Our Healthier South East London
Improving health and care together

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Response to the findings of the six deliberative events held in July 2015

November 2015

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Introduction

In July 2015, the *Our Healthier South East London* programme held six events, one in each borough of south east London. The events aimed to generate discussion around some of the challenges facing health services locally and some of the initial thinking about what could be done to improve them. This report examines the findings from these events and details how they have been considered and incorporated into the development of our strategy.

Background to 'Our Healthier South East London'

The six south east London NHS clinical commissioning groups (CCGs) – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – and the health commissioners from NHS England (London) are working together with local councils, hospitals, mental health, primary and community care services, the six borough Healthwatch organisations and local people on a five year plan to improve health and services for everyone. This five year strategy for the NHS is called *Our Healthier South East London*. We are seeking to address a number of challenges, many of them common across the NHS and some specific to south east London. It is likely that the way in which health services are delivered will change, with more care delivered in community settings outside hospital, a greater focus on helping people to stay well, and making services more joined up.

Our work is informed by two key strategies that have already been developed: the NHS *Five Year Forward View* and *Better Health for London*. The NHS Five Year Forward View sets out a broad strategy for health and care improvement and Better Health for London provides recommendations on how to deliver this in London. In south east London, these are complemented by *Our Healthier South East London* strategy programme (the Strategy) and the CCGs' local operating plans. Together, these provide a real platform for long-term change for the better health of our populations.

Our 'Issues Paper'

In March 2015 we published an 'Issues Paper' setting out some of the challenges we are facing and why we think things need to change. The paper sets out key challenges in the following six clinical areas – these are our Clinical Leadership Groups (CLGs):

1. Cancer services
2. Children and young people's services
3. Community based care
4. Maternity Services
5. Planned care
6. Urgent and emergency care

The Issues Paper contains summaries of key issues and emerging ideas in each of these six areas, or work streams, along with a series of questions for patients, the public and other stakeholders to address. Mental health is also a key priority and is covered in each of the six workstreams, as all of them are relevant to mental health.

Findings from the events

Attendees were a mix of people from the local voluntary sector and recruited members of the public. Members of the public were randomly selected, with the aim of matching the demographic make-up of the local community within each borough. In addition, local voluntary and community groups with an interest in health were specifically invited. Over 440 people participated in the six events, with a range of age, ethnicity and other demographic characteristics.
The findings from the event have been written up into a final report, which can be found on our website:

Event report
www.ourhealthiersel.nhs.uk/Downloads/Report%20-%20OHSEL%20events%20July%202015.pdf

Our response to the findings

We were delighted with the response to the six events and we would like to thank everyone who attended and participated so positively in the discussions. The points raised have been taken back into the programme and considered by each of the six Clinical Leadership Groups.

Many ideas and issues were put forward and they were a mix of:

- Things that we note and are already doing/planning to do as part of our strategy
- Good ideas and suggestions that will be considered locally by each CCG
- Other comments that are out of the scope of our programme but are noted as feedback and will be shared with colleagues as appropriate.

It is important to say that these events are not the only comments or feedback we have received; we have had input from people in south east London throughout the life of the programme and we produce regular updates called 'You Said, We Did, which set out the headline feedback and our response. As part of our next phase of work, we will summarise our response to the feedback we have received to date. All points made to us have been noted and recorded.

This report deals specifically with the recent deliberative events. It goes through each work stream area in detail, considering the ideas, comments and suggestions received at the event and how they will influence the programme as it develops.

1. Headline findings

A wide range of points and questions were raised and these are set out under the 'workstream' sections below, together with our responses.

We were encouraged by the fact that the most frequently raised themes across all areas are issues that our strategy seeks to address. This suggests that the public and stakeholders recognise many of the challenges we have identified and want the NHS to improve in these areas. In this regard, the events were consistent with previous events organised by the programme and previous feedback we have received.

The five most common themes across all areas were:

- Access to GPs
- Communications, information and record sharing
- The need for services to be better integrated and coordinated
- The need for more staff and better training
- The need for more services based in the community.

All of these align with key themes of the *Our Healthier South East London* strategy. Their popularity gives some indication that our strategy is tackling the issues that concern local health service users. (You can see how our draft strategy addresses these points in more detail on our website www.ourhealthiersel.nhs.uk where you can read the whole strategy.)

Some points were raised during the events which, while valid or strongly felt, are not part of the remit of our strategy. These points have been passed on to colleagues in CCGs, provider trusts, local authorities or others as relevant and not all of them are covered in this response, though they are all highlighted in the independent event report. The six CCGs each received individual reports of their local events and are best placed to respond directly to local suggestions and concerns which are not in the scope of our joint strategy.

2. Response from the Cancer Clinical Leadership Group (CLG)

The issues raised and recommendations were grouped into five broad categories for cancer services.

1. Faster access, earlier diagnosis, less waiting time for referral and treatment
2. Better communications, information and record sharing
3. Improved support and/or care before, during and after treatment
4. More integrated and efficient end to end care model with a 'care navigator'
5. Quantity and quality of clinicians.

All of these are areas that we want our strategy to address. Detailed responses to specific points are set out below.

Table 1

Table 1 below shows comments made in the deliberative report by attendees (in the left hand column); the right hand column contains details of the proposed interventions.

You said	Our response
We need faster access, earlier diagnosis, less waiting time for referral and treatment There is too big a gap between diagnosis and treatment	**Early Detection** These are issues that we are trying to address through the strategy. Guy's and St Thomas' Trust (GSTT), is committed to developing a 'vague symptom' diagnostic centre for the population of south east London. The focus will be on non-specific symptoms such as unexplained weight loss, severe fatigue/malaise, abdominal discomfort and pain, that may be cancer symptoms, but do not fall within the rules meaning a patient should be seen within two weeks. Access to the diagnostic centre will be via a referral, following a structured set of initial investigations in primary care, including blood tests, chest X Ray, abdominal ultrasound and the option of CT scanning being explored. A diagnostic centre team will be established. This will include consultant leadership of the diagnostic process, nurse navigators to help patients through the process and administrative support. The team will advise GPs on findings from primary care investigations and provide prompt access and investigations for patients where the cause of the symptoms remains unclear. The patient will have a named consultant, who will coordinate investigations and access advice from relevant clinical teams in the Trust, liaising with the patient and GP to achieve a timely diagnosis or an all-clear for the patient.
Diagnostic training for GPs	**Early detection** Where appropriate and/or applicable a training and education package will cover training for GPs.
Locum GPs don't refer	**Early detection** It is extremely unfortunate and regretful that a patient has experienced this situation when/if a referral was required. We do not believe this comment is a true reflection on the practice of all locum GPs.

