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

Summary of findings second local stakeholder engagement event 18 June 2014 FULL REPORT
30 June 2014
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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 second engagement event held on the June 18th at Charlton Athletic Football Club in Greenwich, and reflects the views of and discussion held by the 48 south east London stakeholders who took part in this event.

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

- Urgent and emergency care
- Primary and community care
- Maternity
- Children and young people
- Long term conditions and physical and mental health
- Planned care
- Cancer

The presentation and information sheets at this second event differed from the first because the draft strategy had evolved between the two events, including being shaped by input from the first event.

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

As with the first event, 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 7 clinical themes were the focus of discussion for much of the day, and there were several common themes across the groups. Participants tended to agree broadly with the aims proposed in the strategy in each area, with detailed comments, suggestions and challenges to the proposed approaches and their implementation. The most important themes in common across more than one of 7 clinical themes include:
Prevention came up in most themes, with an emphasis on proactive action to reduce reliance on urgent care services and wider support for all to live healthier lives.

Participants often referred to comorbidity, particularly of physical and mental health conditions; the strategy was seen as a good place to address this issue.

Knowledge of available services was seen as a key enabler for the strategy – if providers don't know and trust the other services available, people will not be referred to them.

Access to patient information across services was discussed in several contexts, getting this working well would ease the transition between services.

Involvement of the third sector was seen as essential to the success of the strategy. This involvement needs to be supported by better recognition of the value of the role they can play, support in the commissioning process and resources where possible.

The strategy was seen as an opportunity to look beyond healthcare providers to involve local authorities, the third sector, unpaid volunteers and patients in designing as well as delivering services.

Several groups thought the strategy should explicitly address the needs of the workforce (both paid and unpaid) – in terms of training, access to information and resources.

Mental health was discussed in several themes – participants thought it should be a 'golden strand' running throughout the strategy.

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 written reports 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 second of two events, held on **Wednesday 18th June 2014**, at Charlton Athletic Football Club in Greenwich. (The first event was held on Tuesday 3 June 2014, Park Plaza, Victoria).
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 48 participants attended on June 18th.

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. Long term conditions and 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 should be communicated 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 presentation and information sheets at this second event differed from the first because the draft strategy had evolved between the two events, including being shaped by input from the first event. The information 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>
<thead>
<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 Dr Andrew Parson, explaining background to the strategy, the vision for healthcare in SE London and key elements of the Case for Change SE London, 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>— Urgent and Emergency Care</td>
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<td>— Primary and Community Care</td>
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<td>— Planned Care</td>
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<td>— Cancer</td>
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<tr>
<td>1st round of table discussions, where each table discusses 1 clinical theme. 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 are explained, as well as 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 across all table discussions broadly agreed with the strategy, they provided suggestions for improvement, but there were no areas in which participants disagreed with the strategy. Some participants noted that the strategy was very ambitious, but that that should be commended.

While participants recognised that Mental Health and Preventative Health Care were included within the strategy, they felt that these two issues deserved a more prominent inclusion. Both issues cut across all of the clinical themes and the strategy should reference this. Discussion was divided as to whether each should be brought out as their own strategic theme, or whether they should just be referenced more explicitly within existing themes.

Participants saw the delivery of joined up health service delivery as central to achieving the strategy, for this reason they questioned whether the strategy contained enough explicit recognition of the role played by community, voluntary and other organisations. Integrating them into the strategy from the outset will ensure they can help during delivery.

Participants were keen to caveat their support of the strategy with questions about implementation. Without the details of how each aim would be achieved they lacked the ability to provide a detailed critique. In particular they raised concerns over the need for additional investment or resources and how the strategy would be achieved without this. Questions around how the success of the strategy would be monitored were also raised.

Agreement with the case for change

The case for change aligned closely with the experiences of the participants. Across all table discussions participants provided numerous examples of where they see potential for improving service delivery to meet the aims of the strategy.

The key themes coming out of these discussions, prior to tables focusing on clinical themes, are summarised below.

Variability in health care services was discussed at most tables, in addition to the variability in the services on offer, participants raised specific concerns in three areas.

— The provision of care across the workforce, including practitioners, contractors, volunteers and many others, varies hugely. Even within Practices, individuals had different levels of information and skills. This impacts both the level of care and the guidance that is provided.
— Access to health services is not consistent. This is a particular concern for those with disabilities, mental health issues and language difficulties. Participants were clear that access went beyond provision of the service, to making it easy for everyone to access that service.

— Variability in IT provision was seen as a key restraining factor. The inability of service providers to share up to date information regarding patients is leading to repetition and inconsistency of care across providers.

Health care services are not joined up effectively, leading to individual patients being offered and taking up very different levels of services.

— Participants emphasised that the role of the voluntary sector is currently not given the recognition it deserves. In addition to the formal community or charity services, the network of voluntary carers are central to delivering health care and their contributions need to be more formally recognised.

— Even though participants recognised that joined up health services do exist, the complexity of the system often results in individuals becoming ‘lost’ between services and not reaching the next service provider. Having a key contact to help individuals navigate the whole system would be of significant benefit.

Information provision was described as poor. Not only were patients unaware of the services on offer, but members of the workforce lacked the information to support them.

— The level of awareness of all the health care services available to individuals was described as very low. The lack of patient facing information was low and the complexity of the system meant that the workforce were not able to provide complete support for patients to access the services that suit them best.

— The lack of information also extended to patients’ expectations. Without knowing what level of service they should be receiving, patients are not able to take control of their own care or push-back against providers who are not providing satisfactory care.

The reduction in resources is creating more problems in the long term. Services which are central to preventative care have been cut in the recent cuts to services. Reducing the ability for practitioners or patients to quickly identify and respond to changes in health is resulting in more significant complications arising in the long term.
Overarching themes

This section discusses the most important themes in common across more than one of seven clinical leadership groups. The subsequent section contains a more detailed summary of the discussions that took place in relation to each individual clinical leadership group.

Across all of the tables, making more use of community and voluntary organisations was referenced repeatedly. Suggested improvements included:

— Making GPs, patients and other health professionals aware of the services available.
— Integrating voluntary services with traditional health services needs to be more effective, currently there are overlaps which wastes money and gaps which are missed opportunities. Identifying both gaps and overlaps is important.
— Using the voluntary sector to target hard to reach groups.
— More appropriate referring to voluntary sector services: sometimes the services are not suitable for the referred person.
— Payment by results system is hard for voluntary services as long term outcomes take a long time to be measured.
— Recognising that community and voluntary organisations cannot take more on without being paid – they need more resources.
— Making funding easier to access and fewer hoops to jump through.

Participants supported the draft strategy's emphasis on prevention of ill health and contributed the following thoughts:

— In healthcare settings where you have a captive audience, e.g. breast screening, GP waiting rooms, use those opportunities to have helpful conversations on health and wellbeing or give easy to access information.
— When people have multiple conditions, it can be predicted that they are highly likely to develop a third or fourth condition. Using these predictions early in the treatment process to help head off these other conditions would help people avoid declining ill health and save resources.
— Using non health related organisations to address more social issues.
— Finding institutions that can access specific groups easily (e.g. schools with children and young people) to determine who are the best messengers for health education efforts.

Many participants stressed the importance of the needs of carers not being over looked, giving the following examples:

— Carers are more likely to get certain conditions, such as stress related issues, so their health should not be overshadowed by the needs of the person they care for.
— Mutual carers, for example where someone with a learning disability is being cared for by an elderly parent, who is also being taken care of by the child with a learning disability. This dynamic needs to be supported and understood.

