
<td>Maternity Services</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>Immunisations</td>
</tr>
<tr>
<td>Teenage Conception</td>
<td>Breastfeeding @ 6 – 8 wks</td>
</tr>
<tr>
<td>Drug Misusers</td>
<td>Stroke Care</td>
</tr>
<tr>
<td>Ambulance Cat A - 8 Mins</td>
<td>Delayed Transfers of Care (EC)</td>
</tr>
<tr>
<td>Ambulance Cat B – 19 Mins</td>
<td>Diabetic Retinopathy (EC)</td>
</tr>
<tr>
<td></td>
<td>Access to Primary Care</td>
</tr>
</tbody>
</table>
Half Year Operating Plan Review

**Local Intervention**

<table>
<thead>
<tr>
<th>Service</th>
<th>Present Score</th>
<th>Potential Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening</td>
<td>2</td>
<td>2 (3 max)</td>
</tr>
<tr>
<td>Immunisations</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Breastfeeding @ 6-8 wks</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Quality Stroke Care</td>
<td>0</td>
<td>2 (3 max)</td>
</tr>
<tr>
<td>Delayed Transfers of Care</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Drug Misusers</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**South West London/Pan-London**

<table>
<thead>
<tr>
<th>Service</th>
<th>Present Score</th>
<th>Potential Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Cat A – 8 Mins</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Ambulance Cat B – 19 Mins</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Overall Projected Quality of Service Score:** 

GOOD
Content

Vision and commitment

The local case for change

Polysystems update
## Overview

### Where were we?
- Our two outer London Boroughs are relatively healthy in comparison with London as a whole and England.
- We conducted major stakeholder engagement through both the Better Healthcare Closer to Home programme and the strategic plan development for 2008/09.
- For 08/09, we developed eight priority health needs to improve substantially by 2013.
- We also identified the services delivering healthcare that needed to be developed and improved:
  - Hospital care
  - Primary care
  - Community health services
  - Continuing care
  - Mental health
  - Learning disability services

### What we have done
- Met national targets for:
  - 18 weeks
  - A&E 4 hour wait
  - Reducing Healthcare Acquired Infections
  - Reducing smoking
  - Reducing alcohol related harm
  - Staff satisfaction improvements
  - Financial targets
- Invested:
  - £535,000 in an Allied Health Professional and Early Supported Discharge stroke support teams
  - £25,000 in patient education for diabetes
  - £450,000 in end of life care
  - £680,000 in health improvement
  - £975,000 in mental health
  - £1,910,000 in older people’s health
  - £1,320,000 in Better Healthcare Closer to Home

### What we need to do
- Continue to improve health outcomes and life expectancy by:
  - Increasing screening rates
  - Sustaining smoking target
  - Implementing NHS Health Checks
- Continue to invest in preventative healthcare
- Only commission cost-effective services with a robust evidence base
- Deliver simplified patient journeys, based on patient experience, delivering seamless and proactive services across health and social care
- Build on the existing work of BHCH linking with the new Integrated Care Organisations programme to deliver polysystems in Sutton and Merton
- We will implement a number of performance recovery plans in the following key areas: Chlamydia Screening, Teenage Pregnancies, Immunisations, Breastfeeding @ 6-8 wks, Quality Stroke Care, Delayed Transfers of Care, Drug Misusers’ Services and End of Life Care.
Some key needs of our population are unmet; we need to improve the quality and performance of specific services

Demographics

<table>
<thead>
<tr>
<th>2009 population in Sutton and Merton by age, '000s</th>
<th>% growth from 2006 to 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>48.1</td>
</tr>
<tr>
<td>10-19</td>
<td>43.7</td>
</tr>
<tr>
<td>20-29</td>
<td>57.1</td>
</tr>
<tr>
<td>30-39</td>
<td>71.1</td>
</tr>
<tr>
<td>40-49</td>
<td>61.4</td>
</tr>
<tr>
<td>50-59</td>
<td>42.4</td>
</tr>
<tr>
<td>60-69</td>
<td>31.1</td>
</tr>
<tr>
<td>70-79</td>
<td>21.4</td>
</tr>
<tr>
<td>80+</td>
<td>15.4</td>
</tr>
</tbody>
</table>

Population considerations

- Index of Multiple Deprivation
- (out of 354 boroughs):
  - Sutton at 234
  - Merton at 222
- Rising birth rate
- Significant Asian population in some wards
- Some deprived wards