	A training and education package for all staff in primary care will provide further support for all GPs in terms of when to refer a patient; this will be supported by the use of a 'Cancer Decision Support Tool'.
More pro-active screening and early screening for all cancers	**Early detection** Other than cervical screening, GPs cannot screen patients. Screening is a national programme, therefore patients can only be advised and encouraged to attend screening, which we envisage being an intervention area within the education and training package for our emerging Local Care Networks. Local Care Networks, with all health and care professionals working together in each area, are a central part of our strategy.
Breast cancer check and invitation	**Early detection** We agree this is important. Targeted engagement work in our local communities, professional development for all staff in primary care and use of automated invites will support improvements in this area.
Improved support and/or care before, during and after treatment Aftercare following treatment	**Early detection, treatment, living with and beyond Cancer** Improved care before, during and after treatment for both patients and carers has been identified as an important area for improvement. This is a universal concept across all aspects of our proposed model of care for cancer. Implementation of a 'Cancer Recovery Package' will ensure care is coordinated, transition home is supported and patients are empowered to make good life style choices. The 'Recovery Package' is a combination of different interventions, which when delivered together, will greatly improve the outcomes and coordination of care for people living with and beyond cancer. These include Holistic Needs Assessments and care planning at key points of the care pathways as follows: • A treatment summary completed at the end of each acute treatment phase, sent to patient and GP • A cancer care review completed by GP or practice nurse to discuss the person's needs • A patient education and support event, such as a health and wellbeing clinic, to prepare the person for the transition to supported self-management, which will include advice on healthy lifestyle and physical activity The cancer care review and wellbeing event can take place in our Local Care Networks.
Need for emotional support to combat anxiety during diagnosis and treatment	**Living with and beyond cancer** Psychological support for people living with cancer is a key priority area for the Cancer CLG. Earlier diagnosis and improvements in treatment mean that more people are surviving cancer. The impact of psychological morbidity when living with and beyond a cancer diagnosis is well-recognised. The London Mental Health Strategic Clinical Network in partnership with the Transforming Cancer Services Team for London has produced guidance to support commissioners and service

	providers in improving psychological support across the cancer care pathway. The south east London programme proposes to follow the best practice recommendations as outlined in the guidance.
More support for carers	**Living with and beyond cancer** Support for carers is key element of the proposed cancer model. It includes carers' needs assessments being offered as routine and signposting carers to the information and support they need. Macmillan's guidance on support for carers, which has been included in our strategy, also details that carers should be routinely included in both advanced care planning and discharge planning.
Better signposting to end of life care services	**End of life care** End of life care will be provided by the Local Care Network and sits within the Community Based Care CLG. It is a key priority area for our Local Care Networks. There is recognition of the need to start early conversations about end of life care and signpost people to services This is highlighted in the ideas we put forward in the strategy.
Palliative care should be a central part of the service	**End of life care** End of life care will be provided by the Local Care Network and sits within the Community Based Care CLG, where it is a key priority.

You said	Our response
We need a more integrated and efficient 'end to end'care model with a 'care navigator' There is not enough information and education about symptoms and treatments Patients and carers should have access to a named individual throughout the patient journey	The NHS Five Year forward view outlines that patients do not always have the information they need and, crucially, the support they need to understand it. Macmillan-funded research has shown that 37% of people with cancer found the whole cancer support system confusing and would benefit from structured support and guidance on managing their condition. The interventions being proposed by the Cancer CLG to address these important issues are: 1. A care/case navigator role to provide information for patients and carers on where/how to access appropriate information such as psychological support. The care navigator role is seen as pivotal in delivering better integrated and more efficient end to end patient centred care. By working in partnership to navigate and negotiate the health care system, they empower choices and enable the patient to take control over their care. 2. An acute oncology services 24/7 advice line (more details given below). 3. Facilitation for patients and carers to access existing on-line support services. 4. Signposting patients and carers to cancer advice and support centres.
Easier access to expert care Lack of shared information between different facilities	The Cancer CLG is proposing coordinated and consistent acute oncology services across south east London. This would need to be supported by an integrated IT system. There are also national expectations. The National Chemotherapy Advisory Group (NCAG) report and Cancer Reform Strategy recommended the establishment of an acute oncology service in all hospitals for quality and safety reasons: • To provide early recognition, better treatment, fast referral to appropriate team, earlier discharge • To enable close integration with the Clinical Haematology team, as well as Palliative Care, acute Medicine, acute Surgery, Radiology, Pathology etc. and to lead chemotherapy and oncology services at hospital level • Chemotherapy is expected to be provided in appropriate local settings. Acute oncology services provide consistent standards of care and improved access to oncology specialists.

	Early review provides a member of the acute oncology team with: • 24/7 access to telephone advice from an oncologist • Fast track clinic access from A&E/Medical Assessment Unit • Access to information on individual patients across the Trust/Trusts • Protocols for the management of oncological emergencies and referral pathways from A&E and a Medical Assessment Unit • Specific pathways for the investigation and treatment of malignant spinal cord compression (MSCC)
High quality care is needed during treatment process Treatment could be more efficient	**Treatment and Transition** The provision of high quality care sits at the heart of our proposed treatment pathway. As such, the premise of each intervention outlined is to improve patient outcomes and patient experience.
Quantity and quality of clinicians Variability in the quality of care from doctors Lack of cancer specialists – do our providers have the right workforce? NHS clinicians working in the private sector Understaffing of wards can lead to low quality of care in hospitals Improved liaison between clinicians Quality of clinicians	Much of our work looking at issues relating to the quantity and quality of staff are being driven through our workforce supporting strategy. Through this we are identifying the key actions that should take place in order to move the workforce in south east London from where it is today to where it needs to be in the future. For instance, we know that the future care delivery will involve empowering patients and promoting independence, making every contact with our services count and fostering an environment where colleagues engage with each other rather than refer and hand-over. With these significant changes on the horizon, understanding what patients will require in the future and challenging existing ways of working will allow us to plan for a workforce that is fit for purpose and sustainable. Delivery will also require significant cultural and behavioural changes; for instance, we need the entire workforce to make every contact with patients count and to appreciate that patients want more say in the care they receive. The workforce will also need to work differently with each other; there needs to be greater integration and more dialogue between parties - rather than a simple passing on of information and/or a patient. Not only do commissioners and providers need to work more closely together but there also needs to be greater cooperation and integration across different healthcare pathways.
Improved liaison between clinicians	Our Local Care Networks will look at the care around the patient with multiple services working together. Each borough will be developing these schemes.
Healthy living advice from childhood – public health agenda	We fully support these points. Better preventive care is at the heart of our strategy and we are working with public health teams and through our

Cancers due to lifestyle need to be linked with other preventative services like healthcare Contradicting messages about healthy lifestyle advice Awareness of what preventative cancer services there are	Local Care Networks to support patients and carers to live healthier lives, manage long term conditions and illnesses better and get the information they need.

3. Response from the Children & Young People's Clinical Leadership Group

The following sets out the Children and Young people's CLG's response on the points raised, which fell into seven broad categories:

1. Involvement of and support for families
2. The transition from young person to adult
3. Mental and emotional health and wellbeing
4. Communications, information and education
5. Prevention and early intervention
6. Service access for young people
7. Integration of services

All of these are areas that we want our strategy to address. Detailed responses to specific points are set out below. The CLG has also considered how the points are being addressed more widely across London, particularly through the Healthy London Partnership. Where relevant we have referred to such work.

