Our Healthier South East London
Improving health and care together

NHS

Our Healthier South East London "You said…we did"

Engagement on the Issues Paper - April – December 2015

Background

Sustainability and Transformation Plan

Our south east London strategy to improve and integrate health and care services is part of a bigger picture of change across NHS and social care systems.

Recently published guidance outlines a new approach to planning the future of health and care services. NHS organisations are required to produce individual operational plans for 2016/17. In addition, every health and care system is, for the first time, working together to produce a Sustainability and Transformation Plan (STP) covering the period October 2016 – March 2021.

In south east London, a large amount of this work has already started as part of Our Healthier South East London. The new models of care at the centre of our strategy are the product of partnership working between clinicians, commissioners, social care leads from local councils, local hospitals, patients and members of the public. It includes the engagement activity outlined in this report, which was undertaken before the new guidance on STPs was published. We will build on our previous work and use all of our engagement feedback to inform the development of the STP.

A first draft of the south east London STP will be submitted to NHS England in April 2016, with a final version agreed by late June 2016.

More information on the strategy and our latest documents are on our website www.ourhealthiersel.nhs.uk

Public engagement

Engagement with patients is fundamental to strategy development. Informed patients (called public and patient voices, or PPVs) are supported to sit on all our working and governance groups with Healthwatch representatives, and have been part of our strategy development since we began this work. We also run a programme of wider engagement with the public. This includes:

- holding 'deliberative events' or large focus groups where the issues are discussed in detail with stakeholders and invited members of the public;
- outreach discussion at groups including parent drop-ins, patient support groups and groups representing specific populations, e.g. LGBT groups;
- in-depth case studies;
- engagement through Healthwatch, patient groups and other voluntary support groups;
- engagement with CCG patient representatives and groups;
- engagement at local events, fairs and meetings.

The feedback gathered through this engagement and our responses, including how the feedback has been used to develop the strategy, is published in a series of *You Said, We Did* documents. These are available on our website.

From April – July 2015 we continued to engage on other areas of the programme not included in the Issues Paper and therefore not included in this report. This was with the Public and Patient Voices and a focus group looking at the option appraisal process. This is summarised in a report published on our website.

Our Healthier South East London *Issues Paper*

We published *Help us improve your local NHS: Issues Paper* on our website at the end of March 2015. This outlined the challenges faced by our health services in south east London and the ideas we were proposing to address them. We also produced a summary leaflet and an Easy Read version of the paper.

The *Issues Paper* was distributed widely during May 2015, with multiple copies of the full document and the summary leaflet sent to:

- GP surgeries

- Pharmacies
- Hospital sites
- Libraries
- Council sites, including recreation centres
- Nursing and residential homes
- Children's centres
- Healthwatch and local voluntary organisations

Over sixty thousand documents were distributed across almost 1,000 addresses.

In September 2015 we published a follow-up paper, called *Emerging models and further thinking*, with updated and more detailed information on our ideas. This was distributed in smaller numbers to the same addresses.

During May – November 2015 we spoke directly to over 1,700 local people about the issues and our ideas.

- We held six large scale events (one in each borough) in July 2016, attended by over 440 people. We recruited people to attend who reflected the demographics of the local area. A separate, independent report of these events is published on our website.
- We publicised the Issues Paper on social media and through the press to encourage people to respond online.
- The six CCGs carried out local engagement with focus groups, stalls at fairs and festivals, surveys and attending meetings.
- CCGs worked with their local Healthwatch organisations to engage further and more widely with local residents.
- We reviewed our engagement throughout the process and, in particular, looked at the groups and diversity of people we reached. This led us to organise additional engagement with specific communities.

A full list of engagement activities is included in Appendix B.

You Said…We Did

All of the feedback ('You said…') from our engagement has been collated and analysed. We have shared this with the team developing the strategy. We have worked with them to make sure that the feedback is fully understood and that we have, where possible, included it in the strategy or explained how we will use it ('We did…').

We identified a number of themes. We have outlined these below with examples of the things that people told us and what we are doing about it. A detailed summary of the feedback and our response is in Appendix A.

Continuity of care professional

You said:

- [I have] seen four or five different consultants over a couple of years - where is the commitment?
- More advocates needed – to act as a coordinator between different professionals.
- [The] health visitor should have a consistent presence, giving regular communications
- [I] need to know which health professional can help with which issues
- [I want a] single point of contact
- [I want] to know my carer
- There needs to be a one stop shop and assigned care worker for that carer to be able to contact when a crisis or a care problem arises
- Continuity and thoroughness of care from GP [is] more important than extended hours
- A named care worker and phone number, avoiding a call centre who advise you to take the patient to A&E which, for dementia patients, is not a viable solution

We did:

We know that people want to see the same carer or professional during their treatment. This gives them the chance to build relationships, means they don't have to repeat themselves or repeat tests, and that they can be sure of getting a consistent level of care. This is something that we are working towards within our community-based care projects. For instance, we are working towards London Primary Care Standards which

have been set out for us by NHS England. One of the requirements of the standards is for everyone to have a named GP from April 2016.

We are developing roles for professionals (referred to in this document as 'care navigators') to help make sure that patients access all the services they need, and are treated as a whole person. Care navigators will help people find the correct service for their needs and be a single point of contact for people if they need it. We are still working on these plans – for instance, we need to be clear what a care navigator will do and how this will work in different areas, to make sure that everyone in south east London gets the same quality of care and support.

Sometimes it will not be possible to see the same health or care professional – for instance when seeing a different specialist or going to a different organisation. We're developing our information (IT) systems so that information sharing is better between different services.

The continuity of care for pregnant women is a key objective of our maternity improvement work. We are analysing our midwifery workforce to see whether this would be possible for all pregnant women in south east London.

Access and quality

You said:

- [I wish] seeing GPs was possible at weekends, getting appointments easier
- [I wish] that everybody could receive the same excellent service that I get from [my] surgery!!!
- GP appointments too hard to get, have to wait [too] long
- [I want to be able to] receive care when [I] need it
- I need to see someone when I am ill and not 2 weeks after
- [We should] take pressure off GPs e.g. online appointments rather than face-to-face
- Routine procedures could be made available elsewhere so easier to access
- I know doctors and hospitals are very busy places, but sometimes they could be more understanding when a patient comes to hospital and is already anxious. Trying to get an appointment at [my] GP is a nightmare, line always busy, waiting time at hospitals is too long
- Everyone [should have] access to the same/all health services, irrespective of where they live

- There are inconsistencies between services – services can at times be a postcode lottery

We did:

We think that everyone should have equal access to the same quality of services wherever they live. This is one of the principles of our strategy.

We are working to increase access to bookable GP appointments. This means that patients will be able to book a GP appointment locally (within what we call a 'hub' or 'network') between 8am – 8pm weekdays and at weekends. We are exploring alternatives to face-to-face consultations, like telephone and internet-based consultations. We are already using these in some of our boroughs and need to make sure that everyone in south east London can access these if they want. The London Primary Care Standards also require increased use of online booking, prescribing and consultation with targets set from April 2016.

We are working with our local care networks at borough level to find ways of increasing access to other services. We are improving our information (IT) systems so that we can share information better between GPs, hospitals and other service providers.

We know that there are some gaps in mental health services. There is work going on across London to look at what gaps exist and how these can be filled, including looking at staff and their skills. We also want to get better at letting people know what services exist so that people get help before they reach a crisis. Good local examples exist and we want other boroughs to learn from these.

We are considering plans to consolidate routine orthopaedic operations (such as hip and knee operations), with outpatient and follow-up care provided closer to home. Evidence from other centres suggests that this will improve access and quality. These plans could, if necessary, go to a full public consultation at a later stage.

