Healthcare for London

NHS

Healthcare for London
Consulting the Capital

Report on the consultation and recommendations for change

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2 Introduction for the Joint Committee of PCTs

I am delighted to share the outcomes and recommendations of the London-wide consultation *Healthcare for London – Consulting the capital*.

The consultation has been both worthwhile and productive. Worthwhile because it has allowed us to start a dialogue with the population of London about the future development of health and healthcare services in the capital - we will continue this dialogue and will ensure we are inclusive at all times in our planning and delivery of services. Productive, because the consultation has provided a rich and diverse range of views, ideas and perspectives. We have been struck by the quality of the contributions we have received and the general enthusiasm for change. Clearly there are many who are eager to see the establishment of new care delivery models and the development of new care pathways.

In July last year Lord Ara Darzi published his report Healthcare for London: A *Framework for Action*. The report issued an ambitious challenge. It set out a strong case for change and proposed a range of developments and initiatives which together would enable significant improvement in Londoners' health and healthcare. The NHS in London has taken up that challenge and conducted an extensive consultation with people and their elected representatives in every borough. Their comments have added considerably to the argument for improvement that was contained in Lord Darzi's original report.

The case for change has been widely accepted in this consultation and many of the proposals have been fully supported. We have refined others to ensure they are sensitive to some of the anxieties and concerns which have been expressed. In some areas we have been encouraged to go further than the proposals which were the subject of consultation. This will require us to be particularly innovative and resourceful as we work to drive up standards and deliver truly responsive services.

One significant issue which has been reinforced time and again is the need for the NHS to work effectively with stakeholders and other organisations – be it with Transport for London to enable good access to services; with local authorities (in particular social services) to ensure fully integrated care; with staff, to ensure good ideas can be delivered; or with the community and voluntary sector to capitalise on their skills and expertise. Above all, there is a very strong consensus about the need for strong partnerships and collaboration to address health inequalities and improve health and wellbeing across London.

I would like to thank all those who have participated in this consultation exercise. The recommendations set out in this document reflect your contributions and provide a very strong platform on which Primary Care Trusts can initiate local engagement processes and develop plans which will meet the distinctive needs of their populations.

The challenge now is to deliver positive change for all Londoners. This consultation will allow us to approach this challenge with confidence and renewed ambition.

David Sissling
Director, Healthcare for London

3 Executive summary

London is a great city and Londoners deserve the very best health and health care that world cities can provide. The NHS in London aims to work with the people of London to attain that goal. That is why we have spent the last few months discussing this ambitious vision for change with them.

NHS staff, the public, local councils, representative organisations and patient groups have been fully involved in this process and will continue to contribute to implementation. They are impatient for change recognising, for example, that London's stroke services do not deliver the best care possible and that this situation must change quickly.

We recognise, and the people of London agree, that at the moment – whilst some services are first class, excellence in healthcare is not uniform. There are large inequalities of health outcomes and the quality of patient care is not always as good as it should be.

In the words of the Patient and Public Advisory Group "...*the whole process of this consultation has been more comprehensive than any previous one in London".* We recognise that this must continue and become more inclusive as we propose specific services.

This report and its appendices is the next step in the improvement process. It details the process of consultation, the outcomes and the recommendations. It has been discussed by the 31 Primary Care Trusts across London and Surrey PCT at board meetings across the capital. This version is to be discussed and agreed by a Londonwide joint committee of PCTs on 12 June 2008.

The Healthcare for London vision is a health service where:

- Ill health is prevented as much as possible.
- Primary care is comprehensive, accessible and of excellent quality throughout the capital.
- Improvements in care are evidence-based, clinically and patient-led and provided in the most appropriate settings.
- Healthcare is focused on individual needs and choices and is coordinated.
- Improvements are properly resourced.

Having listened to what we have been told, we believe that Londoners broadly support the principles, ethos and strategic direction of Consulting the Capital. However, we know we do not have the agreement of Londoners to carry on regardless. We know that continued dialogue with the public, staff, unions and other stakeholders is essential to ensure our plans for implementation meet the aspirations of local people. Good planning is the key to success; a poorly planned service, poorly commissioned and staffed by poorly trained clinicians would be worse than no change at all. Working together we can ensure this will not happen.

As the Joint Overview and Scrutiny Committee stated in their report, *"Please do not let Londoners and those dedicated to our NHS down; working together we can deliver an NHS of which everyone in this great city can be proud."*

This is our opportunity to ensure that the NHS in London is the envy of the world.

We commend this report to you.

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Philippa Curran	Barnet Primary Care Trust
David Williams	Bexley Care Trust
Gerald Zeidman	Brent Primary Care Trust
Elizabeth Butler	Bromley Primary Care Trust
John Carrier	Camden Primary Care Trust
May Cahill	City & Hackney Primary Care Trust
Stephen O'Brien	Croydon Primary Care Trust
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Kristy Leach	Enfield Primary Care Trust
Michael Chuter	Greenwich Primary Care Trust
Josip Car	Hammersmith & Fulham Primary Care Trust
Richard Sumray (Chair)	Haringey Primary Care Trust
Sarah Crowther	Harrow Primary Care Trust
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Mike Robinson	Hillingdon Primary Care Trust
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Sian Bates	Richmond & Twickenham Primary Care Trust
Malcolm Hines	Southwark Primary Care Trust
Douglas Robertson	Surrey Primary Care Trust
Howard Freeman	Sutton & Merton Primary Care Trust
Caroline Alexander	Tower Hamlets Primary Care Trust
Joan Saddler	Waltham Forest Primary Care Trust
Ann Radmore	Wandsworth Primary Care Trust
Joe Hegarty	Westminster Primary Care Trust

N.B. Please note that this report is, in essence, a summary and should not be read in isolation. The appendices are an essential part of the report. Readers of the report need to take notice of the evidence, the responses and the suggestions included in the appendices when considering future issues or implementing proposals and recommendations.