Our engagement process with clinicians and stakeholders

<table>
<thead>
<tr>
<th></th>
<th>Merton</th>
<th>Sutton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving health</td>
<td>Diabetes and mental health</td>
<td>CHD and mental health</td>
</tr>
<tr>
<td>Tackling inequalities</td>
<td>Bridging the Gap</td>
<td>Fairer, Safer, Greener</td>
</tr>
<tr>
<td>Promoting health</td>
<td>Smoking and obesity</td>
<td>Obesity</td>
</tr>
</tbody>
</table>

1: ONS Population Projections
2: Index of Multiple Deprivation – mid-year estimates
Our local case for change
- Physical health is relatively good compared with other London boroughs and the rest of England but prevention is better than cure
- The major causes of illness in the PCT are cardiovascular disease and cancer, and immunisation rates are relatively poor

Staying healthy – we want to prevent illness wherever possible and need to work closely with our local authority partners to achieve this

Our response to the case for change

<table>
<thead>
<tr>
<th>What we have done so far</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Worked closely with both boroughs to support health improvement community plans with jointly-funded public health consultant posts</td>
</tr>
<tr>
<td>▪ Agreed an action plan with NHS London to improve immunisation performance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What we are planning to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Developing and targeting programmes for reducing smoking, obesity and increasing healthy living behaviours</td>
</tr>
</tbody>
</table>

Our engagement process with clinicians and stakeholders
- Stakeholders: strong partnership working with local authorities, joint leadership on LSPs, joint funded public health and commissioning posts, and strong Borough-focused Professional Delivery Committees
- Clinical leadership: Public health consultant-led work and partnerships
- Community: Outreach work, events and promotions, public health resources service
Maternity and newborn – we need to reduce smoking among new mothers and support high quality services through Maternity Matters

<table>
<thead>
<tr>
<th>Our local case for change</th>
<th>Our response to the case for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Sector-level solutions needed for many of the issues previously identified (e.g. in the Women’s and Children’s review 2009)</td>
<td>▪ New staff member providing stop smoking support at St Helier</td>
</tr>
<tr>
<td>▪ Specific PCT-level issues include:</td>
<td>▪ Invested £700,000 in local maternity services to support compliance with Maternity Matters and other improvements</td>
</tr>
<tr>
<td>– High rate of maternal smoking: 10% vs. 7%</td>
<td></td>
</tr>
<tr>
<td>– Increasing number of higher-risk pregnancies</td>
<td></td>
</tr>
<tr>
<td>– High rates of assisted deliveries</td>
<td></td>
</tr>
<tr>
<td>– Few women see a midwife within 12 weeks</td>
<td></td>
</tr>
<tr>
<td>– Wide variation within the boroughs on key measures</td>
<td></td>
</tr>
<tr>
<td>– Maternity Matters non-compliance</td>
<td></td>
</tr>
</tbody>
</table>

What we have done so far

▪ New birth centre at St Helier and reintroducing DOMINO deliveries
▪ Local care centres to provide more antenatal and postnatal care
▪ Communications plan to promote seeing midwife within 12 weeks

What we are planning to do

▪ New staff member providing stop smoking support at St Helier
▪ Invested £700,000 in local maternity services to support compliance with Maternity Matters and other improvements

Our engagement process with clinicians and stakeholders

▪ Stakeholders: large scale deliberative event as part of the Women and Children’s review; patient views heard through the Healthcare Commission survey, which was built upon by recent Epsom St Helier surveys; also involved in workshops led by BHCH on what services could be moved to LCC
▪ Clinical leadership: clinicians involved in workgroups contributing to our Women’s and Children’s Partnership work; also involved in workshops led by BHCH on what services could be moved to LCC
### Our local case for change

- The Women and Children’s review 2009 and subsequent work have identified the following key issues for Sutton and Merton children’s services:
  - Unknown, unmet need for children with disability and complex needs in the community
  - No on-call paediatric surgeon coverage at ESH
  - Some single-handed paediatric sub-specialty services e.g. cystic fibrosis
  - Teenage pregnancy rates levelled meaning we are unlikely to meet our strategic trajectory
  - Staff training needed to comply with guidelines for safeguarding children

### Our response to the case for change

- Strong local partnerships to integrate services for disabled children
- Developing partnership arrangement with St George’s in line with HfL model
- New investment in service for teenagers to improve access to contraception and advice targeted at vulnerable groups
- Strengthened existing training and will be introducing an e-learning package

