Shaping health services in south east London
Local stakeholder views on the South East London Five Year Commissioning Strategy

Summary of findings local stakeholder engagement events 3 June 2014 FULL REPORT
30 June 2014
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<th>Client</th>
<th>South East London Five Year Commissioning Strategy Programme &amp; South London Commissioning Support Unit</th>
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<td>Title</td>
<td>Shaping Health Services in South East London</td>
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<tr>
<td>Date Modified</td>
<td>11 June 2014</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Classification</td>
<td>RESTRICTED EXTERNAL</td>
</tr>
<tr>
<td>OPM Project Code</td>
<td>9872</td>
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Executive Summary

To inform the development of a new five year commissioning strategy for health services across south east London, the south east London Commissioning Strategy Programme commissioned OPM to design and run two local stakeholder engagement events, and report on the findings.

This is a summary report of the engagement event held on the 3d of June at Park Plaza Victoria, and reflects the views of and discussion held by the 34 local stakeholders that took part in this event.

Participants were given the opportunity to share their views on the emerging strategy across seven key areas:

1. Urgent and emergency care
2. Primary and community care
3. Maternity
4. Children and young people
5. Integrated care for physical and mental health
6. Planned care
7. Cancer

The approach was designed to allow participants to learn more about the background and emerging strategy, and to share their views on emerging thinking.

Participants agreed with most of what they had seen of the draft strategy. However, it should be noted that this agreement was strongly caveated with a need for more detail on some of the aims and with suggestions for additional focus areas.

Most time was spent discussing each individual clinical theme, which provided rich insights regarding the suggested directions of services in those clinical areas, as well as more specific issues in relation to those areas. The most important themes in common across more than one of 7 clinical themes include:

- In a number of the discussions that took place, it was felt that community and voluntary organisations have a significant role to play
- Some tables discussed a need for increased GP awareness of certain issues relevant to their topic.
— There was a good deal of emphasis on the need for improved joined up working and continuity of care.

— Participants stressed the need for care to be as accessible as possible, particularly for ‘hard to reach’ groups.

— Participants emphasised the need to improve the provision of public and patient education on a number of areas.

— Participants felt that more emphasis is needed in the plans on supporting and involving carers.

— The strategy needs to more explicitly address support for patients at end of life and their families. This could either be in a standalone section, or integrated into the existing 7 themes.

— People thought that it is important to consider how public and patient engagement channels can be robustly build into the running of healthcare services.

As the strategy continues to be developed, there will be further engagement locally within boroughs and more widely across south east London.
Introduction

The six NHS organisations (Clinical Commissioning Groups – or CCGs) in south east London with the job of planning and buying local healthcare services, are working in close partnership with local councils, NHS hospitals, mental health and community service providers and with local people, patients and other key stakeholders to develop a new five year commissioning strategy for health services across south east London.

The aim of the strategy is to improve health services for everyone in the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark. The strategy will address those issues that cannot be solved by one area alone or where there is more that can be achieved by working together.

OPM were commissioned by the South London Commissioning Support Unit to plan, deliver and provide a written report on two local stakeholder engagement events to widen engagement on the draft five year strategic plan for SE London (on behalf of the SE London Commissioning Strategy Programme).

The local stakeholder events are part of wider engagement across south east London. In developing their five-year south east London commissioning strategy, the approach of the Programme is strongly focussed on engagement. The commissioners aim to co-design and co-develop the strategy with partners, patients and local people and key stakeholders, with thinking and planning being developed and amended through the engagement process. As the strategy continues to be developed, there will be further engagement locally within boroughs and more widely across south east London.

OPM organised two half day engagement events in early June. This report covers the findings of the first of two events, held on Tuesday 3 June 2014, Park Plaza, Victoria. The second event was held on Wednesday 18 June 2014 at Charlton FC, Greenwich.

Methodology

OPM invited key local stakeholders from voluntary and public sector to these events to share their views on health services in south east London, and to learn more about the partners’ shared emerging vision for local healthcare services. A total of 34 participants attended on the 3d of June.

Participants were given the opportunity to share their views on the emerging strategy across seven key areas. The information provided reflected early thinking on:

1. Urgent and emergency care
2. Primary and community care
3. Maternity
4. Children and young people
5. Integrated care for physical and mental health
6. Planned care
7. Cancer
Our engagement approach was designed to allow participants to learn more about the background and emerging strategy, and to share their views on emerging thinking. More specifically, the aim of the engagement events was to:

— Test the thinking of the SE London Commissioning Strategy Programme to date
— Identify what local stakeholders agree with and what needs more work
— Understand where there is disagreement or a diverse range of views and where things are supported
— Identify what the key issues are
— Identify what further engagement would be helpful
— Identify who else we should be communicating with, and how.

OPM facilitated the event, with input from a Programme representative. The event mixed plenary sessions with facilitated table discussions. Clinical experts were at hand to give expert input on the emerging strategy, in particular the specific Clinical Leadership Group themes. The information provided at the event reflected early thinking of the Clinical Leadership Groups, which at that stage was still work in progress and subject to change.
The event had the following structure:

<table>
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<tr>
<th>Timing</th>
<th>Session</th>
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<tbody>
<tr>
<td>2.00pm-2.10pm</td>
<td>Welcome and introductions</td>
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<tr>
<td>2.10-2.20pm</td>
<td>Table introductions</td>
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<tr>
<td>2.20-2.45pm</td>
<td>Plenary presentation by Programme representative John Moxham, explaining background to the strategy, the vision for healthcare in SELondon and key elements of the Case for Change SELondon, followed by table discussions</td>
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<tr>
<td>2.45-3.30pm</td>
<td>Plenary presentation introducing the 7 emerging themes.</td>
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<td>- Planned Care</td>
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<td>- Cancer</td>
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<td>1st round of table discussions, where each table discusses 1 clinical theme (7 tables in total). Participants discuss whether the issues with the service area reflects their experiences of this health service in south east London, and whether they agree the thinking to date is covering the right focus areas.</td>
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<tr>
<td>3.30-3.45pm</td>
<td>Break</td>
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<tr>
<td>3.45-4.15pm</td>
<td>2nd round of table discussions, participants move to a different table, where they can reflect on and add to the points of a different clinical theme.</td>
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<tr>
<td>4.15-4.45pm</td>
<td>In a plenary session, each table summarises what they think are the main issues for improving health services in south east London that must be addressed within the 5 year strategy. This is followed by a brief response from clinical expert(s).</td>
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<tr>
<td>4.45-5pm</td>
<td>The next steps in development and implementation of strategy were explained, and how to stay involved in future.</td>
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Summary of the discussions

Extent of agreement with the case for change and strategy

Agreement with strategy

Participants agreed with most of what they had seen of the draft strategy. However, it should be noted that this agreement was strongly caveated with a need for more detail on some of the aims and with suggestions for additional focus areas.

The design of the event meant that participants saw a presentation on the Draft Strategy’s overarching case for change and were given the opportunity to choose two of the seven clinical themes to explore through table discussions.

Agreement with the case for change

This section documents participants’ discussions about the case for change presentation. Of the points raised in the case for change, the issues discussed below are those that received most attention in the table discussions, and were not yet going into detail on the clinical themes. Of note is the fact that the point about “needing to spend money wisely” was not really touched upon in these discussions.

Overall, participants broadly agreed that the case for change reflects their experiences. Because most of these themes were discussed in more detail later in the day, this section of the report just provides a brief overview of issues which received particular attention in this discussion.

Variability of quality of care across south east London. In primary care, participants felt that there can be a good deal of geographical variation. In secondary care, participants discussed variability between different hospitals, between different departments in the same hospital, and in the same department at different times of day. Some participants felt that there are areas and services where capacity issues need to be addressed, through staff training and recruitment.

Joined up working and continuity of care was discussed in various contexts, for example, transition from long-term conditions into end of life needs work; there could be more support mechanisms going from one into the other.

Participants felt that there are a number of untapped resources in the voluntary and community sector that could be used more effectively. This can lead to unnecessary duplication of some services and gaps in others.