N.B. The use of quotes throughout the document is to illustrate issues. They do not necessarily reflect a balance of all opinions or signify that Healthcare for London supports their sentiment.

4 Issues for decision

Items for decision have been consulted upon and the JCPCT has the power to make binding agreements on behalf of the constituent PCTs.

The JCPCT:

1. accepts the Ipsos MORI report on consultation responses.

2 accepts the Health Link report on traditionally under-represented groups.

3. accepts the Joint Overview and Scrutiny report and commissions Healthcare for London to prepare a response.

4. accepts the London Health Commission's Health Inequalities and Equalities Impact Assessment and recommends that Healthcare for London, NHS London and PCTs take into account its findings and actively work to reduce inequalities when developing services.

5. accepts the report of the Clinical Advisory Group and recommends Healthcare for London, NHS London and PCTs take account of the report when developing services.

6. accepts the report of the Patient and Public Advisory Group and recommends Healthcare for London, NHS London and PCT take account of the report when developing services.

7. accepts the consultation process was appropriate and met all the requirements of a valid consultation

8. agrees that the principles of Healthcare for London and the vision described in this document, should drive the ethos of the programme and underpin its development. In particular, PCTs will need to become better partners in their local community, working with councils, the voluntary sector and others to understand and implement what will deliver the best health of their population, irrespective of economic, social and organisational boundaries.

9. accepts the case for change, and is clear that the use of evidence in arguing for improvements should continue to be the hallmark of planning and implementing services.

10. agrees that midwives should continue to visit mothers with newborn babies in their homes and PCTs should investigate whether care in local, one-stop settings, (where mothers could see a midwife and other health or social care professional) following early home visits, would be appropriate in their community.

11. agrees that specialist care (e.g. high dependency medical or nursing care, or where admission for observation of more than 24 hrs is anticipated) for children should be concentrated in fewer hospitals with specialist child care. The number and location of these hospitals should be subject to further consultation by PCTs.

12. agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of trauma (severe injury) patients – probably between three and six hospitals. The number and location of these hospitals should be subject to a further consultation by PCTs.

13 agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of patients suffering a stroke (about seven hospitals in London providing 24/7 urgent care, with others providing urgent care during the day).

The number and location of these hospitals should be subject to a further consultation by PCTs.

14 agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of patients needing complex emergency surgery. The number and location of these hospitals should be subject to a further consultation by PCTs.

15 agrees that ambulance staff should take seriously ill and injured patients directly to designated specialist centres, when appropriate, even if there is another hospital nearby.

16 agrees that people should be offered better access to a GP and primary healthcare services, especially before 9am, in the evenings and at weekends. The extent of such provision should be determined by individual PCTs in consultation with local communities.

17 agrees that a greater proportion of future spending should go to help people with long-term conditions stay as healthy as possible by investing in more GPs, specialist nurses and other health professionals and the services they provide.

18 agrees that more outpatient care, minor procedures and tests should be provided in the community. Local hospitals should provide most other types of secondary care.

19 agrees that the polyclinic service model should provide improved primary healthcare in London. The nature (for instance networked, single-site, hospital-based), location and precise services offered should be determined by appropriate local engagement, consultation and decision-making.

4.1 Recommendations

Items for recommendation have been raised as part of the consultation (for instance asking respondents for their views on an issue), or have been raised during the consultation, where the JCPCT felt it was appropriate to express an opinion. However recommendations are not binding on PCTs.

The numbering sequence refers to the corresponding chapter and paragraph in the body of the text. Please note that the agreed recommendations are the ones on the following pages (chapter 4). Later in the report there are instances where the recommendations are extracted from *Consulting the Capital*. Where this is the case the later recommendations do not reflect the modifications made by the committee and the consultation process shown in this chapter.

The case for change

17.1.1 The JCPCT recommends PCTs improve their capacity for data collection and analysis, and ensure providers of care regularly collect, evaluate and report accurate data. Monitoring the efficacy, effectiveness and efficiency of services and the health and well-being of the population is a key component to ensuring continuous improvement.

17.1.2 The JCPCT recommends an innovative campaign is launched to disseminate the recommendations of this consultation. The public must continue to be involved in processes to shape and implement future service developments.

Improving the health of people from deprived communities and disadvantaged groups, and their access to health services

17.2.1 The JCPCT recommends PCTs commission further health equalities and inequalities impact assessments when considering future service changes and redouble their efforts to reduce inequalities to ensure a sustained improvement in the health of the most deprived and disadvantaged individuals and communities.

Preventing ill health

17.3.1 The JCPCT recommends that whilst most health improvement programmes should focus on local issues, there is a place for pan-London campaigns. For example, linked to the 2012 Games, London should lead an initiative focused on healthy eating and physical activity. And if the NHS expects the public to live healthy lives it should help and support its staff to do so.

17.3.2 Older people with the common problems of ageing – poor hearing, eyesight, teeth and feet – should be given good advice and services to put the problems right, whichever health professional they visit. We could help make this happen by locating opticians, dentists, and hearing-aid services in the same place, for example in a polyclinic. The JCPCT recommends health improvement is part of the syllabus for all students training to become health professionals and it should be an important part of continuing professional development. This would help and encourage clinicians to become more involved in improving the health of their patients.

17.3.3 Health improvement initiatives also need to reach people who are not ill. We need to engage with individuals to maintain their health before the onset of illness. The JCPCT recommends that services and initiatives are delivered:

- by a wider range of professionals: for instance, pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, or health visitors; and
- in a wider range of settings: for instance in schools, leisure facilities, the workplace or prisons.

17.3.4 Smoking is the main cause of preventable death in the UK. The JCPCT recommends 'Stop smoking' aids and education are needed to help people give up smoking. PCTs also need to work with partners to reduce people's exposure to second-hand smoke. If smokers could be encouraged to stop before they have an operation this would prevent over 2, 500 complications a year. Avoiding putting these right would be better for patients and save the NHS between £1.5 million and £4 million a year.