Table 2 Involvement of and support for families

You said	Our response
Obesity: • the importance of whole family approach, including using schools • help both young people and parents	We know that obesity needs to be tackled. Obese children become obese adults facing a lifetime of poorer health and quality of life. Unhealthy weight in children and young people is a key area of focus for our local authority and education colleagues. Initiatives being considered include lifestyle weight management services that are family-focused where there are no complex needs identified. Some young people may require a more specialised service, where additional social and/or medical needs have been identified Such interventions would be part of the community-based care model of care.
Support for families and carers Engaging parents and carers in children and young people's health services	There are a number of children's centres across south east London which exist to provide services for local children and young people and their families whose health, education or social needs are special. Our strategy is also looking at creating a dedicated 'transition co-ordinator' role, which would provide families

	and carers with support. As detailed specifications are developed, the views of parents and carers are being sought.
Support for parents to enable them to provide care for children and young people	In relation to the care of children and young people there are key links with our maternity work. Our proposed maternity model recognises the importance of pre-pregnancy education and information to optimise healthy pregnancy and improve lifestyles. These will have an impact on outcomes, well beyond birth, for both mother and child. Work is ongoing to identify the services needed to support parenting, especially in the first year after birth, and even more so with teenage mothers.
Better facilities and support for families to encourage children and young people to be active and healthy	Healthier lifestyles will not only help children and young people with an unhealthy weight but will also impact the health and well being of all children and young people. Primary Care providers already advise on how children and young people – and their families – could maintain a healthy lifestyle. The provision of facilities to support such activity, such as outdoor gyms, is outside of the scope of our programme, but an area in which further developments would be welcome.

Table 3 The transition from young person to adult

You said	**Our response**
Transition into adult services of young people with long term conditions Ensure consistency of services and relationships Transition needs to be better and more support provided	The care model we are suggesting for children and young people proposes that transition for those children and young people with more complex needs should be coordinated by a *transition coordinator.* This individual could come from either the community or acute setting, depending on where the young person has received most of their care. All of these coordinators will work closely with the young person; for instance, taking them to clinics in an adult setting. They will also organise meetings between the relevant paediatric and adult clinicians to agree the future care plan. They will ensure that the GP now looking after the young person is aware of their history. The coordinator will also remain in contact with the young person – and, as appropriate, with their family - for a period of time after they have moved to adult services in order to provide the individual with support at a time when they may feel quite vulnerable. The duration will

	vary from patient to patient according to the complexity of their case but could be for as long as a year.
Provide young people with independent access to GPs and to support in schools	Our young people tell us that they want direct access to advice – advice and support that is discreet. In developing community based care, examples of good practice are being identified such as work being done in some areas by community pharmacists and school nurses. Our strategy also acknowledges that more could be done to leverage the power of new media. Local people are used to quick, online access to information and instant feedback.
Transition of young people at age 16 rather than abrupt change	The point raised is an important one, as the strategy acknowledges that we need to work with children and young people from as young as 12 to prepare them for transition to adult services. The CLG is considering how this might be achieved. For instance, what information do/could school nurses provide to secondary school pupils? Self-management is a key principle of our strategy.

Table 4 Mental and emotional health and wellbeing

You said	Our response
Emotional and mental wellbeing of young people	All agencies recognise how important this is and how vital it is to support parents and carers in the care that they provide to ensure resilience in the young. There is a national focus on mental health and well being, and it is a key aspect of the whole strategy in terms of provision for all, not just children and young people. All of our models of care are considering how the interventions proposed will help maintain mental and emotional health and wellbeing – and if more needs to be done. In March 2015, the Department of Health published *Future in Mind*. In an open letter to children and young people, Future in Mind told them that the report set out a vision that it was hoped reflected what they, as well as their parents, carers and professionals, said was needed, with ideas about how to make it happen. This report has influenced local CCG strategies and plans.
Mentoring of young people and earlier reviews of the consequences of medication for young people with mental health issues	The development of community-based care for children and young people needs to take into account how they are mentored and by whom. The strategy also recognises that young people are at a particular risk of not getting appropriate follow up.

Focusing on "sub-threshold" symptoms for young people's mental health – for example, helping to avoid misdiagnosis of social behavioural conditions, like ADHD, in children	We agree that early – and correct - diagnosis is important. As our thinking is developed in more detail, each area needs to consider how this can be achieved. For example, do those working in the community need further training to help them recognise symptoms more quickly?
Better education in schools on mental well being	Schools and local authority colleagues acknowledge the importance of this.

Table 5 Communications, information and education

You said	Our response
There needs to be a place for young people to raise issues; and confidential sources of information for children and young people	We acknowledge that a GP's surgery is not always the best place for a child or young person to raise issues. Consideration is being given to drop-in centres and the role of community pharmacists. How to harness the technology children and young people use is also being reviewed by all our six boroughs - and across London. Improved communications and the timely sharing of information across the care system are critical to improve access to primary and community services and enable proactive and coordinated care with good continuity.
GPs need more time and training to relate to patients and diagnose better	We are exploring how more specialist knowledge and support can be provided in the community. For instance, there has been a pilot where paediatricians have worked alongside GPs to assess and diagnose children and young people. Advice lines are also being set up in a number of areas, where GPs can get specialist advice. We are also exploring how community nursing teams could have access to more specialist knowledge; for instance an asthma specialist nurse in the Local Care Network.
Knowledge about what is out there in the community for young people	Signposting and navigation for children and young people, and their families, is a key element of our thinking
Better listening and cooperation in hospital for young people	Urgent and emergency care, as well as in-patient acute care, for children and young people is another key aspect of the model.
Young people's health forum	Suggestion noted and to be raised with education and public health colleagues.

Table 6 Prevention and early intervention

You said	Our response
Education and information on healthy lifestyles from young age as prevention is key More education in schools for young people on health conditions	We strongly agree with this point and prevention is central to all elements of our strategy. The NHS *Five Year Forward* view states that the future health of millions of children now depends on a radical

Information to allow informed choices and healthy lifestyles Ensure all agencies give consistent message re healthy lifestyles	upgrade in prevention and public health. However, this is not just the sole responsibility of the NHS; it requires a whole system approach.
Sports and physical activity – need more in schools	This comment will be shared with colleagues in local authorities/education as appropriate
Prevention approach to services	Agreed and central to our community based care model.
Focus from very early years – from breast feeding, nursery and primary – on healthy lifestyles	We have also developed a maternity model of care. This acknowledges that the health and well being of a child starts with that of the mother, even before birth.
Importance of preventing conditions in adulthood if managed better in childhood	Accepted; hence the national focus on prevention and well being.

Table 7 Service access for young people

You said	Our response
Varied availability of young people's services in different areas	Work is ongoing to develop consistent service specifications across south east London. Such specifications will allow for local variation to meet the needs of the local population.
Make NHS services more accessible for young people so that they feel they can approach them	We agree and have set out above some of our thinking – and thinking going on a national level – about how to address this. All six CCGs across south east London are committed to improving access to GP services. Each has clear plans to offer extended GP practice opening hours, including evenings and weekends, and increased access to bookable appointments. Full implementation across south east London is expected to have been achieved by April 2017. In some areas, the plans have already progressed to implementation. For instance, in Southwark and Lambeth primary care access hubs are already offering 8:00 am to 8:00pm, seven days a week bookable appointments for example. This makes it much easier for children and young people and their families to see a GP when school or college is finished for the day.