Carers are not currently given sufficient recognition. Participants felt that they do not always get enough support to carry out their invaluable role. They are also sometimes left out of discussions about a patient which they could have contributed to valuably. As well as being friends or family members, carers often develop a good deal of expertise about the individual being cared for and their condition.
If **supporting people at home** is emphasised, some participants felt that there’s a need to enhance primary care, a need to attend to district nursing capacity problems and community care services. The shift into community care needs to be properly funded.

Some participants felt that there is a need to be more explicit about what **prevention** means; it’s not just about stopping people getting ill, it’s also about **stopping unnecessary deterioration of people with long term conditions** – especially mental health.

**Overarching themes**

This section discusses the most important themes in common across more than one of 7 clinical themes. The subsequent section contains a more detailed outline of the discussions that took place in relation to each individual clinical theme.

While participants generally agreed with the strategy documents, some noted that they lacked the detail necessary to make a clear judgement on the plans. The following points reflect substantive themes from the discussions that took place, not all of which directly fed back on the plans.

In a number of the discussions that took place, it was felt that **community and voluntary organisations have a significant role to play**:

- Some participants felt that these organisations can sometimes provide care directly, in place of existing NHS services. Examples of this include charities caring for people with dementia, or even providing cancer treatment.
- Other participants felt that these organisations could provide support in addition to existing services, for example providing additional signposting to patients, or support for carers.
- Healthcare professionals need to be made more aware of the support that is available, and need to be encouraged to signpost people to it more often.
- It was felt that the possibility of CVS contributions should be made explicit in the strategy, and there should be clear structures to facilitate their involvement. More funding needs to be directed towards enabling a greater CVS contribution, where appropriate.

Some tables discussed a need for increased **GP awareness** of certain issues relevant to their topic.

- GPs could be given better training and support to spot people with mental health problems, as early identification of these is currently not as good as it could be.
- GPs could be supported in developing a better awareness of cancer symptoms, to address current issues with poor diagnosis. It was recognised that there is a balance to be struck between under- and over-diagnosis.
- GPs could support patients before and after treatment more effectively if they had a better understanding of the treatment processes that the patient will go through.
There was however some discussion of the fact that GPs are already stretched, and so these aims may be hard or unrealistic to achieve without action to address capacity issues.

There was a good deal of emphasis on the need for **improved joined up working** and continuity of care.

- This is particularly important for people who suffer from multiple conditions, which is likely to increase with the ageing population.
- Some services felt that they would benefit from having care coordinators.
- Others supported the suggestion of having multidisciplinary teams based in primary care.
- Joined up working relies on high levels of mutual awareness between services, and GPs in particular need to be aware of which services their patient has dealt with.

Participants stressed the need for **care to be as accessible as possible**, particularly for ‘hard to reach’ groups.

- Healthcare services need to be flexible as not everybody is willing or able to access care through the same route. For example, it is not appropriate for all patients to make first contact via a GP.
- Various participants recommended the greater use of community pharmacies to provide information, signposting and care services.
- Participants expressed concern that current out of hours arrangements are variable in terms of coverage and quality. For example, out of hours support for carers and care homes is sometimes limited, and provision of senior level support in A&E is not considered sufficient in some areas.

Participants emphasised the need to improve the provision of **public and patient education** on a number of areas:

- There is a need for more work around helping the public to live more healthily, and providing them with the knowledge and encouragement needed for this. Examples include improving awareness of risk factors in pregnant women, and supporting adults to effectively support health in children.
- Some participants emphasised that prevention is also important for patients who already have a condition. This might be to find ways to stop the condition deteriorating, or to prevent secondary conditions developing.
- If the public are better educated about the full range of services that are available, they will be better equipped to make appropriate decisions about where to go for support. One advantage of this is that it would help to reduce the pressure on currently overburdened services such as GPs and A&E.

Participants felt that more emphasis is needed in the plans on **supporting and involving carers**.
— One issue which was raised was that carers sometimes find it hard to be involved in hospital based support that patients receive, and in getting information about the patient. If they were to be given more information (where appropriate) they could provide more effective support.

— Another issue is that being a carer can be very demanding, and it is important to provide support for their needs including mental health needs. At the children and young people table, it was discussed that some carers are children themselves, and therefore may need different types of support. Supporting carers is likely to also lead to better outcomes for the patient.

The strategy needs to more explicitly address support for patients at end of life and their families. This could either be in a standalone section, or integrated into the existing 7 themes.

— At both the ‘Cancer’ table, and the ‘Children and young people’ table, the need for specific end of life children's services was raised.

— There is need to support care homes to deal with complications at end of life to avoid unnecessary admissions.

— Participants felt that there is a need for more preventative methods to be used in a hospice setting, to avoid conditions worsening. There is need for more mental health support in hospices.

— Healthcare professionals need to be able to have honest and sensitive conversations with patients nearing end of life to ensure their needs are met and they have time to plan.

People thought that it is important to consider how public and patient engagement channels can be robustly build into the running of healthcare services.

— One suggestion was that every GP surgery should have its own patient involvement group.

— This should be proactively targeted to make sure that a wide range of views are represented.

Views on the 7 clinical themes

Primary and community care

There was broad agreement with the aims and elements of thinking in this service area, but patients provided more detail on the issues discussed below.

Participants at this table felt that hospitals are “sucking up resources” and agreed with the need to rebalance health services, and funding, so that more is dealt with at the primary and community care level.

While there may be a need for greater investment in primary and community care, work is also needed to make more use of existing local services (both NHS and from the voluntary sector) and ensure
people know they exist. In particular, GPs need to be more aware of what is available locally in terms of treatments, drugs and forms of support, so that they can signpost more effectively.

To make better use of existing services, participants felt that the strategy needs to focus on navigation of services, rather than just coordination, and highlighted the East London care navigators as an example of good practice. The care navigators have an excellent knowledge of what is available in a locality and can spend more time with patients than over-stretched GPs. However, some participants felt that while care navigators are important, GP advice can sometimes be more powerful as “doctors sometimes have more clout”. It is therefore important that GPs are in a position to signpost patients to what is locally available.

Some existing services were identified by participants as underused. In particular, community pharmacies are currently underused, but contain a wealth of specialist knowledge and offer useful services such as the New Medicine Service for patients with long term conditions who have recently been prescribed a medicine. Additionally, community pharmacies’ longer opening hours compared to GPs could increase the accessibility of primary care. It was felt that community pharmacy is “open to playing a bigger role” in delivering primary and community healthcare, and budgets could be shifted to this sector.

Participants agreed with the strategy’s emphasis on creating a more preventative health service which reaches out to people who are not yet ill, to protect their health and promote good health. They felt this preventative approach should encompass helping people manage their health to avoid reaching a crisis point, which is particularly important for carers who need access to support and information to ensure they perform their role better and for longer.

Promotion of healthy living should not just take place at GPs, as this is where people go when they are ill. Participants suggested health promotion needs to work across a series of community hubs, providing information and promoting behaviour change and awareness of services through non-clinical environments including faith settings, supermarkets, pubs, cafes and exercise groups. Promoting health in a range of environments is important as public education and behaviour change requires messages to be constantly repeated and reinforced. The ‘every contact counts’ initiative was cited as good practice in feeding in health and wellbeing promotion and service signposting at opportune moments.

Participants also felt that health promotion needs to be targeted effectively, including through the use of patient data to deliver targeted communications. Additionally, there was agreement with the strategy factsheet that services should reflect the people who live in South East London.

The importance of accessible communications in the NHS was highlighted by respondents, particularly for those who are deaf or hard of hearing. Reasonable adjustments for these people are still too variable, and a lack of comprehension due to hearing loss is often incorrectly attributed to other conditions such as dementia. Improving awareness and detection of hearing loss has knock on benefits
on healthcare and outcomes, but currently audiology is a low priority in the NHS, and patients struggle to get hearing aids and access follow-up support.

A greater role for patients in supporting and educating one another and inputting to GP practices was thought to be needed. Participants felt that each GP practice needs to be supported to set up good patient forums and patient participation processes to make the most of their input. The Heart Smart patient group for people who have had heart failure was cited as a good practice example, and Lambeth have an individual patient group in each practice, which was also felt to be effective.