17.3.5 The JCPCT recommends PCTs tackle the rising rates of sexually transmitted infections by:

- encouraging more people to use contraception and condoms;
- improving information about healthy living and the services available;
- improving access to services (for instance, longer opening hours); and
- improving the services themselves.

17.3.6 The JCPCT recommends London health organisations and their partners need to continue focusing on health protection – for instance, improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.

17.3.7 The JCPCT recommends PCTs work with local authorities, the GLA, the Mayor and with local voluntary and community organisations to prevent people becoming ill, to address health inequalities and to engage with people who might not otherwise enter the healthcare system. Polyclinics or wellness centres should help in reaching out to these people, encouraging them to take better care of their health.

17.3.8 The JCPCT recommends PCTs consider the responses to the questions in the Staying Healthy chapter of *Consulting the Capital* when planning future services, in particular the value that evidence-based alternative or complementary medicine could play.

Maternity and newborn care

17.4.1 The JCPCT recommends expectant mothers are offered:

- an early assessment by a midwife to ensure their care is right for them; and further assessments during the course of the pregnancy;
- information to enable them to make informed choices, for instance, about the relative benefits and risks of different locations to have their baby and about pain relief;
- care before birth provided at local one-stop centres;
- services that meet their choice of where they give birth – for instance, at home, in a midwifery unit, or in an obstetric (doctor-led unit);
- care with the same team from early pregnancy until after the birth whenever possible;
- one-to-one midwifery care during established labour;
- care following birth in local, one-stop centres as well as at home.

17.4.2 The JCPCT recommends all professionals involved in birth should be competent in basic newborn (neonatal) life-support skills.

17.4.3 The JCPCT recommends there should be more midwife-led units and more support for home births. Doctor-led units should have a partner midwifery unit at the hospital or in the community.

17.4.4 The JCPCT recommends appropriate mental health care should be available for women who suffer postnatal depression.

17.4.5 The JCPCT recommends that prolonged care for seriously ill babies requires a neonatal intensive care unit.

17.4.6 The JCPCT recognises the clear message of the interdependency between obstetrics and paediatrics and recommends that those planning these services engage with clinicians of both specialties to ensure proper consideration of all the issues. The JCPCT also notes the importance of good communication between midwifery and health visiting services. It is the health visitor who will provide ongoing support to families after their discharge from maternity services.

17.4.7 The JCPCT agrees with the CAG and recommends that further work should be undertaken by Healthcare for London on:

- managed networks of care, their size and configuration, and their possible impact on safety and safe transfers;
- the configuration and impact of services which support the midwife as the first point of access in the community for women;
- the possible configuration of obstetric units given the potential changes in paediatric services; and
- the development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries.

17.4.8 The JCPCT recommends that when developing maternity services, PCTs and acute trusts should consider the public and organisation responses made to this consultation regarding the three factors most important to them (Giving birth in a midwife-led unit with a doctor-led unit on the same hospital site; having a senior doctor present on the unit where you will give birth; time taken to travel to the place where you will give birth). Safety of the mother and baby was considered to be the primary concern for respondents.

17.4.9 The JCPCT recommends that PCTs take note of the Royal College of Obstetricians and Gynaecologists' recommendation that units delivering over 4, 000 births a year should have a senior doctor present for 98 hours a week.

Children and young people

17.5.1 The JCPCT recommends a greater effort to provide equal opportunity for children, young people and their families so that they can access services when they are needed.

17.5.2 The JCPCT recommends promotion of breastfeeding because of the proven benefit to infants' well-being and development.

17.5.3 The JCPCT recommends PCTs place more emphasis on preventing the emerging problems that children are facing, for example obesity and behavioural disorders.

17.5.4 Childhood immunisation is one of the safest, most cost-effective, evidence-based interventions, yet many parents do not immunise their children. The JCPCT recommends PCTs should give high priority to ensuring that all children are immunised, with a London-

wide co-ordinated effort. All health professionals who deal with children should know about and be able to offer accurate advice to parents. We need to support healthcare professionals who are trying to promote and co-ordinate local programmes of immunisation. (see also 17.5.13)

17.5.5 The JCPCT recommends that when children are ill, whether the problem is an urgent one or long-standing, they should, in general, re
ceive care close to their home, perhaps at home, in a children's centre or at school. Parents and carers should know clearly how to gain access to the right people.

17.5.6 The JCPCT acknowledges that most urgent care is provided in GP practices. This will continue to be the case, but the committee recommends that all those who deal with ill children have the necessary skills and expertise. Where access to GP services is difficult, PCTs need to explore effective alternatives.

17.5.7 The JCPCT recommends that hospitals that care for children need to be able to guarantee that their services meet National Service Framework (NSF) standards.

17.5.8 Some hospitals will continue to provide the whole range of care that children need, including inpatient care if they are very sick. The JCPCT recommends that they have staff available through day and night with the skills and ability to meet children's needs.

17.5.9 Other hospitals will not have inpatient facilities for children. Even so the JCPCT recommends they have doctors and nurses with training in children's illnesses, who can assess and treat children in specially designed units. Many children who come to A&E departments can be managed in this way without needing admission to hospital. Where the paediatric staff believe an admission is necessary, arrangements must be in place with the ambulance service to transfer the child safely.

17.5.10 Unfortunately, some children are born with, or develop, a life-limiting or life-threatening illness. For these children the JCPCT recommends better co-ordination of services. And if PCTs are to provide the best possible care, they will have to work in partnerships across the whole of London.

17.5.11 As most children are cared for in the community, the importance of co-operative working and of a multi-agency and multi-disciplinary approach was stressed by many respondents. The JCPCT recommends PCTs strengthen partnership and joint commissioning arrangements. In particular, caring for vulnerable children requires an integrated approach between health and local authority services.

