TABLE 'A' DISCUSSIONS

Table Discussions from the Personalised Care Stakeholder Event 17th May 2019

1. What are your thoughts on the content of the' Statement of Intent', are there other things you would include?
2. How could you see the 'Statement of Intent' being used across Cheshire and Merseyside, what next steps would you suggest?
3. Who should be involved in creating the shared vision for delivering personalised cancer care and support for your population and where might this happen?

Question 1

1. Point of contact/organisation- team system/multi agency
   - Community?
   - Clinical?
   - Move away from 'named person'
2. Is the monitoring standardised- demo of outcomes
   - Communicating the process at the beginning
   - Everyone should be involved, not naming individual stakeholders
   - How do we decide on the outcomes and if they have been met
3. What does affordable mean... (Cost effective)
   - Social outcomes- cost of monitoring
   - ? Taking the whole system view (meaning)
4. ….
5. 'The big picture' what does this relate to (shared vision)
   - Duplication/covered in earlier points
   - Consistency of delivering the message
   - Different interpretations
   - Who is the statement aimed at?

General Feedback

A lot of duplication. Wordy/jargon

Understanding of content to those affected by cancer/patients

Lengthy content /can it be condensed

Has the statement been co-produced (i.e. Mac/Alliance/Patients)

Q1) Need to ensure that language used reflects what PLWC will understand:

- test the language with service users to ensure accessible to all partners (including patients)

- ensure relevant for all PLWC e.g. age/young person and educational impact too

- Language of RBY needs to be relevant too

Q3) People who have clinical responsibilities for other patients i.e. Young adults and charities- if alliance wide, needs to encompass all

Q2) Local cancer action boards- feed into these

- will need education of other organisations and this to endure all are involved

- Churches take up a lot of community services (+ other religious and spiritual organisations), they'll need to be involved too

- Volunteers – both existing and potential new volunteers and schemes coming from macmillan or others

TABLE 'B' DISCUSSIONS

<u>Table Discussions from the Personalised Care Stakeholder Event 17th May 2019</u>

1. Where and how should learning from the 'Right By You' test sites be shared to influence wider development of personalised cancer care and support in your system?
2. Are there specific questions would you like to see included in the evaluation of 'Right By You', to strengthen the case for wider delivery of this type of model?
3. What are the opportunities and threats to delivery of a personalised care approach in Cheshire and Merseyside? Are there any actions that could be taken now to manage these during the testing phase for 'Right By You'?

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1. How do we educate wider health workforce

    - link with Health Education England
    -tie into local initiatives, strategy and priorities
    -ICP
    -Engagement of clinicians

2. Measure

    -reductions in hospital attendance and primary care interventions
    -how do we measure lifestyle changes as a result of SSM?
    -How do we measure impact of education delivered in SSM?
    -Measures need to link to local priorities

3. Opportunity to develop a model adaptable to all conditions.

    -engage with other LTC stakeholders what can we learn from them? Don't reinvent the wheel.
    -opp to look at existing outcome measures to obtain solid evidence for future commissioning.
    -involve patients/carers in development. Co-production.

Threats

-Managing public expectations of what can be delivered – creation of inequity between pilot and subsequent project.
-Macmillan marketing.
-not utilising what already got
- go passionately into something new, ignoring what is already working.
- Prioritising change and what we are delivering becomes confusing- shifting goal posts. Terminology- different words and phrases for the same thing.
- imposing our ideals for personalised care rather than looking at what is needed.
? Are basics in place to signpost to?
?are they prioritised, scoped and commissioned?
? Universal credit, benefits for support?

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1. Where and how should learning from pilot sites be shared?

- Short
- Concrete examples
- Commissioning specs for ICPs (high level) – would need to show how it influences population health needs
- Primary care networks
- Health and wellbeing boards
- Public health (LA)

2. Evaluation questions

- How is it scalable to other conditions?
- How does it impact on population health needs?
- Patient experience

- Admission avoidance
- Quality of life indicator?
- Impact on local services
3.   Threats

- System readiness
- funding
- approving outcomes
- Organisational changes
- developing PCNs
- Competing priorities
- engaging with hard to reach groups

Opportunities

- case for change and people want to do it
- more partnership
- less silo thinking
- influencing organisational change

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1.   Who to share learning with?