Early diagnosis and prevention

You said:

- Increase public awareness and information about prevention
- Talks in schools/adult groups about mental health awareness

- Available information in colleges, schools and nurseries
- Continue to promote healthy lifestyles with links and free courses at the local leisure Centre
- More prevention work needs to be done (e.g. Sun Care)
- Teach me to stay healthy
- More information and education to self-manage my health and care
- Identify risks (so they can be minimised)
- Improve access to prevention if I can't get out
- There could be even more emphasis on health promotion, to enable people to take more personal responsibilities for their health and welfare from a young age in order to reduce preventable diseases and disorders later in life

We did:

Preventing illness and supporting people to live healthier lives is fundamental to the changes we want to make. The London Primary Care Standards also require GPs to focus on prevention.

We want to work with people from across south east London to develop ‘strong and confident communities’. These are communities where local people are more empowered to take control of their own health and wellbeing and working in partnership with the voluntary and community sector. We have hosted a conference to get people from different sectors and organisations together to share plans and ideas and discuss how we achieve this. We are also working with our Local Authorities and with local schools and children’s centres to understand how they can support our work around issues such as obesity and mental health.

There are also a number of specific ideas we are working on. For instance, we want all pregnant women to be screened by the 10th week of pregnancy, so that any onward referrals to specialist services happen as quickly as possible.

Early detection has a huge impact on outcomes for people with cancer. We are planning to trial a new way of treating people who have serious but unspecified symptoms so that they get all the tests they need as soon as possible. We are also developing education and training packages for staff working in primary care – GP surgeries, for instance – to help them support people to make healthier lifestyle choices.

Integration, coordination and communication

You said:

- Every time you access any services, you have to come out [as trans] to every clinician you meet as records are never up to date
- There should be someone available at GP practices to link in with people with mental health conditions or better training for GPs to support people
- Care should not be so fragmented
- [We should] improve links between health and social care with respect to dementia patients. The two areas should communicate properly and share information.
- [People are] often given conflicting advice by the consultant and the midwife which does not help with decision making. Advice should be streamlined
- Information sharing between providers needs to be improved
- The surgery now sends texts to remind us of appointments, it saves time and health, it's a simple thing
- Communication between [my] GP and hospital is not very good
- [We should look at] how voluntary sector services and, in particular, churches can link in with Local care networks to support people with mental health conditions and other conditions
- [There should be] better care for older people – joined up services. [I] think older people are left to cope unless [they] have someone to fight their corner and chase things up

We did:

Integration and coordination of services is another priority of our work. We are developing local care networks within boroughs which will bring together GPs and local healthcare with social care and community services, working together around the needs of the patient. The integration of mental and physical health is an essential element of this.

Understanding and supporting mental and physical wellbeing will be part of the care navigator role. Across south east London we are looking at a programme of work designed to provide better mental health support to people with long term conditions and complex needs.

We need to improve communication between different organisations using computer systems. We plan to bring together patient records across south east London. This will mean that GPs working in primary care hubs will have access to the medical records of all the patients they are treating, including patients from different surgeries (this will only be done with patient consent.) We are also working towards linking GP records with community and hospital providers so that information can be shared much more easily. We already have some examples of computer (IT) systems that can help us achieve this in south east London, such as 'Connect care' in Lewisham; and Lewisham and Greenwich "Health Locker" (partnered with South London and Maudsley NHS Foundation Trust).

Person centred care

You said:

- There is some stigma when going to the GP [participant felt that they are] not listened to and taken seriously by GPs due to their addictions
- A more holistic approach rather than the current reductionist [is] needed
- GPs should also be flagging things that are relevant to different patients to include in their health checks
- Clinicians often do not listen to reports regarding side effects of drugs prescribed to trans people
- Medical specialisms – view person holistically
- [I have] caring doctors who are sincere in listening to your health issue and tell you how you can improve your health
- Training in diversity – I have to come out to my doctor each time and it can be embarrassing for both of us
- Health services would do more to check up on the elderly who live alone at home and offer more support with in-home adaptions e.g. stair support, chair lift, community activities, which some people of a certain age may not be aware of
- Health personnel both in hospital and out should treat the whole person and not just the condition

We did:

All our plans are based on providing services that meet the needs of patients and their carers. We want to make sure that we treat patients as individuals, and not as 'medical specimens'. We are working with GPs to develop shared decision-making. This means focusing on the things that motivate people to change, and include a strong self-care element. There are many examples of this work happening locally, such as the 'Year of Care' training in Greenwich, which is developing motivational skills in GPs to help them work with their patients on care plans and self-care. We will share the good work we are doing between boroughs so that local commissioners can access practical advice and materials when they consider how to improve their own services.

The developing care navigators role will help make sure that patients access all the services they need, and are treated as a whole person. Stronger communication through shared IT systems will mean that people do not have to repeat themselves, and their whole history is available to the people treating them.

Role of carers

You said:

- Carers really value opportunities for peer support from the VCS [voluntary community sector] – coffee morning and networking groups
- It should be clearly labelled on the patient's notes that they have a carer, and their contact details
- There are challenges around patient doctor confidentiality. Some doctors won't discuss the condition/health of the person they care for with the carer as it breaks confidentiality. Carers need to understand the condition and treatment options so that they can better support those they care for. This is particularly important for people with mental health conditions
- The importance of patient choice and communicating with carers/family when decisions are being made around end-of-life care
- [I want to have] places to support families so they can see support from others who have gone through similar things

We did:

Carers are a very important group and we recognise the importance of the work they do. We are working with Local Authorities who are required to produce 'carer strategies' to address the issues that have been highlighted in feedback.

Local care networks will mean there are stronger links between health, social care and community services. This will mean more support for carers and better information about what is available to them. We want to work with voluntary and community organisations to get better access to support that is available to patients and carers.

We are working on a number of specific areas, such as end-of-life care, to make a real difference to the experience of patients and their carers. We are sharing what we have learnt from the Bromley Care Coordination Service. This has made a significant impact on helping people die in a place of their choosing, which is usually at home, and helping people caring for friends and family approaching the end of their lives.

Awareness of services

You said:

- [We need] clear information and better access. The public do not all understand where to go for what problem
- There is awareness of services and advice from pharmacies, but little knowledge of out of hours services. It would be good to send NHS information via playgroups and mum and baby groups
- Patients are not accessing the right services for their needs
- Important for everyone to have equal access and to be made aware of the range of services available to them

We did:

Helping people access the most appropriate services when they need them is vital. All six boroughs in south east London now use Health Help Now. This is a downloadable app and a website that helps people find the right service for their health needs, especially when they need medical help fast but it is not a life-threatening emergency. It lists common symptoms and offers suggestions for treatment, with the one which works best for

most people listed first. Health Help Now then links through to local services, and shows whether they are open or closed, their location and directions.

Care navigators will be able to help people access the services they need and support them to do this. We're undertaking a process called 'asset mapping'. This will help us understand what NHS and other help and support services are available in south east London, where they are, and how they can be accessed. We want to make sure this information is widely available, through care navigators, local care networks and through borough councils.

We are also talking to local people about the work that is already happening – the extension of primary care services in some areas, for instance, and the increased support that will be available through local care networks.

Next steps and future plans

Engagement will continue as our plans progress. We are working with partners in councils, voluntary groups, Healthwatch, patients and the public to make sure all our decisions are scrutinised. We will continue to make feedback from these groups part of our development work. Our plans for hip and knee operations may require a full public consultation, so we are starting to work on plans to make sure that everyone can have their say.

CCGs will also continue to engage locally; for instance, on the development of local care networks.

We also want to make sure that local people know about the work that is going on and the benefits they will see. We're doing this by producing information on our plans and any changes that are already happening. We are publishing this on our website and will continue to talk to people locally.