17.5.12 The interdependency of paediatric and obstetric services and the implications for the newborn baby were also a key focus of attention. The JCPCT agrees with these sentiments and recommends greater incorporation of the principles of Every Child Matters and the National Service Framework for Children, Young People and Maternity Services into current and future services.

17.5.13 The public and organisation responses to how the NHS could encourage more parents to immunise their children are warmly welcomed. The JCPCT is very clear that immunisation is a critical public health priority and believes that current mechanisms to improve compliance should be exploited, particularly focusing on encouraging healthcare professionals to educate the public and parents about immunisation. The JCPCT recommends PCTs consider responses to the consultation when planning campaigns to improve immunisation in their localities. The JCPCT is interested in the concept of opportunistic immunisation, but because it will make co-ordination of the schedule more difficult, it recommends it should only be offered if accurate information is available. The

committee agrees with the CAG and PECs,that single vaccines for Mumps, Measles and Rubella should not be supported – on grounds of doubt over clinical effectiveness. However the committee would be interested in seeing plans for the development of clinically established, effective and successful vaccinations such as Hepatitis B.

17.5.14 The report of the London Children and Young People's Pathway Group is welcomed and recommended to PCTs to be considered in future planning of services. In particular we note the concerns the group has that many basic requirements of good healthcare for children (for instance full implementation of the Child Health Promotion Programme) are not a feature of current provision. The group also expressed concern regarding changes in funding mechanisms of the Children and Mental Health Service (CAMHS). The implications for CAMHS service delivery are unclear but we are convinced of the value of preventative work and early intervention. PCTs will need to determine how best to ensure sufficient budget is available to maintain, and enhance services.

17.5.15 The JCPCT recommends PCTs commission further work to identify the reconfiguration required for specialised care for children and the key issues for families, such as how transport might be provided.

17.5.16 The JCPCT recognises the view of the London Children and Young People's Pathway Group that there is a shortage of neonatal intensive care cots in the capital and recommends further work be carried out to ensure an appropriate increase in capacity to meet this need.

Mental Health

17.6.1 The JCPCT recommends:

- Young people between 14 and 25 with emerging mental health problems need to be able to get help quickly. We know this improves care, reduces time in hospital and leads to fewer admissions to hospital involving the police;
- The NHS should make further efforts to reduce the fear of services, taking special measures in communities where it is culturally less acceptable to seek help;
- The NHS should set out clearer pathways to care, so that patients, carers, GPs and those who come into contact with people with mental health problems, such as police officers, know how to contact services and what to expect from them; and
- Cognitive behaviour therapy and other `talking therapies' should be used extensively – but accessing these services is a problem and people in many parts of London face long waits for these services. More mental health workers should be employed to deliver talking therapies. Other therapies should also be explored, including exercise, reading and walking.

17.6.2 The JCPCT recommends people should be able to exercise more control and choice in respect of the care they receive by:

- greater use of patient-held budgets so that they could buy their own services;
- better access to housing, employment and a range of related services. Around 40 per cent of benefit claimants are on incapacity benefit because of mental health problems, but nearly all these people want to work; and
- encouraging mental health services to work in partnership with local organisations, including physical health providers, social care, housing and employment agencies, black and minority ethnic communities, local businesses and faith communities, to help people lead full lives as part of their local community.

17.6.3 Mental health services must meet the needs of minority groups. The JCPCT recommends mental health services use assertive outreach (a system where community

professionals go out to the homes of patients who are reluctant to come in for appointments). Health services, local authorities, community development workers and, in particular, the black voluntary sector need to work together to break down barriers between mental health services and minority ethnic communities.

17.6.4 The JCPCT recommends mental health services work with London's prisons, probation services and others, to develop a pan-London strategy for delivering more effective mental health services to offenders.

17.6.5 Older people with dementia need early access to services and a care plan that addresses their health and social care needs. The JCPCT recommends PCTs provide support for people and their carers as close to their own homes as possible but with specialist assessment and treatment units available if necessary.

17.6.6 While improving community services, the NHS in London also needs to develop a vision for specialist inpatient mental health care. The JCPCT recommends:

- discussion and, where appropriate, review of whether, as admissions to mental health units decrease, inpatient beds are needed in every borough;
- improvements to the quality of inpatient care, from the environment where treatments are given to the quality and range of treatments; and
- encouragement of centres of specialisation amongst London's ten mental health trusts.

17.6.7 The JCPCT agrees with the CAG and recommends that PCTs and NHS London do more to deliver:

- readily available help and advice to manage stress and to reduce alcohol consumption and illicit drug abuse; and improved access to substance misuse specialist services; and
- a skilled, affordable workforce to deliver the range of modern evidence-based interventions and the capacity to offer choice where more than one intervention is needed.

17.6.8 The JCPCT recommends that there should be increased investment in evidence-based alternatives to medication such as cognitive behaviour therapy and talking therapies.

17.6.9 The Mental Health Clinical Care Pathway Group (MHCCPG) supports and expands upon the work of *A Framework for Action* and *Consulting the Capital*. The JCPCT recommends that commissioners of services note the work of the group and use it to build their capability to specify the optimal effective service structures and teams required to deliver better mental healthcare, and to specify the evidence-based care pathways, clinical standards and outcomes to be implemented.

Acute care

17.7.1 To reduce the confusion of having different numbers to call when a patient needs urgent care advice on the telephone the JCPCT recommends there should be active consideration of establishing two points of contact – the existing 999 number for emergencies and a new service. The new service could, for instance:

- provide advice. Professionally trained healthcare advisers would have access to up-to date information and advice, tailored to the patient's address;
- book patients an appointment with a GP or other healthcare professional such as a nurse or a mental health worker;
- transfer callers to a healthcare professional such as a GP or community nurse;
- give directions to appropriate health and social care services close to a caller's home or workplace; or

- transfer the caller to emergency services.