### Our engagement process with clinicians and stakeholders

- The PCT has strong partnerships through Children’s Trust arrangements with both Merton and Sutton. These arrangements are underpinned by a number of partnerships including; CAMHS, Children with Disabilities, Teenage Pregnancy that include membership from a range of stakeholders including; parent representatives, voluntary sector, range of providers and input from engagement with children and young people.
- The Women and Children’s review into the service model at ESH has had wide engagement from patient and user groups and health professions including senior clinicians.
Urgent care – A&E often isn’t the right place to treat urgent illness so we need to provide urgent care services and educate the public

<table>
<thead>
<tr>
<th>Our local case for change</th>
<th>Our response to the case for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Urgent care is too often treated as emergency care leading to costly admissions when appropriate care could be given closer to home</td>
<td>▪ Plans for an Urgent Care Centre in Sutton and Merton are developing – it would provide more appropriate advice and treatment to patients who have an urgent care need, but who do not require emergency specialist treatment</td>
</tr>
<tr>
<td>▪ Despite early progress in reducing A&amp;E attendance, there is still a rise in patients admitted to hospital for less than 24 hours</td>
<td>▪ Integrating UCC with local care centres</td>
</tr>
<tr>
<td>▪ Reducing A&amp;E attendances and short-stay admissions would free up resources to invest in other services for patients</td>
<td>▪ Social marketing campaign to improve patient-use of A&amp;E and UCC</td>
</tr>
</tbody>
</table>

What we have done so far

What we are planning to do

▪ A clinically-led, multi-agency urgent care network (UCN) has underpinned work on urgent care in Sutton and Merton
▪ The development of the UCC has been led by local clinicians and developing a clinically robust model of care has been a critical priority
▪ Workshops have been held with a wide range of stakeholders, with input from external experts
▪ PEC have scrutinised proposals on a number of occasions

SOURCE: St. Helier Urgent Care Centre Outline Business Case; Team analysis
**Our local case for change**

- Much of planned care is carried out in an expensive and sometimes inappropriate hospital-setting
- There has been an increase in GP referrals over the last four years
- There is variation in the clinical effectiveness of commissioned pathways
- We need to achieve 18 week target within specialities - particularly challenging for orthopaedics and trauma

**Our response to the case for change**

- Changing the setting of care through BHCH and increasing the use of independent sector diagnostics
- PbC demand management is challenging GP referrals
- Introduced specialty specific performance scorecards at ESH especially for trauma and orthopaedics

**What we have done so far**

- Implementation of BHCH – Wallington LCC first development
- On-going review of low priority treatments/clinical effectiveness e.g. IVF

**What we are planning to do**

**Our engagement process with clinicians and stakeholders**

- Engagement in referral management arrangements is through PbC Groups which work closely with local GPs to reduce inappropriate referrals
- Performance management arrangements are managed through the clinical quality review groups for each SLA. The membership includes trust clinicians, primary care clinicians and PbC groups.
- Issues of clinical effectiveness are managed through the clinical effectiveness group which reports to the PEC, ensuring engagement of public health and primary care clinicians. Key issues are consulted on with stakeholders.
- Better Healthcare Closer to Home was extensively consulted on with stakeholders, clinicians and the public
## Mental health – we are working with Borough and acute partners to develop a strategy that delivers high quality mental health care

### Our local case for change
- Borough-based strategies need refreshing in light of recent policy guidance on New Horizons and Transforming Social Care
- Services for adults of working age and older people need to be reviewed against latest models of health and social care
- Previously identified unmet need/demand for services e.g. ‘talking therapies’
- Variation in uptake of services across boroughs
- Increasing numbers and costs of high cost continuing care placements

### Our response to the case for change

#### What we have done so far
- Developing service strategy for mental health for Sutton and Merton boroughs and developed Older People Strategy in Sutton
- Needs, capacity and demand analysis
- Engagement with service users and carers
- Extension of IAPT services (from 3,500 to 9,500 yr 1-3)
- Localising National Dementia Strategy: ongoing work in Sutton and commencing project work in Merton for local consultation
- Review of high cost placements

#### What we are planning to do
- Agreed mental health service strategy and supporting joint commissioning strategies – revised models of care
- Implementation of revised models of care for dementia