Appendix A - Collated feedback from Issues Paper engagement work December 2015

All of the feedback from our Issues Paper engagement work has been collated and analysed, drawing together key themes in each of the following six clinical work areas for the programme to consider:

- Community based care
- Planned care
- Cancer
- Maternity
- Children and young people
- Urgent and emergency care

This appendix contains a summary of the feedback and detailed programme response.
As outlined in the You Said, We Did response to engagement, there were a number of overarching themes which were core to all areas, outlined below and in our main paper. More specific feedback is collated and grouped according to the area it relates to. These areas are the main focus areas of the strategy, and we have grouped feedback accordingly.

- **Continuity of care professional** – people need contact with the same healthcare professional throughout their treatment in order to build relationships, avoid duplication and receive consistent levels of care.
- **Access and quality** – everyone should have equal access to the same quality of services irrespective of where they live. People often noted the 'postcode lottery' associated with health services – strongly felt within mental health services in particular.
- **Early diagnosis and prevention** – prevention of illness and supporting people to live healthier lives was a key thread running through all feedback. Education about healthy lifestyles looking at for early signs of mental and physical ill health should start in schools – with healthcare professionals delivering these important messages.
- **Integration, coordination and communication –** to improve quality and consistency of care there needs to be better communication between services – supported by streamlined IT and data systems.

- **Person centred care** – across all clinical areas, there was a strong message that people need to be treated as individuals not conditions. Their care needs to be planned in a holistic way – with them at the centre, being empowered to make decisions about their own treatment and care. Mental health, well-being and physical health need to be looked at as one.
- **Role of carers** – the role and value of carers needs to be more strongly recognised. They are an integral part of the health economy, providing unpaid support to the NHS workforce. A key message was that carers should be more involved in discussions around treatment and care plans.
- **Awareness of services –** There needs to be greater awareness raising about what services are available and how to navigate them to ensure that they are used appropriately

Community based care

A large proportion of the feedback we received was around community-based care (also known as primary care). This is care that is provided outside hospital. It includes care from GPs, district and community nurses, community health services, voluntary sector services, social care, community pharmacy, and community support services for people with long-term health conditions. It can be provided by the NHS, private providers, pharmacists, the voluntary sector and local authorities.

There were some notable examples of good practice. Overall people gave very positive feedback about the advice and support local pharmacies and pharmacists can give. It was felt that more should be done to promote their services. People were also very positive about the online services such as prescription services. This further supports our aim to expand/develop digital and online services. Specific comments from the homeless community noted the importance of walk-in centres, which provide a very valuable service to those who have found it difficult to register with a GP.

However, there were a number of themes that were frequently raised. These were: access to services; prevention; continuity of care; better support for people with mental health conditions; and more focus on self-management. In addition, there were a number of issues that occurred less frequently that we have also covered.

Key themes from feedback	Our response
Access to primary care services Access was a key issue. People noted the challenges of getting an appointment, the need for a wider range of flexible appointments and extended hours. Suggestions included GPs and walk in centres being open 8am – 8pm, and GP practices being open seven days a week. It was felt that more community services should be accessible at the weekend. Children and Adolescent Mental Health	• Improving access to care is a priority for us. We are working towards delivery of new standards for primary care including initiatives such as improved access to bookable GP appointments 8am-8pm and at weekends. In four of the six south east London boroughs there are already primary care hubs, which involve GPs working together to provide additional services and

Services (CAMHS) and other support for children and young people with mental health conditions should also be available after 5pm.	appointments to patients. The other two boroughs (Lewisham and Bexley) are developing other ways to provide this primary care cover. • We are also working to get better information (IT) systems so that GPs from a primary care hub treating patients not from their usual surgery, will have access (with consent from patients) to their patient records. We aim for patient records to be paperless by 2020. • The development of local care networks and primary care hubs will also help us to find ways of improving access to other services, as suggested in feedback. • We are working to address the issues of access to out-of-hours CAMHS services, which is a recognised issue. There is London-wide work underway in CAMHS, such as a 'Crisis Concordat' - a workshop that brought together providers and commissioners to work to resolve issues with the quality of the services and any gaps in appropriately skilled staff. **Areas requiring further work**

	• Additional bookable GP appointments from 8am-8pm and at weekends will need to be clearly communicated to patients and the public. This is already happening in some areas, such as Southwark's extended primary care service. • Alternative options to face-to-face appointments, such as telehealth are being explored. Telehealth is the delivery of health-related services and information via telephone and the internet. It can be as simple as two health professionals discussing a case over the telephone, or patients and health professionals having an online appointment. Telehealth is being used to great effect in some areas already, but usage in other boroughs is variable • We need to make sure that the local delivery, shared standards of community based care provides the same access and quality of services across south east London • We want to support people to access community services earlier to avoid issues escalating to a crisis. This is particularly key to those with drug and alcohol problems, and under 18s and adult mental health service users.

	• In future, there will be integrated GP records linking to community services and acute providers. Integration with social care records remains a challenge. • We already have integrated children's community teams but this is variable across south east London. The programme is looking to standardise how these teams operate
Prevention There was a strong message that 'prevention is better than cure'. More resources and focus should be put into preventing ill health and mental ill health – particularly, to avoid situations reaching crisis point. Consistent messages came through around the need to work better with the voluntary and community sector to deliver preventative services.	• The new London Primary Care standards require GP practices to focus on prevention and a number of programmes have been commissioned. These could include working more closely with partners from acute, voluntary, borough councils and community service providers. • Cancer – earlier detection is a key priority which will be supported by better education and training for staff working in primary care. They will aim to support people to make healthy lifestyle choices. • There are good local examples of early intervention apps (for use by healthcare professionals) around supporting people to make healthy lifestyle choices.

	• We are aiming for increased screening by 10 weeks of pregnancy, ensuring any onward referrals required are followed up. • The programme has already hosted one workshop focussed on *Strong and Confident Communities* – there is a follow-up workshop planned which will review borough plans. Recognition is being given to funding needs for the voluntary and community sector • Structured education and training around specific conditions i.e. diabetes is already happening in Lambeth and Bromley. In Bromley, for example, patient records at GP surgeries are reviewed and individuals identified as high risk are highlighted. • A scheme in Bromley trains carers to diagnose simple urinary tract infections, through the use of a simple dipstick. This can avoid a lengthy hospital admission, keeping patients at home. This is an example of best practice we are looking to share. **Areas requiring further work** • We want to support people to access

	community services earlier to avoid issues escalating to a crisis. This is particularly key to those with drug and alcohol problems, and under 18s and adult mental health service users. • The programme is investigating whether we should include the use of exercise programmes, usually completed before surgery, to aid recovery. A local example of this is the "Escape" programme, currently run by the Health Innovation Network. • Work with schools and children's centres is ongoing to understand how they can support early intervention in areas such as childhood obesity, mental health etc. • The programme is not explicitly addressing cancer in young people. Screening is the responsibility of Public Health (provided by borough councils).
Continuity of care Many people saw the value in having a consistent care provider – feeling it was important to have a named GP – so they get to know the patient and family. It was also felt that better sharing of information and health records would help to ensure more streamlined care.	• Having a named GP is a requirement for patients over 75 and those with a long term condition. We are working to meet the London Primary Care Standards which require every patient to have a named GP from April 2016.