GP access is a key challenge identified by participants, who felt that the availability of GP appointments is a longstanding challenge that has never been solved, which puts people off seeing their GP. Currently there is a lot of variation between practices and boroughs in terms of the ease of access and procedures for getting an appointment, which needs to be made more consistent and simple. GPs also need to be more transparent about access, as at the moment it is not always clear what the situation is. Participants identified issues with the current use of a phone triage service in some GP practices, which can mean people feel the practice is going out of their way to avoid seeing them, and increasingly do not expect to be able to interact with a GP.

To help address access issues, participants agreed that a shift towards multi-channel primary care would be beneficial – with email based service available for busy full-time workers and face to face appointments for people who prefer them. The group also felt that telehealth and Skype approaches to delivering care and support need to play a bigger role, as these can save time and resources and also better meet people’s needs in some circumstances.

More generally, participants felt that GP capacity problems need to be addressed, particularly due to the growing population. However it was noted that just increasing the number of GPs is not the ideal solution and there is a need to consider the role of other players in primary and community services. In particular, community pharmacies are thought to have a bigger role to play, while the number of nurse prescribers should be increased and awareness of them raised amongst others in the health system.

More coordinated and integrated services are needed, particularly in light of the ageing population, as the number of people with multiple conditions is increasing, but the standard (10 minute, one issue) GP consultation is ill-equipped to deal with this. Health professionals need to be much better at joining up and sharing information effectively, and participants were very keen on the idea of multi-disciplinary teams working in GP settings to provide holistic, joined-up care. Other ideas included the use of new technologies to support multi-disciplinary working (e.g. when undertaking case reviews), and the pharmacy medicine delivery service could be used to provide intelligence to GPs on patients who need help and support.

Participants highlighted a number of problems with the district nursing service. In particular, there is currently an undersupply of these nurses and the service faces challenges in recruiting and retaining them. Problems for district nurses arising from these capacity issues include having too many patients, meaning they have to be task focused, and not having time to do training, meaning they struggle to
meet continuing professional development requirements. Other issues discussed by participants relating to district nursing included support for the use of technology to organise and deliver care and questions about whether the acute sector is best placed to manage district nursing, as they may not have a good appreciation of the realities of delivering community health. Additionally, participants noted that parking is a key issue for district nurses that needs to be addressed, as their struggle to find parking is frustrating and wastes time and money. It is felt that the health and wellbeing boards should take on this issue and work with councils to ensure it is resolved.

**Children and young people**

Participants at this table broadly agreed with the proposals set out in the information sheets. However, they did make a number of additional suggestions, and added detail on some points.

One issue that some participants highlighted was the importance of ensuring that children’s **careers are supported in keeping children healthy**. It was felt that there is a need to provide feedback on a child’s health to their parents in a sensitive manner so as not to offend them. One approach is to combine feedback with education so the parents understand why the feedback is being given. For example, if a child is dangerously obese, it may be more effective to teach their parents about the dangers of obesity, rather than just saying that the child needs to lose weight. It was felt that parent education programmes should be considered as an important tool to make sure that parents know what they need to do to make sure their children stay healthy.

Participants felt that making sure that children are living healthy lifestyles should be an aim of the strategy, in addition to addressing their health needs more directly.

It was discussed that there is a need to **make sure that the community and voluntary sector is closely integrated in to children’s care**. This discussion came from the observation that a number of children’s services such as children’s end of life care are delivered with a lot of support from this sector. One way that was suggested to ensure good integration is to make sure that the CVS is closely integrated into GP hubs in the future. There is a huge amount of expertise in the community and voluntary sector which needs to be valued, and used as effectively as possible. Participants hoped to see more explicit reference to this in the strategy.

There is a need to **find ways to measure less tangible outcomes**. Some of the outcomes identified in the information sheets were felt to be very important, but hard to measure in a quantifiable way. An example of this is “making sure services are focused on the child”. It was felt that there needs to be significant thought into how these will be measured. One reason for this is that if they cannot be measured, it is hard to realistically include them in commissioning contracts, and they may therefore become secondary priorities. Many preventative outcomes, such as work that leads to healthy lifestyles can also be hard to measure, but are nevertheless very important. As a more general point, it was felt that it can be frustrating if very good work and initiatives are taking place, but the outcomes of these are not easily quantified. When designing the strategy, it is important to keep these “intangibles” in mind.
There is a need to respect patient identified outcomes. These were felt to be really important across children’s services, and it was argued that they need to be strongly emphasised in the plans. This is a good example of a “less tangible outcome”, as discussed above. In some situations, it can be important to consider the desired outcomes of a parent or carer as well as the outcomes desired by a child.

Participants felt that GP hubs are a useful idea, especially because they could lead to better coordination of care. A concern that was raised, however, was that these may not be the best way to coordinate care for all segments of the community. For example, some BME groups are less likely to access care though a GP than through other routes. It would be important to consider the needs of groups such as this, either by working hard to make the hubs accessible to them, or by making sure that complimentary coordination systems exist, and work well in parallel to the hubs.

The idea of there being “no wrong door” into NHS services for young people was felt to be a laudable aim. Participants were able to think of examples of how the current system leads to inequalities of care based on the type of initial contact. However, some participants questioned how easy it would be to put the “no wrong door principle” into practice. One challenge would be that it would be resource intensive to be able to provide a comprehensive assessment of need at all of the locations that first contact could be made, in order to ensure effective and appropriate referrals take place.

**Maternity care**

Participants at this table discussed a number of considerations they felt were important to consider with regards to planning for maternity care.

Need for focus on prevention of problems and early presentation. Participants discussed the need to raise awareness of risk factors such as obesity and diabetes, as well as issues of prospective mothers not presenting themselves to healthcare early enough in their pregnancies. It was felt there needs to be a focus on early presentation.

Communication about maternity care needs to be improved. It was felt that a clear public health message on the need for, and benefits of, maternity care would encourage early presentation. Making use of community and voluntary organisations to communicate with hard to reach groups was also recommended, and it was emphasised that such communication needs to be culturally sensitive and piloted to assess effectiveness.

There is a need to clarify the offer for transient communities. Participants recognised that not all groups can or will be served in the same way, with maternity services for mobile populations a particular issue. There is a need to create a much better offer for these communities from general practice and other services.

There was agreement with more midwifery led care: but is it realistic? Participants agreed, in principle, with increasing midwifery led care and having a named midwife, which they thought would improve understanding of the patient and women’s feelings of safety. However, they were unsure
whether this is realistic, suggesting that in practice this may be a healthcare professional that will see the patient at the majority of appointments.

One stop shop for maternity care a good idea – but flexibility needed. Participants saw the benefits of providing one place for women to talk about their options, but were unsure which place this should be. One suggestion was that either the GP or maternity services could be the first point of call, which could then ‘unlock’ the other services. It was noted that there needs to be some flexibility in this, to avoid alienating or excluding women for whom seeing a GP would be a barrier.

Mental health care needs much more attention in maternity care. Attention needs to be given to addressing the remaining stigma relating to the mental health needs of pregnant and post-natal women. Giving training to healthcare professionals was considered part of the solution to this issue.

Communication and joined-up working between services needs to improve, with GPs currently sometimes unaware whether their patient has already been to maternity services.

Cancer Care

In general, participants at this table agreed with the proposals set out in the information sheets. They added to and elaborated on the issue presented to them, as set out below.

Participants felt it was very important for there to be a focus on meeting the needs of cancer survivors, and not just patients in treatment, particularly since so many people now survive cancer. Follow-up care and rehabilitation services are currently considered patchy or bad, while community services are not signposted or referred to sufficiently. One participant cited Germany as an example of good practice in follow-up care, which is much better than England.

Additionally, the fact that many cancer survivors go on to develop a second cancer or a different health condition needs to be considered.

A need for joining up services for cancer patients (community, social care, primary care, secondary care etc.) and ensuring continuity of care was identified. Linkages between different services are currently poor, and each service often does not know what the others have to offer, leading to poor signposting for patients. It was also felt that GPs need to be kept up to date on their patients when the patient is in secondary care. The idea of introducing a care coordinator to address this issue was received positively by participants.

One participant from Bexley’s cancer services for children noted that adults’ cancer services are currently much worse than children’s, particularly in terms of continuity of care, and felt that their model of having the patient interact with the same team at all areas of the pathway and across all services, coordinated by a clinical nurse specialist was good practice.
It was felt that cancer services for children and young people need specific focus in the strategy, as these currently vary significantly across the boroughs, with no equity of service, particularly in end of life care.