### Our engagement process with clinicians and stakeholders
- A full stakeholder map and engagement process has been developed
- Governance arrangements in place including clinical and local authority stakeholders
- Service users and carers workshops and forums
- Mental health partnership boards
- Health and wellbeing overview and scrutiny committees
Our local case for change

- Long term conditions represent a real opportunity to improve people’s quality of life and simultaneously reduce associated costs
- In Sutton and Merton:
  - Diabetes and CHD contribute to health inequalities with the highest mortality linked to areas of greatest deprivation
  - Over £10 million spent in 2008/09 on cardiac and vascular emergency admissions
- There are an increasing number of people with long term conditions
- We need to manage people with LTC in the community, preventing unnecessary admissions and ensuring prevention among higher risk groups

Our response to the case for change

What we have done so far

- Using predictive modelling to identify opportunities for early intervention and prevention of unnecessary admissions
- Supporting GPs to manage conditions within the practice and piloting of specialist outreach clinics
- Use of electronic patient records shared between professionals

What we are planning to do

- Maximise outpatient care in LCCs with one stop services
- Maximise health by implementing the NHS Health Checks programme
- Increasing use of telehealth and telecare
- Exploring the establishment of ICOs with clinical leadership for management of long term conditions

Our engagement process with clinicians and stakeholders

- Consultation on stroke services in London
- Close working with cardiac and stroke network and PCT clinical champion
- Well established CHD group with membership from GPs, nurses and consultants across primary, community and secondary care Development of a stroke group and diabetes workshop with wide representation including patients with diabetes.
# End-of-life care – our new strategy will overcome organisational boundaries and ensure more people achieve a good death

## Our local case for change

- The national End-of-Life Care Strategy has enabled us to focus on addressing key issues within EoLC:
  - Poor performance management with relevant data not systematically recorded
  - Lack of co-ordination of services across organisational boundaries
  - Lack of awareness about death, dying and end of life care locally among public and staff
  - 15.8% of people die at home in Sutton and Merton vs. 18.9 of all persons in England

## Our response to the case for change

### What we have done so far

- Developed and filled posts to better co-ordinate and facilitate EoLC
- Launched a fast track discharge pilot
- Piloting ‘Hospice at Home’
- Supporting the Gold Standards Framework in care homes

### What we are planning to do

- Complete EoLC strategy for Sutton and Merton and develop joint implementation plans with local Boroughs
- Setup bereavement support service
- Appoint a Macmillan GP and an EOLC facilitator for primary care
- Pilot electronic summary care record

## Our engagement process with clinicians and stakeholders

- Strategy shared with Interfaith Forum Merton. A similar forum is being considered for Sutton
- Network meetings held with representatives from acute sector, provider services, local authority and voluntary groups
- End-of-life care is led by the Nelson PBC group PCT’s behalf
- Strategic plan engagement undertaken in 2008

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1 National Clinical Health Outcomes Development: 18.9% all persons in England (National Clinical Health Outcomes development website)
One critical element to achieving better care is the implementation of our future polysystem network.

**SOURCE: BHCH Outline Business Cases**
Sutton and Merton polysystems will focus on providing better healthcare closer to home

**Vision**
- Improving outcomes for patients
- Providing more care locally
- Tackling health inequalities
- Meeting changing demographic needs
- Modernising estates
- Using resources more efficiently

**Services**
- Four local care centres (LCC) offering a range of services such as simple, direct access diagnostic tests (ECG, ultrasound, phlebotomy and x-ray), minor procedures, outpatients, community health services, voluntary services, mental health services, GP practices (including a GP-led health centre at the Wilson Hospital site) and dental services
- An urgent care centre at the St Helier LCC

**Key considerations**
- Long-running, politically high-profile programme with highly developed stakeholder expectations
- Integrated Care Organisations being designed with strong strategic fit to BHCH
- Developed in partnership with Epsom & St Helier Trust ensuring a fully shared vision for the future

**Capital requirements**
- The capital costs of the proposed developments are:
  - Nelson LCC c. £21m
  - Wilson LCC c. £11m
  - Wilson ICC c. £13m
  - Wallington LCC c. £13m
  - St Helier LCC c. £17m
  - St Helier Phase 1 redevelopment c. £202m

**Timeline**
- Planned opening dates: Wallington LCC – 2011, the Nelson and Wilson LCC and Wilson ICC – 2013, and the St Helier LCC (as part of the Phase 1 redevelopment) – 2017

