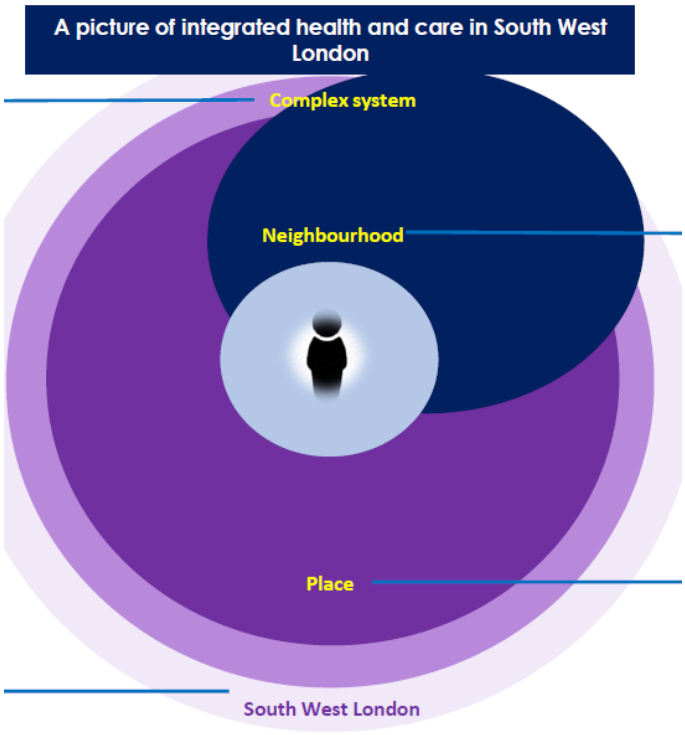
healthwatch Croydon



Let's discuss the South West London CCG NHS merger

Event transcript and notes

Event: Wednesday 23 October 2019

Final draft due for publication

5 February 2020

A. Context

On Wednesday 23 October, Healthwatch Croydon organised a public meeting to discuss the proposal of Croydon Clinical Commissioning Group (which buys and monitors health services in Croydon) to merge with the five other South West London commissioning groups (Kingston, Richmond, Sutton, Merton and Wandsworth) to create a new South West London Clinical Commissioning Group.

We invited the CCG to present and this was led by the NHS Croydon CCG Chair, Dr Agnelo Fernandes, and Jo Austin, Senior Engagement Officer. The event was independently organised by Healthwatch Croydon and chaired by their manager Gordon Kay. There was a presentation by the CCG followed by a series of questions and answers.

The highlights of what was discussed are shown below, along with some follow-up questions that came from a member of the public after the event.

Healthwatch also makes some recommendations of actions to take forward over the coming months.

A full transcript of the event which was independently transcribed can be viewed in Appendix 1

B. What we learnt

- NHS Croydon CCG has agreed to merge with five other CCGs to become South West London CCG.

- This has been driven by the Long Term Plan- all CCGs need to merge into larger groups.

- If NHS Croydon CCG had not agreed to the merger, it would have happened later on next year and they would have less influence on how the merger would take place or the way decisions and funding are made.

- Croydon CCG will cease to exist from April 2020, but a Croydon health system will exist, known as a place-based entity.

- Full delegation of all £560m of financial allocation will be given to Croydon as a place to decide how much then returns to South West London NHS to deliver projects that are better managed across South West London like estates, IT and the ambulance service.

- Big drive for this change was the requirement imposed on all CCGs to reduce their management costs by 20%, this equals to £1.6m in Croydon and £7m across South West London.

- There is also a push for more collaboration rather than competition, which had been the mindset previously. The aim is to move from adversarial (usually over money or quality) to one of collaboration and agreed shared goals.

- Croydon is ahead of the game and South West London is creating a new model in terms of allowing delegation and control at place ie Croydon level, while South West London focuses on projects that go beyond one place such as IT or 111 and also scrutinises each place to ensure their meeting their quality and budgetary requirements, as they will be accountable to NHS England.

- There will be a South West London Committee which will include four GPs and then one from each place (borough). Dr Agnelo Fernandes will be our representative at least until next year.

- There will be more focus on population health and preventative health initiatives.

- The Health and Care Plan has now been released (see link), this drives the strategy and priorities and has been agreed by call key stakeholders including all NHS organisations, Croydon Council both as councillors and those working in services, and key voluntary sector organisations. Resident participation was also encouraged through a series of events, and Healthwatch Croydon also contributed with its own public meeting on the plan's development in June.

- There is also a focus on recruitment particularly locally as 65% of NHS workers live in Croydon – it is also the borough's single largest employer.

- South West London is committed to having a strong patient and public voice and representation with a proactive approach to patient views. The NHS requirement for one layperson on the South West London committee in charge of representing patient and public engagement. South West London has created extra seats one to represent Healthwatch and another for community and voluntary services.

- The challenge for Healthwatch is that is commissioned at place/borough level. How can one Healthwatch representative at South West London represent six Healthwatches? This is under discussion with all six Healthwatches meeting in November to agree on a way by which this might work. One failsafe is that if a decision is being made at South West London level which specifically affects one place/borough more than others then that Healthwatch would be able to represent their residents here on this occasion.

- South West London NHS is keen to ensure they're structures and groups involved to that be best insight on patient and resident experience can be applied with clinical data to make the best decisions for Croydon including flagging areas of concern.

- Healthwatch Croydon and the new Croydon place committee have a common interest in ensuring services are delivered to meet the needs of patients. They work together but with independence.

- The South West London Stakeholder Reference Group will have representatives from all Healthwatches and all community and voluntary services from each borough along with a lay NHS patient and public engagement representative. More details on how this will work are subject to discussions with Healthwatches and community and voluntary services representatives.

- With more power and decision making delegated to place. The Croydon Committee in common will make most of the local decisions, and Healthwatch will have a non-voting representative on this committee.

- The development of these boards is still in flux but Healthwatch are involved in these discussions.

C. Issues raised by Croydon residents and the CCG responses

1 **How is success going to be measured?**

Many of the health-related measures are detailed in the newly-published Health and Care Plan but others including financial and quality will be set and monitored by South West London and NHS England.

2 **How is quality going to be assessed?**

There is a focus on bringing the various quality groups closer together to ensure a consistent approach to quality from hospital to GPs. The hospital is adopting a new qualities framework.

3 **How will this new structure ensure people with learning disabilities get the services they need including annual health checks from GPs?**

It is important that GPs ensuring every one of their patients with learning disabilities gets an annual healthcheck. The role of Primary Care Networks, delivering care at neighbourhood level though a network of GPs should help ensure GPs deliver this. Each GP is measured in terms of quality based on the delivery of this service.

4 **What about the role of patient participation groups in this?** They are currently varied in Croydon and numbers of active ones are being reduced, but there are examples of good practice. How can these be developed further? The creation of PCNs means that PPGs could have a real role to play. Also considering seeing PPGs not just holding GPs to account but being involved in information, awareness of health conditions and supporting social prescribing. With the holding to account role, Healthwatch could work closer together with PPGs including supporting them with data to monitor satisfaction, while PPGs could support Healthwatch in gathering this data.

5 **Why is there a variance in the opportunity for public questions at meeting in public:** There is concern that currently at SLaM meeting there is no opportunity for public questions, while Croydon Health Services is offering four opportunities for public questions, could this be adopted across all Health and Social Care Meetings across Croydon.

6 **Will enough time be planned to allow for reference groups to digest decisions as this is essential for them to be effective in their role?** Careful consideration is needed to ensure the reference group have time to digest decisions before these are validated at Croydon and South West London level. As these are in early days of discussion this can be factored in in terms of timetabling meetings.

7 **How can Healthwatch Croydon's independence be ensured?** The Healthwatch Croydon board will always ensure that it is held independent, advising and influencing, but a closer professional relationship with key stakeholders is key.

8 **Could there be more public platforms for views to be discussed?** There does seem to be a need to provide further regular platforms for residents and patients to express their views which could be fed back up via Healthwatch and Reference Groups. Healthwatch Croydon will explore hoe this could be developed.

9 **How about enhancing the role of volunteers within the NHS**: Adopting the Derby Hospital approach of volunteers supporting engagement and involvement in health system as they do in Imperial Hospital in London, could that be rolled out here, not just in hospitals but within GPs – yet another opportunity to work closer with PPGs.

D. Further follow up questions from an attendee at event, sent to Healthwatch and then onto CCG with CCG reply

An attendee at the event emailed Healthwatch Croydon some days after with further questions which we shared with NHS Croydon CCG's Engagement Lead, Jo Austin:

Q1: How many PPGs in GP surgeries have you visited to establish how many of these PPGs are aware of what is going on in respect of the combining of CCGs and the integration of PPGs as related to PCNs, and the how enlarged CCG Board will work with PPGs?

Q2: Further how many members of the public have you met to discuss the matters set out on your poster other than at the meeting and how are the general public being kept up to date on the merger of the five CCGs?

Q3: The Chair of the meeting and you, and particular the lady who gave the presentation on the screen, continually referred to patient participation. Please be so kind as to provide details of what form of patient involvement has taken place, where, and with whom?

CCG: The merger of south west London CCGs is not considered to be a significant service change and so there was not a requirement to formally consult. Changes will be made to back office management functions rather than front line services.

However, we did want to hear what local people, local patient representatives, oversight committees and partners thought of our plans and to hear any concerns so that we have an opportunity to address them ahead of the proposed merger so that we could adjust them according to the needs of the local population.

We have attached an engagement log of all public meetings which indicates key dates, types of meeting, audience, who presented and where you can find the notes (see end of this section). We continue to engage and are iterating how we get patient voice in the new CCG with Healthwatch and CVAs and have built in a period of review following the merger, to make sure that patient voice is part of the new governing body.

Patient and Public Voice on a new South West London Governing Body

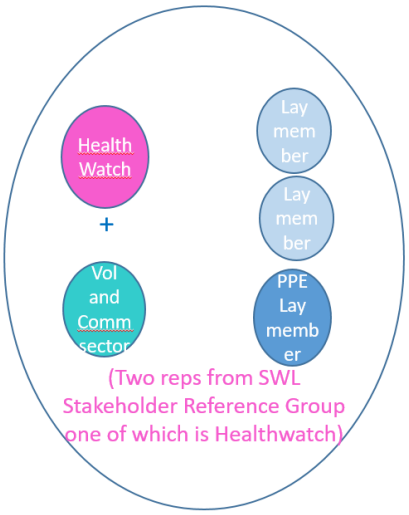
CCG governing bodies are clinically-led and NHS England requires that each governing body has one lay member for patient and public engagement which will also be the case for for

the new SWL Governing Body. We know that local people value the assurance of Healthwatch as a non-voting member of our existing governing bodies. Following discussions with the South West London Patient and Public Engagement Steering Group (PPESG), we propose to keep this role and also to include representation from the community and voluntary sector on the new Governing Body. This will ensure that the patient and public voice remains at the heart of decision making.