Service users need to know what services are at their doorstep through better signposting and information:

— Professionals that refer patients need to know what services to refer them to.
— If we are to steer people away from A&E and towards more appropriate services, there must be good alternatives that are well signposted.
— There must also be trust in those services they are going to be referred to – e.g. go to A&E as they trust they will find the expertise there, to go elsewhere they must trust those services too.

Debate about what community resilience (referred to by some as ‘stronger communities’) actually means:

— An example included increasing the reach of a local neighbourhood watch, thereby using an existing group to create a support network in the community.
— Self-management of long term conditions: if people are living longer they need to be more informed and educated to take care of themselves better.

Mental health – some participants wanted mental health to be its own theme, they did not think it was appropriate for it to be combined with long term physical conditions, as it meant that short term mental health issues could be neglected.

Beyond signposting, many participants wanted to see more emphasis on the importance of clearer communication about treatment options:

— Communication between professionals and patients about what they are going through – especially when they are being passed on from professional to professional, where good communication between those working with the patient is essential.
— Sharing information about a patients history and past conditions needs to better handled, for example, if a pregnant woman has a history of mental health issues, then the GP should see this and signpost to support, etc.

At the end of the event, questions from participants included wanting to know how stakeholders are going to be involved and funded in delivering the strategy. They feared that their involvement would be restricted to comments at the consultation phase, whereas they also want to be involved in providing the services, given the expertise and information they can pass on, such as monitoring and evaluation information.

Another participant advocated for two points to be taken into account when implementing the strategy
— Private Finance Initiative (PFI): no more PFI’s should be set up and existing ones should be re-negotiated.

— Privatisation: the direction of travel is seen to be towards tendering and involving the private sector, which may be counterproductive in terms of the strategy for integration and working together.

Views on the 7 clinical themes

Primary and community care

There was general agreement with the overall aims of the strategy. However, the groups discussing this issue suggested some additions, and raised some practical issues that need to be overcome in order to achieve the aims of the proposed strategy.

The group felt that **there is a need for the health service to be more proactive in engaging with people.** Many sections of the community are never getting to health services such as screening, diagnostics or health education, and they are therefore suffering from worse health outcomes. It was felt that too often they only receive support when they reach a crisis point. Participants expressed a need to think about new more proactive outward facing models of health delivery. This needs to involve “**going to where people are**” – and targeting those who are missing out. This would include deaf people who struggle to access services, tired and stressed carers, or middle aged professionals who may be completely unaware that they are at risk of long term conditions (LTCs). It was felt that the traditional appointment based models of primary care will miss out lots of people.

It was recognised that **GPs should not be expected to do everything** and GPs increasingly need to be working in networks involving: pharmacy services, specialist nurses, healthcare assistants, care coordinators, district nurses, and CVS organisations to share the responsibility for delivering care.

It was noted that **variability in outcomes** can be caused by some groups finding it harder to access services. For example, people with learning disabilities have much poorer health outcomes they are suffering disproportionately from poor health and preventable conditions. Because they struggle to access services, they are not receiving health checks as much as they should.

Examples of how the **accessibility of services** could be improved for particular groups include:

— **SMS texting** for appointments is favoured by many deaf people but GP practice provision of this service is currently patchy.

— **Online interpreter services** are currently underused and could be making a great difference. Increased uptake would help to raise access and tackle poorer health of people for whom English is not their first language.
Using IT more effectively to increase access and efficiency of services was felt to be important. Some group members cautioned however, that this should not lead to the neglect of other access channels as IT is not appropriate for all members of the community.

Having an appropriate amount of time with health professionals. The group felt that if you have a long term condition or you are pregnant the current GP set up of offering only 6-10 minutes is not fit for purpose for getting good care. Those planning and commissioning services need to factor in how key groups can get adequate time and support from primary and community health services. This is vital to addressing poor health outcomes and inequalities.

There was firm agreement that achieving better outcomes and working efficiently will require health services to make every contact count. Some services involve patients waiting in clinics for 30 minutes for a drug to take effect – this is a ‘captive audience’ who could be receiving other services and interventions, such as screening or signposting to health and well-being support services.

Some in the group thought about resilient communities in terms of people with long term conditions supporting one another and providing peer support and education. It was felt that people with long term conditions need continuous access to self-help and peer support in order to improve outcomes. This is particularly important at the point of diagnosis, where many people don’t realise that they can manage their conditions and take control.

It was felt that a major way in which communities can support one another is through carers. The strategy should prioritise supporting carers to care ensuring they can access respite services and services which attend to their health and well-being. Services need to recognise that two thirds of people with learning disabilities live with their families, who may often be older people who are frail and in poor health themselves, it is common for these families to be engaged in mutual caring.

One participant talked about how it can be difficult for carers to access health services. If a carer needs to have an operation or an appointment they need to organise care support which can be expensive and difficult to organise. Added to that, operations may be cancelled, causing yet more time wasting, worry and costs.

When designing and commissioning services, the NHS needs to ensure the right people are sitting around the table. Service user insights need to be at the heart of service design, and there may be CVS providers who can deliver services which are cheaper and more appropriate and accessible. For example, it was noted by one participant that audiology services in their borough are not fit for purpose and are not meeting the expectations of service users.

The strategy needs to emphasise the importance of volunteers. Examples include those who volunteer for health focussed charities, unpaid carers, those who help to run patient support groups and those who sit on patient boards and forums collecting feedback and supporting accountability and scrutiny.
The Community and Voluntary Sector have a range of roles to play. The group felt that in addition to health and social care integration, CVS integration is also important:

— they are well placed to act as experts – informing service design,
— they can be providers of care,
— they can work with services users as sign posters and advocates.

Benefits of networks and clusters: There was hope that forming networks and clusters of GP practice and other primary and community services would help to address variations in outcomes, deliver better standards of care and increase capacity and access. If we are moving toward new models of delivering primary and community care such as hubs and networks, it is vital to ensure that communities understand how they can access these services (e.g. what is a patient’s first port of call?). It is also important that the pathways and protocols are clear and consistent in order to avoid fragmentation and confusion. There needs to be recognition that it takes time for the population to understand new models of health care, and for them to trust these models.

There was also a feeling that networks could be used effectively to involve organisations from outside of normal healthcare system. For example, schools can be effective bases for health education, and might also be able to support early diagnosis work.

It is important that all professions should have a good knowledge of the services and support available. This is not always the case, leading to inappropriate referrals. For example knowledge of services and support for deaf people in Bromley are lacking, with many services and organisations referring to just one deaf organisation. Health professionals need to be working from comprehensive lists and people across the system need to understand pathways and customer journeys more clearly.

Resource constraints: It was felt to be important for planners and anyone asked to contribute to strategies to be mindful of the difficult financial constraints. Some participants felt that the strategy’s aspirations for primary and community care are good, but will be expensive to implement- and they were unsure where this money would come from. There was a discussion about whether savings further down the line could be relied upon. Some participants thought that the aspirations for primary care would lead to bankable savings. Others argued that the savings would be small and hard to recover.

There was agreement with the table expert that the strategy needs to think about workforce recruitment and retention, including reviewing career progression, training and terms and conditions to prevent shortages of key staff, e.g. midwives.

Accountability and oversight: The group agreed that going forward, the structures of accountability and oversight need to ensure that the NHS delivers service models where everyone has ownership – providers, commissioner and users working constructively together to refine and hold services to account.
Children and young people

There was broad agreement among the participants at this table with the challenges identified by the clinical leadership group and the emerging approach for services that children and families use. However, participants felt they needed more detail to fully understand the strategy.