17.7.2 The JCPCT has similar reservations to the public regarding a new telephone service – would the system just frustrate people in 'push-button hell'; and how much would the IT systems cost – would it be effective? However if these obstacles could be overcome the JCPCT can see the benefits in providing a solution. The JCPCT recommends that the comments regarding a new telephone service are carefully taken into account when a telephone service is considered.

Planned care

17.8.1 The JCPCT recommends more surgery should be carried out as day cases, allowing patients to go home the same day. Most patients prefer it, it is more cost-effective, and it reduces the risk of catching an infection. In 2005, London was the worst-performing region in England, performing far fewer operations as day cases than expected.

17.8.2 The JCPCT recommends GPs have access to test and diagnostic facilities in the community to reduce waiting times and save patients unnecessary trips to hospitals. Hospitals should keep appropriate test facilities – providing services for the hospital and local patients.

17.8.3 After an operation, patients need help to recover and return to good health. This is called rehabilitation and the JCPCT recommends it should take place as close to their homes as possible – it is what most people want and it is effective. In some cases rehabilitation will be in patients' local hospital or in a community setting, and in many cases in their homes. However, 37 per cent of pensioners in London live alone, so we will need to work closely with social care agencies to help people return to full and independent lives.

17.8.4 For the best care, the JCPCT recommends more hospitals need to specialise in particular aspects of healthcare. The days of a general hospital trying to provide all services to all patients, to a high enough standard, are over. Hospitals need to focus on areas of distinctive expertise, whether specialised or more general.

17.8.5 The JCPCT recognises that sometimes specialist care will mean more travel for patients. The JCPCT recommends that PCTs ensure they only go to hospital when necessary. For instance, tests could be done close to their home and reviewed by a specialist at the hospital, who could give an opinion remotely – without the patient having to visit. Or the specialist hospital might provide care teams to visit other hospitals. In general, strong clinical networks should be supported allowing care to be shaped by patient needs and expectations.

Long-term conditions

17.9.1 The JCPCT recommends every effort should be made to prevent long-term conditions by promoting healthy living.

17.9.2 The JCPCT recommends GPs, practice nurses and social care staff should be supported to develop effective mechanisms for finding undiagnosed people who do not present themselves to the healthcare system and for undertaking assessments. Encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills.

17.9.3 The JCPCT recommends that people with long-term conditions are enabled to access the full range of support for their condition so that they can manage it more effectively, with professional help.

17.9.4 Whilst accepting that more resources need to be directed to supporting people in investing in more GPs, specialist nurses and other health professionals, the JCPCT also recommends PCTs to work with the voluntary sector. This will be critical to raising standards. The NHS must improve the way it does business with voluntary organisations if patients are going to benefit from their knowledge, expertise, capacity and goodwill.

17.9.5 The JCPCT recommends that appropriate funding for education and research should follow the movement of treatment of long-term conditions into the community – in essence, a greater focus on research and education in primary care.

17.9.6 The JCPCT recommends that in each PCT, funding should be directed according to need and to reduce inequity of healthcare provision; but also recognises that partnership working to facilitate access to the features of life that most people take for granted, such as transport and recreation, social care and good housing, will be key to better outcomes.

17.9.7 The needs of carers were emphasised in relation to long-term conditions. As PCTs develop their plans they must recognise the importance of continuity of a carer and ensure that any changes in service support the needs of carers (including child carers and occasional carers). The JCPCT recommends PCTs also take into account the recommendations of the emerging national strategy (which is subject to a separate consultation). In the long term, carers' requirements will be addressed in a number of specific workstreams, especially mental health, long-term conditions, stroke and polyclinics.

17.9.8 The JCPCT agrees with the CAG view and recommends that PCTs tailor national best practice pathways to the needs of their local communities (for instance using the map of medicine database), rather than developing London-wide guidelines so that patients receive better quality care and can judge if their care is up to the standard they should expect.

End-of-life care

17.10.1 The JCPCT recommends that all organisations involved in end-of-life care meet existing best-practice guidelines.

17.10.2 The JCPCT recommends that patients with advanced progressive illnesses who are identified as nearing the end of their life should be offered the opportunity to have their needs assessed and to identify their preferred place of death.

17.10.3 Whilst PCTs should aim to provide more choice to patients as to their proposed care and place of death, the JCPCT recommends that PCTs give consideration to the wishes of carers and families.

17.10.4 The JCPCT recommends that PCTs support and strengthen coherent and effective development and dissemination of excellence across the relevant professions, disciplines and care settings, and better co-ordinate care for people nearing their end-of-life. This could properly be done by acting upon local baseline reviews and designating end-of-life service providers.

17.10.5 In order to become expert at commissioning high quality end-of-life services and taking advantage of economies of scale, the JCPCT recommends that PCTs work

collectively to commission adult services, and potentially pan-London to commission children's services.

Where we could provide care

17.11.1 While we recognise that healthcare will be provided in a variety of places – for instance, schools, pharmacies and community hospitals - the JCPCT recommends most healthcare be provided in six places: Home; a polyclinic service model (this could be in a network, a same-site or hospital); local hospital; major acute hospital; planned care (elective) hospital; and specialist hospital.

17.11.2 In line with the responses we have received, the JCPCT recommends PCTs develop polyclinic models to meet the distinctive needs of their local populations. Whilst all polyclinic models will have to meet defined standards in respect of range of services, access, and quality, the proposed approach will enable appropriate flexibility and diversity. We do not wish to limit enthusiasm for better primary care across London. Therefore, whilst the development of polyclinic models should be driven by local needs and considered by, amongst others, local people, local GPs and other healthcare professionals, we recommend that Healthcare for London takes responsibility for ensuring that there is a programme of support and continuous learning for PCTs so that different models can be explored and each new development can learn from previous good practice.