	• We are working to develop a care navigator role. This includes setting out what the core skills are for someone in this role. These have been informed by what service users have told us during engagement. We aim to make this a recognisable role within the workforce, and to ensure that education providers offer packages of training to support the development of staff. Roll out will be organised by each CCG. • There are plans to integrate patient records across south east London. This will mean that GPs from a primary care hub, treating patients not from their usual surgery, will have access (with consent from patients) to their patient records. We aim for patient records to be paperless by 2020. **Areas requiring further work** • In future, there will be integrated GP records linking to community services and acute providers. Integration with social care records remains a challenge • The programme needs to assess the current IT systems to understand if they are being used to their full potential. There is also variability in

	data quality and reliability, so we need to understand the gaps.
Mental health There was a very clear message that there needs to be better support for people with mental health conditions in the community and that this should start with providing more training to GPs (who were criticised for a lack of awareness around mental health conditions). It was felt essential that as the first point of contact, GPs should consistently be able to identify mental health conditions, to know what questions to ask and to be aware of what support services there are in the community to signpost people to. It was suggested that there should be greater investment in wellbeing services. People fed back that the waiting times for the Improving Access to Psychological Therapies (IAPT) programme are too long and that in general there were not enough services for people with mental health conditions, leading to people reaching crisis points that could have been avoided with an earlier intervention.	• We are working in partnership with South London and Maudsley NHS Foundation Trust on the development of care navigator roles. The core set of skills of this role will include: knowledge of physical and mental health and wellbeing services; awareness of mental health and the ability to recognise signs of physical and mental distress; listening skills; and motivational skills and coaching. This will give mental health service users a named person who can help them find the appropriate services and coordinate their care. Care navigators will help increase awareness of the services that are available. • There is London-wide work underway in children's and adult mental health services, such as a 'Crisis Concordat'. This was a workshop that brought together providers and commissioners to work to resolve issues with the quality of the services and any gaps in appropriately skilled staff. • Across south east London we are looking at a programme of work

	including GP training designed to provide better mental health support for people with long term conditions and complex care needs, having recognised the impact of mental wellbeing on physical health. • South London and Maudsley NHS Foundation Trust is encouraging a relaxed approach to involving patients with eating disorders in planning their own care. This has helped to keep some patients out of inpatient units. **Areas requiring further work** • We want to support people to access community services earlier to avoid issues escalating to a crisis. This is particularly key for those with drug and alcohol problems, under 18s and adult mental health service users. Good local examples currently exist and other boroughs are learning from this. • Work on alternatives to the national IAPT programme, including talking therapies and electronic support, is underway in Lewisham. We aim to share this work and learn from it. • The current model of clinical triage in the emergency department (ED), with a separate Psychiatric Liaison Nurse

	(PLN) assessment, is often the cause of a long waits and can result in patients absconding and re-attending. We are working to address this through experts streaming at the front door to allow for earlier identification of mental health issues, including dementia, with quicker streaming to specialities for mental health patients. We are also looking at parallel working of the PLN within the ED to triage at an early stage ensuring rapid intervention.
Hospital discharge Both in our feedback about urgent and emergency care services and from community based care, people often raised concerns about hospital discharge. The main concern was that often there was no link up between hospitals and community care. People were discharged from hospital and support was not in place when they got home.	• We are developing improved discharge arrangements in each borough using teams from the community who go into hospital to arrange patient discharge. They are called 'integrated in-reach teams' and will provide better discharge planning and coordination. They also provide better support for people at their agreed place of discharge. For instance, the Greenwich Integrated Discharge and Reablement programme and Bromley Co-ordinated Discharge Centre. **Areas requiring further work:** • We are still developing care navigator skills.

	• Our ‘asset mapping’ work will help us identify all the services – NHS and other – that exist in south east London so that we can identify which can help people best when they need it.
Self-management There was a strong message throughout all areas of feedback that services should be centred on the individual – not the condition. Further to this was the desire for a bigger focus on self-management – encouraging the individual to take more control of their condition and health in general. Specifically, it was noted that self management courses need to be tailored to different needs, including people with learning disabilities and mental health conditions.	• One of the central aims of our strategy is to provide services that meet the needs of the individual and their carers. All our plans have patients at the centre of what we do. • The principle of shared decision-making is at the heart of care planning. This is agreeing a treatment plan with patients, including strong self-care elements and a focus on the things that motivate people to change. 'Year of Care' is a scheme which trains professionals to undertake care planning successfully. • We are also developing structured education and social prescribing programmes.

In addition to the themes above, some points were raised less frequently around specific areas:

Key themes from feedback	**Our response**

GP practices – It was suggested that there should be senior doctors on call and social workers linked to each practice. It was also noted that care should be standardised across practices so people know what they can expect.	• Our community based care work focusses on shared standards, local delivery. This means that we aim to ensure the same access to and quality of care for people in south east London wherever they are, though the details of schemes and processes are worked out locally. That includes improved access to bookable GP appointments 8am-8pm and at the weekend. In four of the six boroughs there are already primary care hubs, with the remaining two boroughs developing other ways to provide this primary care cover. • Our local care networks are bringing together the different organisations, individuals and agencies involved in the care of a patient, including social care and specialist advice when required. **Areas require further work:** • We need to work with CCGs to better define what a local care network is, and what elements are standardised across south east London - this is a balance between locally delivered services but a consistent and equitable service across south east London
Coordinated care - People with multiple conditions should be better supported to	• There are care coordinator/ navigator

coordinate their care. 'Care navigators' should focus on signposting and giving information re local services.	pilot projects now being run across south east London. They are developing a set of core skills, aiming to make this a recognisable role within the workforce. Roll out will be organised by each CCG. They are developing a set of core skills, aiming to make this a recognisable role within the workforce. Roll out will be organised by each CCG. • Asset mapping will detail NHS and non-NHS services, including social prescribing, community connections and champions who can direct people to local services. • There is a duty on Local Authorities, as part of the Care Act, to provide information and advice about local services. • There are good examples across south east London of working with patients, carers and staff to review medications. For instance, a scheme in Lewisham looks through a patients prescribed medication to make sure that they are effective and, when multiple medications are being taken, that one is not counteracting another. We can also save money by switching from branded to generic medication, which does not affect patient outcomes.

	• Improvements in support for carers should be set out 'Carers strategies' produced by Local Authorities in partnership with the NHS. These should reflect the national priorities for carers which are that carers should be:
	  ○ recognised and supported as an expert care partner
	  ○ enjoying a life outside caring
	  ○ not financially disadvantaged
	  ○ mentally and physically well, treated with dignity; and that
	  ○ children will be thriving, protected from inappropriate caring roles.
	
	Areas requiring further work:
	• There will be a need to develop clear communications for patients and the public around the role of the care navigator
	• There is a planned programme of work to develop care navigator skills

Local care networks - There was a suggestion that existing community hubs should be used so that people feel comfortable in familiar environments.	• Local care networks are central to our plans to improve community-based care. They are networks bringing together the different organisations, individuals and agencies involved in the care of a patient. These are

	virtual networks – this is not about building new facilities or creating new organisations, but working together in a different way, with the patient's needs at the centre of the service. Most of the time, patients will be seen in existing community facilities.
Frail and elderly - Further work needed to support vulnerable and frail people in the community	• Work to support the frail elderly is underway. This is part of the care planning previously described. We are also focusing on risk stratification, which identifies people likely to be at risk because of age or other factors so that we can work with them proactively to manage their health. Working with at-risk groups, in particular the elderly, is a focus for local care networks. • End of life care coordination "coordinate my care", an IT package which helps professionals support patients, is already widely used across south east London. We are focusing on end of life care and sharing best practice within each CCG.
Trans* community – During a focus group with people from the trans* community it was noted that people are often misgendered – either in GP surgeries or sexual health clinics. It was suggested that health settings should be 'visibly' safe with confidential	• GP surgeries are set up to provide confidential spaces. Patients should never feel required to reveal information in public settings. • Reception staff are trained to respect

environments (including reception staff) where you do not need to verbally explain why you are there. *(Trans* is an umbrella term encompassing anyone whose gender identity or gender expression does not conform to the binary of the gender they were assigned at birth).*	patient confidentiality, and patients should not be required to explain why they are presenting at a health clinic.