During the discussion a number of principles emerged that participants felt were important to consider when reviewing services used by children and young people:

— The support needs of the whole family, not just the child.

— The needs of carers – and in particular young carers – are often overlooked, and they lack adequate support.

— Services should be young people friendly. The ‘You’re Welcome’ Department of Health initiative was mentioned, and one participant had seen young people going into services as peer assessors. This included looking at communication issues. This was seen as a valuable approach that needs to be embedded to ensure that services are genuinely geared towards children and young people.

— Safeguarding needs more emphasis – this underpins all services and contacts with children and young people, but participants thought this was not reflected well in the information sheet provided.

There was unanimous agreement that coordination between services is a big challenge. Particularly for children and young people with long term conditions who tend to face the most fragmented care pathways. Services can still have a silo mentality, which can make them hard to navigate for children and families.

A key worker can play a crucial role in helping with integration at a very early stage. There is good practice from early years’ services that could be drawn upon and extended into later years in childhood. However, there was recognition that there was likely to be insufficient funding to provide the number of key workers needed.

The lack of a shared IT infrastructure or information sharing protocols can hamper communications between services.

The thresholds and criteria for accessing services are different between social care and the NHS which can add to the complicated pathways for children and young people.

The integrated child health project at the Evelina Hospital was cited by participants as a good example of connecting primary, secondary and tertiary care to try and improve outcomes and efficiencies.

There was support for the GP Community Hubs and participants agreed that this had the potential to offer more and different services, encourage more joined up working, communicating more effectively about services available, and being able to offer more complex care in the community.
The transition from children to adult services tends to be poorly managed. One participant described it as a ‘shock to the system’ for many children, due to the difference in approach and the lack of preparation that is carried out with children and young people in advance of the move.

Most participants acknowledged that there is a lack of consistency of services across and within boroughs. Children and young people have very different experiences. They were pleased that the strategy explicitly acknowledges this. The aim of having excellent care regardless of the time of day was felt to be a good one.

Participants felt that there was a long way to go to empower children and families, particularly in hospitals. One participant commented that there is still little choice. Decisions about care are made on behalf of children and families, rather than with. However, other participants commented that they had noticed some changes, particularly around self-management approaches to asthma.

Prevention and early intervention was an issue that came up frequently in the discussions. Participants agreed that there needed to be more focus on this to avoid reliance on urgent or crisis services further down the line. Participants also stressed that a preventative approach would involve a range of different providers addressing diverse needs – not just the NHS. An example of this was given by the clinical expert who explained that mental wellbeing has to be taken into account – not just mental health. This involves thinking not just about those who have already been diagnosed with mental health issues, but also considering how to promote mental wellbeing before problems escalate. An example was given from the Evelina Hospital where psychiatrists focus on early intervention and ensuring that children are ready to start school and have the right support in place.

Participants discussed how the notion of community resilience is broader than the NHS alone and would require new ways of working at a very local level – involving more partnerships, and work that focussed on behaviour change. One participant felt that asset based community development needed further focus – as this had direct relevance to community resilience. This would also encourage a focus on strengths, rather than just deficits amongst children and young people. Social prescribing was also mentioned as an approach that should be developed more.

However, in these discussions, representatives from the voluntary and community sector were keen to stress their challenges in the commissioning process. Many smaller providers were already working around preventative services, and could add a lot of value of in terms of ‘knowing their patch’. But they were concerned about being squeezed out due to funding issues and not being able to fit in with new initiatives, like payment by results, due to the length of time it can take to evidence outcomes in some of the areas they were working in.

Participants said that commissioning should recognise the value of the local voluntary sector in having a reach that mainstream services often do not have and commission on that basis.

The ‘no wrong door’ concept needs to be explained more clearly. Participants agreed with the idea of recognising different access points to services for children and young people (e.g. schools, children’s
centres) and not turning people away, but were not sure that the strategy quite captured it in the necessary detail.

Participants discussed how the strategy was an overall shared effort, but felt strongly that **each local plan would be unique**, reflecting their specific population needs, and would be delivered differently at a local level. Therefore participants felt that the point about ‘system-wide partnership working that reflects local plans and extends and builds on existing networks’ should start with the local plans.

**Maternity care**

Participants in this group were particularly interested in the intersection of mental health issues and maternity care.

**Early identification of risk factors** was strongly felt to be crucial to successful outcomes in maternity care. This is made more difficult where a lack of communication between teams means those working with pregnant women aren’t aware of their history. It can be particularly difficult for women to disclose issues about which there is some stigma (mental health or domestic violence) in a first assessment with a midwife. Participants thought this emphasised the need for experienced and qualified midwives.

**Identifying mental health needs early in pregnancies**, and thus providing appropriate care, was seen as a key challenge to maternity services. An example of where this is working well was in Lambeth and Lewisham, where specialist midwives assess pregnant women with a history of mental health issues and refer them to an appropriate team, like the perinatal unit at South London and Maudsley Trust.

Participants suggested that part of the strategy should be to ensure that **a general knowledge of mental health issues was available across all health practitioners**, enabling them to identify potential issues and refer people to specialist treatment quickly. The group acknowledge the high costs of mental health service provision, and felt that early diagnosis and intervention was the best way to reduce the need for more specialist or complex treatment.

**Information about which services are available** was seen as an important aspect where there is variability in service quality. Participants spoke about an example in Lambeth, SLAM, where the mental health specialist midwives work alongside the mental health perinatal team. This does not exist in Bexley, Bromley and Greenwich and participants felt the boroughs lacked sufficient specialist support. They suggested that as well as information there should be more sharing of good practice between services to reduce variability.

There was recognition of the **role of the voluntary sector in guiding women to services**, but concern that commissioners did not recognise this. It was felt that more support for the voluntary sector could help with this facilitating role in the community, which the NHS relies on, and involve more commissioning of the voluntary sector, rather than NHS services.
Cancer Care

Participants in this group did not exclusively discuss cancer; they made many points which they acknowledged were relevant to other long term conditions.

Participants were keen that the strategy should consider healthy behaviours to reduce the risks of cancer, as well as treatment. They felt that the best examples of changing behaviour were word of mouth and support from ordinary people on the ground who are making changes like quitting smoking or undergoing cancer screenings. They identified that there are a whole range of societal pressures which mean that information about healthy choices is not enough.

Participants saw a connection between healthy lifestyles and resilient communities – identifying strong social networks as important to health. A good example was a group which emerged from men’s health week in Greenwich to address social isolation – there is no pressure to make lifestyle changes, but the group is addressing one of the factors (isolation) which can be a barrier to change. These networks were also seen as useful in guiding people to relevant services.

Late presentation of cancers was another priority area for the group; they argued that the UK had a particularly poor record for this. It was felt that the strategy should reflect that there are a range of factors which contribute to late presentation, and that these are often culturally specific. One suggestion was for community champions to promote actions like screening within their own communities, reflecting the specific needs of that community.

Another area discussed by the group was end of life care, with a detailed discussion about involving communities in designing end of life care. They suggested that it was important to talk to people about ideas of “a good death” much earlier, and have these conversations in communities, not just with individual patients. Some in the group felt that faith groups had an important role in this task, including an example of a hospice working with local churches to train volunteers to speak about dying. Others in the group felt that this was too limited, given the need to involve people not engaged with faith groups.

A related point was the need for end of life care to be improved across a wider range of healthcare settings, and not just in specialist units. End of life care does not always involve specialist services such as hospices.

The group felt there was scope to make better use of community and third sector capacity, but only if it was adequately supported. This support could take the form of financial support, with a suggestion that CCGs should commit to support groups with a certain portion of their budgets. Other types of support could be via better knowledge of their services for GPs, social prescribing – where GPs prescribe that someone take part in an activity or group.