Participants noted the need to raise awareness of cancer symptoms, among the both the general public and ‘hard to reach’ groups. In particular, it was suggested that people are often unaware of cancer symptoms such as loss of weight and appetite, which need to be publicised as not all patients have the main symptoms associated with a particular cancer. Campaigns such as the “blood in poo” campaign were considered very successful at raising awareness, particularly due to their clarity, and it was suggested that other symptoms could be publicised in a similar way. Additionally, alternative routes for raising awareness among hard to reach groups should be considered, for instance through pharmacies and churches.

Improving GPs’ awareness of cancer symptoms and ability to diagnose was a key need highlighted by participants. There is a need to educate GPs on the full range of cancer symptoms so they do not overlook these if the normal primary symptom is missing. Diagnoses should not be made based on only the single most common symptom for the particular cancer (e.g. blood in poo) as this does not occur in all patients.

In addition to the need for education and support through telemedicine, it was felt that current diagnosis problems are related to GPs being “overwhelmed” with work, and having to balance the risks of referring too many patients versus too few. It was suggested that the better use of telemedicine could be used to support GPs in diagnosing cancer.

To deal well with patients after they have been diagnosed, participants felt that GPs need to be more aware of the cancer treatment process their patients will undergo, so they can discuss this effectively with their patients and also to ensure they understand the situation patients are in when they see them again after their treatment.

As in other clinical themes, participants stressed the need in cancer care for increasing awareness and uptake of support from community and voluntary services. In particular, these services are thought to address many of the non-clinical needs where cancer patients and survivors currently lack sufficient support. It was highlighted that many such services are already available, but that GPs and other healthcare professionals need to be made aware of them and then act on this by signposting and referring patients. It was suggested that sometimes healthcare professionals are reticent to refer patients to community and voluntary services, and that training and education is needed to address this.

More generally, it was felt that the plan needs to recognise voluntary sector input, as currently they are an important part of the cancer care landscape and provide a large range of services including some acute interventions.

Providing effective support for carers was considered important by participants who felt they are not sufficiently considered in the current plans. One particular problem noted was that GPs and other health
professionals are currently unaware of services and support available to carers and are therefore not signposting to these. To address this, one participant suggested that GPs should be educated about the needs of carers and the services available, and also be provided with a wall chart of services available, which they could refer to and also give to patients.

**Urgent and emergency care**

There was broad agreement with the identified issues around Urgent and Emergency Care, with participants at the table being keen to add detail to some of the areas mentioned and also to highlight opportunities currently missed and best practice from elsewhere.

**On-call arrangements and access to diagnostic equipment.** The issue of hospitals currently lacking senior people on site at all hours was discussed, as although in theory consultants are available through on-call arrangements, evidence suggests that having consultants on site is better for outcomes. Concerns were also expressed regarding on-call arrangements of senior support for palliative care and nursing support for care homes, hospitals and in the community. Participants felt these were relatively understaffed and that nursing support in particular is not organised efficiently, which may lead to unnecessary emergency admissions.

Physician and patient access to diagnostic tests at all hours was also raised as a potential issue – because if this is not in place, patients may spend longer than necessary in A&E.

Participants were concerned that **care homes lack confidence, knowledge or support to deal with complications** in long term conditions, as evidenced by what they felt were unnecessarily high rates of A&E admissions from care homes. Often patients are admitted to A&E when they are dying and medical intervention is unlikely to be successful or desirable, or are readmitted to hospital due to a lack of support in the home. Care homes may need more knowledge and confidence and have better access to appropriate local and multidisciplinary help to deal with these situations more effectively.

More generally, participants felt that patients and carers (paid and unpaid) are given **insufficient support upon discharge from emergency services**, which may lead to unnecessary readmissions. It was suggested for example that the discharge pack provided by Southwark carers could be effectively given out on discharge if it was linked up with A&E services.

Participants felt that the **public lack awareness of the difference between A&E, urgent care centres and GPs** is an issue. Alternatives to A&E need to be effectively publicised, potentially through channels including school citizenship classes, first aid courses, other healthcare services and VCS organisations.

**Issues with out of hours care and A&E.** Participants recognised that extending GP opening hours could help reduce unnecessary visits to A&E, but this will only work if patients know which surgery to go to, and if this is easily accessible. Some suggested that a single 24/7 or extended hours GP service in a central location may be more effective than a rotating system between different GPs. Access to medicines was also identified as a key factor in out of hours care, as late night pharmacy services are
very spread out, meaning that urgent care centres must have access to drugs to reduce the burden on A&E.

Where patients requiring a GP do present at A&E, it was noted that a couple of hospitals have GP and urgent care services alongside A&E, to which patients can be directly referred, speeding up the process. Some places also have a senior consultant on triage, which is thought to speed this up and result in better decisions.

To ensure that appropriate referrals can be made, participants identified a need to educate acute care professionals about the range of community services available. Often these professionals do not have the knowledge or confidence of what is available to direct the discharge of people to these services.

For patients with long-term conditions who are already receiving social care, at home or in a care home, rapid access to services through initiatives such as Greenwich End of Life Care’s 24/7 Rapid Response Service work well to speed up the process and avoid A&E. Access to beds outside hospital was highlighted as a need for patients who need a bed, but not necessarily a hospital bed (e.g. hospice, care homes, mental health). For example, the Great Western Hospital commissions beds from the Prospect Hospice. This approach can avoid hospital admissions and facilitate discharge, while also addressing the issue of elderly people often leaving hospital less well than they were before the acute incident.

Finally, respondents stressed the need to avoid perverse incentives in service commissioning. Current examples of these include Bexley patients calling the emergency night service for a catheter change as the regular evening service lacks capacity, as well as the London Ambulance Service not responding if someone with poor mobility needs moving from one room to another, but they are able to take them to hospital and back again to the required room.

Planned care

Central to many of the discussions about planned care was the importance of support for patients outside of the core clinical disciplines. Within planned care, the focus of the strategy should be on creating networks of support organisations which can provide care within patient’s planned care rather than them adding bits of support as and when possible.

Flexible pathways to care. The group felt that it is important to recognise that each person has their own complex needs and that these need to be met in a way that still allows for some standardisation. The group felt that defining care pathways within planned care is difficult because each patient has unique needs and unexpected circumstances can cause the plans to change. There is a necessity for the health system to use standardised approaches to develop flexible pathways which suit each patient e.g. a flexible mould for each patient’s care.
The pathway from diagnosis to treatment to aftercare needs to also include consideration of the times between each stage – it is in these gaps that there is a big opportunity to improve patient experience. This could include reduced waiting times, improved information or clarity over the next stage.

The group felt that the strategy needs to make room for inclusion of actual long term plans for each patient to provide them with clarity over the steps they will be moving through, e.g. a discussion of the kind of life they want to lead around and after treatment. However, the group also felt that there should be some standardisation around outcomes and expectations – this would underpin the treatments and ensure quality of care across the system.

The nature of planned care means that changes to a plan are likely, whether through additional medical issues or delays on the part of the practitioners. There was consensus that these changes are predictable to an extent – there is a known probability of medical complications and there should be allowances built into the plans, to avoid the need to entirely redesign a plan if a difficulty arises.

The group agreed that there is a significant role for additional support and social services to be delivered alongside the core clinical work for planned care. The strategy needs to ensure that this support is integrated into a coherent plan alongside clinical care. There was agreement that this approach could increase the quality of care while reducing the cost. The additional care does not need to be delivered by clinical experts, instead it can be delivered by support experts.

The sources of additional support should include friends, family and carers, charities and community organisations. Family and friends require support to provide this support. Bringing in other organisations needs to be done in a formal and strategic way, building formal networks of support organisations who can be brought into support each patient, rather than each patient having to find their own support. Additional support should also be provided to family and carers who are involved in the process. Whether they are providing support to the patient, or providing care in a more formal capacity they need to understand the planned care process and how they can be involved.