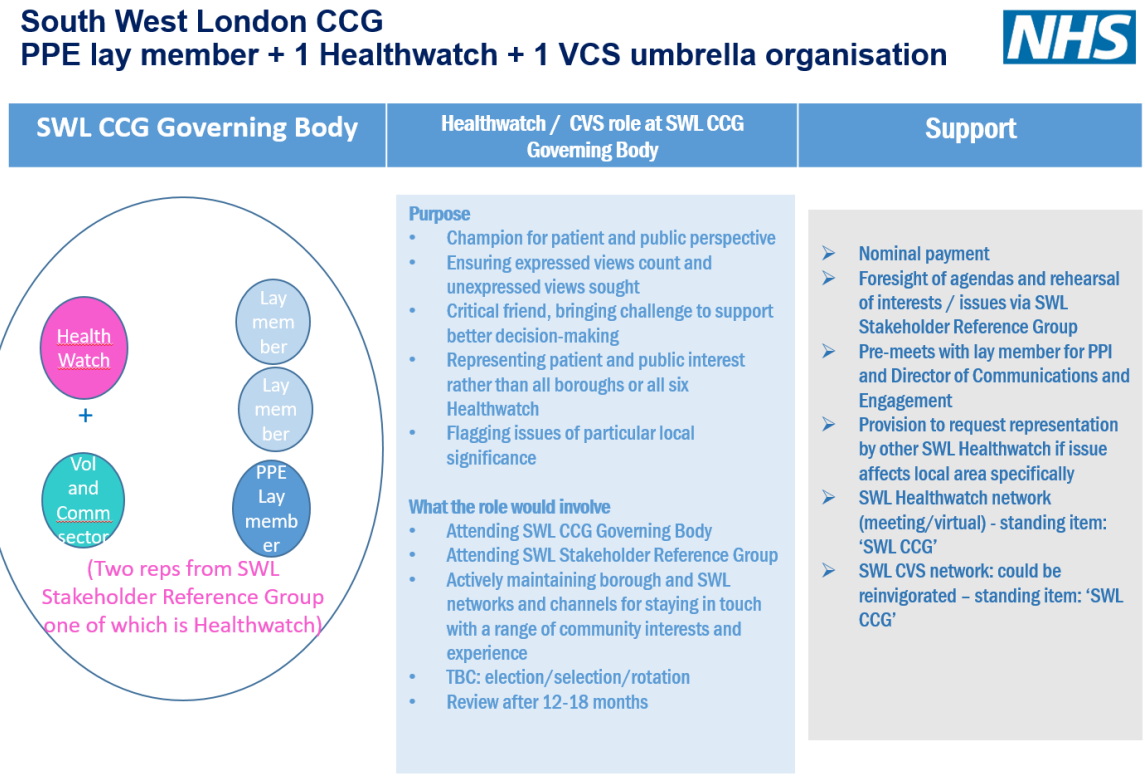
The structure agreed was one lay member, one Healthwatch representative and one representative from the community and voluntary sector, see below.

South West London CCG
PPE lay member + 1 Healthwatch + 1 VCS umbrella organisation

NHS

SWL CCG Governing Body	Healthwatch / CVS role at SWL CCG Governing Body	Support
	**Purpose** • Champion for patient and public perspective • Ensuring expressed views count and unexpressed views sought • Critical friend, bringing challenge to support better decision-making • Representing patient and public interest rather than all boroughs or all six Healthwatch • Flagging issues of particular local significance **What the role would involve** • Attending SWL CCG Governing Body • Attending SWL Stakeholder Reference Group • Actively maintaining borough and SWL networks and channels for staying in touch with a range of community interests and experience • TBC: election/selection/rotation • Review after 12-18 months	➢ Nominal payment ➢ Foresight of agendas and rehearsal of interests / issues via SWL Stakeholder Reference Group ➢ Pre-meets with lay member for PPI and Director of Communications and Engagement ➢ Provision to request representation by other SWL Healthwatch if issue affects local area specifically ➢ SWL Healthwatch network (meeting/virtual) - standing item: 'SWL CCG' ➢ SWL CVS network: could be reinvigorated – standing item: 'SWL CCG'

The structure agreed was one lay member, one Healthwatch representative and one representative from the community and voluntary sector, see below.



It is suggested that the SWL lay member for PPE Chairs this group one week before the SWL CCG governing body meeting and that the group will discuss the agenda. The lay member is then responsible for representing the view of the group to the governing body. We are in the process of co-designing this reference group with our partners in the community and voluntary sector along with local people and we are keen that it broadly represents all groups of people living in Croydon, paying particular attention to those with protected characteristics outlined in the Equality Act 2010.

Q4: Have any invitations have been made to the PPG Network as this has representatives from a number of different practices across the borough to meet with you to discuss the new arrangements?

CCG: In future, it is anticipated that Primary Care Networks will review how they can best engage with their local communities as well as their existing patients. This is particularly

relevant in terms of the social prescribing aspect of the networks. We have committed to supporting the PCNs' development by advising them on best practice in this area.

Members of the CCG engagement team are regular attendees at the Croydon PPG Network and ensuring that members of the PPG Network were invited to our public forums about the future of engagement and participation in our new ways of working. We were very pleased that many network members, including the network co-ordinator, attended both patient forums. We invited more than 350 people to these meetings directly and we encouraged people to share the invite with their networks.

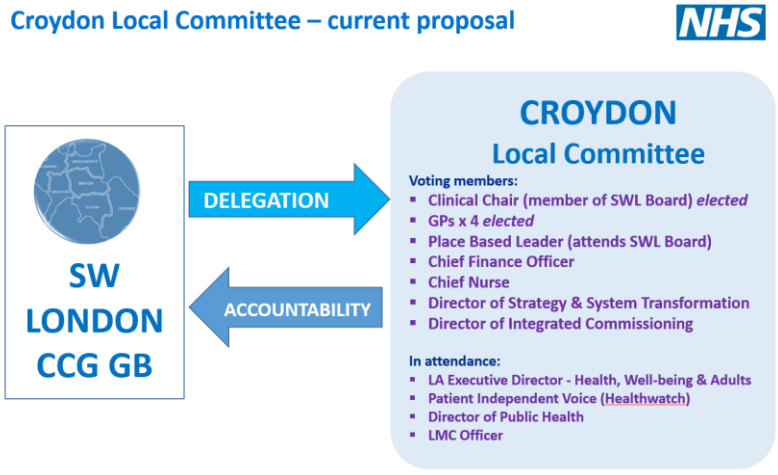
In terms of Patient Participation Groups, they are not required to integrate as practices start to work as Primary Care Networks. Some PPGs may decide that is a more efficient way for them to work and this will continue to be for PPGs to decide locally what works best for them and their practice.

There are no changes proposed for the local engagement structures as part of the South West London CCG merger and they will continue to work with both the PPGs individually and with the PPG Network.

In future, if PPG members would like to be added to this mailing list so that they are invited to these events directly as well as receive other information about health and care services in Croydon, they can email us on Croydon-GetInvolved@swlondon.nhs.uk specifying that they would like to be added. We are unable to add people without their explicit permission owing to GDPR.

Croydon Local Committee

From 1 April 2020, within the South West London CCG, each borough will have a local committee. The membership of the Croydon Local Committee is outlined below.



Q5: At the last open meeting at CUH, I was informed by the Chief Executive that for the past 10 years CUH has had to negotiate with the CCG to obtain the funds they required to operate their hospital and over the ten years had to resort to arbitration to obtain the money needed. I understand that the cost of going through this arbitration process was approximately £1m, i.e. over 10 years a sum of £10m. I understood from the CE this was to be avoided from continuing for, as at April 2019 the Board of the CUH and CCG were to be combined and would agree on the CUH financial requirements, this could avoid CUH spending £1m going to arbitration to get the money required to operate the Hospital. When this new combined CCG in the South West is formed, will this also take in the board of CUH, in order that the finance for the CUH will continue to be agreed as one body?

CCG: The vision across South West London vision is that each borough will bring together health and care leaders in a local system so that care would be planned and delivered locally with strong clinical leadership. Local health and care partners are currently working together to consider options for their borough.

NHS Croydon CCG is committed to ensuring that the new local health system is both clinically led and retains the ability to engage with and consider the needs of our local communities. If we were to merge, we want to make sure that we design our own model for the way that we work together and in a way that works for our GPs, for our partners and for local people in Croydon.

Croydon is at the national forefront in appointing Matthew Kershaw as joint Trust CEO and Place-Based Leader for health in August 2020. A joint management team is also now in place for the two organisations who are leading a new partnership of NHS organisations working together to improve the care and wellbeing of people in one of London's largest and most diverse boroughs.

We are already making great progress by bringing some of our health services together and working side-by-side with the local authority, GPs, mental health services and voluntary groups, we are looking to do more to meet the needs of our different neighbourhoods across Croydon.

The Trust and CCG now have a shared financial control total helping to ensure the best value as the two organisations continue closer working to improve the health and care of Croydon.

Q6: When the new combined Board of the South West CCG is set up, what will happen to the Board Members and staff of the five CCGs which will not be required, as I understand it, only one Board member for each function of existing boards will be designated to serve on the new overall board. What will be the cost of dispensing with the surplus board members and staff?

CCG: We currently have six Governing Bodies, 18 associated statutory committees, six sets of annual accounts and auditors and six assurance processes from NHS regulators. It takes considerable clinical and managerial time, money and focuses to work in this way. By moving to one governing body, we will save £1.6million which can be put back into front line services.

As part of the programme, a staff consultation to share proposed team structures for a single South West London CCG launched on 21 November and ran until 23 December 2019. All comments received from staff are currently being considered by the South West London senior management team and a consultation outcome document will be produced including the final structures which will be shared with all staff in the coming weeks.

All Governing Body remuneration is published in the annual report, the annual report for 2019/20 will be published by the end of June 2020.

Q7: Who in the public domain did this new proposed set up of combining to CCGs consult with before coming to the conclusion that a combination of the CCGs would be more economical than the current set up, and how much will it save?

CCG: The NHS Long Term Plan sets out the intention that by April 2021 all of England will be covered by an Integrated Care System, involving a CCG or CCGs working together with partners to deliver a streamlined and single set of commissioning decisions. The NHS Long Term Plan also expects CCGs to make a 20% reduction in management costs as a result of commissioning across larger footprints. The NHS Long Term plan is a National Policy document and NHS England led on the engagement with patients, the public and stakeholders.

NHS England engagement on the Long Term Plan involved:

- 14 working groups that ensured proposals benefited from a breadth of expertise and experience with membership drawn from a wide range of organisations including patient groups, staff and clinical representatives and senior doctors, nurses and allied health professionals, as well as local NHS leaders.