Less formal volunteering was also suggested, with examples like a website in Greenwich where people could request help with a particular job like gardening (although this is currently a paid system). Participants felt this could be extended to include things like volunteers taking patients to appointments.
IT was seen as a good tool for disseminating information, but only when it is used properly. Participants all felt databases of available services were prone to becoming out of date, and gave the example of a system in Greenwich where it is mandatory for carer support groups to update their details periodically or they are removed. This avoids raising expectations or hopes where services are not available anymore.

**Urgent and emergency care**

Whilst agreeing with much of the current content of the Urgent and Emergency Care section of the draft strategy, participants at this table made several suggestions to improve its clarity and content.

Participants suggested that the strategy could helpfully include some **short case studies or vignettes to illustrate what the ambition would look and feel like in real situations**. There was also a wish to see more of what is already being done well included in the strategy. A plea was voiced for more clarity in places, for example ‘other significant programmes of work underway’: it would be helpful to know what sort of programmes these are. The **workforce should appear throughout the strategy** – paid and unpaid, was another request by a participant to illustrate the human involvement in the proposals.

Turning to the content of the strategy, participants talked about the **importance of building education and awareness about, and trust in, the alternatives to A&E** if people are to be steered in their direction. It was felt that people often use A&E because it is familiar and trusted. Further comments that continued this theme included:

— Education of staff across the system is important, not just education of the public. For example care home staff need to understand what is and is not an appropriate referral to A&E

— Educated staff can deflect an inappropriate referral at different points in the process, right up to the front door.

— Alternatives to A&E need to be there, resourced and accessible, and likewise the services which can relieve A&E at the discharge end of the process.

One participant commented that in the context of the Lewisham A&E issue locally, this document could be interpreted as pointing towards A&E closure at some future time.

Participants felt that **solutions should make use of IT**, but not necessarily rely on large new IT models or systems.

**Mental health should be specifically covered** in the standards that are cited. This may well be in mind, but should be specified to show they have been considered.

Participants suggested the following **ideas for improving urgent and emergency care** services in south east London:
— **Fast tracking people with learning disabilities at A&E** as they can find it hard to cope waiting a long time.

— **A good out of hours service** is very important in keeping people out of A&E. It needs to be **clinical-led** in order to do that.

— **Passports for people with certain conditions** were suggested as a way to help speed up people’s experience and save time for the system. Participants discussed issues with a patient specific protocol (PSP), meaning the person can be treated in situ by paramedics without being taken to hospital every time, but the paramedics have to fill in so many forms that it takes up their time in other ways instead.

**Planned care**

Participants on this table were supportive of the aims to improve planned care, particularly identifying with challenges around waiting times, long hospital stays and better planning for discharge. They commented on several of the suggested improvements, identifying areas of caution as well as some examples of good practice like the Guy’s Hospital neurology department and diabetes care in SE London.

Participants discussed the length of waiting lists and hospital stays for planned care, focusing on **having the right resources available to move people through hospital efficiently**. They thought this was particularly important in light of the aging population. In terms of waiting lists participants thought that more theatre resources were needed generally, but also thought it could be more efficient to move to a 7 day service, rather than Monday to Friday. A challenge identified for availability of beds was people staying in hospital because an alternative wasn’t available – either because they had no long term housing, or because they were in a specialist facility and no bed was available in a more general one. The group felt this could be addressed partly by planning for discharge before people are admitted, but also identified a lack of resources for services like hostels which people could be discharged to in the short term.

Participants also talked about **reducing inefficiencies in the planned care system**, several had examples of situations where administrative mistakes had wasted patients time, or caused them to lose trust in the system. It was felt that a more joined up system with better communication and less silo working could reduce the number of cases where patients are given conflicting information. Participants also felt that improving primary care provision could help to reduce the number of people using other services because of a lack of access to or confidence in primary care.

Participants felt it was **important not to focus simply on reducing outpatient referrals** as a way to reduce the burden on planned care. Some felt that this type of target could result in GPs feeling that they weren’t able to refer patients even if it was clinically the most appropriate action. This concern was
associated with the idea of ‘rationing’ care in an aging population and cited examples such as reduced screening for older people.

The aim of **empowering patients to make decisions about their own care** was recognised as important, and participants felt that this should start early and be incorporated into better general health education. They also identified a need for support to help those less able to make decisions, or with less of a support network; people with dementia for example. Participants also discussed how non healthcare services could support this type of need – giving the example of a Lambeth Community Neighbourhood Watch Association that now provides support to elderly, vulnerable or isolated members of the community.

There were some concerns about **aspects of the strategy which participants thought would reduce flexibility**. Firstly, some suggested that standardising an approach too much would remove the ability for clinicians to make decisions which take into account the local conditions, resulting in less appropriate treatment. Secondly, some questioned whether having senior clinical involvement would actually improve outcomes – they felt that good care delivered by less senior staff at the right time was better than waiting for excellent care from a more senior clinician.

Other aspects covered were the need for **clear assessment criteria for the strategy**; including both clinical outcomes and patient experience. A few participants also mentioned the **need for robust financial planning**, with Private Finance Initiatives singled out for criticism.

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

Two groups discussed long term mental and physical conditions – both were generally supportive of the strategy and its aims, but wanted more information about how it would be implemented. Many of their suggestions were around topics running through the entire strategy; consistency of care, access to patient information and improved communication. One group discussed whether it was appropriate for mental health to be combined with long term conditions in the strategy. While recognising the connectivity between physical and mental health they were concerned that mental health does not always receive sufficient focus, or funding, and that combining the two areas would exacerbate this.

**Consistency of care** was a focus for one group, with participants identifying a need for greater consistency across providers, services and individual members of the work force. They discussed a range of tools for ensuring consistency, including shared best practice and lessons to be learned.

In terms of **consistency from staff** there were two several aspects. Firstly, the need for consistent customer (rather than clinical) care, particularly where agency staff are involved. Secondly, participants identified a **lack of awareness of available services** among practitioners which means not all service users are directed to potentially valuable care options. Mental health was seen as a priority in this area, because patients often require multiple levels of care, and more support to access that care. Training for staff was seen as an important enabler for this, giving them a better overview of the network of care options available.
A related area was **access to care for those with particular communication needs** – for example those with mental health issues or disability. Participants felt that while some services were particularly good at enabling communication from those with special needs this is not universal. There could also be variability within services – for example out of hours services might rightly prioritise emergency cases, but at the cost of minimising support for those with special needs at those times.

Participants discussing long term conditions often discussed the **importance of preventative techniques**, to reduce the incidence, severity and complexity of long term conditions. It was identified that people with long term conditions are often suffering from several coincident conditions. Particular examples were older people, who may have multiple conditions, and the linkage between mental health conditions and physical health needs. A best practice example given was work by the Charlton Athletic Community Trust to provide early intervention in cases of psychosis.

Prevention was also discussed in relation to **cost-effectiveness of care**; with early intervention and diagnosis seen as reducing treatment costs. One participant suggested that self-management could actually contribute to early diagnosis as patients with more active involvement in their care are more likely to identify changes in their condition, rather than waiting for detection at an appointment. A few participants in each group voiced **concerns about involvement of private companies in healthcare services**, including via Private Finance Initiatives, participants felt that commercial relationships often were not cost effective and reduced the quality of the links between community and healthcare. The voluntary sector tended to be seen as a more appropriate partner to provide cost effective care outside of the NHS. One participant suggested that the strategy should commit to commissioning in line with the Social Values Act, to support providers who contribute to local communities.