Access to planned care is contingent on knowledge and awareness of care pathways and options. At a simple level, the group felt that education and awareness is necessary for patients to choose the appropriate diagnosis, treatment and care options. There was broad agreement that increased education will help with the preventative care aspects, allowing patients to quickly access diagnosis and enter a treatment plan. On a deeper level, there is education and training which would enable the patients and their carers to better take advantage of the planned care process. For example, support for how to develop an appropriate care plan, navigate the options, and manage practitioners to deliver the plan. This kind of support would not only directly improve health outcomes by ensuring appropriate treatment, but it also gives indirect benefits to in patient wellbeing through being involved and confident with their care plan. The table expert noted that this is already being considered in the separate supporting part of the strategy.

Participants felt that for many of their suggestions, it is necessary to provide training to the people involved.
The key requirement for the health practitioners is to be able to identify and provide flexible care plans which include both clinical and non-clinical support. There is also a need for them to be able to respond to changes and manage patient experience throughout the process.

As mentioned above, patient support to manage their planned care is key. Significant health issues can occur when a patient undergoes excess stress due to the uncertainty of their planned care.

While innovation was welcomed, without more details participants were not convinced it would be realised. There was agreement that where tried and tested methods for treatment where available these should be relied upon. They should be integrated into a standardised offering for all patients where appropriate. Innovation is potentially in conflict with attempts to reduce variation and improve consistency of care – the nature of innovation means trying out new methods and this is likely to result in variation across areas.

**Long term conditions: mental and physical health**

Participants at this table generally agreed with the CLG’s aims for long-term conditions. Most of the discussions took centred around more concrete aspects of each of these aims, e.g. improvements that needed to be made to support these aims.

There was agreement on the importance of detection and prevention for long term conditions. To support this, there was a discussion around whether the range for health checks currently right (currently it’s 40-74 – one stakeholder said for men it should be from 30 up). Participants saw a need for concrete plans explaining how to get more people to take part in health checks. A good practice example raised by the group was the setting up of a mobile clinic to do checks outside of a local Morrison’s.

There was concern that lifestyle issues should be addressed earlier on, before they become long-term conditions, and this is not done sufficiently. People felt that GPs have an important role in this, and questioned why it is not happening more already. They felt that individuals should be given more frank information about risks of their lifestyles earlier on.

The group felt that early detection work can be improved by getting services to work together more. For example screening for alcohol, drug issues in health checks, or assessing people’s depression, mental health when they come in for long-term physical conditions. Then treatment of one can occur alongside the other, which was felt to be a far more successful model. ‘Making Every Contact Count’ was felt to be a really important idea. This should not just be GPs, but should include other organisations such as community pharmacies.

The group felt that to improve prevention and early detection, more focus is needed on outreach into the community, and services should be designed around the community rather than the hospital. Outreach services should come to the individual and not expect the individual to go to the services, e.g.
GPs. Good examples of this currently happening included having nurses in shopping centres, and GPs going into care homes.

The group felt that **more work should be done with the Community and Voluntary Sector (CVS).** There was wide agreement that this sector is very important in the long-term conditions field, and is already a great asset in South East London. Participants felt that CVS organisations are sometimes better placed and have better expertise than their NHS equivalents. The focus should be on how to work more effectively with these organisations, and more services should be sourced from them. The group felt that this would require a culture change in the NHS, to change existing attitudes to CVS organisations. Participants also felt that there are currently organisational barriers to collaborative working with CVS orgs, and that these need to be removed. An example of good practice comes from Tower Hamlets, where there is a centralised directory of available services so that NHS staff know who can be referred where. It was suggested that councils should have information hubs in the community, e.g. in shopping centres, where people can explain CVS services.

**Community pharmacies** were seen as crucial in long-term care. All people with long-term conditions take medications, which they get from their pharmacies- whose staff often know all the patients by name. These staff are well placed to provide additional care, such as flu jabs, and regular health check-ups, to reduce pressure on GPs. Better information sharing between these pharmacies and other parts of the NHS needs to take place.

Participants felt that the aim of having “**engaged and supportive communities**” is currently a little vague. They hoped that it referred to informing communities as well as engaging them in decisions. There is a need to make sure that engagement is inclusive, rather than just involving the “usual suspects”. This may require proactively seeking out the views of certain groups. Lewisham’s pensioners’ forum was cited as a good example of a way to help community’s become more supportive.

There was some confusion about what the aim of having “**involved and informed patients**” meant. Some thought it referred to patients being involved in overall service design. Others thought that it meant that patients need to be involved at an individual case level. The group thought that both aims were important, and need to be addressed separately. However, it was felt in on an individual level, it is also important to inform non patients, in order to promote healthier lifestyles as an important part of the prevention of LTCs.

The aim of having “**adaptable and capable staff**” was also felt to be a little imprecise. Participants were not sure exactly what it meant. There is a need to clarify how it will be ensured that staff are adaptable and capable. Participants identified a need for an ethos of care and to invest in staff. They also felt that this goes together with integration. If staff have broader skillsets, this could cut down on extra visits/interventions. E.g. a social worker would be able to do some tests themselves without the need of a District Nurse. However, they also felt that this approach would not always be cost effective or ideal, for example where a particular task can be done more effectively by a specialist.
Appendix I. Participant feedback on the event and future involvement

Participants had the opportunity to provide us with their feedback on the event. A total of 21 participants filled in the form, of which the following is a summary.

<table>
<thead>
<tr>
<th>Question</th>
<th>Average response:</th>
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</thead>
<tbody>
<tr>
<td>I know more about the SEL 5 year commissioning strategy</td>
<td>Tend to agree (4.2)</td>
</tr>
<tr>
<td></td>
<td>No respondents disagreed with this statement.</td>
</tr>
<tr>
<td>There was enough time for me to say everything I wanted to</td>
<td>Tend to agree (4.3)</td>
</tr>
<tr>
<td></td>
<td>One respondent tended to disagree.</td>
</tr>
<tr>
<td>It is clear to me how the results of this process will be collected and used</td>
<td>Tend to agree (4)</td>
</tr>
<tr>
<td></td>
<td>Two respondents did not know.</td>
</tr>
<tr>
<td></td>
<td>Two respondents tended to disagree.</td>
</tr>
<tr>
<td>I feel confident the results of this event will make a difference</td>
<td>Tend to agree (4.2)</td>
</tr>
<tr>
<td></td>
<td>Two respondents did not know.</td>
</tr>
</tbody>
</table>

Table 1: Initial questions. Respondents asked to state to what extent they agreed or disagreed with a statement. 1 = strongly disagree, 2 = tend to disagree, 3 = neither, 4 = tend to agree, 5 = strongly agree

Who else would it have been useful to have in the room today?

— Health professionals e.g. GPs, health support staff, midwives, community nurses
— Voluntary sector and faith/community leaders
— More patients from south east London, particularly from ‘hard to reach groups’
— Representatives from police/ refugee organisations
Jeremy Hunt

What further engagement would be helpful in the development of this strategy?

It was felt more people should be involved in the engagement process including going directly to NHS workplaces, asking more representative groups of the population and engaging with those that currently do not use the service but will in the future.

Feedback from the meetings being held should be given locally as well as through email updates. This should include what points have been taken into account and what has been done about it.

“Developing a strategy is one thing but implementing it is another, so it would be useful to include these kinds of meetings in every step of the implementation of these strategic points.”

Who should we be communicating with, and how?

General public: including young people and hard to reach groups through public forums, public places, places of worship and community groups e.g. focusing on housing/policing rather than health.

Health professionals and patient groups: including people directly treating patients and employees at NHS workplaces.

Voluntary sector: including engagement with the six voluntary councils.

One respondent noted a ‘Community Conversation’ group in Lewisham: Downham Nutrition Partnership.

If we run similar engagement events in future, is there anything we could do differently?

In addition to expanding time, more user involvement from the children’s sector and having a separate session for patients/general public were recommended.

Events focusing on a single issue where the strategy will be implemented was suggested, as well as looking at research on good practice projects to implement.

Other suggestions include: a greater focus on outcomes including how the outcomes of the event feed into the strategy, having more of an outline about the whole strategy and having a podcast.

Extra comments:

— Concern that end of life care is not being looked at
— More emphasis on diagnosis and pre-care aspects of health
— Focus more on innovative projects
— Focus on preventative healthcare – mobile health education
Structured well and interactive session. Facilitated well!

Do you have any reports or research you think should be considered in creating the SEL commissioning strategy?