Ideas:

We received a number of suggestions about how community based care could be improved for trans people:

Your ideas	**Our response**
Better monitoring forms that include more options around gender (so that trans* community are not forced to choose a gender that might then affect the service and treatment they are trying to access)	This has been raised with colleagues responsible for equalities within CCGs to take forward at a borough level and consider changes to monitoring and other forms.
Better information about what services are available	There will be an area wide campaign to raise awareness of local services, once the programme is fully implemented. This would include tools such as Health Help Now – an app that gives you guidance about which local services to use, based on your symptoms. The care navigator will support people by helping people identify appropriate services and support people to access them.

More online booking of appointments	The London Primary Care Standards require the increased use of online booking, prescribing and consultation with targets set from April 2016. We are working towards these targets.

Planned care

Feedback about planned care fell into four main categories: communication, travel and transport, discharge and access.

Key themes from feedback	**Our response**
Better communication Issues around how communication could be improved were frequently raised. Patients noted how they had had to be the ones to chase up their test results – when it should not be down to them. Similarly it was noted that appointments often got changed at the last minute (either time change or cancelled) and that communication around these did not always reach the patient concerned. Lastly, it was felt that there should be better communication about the nature of each appointment - what it is for, who it is with, whether the patient needs to do anything in advance to prepare. People need clear information and what to expect from their condition, care and treatment.	• We have not yet looked at specific initiatives relating to communication. However, they will be built into the next stage of work in planned care (pathway reviews). • We are developing plans to consolidate some elective orthopaedic care. A consolidated service would be for routine planned operations such as hip and knee replacements. One of the aims is to reduce cancellations. Any developments will look at the best practice pathway to ensure the highest quality and best patient experience, from diagnosis through to rehabilitation and after-care.

Travel and transport Comments around travel and transport were two-fold. Firstly, people noted that if they needed to travel outside of their local area to access services, then consideration should be given to transport links. Secondly, concerns were raised around the quality of hospital transport - people noted that if patients are delayed then they can miss their appointments which put extra pressure on the service.	Areas requiring further work: • Patient transport has not been considered as part of planned care. We recognise that is does impact on care, as if patients are collected late they can also miss their appointment. The programme could explore working with voluntary and community service providers to consider solutions to this • For elective (planned) orthopaedic work, the programme is considering the development of dedicated centres for routine operations. Patients would see their local consultant at a centralised centre, with outpatients and aftercare provided closer to home. This would improving access and quality. These ideas are based on a service already in existence – the South West London Elective Orthopaedic Centre. Here patient transport is arranged to and from the centre via taxi.
Discharge Problems around hospital discharge were frequently mentioned issues. Problems fell into 3 main categories: patients being discharged from hospital too early or at inappropriate times, support not in place directly when they arrived home (caused by	• Through the development of local care networks the strategy is building links between hospital and community care. • All CCGs are developing improved discharge arrangements using teams

a lack of coordination with social care and community services) and a lack of aftercare following an operation.	from the community who go into hospital to arrange patient discharge. They are called 'integrated in-reach teams' and will provide better discharge planning and coordination. They also provide better support for people at their agreed place of discharge. For instance, the Greenwich Integrated Discharge and Reablement programme and Bromley Co-ordinated Discharge Centre.
Access Feedback noted that the speed of diagnosis could be improved if GP and community hospitals were able to test and diagnose on one site. It was also suggested that test and diagnosis centres need to open for extended hours.	• For elective (planned) orthopaedic work, the programme is considering consolidated centres for routine operations. This would mean patient see their local consultant at a centralised centre, with outpatients and aftercare provided closer to home. This would improving access and quality. These ideas are based on a service already in existence – the South West London Elective Orthopaedic Centre. Here patient transport is arranged to and from the centre via taxi. • There is evidence to show plans to consolidate elective orthopaedic work will mean an increase in quality and access and may also help reduce pressure on A&E **Areas requiring further work:**

	• Mental health has not yet been considered in relation to Planned Care - a simple questionnaire could be introduced to understand any needs

Ideas

Suggestions around how planned care could be improved revolved around streamlining communication and information. Of note:

Your ideas	Our response
Could patients be given copies of their own notes/letters and telephone numbers for consultant secretaries and information packs?	• These suggestions will be considered at a later stage as our pathway planning becomes more detailed.
Could some paperwork/forms be filled out online?	• We would need to carry out further engagement work to understand what forms, if any, could be completed online for planned care appointments and procedures

Maternity

Areas to work on:

Six areas frequently came up during discussions around maternity services. These were: attitude of staff, breastfeeding support, consistency of advice and care, discharge from hospital, better information and education and staffing shortages.

Key themes from feedback	**Our response**
Communication The attitude of some staff came through as a key area for improvement. People strongly	Staff communication with patients, including attitude, consistency of advice, and support and information is not currently a specific

felt that the attitude of some midwives, clinical staff and staff on labour wards needs to be improved. Feedback consistently suggested that women felt 'spoken down to' and that they were treated in a condescending manner. Breastfeeding - A very clear message came through that breastfeeding support staff need to be more supportive and sympathetic – not leaving people feeling daunted. Consistent advice – patients said they often receive conflicting advice from midwives, health visitors and consultants. They need to give out the same messages**.** Core issues that were raised were around the importance of being informed about what is happening during pregnancy and birth and knowing what options and choices are available to give birth. People noted that they would like more information online and tailored to the individual.	intervention outlined in our plans. However this theme, which has been stressed in several areas, will be fed into the Maternity Network to take forward. The Maternity Network is made up of senior midwives and consultants working in south east London, and can address these issues at a Trust/provider level.
Breast feeding It was noted that in general, mothers felt that they needed more support around breast feeding.	Financial savings within Local Authorities may impact breastfeeding service and support cafes – this needs to be better understood
Consistency of care Feedback highlighted that consistency was a factor in three areas: advice (dealt with	**Areas requiring further work:** • Further work needs to be undertaken

above), quality of care and named professional.
Quality of care – consistency in the quality of post natal services was often raised – there was a suggestion that this varied, particularly in areas of high deprivation.
Consistency of midwife care – many people strongly felt that people should work with a named midwife throughout pregnancy, labour and post birth care.
	to better understand the maternity workforce to know whether it is possible to give women a named midwife for the duration of their care (noting that all hospitals are now achieving the required midwife to patient ratio)
	• Continuity of care professional is a key objective of the maternity work stream and is the remit of a specific working group within the programme. There is some good practice already in existence, but this is variable.
	  ○ Low risk births should be supported through local care networks
	  ○ Higher risk births should be supported through services from across local care networks
	• Across south east London, maternity services vary in the amount of contact they have with new mothers following birth (post-natal care). The programme want to ensure new mothers have a consistent offer of support through an agreed protocol, so that they receive the right level of support, based on best practice.

Discharge from hospital Two issues were raised around hospital discharge. Firstly, that problems can occur	The South East London Maternity Network is considering how to address this issue.

when mothers are discharged from hospitals following birth, if outside their normal borough. Secondly, it was noted that some patients were discharged too early because of a lack of beds.	
Mental Health and wellbeing It was strongly felt that mental health needs to be an integral part of maternity care. Health visitors should be trained to check for postnatal depression, signpost to local services and be a point for regular communication.	Continuity of midwife-led care will do much to maintain the emotional wellbeing of women and allow those who are experiencing mental health issues to be identified quickly and appropriate support secured. The programme will consider how to improve the training for midwives in understanding areas such as perinatal mental health and FGM.
Staffing shortages A recurring issue was around ensuring that there are enough sufficiently trained staff available when required. Of note – concerns were raised around the numbers of midwives and consultants.	• In line with the London Quality Standards (a set of standards that acute emergency and maternity services are to meet), the programme is looking to extend paediatric consultant and obstetrician cover, which will be led by our providers. • All hospitals are now achieving the required midwife to patient ratio.

