NHS
Haringey
Clinical Commissioning Group

Haringey CCG Network Meeting – Feedback Report
Monday 15 September 2014 (Winkfield Resource Centre)

This Network meeting provided an opportunity for members to discuss and give feedback to help shape commissioning intentions in four important areas: mental health, Better Care Fund / integration, end of life care and supporting people with long-term conditions. We have summarised your discussions and feedback in this report. However, if you think we have missed anything please let us know. We will be sharing this report with the commissioning leads in each of these areas to ensure they use your insight to inform their commissioning plans. We will feedback to you in March about how your feedback has been used.

1. Mental Health

We asked:
What would improve experiences for people with mental health needs…
   a) At their GP surgery?
   b) In any other clinical settings e.g. at community mental health teams or inpatient ward?

You said (a):
- The range of services available, including local community support services, needs to be better promoted to patients and GPs, for example, IAPT telephone support, Big White Wall online peer support etc.
- More training for GPs and other practice staff to identify and support people with mental health issues, such as mental health first aid training or training provided by the mental health trust academy etc.
- GPs to be more thorough in their check-ups with patients – asking more than the basic 'how are you' questions.
- GPs to monitor patients' stress levels as this is a cause of mental health problems. GPs could give all patients an annual check-up on overall wellbeing and book in a follow up session there and then for patients who present with a mental health issue.
- Some kind of advertising / anti stigma campaign to help people recognise the range of mental health issues and how to get help (early).
- GP surgeries could have drop in / support sessions available for patients.
- A calming reception environment, perhaps with a dedicated quiet area where patients could wait to be seen.

You said (b):
- Make sure hospital inpatient wards have access to people with mental health expertise.
- Ensure feedback from other clinical settings is always given to the patient's GP so they remain up to date.
- Facilitate access for mental health support services and advocacy services into clinical settings.

- Develop the capacity of community organisations and their staff to be able to deliver mental health services.

2. Better Care Fund / Integration

We asked:
1. Do we have a good case for wanting to integrate health and social care services for older people (65+) in the first instance?

You said:
- Yes, absolutely. The case for change completely makes sense.
- We have a good case for integrating health and social care for elderly people as it can be difficult for individuals to work out their entitlements to services and navigate the system.

We asked:
2. Would the proposed pathway improve things for older people?

You said:
- It is a good model on paper and in theory. Some concern over its practicality.
- The proposed pathway would improve things as long as the whole structure is properly resourced and there are enough (and properly trained) care co-ordinators to support people.
- There is a need to ensure that not everything is online and to make sure phone calls and face to face parts of the pathway are well resourced.
- There would need to be funding for the community and voluntary sector organisations from the NHS and council. A workforce plan might also be needed to ensure they are ready to play their role in the pathway in a sustainable way.
- A navigation/care-coordination role would be really important – helping people navigate the system – and will be especially helpful for older people.
- If the pathway improves communication between the services then it will be a really good thing for older people.
- There were some concerns raised:
    - Around the minimum age of 65 – by 2019 this won't be the pension age. Perhaps "need" rather than "age" assessment would be preferable.
    - Concern that one size won't fit all – various aspects work differently in different parts of the borough.
    - Concern surrounding how it will work with specialist sector services out of Haringey.

3. End of life care

We asked:
1. We'd like to ask about people's experiences with friends and family who have received care at the end of their lives in Haringey – what worked well and what didn't?

You said:
- There was a good personal experience of a neighbour with cancer who was supported to die at home (his place of choice)
- The level of care depends on the hospice – it feels like some are well-monitored and well-staffed and others are not.
- Good feedback from experiences at St Ann's Green Trees ward – similar methods of care could be used.
- Large hospitals such as the Whittington tend to send patients home, which can leave them feeling worried at home without immediate access to treatment.
- Heard experiences of GPs sometimes not listening to the relatives.
- Concerns were raised over care homes dealing with end of life care – do they know what to do? Are they trained for this specifically?

We asked:
2.   We would like people's views about how we could measure whether the service has improved.

You said:
- Improvements can be measured through family feedback and following up with them when they feel able to talk about it.
- Measuring improvements needs to be more of a qualitative-based assessment if possible.
- Asking questions such as did the person die in their chosen place of death?
- Random checks for quality could be implemented – the social hours of hospices, what happens on weekends etc.

We asked:
3.   We're going to be running training events for the staff that are moving into the new service and we'd like to know whether the network has any key messages for the providers?

You said:
- Ensure religious and cultural differences are considered – sometimes they may need to enlist the help of voluntary organisations to communicate people's wishes and needs.
- Be proactive in explaining what will happen to people – to the patient and to their families/carers. Make sure training for staff covers what questions they should be asking people (and how to do this tactfully).
- Prepare people for possibility of discussion about resuscitation; also ensure after death issues and wishes are discussed with people.
- Ensure there is support for the carers of people at the end of their lives to be able to do what the patient wishes e.g. a 24 hour phone line that a carer or partner could call for advice if something changes with their condition, so they don't feel their only option is to call an ambulance for example.
- Ensure that patients/families are fully aware about what is available to them/ what the options are.
- Promote full range of services that hospices provide e.g. therapy and bereavement counselling

- The point of entry into the right service is important
- Ensure that hospital assessments consider people's mental wellbeing as well e.g. sometimes if a patient is physically well enough, they are discharged yet they may not necessarily be mentally well enough to leave hospital.

4. Long-term conditions

We asked:
1. Can you tell us about any examples of times where you, family members, or friends have been really involved in care decisions? Or where people you know about are really informed and involved in managing their own health or conditions? If so, how did this happen? What could we learn from these experiences?
2. Have you got any contrasting experiences, of decisions being made without you, or of people really not being able to manage their condition? Again, what can we learn?

You said:
- These questions didn't seem to elicit many (any!) responses – so if you have any experiences you would like to share now the meeting is over, please let us know.

We asked:
3. How, as a CCG can we help to create a whole system that helps to promote and support self-management?

You said:
- Community groups/peer support groups are very useful for educating people and supporting people to manage conditions such as diabetes. In particular, specific cultural groups might be beneficial to get people engaged and informed.
- Giving people options of when to engage with support services is important because different people are ready at different stages. Services need to be available at any time – even years after diagnosis.
- Ensure people are well informed about the range of relevant services and support available for them to link in to. Use local voluntary groups to help get health promotion/prevention messages out to people.
- There needs to be a big focus on prevention… and keeping people healthy across the health and social care system
- Clear measures should be implemented to show that the supported self-management framework is working.
- Look at inequity of how and where support services are delivered across the borough– some are free through GPs but not in pharmacies for example.
- Focus on getting local people registered with a GP – this is the first step to making sure people's conditions are identified and people can be supported to self-manage.
- There was some confusion surrounding managing one's own care practically - will individuals who are managing their care have a budget to do this and then choose from a service list?