- HIN workstreams/ HESL strategy
- Supported employment
- Together for Short Lives needs data/research around the number of children with palliative care needs
- TOPAZ is evidence of good practice in Lambeth
- Utilise assets in south east London research on use of open spaces in preventive healthcare (University of Edinburgh)
- Mindfulness
Appendix II. Presentation

Slide 1

Shaping health services in south east London

South east London five year commissioning strategy
Local stakeholder engagement event
3 June 2014, Park Plaza Victoria

Slide 2

WELCOME

Slide 3

We want to hear your views

• To inform the development of the five-year south east London commissioning strategy

• To test our thinking to date, find out:
  – What you agree with
  – What’s missing
  – What needs further discussion

• The local stakeholder events on 3 June and 18 June are part of a wider local engagement process
Slide 4

What will happen to your feedback

Where does it feed into?
• The feedback will be considered by the programme as part of further development of the strategy and the programme

When can people expect a summary report?
• Summary report will be produced at the end of both events and by the end of June 2014
• Programme will respond with a ‘you said, we did’ report in July 2014

Slide 5

For further information

Contact person:
Patsy Ryan
Strategic Communications Adviser
M: 07896 145749
E: patsy.ryan@nhs.net

Slide 6

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>1.30-2.00pm</td>
<td>Welcome and Registration</td>
</tr>
<tr>
<td>2.00pm</td>
<td>Start</td>
</tr>
<tr>
<td></td>
<td>• Welcome &amp; introductions</td>
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<tr>
<td></td>
<td>• Setting the scene</td>
</tr>
<tr>
<td></td>
<td>• Round I - Discussing the clinical themes</td>
</tr>
<tr>
<td>3.30pm</td>
<td>Break</td>
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<tr>
<td></td>
<td>• Round II - Discussing the clinical themes</td>
</tr>
<tr>
<td></td>
<td>• Rounding up the main emerging themes, issues and questions for improving health services in south east London</td>
</tr>
<tr>
<td></td>
<td>• Next steps</td>
</tr>
<tr>
<td>5.00pm</td>
<td>Finish</td>
</tr>
</tbody>
</table>
Housekeeping & Ground Rules

- Respect other people’s opinions
- Do not speak when someone else is speaking
- Listen actively
- Give everyone a chance to contribute and encourage others to do so
- Ask when something isn’t clear
- Breaks when necessary
- Mobile phones off or on silence

Introductions

SETTING THE SCENE
What is the five year strategy?

- A new 5 year commissioning strategy for health services across south east London
- To improve health services for everyone in Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark
- Addressing issues that cannot be solved by one area alone or where there is more that can be achieved by working together

Who is involved?

- Six NHS organisations (Clinical Commissioning Groups – or CCGs) in south east London
- NHS England (London)
- Shaped by 7 Clinical Leadership Groups (CLGs)
- In close partnership with local authorities, providers of care and other partners
- Patient and public voice

How are we doing it?

- Listening to local voices and building on work at borough level
- Involving partners, patients and communities
- Focusing on improving health and reducing inequalities
- Building a common understanding of the scale of the challenge and a shared vision and ambition for the next five years
- Being open and transparent throughout the process
- Working with the Health and Wellbeing Board in each borough
Health outcomes in south east London are not as good as they could be:

- We don’t treat people early enough = early deaths and preventable ill health
- Health outcomes vary significantly from area to area
- High quality care is not available all the time
- Experience of care is very variable
- Care is not joined up
- The money for the NHS is limited and need is increasing

The longer we leave these problems, the worse they will get; we all need to change what we do and how we do it.

What are we trying to achieve? (1)

- Supporting people to be more in control of their health and have a greater say in their own care.
- Helping people to live independently and know what to do when things go wrong.
- Making sure primary care services are consistently excellent and with an increased focus on prevention.
- Reducing variation in healthcare outcomes by raising the standards in our health services to match the best.

What are we trying to achieve? (2)

- Developing joined up care so that people receive the support they need when they need it.
- Delivering services that meet the same high quality standards whenever and wherever care is provided.
- Spending our money wisely, to deliver better outcomes and avoid waste.
Slide 16

**Your experiences**

At your tables, please discuss:

- Does what you just heard reflect your experience of health services in south east London?
- Are there any other important issues we missed?
- Are there any good practice examples that you would like to share?

Slide 17

**7 CLINICAL THEMES**

Slide 18

**Clinically driven strategy**

- 7 Clinical Leadership Groups (CLGs) working on the south east London five year commissioning strategy.

- The groups include senior experts from south east London’s health commissioners, NHS organisations, social care services, public health services, Healthwatch and patient and public voices.
Slide 19

7 service areas

1. Primary and community care
2. Long term conditions - physical and mental health
3. Planned care
4. Urgent and emergency care
5. Maternity
6. Children and young people
7. Cancer

Slide 20

Round I

At your tables, please discuss:

1. Do the issues with [service area] reflect your experiences of this health service in south east London?
2. Emerging elements of Clinical Leadership Group thinking to date: which do you agree with and why? Is anything missing and why?
3. What other information should be taken into account in developing the strategy on this theme?

Slide 21

BREAK
Slide 22

Round II

Move to another table, discussing a different clinical theme.

At your new table:
• Review what’s already been said about this theme
• Discuss and add any observations, issues or questions

Slide 23

Key issues

• What are the main issues for improving health services in south east London that must be addressed within the 5 year strategy?

Slide 24

NEXT STEPS
Next steps

• Further development and implementation of strategy
  – Test proposed design through further engagement with stakeholders and public
  – Refine design and how it may change the way services are provided and the way we interact with them

• How to stay involved
  – Further stakeholder events to be arranged
  – Contributing to future engagement activities

Next event

Wednesday 18 June 2014
(Charlton FC, Greenwich)

THANK YOU!
Appendix III. Info Sheets

This section contains the information sheets provided at the 3 June event. Please note these reflect early thinking of the Clinical Leadership Groups, at that stage still work in progress and subject to change.

What is a Clinical Leadership Group?

There are seven Clinical Leadership Groups (CLGs) working on the south east London five year commissioning strategy. They each develop plans for the seven clinical elements of the strategy. They look at health and services across south east London.

Members of the clinical leadership groups include senior experts from south east London’s health commissioners, NHS organisations, social care services, public health services, Healthwatch and patient and public voices.

Each group is a clinical or expert-led working group. They work to develop a view of what services in south east London would need to look like in five years time to achieve the aims of the commissioning strategy. They also assess the impact of any proposals they may be making on other parts of the health and social care services in south east London.

They cover the following service areas:

1. Primary and community care
2. Long term conditions - physical and mental health
3. Planned care
4. Urgent and emergency care
5. Maternity
6. Children and young people
7. Cancer
Cancer care

Services used by people who have, or may have, cancer.

What is already done well in south east London?

— There has been a steady decline in the number of people dying from cancer in south east London as well as in London and England as a whole.

— An Integrated Cancer Centre has been formed to combine ground breaking cancer research with first-class clinical care for cancer patients.

What are the challenges in south east London relating to cancer care?

— Cancer is one of the biggest causes of early death. Whilst there have been some improvements across the six boroughs, the number of people with cancer is still above the national average.

— Some people with cancer waited for longer than they should have done for their first hospital treatment. We need to look at why and what we can do about this, as early treatment is best for helping people with cancer to recover or live longer.

— There is a big difference in the services offered to cancer patients between the south east London boroughs.

What are the Clinical Leadership Group's aims for cancer care?

— The CLG will look at what cancer services in south east London will need to look like in five years time to meet identified needs and consider the impact of:

— Delivery of the London Cancer Strategy

— Making every contact count - so this is the focus across the whole system

— Improving screening and early detection

— Transforming end of life care

— Improving the support given to carers

— To improve support for those patients cured and living with cancer and those with complex needs as a result of their cancer or cancer treatment.

What are the key elements of the thinking to date around cancer care?

— We should focus more on ways of preventing cancer such as targeting hard to reach groups.

— There is a need to implement best practice commissioning and clinical pathways where they are agreed (dependent on cost) across south east London providers (including GP access to diagnostics).