Table 8 Integration of services

You said	Our response
Social prescribing – not just GPs but other services in the community	GPs with other professionals, carers and voluntary sector workers will be encouraged to look outside standard medical therapies to help resolve or alleviate ill health, e.g. Southwark Safe and Independent Living (SAIL) is a brand new service which provides a quick and simple way to access a wide range of local services to support older people to maintain their independence, safety and wellbeing. A key proposal for children and young people's care is that there should be better integration of services for children and young people, particularly those with more complex needs. We are exploring how best those working in the community care and in primary care can work more closely – and how to provide them with specialist support and advice they may need to ensure that a child or young person can be cared for in the community. Such integration will seek to bring together a core group of paediatric services and improve mental health integration. In particular, we seek to avoid unnecessary trips to A&E – and to return those children and young people who do go to hospital back to the community as quickly as possible, with the right support.
Integrated teams should include legal teams and sexual health services	We agree – this needs to be considered further as part of the ongoing work.
Referrals to community based specialist knowledge – rather than going to A&E	Please see above
More wellbeing/health centres to take pressure off hospitals	Agreed and a key part of our strategy.

4. Response from Community Based Care Clinical Leadership Group (CLG)

The following response is structured to mirror the grouping of issues and recommendation into six themes within the report:

1. More, better and quicker GP and/or walk in centre access
2. Better communications, information and record sharing
3. Integrated, person centred services with a 'care coordinator' to navigate the system
4. Service improvements
5. More training for staff/professionals
6. Targets and funding

All of these are areas that we want our strategy to address. Detailed responses to specific points are set out below.

Table 9 More, better and quicker GP and/or walk in centre access

You said	Our response
Appointments at more convenient times including Saturday and Sundays Difficulty getting appointments	All six CCGs across south east London are committed to improving access to GP services. Each has a plan to offer improved access to bookable and walk-in GP and nurse appointments, including early morning, evenings and weekends. The plans should be fully implemented across south east London at the latest by April 2017 with some boroughs delivering earlier. In Southwark, for example, with the support of the Prime Minister's Challenge Fund, primary care access hubs are already offering 8:00 am to 8:00pm, seven days a week bookable appointments and Lambeth is implementing a similar solution. In other areas, different approaches are being taken. Hubs, walk-in centres and bookable GP appointments within Urgent Care Centres are already offering improved access and being further developed to meet the Primary Care standards for London and to support the successful delivery of the *Our Healthier South East London* Community Based Care programme.
Longer appointments	Many GP practices already offer longer patient appointments where necessary, for example when undertaking a diabetes review. Across each borough, the CCGs are actively commissioning or considering proposals from GP federations to offer extended appointments, i.e. for patients with long–term conditions and complex needs.

More primary care access in alternative ways – e.g. Walk in clinics, online appointments	All GP practices across south east London have in place the technical ability to offer online bookings and repeat prescriptions, email and telephone consultations. Each CCG has plans to ensure that practices are both advertising these arrangements and enabling utilisation, by offering bookable appointments on-line for example. The CCGs are also committed to working with GP practices to find ways to implement single telephone triage and booking arrangements across the new Local Care Networks and/or GP federations to improve access and the patient experience. Delivery across south east London for online access and email consultations should be implemented by July 2017 with some boroughs delivering earlier.

Table 10 Better communications, information and record sharing

You said	Our response
Communication between different NHS services need to be linked Communication between GPs and other community based services like pharmacies needs to improve	We recognise that improved communications and the timely sharing of information across the care system are critical to: • effectively and successfully improve access to primary and community services • and enable proactive, coordinated and personalised care with improved continuity.
Sharing of information and personal health records to ensure continuity of care Medical records to be shared across locality	All GP practices are using patient information systems that offer the ability to share medical records online. All CCGs are also progressing with plans to safely and appropriately share patient records across their Local Care Networks and/or federations by April 2017. Plans extend to sharing records with acute and social care providers and these are already quite advanced in some areas. In Southwark, for example, the primary care hubs already have access to the primary care record (subject to patient consent), whilst Lewisham is implementing 'Connect Care' across the borough which will support patient record sharing across primary, secondary and social care.

Table 11 Integrated, person centred services with a 'care coordinator' to navigate the system

You said	Our response
There needs to be a person – a 'care coordinator' or 'care navigator' – to guide patients through the complexity of service provision	Across each borough, locally commissioned schemes are developing the 'coordinator' role to support vulnerable people with complex care needs and others who would benefit from such support. Coordinators are helping to

Would like to see more integration of social issues that have an impact on health – housing, poverty, education	improve communication, signposting patients and carers to information and services, helping to ensure that those who need it receive joined up and integrated care, promoting and encouraging self-management and promoting prevention.
A good service is an integrated service, with shared records and a service in which you have a choice and which is patient centred Coordinated care for people with multiple conditions Voluntary and community services involved in delivery of preventative healthcare	There are a range of initiatives across the whole of south east London such as: • The Bromley Patient Liaison Officer scheme, where GP reception and administrative staff have been trained to help coordinate and contribute to effective care for vulnerable and housebound patients: facilitating communications between the practice, patients/ carers and external agencies; signposting patients and carers to services and acting as the patient 'friend'. • The Greenwich Care Navigator pilot, where patients with complex needs are referred to a non-clinical person who works with the patient to understand and help them to articulate their problems and wishes. They represent the patient at a specially convened multi-professional meeting which includes the GP, mental health, social care, voluntary sector and other agencies as appropriate. They meet to agree a personalised care plan for the patient that takes account of their expressed needs and wishes. • The Lewisham Community Champions scheme, commissioned from the local voluntary sector, which is helping local people access services, advice, information and support as appropriate. • A practice initiative in Bexley, where local volunteers act as 'friends' to visitors to a large practice to help with administration, advice and signposting etc; now being rolled out as 'health champions' across six other practices as part of a wider social prescribing initiative.

Table 12 Service improvements

You said	Our response
Specific initiatives: Would like to see peer support not just for mental health patients. e.g. buddy-up diabetes sufferers Healthcare assistants, dentist and urgent care centre staff to be able to make referrals Home physio and occupational therapy should visit for longer than six weeks – up to a year.	The service improvements within Community Based Care that we are planning (or already delivering) are numerous and varied. In addition, each CCG has signed up to our 'target model' for community base care. This model commits each borough to implementing a number of 'big hitter' schemes. These are so called because of their potential impact in improving the health and well-being of people, addressing inequalities, improving quality and outcomes and helping commissioners to make the best use of available resources. These include: • Supporting people to manage their own health • Prevention – obesity, alcohol and smoking (Public Health England priorities) • Improving core general practice access (including evenings and weekend working) • Enhanced primary care call and recall systems to improve screening rates, aiding early identification and better management of long-term conditions • Reducing the gap between recorded and expected prevalence in long-term conditions • Supporting vulnerable people in the community including those in care homes and domiciliary care • Reduction in variation in primary care management of long-term conditions – level up • Reablement schemes – such as rapid response, virtual wards and step-up/down intermediate care beds to help prevent unplanned admissions and support effective discharge from hospital • Multi-disciplinary team working with a particular focus upon the main long-term condition groups (including mental health) and the frail elderly • Improved end of life care services
Each CCG, working with its key partners and stakeholders (local authorities, providers, the voluntary sector, patients and carers) is developing and delivering its own local plans for these target areas based upon local need and priorities. The CCG directors responsible for delivery meet monthly with clinical, local authority and service user and other representatives to review local progress, share learning and best practice, support local delivery and ensure consistent standards across south east London.	