Ideas

Some specific suggestions were provided re how maternity services could be improved:

Your ideas	**Our response**
Mothers should receive a named health visitor who is consistent through their care (pre and post birth).	The number and roles of children's Health Visitors may change in the future.

There should be specific ante-natal classes for mothers with mental health problems – to provide greater peer support.	These suggestions will be taken forward through the South East London Maternity network.
There should be a specialist midwife on call for women who lose their babies during pregnancy or labour.	
Post-natal care should also reference contraception.	This is part of current practice.

Children and Young People

Already good:

It was noted that there is a good service for Children and Young People at Lewisham A&E as they have their own department.

Areas to work on:

There were three themes that came up the most frequently during discussions about services for children and young people. These were communication, mental health and the transition from children's to adult services. Specific points were also raised on a less frequent basis which are noted later in this section.

Key themes from feedback	**Our response**
Communication Children told us that clinicians tend to talk to parents rather than patients. It was strongly felt that children should be treated as the patient and doctors should discuss their condition with them. Further to this, it was	A number of communication issues have been highlighted in feedback. This is not currently addressed in the strategy and will be fed back into the children and young people's clinical leadership group for consideration.

noted that children can have trouble explaining problems/symptoms – and staff should exercise patience. It was suggested that GPs need to communicate more clearly about immunisation and that fathers can be the main care giver – and information/messaging needs to go to them too.	
Transition from children's to adult services Concerns were consistently raised around the transition from children's to adult services. Of note, the transition period itself can be too short – it should be at least a year and there is inconsistency in when someone is considered an adult. People noted that it could be difficult getting access to the service they once had (as a young person) when they turned 18.	This is an area we have identified through our work. As young people transition to adult services, there is no consistency at a strategic level, despite some local best practice examples. More work will be undertaken in this area to support young people going from children's into adult service
Mental health Within mental health, there were three key themes: earlier support, attitude of staff and support from schools. As with many of the other health agendas – there was a clear focus on prevention and early diagnosis. It was noted that support for children and young people with mental health conditions needs to start earlier so that it does not escalate to crisis point. Specifically, more support is needed for 'sub-	• Work in child and adolescent mental health services (CAMHS)/adult mental health services around a "Crisis Concordat" to resolve issues with the quality of the services that are being commissioning and any gaps in appropriately skilled staff – this is part of CCG's children's and young people's Mental Health and Wellbeing Transformation Plan. The programme is reviewing these to

threshold' symptoms with more services needing to be delivered at home. The attitude of healthcare professionals was questioned by some – with experiences from children and young people highlighting that some clinicians have dismissed their mental health conditions – people felt that they were not taken seriously. Lastly, it was felt that schools need a significant amount of additional support to effectively work with children, who have, or are developing, mental health conditions. There needs to be better education re health and wellbeing – possibly delivered by health care professionals in school settings rather than by teachers.	identify opportunities that could be delivered across south east London. • Strategy aims to deliver a holistic approach to the care of children and young people. Service design will take into account the physical, social, emotional and mental wellbeing of the young person plus that of their carers and siblings. • An integrated approach to community based care is being developed for those children and young people with more complex needs. A working group is looking at those children and young people who have more complex needs, as the majority of young people will be cared for by their GP and the local care network. • Urgent and emergency care is looking at children and young people's mental health and designing interventions for those reaching crisis point and attending A&E, including rapid access to Psychiatric Liaison Nurse (PLN). Areas requiring further work: • Currently, under 18s and adults face different waits to access psychiatric liaison services, with the skill mix being very different. There is an intervention within the strategy to

	combat this. • Children and young people with complex needs require further consideration. • We need to consider whether mental health training in schools is within the remit of the programme. • Work with schools and children's centres is on-going to understand how they can support early intervention in areas such as childhood obesity, mental health etc.

Ideas:

We received a number of suggestions and ideas around how services could be improved for children and young people. These fell into four main categories: mental health, education and information, short stay paediatric units and planned care.

Your ideas	**Our response**
Mental health (CYP) • It was suggested that there should be 8am-8pm services for counselling, sexual health and mental health services • More services for children aged 6 to teenage for mental health, eating disorders and teen cancer were needed	These suggestions will be considered further as part of the ongoing development of mental health interventions.

• More talks in schools about mental health awareness – delivered by healthcare professionals • More services to support families of children with mental health conditions	
Education and information • Advice line for carers – to check what to do or whether something is a problem • Information about local services should be made available at play groups and baby groups • Education around prevention and wellness should happen from birth and throughout education system • Professionals should work with the whole family to teach children about health lifestyles – including what to cook	• Carers' strategies are being produced by Local Authorities in partnership with the NHS. • These interventions are the responsibility of Local Authorities. The feedback will be further considered to determine whether these issues have been covered or if more needs to be considered.
Short Stay Paediatric Assessment Units • Largely there was support for a Short Stay Paediatric Assessment Units. However people felt that further consideration need to be given to whether younger and older children should be mixed together. Could there be different sections arranged by age?	• Short stay paediatric assessment units across south east London are being evaluated, to understand any differences in quality and how the units operate.

Planned care Elective care centres – it was suggested that there should be areas where parents can stay with their patients and that we need to consider travel times.	• For elective (planned) orthopaedic work, the programme is considering consolidated centres for routine operations. However, this is for adults services only and will not impact on the children's pathway.

Urgent and Emergency Care

Areas to work on:

We received a significant amount of feedback about urgent and emergency care. There was particularly rich information from mental health service users and their experiences of this service. Feedback has been themed into 4 key areas – with issues pertaining to mental health service users populated throughout. These areas were: access (including lack of access to other services), awareness of other services, quality of service at A&E and discharge and aftercare.

Key themes from feedback	Our response
Access It was frequently noted that if people had better access to GPs and community services, they would not feel the need to go to A&E. It is therefore essential to improve community care. This point was strongly made by mental health service users. People might not present at A&E with mental health conditions if there was better support in the community and from their GPs. It was further noted that people need support earlier so that they don't reach crisis point. There needs to be immediate support for people in mental health crises and access to emergency care (rather than having to go to	• For both under 18s and adults with mental health issues, more needs to be done to tackle long waits in relation to urgent and emergency care. There are different teams across hospital sites and services vary dependent on the time of day • Part of the community-based care strategy is increased training and awareness of mental health for GPs. There is a strong focus on increased access to community services through extension of bookable appointments and links to other