   –   Commissioners-evidence that will be useful to them
   –   GP's- primary care networks- showing impact on service
   –   Local authority- links with social care/services
   –   Public health teams
   –   Housing associations
   –   Local voluntary sector/community groups- CVS-volunteering- future resources
2.   Questions to include in evaluation?

   -        Individualised measures that reflect sense of wellbeing
   -        Metrics that speak to different stakeholders/commissioner
3.   Opportunities/threats to delivery

Opportunities

   -        developing community resilience
   -        Localised- place based support through primary CN
   -        Key stakeholders/partners supportive and around the table
   -        The number of people who will be supported

Threats

   -        National measures/targets
   -        Who will finance in future- CCG budgets-NHS LTP- link worker- generalist service?
   -   Demands/expectations

TABLE 'C' DISCUSSIONS

Table Discussions from the Personalised Care Stakeholder Event 17th May 2019

1. What are your thoughts about the Personalised Care/ 'Right By You' model described today?
2. What are the strengths, weakness, opportunities and threats of this approach?
3. Could you see this approach working in your system?

Current issues and solutions:

- Patient gets different messages at different points
- If HNA is the assessment 'tool' one system that all can access
- All teams communicating * patient has to be involved
- HNA in the acute setting is done, and then completed again in the community (both on EHNA system) but both teams cannot view.
- The HNA needs to be a live fluid document (clinical HNA/community HNA/other) it needs to be seen and recognised by all teams involved keeping the patient at the centre.
- How is the HNA viewed by all?
- POINT 1- address needs- could we focus on the patients wants
- POINT 3- needs to adapt to suit area "one size doesn't fit all"
- HNA needs to be a conversation "not a tick box exercise"

ACUTE

OTHER

Communication is
the key

COMMUNITY

PRIMARY CARE
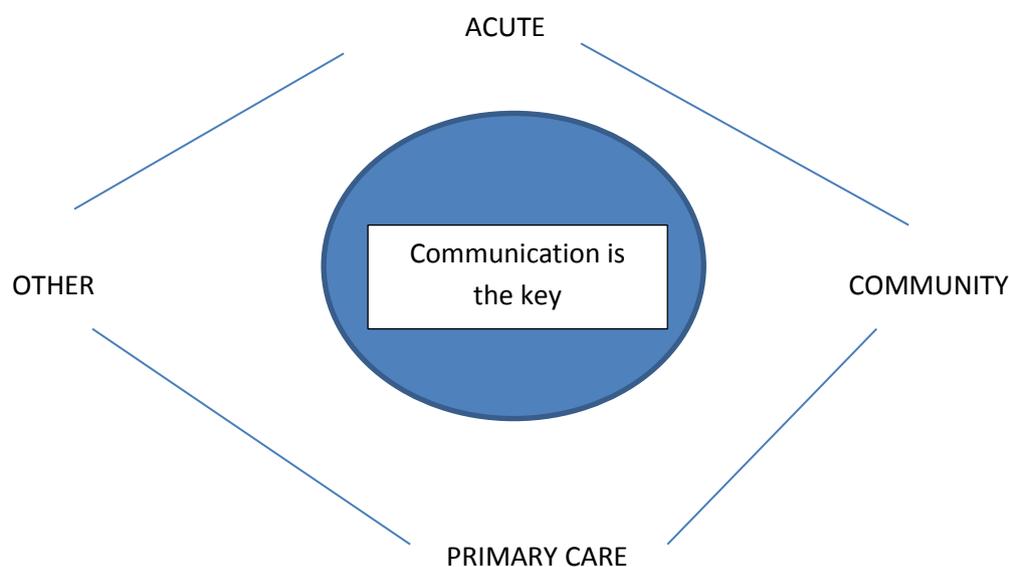
- Teams know who does what and understanding roles
- HNA and care plans follow the patient
- Professionals talk to each other
- Patient should not have to repeat themselves all teams should contact

Right by you- report- view in each area not nationally- need to see variation

1.
-very worthwhile
-Dependant on having appropriate navigators/training
-Having a named contact

2. Strengths
-taking pressure of GPS's
-joined up services/communication
-Roles are affordable – several navigators for cost of other staff
- cost savings by using support workers

3. Weaknesses
-financial costs
-suitable staff/workforce
-need a mapping exercise of primary care network and define/identify which practises are involved. Audit/scope practises- see what staff they have.

4. Opportunity
-One size doesn't fit every community.
-Psychology- lack of services
-appointment issues/1 topic only etc.?