Our Healthier South East London Planned Care Reference Group

Report from first meeting 25th January 2016

Document History

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Revision date	Author(s)	Change summary	Version*
04/02/16	Oliver Lake	Proof reading and additions re table discussions	0.1
05/02/16	Rory Hegarty	Proof reading and further detail from table discussions	0.2
09/02/16	Peter Gluckman	Drafting amendments, additional paragraph on the use of social media, further information from plenary discussion.	0.3
10/02/16	Jill Mulelly	Amends to final draft	0.4
15/02/16	Mark Easton	Final amends before publication	0.5

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1. Executive summary:

We have been considering opportunities to improve planned care orthopaedic services and have reached the stage where we want to test our thoughts with a wider group of voluntary and community sector stakeholders, service users and the organisations representing them.

The objective of this meeting was to test these emerging ideas and get feedback from participants. If these ideas develop into proposals for significant change then the programme may wish to consult formally with the public on them.

Thirty-six people from across the six south east London boroughs registered for the meeting, with twenty-three people attending on the day. There were representatives from each borough and from each of the groups likely to be most affected by any change to planned care services.

The meeting was formed of two key areas:

Firstly, we presented on why planned care orthopaedic services need to change. Attendees were then invited to share their thoughts about the challenges.

Overall, participants agreed that their experiences, or the experiences of the people that they support/work with, matched the challenges highlighted during the presentation. However, there was a desire to know more about the evidence behind the challenges and to understand the scale of the problem and whether similar models, used elsewhere, work**.** There was collective agreement that it was important for the challenges to be addressed. Of note it was agreed that improvements need to be made in order to reduce the number of cancelled operations.

Secondly, we presented some ideas about how services could be improved. Attendees again broke into table discussions to explore these ideas in more detail.

Overall, there was support for a centralised model – however, it was noted that we need to be clear how the quality of care will be improved. People felt positively about the south west London elective orthopaedic centre (SWLEOC) model as presented, but wanted further information about its effectiveness and how its quality has been measured. It was noted that *if* there were more certainty about the care – in terms of: procedures not being cancelled; early discharge; higher quality services, more confidence in treatment given; better preparation and aftercare – then patients would be prepared to travel.

Key points that were raised throughout the meeting related to: ensuring that all options were looked at including the status quo; careful consideration being given to

location of sites and transport/access links and further work needing to be done to ensure that IT systems are compatible across the health and care system (being particularly important if patients are discharged from sites out of their normal borough).

2. Introduction

Our Healthier South East London (OHSEL) is a partnership between the six NHS Clinical Commissioning Groups (CCGs) for south east London – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – working with NHS England, local provider trusts local authorities, patients and members of the public to develop a future strategy for health services in our area.

The overall aim of the programme is to improve the quality of services for local people across the area.

We have been considering **opportunities to improve planned orthopaedic services** and have reached the stage where we want to test our thoughts with a wider group of service users and those organisations representing them.

The **objective** of this meeting was to test these ideas and get their feedback. It was noted that if these ideas develop into a proposal for significant change, we may wish to consult formally with the public. At this stage we want to raise awareness of the issues and get an initial reaction to them.

3. Methodology

In order to help shape how plans are being developed for improving planned care orthopaedic services, we decided to form a 'planned care reference group' comprising key voluntary and community sector stakeholders and patients and the public. The remit and membership of this group was informed by discussions at the South East London CCG Stakeholder Reference Group meeting held on 8th December 2015.

The planned care reference group held its first meeting on 25th January 2016.

The meeting was open to all interested parties from these sectors.

Invitations were sent to:

- Local Healthwatch organisations
- Voluntary and community sector umbrella organisations
- Equality groups from communities who would be most impacted by any changes to planned care services: older people; carers; people who live in areas of socioeconomic deprivation; people with physical disabilities; people with mental health conditions and people with learning disabilities.
- Local campaign groups
- Patients and the public (recent service users – who were recruited through word of mouth and via outpatient clinics)

The meeting was independently chaired by Peter Gluckman and facilitated by the OHSEL communications and engagement team. Those present included the Clinical

Chair of the programme (Dr Amr Zeineldine) the Senior Responsible Officer for planned care (Sarah Blow), the Programme Director (Mark Easton) and the planned care clinical lead (Lesley Graham). A full list of attendees can be found in Appendix 1.