17.11.3 The JCPCT recommends PCTs should note and take into account the consultation responses if pursuing proposals for any polyclinic models based on a single-site. PCTs should ensure that continuity of care is there for those patients who wish it alongside the easier access to a wider range of better services.

17.11.4 The JCPCT recommends that PCTs, when considering polyclinic models, consider the consultation responses regarding the types of services that could be provided (the three most important factors were GP services, tests and minor procedures).

Finance and commissioning services

17.12.1 The JCPCT recommends PCTs consider the impact of changes to services and reflect them in future Strategic Plans and accompanying analysis. PCTs will need to get better at self assessment, critically analysing their own plans, to ensure that healthcare is affordable, fit for purpose and does not adversely impact on other parts of the health economy.

17.12.2 The JCPCT recommends all detailed proposals are fully costed, within available resources, procured from the most cost-effective providers and include contingency plans should funding or activity levels vary. This will require comprehensive, robust business plans.

17.12.3 The JCPCT recommends that Healthcare for London decisions become an integral part of PCT Commissioning Plans. It is essential that changes in commissioning costs are reflected in PCT annual and medium term plans, rather than be seen as part of a separate commissioning plan.

17.12.4 The JCPCT recommends PCTs pay particular attention to transitional processes. Detailed and comprehensive plans (including finance and commissioning) need to be

developed and it will be critical that there is no deterioration in quality or availability of services as new models of care are introduced.

Workforce and training

17.13.1 The JCPCT recommends that NHS London takes the lead in organising and providing a world-class training regime and supporting PCTs and other organisations in planning, contracting, quality-assuring and managing training that will ensure the London health workforce is second to none.

17.13.2 NHS staff will be vital to driving improvements to healthcare. As they take on new tasks in new settings it will be important for them to have opportunities for training, and where there are areas of significant change, a transition path will be needed. The JCPCT recommends the prioritisation of training throughout the NHS, but especially for the London Ambulance Service; and the development of a pan-London workforce strategy. Future work will need to continue to include key partners such as staff, hospitals, PCTs, unions and training and education providers. In addition the London NHS Partnership Forum, bringing together London NHS Unions, employers and NHS London is working to ensure the appropriate involvement and representation of staff. This should involve the establishment of sectoral or other geographic joint arrangements.

17.13.3 The NHS is a major employer. The JCPCT recommends the NHS in London continues to encourage applicants from local areas of deprivation and to reflect the cultural diversity of London.

17.13.4 The JCPCT recommends that the proposed workforce strategy being developed by NHS London is flexible, sustainable and comprehensive.

Partnerships and social care

17.14.1 The JCPCT recommends PCTs become better partners with a range of organisations in their local communities, especially LINks, understanding what will deliver the best health of their population and working with others to ensure economic, social and organisational boundaries do not obstruct provision of better healthcare.

17.14.2 The JCPCT recommends PCTs work with London councils and the Mayor to tackle the challenge of improving the health and social care of Londoners, and reduce health inequalities. PCTs and NHS London must quantify the impact of changes in healthcare on social care budgets and services and work in partnership to provide a seamless service.

Patient choice and transport

17.15.1 The JCPCT recommends that each strand of detailed planning and implementation demonstrates how it will better inform patients and the public across the capital so that Londoners are empowered to choose the type and location of high-quality services that is most suitable for them.

17.15.2 The JCPCT recommends NHS London works in partnership with Healthcare for London, TfL, the London Ambulance Service and others (such as community transport organisations, the GLA and councils) to develop the TfL recommendations into more comprehensive guidance that could be used when PCTs consider any service reconfigurations.

Capital investment – information technology and estates

17.16.1 The JCPCT recommends NHS health organisations in London deploy and support IT systems which ensure that patient information is available where and when it is needed; and ensure policies on access to medical records are up-to-date – and that staff are well-versed in them.

17.16.2 In order to catalyse the scale of transformation of services and facilities contemplated in Healthcare for London the JCPCT recommends that NHS London develops a pan-London estates strategy. This should focus on:

- Making best use of the estate entrusted to the NHS, both as a strategic resource and physical space;
- Unlocking the latent value within the NHS estate;
- Ensuring an equitable distribution of this scarce NHS resource for all Londoners; and
- Enabling commissioners and providers to deliver improved healthcare.

A coherent approach to implementation

17.17.1 We have established a compelling case for change. We have raised expectations. We have and will continue to adopt an open and inclusive approach as we plan and implement improvements. We must deliver. To enable this, the JCPCT recommends:

- The SHA continues to adopt a position of effective strategic leadership;
- Direct responsibility for change rests with PCTs as commissioners;
- A dedicated resource – the Healthcare for London programme team – supports PCTs in planning and implementing change;
- A London Commissioning Group maintains responsibility for planning and overseeing the programme. It is important that implementation is carefully monitored; and
- A committee of PCTs be established where there are London-wide issues to be consulted upon.

5 Setting the scene

In 2006, NHS London commissioned Sir (now Lord) Ara Darzi to produce *The Case for Change*. The report, published on 9 March 2007, made a compelling case why healthcare in London has to change.