- 200 distinct engagement events and over 2,500 responses to their engagement questions from a range of respondents and organisations together representing a combined total of 3.5 million individuals and or organisational members/supporters.

- Work in partnership with the Patients Association and Healthwatch England to engage patients and the public with Healthwatch England submitting evidence from over 85,000 people.

You can read more about NHSE's engagement on the Long Term Plan here: *https://www.longtermplan.nhs.uk/online-version/chapter-7-next-steps/engaging-people/*

Further points

Background Information

The six CCGs in south west London - Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth - have been working together for over a year on new developments such as the development of Primary Care Networks (PCNs), strengthening of local health and care partnerships and the development of six local health and care plans.

In 2019, the Governing Bodies of the six south west London CCGs formed the 'Moving Forward Together' programme, to consider options for potentially merging into a single CCG for south west London.

The vision is that each borough will bring together health and care leaders in a local system so that care would be planned and delivered locally with strong local leadership. A merger application for a south west London CCG was submitted in September 2019 following a majority of all GPs across the six boroughs voting in favour of a merger and this was approved by NHS England in October 2019.

Our approach to engaging on the merger

The publication of the NHS Long Term Plan in January 2019 announced that CCGs would be expected to work across larger footprints, and also to make savings of 20% in management costs (£1.6million in Croydon), money which is to be put back into frontline services via Primary Care Networks.

Our principles of engagement are to engage early and we adapted our proposals in response to the views of our partners, GP members and local people. The merger plans have been through several iterations as a result of the views we heard.

What did we focus on?

- Our 'case for change'
- Proposed governance arrangements on a borough and south west London basis
- How we make sure that the patient voice and voluntary and community sector voice remain at the centre of our work and feed into our governance structures at both Croydon and a south west London basis
- Our staff
- Our partners, including our Local Medical Council, GP members and council colleagues.

We hope that this helps to clarify things for those who asked these questions. If they require any further information, please let us know, or they can contact us directly on CroydonGetInvolved@swlondon.nhs.uk or by telephone on 020 668 1384.

Answers provided by Jo Austin, Senior Engagement Lead, NHS Croydon CCG.

NHS Croydon Clinical Commissioning Group

Moving Forward Together (proposed merger of South West London CCGs - Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth)

Date	Name of meeting	Audience	Presenter	Notes
5th March 2019	CCG Governing Body	Meeting in public - approx. 10 members of the public	Andrew Eyres - Accountable Officer Croydon CCG	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx (item 8)
10th April 2019	Croydon Health and Wellbeing Board	Council / public	Andrew Eyres (Accountable Officer) Agnelo Fernandes (Chair)	
16th April 2019	PPI Forum	Public meeting - 70 members of the public	Andrew Eyres - (Accountable Officer) Agnelo Fernandes (Chair)	
7th May 2019	Governing Body	Meeting in public - approx. 10 members of the public	Agnelo Fernandes (Chair)	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx (item 8)
14th May 2019	CCG/CHS Meeting in Common	Meeting in public - approx. 60 members of the public	Karen Broughton (SWL)	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Governing%20Boday%20Papers/AGENDA%20%20and%20Papers%20Meeting%20in%20Common%20with%20CHS%20Trust%20Board%2014%20May%202019.pdf
25th June 2019	Croydon Scrutiny Health and Social Care Sub-Committee	Croydon Council + public	Andrew Eyres (accountable Officer), Agnelo Fernandes (Chair)	https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=168&MId=1951&Ver=4t
2nd July 2019	CCG Governing Body	Meeting in public - approx10 members of the public	Agnelo Fernandes	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx (item 8)

19th August 2019	NHS CCG and CHS joint patient and public forum: What is moving forward together and what does it mean for people living in Croydon?	Public meeting – approx. 65 members of the public	Agnelo Fernandes (Chair) Mike Sexton (CFO)	https://www.croydonccg.nhs.uk/get-involved/engagement-events/Documents/Joint%20Patient%20Forum%2019%20August%202019%20FINAL.pdf
3rd September 2019	CCG Governing Body	Meeting in public – approx.. 10 members of the public	Agnelo Fernandes (Chair) Mike Sexton (CFO)	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx (item 7)
24th September 2019	Croydon Scrutiny Health and Social Care Sub-Committee	Croydon Council + public	Agnelo Fernandes (Chair) Mike Sexton (CFO)	https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=168&MId=1952&Ver=4
23rd October 2019	Healthwatch public meeting "Moving forward together: Proposal for a single SWL CCG"	Healthwatch and public	Agnelo Fernandes (Chair), Jo Austin (Croydon Engagement Lead)	https://www.croydonccg.nhs.uk/get-involved/engagement-events/Documents/Joint%20Patient%20Forum%2019%20August%202019%20FINAL.pdf
5th November 2019	CCG Governing Body	Meeting in public – approx.. 10 members of the public	Sarah Blow (Interim Accountable Officer), Agnelo Fernandes (Chair)	https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx (item 8)

E. Suggestions to be considered by all stakeholders

1 **Representation:** Healthwatch Croydon to agree a way forward on representation at South West London NHS Board with the other five Healthwatches of Richmond, Kingston, Merton, Sutton and Wandsworth.

2 **Role of PPGs:** Healthwatch Croydon to discuss with the CCG to look at how PPGs can be developed within Primary Care Networks and Integrated Care Networks, not just in monitoring services but in information and advice and social prescribing.

3 **Closer working between Healthwatch Croydon and PPGs:** Healthwatch Croydon to explore how they can support the work of PPGs and also encourage their development, as well as a role of gathering and sharing data to influence better services.

4 **Public questions at NHS meetings in public:** Healthwatch Croydon and NHS stakeholders to hear feedback from Croydon Health Services NHS Board on public questions at sections of the meeting, and then see if these could be adopted as standard at all meeting in public by providers of health and social care services.

5 **Timetabling of public meetings:** Healthwatch Croydon to raise queries on the timetabling of meetings in public to allow enough time for effective scrutiny by reference groups and those supporting those. Maybe a role for Healthwatch to be involved in the agenda-setting meetings, which allows maximum time for partner Healthwatches to research and respond and therefore be effective for the reference group.

6 **Independence:** The Healthwatch Croydon Local Leadership Board will ensure that the organisations reputation for independence is maintained.

7 **Forums and platforms:** Healthwatch Croydon to consider the coordination of regular place-based platform events such as this, where residents can freely share their views which can then contribute to future decision-making. Regular panels and other digital ways of sharing views beyond an event are also to be considered.

8 **Role of volunteering:** Croydon Health Services and the place-based team to consider the role of volunteers helping in the hospital on a range of services including gaining patient views.

Appendix 1 - Full transcript

Please note all residents are represented anonymously, even where they refer to each other in the comments. Only CCG staff and Healthwatch board and staff are directly referenced.

Event begins 15.05

Gordon Kay: Make sure that we're there. Then I'm going to hand over to Agnelo.

Agnelo Fernandes: Thank you. As Gordon said, this is a fast-moving feast. Starting in January this year, the new NHS long-term plan was published. The long-term plan stated that there will only be one CCG across integrated care systems. What that means for us is it will be one CCG across South West London. All around the country CCGs will have to merge, and that's been the direction of travel. As you know, the CCGs were created in the 2012 Health and Care Act, so in terms of Parliament they're still organisations. However, if you watch parliament on TV you'll know there was a Queen's Speech and the long-term plan was part of that in terms of moving the plan forward. The government has said they will have a bill to enable the long-term plan. That's for politicians in terms of what they want to do. What does this all mean for us? When you get as old as I do you've been through every change there's ever been, and there are constant changes in the system. Every time there's a new suit in a new central government or NHS they think of new ways of doing things, and transitions can be difficult. The long-term plan is where this all comes from, so since that time governing bodies have been discussing this together with management and GPs. In September a governing body meeting came together to support the proposal for developing a single CCG across South West London.

Croydon was the last to go in terms of votes, because the membership has to vote for a change in constitution. The change in constitution was to move from our current one to a new CCG constitution. All other CCGs have had majority vote, some have had unanimous votes. Ours was 39 to 5, so over 80%. That's quite a substantial yes to the change in the constitution. Knowing that this is the direction of travel and knowing it was going to happen anyway, you can either dig your heels in and expect the inevitable. It's better to work with and show them we'll get the best out of the situation. That's what we've been working on in terms of Croydon all this time. We've managed to get all the GPs, to get all the LMCs (Local Medical Committees), the SMTs (Senior Management Teams) and South West London to

ensure the place. Croydon as a CCG won't exist from April, but Croydon as a health system will. It will be called a place. All the CCGs will be places. Our Croydon place will still have an entity. We've moved from acronyms to places now. We've got Croydon place. What we've achieved in all the discussions is a model that is most evolved in London so that we get full delegation, so the £560 million due to come to Croydon will still come to Croydon. We'll have the ability to decide on how we use that money. Some we can delegate back up to South West London because it makes sense.

Some things like specialised services, LAS for example, digital, estates, workforce, won't be done at that scale. There are things we can do in Croydon that we can only do at place-based level to make the most change. Maximum decision-making in Croydon has been critical in what we've been negotiating so far so that spending the funding due to Croydon is maximised. From a governing body point of view you will have, on South West London, a local Croydon committee which hasn't been formed yet. We'll be formed. Croydon was the last to vote, an application had already come in saying if any of the CCGs voted 'no' the application for manager would have been pulled. However, all voted yes, so the application for merger has been kept in and has been approved. There's an article on all the CCGs around the country that accepted merging, and South West London is one of them. We have the most evolved model. South East London has a very centralised model where their local-level control is far less than we've managed to achieve here. The negotiations going on in the background between everyone has been beneficial. In terms of case for change there is a long-term plan, so this is direction of travel.

One of the reasons for this big drive is that last December all CCGs were told they would have to make 20% management savings in this financial year. For Croydon that would be £1.6 million, nearly £7 million across South West London. If we didn't merge and they said we needed to make more savings, it would impact the way we run CCGs in their current form. By putting all governing bodies into one, that's part of that saving. The other big change is about moving away from competition to collaboration. We already started on that journey in Croydon in terms of working closely with Croydon University Hospital. There's been a purchase and provider split for a long time in England, where competition was meant to be driving improvement, but it never always succeeded in doing that. If we're going to move to integrated care we need collaboration. It also means the system has to change behaviour, so that adversarial approach between commissioner and provider has to change to be more collaborative. I think we should be proud that in our local trust we've managed to do that transition well since April. We're ahead of the game. Rather than them and us it

is we, and the difference is palpable when you're in a meeting and you don't realise who is who. We're trying to solve a problem together rather than looking it it from a commissioner or provider perspective.