Twitter was used throughout the event by programme staff and attendees. At the start of the session attendees gave permission for the use of social media during the event and for the taking of photographs.

Attendees were divided into four tables of approximately six participants. Each had an expert facilitator (one of the planned care leads from the programme), and a scribe (a member of the programme's communications and engagement team).

3. Programme

Topic	Speaker	Time
1. Introduction and welcome	Peter Gluckman, Independent Chair	1.00pm
2. Introduction to the programme	Dr Amr Zeineldine, Clinical Chair, OHSEL Programme	1.15pm
3. Orthopaedic service issues	Sarah Blow, Chief Officer Bexley CCG and Planned Care SRO	1.45pm
4. Discussion (1)	Table work and feedback	2.15pm
5. Some ideas on how we tackle the issues	Sarah Blow, Chief Officer Bexley CCG and Planned Care SRO	2.45pm
6. Discussion (2)	Table work and feedback	3.15pm
7. Next steps and wrap up	Peter Gluckman, Independent Chair	3.45pm

4. Summary of discussions

The meeting was formed of two key areas. Firstly, we presented on why planned care orthopaedic services need to change. Attendees were then invited to share their thoughts about the challenges. Secondly, we presented some ideas about how services could be improved. Similarly, attendees broke into table discussions to explore these ideas in more detail.

4.1 Why planned care orthopaedic services need to change

After providing some context to the south east London programme, the first part of the meeting looked at why planned care orthopaedic services need to change. The presentation went through some of the key challenges that are currently faced.

Attendees were asked:

Discussion one, question one: Do the challenges that we have set out match your own experience? And/or do these problems sound like a cause for concern?

Overall, participants agreed that their experiences, or the experiences of the people that they support/work with, had matched the challenges highlighted during the presentation. However, there was a desire to know more about the evidence behind the challenges and to understand the scale of the problem and whether similar models, used elsewhere, work.

All of the table discussions have been captured below – where relevant under each presented challenge, or as additional feedback at the end of this section.

Challenge: the worsening **capacity problems** caused by increasing referrals are leading to waiting list problems and costly **outsourcing** to independent hospitals.

- With current services there are frequent delays. It is assumed that pressures within hospitals to deliver emergency care (the PRUH was cited as an example), are responsible for the cancellation of planned operations.
- There is high demand for planned orthopaedics among patients with learning disabilities - cancelled operations are a major issue because these patients come to hospital earlier to prepare, then have to stay in hospital while their surgery is re-scheduled. It is very negative for them, carers and families.
- Cancelled operations have a significant impact on patients, their families and carers, so it is not just about the patient. We need to consider this reality carefully.
- The impact of a cancelled operation for someone with learning disabilities can be felt even more profoundly than by the general population. Of note – the effect of not being able to eat before an operation can cause considerable stress and discomfort for people with learning disabilities.

- There are more cancellations where hospitals have a co-located A&E – it would be good to resolve this issue so that A&E cannot take beds away from planned services – ring-fenced beds would solve this dilemma.

Some personal experiences were cited which corroborate the challenges around capacity and outsourcing:

- There can be confusion between providers about where a patient is seen. The situation was not discussed with the patient, nor were they made aware that they might be sent to the private sector for their surgery. This resulted in a number of conflicting and confusing telephone calls from different providers to the patient, about their planned operation. Ongoing communication should happen between the patient and the service, and between providers of care as standard. On this occasion, the patient waited eleven months for surgery.
- Even though a patient had been through the pre-operative checks, they were still "forgotten" and missed off the list – delaying their surgery by a number of months. It's important to ensure that this undesirable outcome does not happen in the future and that strong processes are in place.
- Having recent experience of orthopaedic surgery within the private sector (funded by the NHS), it was suggested that tackling loneliness on wards is important for rehabilitation.

Challenge: evidence of surgeons undertaking **low volumes of specific activities** that may well result in **less favourable outcomes** as well as increased costs.

- It was agreed that you cannot have surgeons just doing one or two procedures each year (point made by retired GP).
- We should make sure fewer doctors have specialist interests – make them more specialised and better at their jobs.

Some personal experiences were cited which reinforced the need to ensure standardised high quality care:

- Experience as a carer – husband is a pianist, broke his shoulder. Went to King's College Hospital and had excellent experience. Excellent support through A&E, surgery and follow up. He was playing the piano again within months. It's not like this for everyone though and that is a concern.