— The time it takes from urgent GP referral to first treatment should consistently meet national cancer waiting time standards with a focus on reviewing any long waits (over 100 days).
— Information sharing should be agreed to support seamless patient care.
— Non-complex chemotherapy should be provided closer to home.
— The number of patients discovering they have cancer after going to A&E should be reduced.
— Cancer should be recognised as a long term condition and managed by Primary and Community Care.
— Early identification of patients approaching end of life to plan better and support more patients to achieve their wishes.
— Develop the right workforce to provide support in the right place whether hospital, hospice or community/primary care.
— Improvements in patient experience across the NHS.
— Understand and target interventions around cancer inequalities e.g. late diagnosis, healthy lifestyles.

Children and young people

*Services used by children and families.*

*What is already done well in south east London?*

There are signs the number of young people smoking is decreasing.

New initiatives in the area, including partnerships, are already beginning to show promising results, these include:
— Psychiatric Intensive Care Units network
— Neuro-disabilities network
— Health Visiting Expansion Programme
— Borough, Primary and secondary care beginning
— Lambeth Early Intervention Partnership (LEIP) 0-3s – building relationships
— New diabetes pathway: Kings, Evelina and Lewisham hospitals
— Payment by Results
— Neo natal: funded clinical networks avoid silo activity

*What are the challenges in south east London relating to children and young people services?*
— The number of children in south east London aged 0-14 is set to increase to 356,000 by 2021
— There are a significant number of children and families in south east London who live on lower incomes, which can impact negatively upon their health
— Many children in south east London are classed as overweight
— Many young people suffer from undiagnosed mental health problems
— The number of teenage pregnancies in south east London is higher than the national average and many of these mothers find it harder to stay healthy and to keep their children healthy.

**What are the Clinical Leadership Group's aims for children and young people services?**

The CLG will work to:
— Deliver and understand the impact of delivering the London Quality Standards for paediatric emergency care.
— Consider local borough-driven plans for children and young people and identify what overarching standards and outcomes should apply across south east London to drive better outcomes for children and reduce service demand.
— Identify whether there are any key pathways requiring a consistent approach at south east London level, based on need, volume or other criteria – for example, pathways for children with complex long term conditions and children with long term disabilities.
— Recognise London-level work in specialist paediatrics (e.g. paediatric cancer services) and, if appropriate, be clear on south east London’s response.

**What are the key elements of thinking to date around children and young people services?**
— All services should focus on the child with an emphasis on prevention and early intervention. For instance, GP Community Hubs should enable access to community based services and urgent care.
— Improved access to healthcare services for children and young people - there should be “no wrong door”.
— A focus on managing long term conditions with common, transparent pathways for asthma, diabetes, autism etc. across south east London. This will be supported by Community Child Health Teams, including specialist nurses and improved working between community, acute and specialist services both to avoid admissions and support earlier discharge home from hospital.
— Reduction of avoidable hospital admissions through effective assessment and coordination.
— There should be a greater focus on mental health and the changes to adult care.
— System-wide partnership working that reflects local plans and extends and builds on existing networks.
Long term conditions and physical and mental health

Our ambition is to ensure that high-quality integrated care is available to high-risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems). Effective working between health, social care and third sector providers will prioritise the needs of individual citizens and enable them to be active and to feel well-supported in their own homes wherever possible.

What is already done well in south east London?

— In some parts of south east London, health and social care services already work well together to make sure people have all the right services at the right time in their homes. This means more people can stay at home and be properly cared for and it also means they can be discharged from hospital safely and more quickly.

— South east London’s mental health services are among the best in the country at making sure people with mental health problems have their care plans looked at and regularly updated, ensuring that people continue to get the right care and help for their problems.

— All boroughs within south east London are already driving forward their own programmes that focus on providing integrated care for patients with long term conditions e.g. Greenwich’s ‘Pioneer Project’.

What are the challenges in south east London relating to long term conditions?

— Patients tell us that their care is not joined up between different services.

— Older people often have more than one health problem and need more than one kind of health service to help them. This means that health and social care providers need to work together to ensure an effective service.

— There are many people with mental health problems in south east London. People with very serious mental health problems often die sooner than they should and patients with a physical long term condition may also develop mental health problems such as depression.

What are the Clinical Leadership Group’s aims for long term conditions?

The aims for the CLG are to have:

— A relentless focus on the health and wellbeing of people with long term conditions and physical and mental health problems

— Involved and informed patients

— Engaged and supportive communities

— Adaptable and capable staff

— Services designed to meet individual patient’s needs

— A flow of information about patient care between service providers
— Addressing the culture change that needs to go hand in hand with IT and information governance sharing

**What are the key elements of thinking to date around long term conditions and mental health could we make?**

— Patients and carers should be told about their care and be involved in making decisions with care plans developed by and with them, to support them to stay independent and active.

— Engaged and supportive communities have been shown to be better at helping patients to continue to live at home.

— Adaptable and capable staff should work together between hospital and community services, mental health, social care and the voluntary sector to provide joined up, flexible assessments and care packages.

— Services should be designed around what individual patients need. They should have a named care coordinator which may become a more specialist role as the patient’s needs become more complex, to ensure services are delivered effectively and to encourage patients to participate in their care.

— Multi-agency designed patient care should include health, voluntary, social and local authority sectors and enable all patients to self-manage better.

— Information should be shared between providers to support coordinated care and identify patients before something goes wrong.

— IT systems can help in sharing health information and allowing patients to manage their own care.

— Services should respond quickly to patient needs.

**Maternity care**

*Services that women and their families use when they are expecting and having a baby and afterwards.*

**What is already done well in south east London?**

— There are four midwifery-led birth centres co-located with hospital maternity services, a popular option for many women.

— There are well-developed Maternity Services Liaison Committees across south east London which work closely with maternity services, improving patient services and influencing decision-making.

— There is an availability of multi-disciplinary specialist clinics such as diabetes and HIV, with access to excellent sub-specialist consultants across all south east London maternity services.

— South east London has higher home birth rates than elsewhere in London.
What are the challenges in south east London relating to maternity?

— No hospital in south east London fully meets the London maternity standards for safety and quality in maternity services.

— There is a rising birth rate with more complex pregnancies resulting in more women at higher risk. This is due to a number of factors such as an increase in multiple births, obesity and diabetes and more women giving birth at an older age.

— There are not enough trained maternity staff in south east London for the number of babies being born, due for example to an aging midwifery workforce, recruitment competition across London and skilled people leaving London to work elsewhere in the country.

— Some patients were not happy with staff attitudes in postnatal wards, and complained about issues including pain relief and breastfeeding advice and support.

What are the Clinical Leadership Group's aims for maternity care?

The CLG aims to:

— To place the needs of women and their families at the centre of maternity care supporting choice of place of birth and continuity of care.

— Support women to have a normal birth, in the right location for them.

— Ensure that services are as safe and effective as possible and that women, who need it, have access to the highest quality medical and specialist services.

— Develop services and a workforce that promote healthy lifestyles.

— Propose appropriate models of care and determine the impact of implementing the London Quality Standards and the work of the London Strategic Clinical Network for Maternity Services.

— Ensure effective use of existing services and consider workforce issues and outcome measures.

— Include in-scope, neo-natal services and perinatal and postnatal mental health.

What are the key elements of thinking to date around maternity care?

— Maternity services should work in conjunction with primary care, public health and others to promote early antenatal booking and health information to improve awareness of problems in pregnancy and the impact of lifestyle choices.

— Every woman should have a named midwife responsible for ensuring that she has personalised, one-to-one care throughout pregnancy, childbirth and the postnatal period.

— Newly pregnant women should only have to go to one place to find out about their options and choices before their first antenatal appointment.

— Home births should be promoted to low-risk women who have already had a baby.

— Birth centres should be promoted to low-risk women having their first baby.
— Developing more specialist midwifery teams that offer enhanced midwifery and multi-disciplinary team support for high risk women.

— Standardising health records and other information across all south east London maternity services to support information sharing between maternity services.

— Midwives based in communities should talk to GPs and health visitors in their local area often.

— Increase the level of timely identification, referral and access to specialist services for those women with high risk or complex needs.

Planned care

*Care that takes place when people are offered treatment and there is a pre-planned way of carrying out this care.*

**What is already done well in south east London?**

The South East London Community Based Care Strategy has delivered significant progress across planned care. For example, Lewisham CCG has transformed its diabetes pathway making it easier for people with diabetes to get the different types of care and support they need.