**Access to patient information** was a topic mentioned in both discussion groups, with access to relevant information seen as essential to provide joined up care across different service settings. For some this was an issue of patient experience – the current system often causes delays and affects patient access. It was felt by some that in principle patients should not have to give basic information again when moving to a new service. It was also felt that staff needed to focus more on communicating with each other and with patients when they are moving between services, particularly in long term care, where there is often a lack of contact in the lengthy gaps between appointments. An example of a different model was the Proactive Primary Care approach proposed in Lewisham.

This need for reliable sharing of patient information was accompanied by a clear sense that **privacy should be respected at the same time**. Patients needed to feel confident that the information they give to healthcare professionals will be stored securely and not used for inappropriate purposes.

**Other concerns about information sharing** were to do with carers; with some participants arguing that a lack of data sharing with carers was a particular problem for people with long term conditions who rely on carers to guide them through the healthcare system. Another concern was that relying too much on digital tools could exclude some patients; an example of a simple but effective system was the log books used where people are cared for in their homes.
Participants in both groups talked about integrating services better, and finding opportunities to improve patient care by bringing different services together. One example of this was a diabetes treatment that involved a half hour period in the treatment room, and asked whether that would be a good opportunity for a different team to check peoples feet (a common problem area). There were a number of challenges identified to integration, which the strategy could begin to address, including the absence of a culture of joined up working. Participants felt that staff in different services weren’t always trusting of each other, and so could be unwilling to refer patients, particularly from inside the NHS to outside providers.

Some participants talked about involving patients in the design of integrated services; participants generally thought this was a good aim, but felt it should be an inclusive process, involving patients, carers and service users. One participant suggested that it was important to be clear about what each party (service provider, patient, and carer) is willing and able to do in order to design care pathways which are sustainable. A good example given of a strategy which integrated care across different service areas was the South London and Maudsley Foundation Trust strategy on mental and physical health.

Aside from delivering health care services, participants in one group talked about the strategy going beyond health care to encompass environmental conditions like deprivation. The group felt that, particularly in relation to mental health, there were some factors like reducing availability to illegal substances, or improving access to good quality nutrition, which could have a real impact on the incidence of conditions. The group felt this should not just be about limiting harm, but also considering the quality of life of service users, which could improve long term conditions.

The voluntary sector was seen to have a key role in the strategy, but there were concerns about a lack of funding to reflect the increasing role of the sector – participants felt that sometimes the voluntary sector was treated as a ‘cheaper’ way to deliver services than NHS or private bodies. One group felt the voluntary sector needed more support, both to apply for funding, and to provide more joined up services, rather than focusing on individual aspects of care. An example of a programme which incorporates third sector and multiple health areas was the 3DFD service which addresses poorly controlled diabetes and mental health issues.

The groups also discussed several aspects of delivering the strategy, including concerns about the capacity of GPs. Participants felt GPs sometimes lacked the resources or motivation to take on all of the new responsibilities of an integrated model. A similar concern was raised about pharmacies, which have a larger role suggested in the strategy. It was seen as vital that there is monitoring of outcomes, to know whether the strategy is working – including patient experience. A good example was the Annual Health Check programme, where evaluation needed to happen at multiple points, not just counting how many took place but also whether they were followed up (although the group tended to feel the programme itself was not being implemented well).
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 37 participants filled in the form, of which the following is a summary.

<table>
<thead>
<tr>
<th>Question</th>
<th>Average response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know more about the SEL 5 year commissioning strategy</td>
<td>Tend to agree (3.8)</td>
</tr>
<tr>
<td></td>
<td>One respondent strongly disagreed with this statement.</td>
</tr>
<tr>
<td></td>
<td>Another respondent tended to disagree.</td>
</tr>
<tr>
<td>There was enough time for me to say everything I wanted to</td>
<td>Tend to agree (3.5)</td>
</tr>
<tr>
<td></td>
<td>8 respondents either strongly disagreed or tended to disagree with this statement.</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 (3.7)</td>
</tr>
<tr>
<td></td>
<td>6 respondents tended to disagree with this statement.</td>
</tr>
<tr>
<td></td>
<td>1 respondent did not know.</td>
</tr>
<tr>
<td>I feel confident the results of this event will make a difference</td>
<td>Tend to agree (3.6)</td>
</tr>
<tr>
<td></td>
<td>13 respondents neither agreed nor disagreed with this statement.</td>
</tr>
<tr>
<td></td>
<td>2 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?

— Representatives of the local area including: local councils, social care and social services, health watches, care home managers, local education decision makers.

— More of the NHS itself and its workforce e.g. NHS London, GPs, commissioners, acute hospital representatives and people that work in the mental health sector.
— One respondent felt it would be useful to have a representative from NHS England to talk about the interface with local commissioning. While another felt the event should have been fronted more by SEL NHS/CCG members.

— Finance.

— A greater CVS presence including health charities for each area e.g. Bowel Cancer UK, MacMillan, Breast Cancer UK for the cancer table, the Autistic Society.

— Young people from the 14-19 age group.

— People before Profit and political decision makers.

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

— Greater emphasis in the strategy on the intention to jointly integrate including social care and the role of public health. One respondent felt the strategy should be more joined up with NHS England, in particular specialised commissioning.

— Greater engagement with health organisations, staff teams, service providers and patients, hard to reach groups, community groups, and the voluntary sector across all boroughs. It was felt local community representatives should be involved at an earlier stage of the development of the strategy.

— The continuation of this process with the people present in the room, and further meetings allowing for involvement in the progression of the strategy and updates on progress. This includes a full discussion of how the aims of the strategy are to be achieved and feedback on how ideas are implemented.

— More localised discussions on each theme to allow for in depth dialogue with selected groups.

— Make copies of 20 June draft widely available.

**Who should we be communicating with, and how?**

**NHS and patient groups:** Including GPs, care networks and carer's groups, Healthwatch patient groups, practice manager forums, LINK.

**Community and voluntary groups:** including schools, neighbourhood watch, organisations that are member led. It was suggested communication with the public more widely could take place through doctor's surgeries and libraries, radio, events, assemblies and wider email dissemination of draft documents for feedback.

**Particular interest groups:** including social groups for people with sight difficulties, sector skills councils (for functional analysis and market information to assist with a high quality ‘workforce’ component of the strategy), People Before Profit. One respondent pointed out it was important to go directly to local groups, not to expect users and carers to come to you.

**Members of the public:** who are not currently involved in the health service, including young people.
“I thought it was an interesting mix of people – I suspect that some issues (i.e. communication with deaf and learning disabled people) only came up because there were people here from those groups so I wonder who was missing that we did not even think about.”

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

— More notice and allowing extra time for table discussions. Two respondents suggested sending information in advance to avoid duplication and wasted time and provide more strategic direction to participants.

— Sessions that are more specific e.g. events that are commissioning and provider oriented rather than with a patient/ public focus.

— Patients could represent specific disease groups to give an individual perspective. Likewise, representatives from community groups should be identified for each area.

— It was suggested that local Healthwatch groups could be commissioned to run focus groups.

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

Suggested publications and research:

— Travellers report – health and social care needs.

— Healthwatch reports.

— The University of York’s (March 2014) research into financial mechanism – integration, costs and savings quoted by Sima Stevens to Health Select Committee (AFC 29/04/2014).

— South London Child Development Studies, Pawlby, Susan et al – impact of untreated ante / postnatal depression.

— Proactive Primary Care in Lewisham Community Development.

— ‘Sick of It: How the Health Service is Failing Deaf People’ www.signhealth.org.uk

— GP Survey 2010 British Society for Mental Health and Deafness.