A&E).	services through the local care networks **Areas requiring further work:** • More focus is needed on mental health before reaching the emergency department as well as in the emergency department.
Awareness of other services Linked to the above, it was suggested that there needs to be greater awareness of other urgent care services to alleviate the pressure on A&E. Often people experiencing an acute episode or crisis point (mental health) call an ambulance to access emergency services. People are not aware of what other options are available. There needs to be better promotion of other services that people can access for urgent mental health support – rather than going to A&E. Further to this, 111 service needs better promotion.	• The recent publication of the facilities specification for urgent care centres and departments will give clarity to service users about what to expect from out of hours services, including opening times. This should focus, in part, around information to mental health service users, to help avoid crises. • Area wide campaign to raise awareness of local services, once the programme is fully implemented. This would include tools such as Health Help Now – an app give you guidance about which local services to use, based on your symptoms • Asset mapping; online resources and care navigators sign-posting and supporting local people. **Areas requiring further work:** • Better signposting to community services is required to avoid patients

	escalating to a crisis. This is particularly key to those with drug and alcohol problems and under 18s and adult mental health service users. • Information about local services held by 111, in their directory of service, needs to be shared with patients and the public.
Quality of service at Accident and Emergency Departments Comments around the treatment received at A&E focused on experiences of people with mental health conditions and the experiences of children and young people. Currently, patients' physical conditions will be treated before their mental health conditions. These need to be assessed together to reduce stress on the patient and to begin treatment/referral as efficiently as possible. Children and young people said that they can find A&E challenging if they are mixed with adults – there should be dedicated, age-appropriate space.	**Areas requiring further work:** • Need to assess mental health as well as physical health in parallel assessments. • Paediatric emergencies should be streamed separately to adult cases, we know this doesn't always happen at the moment.
Discharge and aftercare Overall, people reported delays to discharge or had concerns about being discharged late at night without a homecare package in place. For people who had accessed A&E with a mental health condition, aftercare was felt to	• We are aiming to develop in-reach integrated discharge teams supporting better planning and co-ordination of discharge. • Fractured neck of femur – often elderly patients are moved to a step-down ward during recovery, when in

be particularly important. Without follow up care and support, people can easily relapse. Further support is needed to prevent this cycle of crisis and emergency treatment. In addition to follow up treatment (whether from a psychologist/homecare team/resilience team), support from the voluntary sector has been invaluable, as has keeping active.	fact this can sometimes set back their recovery time. We are giving a clear recommendation to our providers to keep patients with this condition on the same ward, or to move them quickly following surgery. • Increased awareness of the services available in the community, particularly for people with mental health needs, will be taken forward through asset mapping is underway to detail NHS and non-NHS services, including social prescribing, community connections and champions who can signpost to local services. **Areas requiring further work:** • For patients accessing urgent and emergency care discharge and aftercare, including late night discharges, needs to be better thought through. The strategy links to rapid access teams, but this has not yet been picked up. • There needs to be better joint working with social services to enable discharge to happen on time.

Ideas:

Your ideas	**Our response**
There needs to be better, and clearer, information available to the public about	• Area wide campaign to raise awareness of local services, once

where to go to access what service	the programme is fully implemented. This would include tools such as Health Help Now – an app give you guidance about which local services to use, based on your symptoms.

Cancer

Areas to work on:

Five themes came up the most when discussing cancer services. These were prevention, earlier diagnosis, education and information, mental health and travel and transport.

Key themes from feedback	Our response
Prevention It was consistently fed back that there needs to be a bigger focus on prevention. Screening needs to happen earlier. This needs to be better promoted. There needs to be better information about prevention and leading healthy lifestyles.	• The community-based care strategy is focused on prevention, with support to help people lead healthier lifestyles – for example 'Year of Care'. • More on the screening interventions. • The programme is not explicitly addressing cancer in young people. Screening is the responsibility of Public Health.
Earlier diagnosis People felt very strongly that people need to be diagnosed earlier. Central to this were problems getting GP appointments. It was felt that there should be easier access to expert care. It was felt that doctors should be more responsive to individual concerns. If a	• CCGs are in the process of agreeing a funded pilot for a serious but unspecific symptoms pathway, based on the Danish model. This pathway would cover patients with non-specific symptoms, that may be those of cancer, but do not fall within the

patient suspects cancer, then follow up tests should be conducted. It was further felt that the gap between diagnosis and treatment should be narrower. People felt that 62 days was too long to wait before receiving treatment.	definitions of the two week wait pathways. Patients who have serious symptoms, that cannot wait two weeks for investigation will receive 'straight to test' direct access to diagnostics. • Cancer – early detection is a key intervention which will be supported by Education and Training packages delivered through Local care networks. They will aim to supporting people to make healthy lifestyle choices through brief advice.
Education and information People told us that there is a lack of information and advice about treatment options. People need to know what treatments exist in order to make an informed decision about what treatment option is best for them. People need better information and education about the symptoms and services.	• Online training courses are available to assist health and care professionals to work with patients to encourage healthy lifestyles, aiming to prevent cancer. • The Acute Oncology Service will be providing a phone line to triage oncology patients, directing them to appropriate services and avoiding an admission via A&E. If an admission is required, patients will be sent directly to the appropriate facility. • The development of a Cancer Care Navigator. At diagnosis, this role will provide: o Care navigation

	○ Information ○ Signposting • Asset mapping is underway to detail NHS and non-NHS services, including social prescribing, community connections and champions who can signpost to local services. • There is a duty on Local Authorities as part of the Care Act to provide information and advice about local services.
Mental health People emphasised that stressful treatment for cancer (such as chemotherapy) can exacerbate mental health conditions. Individuals need to be treated as a whole person – chemotherapy in conjunction with mental health condition and treatment. Healthcare professionals must be aware that one treatment or condition can affect the other.	• As part of a cancer education and training package, carers will be offered a needs assessment (including around mental health), support, online tools. • We recognise the importance of both mental and physical health and think that local care networks could play a key role in providing psychological and emotional support for people in their local community. We are currently in the scoping phase of this work.
Travel and transport It was also noted that whilst cancer specialist centres may provide the best service, they can be difficult for older people to access as they are further away. Consideration needs	• Travel and transport to access specialist cancer services is out of scope for the strategy. Two new cancer centres will shortly be opening in south east London, and transport

to be given to travel and transport.	should be looked into.

Suggestions:

Several suggestions were made about how cancer services and support services could be improved:

Your suggestions	**Our response**
At diagnosis, GPs should be trained and enabled to conduct some of the initial tests themselves – for example conducting blood tests and scans	• Early detection is a key intervention which will be supported by education and training packages delivered through local care networks. These will be aimed at GPs and a range of other health professionals.
More education on symptoms and screening for younger people – to support early detection.	• We are introducing a training package for staff working in primary care to help them to recognise symptoms and achieve earlier diagnosis. • A multidisciplinary diagnostic centre pilot will help us to diagnose cancer in all patients more quickly
A buddy system for patients undergoing the same treatment so that they can provide peer support and share their experiences with each other	• This may be out of scope for the programme, we will flag to voluntary and support services
There is a need to challenge the negative narrative around cancer treatment. Rather than focusing on the negatives of cancer treatment, professionals should talk about how treatment has advanced and how much better it has become.	• The Talk Cancer training – part of our education and training package – will help health professionals to talk about a cancer diagnosis and give information about cancer treatments in the right

	way.

Information Management and Technology

There were two key themes related to improved information management and technology that came up consistently across all clinical areas. These were better information sharing and transferring of data and improved tele-health options.

Key themes from feedback	Our response
Improving information/data sharing Improving communication and record sharing between different parts of the NHS and with social care was a core theme throughout all clinical areas. Information sharing needs to be improved for a number of reasons: to prevent patients having to re-tell their story or history, to improve continuity of care and to support records being kept up to date. It was also noted that there can be significant problems transferring medical records between GP practices – which can lead to delays in appointments and treatments. People wanted the ability to share records digitally – for there to be one digital database for all UK patients.	• There are plans to integrate patient records across south east London. This will mean that GPs from a primary care hub, treating patients not from their usual surgery, will have access (with consent from patients) to their patient records. It is anticipated that patient records will be paperless by 2020. • We are introducing a “flag system” on hospital computer systems, specifically around urgent and emergency care and cancer. This means that, even though you might not be seeing the same care professional, key information is shared and highlighted, so that you don’t need to tell your story over and over again. Implementation plans to roll this out across south east London are being finalised by June 2016.