Table 13 More training for staff/professionals

You said	Our response
Training for GP surgery staff on communication, people skills and services available Sufficient qualification for pharmacists if they take on a diagnostic role More training on treatment of LGBT community	Whilst direct responsibility for the training of staff and care professionals working within the community based care system sits with the employers, the programme recognises that the workforce is critical to delivering successful and lasting change. Consequently, the programme is developing its own workforce strategy. The strategy recognises the importance of integrated and effective leadership across the Local Care Networks to ensure success. Each CCG is working with local providers and the emerging GP federations to ensure that these skills are in place Our strategy is to: • help identify and clarify the enhanced and perhaps new roles, competencies, behaviours and characteristics required to deliver the person-centred, proactive and empowering, multi-disciplinary and holistic care and support services that service users and carers tell us that they want and need; and • influence local community education provider networks and London-wide education networks to train and develop existing staff, introduce new and flexible ways of working and ensure that new staff have the new learning embedded in their vocational education programmes.
The coordinator/navigator role has been identified as critical, for example, and we are aiming to set out the core competencies required with the support of our Public and Patient Advisory Group. We will use this to influence the training and development plans of local community education provider networks and the commissioners and providers of education programmes to ensure that such training is available. Similarly, motivational interviewing and health coaching skills are seen as critical attributes for the community based care workforce and each CCG has been asked to develop plans for commissioning such training for staff working in community based care.	

Table 14 Targets and funding

You said	Our response
Targets and competition between services is concerning GPs should be judged by patient satisfaction and health using preventative measures	A critical component of the whole *Our Healthier South East London* programme is the challenge of ensuring and sustaining financial balance across the NHS. This is in the context of ever increasing demand and growing costs, much of which is associated with the consequences of people living longer with increasingly complex care needs. Our community based care programme has a critical role to play in helping to support people with complex needs in a proactive rather than reactive way and in community rather than hospital settings, wherever safe and appropriate. It also has a fundamental role in helping to improve quality and outcomes and the longer term health and wellbeing of the people of south east London.
Finance – prevention is better but is it cheaper?	Commissioners and providers are increasingly looking at contracting models that are based on outcomes for the patient, rather than purely on the clinical activity. Commissioners are looking at ways of rewarding quality and patient experience, and measurable improvements in health and wellbeing; encouraging providers to work together to share the benefits and risks.

5. Response from Maternity Clinical Leadership Group (CLG)

The following sets out the CLG's comments on the points raised, which fell into six broad categories:

1. Quality, safety and consistency
2. Staff related
3. Communication and education
4. Community based services
5. Policy
6. Service process/design

We recognize all of the points raised.

Table 15 Quality, safety and consistency

You said	Our response
Much better early pregnancy care and assessment of risks Early scans/variable treatment/consistency of service in early weeks of pregnancy	We want women to seek support and advice as early on in their pregnancy as possible. Currently the national standard for a woman's first appointment is nearly 13 weeks but we want to encourage women to access services by week 10. This will allow for an appropriate monitoring and care plan to be put in place and assign the most appropriate midwife team from the outset. Early access to maternity services whether via a GP referral or direct access by 10 weeks enables early risk assessment and access to screening and scans. Early screening will allow us to assess pregnancy risk. For instance, those at low risk would be supported by community midwife teams. Those at greater risk would be referred to a specialist team in the community.
Infection rate as low as possible and high standards of hygiene	We agree this is critically important. Staff training at all levels gives particular focus to the importance of high standards of hygiene at all stages of pregnancy.
Continuity of care throughout; from pregnancy to delivery	We acknowledge how important this is. Women who receive midwife continuity of care are more likely to have a more positive experience of labour and birth and successfully breastfeed their babies. In addition, they are more likely to have a vaginal birth and few interventions during birth. Importantly, they are less likely to experience preterm birth or lose their baby before 24 weeks' gestation.

	Therefore our proposed approach supports every woman having a named midwife to improve women's experience of maternity care. For example, helping to avoid women having to repeat themselves at each visit to maternity services. Midwife-led continuity of care is one of the main enablers in the delivery of our maternity model of care and in delivering the positive impacts of a reduction in lengths of stay on the obstetric ward and in caesarean section rates. There a number of good examples across south east London where continuity of midwife-led care is being provided. For instance, St Thomas' Hospital maternity services have group midwifery practices based in the community providing continuity of midwifery care for women both pre and post birth.
Good quality, personal and individual care	As stated in our Issues paper – *Help us improve your local NHS* - our aim is to make sure that mothers-to-be receive a more personalised service, with better continuity of midwife support and care with the right information to enable them to make an informed choice for their birthing options. This may include home birth or birth in a maternity unit. We want to provide better support for women to have a healthy straight-forward birth in a setting of their choice where possible. Women should have a positive experience of pregnancy and birth. The happier they are will also have a positive impact on the well being of their partners and wider families – particularly other children (if any). In south east London, we have been rolling out an innovative approach to improving user experience called *Whose Shoes?* This brings together service users and NHS staff to talk about their experiences, so helping to develop sustainable improvements. In the future, we need to ensure that patient experience is consistent across the region.

Table 16 Staff related

You said	**Our response**
Highly skilled workforce	We have a highly-skilled and dedicated workforce. However, we continually review training for all levels of staff. For instance, given the development of Local Care Networks we are looking at how community midwife based teams based in these networks will connect with specialist services – and coordinate such care.

Vital who provides your care – assigned consistency of care. Choice of individual who cares for you Consistency of care – need dedicated and consistent team for mothers during pregnancy and birth Lack of staff and lack of beds Not enough midwives	As mentioned in section 1, continuity of midwife-led care is viewed as critical. However, we also acknowledge that additional midwives are required. In terms of bed numbers, we are seeking to increase the number of birth centre births for low risk mothers – and to increase the number of home births for such women. This would help to improve the birthing experience for these women and ensure that beds in hospital obstetric units were available for those at highest risk.
Emergency midwives on call Consultant visibility and availability	We note these points, but our immediate focus is on meeting the 'London Quality Standards'; in particular, to achieve 24/7 Consultant presence on labour ward and midwifery staffing ratios of a minimum of 1 midwife to 30 births, across all NHS locations where women give birth. In addition, midwives providing care will be part of team. Consequently, should a pregnant woman not be able to reach her named midwife she would be able to contact someone else in the team in an emergency.
Presence of midwives at home births – and a care plan in place if things go wrong	We are seeking to increase the number of home births. The aim is that every pregnant woman should have a named midwife who co-ordinates her antenatal and postnatal care. Each pregnant woman will have a care plan.
Supporting good staff	Agreed; our workforce is one of the key enablers of the maternity model. We have a duty of care to look after their health and well being, as well as that of those women for whom we care. Our workforce needs to be resilient if we are to meet the increasing demand for care.

Table 17 Communication and education

You said	Our response
Better education to avoid teenage pregnancies	We are unlikely to stop all teenage pregnancies, but the numbers have fallen over the last few years. This reflects efforts to make sure that young people have good "sex and relationship" education and access to contraception. We will continue to work with public health colleagues to maintain this work.