— Joseph Rowntree Trust report on researched models of care

— Publications on user involvement

— National mencap and the British Institute of Hearing Disabilities research

— Children and Families Act 2014 and Education Health and Care Plans

— ABCD pilot work, community budgets/ Our Place pilots
Suggestions for future research:

— Carers’ needs
— Impact of the PFI burden on the NHS
— A baseline study of local patient views on local healthcare to be replicated year by year
— Impact of the NHS estate on enabling implementation of the strategy
— Cost benefit analysis of Private Financial Initiatives, bed blocking

Extra comments:

— We need to be satisfied that the strategy will now be widely consulted on.
— Keep us informed of what was said, what and if you are using it, so we can see what a difference we have made.
— Discussion seemed vague with vague aims and no explanation as to how they will be achieved.
— Have a good understanding of the differences between voluntary sector organisations – not lumping us all together – volunteer run groups – big national charities.
— Use healthwatch to monitor outcome of strategy.
— The choice of venue in terms of access was appalling. Charlton FC is not signposted.
— I’d like to emphasize the importance of Perinatal Mental Health Services (midwife with mental health expertise, both a trained workforce plus specialist services – Perinatal Mental Health Teams) as part of the mental health and maternity CLGs. Perinatal mental health problems are a public health priority. 10-15% with postnatal depression, 7% with antenatal depression. This is very common. Untreated problems lead to suicide / infanticide and impact on developing child; spectrum of outcomes.
— Will the SEL Programme Office consider signing up to the ‘getting it right’ charter?
— We need to get health and wellbeing on the agenda, and get GPs doing more HW care. Is there room for HW clinicians on the Long Term Conditions CLG?
— Should be some information on financial impacts of the strategy and whether it will contribute to enabling the NHS to function with reduced budgets.
Appendix II. Presentation

Slide 1

South east London five year NHS commissioning strategy

Stakeholder engagement event
18 June 2014, Charlton FC

Slide 2

WELCOME:
SUZANNAH KINSELLA, OFFICE FOR PUBLIC MANAGEMENT

Slide 3

We want to hear your views

• To inform the development of the strategy

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

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

**What will happen to your feedback**

Where does it feed into?
- The feedback will be considered by the people shaping the strategy as part of further development

When can people expect a summary report?
- Summary reports are produced at the end of both events and available from July 2014
- Strategy will publish a 'you said, we did' report covering engagement to date in July 2014

Slide 5

**For further information**

Contact person:
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Slide 6

**Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<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>3.00pm</td>
<td>• Welcome &amp; introductions</td>
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<tr>
<td></td>
<td>• Setting the scene</td>
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<tr>
<td></td>
<td>• Round I - Discussing the thinking of the Clinical Leadership Groups</td>
</tr>
<tr>
<td>3.30pm</td>
<td>Break</td>
</tr>
<tr>
<td></td>
<td>• Round II - Discussing the thinking of the Clinical Leadership Groups</td>
</tr>
<tr>
<td></td>
<td>• Rounding up the main emerging themes, issues and questions for further development of the strategy</td>
</tr>
<tr>
<td></td>
<td>• Next steps</td>
</tr>
<tr>
<td>5.00pm</td>
<td>Finish</td>
</tr>
</tbody>
</table>
Slide 7

**Housekeeping & Ground Rules**

- Please respect other people's opinions
- Please do not speak when someone else is speaking
- Please listen actively
- Please give everyone a chance to contribute and encourage others to do so
- Please do ask when something isn't clear
- We can take breaks when necessary
- Mobile ‘phones off or on silent please

Slide 8

**Introductions**

Slide 9

**SETTING THE SCENE**
Slide 10

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

Slide 11

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

Slide 12

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
Slide 13

Health outcomes in south east London are not as good as they could be:

- Too many people live with preventable ill health or die too early.
- The outcomes from care in our health services vary significantly and high quality care is not available all the time.
- We don’t treat people early enough to have the best results.
- People’s experience of care is very variable and can be much better.
- Patients tell us that their care is not joined up between different services.
- The money to pay for the NHS is limited and need is continually increasing.
- It is taxpayers’ money and we have a responsibility to spend it well.

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

Slide 14

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.
- Helping communities to support one another.
- Making sure primary care services are consistently excellent and with an increased focus on prevention.

Slide 15

What are we trying to achieve? (2)

- Reducing variation in healthcare outcomes by raising the standards in our health services to match the best.
- 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

What have we done so far?

- Developed a Case for Change for south east London, informed by local engagement and used to set the priorities for the strategy.
- Developed a proposed overarching integrated system model for further engagement.
- Clinical Leadership Groups have developed early proposals for new models of service for primary and community care, long term conditions, planned care, urgent and emergency care, maternity, children and young people, and cancer for further engagement.

Slide 17

Where are we now?

- A strategy document needs to be submitted to NHS England for review on 20 June 2014.
- This is just an early milestone in the long term development of the strategy and considerable further and wider engagement on the strategy is planned from July 2014 onwards.
- The strategy document so far includes the vision and a proposed integrated system model of health and social care across south east London for further engagement.

Slide 18

What are we doing next?

- Further wider and local engagement with local clinicians, partners, stakeholders and people across south east London from July 2014.
- Testing and developing the proposed service models and evidence to support them.
- Understanding the impacts of the strategy.
Slide 19

Our Expectation

That at the end of the strategy implementation our health system will deliver better outcomes for local people and patients in south east London in a way that is sustainable for future generations.

Slide 20

Your experiences

At your tables, please discuss:

• Does what you just heard reflect your experience in south east London?
• Are there any important issues we may have missed?
• Are there any good practice examples that you would like to share?

Slide 21

7 CLINICAL LEADERSHIP GROUPS
Clinically-driven strategy

- 7 Clinical Leadership Groups are developing the strategy.

- The groups include clinicians and senior experts from south east London’s NHS commissioners, providers of NHS services, social care services, public health services, Healthwatches and patient and public voices.

7 Clinical Leadership Groups

- Primary and community care
- Long term conditions - physical and mental health
- Planned care
- Urgent and emergency care
- Maternity
- Children and young people
- Cancer

Proposed Integrated System model

Resilient communities as the foundation

1) Primary & community care including social care – universal service supporting whole population
2) Long term conditions, physical and mental health – supporting those with long term physical and / or mental health conditions
Pathways of care requiring hospital intervention – support patients through episodes of care
3) Planned care
4) Urgent and emergency care
5) Maternity
6) Children & young people
7) Cancer
Proposed Integrated System model

Underpinned by eight characteristics:

• Build resilient communities
• Promote health and wellbeing
• Provide accessible and easy to navigate services
• Join up services from different agencies and disciplines
• Deliver early diagnosis and intervention
• Raise the quality of services to the same high standards
• Support people to manage their own health and wellbeing
• Achieve improved outcomes for people in south east London

Round I

At your tables, please discuss:

1. Do the issues with [service area] reflect your experiences in south east London?
2. Emerging elements of 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?

BREAK
Slide 28

Round II

Move to another table, discussing a different Clinical Leadership Group’s thinking.

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

Slide 29

Key issues

• What are the main issues in south east London that should be addressed within the strategy?

Slide 30

NEXT STEPS
Slide 31

How to stay involved from July 2014

• Public recruitment process for more patient and public voices
• Local and wider stakeholder events
• Contributing to future engagement activities

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E: patsy.ryan@nhs.net

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THANK YOU!
Appendix III. Info Sheets

This section contains the information sheets used at the 18 June engagement event. The information sheets were updated after the 3 June event. Please note these information sheets reflect early thinking of the Clinical Leadership Groups, which at that stage was 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 does south east London already do well?**

— There has been a steady decline in the number of people dying from cancer across all boroughs in south east London in line with 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.