**What are the challenges in south east London relating to planned care?**

Many people would like to have more control of their own health and do more to care for themselves. We need to help people to understand their own health problems better and to learn how to keep as healthy as possible or to avoid getting ill.

**What are the Clinical Leadership Group's aims for planned care?**

The CLG will address variability in quality, outcomes and access by:

— Sharing standards for elective care across south east London, encompassing referral management, a strategic approach to treatment access and key pathways

— Proposing high quality sustainable solutions for diagnostics in south east London, including for both direct access and consultant-referred activity

— Defining a proposed elective model for south east London that delivers high quality elective care at the right capacity to meet local need in a sustainable way

— Reviewing innovative contractual and payment mechanisms to support delivery of any agreed models.

**What are the key elements of thinking to date around planned care?**

— Patients and professionals should be encouraged to make more detailed plans for both before and after an operation.
— There is a need for greater use of innovations in areas including: Referral Management Systems; Decision Making Tools; Smart Contracting; and Diagnostics

— The standards of elective care should be the same across all areas of south east London.

— Patients should feel they have the knowledge and power to make decisions about their own care.

Primary and Community care

*The care given by GPs, pharmacists (local chemists), opticians and dentists.*

**What is already done well in south east London?**

— South east London already provides a great deal of good care in our local communities that would previously have taken place in a hospital. These include audiology services for over-50’s and skin clinics.

— These community-based services are easier for people to get to, provide the same or better quality care and free up our hospitals for the people who need them.

— The south east London Community Based Care Strategy is already working on making primary and community care better for everyone, for example by planning ways to make sure more people can get to see their GP when they need to without waiting.

**What are the challenges in south east London relating to primary and community care?**

— Many patients say they find it hard to get an appointment with their GP in some parts of south east London. Sometimes this is because it is hard to contact them. Sometimes it’s because GP’s surgeries are not open when people need them.

— There is also a variation between the standards of GP practices, with some shown to be much better than others at improving their patients’ health.

— Less is spent on primary care services in south east London than in some other parts of the country.

— The population of London continues to grow, with both more people choosing to live in the capital and prolonged life expectancy for older residents. This means that more people are living for longer with health problems, and consequently, that we need more GPs and other professionals such as pharmacists, opticians and dentists who can help with health problems in their local communities.

— Many people would like to have a greater involvement in their own health care and do more to care for themselves. We need to help people to understand their health problems better and to educate them about how to keep as healthy as possible or to avoid getting ill.

**What are the Clinical Leadership Group’s aims for primary and community care?**

— The CLG aims to integrate primary and community care so that services:
— Are generalist-led and clinically-driven from the bottom up
— Put patients in control (e.g. shared decision-making)
— Re-establish primary and community care at the heart of the NHS system and make primary and community care services more attractive places to work
— Keep what works well (but may be better configured) to deliver an increased range of services to patients and reduce variation in access and quality
— Integrate with other services on a population health basis
— Provide accessible care 24/7 where appropriate.

*What are the key elements of thinking to date around primary and community care?*

— Services should be provided by a ‘care team’. This includes people working in general practice, community services, social care, mental health, pharmacy and specialist care.
— There should be more services available outside of hospitals.
— These services should reflect the kinds of people who live in south east London.
— Services should be flexible enough to respond to individual patient needs.
— Service providers will become increasingly dependent on each other and thus will need to learn to work more effectively together.
— More care should be based on networks of practices, aligned to and providing the platform for integrated care systems.

**Urgent and Emergency Care**

*All the services people use when they have had an accident or become suddenly very ill.*

*What is already done well in south east London?*

— Recent changes to the London trauma system have already transformed the treatment of people who suffer a serious injury or major trauma and who need high quality, specialist care to give them the best chances of survival and recovery. At the end of the first year it was estimated 58 Londoners were alive who would otherwise have been expected to die of their injuries.
— Other significant programmes of work are underway across the capital to improve services for urgent and emergency care.

*What are the challenges in south east London relating to urgent and emergency care?*

— Not all our hospitals have their most senior doctors working at night and at weekends. We need to improve this so that people have the best care as soon as they need it in hospital, whatever day or time it is. This would mean changes in the way hospitals work.
— No hospital in south east London fully meets the London standards for safety and quality in emergency care.

— Many people are calling 999 or going to A&E instead of using other urgent care services outside of hospitals. This means many people are going to A&E unnecessarily when other more suitable care is available.

**What are the Clinical Leadership Group’s aims for urgent and emergency care?**

— Our plans for urgent and emergency care will look at variations in quality and outcomes for urgent and integrated care; the reasons for any poor experience of services and the need to meet rising demand in a sustainable way. It will determine the impact of:

— Implementing the London Quality Standards for acute care

— The London response to the Urgent and Emergency Care (Keogh) Review

— Recommendations on 24/7 working in urgent and emergency care

— Testing and challenging any proposed scale and ambition.

**What are the key elements of thinking to date around urgent and emergency care?**

— There is a need for Long Term Condition Management in the community to avoid unnecessary attendance at A&E. This would involve:

— Rapid Access Services – bringing the urgent care into the home and offering specialist rapid response clinics, probably located in a hospital to ensure access to diagnostic services;

— Assessment and some treatment;

— More care provided in community settings, such as care homes and general practices;

— The relationship between acute and community providers needs to develop so that care homes and other community services have the confidence to retain patients where appropriate, rather than admitting them to hospital by default.

— People should only be admitted to hospital for the time it takes for their care to be delivered. They should then be able to return home as soon as they are ready to do so. We should aim to reduce the length of stay.

— Health and social care services should be delivered together outside of hospitals with clear paths for patients to follow.

— The professional who has originally referred the patient to hospital should be the person who decides when the patient is ready to return home.
Appendix IV. Best Practice Examples

The examples that participants raised at the 3d of June engagement event did not always relate to the theme of the discussion that they were having. These have therefore been grouped thematically, rather than according to the discussion that the example originated from.

**Urgent and emergency care**

— The Royal London and Charing Cross hospital both have GP/Urgent care services alongside A&E. If you wait at A&E and need a GP you don’t wait twice – they cross refer and can call on each other for help.

**End of life care**

— Greenwich End of Life Care have a 24/7 Rapid Response Service which works very well.

— The Great Western Hospital successfully commissions beds from Prospect Hospice for those patients who fit the hospice’s criteria.

**Integrated care**

— Diabetic foot clinic for A&E in Kings College Hospital. This is good because they look at the interrelated needs of whole person, not just their foot. A good example of holistic care. They are also good at keeping the patient informed about what will happen to them next.

**Long term conditions**

— The Netherlands have an effective step up/step down approach to beds in care homes, used to avoid hospital admission and to facilitate discharge.

— The Alzheimer’s society organise “dementia friendly communities”. These are apparently effective, and the model might be able to be expanded to support people with other conditions as well. Lewisham is successfully developing “compassionate communities” where residents look out for one another.

— Lewisham Community Support Service is effectively helping people to transition between services, so that they cannot fall into any gaps.

— The Heart Smart patient group for people who have had heart failure is an effective support group.
Cancer

— One participant who works for Bexley children's cancer services felt that their model of having the patient interact with the same team at all stages of the pathway and all services (including hospice care, community care etc.) is very good and allows for a seamless service and continuity of care. This model also considers the needs of the whole family.

— Campaigns such as Blood in Poo etc. were considered very successful at raising awareness of symptoms, particularly as they are very clear, and it was suggested that more campaigns should be run on other symptoms.

— Germany was given as an example by one participant of where follow-up care for cancer patients is extremely good, and much better than here.

Other/General

— Southwark carers provide a discharge pack with key information, advice and contacts for patients and carers, after a hospital stay.

— Social prescribing is currently being used effectively in Tower Hamlets.

— Co-commissioning. Greenwich & Bexley Community Hospice use trained volunteers to support detailed advanced care planning discussions with patients.

— Good work is being done in one area to prevent fractures. An at-risk generational cohort was identified and is being targeted with intervention, Vitamin D programmes. People who had fractures were referred to a fracture prevention nurse & an osteoporosis clinic to prevent further fractures.

— One area is doing health checks outside of supermarkets, in order to make them more broadly accessible.