

**LAY MEMBER'S HEADLINE FEEDBACK FROM THE WANDSWORTH PCT  
PROFESSIONAL EXECUTIVE COMMITTEE (PEC) MEETING WITH THE  
PCT MANAGEMENT TEAM  
21 OCTOBER 2008**

These headlines are for rapid briefing purposes about the lay/user issues arising in the meeting. It is not a full report from the meeting.

PEC and PCT Board papers are available on the WPCT website:  
[www.wandsworth-pct.nhs.uk](http://www.wandsworth-pct.nhs.uk)

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## **Presentation**

### Cancer Reform Strategy

Charlotte Joll, SW London Cancer Network Lead, said PCTs have statutory a responsibility to implement the cancer reform strategy and this would be impossible to do without more involvement from primary care on the ground. Over half of cancers could be prevented by lifestyle changes. A national social marketing campaign to increase awareness of causes was in the offing. Every PCT should have early diagnosis and intervention initiative and look at 1 year survival rates against international benchmarks. Emergency admissions for cancer amounted to failures of care.

In discussion it was confirmed that cancer was in the PCT's Commissioning Strategy Plan (CSP) as part of larger objectives. The SW London Cancer Network was the best performing in England in terms of changes in cancer mortality rate from 1997-2007 in <75s. There was a target to achieve a further reduction in mortality of 20% by 2012. To do this the Network needs to be influenced more by primary care, as historically the dominant influence has come from the acute/secondary sector. A commissioner-led process to cut through the politics was needed.

The PEC agreed that public health should lead on a project plan for cancer which brings in work already done in end of life care and which focuses on prevention. It should also and identify the failing practices who are not making an appropriate level of referrals for diagnosis.

## **Items for Approval**

### Communication & Stakeholder Engagement Strategy

PEC agreed at its September meeting that more work was needed on this strategy and in the interim a group including myself, Dr Sian Job, Colin Smith.

Michelle Heller from PALS, Ros Lobo, Margaret Adjaye, Rachel Miles, Lizzie Whetnall and others undertook it. The Board had a vision paper about the strategy at its last meeting. I presented the strategy using the following note:

**What you have now is the full strategy and appendices showing its application to 2013. We believe it is fit for purpose and can be refreshed as we go along. It will need to be reviewed as there are many independent variables not under our control that impact on the policy.**

**The strategy is an essential part of achieving World Class Commissioning competencies, the PCDT's Commissioning Strategy Plan and key parts of Healthcare for London changes. The Chief Executive's introduction makes it clear that *"involvement is key and the PCT needs to develop processes to make sure that we listen to patients and the public as we shape ideas for new service delivery models – we need to make sure patients and the public are with us on the journey of service re-design as we consult, develop service specifications, consider tenders, and monitor contracts."***

**This strategy is about a lot more than engagement and consultation. That is the minimum the Department of Health requires, but we must do more. The following statement on p 4 about the relationship between involvement, engagement and communications summarises the overall approach: *"Throughout this document we refer to involvement, engagement and communications for patient and public empowerment. Involvement for empowerment is the overall objective. Engagement is a tool used for specific purposes, including formal consultations. Communications is the range of techniques and tools used to interact with people, listen, understand their feelings, and communicate with them appropriately and feed back to them what they said. The result of this is helping people feel that they are continually involved in our business."***

**The principles, national and regional drivers, objectives, priorities and key audiences are described in the main report. None of this should be a surprise. What is new is the spread of the strategy across the organisation so that it is everyone's business.**

**Appendix 1 shows involvement activity by directorate and also the provider services; Appendix 2 maps the process which puts service users and the public in the centre (a stakeholder relationships diagram of this is on page 11 of the main report); Appendix 3 has information on the numerous involvement, engagement and consultation exercises ongoing in the PCT grouped by initiatives identified in the strategy.**

**Section 9 of the main report on "measuring success" includes the metrics the PCT will use to measure impact and effectiveness. Costs in section 12, which really means "investment", show some £758k of direct costs over the next three years plus non-recurring expenditure of £352k (social marketing for improving health behaviours is a big part of this).**

**So in total we are investing more than £1m over the next three years in our involvement, engagement and communications integrated strategy.**

**The challenge to the organisation is to ensure that we get every scrap of value possible out of this investment in order “to make sure patients and the public are with us on the journey” (as it says in the CE’s introduction). We talk about metrics in the strategy, but the ultimate metric is what people tell us -- if we ask them in the right way -- about achieving our strategic objectives. We will know we are there when people say their needs are being met, they feel involved in our business and they would recommend the services we commission to others.**

Points in the discussion focused on whether the PCT was spending enough given the importance of this strategy to its overall success (social marketing linked to healthier choices in particular might require more resources) ; the PCT’s need for a more systematic way of capturing patient experiences and then publishing all the information about everything known about the performance of all providers; and need to invest more in external aspects of the strategy, such as brand building, stakeholder relations and reputation management.

## **Reports for Information**

### Finance Report

At month 6, the PCT was looking at surplus of £2m above the planned surplus limit of £3.296m. Additional investments in service development are being made to keep within the surplus control limit as required by NHS London. The PCT will be discussing with the 3<sup>rd</sup> sector and the Local Authority about opportunities for non-recurring investment to improve health especially to help offset the effects of economic downturn.

### Neurorehabilitation Review

The review spanned the five PCTs in South West London and ran from July-August looking at existing neurorehabilitation services against national standards and information from service users. Reasons for referral to neuro-rehabilitation services was wide ranging: from single, acquired brain injury (accident, stroke, tumour etc) to long term neurological conditions such as multiple sclerosis, to diagnosis of progressive neurodegenerative conditions such as motor neurone disease. Most patients with a neurological disability were managed in the longer term in the community. The review looked at referral pathways and recommended *“That a systematic pathway is developed for patients with long-term progressive neurological conditions such as MS or Parkinson’s, which ensures that they are supported and reviewed on a regular basis.”*

**In discussion I commented that the most important thing to take on board to improve services was the metrics developed alongside the NSF for Long Term Neurological Condition which should be applied locally**

and lessons learned from their outputs as they spanned health and social care. Progress would only be made by doing things jointly with social care services as most long term neurological conditions are managed outside of hospital. There were considerable implications in the neurological disability area for personalisation of services and individual budget holding and the review did not take account of this. For the progressive deteriorating conditions such as MND, the report needed to be clear about how palliative care and end of live care decision making fully involved patients and carers. And the role of carers generally was under-represented. I supported the recommendation for a neurological network and said it was surprising – given the importance of the cancer and heart disease networks to demonstrable progress in those areas – that the SW London sector lacked such an approach.

**Next Meeting of the PCT Board:** 09h30, Wednesday 29<sup>th</sup> October, Sheen Room, 2<sup>nd</sup> floor, Queen Mary's Hospital, Roehampton. Board papers are available at [www.wandsworth.nhs.uk](http://www.wandsworth.nhs.uk) For further information contact Sandra Notridge on 020 8812 7740 or e-mail at [sandra.notridge@wpct.nhs.uk](mailto:sandra.notridge@wpct.nhs.uk)

**Next Meeting of the PEC:** Tuesday, 09h30 on 18<sup>th</sup> November 2008, Rooms 2/3 WBH