— Most of our services are compliant with NICE Improving Outcomes Guidance (IOG) and have well established pathways in place.

— There are an increasing number of cancer nurse specialists in SE London.

— All providers and commissioners are prioritising cancer and investing in cancer services.

— Dimbleby Centres and MacMillan Information Centres are well established in south east London focusing on supporting and providing better access for local people to information and support.

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

— Cancer is now the biggest cause of premature (and also avoidable) deaths in London.

— Some people with cancer waited for longer than they should have done for their first hospital treatment. Cancer waiting times are not consistently met across south east London with some patients waiting over 100 days to be treated. 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 are differences in patient outcomes and experiences across south east London.

**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. They aim to:

1. **Encouraging patient/public ownership of health**
   — Better health promotion and primary prevention
   — Promoting healthy lifestyle choices for patients and family including before, during and after treatment
   — Care plans and care co-ordination in place
   — Patients and their carers better supported to self-manage, underpinned by excellent information and rapid re-entry access when needed
   — 24/7 patient helpline
2. Patient experience

- Improved patient experience and shared decision making in their care
- Less variability in dying at place of choice and at home
- Access to diagnostics, treatments and services based on clinical need, reducing inequalities including for older patients
- Equity of access to psychological support

3. Pathways

- Improved screening
- Stratified pathways
- Delivering Cancer Waiting Times, and going further where possible
- Streamlined access to diagnostics

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 seldom heard groups.
- Understand and target interventions around cancer inequalities e.g. late diagnosis, healthy lifestyles.
- Improving screening and early detection and aiming to reduce the number of patients diagnosed in A&E.
- Making every contact count across the whole system - to encourage prevention, utilise teachable moments and to improve the patient experience.
- 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.
- To improve support for those patients cured and living with the consequences of their cancer or cancer treatment.
- Cancer should be recognised as a long term condition and managed by Primary and Community Care with improved support for patients to self-manage.
- Transforming end of life care though early identification of patients approaching end of life to plan better and support more patients to achieve their wishes.
— Improving the support given to carers.
— Develop the right workforce to provide excellent support in the right place, whether in hospital or in community-based settings, including the third and hospice sectors.

Children and young people

*Services used by children and families.*

**What is south east London already doing well?**

— There are signs that the number of young people smoking is decreasing.
— The number of under 18s staying in hospital due to alcohol is low compared to the national average
— 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
  - 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.

— To support all aspects of care (continuum of care) including - prevention, early intervention, targeted intervention, urgent care, complex needs e.g. mental health, emergency care, and conditions requiring highly specialised care.

What are our ambitions to improve 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.

— An integrated assessment and coordination service between primary, secondary and tertiary care.

— An improved interface between community and acute / specialist services.
Long term conditions and physical and mental health

Our ambition is to ensure there are high quality integrated services for people with both physical and mental health long term conditions and that those healthcare providers (including social care, the independent and voluntary sectors) are working together putting individuals at the centre. This will enable people to be active and to feel well-supported in their own homes wherever possible.

What is south east London already doing well?

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. For example:

— Greenwich’s ‘Integrated Care Pioneer Project’, which is delivering coordinated care for older people and people with physical disabilities, are rebasing services within clusters of GP practices to improve community care for patients, building on 3 years of fully integrated services between health and social care.

— A case management approach is already well established in Bexley with practices using a risk stratification tool (combined model) to identify patients with complex needs and holding integrated multi-disciplinary team meetings to proactively plan care and monitor outcomes.

— Lambeth and Southwark: Southwark and Lambeth Integrated Care (SLIC) is well established partnership between local GPs, King’s College Hospital, Guy’s and St Thomas’ Hospitals, the South London and Maudsley Mental Health trust, social care in both local councils, and Lambeth and CCGs. To date, the partnership has focused on care for older people and people with long term conditions, redesigning and improving care for these groups by bringing together local people and their carers with the professionals who care for them, to plan changes and monitor how they are working.

— Lewisham: Lewisham’s population-based programme builds on work to integrate services in a number of areas such as integrating Local Authority reablement and provider intermediate care team to create a single service to avoid unnecessary hospital admissions/readmissions and reduce need for high level health & social care services and creating integrated Multi Disciplinary Teams working with primary care.

— Bromley: Locality pilot underway with a core team including community provider and GP practices identifying complex patients requiring case management.

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 and 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.

— Patients are not well informed about the variety of interventions and services available to them in the community to enable them to self-manage.
— Services have been designed to provide an efficient service to a large group of patients and there is a lack of personalised care design meaning that services can be unresponsive and slow to react to patient need, particularly in a crisis.

— Barriers exist between acute and community services because our workforce is not as adaptable, skilled and flexible as it needs be to provide patient centred care across services and locations.

— Not everyone is working towards the same outcomes for patients. There are no universal outcome measures across the system, focussed on what patients want to achieve, that everyone is working towards.

— A lack of information sharing agreements and different IT systems currently prevents more coordinated and integrated care. This deters from effective case and collaborative management of patients across services and locations.

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

The aims for the CLG are to have:

— Services designed and commissioned around the patient

— Adaptable and capable staff to work across services to support coordinated care

— Involved and informed patients to enable better self management

— Being able to identify people proactively who need multiple agency care

— Improving the transfer of place of care between hospital and home so that care is more continuous and coordinated

— Developing connected Information Technology and Information Governance to enable information sharing agreements across south east London to enable a flow of information about patient care between service providers

— Addressing the culture change that needs to go hand in hand with Information Technology and Information Governance sharing

What improvements to the treatment of long term conditions and mental health could we make?

The LTC clinical leadership group model is one system that describes different levels of complexity depending on the person’s need. People can move between the elements as required. People with physical and mental health problems will be supported by integrated health and social care teams and will access specialised services as required with information flowing between services so that the person experiences a continuity of care. Primary care will be at the heart of the model of care. The key improvements will be:

— Services for people with stable or well managed long term conditions to mainly be provided by GPs and pharmacies with access to hospital and wider community care as required.

— For mental health screening for depression and anxiety for people being diagnosed with LTC.
— Support for the person to manage their own condition through better information and signposting; access to support groups etc.

— A focus on secondary prevention with the aim of improving underlying conditions and preventing deterioration/development of further long term conditions.

— Local Care Networks will be developed to ensure that coordinated services are provided for people with more complex needs.

— To take a reablement and rehabilitative approach to people with LTCs.

— To have access to rapid response if care needs change suddenly; care packages reviewed with further reablement. Admission to step up/step down or hospital facilities as required with the aim of enabling people to live their lives fully. This will include support to die at home.

— Where needed a multi agency/professional assessment with the involvement of wider council (housing, benefits etc.), voluntary sector as well as health & social care with a problem solving approach will be available.

— Unique packages of care to support the individual to live their life. Transfer package into less complex packages of care as required and to support further in a crisis. For those people with the needs that are most difficult to meet, there will be a ‘Very Important Patient (VIP)’ process so that people can access services swiftly to keep people safe should changes occur.

— A relentless focus on the health and wellbeing of those most vulnerable people in our society who live with life long severe mental health problems.

Maternity

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 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.

— 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 a good safety record across all SE London maternity services.
What are the challenges in south east London relating to maternity?

— 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.

— Early access to maternity services - not all women are booking early for antenatal care and this can be an issue for example, in the identifying any risk factors to the pregnancy as soon as possible and ensuring women access scanning services at the right times during their pregnancy.