	Areas requiring further work: • In future there will be integrated GP records linking to community services and acute providers. Integration with social care records remains a challenge. • IT systems such as "Connect care" and the Lewisham and Greenwich "Health Locker" (partnered with South London and Maudsley NHS Foundation Trust) are viewed as best practice models we would like to share learning from across south east London. • Need to assess current IT systems to understand if they are being used to their full ability. There is also huge variability in data quality and reliability, so we need to understand gaps.
Telehealth Feedback consistently pointed at the need for more tele-health options and to use technology more effectively. People fed back that they would value the option of having Skype appointments with their GP or consultant, and that they would prefer more opportunities for telephone consultations. It was felt that Skype, e-mail or phone appointments can all be used to gain quicker access to GPs and other health professionals.	• Telehealth is being used to great effect in some areas, but usage in other boroughs is variable. It would be the programmes aim to increase the usage of telehealth.

Workforce

Across all sources of feedback and clinical areas, there were some very strong themes related to workforce requirements and working environments. The themes that cut across all populations are noted below. There were also some specific suggestions about particular groups that are addressed later in this section. The cross cutting workforce themes were: a whole person approach to care, investing in staff and further training for staff.

Key themes from feedback	Our response
Person centred care There was a big push to encourage the NHS to work from a more 'patient centred' perspective. It was recognised that this would take a significant culture shift – to put the patient at the centre, seeing them in their entirety rather than focusing on their condition or symptoms. It was felt that additional training would be needed to support staff to see patients as individuals and big shifts needed in the system to enable patients to be treated holistically rather than in the current piecemeal way.	• The programme has developed strategic priorities, with a series of objectives at south east London and borough level. These aim to ensure that in future patients will see the right staff with the right skills in the right place. These staff will treat patients holistically and as individuals, meeting their care needs. • In line with the London Quality Standards, the programme is looking to extend paediatric consultant and obstetrician cover, which will be led by our provider. • The development of a Cancer Care Navigator. At diagnosis, this role will provide: o Care navigation o Information

	○ Signposting **Areas requiring further work:** • Further work needs to be undertaken to better understand the maternity workforce to know whether it is possible to give women a named midwife for the duration of their care (noting that all hospitals are now achieving the required midwife to patient ratio). • Continuity of care professional is a key objective of the maternity work stream and is the remit of a specific working group within the programme. There is some good practice already in existence, but this is variable. ○ Low risk births should be supported through the local care network. ○ Higher risk births should be supported through services from across the local care network.
Investing in staff Across all clinical areas it was noted that we need to invest in our staff: providing further training, better pay and looking after their health and wellbeing too. It was also suggested that the NHS could work more with volunteers in order to extend the	• Mapping the current workforce to understand how many staff there are in south east London, their skills and competencies, demographics and any gaps the system may be facing. Tools are being developed to understand the impact of new ways

workforce.	of working, this should tell us whether we need more staff and any new skills. • Ensuring good staff engagement and reflective practice through programmes on compassion and mindfulness. In clinical settings, Schwartz Centre Rounds are also used to support the workforce (a monthly session for staff to discuss difficult emotional and social issues arising from patient care). • Training and education is being offered to carers as well as a routine offer of a carers needs assessment. As part of duties under the new Care Act, this happens across all boroughs, but quality is variable. It is important to recognise that some people don't want to be labelled as a carer if supporting their husband, wife or other family member, and there is work to do with breaking this stigma.
Training for staff There were many suggestions around what further training health care professionals need. Across the board it was felt that all healthcare professionals should receive further training around how to be caring and compassionate. More specifically, there should be further training for GPs around: HIV awareness;	• We are working in partnership with South London and Maudsley NHS Foundation Trust on the development of care navigator roles. The competencies will include physical and mental health and well-being services; awareness of mental health and ability to recognise signs of physical and mental distress;

mental health including self-harm, how to communicate with people who have hearing impairments and greater awareness and sensitivity towards the LGBQ and trans* community. Of note currently GPs only receive one hour of training around gender identity issues. It was suggested that trans* people should be involved in delivering this training. Some people from the LGBQ and trans community reported that every time they see the GP they have to explain their gender or sexuality. It was also suggested that people supporting end of life care should be trained to better look after people in their own homes.	listening skills; and motivational skills and coaching. This role will provide patients with a single point of contact who can signpost to appropriate services and coordinate care. • Online training courses are available to assist health and care professionals to work with patients to encourage healthy lifestyles, aiming to prevent cancer. • GP training is available, including health coaching and motivational skills (Year of Care). • End of life care coordination "coordinate my care" is already widely used across south east London. • We are funding training for primary care staff, GPs and practice nurses around cancer prevention, diagnosis and post-treatment support. • Trans issues haven been fed back through the CCG Equality Group.
Trans*friendly environments During a focus group with the trans* community, the point was made that many primary care setting are not safe environments for trans* people. For example, there are not confidential environments for disclosing information that could publically	All GP surgeries should have confidential space for patients, and there should be no requirement for patients to give confidential details in a public setting.

‘out’ them. There was a suggestion that the NHS create an accreditation for ‘trans friendly’ healthcare settings.	

Out of scope

Whilst the vast majority of the feedback received pertained to issues within the Our Healthier South East London strategy, there were some areas of feedback that are outside the programme's remit and therefore not within our gift to address. These comments are noted below:

- There should be more money for social care services.
- There are not enough NHS dentists
- Services for trans* community - even though people have changed their gender and have certification, the NHS still sends inappropriate screening requests. i.e. cervical smear tests, to trans men and prostate exams to trans females. If you have changed your gender identity, but are waiting for surgery, then you are no longer eligible for screening. For example if you were assigned a female gender at birth, but now identify as male, even if you have not had surgery, you are no longer entitled to breast or cervical screening – leaving you at risk. Evidence suggests that this causes higher rates of prostate cancer within this community.

Appendix B

Sources of feedback on the Issues Paper

1. **Outreach to local groups/communities**

Lewisham	Phoenix Festival (May 2015)
Southwark	Surrey Docks Health Centre – Information stall
Southwark	Southwark Locality Meeting
Southwark	CoolTan Arts – mental health service users
Bromley	Beckenham Beacon volunteers
Bromley	Transformation event, Bromley CCG
Lambeth / Southwark	SLIC Citizens Forum
Lewisham	Lewisham People's Day
Lewisham	Lark in the Park
Lewisham	Positive Aging Council
Southwark	Cardiac support group - GSTT
SEL wide	Kings College Hospital AGM
Lewisham	Ageing Well
Southwark	Substance Misuse Council
Southwark	Dulwich Tenants and Residents Association
Bromley	Commissioning intentions survey
Southwark	Copplestone Church
Bexley	Bexley Youth Ambassadors training session
Lewisham	Deptford Reach
Bexley	New Generation Centre Toddler Group
Lewisham	Carers Lewisham

SEL wide	Metro transgender focus group
SEL wide	SLaM CAMHS focus group
SEL wide	SLaM Urgent and Emergency Care focus group
Southwark	Hayles Residents Association
Southwark	East and West Walworth Tenants and Residents Association
Southwark	Dragon Café – mental health service users
Bromley	Healthwatch managed focus groups: - Nigerian Schools Sports and Family Fun Day - Bromley Positive Support Group (The Junction) - Bromley Mencap (via the Job Match programme) which allowed engagement with unemployed mental health service users - Members of the deaf Community in Bromley - A local 'independent living' facility
Southwark	Cambridge House Camberwell (SLIC)
Southwark	East Street Market – information stall
Southwark	Healthwatch public forum day
Lewisham	Phoenix Festival (October 2015) – including: - Stonewall - Bellingham Community Project - Coalition of Disabled People - Community connections - Phoenix Housing Association - Riverside Housing Association - Volunteer police cadets - Pre-school learning alliance (family support, parenting skills, ESOL)

2. **Deliberative events**

   Six deliberative events were held in July – one in each south east London borough with recruited patients and the public and key voluntary and community sector stakeholders. There were over 440 attendees over the six events.

3. **Responses from individuals**

Twenty-two responses were received from individual members of the public