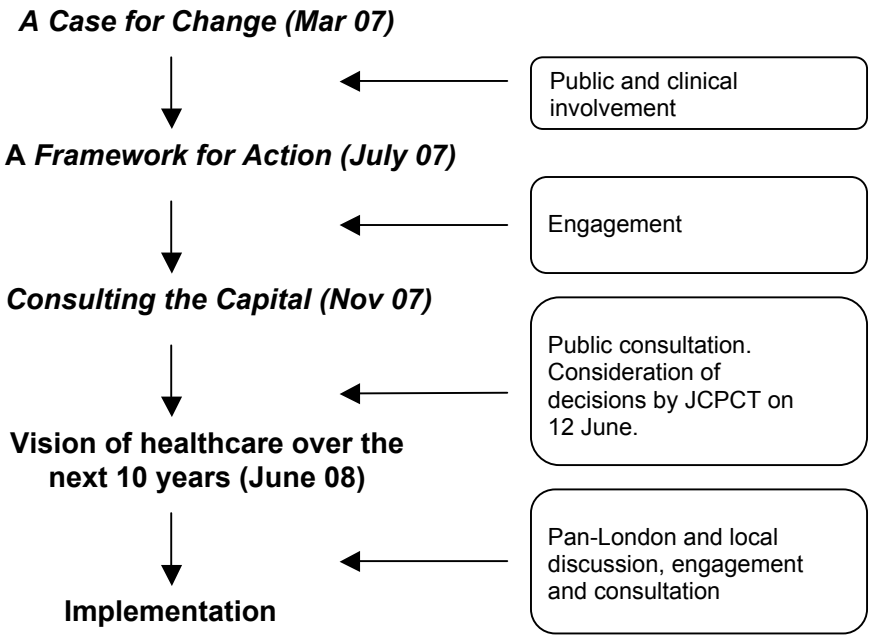
The report set the scene for the second piece of work: A *Framework for Action* which looked at the future demands on healthcare in London; how care could be improved; where it could be delivered; and considered some of the key drivers for change. At its board meeting held in public on 8 August 2007, NHS London commended A *Framework for Action* to the PCT boards and requested that they consult on the recommendations.

The Healthcare for London programme office entered into further discussions with stakeholders and PCTs to ensure the resulting consultation document reflected the views of PCTs and took into account comments from stakeholders. Readers of this report should therefore note that the recommendations in *Consulting the Capital* and A *Framework for Action* are not interchangeable.

"Although we do have some reservations over the questionnaire, BBGLPC believes the current consultation document is a great improvement when compared to the original proposals and welcome the changes that have been made. It now provides a sensible way forward even in an area where the population is relatively spread out."

Bexley, Bromley and Greenwich Local Pharmaceutical Committee

Healthcare for London: Consulting the Capital was published on 30 Nov 2007 and marked the beginning of a consultation that closed on 7 March 2008.



6 The case for change

The following section is taken from *Healthcare for London: Consulting the Capital*.

The Case for Change, **(Appendix 3)** published on 9 March 2007, proposed eight main reasons why healthcare in London has to change:

1. **The need to improve Londoners' health**
2. **The NHS is not meeting Londoners' expectations**
3. **One city, but big inequalities in health and healthcare**
4. **The hospital is not always the answer**
5. **London should be at the cutting edge of medicine**
6. **The need for more specialised care**
7. **Our workforce and buildings are not being used effectively**
8. **The need to make the best use of taxpayers' money**

1. The need to improve Londoners' health

London faces specific health challenges, for instance high rates of HIV/AIDS, substance misuse, tuberculosis, mental health problems and childhood obesity. Every year in London obesity kills 4,000 people. One Londoner dies every hour from a smoking-related disease.

2. The NHS is not meeting Londoners' expectations

Twenty seven per cent of Londoners are dissatisfied with the running of the NHS, compared to 18 per cent nationally.

A significant number of people are not satisfied with access to GP services in the evenings and at weekends.

Around 60 per cent of 7,000 Londoners questioned in a poll said they wanted cleaner hospitals and shorter waiting times to see A&E consultants and to have routine operations.

3. One city, but big inequalities in health and healthcare

There are very big differences in the quality of life in different parts of the city and even in different parts of the same borough. We must recognise the needs of a diverse population, speaking 300 different languages, and the needs of the one million commuters coming into London every working day.

For instance:
- There are far fewer GPs per head of population in some areas where health need is greatest, for instance, in Barking and Dagenham and in Newham;
- The infant death rate in Haringey is three times that of Richmond;
- The teenage pregnancy rate in Lambeth is almost four times that of some other areas in London;
- The 20 per cent of most deprived electoral wards have more than twice as many mental health inpatients as the 20 per cent least deprived.

4. The hospital is not always the answer

Surveyed patients and the public say they want more care to take place nearer to their homes. Most patients do not need hospital care, but we have a long way to go to make alternatives a reality. Many minor surgery and tests should not need a trip to hospital; and people with long-term conditions like diabetes should be supported to stay at home.

Patients with other long-term conditions, such as bronchitis, would benefit from rehabilitation in the community and care from a GP and specialist nurses and therapists, who could reduce the need for them to go into hospital.

We believe many people go to A&E departments because they are dissatisfied with the availability of services outside working hours. This is far from ideal. Patients are seen by junior doctors in hospitals rather than by GPs who are better skilled at treating minor illness and injury.

5. London should be at the cutting edge of medicine

London is the leading centre for health research in the UK. Fifty per cent of the UK's biomedical research occurs in the capital and 30 per cent of healthcare students are educated here.

However, the UK is lagging behind its international competitors in medical research. The UK spends half as much as the US on research, as a proportion of its economy.

To enable patients to benefit from the latest scientific breakthroughs, hospitals and universities in London need to co-operate more closely. By working together, researchers, academics and healthcare professionals will be able to focus on creating and developing new life-saving treatments quicker than ever before. One option is a new form of university / hospital partnership. For instance, Hammersmith Hospitals and St Mary's Hospital have recently joined with Imperial College, London to create the UK's first Academic Health Science Centre.

6. The need for more specialised care

The most seriously ill patients need specialist care. We need to develop, and take advantage of, exciting clinical and technical advancements and we need to concentrate specialist equipment and expert staff in centres where each specialty treats enough patients to ensure the best quality of care is obtained.

7. Not using our staff and buildings effectively

The NHS' staff are its greatest asset, but their abilities are not always fully used. Staff need more support so they can work flexibly to deliver the best care.

The NHS occupies a large number of buildings in London – almost 100 hospitals, 500 mental health facilities, 900 other sites and over 1,500 GP practices. Servicing these buildings costs the NHS £700 million a year. Many buildings are old and difficult to clean. Work to bring them up to date would cost another £800 million.