Challenge: length of stay and **efficiency measures** below the London average.

- The NHS needs to change; we cannot carry on as we are. How do we mobilise our expertise to meet the highest standards in as many places as possible?
- Services be more standardised to maintain quality and outcomes.

Some personal experiences were cited which corroborate the need to improve efficiency and patient experience:

- Five years ago, a family member suffered fractured neck of femur, so it was an interesting experience supporting them. It is difficult to get people through the system. An inefficient system hurts patients – older patients suffer for longer and younger patients suffer financial loss through time off work, etc.

Challenge: evidence that a model of intensive rehabilitation during the acute phase achieves better outcomes when delivered seven days a week, but there must be sufficient investment to fund this development, instead of simply stretching five day services over the longer period.

- Q: Could we move to seven day services to increase capacity?
- We should prepare people better for surgery in advance. People don't always get the support they need to prepare for surgery or to recover afterwards
- There needs to be more intensive support before and after operations
- Some older patients die prematurely because they get stuck at home without enough support - they are isolated and depressed – often there is not enough support in the community when people are discharged
- Some groups of patients will be reliant on other services following their procedures (both NHS and non-NHS) which, if not coordinated properly, can lead to a delayed discharge. Several participants had had experience of waiting for Occupational Therapy or Physiotherapy support before they were allowed to be discharged. There needs to be a reduction in variation in how hospitals handle discharge so that everyone has a similar experience.
- If patients are discharged too early without proper support, they can also end up back in hospital.

Challenge: elective orthopaedics requires an **environment in which the infection risk** is minimised. This will involve 'ring-fenced beds', which not every unit in south east London has

- It was noted that there is potential to reduce the risk of infection through physical separation of planned and emergency activity.

Challenge: better procurement could save costs - standardisation of prostheses.

- Consultant's choice of prosthesis varies from hospital to hospital – potential solution is to work with clinicians to review evidence for different products.
- It is worth spending more on prosthesis to get the best quality, as this has an effect on efficiency and likely lifespan of replacement.

Additional comments were made by participants for consideration:

Workforce

- Staffing numbers and retention are both issues, especially in London. This is not helped by the lack of affordable housing. Outer boroughs also do not pay inner London weighting, which makes it more difficult to recruit.

Carers

- If a carer goes in for an operation – there needs to be very tight coordination with respite care services.

Patient choice and experience

- Patients are being offered choice of where they would like to have their surgery, but some of these centres were not equipped to deal with multiple conditions. There were complications with the surgery due to pre-existing respiratory conditions and recovery was longer than initially stated. It is important for services to know case history of the patient.
- There needs to be better information for patients to enable them to make an informed decision about where they would like to have their surgery.

Prevention

- Consideration also needs to be given to preventative measures – to keep people out of hospital – such as falls clinics. It was noted that some of these clinics have been closed recently.

Advocacy and capacity

- More consideration needs to be given in considering capacity to sign consent forms. There is some good practice, but there is variation. This can mean planned operations cannot be undertaken.
- There is more to do around advocacy, both for those with mental capacity issues and those who are vulnerable.

Social isolation and holistic support

- Some patients do not want to go home due to a lack of family and/or support networks. Proposals need to take account of both the medical and social aspects of patient needs. As a first step, the consideration as to how health, care and the voluntary sector work together to support patients holistically needs further exploration. There is a clear relationship between social activity

and wellbeing. Due to funding cuts, fewer community activities are now available, and the NHS does not always recognise the value of the voluntary sector or invest in it.

- There needs to be a connection to voluntary sector support services and support for carers. Voluntary sector services are now dealing with people who have multiple conditions and issues. How will the rest of the system catch up with increased volumes of orthopaedic work? For example, social care and the third sector.

Public Health

- Focus on public health is reducing since it has been transferred to Local Authorities and the budget is not always ring fenced. There needs to be a more holistic model.

Politics

- Recognise issues for transport as not all places are accessible. Recognise all 'elephants in the room' – specifically the issue of Local Authority funding shortages
- The public and patients get inconsistent messages from the Government about funding and regulations with guidance change too frequently, so it's difficult for trusts and commissioners to keep up. NHS staff are too polite – should push back at NHS England and the Department of Health more often.

Mobilising expertise

- If the programme's assessment about planned care is valid, then it would be very important in convincing the public that all relevant expertise within the NHS be mobilised around the proposal.