That full delegation, planning locally, changing the way we do things. We were just discussing the clinical leadership in Croydon, because the GPs on the local Croydon committee will have to be elected. There will be four GPs and one clinical chair on that committee, and one GP from each of the boroughs will sit on the governing body of the South West London CCG. It means a slightly different clinical leadership model so that we make most decisions locally but have enough representation with clout at the South West London level to be able to fight our corner if needed. We have six chairs across the six CCGs at the moment and they will be consolidated into one. Whichever CCG that chair comes from, they will have to replace the chair in that CCG with someone else. Those plans are already happening. It says evolution, not revolution. It is evolution in the sense that change in behaviour from that adversarial purchaser provider split which has been part of the English NHS for a long time is changing to collaboration. The biggest other change is about focusing on population health. The development of primary care networks from July in Croydon, we have nine of them, around populations meant to be around 50,000. One is 70,000, but it's around populations and practices.

It's about how we integrate the services for the population around those groupings and developing what we call the Integrated Care Network Plus. Before the new GP contract in April there were six networks in Croydon, but those were localities that had been developed by the CCG and Primary Care Trusts before that and providers. PCNs were given carte blanche in terms of how they were with each other in terms of localities. If all the other services are across those six localities and we want to develop integrated care with the council, community services, the sector, then we need to have some point of locus of consideration. There's Integrated Care Network Plus for this, because we already have integrated care networks at the moment with teams working in those six networks, huddles in every GP practice looking at patients with long-term conditions and who may have need for additional support to prevent them going to hospital. We already have some of that in place, so the next step is about integrated care networks. The other big case for change which is not on that slide is the Health and Care Plan. Just trying to think. When is that being officially launched?

Jo Austin: Today.

Agnelo Fernandes: Okay. That's been a long time in the making, but actually has got support from across the piste. I think many of you here were involved in helping with that, and the film of that big event that took place was the showpiece for Croydon and chair of the health and wellbeing board, Louisa Woodley and myself, presented it to a national meeting. It's all happening relatively quickly. It highlighted some of the changes we proposed which would try to make a difference. The first is, we've always thought about being reactive. The Health and Care Plan is about being proactive, trying to keep people well, enabling them to look after themselves. The second is about mobilising communities to look after each other and keep people well. The third is to try and bring services as close to people as possible to their homes, as near as possible to their homes, so that we're localising services. The council plan is also about developing localities, and they've started with one locality because of the data showing the need. They'll start there and then consider others, as well as the rest of Croydon from thereon. We're pushing through an open door in terms of collaboration in Croydon, not just in terms of health organisations.

We've got One Croydon Alliance as a good example of that, in terms of the CCG, the trust, the local authority, the mental health trust, and the GP Collaborative representing the GPs in Croydon. We already have examples of that in Croydon. We then want to take that to the next stage in terms of integrated care. You're all familiar with this timeline, so we're in November now because the mergers have already been ratified. Now the staff consultation will be taking place across all of South West London with a view to going live in April 2020. The next thing would be, if we have any CCG across South West London in April 2020, the long-term plan is about a CCG across an STP (Sustainability and Transformation Plan) area is only a staging point to an ICS (Integrated Care System) which will involve all the providers as well. Someone will say this is where we started 30 years ago in terms of providers and commissioning being part of the same system, but what goes around comes around. This'll be an ICS in terms of direction of travel. The long-term plan says by 2021, but some areas are already going in 2020. This is all laid out in the plan. For once, you can say the politicians have been distracted by other things. The long-term plan is actually what NHS England, in consultation with the NHS, came up with. No one can blame the government for this one.

This has been NHS England, consulting widely with patient and specialist groups to come up with the plan. To be honest, the politicians don't even know what this is about because they have other things on their mind. What we're trying to do is integrate health and care,

starting with patients in localities and population sizes of 30-50,000. You can ask why 30-50,000. This has been the holy grail of developing optimal care for a long, long time. It's not new. There's a lot of literature from all over the world that shows if you work within that population size you can influence the health of patients and the public, the population of that area, both in terms of managing existing problems and preventing problems. It's more cost-effective in terms of public time and how they access services, because you can localise services closer to them. It's also effective in keeping people well instead of responding to things not going well. No more CCGs from April. It'll be Croydon place. Those areas will be called neighbourhoods. At the moment Croydon call them ICN Pluses (Integrated Care Networks). You'll have the PCNs (Primary Care Networks) working across the six ICN Plus networks. Then you'll have a bigger footprint beyond Croydon. We've already got flows into St George's for trauma, orthopaedics, and the cardiac (heart) centre.

There's already a footprint of loads of things going on beyond Croydon, because you need to have a critical mass of specialists at that level which you can't do easily at a borough level. All the local authorities in South West London have been party to these discussions, and though they didn't vote they did support all the changes going forward. One is to ensure their boroughs have control, but also that they have a place in the development of ICSs across South West London. Local authorities have been integral in the development of this. In terms of having a single CCG, it's a population of 1.3 million across South West London, doing things that need to be done on a bigger footprint. Workforce is one of those. How can you work with the workforce you have and how do you recruit and retain? Croydon University Hospital is now dependent on recruiting from abroad for nurses and doctors. There's always a risk because people come and they go back. You're always on a recruitment journey. How do you retain? Not only the ones you recruit from abroad, but also from home? You need to have a bigger footprint to be able to do that, offer different services, share staff across different institutions, so that you get care that is as close to people as possible.

Agnelo Fernandes: One of those areas where performance, certainly from a Croydon point of view, we're actually the best in London. The 62-day standard wait for cancer is the only one we're failing, and the reason we are is because of other areas, other hospitals. We can only influence what we can, but in the bigger footprint of ICS we have a better opportunity in terms of improving on targets. Maternity services, we outperform most areas in London. London Ambulance Service (LAS) works over the footprint of London, but even the South West London footprint probably isn't enough. It's big enough to work with, though, LAS and NHS 111, than it is from an individual borough point of view. There will

be some specialist resources, but we have to work on a bigger footprint. It reduces duplication of having everything in every area when it's limited, especially specialists for difference areas. The other is by reducing the governance in the structures given that all CCGs have to make a 20% reduction by April by working differently, looking at how you have centralised estate, IT and workforce.

The other is that investment into primary care, developing those ICN Plus as part of PCNs, and ensuring that that vision of optimising the care both from a proactive point of view and empowering those communities and from taking services as close to people as possible, is developed. That is the out of hospital agenda. If we didn't do this, then the deficits in the system would continue to grow, and the challenge would have been between £400-500 million. We need to work together to be able to manage that risk. We can't do that as a CCG on our own or borough on our own, we have to do it across a bigger footprint. How will governance work? We start with six CCGs. That will go into one governing body. In that body you will have a clinical majority, because governance of CCGs are already laid down and that's no different to our current CCG. You'll have a clinical chair, accountable officer, chief finance officer, three clinical members, second care doctor, nurse member, and a place-elected representative. It will be one GP from every CCG. Initially all funding will be delegated directly to place, so Croydon local committee will be our place committee. We'll then delegate upwards in terms of what needs to be done in South West London, not the other way around.

There was always a worry that actually what money came to Croydon would be siphoned off before it came to us. In this set-up the money will come to us and then we delegate upwards depending on what needs to be done on a bigger footprint. That's why all the CCGs voted almost unanimously for the model that has been negotiated, because we retain the authority and power to do that. The Croydon local committee is where the influence, and Gordon has been part of the South West London development and patient representation. This local committee will be the CCG governing committee in all but name. We'll have an elected chair and that elected chair will sit on the South West London governing body. This will be a sub-committee of the South West London CCG. We'll have four elected GPs and officers in terms of place-based leader, finance, chief nurse, director of staff and system transformation, and director of integrated commissioning, who is joint with the local authority. In effect, we have a slightly different approach to this. Every CCG will have that. We also have our officers who are joint directives of the trust. Actually we'll make better use of working together and across organisations.

Just as we have on our governing body at the moment, we'll have our local authority executive director, Healthwatch, director of public health, and an LMC officer, local medical committee officer, in attendance as well. South West London will delegate to this local committee, but the accountability will be with South West London. We'll be given autonomy but if we don't know what we say we're going to do then South West London will intervene. We need to make sure we do what we say, because the accountable organisation will be South West London CCG and they will have to act, whether it's quality or finance, etc. This devolved model in South West London actually gives us the autonomy within the changes that are happening because of the long-term plan and having to make 20% savings and shifting care and services closer to where people live. I think the positive part of this is that local committee is then held in common with CHS committee, and therefore that joint committee in common with CHS. They still have to be separate, from a conflict of interest point of view, from the Croydon University Hospital Trust Board because that's a provider board. There's no reason they can't meet in common to save a lot of time and effort on decision-making. That will be the first stage of integration in terms of Croydon.

The next stage would be, within the next year, we have the Croydon local committee, which is a sub-committee of the South West London CCG to which Croydon's £560-580 million will be delegated. We have the CHS, Croydon University Hospital's Trust Board, which will star meeting in common with the local Croydon committee because we share executive directors. We'll have to have Health and social care integration, so the concept at the moment is to develop a health and social care board. Effectively by all those committees meeting in common you could have the start of a health and care board, because there will be conflicts. The big change in terms of primary care networks, PCNs, the long-term plan says they will be represented on an ICS board. There are 42 PCNs in South West London. They can't all be sitting on that board. They could have representation on a place-based ICS board, however, or this health and care board in common. That's why PCNs are on there. In the direction of travel, the hospital as a provider and PCNs are the same in terms of being providers. PCNs, having created out of the contractual changes in the GP contract as providers. That's no different in terms of function as the hospital as a provider. Bringing in the council and patient voice actually creates more of a one-approach to Croydon in terms of developing the One Croydon Alliance further.

There's taking what we have on the health and care board, having an oversight by the Health and Wellbeing board, given the Croydon Health and Care Plan is owned by the Health and

Wellbeing board in Croydon. The function we have in terms of the Health and Care Plan fits into the wider South West London Health and Care Plan. I don't know when that will be published, but Croydon has its identity. It's there and it's transparent and you can see what's from Croydon. We haven't lost any of our identity. We carry on doing what we want in Croydon and that's reflective in changes in South West London. A lot of those of you who had black hair at the start don't now. It's a lot of discussion, meetings, organisations getting together in a relatively short space of time since this year. If that's not a revolution I don't know what it is. The important thing here is we've done it in a collaborative way, so whether it's the hospital, the council, the GP Collaborative, the One Croydon Alliance, people have been on the same wavelength in terms of wanting to work together to have the best outcomes going forward. The Healthwatches in South West London have been actively involved in it, and the next phase is how the public want to present that patient life on a local footprint as well as a South West London footprint.