Better communication between doctor and patient from earlier stages of pregnancy Patient clinician relationship – better communication and better joined up patient history First time mothers – reassurance and guidance Communication about decisions involved in care of mother and baby	We recognise that good doctor/patient communication will help to make sure that women have a positive experience from preconception to 12 months after birth. We are supporting a programmes called *Whose Shoes?* which will help our workforce see service delivery through the eyes of service users. Midwife-led care will make sure that communication is even better. Women will be known to the midwife and will have to tell their stories only once. In addition, developing better communications and information sharing with primary care and health visiting across maternity care will enable a smoother transition from maternity services to primary care and health visiting support in Local Care Networks.
Informed choices around different birth settings More information about different birthing choices, like home births Informed about different birthing choices	We agree that women and their families should receive the best possible information and communication to ensure that they are able to make an informed decision about where to have their babies – at home, in a hospital alongside birth centre or in a hospital obstetric unit. Continuity of midwife-led care will support women to make informed choices about their birth plan, including place of birth.
10 week assessment is too late - earlier assessment integrated with lifestyle issues	We agree that the health and well being of a woman before conception is vitally important. We want to provide women with access to information in a variety of settings, such as GP surgeries, children's centres and pharmacists. Again, we need to work closely with public health colleagues to encourage women to maintain a healthy lifestyle.
More services available in hospitals	Our proposed maternity model supports increasing the number of births in midwifery-led units, co-located with an obstetrics unit. This model is beginning to prove popular with women who are deemed to be low risk and therefore suitable for this option.
Education needs to fit the needs of the individual and be accessible	Agreed.

Table 18 Community based services

You said	Our response
Care being locally based Prevention and health services in the community for pregnant women	Community-based, midwife-led care is key feature of our proposed model; both in the early stages and during birth. We want to increase the number of midwife-led births in specialist birthing units and the number of births at home. The findings show that women who choose and are suitable for home and midwife-led birth centre births, have birth experiences that are positive and lead to high quality emotional and psychological outcomes for both mother and baby with a low risk of adverse outcomes. Examples in south east London include midwife-led birth centres at Lewisham Hospital, at The Princess Royal University Hospital and at St Thomas'. In February 2015 a new six-bedded birth centre was opened at Queen Elizabeth Hospital, Greenwich.
Better postnatal care in the community Not enough emphasis on postnatal care, health visitor care	Postnatal care needs to be developed in order to improve access to support for women and babies. Women should receive coordinated postnatal care delivered according to an agreed pathway of care which covers both medical and social needs of women and their babies. This will include ensuring that there are sufficient postnatal options in the community and hospital for women, and that continuity of midwife-led care continues.
Greater use of the community based services and assets in the community	We are working closely with colleagues developing our Community Based Care strategy. In particular we are exploring primary prevention and wellness programmes and Local Care Network based community midwifery teams We want to see services working collaboratively at all stages of pregnancy, including maternity, health visiting, children's centres, primary care and pharmacists.

Table 19 Policy

You said	Our response
Uniform natal policy applying to all diverse backgrounds	A key aim of our strategy is to deliver consistency of service for all.

Table 20 Service process/design

You said	Our response
Midwife-led units and a wider range of options	Please see Table 17 re informed choice and birthing units.
Including mental health as part of maternity	Making sure women have access to perinatal mental health support is a priority across London. The six CCGs in south east London are currently developing transformation plans that will be published towards the end of the year.
Number of beds for midwifery	Please see Table 16
Leaving hospital too early	New mothers who have had a straightforward birth should not stay in hospital unnecessarily. For many of those who are low risk, giving birth in a specialist birthing unit or at home could well be a more positive experience for them and for their families. In particular, continuity of care by a midwifery team may make first-time mums feel confident about earlier discharge Appropriate discharge will make sure that beds in hospital obstetric units are taken up by those who are at greater risk and potentially may need inpatient care for longer.
Interim care before labour Shortage of beds when taken to hospital	Please see Table 16

6. Response from Planned Care Clinical Leadership Group (CLG)

Introduction

This response is structured to mirror the grouping of issues and recommendations which fell into five broad categories within the report.

1. Improve access (time and location) to services and improve appointment system
2. Better communication and information, and better communication between different parts of the system
3. Improvements needed in continuity and aftercare
4. Quantity and quality of nurses and clinicians
5. Pressure or resources

A significant proportion of the key areas highlighted are already priorities of the Planned Care CLG and are being addressed by the proposed Planned Care model for *Our Healthier South East London*. Comments which are outside the scope of the programme will be passed on to colleagues as relevant.

Table 21

You said	Our response
Reduced cancelled appointments Transport issues – need to support access to services Planned care appointments are too often moved or cancelled With proposed changes in planned care, patient transport and parking require full consideration Elective care centres are a good idea but need to be accessible Travel and access to specialist care centres – particularly for older people	**Elective Orthopaedic Centres** One of the key requirements of the Planned Care clinical model is to implement elective orthopaedic care centre(s) treating injuries to bones, joints, ligaments, tendons, muscles and nerves. To progress this work it has been agreed between the local Trusts and commissioners to conduct a piece of work looking at different models and considerations for implementing an elective orthopaedic care model. This will take place through a series of workshops. It should be noted that the programme is taking advice to make sure it follows best practise process in terms of correct membership of the working group, governance arrangements, options appraisal process and competition law. One of the key successes of elective care centres is a standardised patient pathway with standardised practices and procedures to improve patient outcomes, experience and safety. There is evidence available from examples of elective orthopaedic models (such as the South West London Elective Orthopaedic Centre – SWLEOC) implemented nationally that demonstrate: • A significant reduction in cancelled appointments • Using the centre's own patient transport ensures ease of access and reduce issues of travel to and from the centre (South West London Elective Orthopaedic Centre) • Standardised information for patients both pre and post

	operation Other benefits for patients of the SWLEOC model (which is being explored alongside other models) have included: • Improved quality of care seen in reduced waiting times • 90% patients achieved their estimated date for discharge (the national average is 50%) • Average lengths of stay reduced • Reduction in post operative complications • Patient feedback is positive • Care Plans and discharge plans shared with GP • Early supported discharge with access to a standardised rehabilitation programme The Planned Care CLG recognises the importance of access for patients and this will be considered carefully as a key priority. We will be considering impact on travel as part of any new model.
Information on discharge about after care and support available More efficient discharge for patients People being discharged too early with insufficient aftercare Need more connection/response from local care on discharge Ensure there is support on discharge from an operation We want better information at every step and standardised processes The GP must be informed of all that is happening to you	**Elective Orthopaedic Centres and pathway review** Our proposed elective care model has a number of standardised processes, including standardised information for patients before, during and after a planned care procedure. Intensive rehabilitation programmes are available on the ward and again following discharge to further support a patient's recovery. The model is also characterised by early **supported** discharge to ensure that patients, their carers and care packages are ready and in place to facilitate a safe and timely discharge. GPs receive copies of care plans as standard practice and remain pivotal in the process.

Table 22 Improve access (time and location) to services and improve appointment system

You Said	Our response
Standard process for accessing GPs – walk in appointments and possible fines for non-attendance Self booking and Cancellation of appointments Standardised approach to GP access	This is largely being driven by our Community Based Care work stream. They are looking at improving access by developing a standardised single point of entry to telephone triage and GP appointments across a network.