Growth and changes in the population

- As the size and age structure of the population changes over time, so there will need to be related changes in health services. There is, however, a time lag and the programme has to show that planned care services need to change, to respond to and to catch up with changes in the population.

Alignment of health and social care time lines

- As well as acknowledging the serious impact of cuts in social care services, NHS and social care services have different views about what is meant by 'emergency', 'urgent' and 'planned care'. As a result, what is seen as an adequate response time by either health or social care often diverges, causing mutual frustration. There needs to be sufficient agreement between the two about response times to enable the system as a whole to work.

Costs

- The programme needs to be explicit and frank about the costs of proposals, so that patients and the public do not see them as simply cost cutting exercises.

The second part of the discussion around the challenges facing planned care orthopaedic services delved deeper into whether people agreed that we should be doing something about them:

Discussion one, question two: should we do something about them?

There was collective agreement that it was important for the challenges to be addressed. Of note it was agreed that improvements need to be made to waiting times and the numbers of cancelled operations. It was further noted that there needs to be simple information about the benefits of consolidating services.

People felt that if the planned care pathway was standardised then this would help prevent patients from 'slipping through the net' and reduce variance in practice. The discussions also highlighted the importance of person-centred care – treating people as experts by experience and ensuring that people are still given the choice of where to go that's best for them.

4.2 What can be done to improve planned care services?

The second half of the meeting focused on what could be done to improve planned care services. Initial thoughts were presented to the group (below) and then tables were asked a number of questions to explore this further.

Our ideas about what can be done:

We have been working with a group of clinicians, managers and patient and public representatives to think about these issues. No decisions have been taken but this is where the group's thinking has got to:

1. We think all the local hospitals in south east London should retain their emergency orthopaedic services to support A&E departments
2. We think all local hospitals should retain their outpatient and day case services to preserve local access to care
3. We think provision of planned orthopaedic care needs to increase to meet waiting time standards, reduce cancellations and stop us having to outsource work outside local hospitals
4. We should look at the feasibility of creating one or two expanded centres for planned care to take all the of this activity in south east London:
    i. We could deliver care to consistently high quality and efficiency
    ii. It might be the cheapest way to increase capacity
    iii. It might bring specialist services together

A centre of this type has already been established in South West London- 'South West London Elective Orthopaedic Centre' at Epsom hospital

- Transport provided to the centre by taxi
- Very high patient satisfaction
- Good quality outcomes
- Fast treatment

In south east London we could have one or two centres

Possibly one would focus on specialist and complex procedures

We have not yet taken any view on where the centre/these centres would be located.

Discussion two, question one: what are your thoughts on our ideas? Do they address the problems?

Overall, there was support for a centralised model – however, it was noted that we need to be clear how the quality of care will be improved. People felt positively about the SWLEOC model but wanted further information about its effectiveness and how its quality has been measured and compared to the outcomes of previous arrangements on south west London. It was suggested that if there was more certainty about the care – in terms of procedures not being cancelled; early discharge; higher quality services, more confidence in treatment given; better preparation and aftercare – then patients would be prepared to travel.

"South West London Elective Orthopaedic Centre" (SWLEOC) model

- In principle it seems like a sensible structure. The ideas look workable.
- The SWLEOC model is tried and tested, there's no reason to believe it wouldn't work here in south east London.
- Noted that if day cases and outpatient work stays with existing providers that means over 9000 cases going to an elective centre – seems like a lot of people.
- Need to be aware of any unintended consequences – for example – destabilising other providers who might be losing business/work/funding if non-complex cases went to one or two sites.
- Important that any unit/ward environment is accessible for disabled people and their carers/support workers

Although the SWLEOC model and concept of consolidated services, was largely supported, people also felt that in order to consider a full range of options, it would be important to test the existing model against the challenges and then judge which is better – e.g. is it possible to address some of the challenges by making improvements to the current system?

Questions around SWLEOC model

A number of questions were raised about the model:

Would an elective centre be newly constructed? No – it is anticipated that if this went ahead, it would be part of an existing site.

Was SWLEOC newly built? No – it was located on an existing empty site.

Would we need to competitively tender? The SWLEOC model is a collaboration of all providers and, at the time, did not need to go to tender. If this was mirrored in south east London, we would hope to follow a similar collaborative approach,

although tendering is always a possibility depending on provider response and legal requirements.