I haven't been directly involved in it so I will leave that to the experts, who can take us through the next bit. We're on this journey. Place-based committee, having that devolved budget, moving towards social care integration including primary care and mental health, moving to this ICN Plus structure, having the key values of the Health and Care Plan in committees and neighbourhoods, so that we can build on what we already have. There is this strong sense of place. 65% of staff work in Croydon, and we have this wider vision of regenerating Croydon and moving upstream. Instead of just fixing people when things go wrong, it's preventing things going wrong in the first place and keeping up the vision of longer, healthier lives for everyone through health, social care, mental health, and a holistic point of view. That's the vision and we're already on that journey. The next step is developing that health and care board. I'll now hand over to Jo to talk about how the patient and public voice has developed. I was at one meeting in Croydon but haven't been party to all the Healthwatch discussions that have been going on. I'll hand over to Jo.

Jo Austin: Thanks. I was just going to run through how the patient public voice will work on the governing body for South West London. In terms of your experience locally, it will be the same. It will still have engagement people based in borough and locally, so all those groups will still be feeding in. Just a flick through. Started off by looking at some principles we can go back to.

Male resident 1: Sorry, I must have missed something. I didn't catch your name.

Jo Austin: Sorry, I'm Jo Austin and I'm here doing some cover for Ros Spinks who most of you know. She's the senior engagement lead at Croydon CCG. We started out looking at some principles of patient and public voice to refer back to when making decisions. This is different for Croydon. The first thing was about the distribution of time, effort, and representation of local people in governance. They agreed on this principle that it would be a proposed 80-20% between Borough and South West London CCG, but actually in Croydon we've decided to keep it at 100% local level. Expectation of transparency in decision making and local accountability, so we maintain the same ways of letting you know what's going on and letting you feed ack your views. Representation of public voices in a future South West London CCG should be managed so we can maintain a clinically-lead organisation, because the governing body is prescribed as something that is clinically lead. It was important to preserve the distinction between patient and public voice representation in the governance of the organisation and activities or engagement, so talking to groups like this. Also, a pragmatic approach to patient and public voice drawn from place or professional. A single voice from a borough or professional group so that it's drawn into the governing body properly.

In terms of what NHS England have said is the minimum amount of representation, it's this lay member here for PPE. That's patient and public engagement. South West London have agreed that's not enough patient voice in the South West London governing body, so it's been agreed that Healthwatch and the voluntary section will also have representation. That's new and is not in the governing bodies right now. They'll be attending as non-voting members, and the reasons for that were around championing the patient and public perspective, making sure that people's views counted and can be expressed. Even if people weren't expressing, there would be channels for that. Also acting as a critical friend, bringing challenge and supporting better decision-making be ensuring all angles are considered. Representing the patient and public interest rather than individual boroughs. It's more about looking at whether the right people were asked, asking the right questions around how we talked to people about issues. Also flagging issues, flagging anything of particular local interest. People would be attending the governing body. Agnelo was talking about the stakeholder reference group. They'd also attend that, and that would be where all the local views would be shared so that that person is in a position to feed that into the governing body.

Actively maintaining borough and South West London networks and channels and staying in touch with community interest and experiences. Making sure it's demographically

representative. There are a lot of conversations that need to be had now around Healthwatch. You have a meeting, don't you?

Gordon Kay: All the South West London Healthwatches are working together. Part of this whole process in South West London, is that all the Healthwatches in South West London, have taken an interest. All the offices and chairs. The challenge for Healthwatch in all of this, though it's good all these things are happening, is that we're constituted at a place level, not a South West London level. There is no legal remit for a South West London Healthwatch, and there are issues with accurately representing that. At this time I felt it was important from our perspective that whatever decision happened in Croydon needed to be discussed with all the others. We're lucky in South West London. All the Healthwatches do get on well with each other, and there's a significant trust. There are people who, whatever feelings you may have about representation, will feel exactly the same. We need to find something that's going to work for all of us. At the moment ideas are being proposed, and that's effectively something we're waiting to discuss but it's still open for discussion.

Jo Austin: This bit has been agreed, so that will be the structure, but these bits that are to be confirmed over the next weeks are about election, selection, potential rotation of who the person is. The support that person would be offered would be a nominal payment. They'd be able to see the agendas so that they can talk about issues specific to agenda coming up. They'll have pre-meets with the lay member for PPE.

Jo Austin: Also with the Director of Communications and Engagement for the new CCG. Provisions request representation by other South West London Healthwatch if there's an issue. If there were something specific to Croydon then Gordon or someone from the voluntary sector would be able to request that they come along and be part of the meeting, because they'd feel it affected Croydon more than other people across South West London. That's something that may be possible and encouraged for people to do. The governing body may even ask and flag that's something they'd like to happen.

Gordon Kay: Is this to offset the challenge of representation? A lot of these principles still need to be digested, but it's being offered to us.

Jo Austin: It's anticipated most decisions across South West London won't be those decisions, because that would happen at the local level. You'd hope that wouldn't happen often.

Gordon Kay: It's a failsafe in case it does affect us more than others. Whoever we agree on to represent us in South West London may not necessary be a Croydon person.

Jo Austin: The most important thing on this page is that it's built into it that it will be reviewed after a year of 18 months time, and people will have an opportunity to look into how that way of working is happening.

Agnelo Fernandes: The other point to make is that if it's a Croydon Healthwatch issue, it'll be work with the Croydon clinical lead who will be on the governing body. We have a common interest.

Gordon Kay: Yes, I think there will be a Healthwatch representative at all those local boards. You may think a lot of things discussed at those board meetings, a lot of the work goes on between the meetings, share of data etc. These are the places where decisions are validated but the information brought for those happen outside. I think this is very new for you, but for Healthwatch this isn't our local area. This is happening across the country, and I hear discussions elsewhere about the challenges of this new development. Bearing in mind we're still commissioned at place level only.

Jo Austin: This bit is around the stakeholder reference group. At the moment there's something called PPSEG - the patient and public engagement steering group. That will be replaced with something called the South West London Stakeholder Reference Group, and that will be an assurance that South West London are carrying out their engagements properly. The proposal is that they'll meet six times a year. It will be chaired by the lay member for Patient and Public Involvement (PPI) who sits on the governing body. The membership for that will include one to three members from each place committee, so Healthwatch, someone from CVS (community and voluntary services), and then one other, a selected one. The South West London CCG Director of Communications and Engagement and then other members of South West London programme team such as the director or strategy, head of engagement. It will be supported by the South West London communications and engagement team. That includes people who work in the boroughs. That's just a reference group for decision making. It's an advisory role for engagement and

comms at South West London level and will review the current agendas, provide a link between all the Healthwatch and voluntary representatives and nominated reps for the South West London CCG and programme board, and feedback between the borough networks. It will be the conduit between the boroughs and the central CCG.

Gordon Kay: Thank you, Agnelo and Jo for giving us an overview of that and being detailed. I knew a lot in there but there's a lot of new stuff, so it shows the value of being able to be here today. What we want to do now is if people want to grab a chair and then take questions. It's very open. I'm sure you have a number of questions. One question that came to me, we said this is the most devolved model. There was also an aspect about accountability with South West London governing body having accountability. I wanted to know how this most devolved model is working and how it differs from what's happing elsewhere in the country.

Agnelo Fernandes: The concerns of Croydon GPs were, one, we're in a good place at the moment. Not in deficit, lots of good things going on. When we were in bad times nobody wanted to know us and now we're in a good position everyone wants us. Why should we join the others because some of them are in deficit? Secondly was that it's working well, what do we need to fix? Thirdly, lots of autonomy and decision-making. Those were areas they were concerned about. We've had volatile meetings with GPs in terms of why we voted for constitutional change. Part of that is answering those three questions. We can't stay the way we are. We still need to make savings. If we cut out management costs in the way it will be detrimental to the rest of Croydon. In terms of working with other CCGs, there are possibilities of doing things once instead of in every CCG. There are opportunities in terms of utilising resources better. The third bit was, how do we ensure that there is decision-making power and real funding coming to Croydon to decide on its future? We started saying there would be 80% coming to us with 20% going to South West London, but that's a lot of money. Rather than than, having 100% devolve to place, to Croydon, and then Croydon and the other places deciding what goes up. This being the direction of travel, what's the best deal we can get for Croydon?

That's what our perspective was and that's what GPs were asking for. Part of that negotiation was having, accountability sitting with South West London and devolution at place so that we can have the most autonomy in deciding our future and doing what we think is right.

Gordon Kay: Is that review on a regular basis? It's about £560 million, so that will come down and you'll budget for that year, and next year a similar thing?

Agnelo Fernandes: Yes, that will come to Croydon, 100%.

Gordon Kay: Then the local place committee will decide?

Agnelo Fernandes: What needs to go back up, for what, rather than the other way around.

Gordon Kay: The decision really lies with the place committee, in that respect. South West London model, is that what is meant by the South West London model, and that's not being done in other parts?

Agnelo Fernandes: There's something about, if you know the direction of travel you can get there early and shape the future rather than have it done to you.

Gordon Kay: What might happen, what's the risk of not doing this?

Agnelo Fernandes: We're agreeing we're going to have this. If we didn't, we'd be forced to do it anyway.

Gordon Kay: It was always going to happen, an NHS England decision?

Agnelo Fernandes: Yes, so once they change the law, which won't be long.

Gordon Kay: Might be longer than we expect.

Agnelo Fernandes: It's happening despite the law, the same as with Healthwatch, being the NHS long-term plan. Then it would be forced on you and you may not have the autonomy you have now. You would not have th ability to say what you wanted to happen. 20% is a lot of your budget.

Gordon Kay: I heard about this that that's how the NHS works. It gives you a year to try something out yourself and then adopts certain models. To us not involved in it, April's not

far away. Is that why you were going at pace, partly because this innovative model could only be tried now?

Agnelo Fernandes: Yes, as we're pushing against an open door. After being forced to do it we haven't got control over what they force upon us. We know that's the history.

Gordon Kay: Right, thank you. Thank you very much. There's a question back there.

Female resident 1: One of my questions was going to be around what drove the decision for us to have the devolved model. Is it devolving just on budget, or is it also around processes and the way in which we do things? Part of saving money is to do things differently, more efficiently. There's the workforce element, but how do we measure the outcome of whether this model is working versus other models, and is Croydon continuing to be in good shape? As the GPs have said, we want it to be moving not in the wrong direction but in a better direction.

Agnelo Fernandes: It's a good question. There's quality, finance. We know the finance bit because we came from there, and the biggest risk in Croydon is the hospital. Both quality and finance are aligned to the hospital. By being aligned and having joint finance and quality and oversight committees and boards, we reach the point where we can see the icebergs before we hit them. We didn't have that before. Secondly, by having a committee in common with the trust, that being where the bulk of funding goes to, we can work to mitigate some of those risks towards developing an integrated care model. Also being able to focus on what we want in terms of outcomes, quality, patient experience, and doing things more cost-effectively. Over the last six years Croydon has made efficiency savings of £98 million. By the end of this year it will be £102 million, which is a huge achievement focusing purely on the quality as opposed to slicing and dicing and making savings. We haven't got everything right, but to be able to have made those savings without major problems and given we were on the back foot, inheriting deficit, being underfunded, we're now within 5%. We were 11% below funding when we started as a CCG. We've been through those times and are conscious of alarm bells when they ring before they even ring.