**Key barriers**
- Current economic climate may present previously unforeseen risks to affordability of programme
- Approval of business cases for capital expenditure by NHS London and DH may slow progress
- Significant workforce and service transformation required to deliver full benefits of BHCH

1 Including home-based intermediate care (65-85 places)
Each LCC will provide a wide range of primary, secondary and community services, to provide better healthcare closer to home 

2022/23

<table>
<thead>
<tr>
<th>Proposed services</th>
<th>Nelson</th>
<th>Wilson</th>
<th>St Helier</th>
<th>Wallington</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP practices (List size)</td>
<td>✓ (23,000¹)</td>
<td>GP-led health centre</td>
<td>✓ (11,000¹)</td>
<td>✓ (20,000¹)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12h x 7d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental services</td>
<td>-</td>
<td>2 chair³</td>
<td>2 chairs</td>
<td>1 chair</td>
</tr>
<tr>
<td>Urgent care centre</td>
<td></td>
<td></td>
<td>✓ (24hx7d)</td>
<td></td>
</tr>
<tr>
<td>Outpatients (attendances)</td>
<td>45-50k</td>
<td>30-35k</td>
<td>80-85k</td>
<td>40-45k</td>
</tr>
<tr>
<td>Minor procedures (spells)</td>
<td>c. 0.9k</td>
<td>c. 0.2k</td>
<td>c. 0.6k</td>
<td>c. 0.4k</td>
</tr>
<tr>
<td>Community health services</td>
<td>124</td>
<td>124</td>
<td>38</td>
<td>70</td>
</tr>
<tr>
<td>Community health services (sessions/week)</td>
<td>124</td>
<td>124</td>
<td>38</td>
<td>70</td>
</tr>
<tr>
<td>X-Ray, ECG, ultrasound and phlebotomy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Voluntary sector services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental health services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Opening times</td>
<td>12h x 5d</td>
<td>12h x 7d²</td>
<td>12h x 5d</td>
<td>12h x 5d</td>
</tr>
</tbody>
</table>

¹ Based on list size of GPs currently planning to relocate to each LCC
² Initially for core primary care services only
³ Once Community services dental chair and additional dental chair for general dental services
Once completed, Sutton and Merton polysystems will align with the polyclinic description in *A Framework for Action*

Polyclinic description from *Framework for Action*, with LCC differences highlighted

A full urgent care centre is planned to be co-located with A&E and the LCC at St Helier

It is envisaged that the other LCCs will provide ‘urgent care’ through GP primary care services, operating at least 12h x 5 days per week (at Wilson delivered 12h x 7 days as part of the proposed GP-led health centre)

<table>
<thead>
<tr>
<th>Activities</th>
<th>Infrastructure</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice services</td>
<td>Consulting rooms</td>
<td>GPs</td>
</tr>
<tr>
<td>Community services</td>
<td>Procedure rooms</td>
<td>Consultant specialists</td>
</tr>
<tr>
<td>Most outpatient appointments</td>
<td><em>Urgent care centre</em></td>
<td>Nurses</td>
</tr>
<tr>
<td>Minor procedures</td>
<td>Dedicated child-friendly facilities</td>
<td>Dentists</td>
</tr>
<tr>
<td><em>Urgent care</em></td>
<td>X-ray, ultrasound, and other diagnostics</td>
<td><em>opticians</em>, therapists</td>
</tr>
<tr>
<td>Point-of-care pathology and radiology</td>
<td>Healthy living/information centre</td>
<td><em>Emergency care practitioners</em></td>
</tr>
<tr>
<td>Interactive health info services</td>
<td>Pharmacy, <em>optician</em></td>
<td>Mental health workers</td>
</tr>
<tr>
<td>Proactive management of long term conditions</td>
<td></td>
<td>Midwives, health visitors</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>Social workers</td>
</tr>
<tr>
<td><em>Other health professionals (e.g. optician, dentist)</em></td>
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Dentists and possibly optometrists, but not ‘opticians’, envisaged at LCCs

The LCCs in Sutton and Merton are a ‘PCT solution’ based on a holistic assessment of present and future needs and resources across both boroughs, not ‘one-off’ solutions

A significant amount of activity will shift to our polysystems

Outpatient activity allocation based on BHCH (adjusting to what would be clinically viable by 2018) and updated with local PCT input, %

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1 For all other specialities (20% of activity), use Healthcare for London assumptions

SOURCE: BHCH project; SW London PCT input; Healthcare for London; WSDP report