Accessibility

- South east London has a huge population, and the current configuration of services is concentrated into central London. It would be important, in future, to have services easily accessible for those in the **outer boroughs**.
- Providing **taxis/ transport** is essential when thinking about centralising a service. This could be done by linking with local voluntary transport schemes rather than private sector taxis. Must make sure that visitors/families/carers are not penalised by having to travel, pay parking fees etc. Access will be a big issue with any elective site to avoid difficult journeys and excessive costs.
- Any sites selected will need to be **physically accessible** to patients and carers, including the provision of blue-badge car-parking (if looking to build a new purpose-built site).
- Some patients would benefit from a centralised service, but it would be difficult if they were not **discharged quickly** and had to stay far away from home for a prolonged period.

Clinical and provider buy-in

- Important to be clear that clinicians have been involved in the design of these ideas.
- Can we really make any of this happen? Will the political dynamic between providers get in the way or prevent it in reality? What is the provider perspective?

Service specification

- It would need to be clearly explained how doctors would be rotated to any unit, to give confidence that a resource is not being taken away from local hospitals.
- Important to demonstrate how intensive care would be accessed if there is an emergency during a procedure.
- Any specialist site would need to be co-located with an A&E.
- Consider providing hydrotherapy services on any site.
- There should be telephone access to the hospital after discharge.

Holistic approach to care

- Care should be designed to suit the individual and ensuring that all needs are met. This should include all stakeholders –GP/social care/voluntary sector/ care navigator – remembering that one size does not fit all.
- There is a balance between personalised and centralised services.

- Need to take account of the fact that local / community means different things depending on circumstances.
- Implications for carers - balanced against reduction in length of stay and complications.
- Implications for elderly people – plans could fall down if home support were not built in. System needs to be built to address this necessity. Example was given of the Guy's and St. Thomas' community commissioned service – 'hospital at home'.

Discussion two, question two: do you think that we should keep these services local, where hospitals already have?

- Facilities to deal with emergency orthopaedic cases
- Orthopaedic outpatient appointments
- Orthopaedic day case operations

Overall, it was noted that the more care that is 'planned', the better it is for everyone – patients, families, carers etc. It was felt that patients would feel more comfortable with centralising routine orthopaedic surgery if outpatient appointments and emergency orthopaedic surgery remained local. For simple day case operations, these could also potentially be centralised – providing transport was arranged. People would like as many local services as possible. It is crucial that follow up appointments are at a local level and that rehabilitation and physiotherapy are available locally and at an intensive level.

The following themes were also raised during discussions:

Communication

- Communication with patients about any changes needs to be extremely clear, so that they understand what will happen where.
- Use of case studies/patient journeys could help explain any change in service delivery.

One size does not fit all

- There should be personalised case management. E.g. 80:20 model – for some people it would be more appropriate for them to attend a local site – for example if they need a co-located intensive care unit.

Design

- Need to learn lessons from the SWLEOC model and others.
- Co-design how the service works with service users
- How does the structure learn? It needs to be flexible and responsive.

Discussion two, question three: what do you think are the advantages and disadvantages of centralising inpatient elective orthopaedic work?

Advantages of centralising inpatient elective orthopaedic work:

- Tried and tested model in south west London.
- Therapy and support staff onsite would be solely focussing on inpatient elective orthopaedic work.
- Infection rates are lower than in an acute environment.
- Will work well IF discharge/ follow up care is well designed and supports the process from the beginning of the patient pathway.
- There will be better quality/reputation and it will build confidence in the service.
- It could be easier to cover staffing rotas – absence/ turnover
- Centralising inpatient elective orthopaedic work would improve training/ peer training.
- Centralising inpatient elective orthopaedic work would introduce higher standards/uniformity.
- More certainty around care and better planning is good – particularly if it is less likely to be cancelled
- People being treated promptly. Seeing people faster for less money
- Bigger pool of surgeons so you can choose the most skilled.