The finances will drive a lot of what we do, and showing that's linked to quality as well. Developments out of hospital in terms of the ICN Pluses and the PCNs and everything, the wellbeing factor, we want to achieve the three things I mentioned and those outcomes. We have a proactive joint board between health and social care, which is actually setting out

what those outcome metrics might be as well. You need to have measurements in terms of, is this succeeding or not? The big barometer is going to be finance. If you're not going to be in financial balance or on plan then you've got South West London CCG on your case. We need to achieve that and at the same time be able to mitigate some of those risks, as well as delivering on our plans for improving the system locally in terms of quality and experience of local patients.

Female 1: Those outcome measurements in terms of patient experience and outcomes are still being defined?

Agnelo Fernandes: Yes. The Health and Care Plan outlines some of them. That's the overarching plan. You have the long-term plan as a national, locally-implemented plan. The Health and Care Plan mirrors a lot of what the Health and Care Plan says. There will be some things not in the Health and Care Plan, which will be local. Youth violence sits outside in different parts of Croydon's system but links into that. There are lots of positives that when we were mapping the long-term plan to the Health and Care Plan of what is in scope and what is not, and everything is within scope within Croydon but not necessarily under the Health and Care Plan. Those outcome measures are important. You need to know whether it's working or not, and we have to make it work from our perspective. When we go to South West London, we're part of the same team. We're team Croydon. There's Healthwatch, a place-based leader, because effectively there was only going to be one voting member on that governing body, which will be the clinical chair of the local committee, which will be me until my term runs out in June next year. Then stand for election or whatever, but if it's about having the team in terms of patient public representation, voluntary sector, and the clinical leads and the place-based leader, when we go there we are speaking as a team because we have common interest in terms of our place.

Gordon Kay: The quality question on that process, there is a whole lot of work going on in terms of reviewing quality. Quality is historically set under the role of chief nurse. Now you have a joint chief nurse. Can you give us a bit more about how these policy processes are being put in place, so that you can see how measures are being measured?

Agnelo Fernandes: We've had three different arenas for quality review. The biggest one is to do with the hospital. We have a clinical review quality CQRG, quality review group, with the hospital, which is a CCG one. The hospital has to have a quality committee. A lot

of what was happening in the quality committee was then rehearsed in the CQRG, so it made sense for the CQRG to be merged with the CHS quality committee, but having the scrutiny from the CCG colleagues attending. We have now got a GP in that quality committee. We have a chief nurse, who wears both hats but still has a CCG hat. The LMC were concerned about quality as well. The local medical committee, it's been agreed by the committee, chaired by a lay member, that there will be an additional independent GP who is the local medical committee member, who will be Peter Boffer who has been longstanding in Croydon. There are things you can see in quality which can't be measured but you know. The one thing that GPs see that others don't is that you get told lots of things about system experience. That's the CHS one. The next stage is to try and align the CCG quality committee, which has oversight over all the commission services.

Agnelo Fernandes: The second CQRG has been the mental health one, or the SLaM one. Unlike South West London who have got a single provider, Croydon's the only borough in South West London who has SLaM as a provider. We're a small part of SLaM because they cover the boroughs in Southeast London. We go to their CQRG (Croydon Quality Review Group) and triangulate the mental health quality as well, which feeds in from public events and local authorities. To try and help develop that further in terms of mental health and social care, there's a huge link between health and mental health and social circumstances. We have a joint director now, so that brings that together so we start linking it with social care but also bringing some of that quality element. The third element was a primary care CQRG, looking at general practice in Croydon and the quality of it. A lot of the data is already published, CQC reports, activity data, achievements in terms of quality and outcome framework, patient satisfaction service. These are all in the public domain and we're bringing it all together. Rather than waiting, at the moment there is no Croydon practice that's under the special measures with CQC but we have had some issues where they've almost been closed down or closed down for other reasons. It's about keeping that quality of care at the best level possible, so that's CQRG.

Some of what the CQRG is doing will go to the PCNs, because they're focusing on quality as well and they're measured on quality. That was the primary care CQRG which is still going on. We need a Croydon-wide view of it so that we can have that and share it with the PCNs. We used to have a number of different services. Any service commissioned has to have a quality element to it, so we used to have CQRG for smaller commissioned services. More and more through collaboration we're having fewer contracts with private providers and everything else. That's got less and is incorporated elsewhere. The final CQRG is about a

specific contract relating to urgent care, relating to GP hubs, 111, GP out of hours. Given that the main contract holder for that is CHS, it's trying to consolidate that onto the quality committee. You have all these meetings going on, and to prepare for all of them using the same data, people in different places discussing the same thing, we can consolidate that and focus on what you want. What does it mean in terms of quality and experience? Externally there is one for NHS 111 in South West London as well, and one in London related to that as well. There's a whole range of quality governance issues going on as well as public feedback and complaints and things.

We need to have metrics in which people can see differences, simple ones, not complicated data. If anyone's been to CHS recently, the morale is changing. People are enthusiastic about making changes to improve things. There's a quality improvement initiative being started, and those on Twitter will pick up on some of the things they're doing in the staff and what a difference they're making. They're energised. What we're trying to do with our long-term plan and the public and citizens is what they're doing in the hospital, energising people to make positive changes. We want to make that contagious across the health and care sector in Croydon so people are continually improving rather than feeling they can't make a difference. It's not always about money but about motivation for staff as well, and conditions and how they work. There are lots of things that need to change, but there are moves afoot. This is a mega change. The biggest decision Croydon GPs had to make was last Thursday. It's in effect the opposite of Brexit. It's about devolving responsibility by retaining power. The deal we've got and negotiated for Croydon is one where we retain that power and the ability to make decisions, and the finances, while still being part of the changes in terms of developing a South West London CCG and fitting into the long-term plan. That's why we voted for it.

If we'd voted in September it would have been no, but after all these changes to the constitution were made it was something they bought into. There will always be people who don't like change, but no change was not an option. We're going to have to do it. As we said, if we don't move in that direction we'll be forced to and we won't have the benefit of deciding what we want.

Male resident 1: It's interesting you gave the insight that it's taken that long to get GPs onboard, and that things got changed at a South West London level to reflect our issues. The missing part in your quality discussion is patient experience and you as residents being able to feed that through Healthwatch or through the various different ways, like the

hospital encouraging GPs to listen to their patients more. It's something that is lots of discussion but not much work having happened yet. Healthwatch has a role to play, voluntary sector.

Male resident 2: I know you've saved money. If you have a learning disability and you sign with a doctor, you're entitled to an annual health check. Is there anything that would be changed about that?

Agnelo Fernandes: I think the answer to that is you should have one, and if there's going to be improvement everyone who si entitled to one should have one and preferably more. Primary care networks will be monitored on lots of different things. They don't know what they signed up for. From April they will be delivering a number of different things. In terms of medication reviews that's one thing affecting everyone, including people with learning difficulties, but also CQC is focusing on care for people with learning difficulties as well. Practices are being encouraged to make sure they focus on these areas, whether from a contractual or regulatory point of view. None of those necessarily involved encouraging people with finance, because they already signed up to it. It's about delivering some of those.

Male resident 1: They've had the money already. That's having it at the local level, rather than it previously being more fragmented.

Agnelo Fernandes: There's always more to be done, and I think working with the local authority as well. It's about giving a holistic approach. You can do a check, but what does that mean? The check will come up with things you need. You need to have a rough holistic approach. |There;s no point having a check if you can't do anything else, but there's a basic check you should be having at least annually.

Male resident 3: Where does the patient participation come into all I've been listening to for the last hour and 20 minutes? Where are the patients being consulted in any way? Your notice there says your voice can deliver better service, but I haven't heard anything where patients are being brought into any of these boards or discussions or things coming from the top right through to the patient sitting in a PPG group. Why not?

Female resident 2: She mentioned that earlier on.

Male resident 3: She didn't.

Jo Austin: Which structure did you-,

Male resident 3: Yes, I read that.

Jo Austin: Which you referring to?

Male resident 3: Are there any patients being invited to sit on these boards?

Jo Austin: No, not on the governing body.

Male resident 3: If they're not invited to sit on these, how can they be in participation of what's going on in our health service?

Jo Austin: We'll have the same engagement we have now at a local level. There won't be any changes to the PPGs or their networks. All those are still existing. We've got Healthwatch and the voluntary sector representation. The patient voice is right in the middle here. That would be the channel or it to go through, the place committee.

Male resident 1: In terms of patient policy, are there any plans at the local level? Healthwatch are involved, a lot of those others are committees. Are there plans for an actual patient voice group as well building that? This is new to me.

Jo Austin: This is one of the things that needs to be thrashed out. The initial thing was sorting out how we did the South West London governing body. The local arrangements are the next stage and will be done together, so they're not something we're going to come along and tell you how to do. We did have vague plans to set up something that represented the public. One of the things we were looking at is how we would make sure it represwnted the cross section of people living in Croydon. That would be members of the public but also representatives of the voluntary sector to make it sure it was demographically representative, and that would feed into the local stakeholder reference group.

Male resident 1: There'll be a stakeholder reference group and then a wider one?

Jo Austin: Yes.

Male resident 1: Is that open, or will people be selected and how?

Jo Austin: That hasn't been decided yet. That's something we'll be talking about.

Male resident 1: A lot of these structures that they've needed to put in place, it is fair to say, as South West London Healthwatch, we haven't even had the discussion yet about our approach to this. This is a piece of the puzzle yet to be decided. It does create an opportunity, though, which is part of why we're having this event today and why we'll have future events to unpack this more.

Jo Austin: We don't want to come and tell you what we're doing, we want to ask how we should do it.

Agnelo Fernandes: We have an opportunity for developing that at place level.

Male resident 1: Also at neighbourhood level. I think that's where PPGs will have potential roles. Now you're starting to develop health, the PCNs, which are about four or five surgeries each, if each of those have their own PPG they can feed into another. looking with eyebrows raised, but I think the problem before us, these networks have always been much looser ideas. This is a legal structure of accountability.

Jo Austin: I think one of the differences with PCNs is they are being encouraged to look at their communities as well as their patients. It might be that things evolve slightly differently to traditionally.

Female resident 3: Female resident 4 and I last year completed a survey which Agnelo Fernandes had seen. I hope he was suitably shocked. When I first set up the PPG network, there were 20 out of 60 patient groups. Most of which were reasonably active. We're now down to something like five or six activities.

Jo Austin: Really?