Table 23 Better communication and information, and better communication between different parts of the system

You said	Our response
Shared IT systems across services Communication of results Blood tests – why can't GPs and hospitals share information I go to two hospitals – they have to ask permission to see results of tests Communication of appointment times/ cancellation	Sharing information between GP systems and primary and secondary care are either being planned or being implemented at various speeds. All CCGs are moving to GP systems that will enable sharing of records across GP practises supporting Local Care Networks. CCGs have plans in place to improve the digital sharing of information. However additional transformation initiatives that may require agreement and funding at a south east London level have not been explored or agreed at this stage. The Planned Care CLG recognises the importance of IT to enable better communication and shared results between services in order to reduce delays and unnecessary duplication. These helpful comments will be shared with the IT enabler supporting strategy.

Table 24 Quantity and quality of nurses and clinicians

You said	Our response
Need more front line staff Variability in nursing care We need GPs to be more open that conditions may affect different people/ ages and not make assumptions When patients say something is wrong, don't stop at first test Communication between staff involved in care Champions for patients who can guide them through the planned care pathway Lack of continuity of care staff when going through a procedure	Much of our work looking at issues relating to the quantity and quality of staff are being driven through our workforce supporting strategy. Through this we are identifying the key actions that should take place in order to move the workforce in south east London from where it is today to where it needs to be in the future. For instance, we know that the future care delivery will involve empowering patients and promoting independence, making every contact count and fostering an environment where colleagues engage with each other rather than refer and hand over. With these significant changes on the horizon, understanding what patients will require in the future and challenging existing ways of working will allow us to plan for a workforce that is fit for purpose and sustainable. Delivery will also require significant cultural and behavioural changes; for instance, we need the entire workforce to make every contact count and to appreciate that patients want more say in the care they receive. The workforce will also need to work differently with each other; there needs to be greater integration and more dialogue between parties - rather than a simple passing on of information and/or a patient. Not only do commissioners and providers need to work more closely together but there also needs to be greater cooperation and integration across pathways.

7. Response from the Urgent and Emergency Network

The Urgent and Emergency Care (U&EC) Network (previously the Urgent and Emergency Care Clinical Leadership Group) and its proposed model of care are informed by the views of service users. The following sets out the Network's comments on the points raised, which fell into six broad categories:

1. Ease and speed of access to GPs
2. Improving community care as an alternative to A&E
3. Improving processes and systems – greater integration
4. Communications, information and record sharing
5. Quality and quantity of staff
6. Dealing with funding pressures

We recognise all of these concerns and our strategy aims to address them.

Table 25 Ease and speed of access to GPs

You said	Our response
Patient access to GPs and the knock-on impact this has on urgent and emergency care services. Earlier GP access so cases don't become emergencies Length of time it takes to get an appointment with a GP How the delay in seeing a GP can have a knock-on effect on A&E There is a perception that getting an appointment with a GP is very tricky, which in turn drives people to go straight to A&E If a GP is unavailable – people can feel bewildered – they don't know what services are best to help them and where to find information on where to go GP access [needs to be] consistent and reliable Ideas that emerged were: • More nurses in GP surgeries - whilst improving awareness of what you can see a nurse about rather than a GP - and the "option of telephone consultations" • Giving more responsibility to nurses	The U&EC Network and emerging Local Care Networks (LCNs) have proposed extended staffing and hours to reduce the lack of access to timely care in the community. LCNs will: • Provide extended hours from 8am-8pm and out of hours cover so there is 24/7 cover to provide improved urgent care • Be staffed by GPs and nurse practitioners • Link to rapid access services to support the frail, elderly and those patients with long term conditions. • This will include mental health liaison for patients in crisis such as perinatal, drugs and alcohol, children and young people and older people and dementia patients. We recognise that the current points of access for care can be confusing for the public and health care professionals and lack a single clinical structure. Opening times can differ as well as the type of care that can be received. In order to provide consistent and less confusing points of care in the community, we are proposing that all standalone urgent care centres will: • be integrated over time with the Local Care Network and be part of the Emergency Department (A&E) clinical network to improve safety and quality • have longer opening hours, improved access for unregistered patients and reduce the need to go to the Emergency Department • work closely with Rapid Access Services in the community and in the hospital setting.

Table 26 Improving community care as an alternative to A&E

You said	Our response
There is a need to improve community care as an alternative to A&E Better care in the community to prevent emergency admission Better discharge procedures were needed.	We recognise that currently the only service available 24/7 is the Emergency Department. Stable, short term medical needs are met by admissions to hospital due to a risk averse culture and lack of confidence in community skills to support patients in a home setting. Our community based care workstream aims to bring consistency to Rapid Access teams so that they:

Better community level urgent care provision to reduce pressure on A&E More professional staff working in the community could help 'filter' patients and reduce demand on A&E Having minor surgeries in a GP surgery would help ease pressures on other parts of the NHS. There should be more convenient opening hours for community based urgent care	• Are a single point of access providing navigation for GPs, clinical advice and supporting cross boundary working and speeding up discharge with more care packages for the elderly away from the Emergency Department. • Support patients at home through a 'Home Ward' – where a patient who would otherwise need to stay in hospital is discharged home with effective support by a healthcare professional or a multi-disciplinary team • Ensure patients are 'risk stratified', with enhanced/faster access for very vulnerable patients. • Have integrated IT that is also patient held to support cross boundary and service working • Are consistently capable of assessing and treating people in their own home or nearby. • Give all places of care the confidence they need to hold patients safely until they are able/need to move to the next part of the system. • Enable care homes in particular to be capable of holding onto the patient, assessing and treating those with long term conditions and mental health conditions
Ideas that emerged were: • That GPs should be more involved in communities • Better links to social services to set up the monetary side of discharge services • The importance of awareness-raising, so that people are aware of the options available to them out-of-hours.	Mapping community services so that patients can be signposted to them is a key theme of our community based care strategy. South east London has run a 'Yellow Man' campaign for the last two winters to flag alternative services to A&E. Posters were visible on buses, in GP surgeries and pharmacies and at bus stops for a range of different illness and ailments. We agree that this is an important area of communication with patients and one we will continue to review and develop, considering different approaches.

Table 27 Improving processes and systems – greater integration

You said	Our response
The need to improve processes and systems in and around hospitals. Reducing pressure on GPs so non-emergency cases do not become emergency cases. Prioritising people's needs when they enter urgent or emergency care to minimise waiting times. Reducing waiting times in A&E Important to have reliable access to urgent care at any point during the day or night Lack of proper aftercare on discharge	Currently the Emergency Department (A&E) is the only route to assess and treat patients directly referred from GPs and community services. Providing an alternative could help manage the large number of patients turning up at the front door of the Emergency Department with a GP letter because of a lack of access to clinics. The U&EC Network has proposed easy access to specialist advice and being able to refer directly to a 'specialist hot clinic' rather than A&E. This could be made available through telemedicine, telephone lines or community based consultants with advanced access to local urgent care for minor illnesses/injuries for vulnerable patients and a prioritising of over 75s.
Ideas were: • Educate patients about how to navigate services more intelligently - advertising campaigns on buses and newspapers • Ensuring resources are used adequately, so there are more nurses • Hiring more staff • More triage at reception • Fining people who go to A&E for the wrong reasons • Doctors should aim to discharge patients as soon as they get in to A&E, in order to get them back in the community and allow more space in hospitals	South east London has also run a 'Yellow Man' campaign for the last two Winters to flag what alternatives there are to A&E. Posters were visible on buses, in GP surgeries and pharmacies and at bus stops for a range of different illness and ailments. However, this is an important area of communication with patients and one we will continue to review and develop. Consistent streaming at the front door of all our emergency departments will bring: • A single clinical governance structure for urgent care centres and emergency departments • A single 'front door' for urgent care centres and emergency departments • A GP- led 'minors' service for non-emergency cases • Patient Advice Liaison Services (PALS) with the same 8am-8pm hours of operation. • Cross-working and training of Emergency Nurse Practitioners and GPs across the emergency department and urgent care centre, to improve capacity and capability. • An appropriately qualified streaming decision maker will stream patients at the 'front door' to get the initial decision right and direct patients to