Disadvantages/challenges of centralising inpatient elective orthopaedic work:

- Detailed consideration of where any sites are located. Balance between inner and outer south east London. Appointment times should take into account where people live and their care needs.
- Travel/transport/access need to be explored in detail (with patients, families and carers). People with learning disabilities may find new routes/areas even more stressful as they can become unsettled by different and unfamiliar environments.
- Need to be able to demonstrate clinical buy-in, or this could destabilise any proposals.
- Need joined up IT systems across systems – social care, GPs, NHS provider Trusts and CCGs. It will be harder to pick up aftercare from a centralised site. Access to medical records needs to be seamless across south east London.
- Need to ensure communications about any changes are clear for patients, staff and the public.
- Ensure discharge arrangements are in place with local services (including consideration of any reablement and social care needs). Discharge is already complex- this would be worse if people were being discharged from hospitals outside their normal borough

- Risk of developing a large organisation that becomes too large to communicate effectively with patients.
- Could cost more money
- Are day case patients disadvantaged by this development? What if the best care were only available at the elective centre?
- Potential reduction in patient choice.

1. Question and Answers

Q: South east London is a diverse community with worse services than other areas.

A: It was noted that any new plans needs to be equitable for all patients.

Q: The presentation noted that the numbers of referrals are increasing. Is this because there are more inappropriate referrals?

A: No – it is because we have an ageing population and demand on the services is increasing.

Q: Will centralised services have intensive care units?

A: Not necessarily. If we followed the same model, those with complex needs may not be sent to the centralised centre – they may be treated at a local site where there is intensive care provision.

Q: Is it possible that some decisions will be made in the interests of providers? There needs to be robust scrutiny so that decisions are made based on patient outcomes and improved efficiencies.

A: There will not be any providers on the final decision making panel (during the options appraisal process). The SWLEOC model is a collaboration of all providers and designed to be sustainable for all providers across the area.

Q: We need to be better at selling the solution.

A: Agreed – we need to clarify how the system works and draw a picture of what services should look like.

Q: If planned care is not provided locally, it will not be there to act as an emergency tank for A&E patients.

A: The aim is to create additional capacity across the system – centralising planned care orthopaedics could have a positive impact on capacity issues at A&E.

2. Next steps

The programme has taken on board the feedback given during the event on 25th January 2016 and would like to hold a follow up session on the 16th March 2016 with the following objectives (subject to change):

- Provide more information and evidence on case for change
- Explore proposed model in detail – including where we are on specialist/complex care
- Discuss the facilities specification and evaluation process
- Test thoughts on engagement and consultation.

In light of feedback from the event, the programme will be inviting the Director of the South West London Elective Orthopaedic Centre to brief the group on: how it was planned; what it is like to work there; the collaboration between providers; how the balance between planned and emergency work is managed and lessons learned.

The programme will also endeavour to invite a senior representative from one of the borough social services departments, with relevant experience of the OHSEL programme, to attend, as well as an orthopaedic clinician.

Before and during the meeting, the programme will provide a deeper level of detail about the challenges being faced and evidence behind the suggested solutions – including financial information. Of note – research demonstrating that:

- Concentrating planned care services delivers better outcomes
- A model of intensive rehabilitation during the acute phase achieves better outcomes when delivered seven days a week
- The kind of saving that might be achieved through better procurement and standardisation of prostheses – taking account of the point made at the event that the best and longest lasting may cost more than the cheapest changes.

Attendees said that it was also important for the programme to state how decisions will be made and the proposals taken forward:

- Moving from a potential ‘long list’ of possibilities, to a ‘short list’ of practical and affordable propositions that achieve the required improvements in services
- Potentially holding a full consultation and engagement process if the proposed changes warranted such a move

- Building service users' experience into the case being made for any change
- Using the next period and any consultation process to build confidence in the proposals
- How communications would be used to inform patients, public and local voluntary and community organisations
- How IT would be developed and used to underpin the proposed new arrangements for planned care
- How health and social care components of the new arrangements would be effectively integrated.

3. Appendix 1 – attendees

List of all those who registered for the event, including those who sent their apologies on the day:

Name	Organisation	Registration
Aline Macready	Bexley Snap	Apologies
Barry Silverman	Member of PPAG (Southwark)	In attendance
Caroline Hallett	Southwark Young Carers	Apologies
Catherine Pearson	Healthwatch Lambeth	Apologies
Catherine Negus	Healthwatch Southwark	In attendance
Cathi Blake	Age UK Lambeth	In attendance
Clare Treganowan	Greenwich Carers Centre	In attendance
David Barnet	Advocacy For All – Bromley	In attendance
Dominic Campbell	Meet me at the Albany	In attendance
Elaine Carter	Kent Association for the Blind	In attendance
Elaine Reeves	Patient/Service User	Apologies
Harbhajan Singh	Multifaith forum	In attendance
Jacky Bourke-White	Age UK Lewisham & Southwark	In attendance
Jan Donnelly	Advocacy For All	Apologies
Janaki Kuhanendran	Healthwatch Lambeth	Apologies
John King	PPAG – Chair (Lambeth)	In attendance
Katy Wright	South East London Vision	In attendance
Kaz Obuka	Lewisham CCG	In attendance
Kellie Pearce	Greenwich Carers Centre	Apologies
Lesley Wickens	Lambeth Mencap	Apologies
Leslie Marks	Healthwatch Bromley and Lewisham	In attendance
Lotta Hackett	Healthwatch Bexley	In attendance
Marsha Decordova *	South East London Vision	Apologies
Pat O'Shea	Bromley Mencap	Apologies
Patricia Kanneh-fitzgerald	Greenwich CCG	Apologies
Paul Brown	Member of PPAG (Bromley)	In attendance
Rob Danaveoo	Southwark Carers	In attendance
Robert Hill	Lambeth Mencap	In attendance
Rosemary Akaighe	Advocacy For All	Apologies
Sharon Hegarty	Lewisham Nexus	In attendance
Stephanie Wood	Healthwatch Bromley and Lewisham	In attendance
Steve Davies	Bexley Mencap	In attendance
Sue Elsegood	Greenwich Association of Disabled People	In attendance
Susie Wilson	Healthwatch Greenwich	In attendance
Verinder Mander	Southwark Carers	Apologies
Wendy Horler	Keep our NHS public	In attendance

In attendance from the Our Healthier South East London (OHSEL) programme:

Dr Amr Zeineldine, Clinical Chair, OHSEL Programme

Sarah Blow, Chief Officer Bexley CCG and Planned Care SRO

Mark Easton, Programme Director, OHSEL

Lesley Graham, Clinical Chair – planned care

Katy Dickson, Programme Manager – planned care

Rory Hegarty, Director of Communications and Engagement

Oliver Lake, Partner - Transformation, Communications and Engagement Team

Jill Mulelly, Communications and Engagement team

Fiona Gaylor, Communications and Engagement team

Sam Ridge, Communications and Engagement team

Lucy Ing, Communications and Engagement team

Independent chair

Peter Gluckman

4. Appendix 2 – evaluation form feedback

Event evaluation

How much do you agree with the following statements?				
	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
1. There was enough time to discuss the issues	0%	0%	90% (18)	10% (2)
2. I felt able to express my own opinions	0%	0%	84% (16)	16 % (3)
3. I feel my views have been listened to	0%	0%	84% (16)	16 % (3)
4. I understand why the meeting took place	0%	0%	75% (15)	25% (5)

5. Any other comments?

- Interesting as I didn't expect such an inclusive group, I felt that it was a real opportunity for involvement.
- Might be worth having a discussion around the use of Multi-Disciplinary Teams in centres and how that relates/works in conjunction with the proposed local care networks in each borough.
- Good event given limited time. Good start!!!
- Very important to feedback to participants exactly what outcomes have happened from this meeting and what is the final decision.
- More information to underpin the discussion may have been helpful e.g. number of cancelled or postponed operations in the last year.
- Attended on behalf of SELVIS (South east London Vision) a charity supporting blind and partially sighted adults in south east London. It was interesting to observe similar problems experiences by other people in other health/ medical areas, yet is similar to service users with sight loss that we support. Interested to attend the reference group meeting regarding community based care. Agreed mostly with shared experiences of others and the possible benefits all round of providing a centralised service.
- Able to explain things so I could follow for most part. I would have liked a better idea of the models that were being explored. The protocol what would be

operated to decide where you would be seen. Overall I think things are moving in the right direction.

- That I be given the option (where possible) to have the procedure further away if it happens more quickly. I would be happy not to have family visits if it meant the procedure happened more quickly.
- I find this meeting refreshing, since comments were unbiased by participants' exposure to arguments.
- Need to see where it's going re providers – argument on planned centres.
- Consultation with service users/ disabled people would continue to be essential in the process. Please consider inclusive accessible design in any new centre. Intensive care facilities may be needed for some patients with existing conditions after surgery. Some disabled patients need assistants to stay in hospital to support them – so need overnight facilities.