Female resident 3: Really. If speaking about Selsdon, we have three practices in Selsdon all with relatively large patient outreach. One sort of has a PPG, but it's a secret society. I

don't even know who's on the PPG, we get nothing from them. Apparently, they're reaching out for under-65s but most of the members are well into their 80s. Farnley Road has a reasonably active PPG, and Queenhill has a PPG. I make no comment. That's an example. There are GP practices without PPGs, and that's not fair to the patients.

Male resident 1: Are they legally obliged to have one?

Female resident 3: They're contractually obliged.

Agnelo Fernandes: They can have a virtual one.

Female resident 3: We all know about virtual ones because nothing happens.

Male resident 1: We're talking about quality and how CQC is assessing GPs. What could be done? Not everyone can turn up for meetings and you could have a very active virtual one. It's not the structure as the output. Patient experience is translating into change. You said, we did. Have you had any good examples of where it's really working well?

Female resident 3: I haven't been a member of Parchmore for years, but I think we did have a fairly robust PPG there. We were able, without rancour, to bring issues. The telephone was always brought up, but we were able to have really good discussions. I'm not saying it because he's sitting here, but I would suggest that Farley Road is quite a good model. There's only one GP in the practice who's not deeply involved in that practice. That model in Parchmore where you had a different GP allocated to each meeting was extremely good. You got to know all the GPs and they didn't have to keep coming and listening to us. In my view, and it would be the national association's view, PPG should be now far, far more proactive. It's gone beyond getting people to come get their flu jab. Brenda's going to have a tea party on Saturday, and we as part of social prescribing are going to be singing.

Gordon Kay: They're almost community development, then.

Female resident 3: Absolutely.

Gordon Kay: There's an opportunity there to bring those aspects in. What do you think, beyond the GPs mindset, which I think they all want a good model.

Male resident 1: What do you think are other barriers?

Male resident 2: We can cover the barriers, but in terms of opportunity it's the PCNs and how developing a PCN, PPG, even if it's once every three months, approach would be really helpful.

Female resident 3: You need to have the PPGs in each practice.

Male resident 2: That's where you need different PPGs to encourage development of others. The GPs in that PCN need to be feeling encouraged to do it. Sometimes they don't know how or are nervous about doing it. It's about how the PCN have developed that patient voice locally.

Female resident 3: I was told recently about a practice on London Road where one person decided they needed to have a PPG. I must go down and find out how it happened, but over 50 people turned up to the initial meeting in an area I wouldn't expect that to happen. It happened before when Ed Rosen was around. He went to a practice in Thornton Road and couldn't get them all in. They were up the stairs, 70 or 80 people. The will is there among patients. I understand the problems GPs have and the time it takes, but in some respects it doesn't have to be the GP. It could be the practice manager. They sometimes get in the way. It has to be collaborative.

Jo Austin: I think you're right, Female resident 3. It's a good opportunity to do it while the PCA is developing. It's a good way of asking what asks best for the PCA in a practice. Agnelo Fernandes was saying the various things they've committed to, there is an engagement element. It's built each year. It is something they're conscious they need to do, so we can work together to find something that works. I think we've done a lot in outreach work and talking to people in their own settings and hoping to engage them in that way. It can be a bit daunting coming to something.

Female resident 3: I'm glad you brought that up. The PPG network is doing what I consider to be really good work. We've had a number of very large groups of people come to speakers. Recently there was one done not by the network but by a GP practice. There were 20 or 30 people. That's the sort of thing w can do as a network. We've had two prostate cancer talks, one to which over 70 men turned up. We had 27 men turn up to the

other. We've had over 125 for MSK issues, joint pain, etc. That's how I see PPGs and the network.

Gordon Kay: It's more than just getting views, it's also being a place for sharing information.

Female resident 3: We had a meeting in Shirley for joint pain.

Gordon Kay: I think this is an opportunity for PCNs. Getting back to your original question?

Male resident 4: It's been backed up to 1000% by what Female resident 3 just said. How many times have any of these people that are operating the Croydon local committee ever attended PPG meetings? Have you ever?

Gordon Kay: I've attended the Selsdon one on a couple of occasions. I know we've attended others. Sometimes we're invited. I was invited to chair a discussion about setting up a PPG at Auckland Road. Our remit is wide. It's something I've been discussing with Female resident 3 since being involved in Healthwatch. I think the challenge is finding the opportunity, and I think now there's potentially an opportunity. This is something where the GPs are listening because something's happening at the absolute local level. Lots of things are happening in other areas. I know the hospital are trying to engage differently. You know a bit about what's going on. There's a whole patient experience framework being set up at the hospital. We are supporting those as well. Our strategy has changed a little bit, certainly since I've become manager. The view is that we will do reports where we know they're going to meet somewhere, not just because we think it's a good subject. Where is this piece of insight going to land? We're trying to find things that can create change, and we can learn from those. I also think there's a bigger role that Healthwatch can play with PPGs, supplying them with data they can analyse and feed back.

They can then comment to us and we can feed back to them. Get us to work in a team and we can do the analysis for them very easily and feed them back the data that would be useful.

Male resident 5: Just a housekeeping thing. Are these slides on the CCG website?

Jo Austin: I don't think they are at the moment.

Female 1: They can be.?

Gordon Kay: They can be. We'll put them in our website. We have a page on the long-term plan.

Male resident 5: Referring to slide two, SLaM does not have a public questions from the thing there. I would hate for these other boards being set up not to have a public question and answer session at the end. If there was something any member of the public felt they were not getting through, they could go and put their question to it.

Jo Austin: The South West London governing body will operate in the same way that the local ones do now.

Gordon Kay: I'm very interested in the hospital model here they've decided to break the meeting into four sections and take questions at the end of each section.

Male resident 3: When's the next one?

Gordon Kay: Next week.

Female resident 1: Tomorrow.

Male resident 1: At the town hall, yes. It's an opportunity to see how that might work. I think part of the challenge sometimes is that questions are raised after decisions are made. They made an open approach at the last hospital board meeting. It was only announced then. Maybe you could adopt the same.

Male resident 3: Can you clarify that? I thought the CHS board was meeting next week?

Gordon Kay: Sorry, it's next week. Not tomorrow. My apologies. It's the 30th at the town hall at 5:30.

Male resident 4: May I ask a question? I'd like to make an observation, which touches on the point that Male resident 4 was making. I'm going to make an analogy that some may

resent. It strikes me that the national health service in particular is one of the few spheres of activity in our national life where the providers don't talk to the customers. It stands out like a sore thumb when Agnelo Fernandes was presenting the work that's gone on into creating the terms of reference and the organisation of the South West London CCG. Huge amount of effort has gone into making sure that the clinical leadership of the CCG is properly accounted for and evolved. I'm grateful to you for the presentation you've made today. When I look at it, though, and it touches on Healthwatch, the failure in that structure to effectively or even think of organising for public voice, and then come to look at the slide behind you which shows a number of organisations being involved and still trying to evolve a patient voice, I'm struck by the discrepancy. All that effort into making sure the medical side of the CCG, which by law is how things work, has no direct accountability to the public. It goes through a convoluted process of accountability through our councillors and parliament.

You'll know if you ever listen to a (parliamentary) health committee the amount of frustration that goes on among MPs about the absence of answers from the NHS bureaucracy. What's going on here is an organisational restructure and normally I wouldn't worry as long as I was getting the services I needed out of them. It's a public organisation and there's no accountability. I keep coming back to it. There's no way that you, Agnelo Fernandes, on the CCG, is publicly accountable in any way. Another thing I note is that on our existing CCG, we have a member specifically appointed to deal with public and patient engagement. I couldn't see that in the structure up there apart from through a convoluted process.

Gordon Kay: It just mirrors what happens now.

Jo Austin: That person is still there.

Male resident 4: Okay, thank you for clarifying that.

Jo Austin: There are three members. I don't know if I can make it bigger here.

Gordon Kay: I was going to say about the lay member, that lay member role seems to have a much more defined aspect than I have to say the current lay member does. It's going to have a much more coordinated role, where in the past lay members haven't had that kind of responsibility. It's going to be much more fixed with a regular timetable of what they've got to do. It's going to be a very active role.

Male resident 4: I was talking about Healthwatch. Historically, Healthwatch has not been a proactive organisation. I wonder whether by statute you're limited in that regard. For you to take on board the role and responsibility of actually mirroring, if you like, the day-to-day views of an active population involved in health matters, I think it would be quite difficult for you. The question is, how would you reflect that back to the great panjandrums in Wimbledon? I don't know if there's a limitation in Healthwatch that prevents you doing what I would have thought some sort of public forum at each place would need to do.

Gordon Kay: When you say we're not proactive, what do you mean by that?

Male resident 4: You research and you report on what's been happening, but in terms of a group of persons wanting to have a view or range of views about issues arising from the positions of either a place-based committee or the South West London CCG, you would find it difficult, I think, to garner that organisational framework and be able to represent it. I know some limitations in the constitution of South West London CCG exist on how papers are presented. I didn't see much about them being publicly available. The dissemination of those to the wider public strikes me as being limited.

Gordon Kay: : Just to clarify, what you're talking about is where decisions are proposed to be made at either the place-based level or South West London level, and that there's been enough time to get a public view on that decision which we can feed back at the relevant meeting. Is that what you're saying?

Male resident 4: Not specifically. Circumstances can arise. We saw it in parliament the other night where something can come along very hurriedly.

Gordon Kay: This is a discussion that we're also having at a South West London level. One of the questions raised is how we're going to find a single representative. The question raised by another colleague is, when papers are coming out with a few days' notice, how can we digest this? We've already raised the question about commitment for a bit more order. These things need to be considered in more detail. If they're being shared to us there's no reason they can't be shared with the public more. I know this after digesting 200 pages on three days' notice. There's a legal requirement on when it needs to be out and you've improved significantly, but bearing in mind you're going the extra mile, just

planning the things well enough to give us time. There's supposed to be a reference group and we may want to discuss some of those things before we go. I think it will be one of the big discussions that comes up in a few weeks' time, because if one rep will represent South West London they need to be informed. There could be panels and more meetings like this, but we need to know the decisions in advance. That will be easier now because the Health and Care Plan advertises what the plans are for the next few years. We'll be able to see things as they come along.

Jo Austin: This is built into this. Meet six times a year, and it is aligned ton when the South West London governing body is reviewing the agendas. Ahead of that, the representatives from that will be meeting with the local groups.

Gordon Kay: The question is what we do at the local level to help with that. That's the first time I've seen that today. I've heard rough ideas of this. I don't know if Edwina's (Healthwatch Croydon Chair) seen something like this before?

Edwina Morris: Not exactly like that, but that idea.

Gordon Kay: I've had a similar thing. There's an opportunity for us to have at the local level a forum that feeds into that. That answers your question about trying to get a relationship. We would still be independent. It's very important that Healthwatch sits independently. We sit on these boards but it's very clear we are non-voting. We merely present advice. If a big decision had to be made, having heard form the people we have heard from, and we always show our workings, we feel that you should consider this decision in your final decision.