	the correct department - or back to their GP. • Decisions are made with the correct pathway and outcome in mind to avoid unnecessary delays when the patient is ready to go home • Earlier identification of mental health cases (including dementia) with quicker and direct streaming to psychiatric liaison nurses for mental health patients. • We recommend the streaming role is not covered by bank or agency staff • Access to paediatric specialists at the 'front door' and to other specialist services such as drug and alcohol support. We recognise there is shortage of nursing at the band required for 'front door' streaming and this is being addressed as part of our workforce strategy. We will support patients to go to the right place to meet their needs. Inappropriate attendances at A&E are often due to the fact that patients see it as the only available option.

Table 28 Communications, information and record sharing

You said	Our response
Improving communication between services (including record sharing) and improving the sharing of information with patients Need to raise awareness about the different options that are available to the public, with awareness-raising in schools and other non-medical sites, as well as in newspapers if needed Better digital sharing of patients' records More awareness of other urgent care models other than A&E Concerns about 111 services - "trust needs to be restored" so that more people use 111 services	The U&EC Network have identified two areas of focus to improve IT for the benefit of patient care: • Being able to see GP records, especially in relation to medication, so the right patient information is available to provide the right care • Being able to track patients through the system The re-procurement of the 111 service will focus on ensuring that: • Call handlers are educated/trained in the new models for SEL

	• They are able to give advice, provide internal triage and coordinate onward referral to other parts of the system, other than defaulting to an Emergency Department • The services operates 24/7, managing 'appointments' to out-of-hours services or an Emergency Department to support demand management • Clinicians are involved in making decisions • Call handlers have access to a simplified but comprehensive Directory of Services
Communication between other services and mental health services Better education needed; particularly to ensure parents are aware of when they should seek urgent care There should be up-to-date training for GPs about mental health issues and services Improving mental health for young people and providing more pastoral care to them	Mental health is integral to the whole strategy and the U&EC Network has highlighted the following areas for improvement: • Provide specialist input at an early stage to avoid long waits especially in the 16-18 year age range. • Provide an increase in specialist services within Emergency Departments according to level of need across south east London • A maximum one hour wait for mental health patients to be referred to a psychiatric liaison nurse following triage.

Table 29 Quality and quantity of staff

You said	Our response
Staff resource management needed to be improved Need to maintain the excellent caliber of staff – and increase the number of staff available The NHS should focus on more nurses and fewer managers More staff on reception to guide people as they arrive at A&E	The U&EC Network recognises there is a shortage of Band 6 qualified emergency nurses and will consider how to address this with improved HR support for recruitment, as currently there are more attractive options elsewhere in the system for band 6 nurses with less anti-social hours. In addition: • The expense of accommodation in London can make it difficult for nurses to stay living in the capital • Mobility - staff drift out of London/overseas after gaining their training • Processes/systems do not support what the future workforce needs (e.g. nursery care) It is proposed these issues could be addressed through: • South east London being able to develop and train nurses • Where there is a shortage of a particular set of Emergency Departments (ED) staff across south east London, recruitment could be undertaken at a south east London level to share costs • Financial support to train up advanced nurses

	• Opportunities for closer working between nurses and London Ambulance Services • IT support to develop one clinical record for all patients and provide online support to help patients manage minor illnesses • Working more effectively with social care to reduce length of stay in hospital, which in turn helps reduce pressure on Emergency Departments • Better support and incentives for flexible working • Pharmacy support in Emergency Departments • Patient Advice and Liaison Service (PALS) Officer in waiting rooms to support patients • Local Care Networks to provide local community education on what GPs can help with

Table 29 Dealing with funding pressures

Funding pressures also featured as an issue, but it was less prominent than the other issues describe above

You said	Our response
Lack of funds Concerns around downgrading of A&E departments	Our work to date suggests that investment in community and primary care services will help us avoid a further increase in A&E activity and hospital admissions, but will not significantly reduce it. Commissioners expect to need all of south east London's existing A&E departments.
Could hospitals sell land? Could there be one government contract supplying everyone, thereby saving money	This has been noted, but is outside of the scope of the U&EC Network
More education available to the public so they know about alternative options.	To ease pressure on accident and emergency (A&E) departments during the winter period, the South East Commissioning Support Unit developed and implemented a 'Don't go to A&E' (the Yellow Man) campaign over two years, on behalf of ten CCGs across South London [Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark, Croydon, Merton, Sutton and NW Surrey]. The campaign, which launched across south London from 1 November 2014, is reminding local people that A&E is not for common health problems associated with the colder weather but for serious emergencies like loss of consciousness. Instead of waiting many hours in A&E, people with coughs and colds can get quicker and more appropriate treatment locally. Posters featuring yellow figures experiencing different

	symptoms – from coughs and colds to sore throats – have appeared across each borough, signposting people to www.nhs.uk where they can find out about other available local services, including minor injuries, walk-in services, and local pharmacies. In addition people can download a guide to local alternative services from each CCG website or pick up a guide from their GP practice or pharmacy. The key messages of the campaign are: • Winter is a very busy time for local A&E departments. The season puts severe pressure on hospitals with far too many people turning up for treatment for seasonal illnesses, rather than serious life threatening emergencies. • There are many other services out there when it's urgent where you can get you the treatment you need and avoid a long wait in A&E. Go to www.nhs.uk to find the right service or pick up a service guide from your GP practice/pharmacy/CCG website (NOTE: Some CCGs opted to include signposting to 111) • The cost of each A&E assessment ending in advice only is around £68 and more than £100 million over a year. Inappropriate visits to A&E are rising, and national data shows that around 40 per cent of people who attend A&E departments are discharged requiring no further treatment.

Concluding remarks and thanks

The insights and suggestions raised by those who attended the deliberative events are helping to inform the detailed development of services across south east London.

Through this response, we hope to have demonstrated to participants at the recent deliberative events that we are already addressing or planning to address many of the great ideas and suggestions made.

We do recognise, however, that within the report of the events there are some other good ideas and suggestions. We believe that these are worthy of further local consideration within each CCG area, where delivery is occurring, to help both strengthen and improve our strategy and future health services. Consequently, we will be sharing the report of the deliberative events and this response with local CCGs and provider trusts for their further consideration and action as appropriate to help inform the design, commissioning and delivery of local services.

We would like to thank The Campaign Company, who provided independent facilitation at our events and an independent report, which has been sent to every participant. We would also like to again thank everyone who attended the events and all of those – local people, patients, clinicians, local authorities, health service managers and others – who have contributed to our developing strategy.

We will continue to listen to your views and to keep you informed as our plans develop.