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

— Workforce requirements: for example ensuring there are enough trained midwives and obstetricians with the right skills and enhanced skills to meet requirements such as continuity of care, 1:1 support during delivery and to achieve 24/7 obstetric consultant cover in labour ward.

— There is not always good integration with mental health services, including access to psychological therapies, emotional support linked with community support, and enabling early identification of mental health issues and postnatal depression.

What are the Clinical Leadership Group’s aims for maternity?

The CLG aims 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 ambitions for 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, including those with mental health issues.

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

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

— Improve women’s experience of maternity services and postnatal care ensuring that there is sufficient support for women and their families once they have had their baby.

Planned care

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

What is already done well in south east London?

There are areas of good practice and evidence of significant progress across planned care in South east London. For example, a community based Musculoskeletal (MSK) service in Greenwich incorporates direct access physiotherapy and other aspects of MSK/pain services currently provided in secondary/community care.

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

When patients are not well, there are sometimes long gaps from when they receive a diagnosis to when they receive their treatment. We need to address these delays through more joined up working between services. When patients need to receive a diagnostic procedure or treatment they should be able to access services in a timely way that meets their needs. We also need to help patients understand when their health has changed and how to actively discuss and take joint responsibility for their treatment and care.

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

— The CLG will define a south east London approach that delivers high quality elective care:

— Patients are seen by the appropriate level of clinician / staff, with senior expertise early in the pathway

— Patients and professionals should be encouraged to make more detailed plans for both before and after an operation
— Patients are involved in decision-making and know what to expect at each stage of their treatment and there is a strong shared responsibility between patients and their health professionals for their health and care

— There is a standardised approach in the way planned care is provided and commissioned across south east London

— Patients do not have long waits for treatment or have to stay longer in hospital if it is not needed

— Treatment will be safely provided in community and patients will only have to stay in hospital when it is necessary and safer to do so. This ensures that regardless of where patients receive their treatment, it will be of a high quality, effective, timely and safe.

— Services across the wider system will work together through stronger communication and coordination to support the general health and well being of people as well as patient treatment and care when they need it

— Health services will work closely with Local authority services including social services to improve the coordination of care for people after they have had their treatment

**What are our ambitions to improve planned care?**

**Pre-treatment and diagnosis**

— A more standardised approach across primary and community care services for pre hospital care, assessment, referrals, the transfer of care and discharge

— Strong patient education and health literacy so they can be more active in decisions about their health and share responsibility for their care

— Services will be joined up so that there is closer working between professionals across physical and mental health; social care and the voluntary sector

— Diagnostics are done once at the right place and patients are able to access them when they need to

— There is senior clinical opinion and decision making early on to ensure patients receive the right care at the right time

— More treatment is available in the community where appropriate

**Treatment**

— Treatment is provided as soon as appropriate to ensure the best outcomes

— Patients do not have to stay in hospital for treatment if it is safe for them not to

**Post treatment**

— More treatment is available in the community and patients are transferred to the community as appropriate

— Patient care is planned as early as possible after diagnosis
Primary and Community care

The care given by a wide range of community based providers and individuals in south east London including GPs, pharmacists, voluntary organisations, etc.

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?

— People who live in south east London are living longer. This is because they are healthier overall. But it also means that they may have to live with long-term health problems, like dementia or diabetes, for longer. They may also need more social support to be able to live as independently as possible.

— The population of London continues to grow, with more people choosing to live in the capital and prolonged life expectancy for older residents.

— 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.

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

— 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.

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

To address the challenges in primary and community care and support the emerging model that will drive its transformation, four high impact interventions have been identified. These are activities and
interventions which contribute to improving health and wellbeing by increasing self-reliance, capacity and resilience in both patients, the people who support their care and across local community networks.

— **Proactive Care** – providing a holistic approach that supports population health, wellbeing and prevention building on community networks and encouraging self-reliance.

— **Accessible Care** – supporting all patients, irrespective of their individual circumstances, lifestyle and condition, by providing options to access care that are appropriate to their needs and support their continuity of care.

— **Co-ordinated Care** – providing an enhanced level of service for patients who require continuity, support, care planning and continuous review in order for them to live healthier and stable lives in their communities.

— **Continuity of Care** – providing continuity of care for patients who need it, enabled by the effective and timely communication and information sharing between health care professionals, which ensures that patient care can be coordinated by one clinician or safely transferred between clinicians to provide consistent and coordinated care.

**What are the ambitions for primary and community care?**

— Primary and community care services should be provided on a geographically coherent population basis.

— 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 an emphasis on prevention, early identification and self management in all areas of care.

— There should be more services available outside of hospitals with consistent quality of care and service offer.

— These services should reflect the kinds of people who live in south east London.

— Services should be flexible enough to respond to population and individual patient needs.

— Exact form may vary… BUT services should be provided through local care networks of community based providers, forming the platform for integrated care systems that utilise the registered list as a unique feature of our primary care system.

**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 emergency 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 ambitions for 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.
— Improved flow through and experience of emergency departments.
— Enhanced 111 to help self-management and to provide a focal point for all services.
Appendix IV. Best Practice Examples

_Cancer_

— One participant was involved in the integrated care pioneers programme in Greenwich (Greenwich is one of many integrated care pioneers). The heart of their idea is a multidisciplinary team to meet the needs of the individual. So far it is very successful. She recommends the “I statements” model for helping meeting health and social care needs. The “I statements” include things like “I only have to tell my story once”.

_Primarv and community care_

— In Greenwich a group evolved after men's health week to address social isolation as many were found to be isolated. These men come together to talk, and see it as a social club, but they do talk about their health and it has had good outcomes. It works partly as there is no pressure for the men to do anything, it is just about talking to each other. Greenwich Public Health is involved with this.

— Lewisham’s ‘4 neighbourhoods model’ where GP practices are working as clusters, was seen as a good example of integrating CVS organisations into the work of the health service.

— Lewisham have “proactive primary care” in which they are phoning people with two or more LTCs and doing motivational/supportive interviews with them, and linking them up with services. Greenwich have something similar.

_Children and young people_

Examples of best practice include:

— The Haringey pilot on social prescribing. Signposting to other advice, focussing on family support.

— Asset based community development in Croydon

— The model of specialist children's nurses working in the community to avoid admissions to hospital. This is a community enterprise in Salford

— Kaleidoscope children’s centre in Lewisham as a model of bringing different health providers together around the needs of children and young people.

— The New Generation Youth Centre in Lewisham is an example of successful outreach from GPs and Nurses going out to young people in their own environment.
**Long term conditions**

— South London and Maudsley Foundation Trust was suggested as a good example of integrated physical and mental health strategies.

— Charlton Athletic Community Trust work with early intervention teams to provide early intervention in psychosis was cited as a good example of prevention work.

— Lewisham’s Proactive Primary Care and Community Connections were felt to be effective.

— 3DFD an integrated service for poorly controlled diabetes and mental health, is a good example of a service including third sector input.

**Maternity care**

— In Lambeth, mental health specialist midwives can successfully assess pregnant women with mental health issues and send them to the mental health perinatal case loading team. This is a good example of communication between different teams to improve early diagnosis and intervention.

**Planned care**

— The neurology department at Guy’s Hospital was felt to be very joined-up.

— The Hidden Voices Project in Lambeth was also felt to be effective.

— Lambeth Community Neighbourhood Watch Association has started expanding their remit, they produce a monthly newsletter bringing together news about good things happening, and trying to make sure that elderly, vulnerable or isolated members of the community are linked with the group, including knowing the contact details of their relatives and care providers in case anything happens.