Male resident 4: I want to finish by saying I'm concerned about a comment Agnelo Fernandes made earlier about Healthwatch representative working hard in glove with a place-based representative on the CCG. There might be circumstances where your independence is put at risk by the fact you're considered to be working hand in glove with your local place-based board. It seems to me there might be circumstances where your independence is put at risk b the fact that you are considered to be working hand in glove with your local place-based board.

Gordon Kay: I think we will always hold our independence. I say every meeting to our board to challenge me and us if we think we're being anything other than independent. It's so important. I think it's recognised from your point of view.

Agnelo Fernandes: If there was a Croydon issue that Healthwatch Croydon brought up which we couldn't fix locally. It would make sense to work together on it.

Male resident 4: If it were a South West London issue that Croydon place-based board agreed to as part of the CCG which Croydon residents were not happy with and you couldn't reflect that.

Gordon Kay: We can. We're independent. We have no voting right. All those decisions are made. We might influence before a decision is made based on the evidence or insight we can bring, but we're not party to that position.

Agnelo Fernandes: I would expect Healthwatch Croydon to be pointing this out to me because I'm the only person with a vote on the South West London one. That's why one of the things Croydon GPs wanted was the ability to vote for members and to vote to take them off as well. If elected members are having tea instead of doing what they're supposed to, you can deselect them. The chair for South West London, if there's a 60% majority among the other chairs then they can deselect the chair of the South West London CCG. There's accountability there.

Gordon Kay: Female Resident 5 at the back, and then I'll take your questions. Female Resident 5?

Female resident 5: It's just a question about semantics. You had something about patient voice. I come from the carers information service. I was wondering if you could add carers as well. They're equally important and have an equal role, and are part of the NHS long-term plan as well. They're often seen as an add-on.

Agnelo Fernandes: That's an important point. I'll reflect that back.

Female resident 5: Another thing, I'm not familiar with some of the terminology. If we are going to be doing more public engagement we could maybe have someone explaining the acronyms.

Agnelo Fernandes: I thought listening to Male resident 4, he was in full flow with the lingo there.

Jo Austin: I have got a glossary. Maybe I should trim it.

Male resident 4: I'm sorry, I didn't use my usual disclaimer saying to put your hand up for anything you didn't know. Go on.

Female resident 6: One was going back to the plans. One of the ideas was to leverage synergies across the CCGs in terms, and I'm assuming some of those will be processes as well as systems. Where are the plans for defining best practices and processes? Each CCG today does things slightly differently under the NHS framework. It's also consolidating systems, huge savings. Are those plans part of what some of the next steps will be?

Agnelo Fernandes: There was a big clinical conference over summer looking at the clinical priorities across South West London. Those are being developed based on RightCare and other data. How do we collectively work on them? There will be some differences at local level but generally they're the same issues. How do they mirror onto PCNs, as well, because PCNs will be focusing on that as well. There's normally South West London but also supporting PCNs to develop. The other thing is that if you're working at scale you attract more funding. The most recent example is children's mental health. It was only four CCGs that got it from the South West London cluster. Applying as South West London, including Croydon, we got a whole lot more. Our schools and children in Croydon are benefiting from that already. If you come to the health and wellbeing board next Wednesday there will be a presentation on it. That's happened as a result of working collectively together to attract funding. Whatever you think of the current situation, Croydon hasn't done badly with a new A and E (accident and emergency) and funding for a new critical care unit, and a new hospital in South West London. We've benefited because we can demonstrate we're doing things differently. The element of being able to attract funding is really important, because there's no capital funding in the system to develop things.

There are also one-off monies which can make a difference. At the moment, big clinical areas are cardiovascular, diabetes, respiratory. We still have some problems but in Croydon we have the worst streak in the country for asthma emissions, in the country. How do we focus more on that as well as Chronic Obstructive Pulmonary Disease (COPD), whereas for

South West London it's COPD. Children's mental health, we know the most number of self-harmers in terms of teenagers is in Kingston. We've got less self-harm in Croydon than in Kingston, but we have lots of children's mental health issues in Croydon. We have a good voluntary sector for children's mental health. AGM coming up soon in November and a drop-in as well. How do we build on what we've got within that framework across South West London? Those are a couple of examples.

Female resident 7: In that example, we've got the South West London CCG. Within that, one of the places, Kingston, has poor results in child mental health. Is the idea that we would look at practices in other places to get better at that in Kingston, and leverage those synergies and implement best practices in Kingston so that as a CCG we have a better outcome as a group but also as individuals?

Agnelo Fernandes: Yes.

Jo Austin: Stephanie Kendrick (CCG Engagement Manager) and I have seen benefits. We've been working as a team for a couple of years now and it has been useful to be able to talk to other boroughs about what they're doing to engage with people and sharing. We don't have to spend time reinventing the wheel. We can reorganise things we know will work in our boroughs.

Female resident 7: Are there plans to consolidate the IT systems?

Agnelo Fernandes: Yes, it's already started. Getting discharge letters from hospitals, from a GP point of view, has been a big issue. Now we can see them on the hospital system electronically and they can see ours. They're not integrated but we can see each other's through the computer, and cross South West London. IT will benefit from being a bigger footprint. We don't live in isolation as a CCG. We're connected to hospitals. All these things in terms of IT being able to link up so that care of patients can be continuous, instead of blind. In Croydon being able to see the record has made a big difference already. All the practices in South West London will have what's called Doctorlink, which will be at the front end of every surgery system. More people want to do online consultations. We know that Babylon, the GP at hand, is successful, because more and more young people don't necessarily want to talk to someone. They want to follow their symptoms and be booked in directly. I was talking to one of my trainees in another practice and they use the system there. It's seamless from a patient point of view. More

and more people will use that system. That will be all across South West London for every practice. Also mindful that there's going to be competition in the system.

GP at hand, the system provider that has an NHS contract to prevent online video consultations, has now got a base in Merton. If you register with this organisation, from a young person point of view they rarely use the health service. When they do they need to be able to talk to someone whatever time it is. Nowadays people live a 24-hour culture. That service is popular. Matt Hancock (Health Secretary) is registered with it. The problem with the rest of the system is if a patient registers with that service, they get deregistered with their local practice. The money follows the patient. They're seeing generally younger people, so money is taken out of the local NHS and so there's less funding for traditional general practice looking out for older patients with long-term conditions and greater needs. That's the worry of many people. It's the first start, and then from April next year it will be about video consultations.

Male resident 4: Doctorlink will provide a similar service, but the money stays in Croydon. That's the problem.

Agnelo Fernandes: Practices based in West London and spreading to Birmingham, they have Babylon.

Male resident 4: We are nearly on five o' clock.

Female resident 1: It was just about the retention and retaining staff within the health service. Are there any plans at looking at the inner London waiting and outer London waiting? That is such a major issue for staff applying for jobs. I'm aware that when recruitment is put out you don't get the applications. I've heard that's because of the waiting system and Croydon not fitting into that. It discourages staff from applying.

Agnelo Fernandes: It's a universal problem that Croydon has, with health, social care, or anything else. How do you work differently? It's easy to recruit in Epsom or wherever because they have inner London waiting or better terms of service. How can you use the same staff to be circulating around areas like Croydon as well? They're thinking about implementing something where you work X amount of time in different areas, but employed at a place where you can get maximum wages.

Gordon Kay: Edwina?

Edwina Morris: Was it about this particular topic?

Male resident 5: NHS staffing.

Edwina Morris: Does Michael want to go first?

Gordon Kay: Michael first, then Edwina.

Male resident 5: My wife and I have been much impressed by the Derby Big Hospital experience on the NHS in bringing volunteers who would never have considered the NHS as a career, bringing them in, getting them to see how fulfilling it is. Challenging, but fulfilling. We would recommend anybody here to see it and any manage who has an influence in getting staff into the hospital to see it.

Gordon Kay: That was the Derby Hospital?

Female resident 7: Yes, it's being filmed at the Derby Hospital but it's called the Big Hospital Experience. I'm a volunteer in some areas in Paddington and I've been watching it. I find it very impressive.

Agnelo Fernandes: Imperial hospital.

Female resident 7: It's a charity, Imperial Health Charity.

Agnelo Fernandes: I've forwarded that to Matthew (Kershaw – CEO of Croydon University Hospital and Croydon place-based health leader). The point you're making is that ur biggest asset is people, and we have lots of people willing to help and support. It keeps people well an interested but also helps efficiencies in the system. We know a lot of people access healthcare when they didn't need to because they have problems that could be dealt with in a different way. What you're describing in terms of the demand on the NHS is probably reducing it by 20% by keeping people well. If you had that element in A & E, there are a large number of people who don't need to be there because their problems need to be dealt with in a different way if they're supported. It's not always physical or mental health. It's about other things, social housing, things that can be dealt with in a

different way. Imperial healthcare is looking at how they've reduced their attendance by 30% for people that were recurrent attenders. It's about, how do we work differently in working in this way? Even in Croydon, there are still GPs in practices who don't believe yet, and places in the country who don't believe yet. Today the announcement that there will be a national academy for social prescribing. It's trying to convince people that this is the right thing to do. It's not always easy. It's hearts and minds.

In terms of the PPGs engaging with social prescribing, having events, keeping people well, that's about empowering communities to support each other and be part of something which is better than any medicine.

Gordon Kay: Makes you wonder if that Big Hospital experience could be a big GP experience. There are those PPGs that sit there and compare surgery, but you were offering a wider model that overlaps between information and social prescribing. I think there's a big role to play. Edwina?

Edwina Morris: It's more an observation. I've been involved with Healthwatch for about 18 months now and am chair of the board. One of the things I've heard today is that although we're all in different parts of the health and care system or are residents and patients, we're all involved in Croydon in different ways and trying to do the same thing, which is improve health and care services for people in Croydon. What I make a commitment to from this meeting today is that the board will look at the outputs from this meeting with a critical eye with a view to amending, changing and developing the way we operate so that we can have more of an impact. We do interact with the CCG, the CHS, all the other players in Croydon, in a number of different ways, and we do exert influence where we can and where is appropriate. I'm sure there are ways we can do that more consistently and effectively and we're learning how to do that as we go. Thank you to everyone who's been here today and we will make sure that we make good use of the output from today's meeting, so thank you.

Gordon Kay: Thank you. Thank you Agnelo Fernandes and Jo for presenting this. I hope you feel more informed about the changes going on. We have recorded all this. It will be typed up and analysed and published so you can see it to help your decision-making. The big questions we now have about patient representation, the experience here, hopefully we'll be able to clarify those and put it in different aspects. Thank you for your time and

questions. They were very good and interesting, and I hope we can use this as an influence and improve things for all. Event ends 17.00