8. The need to make the best use of taxpayers' money

In 2005/06 the NHS in London ended the financial year with a £90 million surplus. Only a small number of trusts were overspent. This money can be used to improve healthcare in the capital. We expect that over the next few years, PCTs will continue to receive above inflation growth in their budgets. But any money spent inefficiently on one aspect of healthcare is money that could be used to save lives elsewhere. The NHS in London spends a great deal of money on providing healthcare – £10.1 billion in 2005/06, or £27.7 million a day.

London's population is growing, and living longer. New technologies can help treat more and more people. The rising cost of drugs, new technology and treatments will challenge the NHS. Demand for services will grow. Our forecast, comparing the cost of services with funding in ten years' time, shows that if we carry on without making any changes we will not be able to afford the kinds of improvement in quality of care and new technology which could improve the health of Londoners.

7 Governance

7.1 Establishment of Joint Committee of Primary Care Trusts (JCPCT)

On the 9 August 2007 the London Commissioning Group (LCG) wrote to London PCT Chief Executives, and PCT Chief Executives in Strategic Health Authorities (SHAs) bordering NHS London (the London SHA) [1], setting out a provisional framework for a formal first-stage public consultation on the models of care and delivery set out in *Healthcare for London:* A *Framework for Action*.

The framework proposed that "PCTs in London and surrounding London for whom the implementation of the models of care in A *Framework for Action* might amount to a substantial variation or development for part or all of their population, consider establishing a Joint Committee (in line with Regulation 10(4) of NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulation 2002) in order to:

- Approve the consultation document;
- Relate formally to the Joint Overview and Scrutiny Committee which corresponding local authorities would be required to establish;
- Receive the report on the outcome of consultation and consider the Health Inequalities Impact Assessment (HIIA) on A *Framework for Action* (the latter to be commissioned); and
- Take decisions on the models of care and delivery models taking into account the outcome of consultation and Health Inequalities Impact Assessment."

PCTs were asked to indicate whether or not they intended to participate in the public consultation, following discussion with their Overview and Scrutiny Committees, and Patients' Forums.

Whilst it was assumed that London PCTs would participate, they were asked to discuss this at their boards (convening an extraordinary board meeting if necessary), and formally pass a resolution regarding participation. The outcomes of those Board meetings were monitored by London Commissioning Group (LCG).

PCTs outside London were asked to consider whether or not the proposals in the framework would, if adopted, constitute a variation in service to their populations or part of their populations. If their boards felt that the answer to this question was yes, they would have a statutory duty to participate in the consultation. PCTs were offered the option of declining to participate in a first-stage consultation, but taking part in future consultations where there would be greater clarity about the practical impact of proposals. PCTs outside London (and their respective SHAs) were urged to respond to the LCG and/or the Programme Office on a number of occasions[2]. They were asked to indicate whether they required more information before making a decision. For those PCTs that indicated they

[1] copying the letter to: CEs of London FTs; London NHS Trusts; London Ambulance Service; Dr Maggie Barker, Deputy Regional Director, RPHG, Government Office for London; Matt Tee, CE, NHS Direct; NHS London, Chief Executive and Directors; SHA Chief Executives bordering London SHA

[2] Follow-up messages sent between 18-19 September 2007, and again between 16-19 October 2007, via email and telephone calls.

would like to participate, or they were unsure and required more information, a meeting was convened at the NHS London offices on 26 October 2007[3].

A meeting of PCT representatives likely to join the Joint Committee of PCTs was held on 7 September 2007. This meeting was not held in public. The meeting was an opportunity to discuss the proposed Terms of Reference[4] of the substantive JCPCT, and to discuss appointment of a Chair. West Kent PCT were represented at the meeting but subsequently decided not to participate. Surrey PCT was the only PCT outside London which decided to participate in this stage of public consultation[5].

The first formal meeting of the JCPCT was held on 21 Nov 2007. The meeting was held in public and elected:

- Richard Sumray (as Chair); and
- Howard Freeman and Joan Saddler as vice chairs

And, for the following papers presented to them:

- Noted A – Formation of a JCPCT (the board report agreed by all PCTs)
- Adopted B – Haringey Teaching PCT Standing Orders (Chair's Standing Orders)
- Agreed C – Notes of the informal JCPCT
- Noted D – London Commissioning Group governance arrangements (relationship to the LCG)
- Noted E – Patient and Public Advisory Group terms of reference
- Noted F – Establishment of the Clinical Advisory Group
- Noted G – Stakeholder engagement analysis
- Endorsed H – Consultation Strategy
- Endorsed I – Stakeholder Engagement Action Plan
- Endorsed J – Consultation Document

Please see **Appendix 1, items A – J**

The minutes of this meeting and a note of the requested amendments to the consultation document can be found in **Appendix 2, items A – B**

[3] This was at the behest of a meeting of PCT representatives likely to join a JCPCT on 7 Sept 2007.
[4] Draft Terms of reference, plus briefing papers on the Patient and Public Advisory Group, and governance arrangements for the London Commissioning Group, had been circulated via email on 4 Sept 2007.
[5] Resolution passed at Surrey PCT Board Meeting of 28 August 2007

7.2 Establishment of Joint Overview and Scrutiny Committee (JOSC)

On the 10 August 2007 the London Commissioning Group wrote to: Chief Executives of London Boroughs; Chief Executive of Common Council of City of London; and Chief Executives of Social Services Authorities in SHAs neighbouring London. Recipients were advised of the invitation issued to London and outside London PCTs. The letter stated "We anticipate that PCT boards in London will agree to the establishment of a Joint Committee of PCTs at their board meetings in September. Were that to be the case, there would be a statutory requirement on London Boroughs and the Common Council of the City of London to form a Joint Overview and Scrutiny Committee (JOSC). The composition of that committee, arrangements for chairing the JOSC and supporting it will be matters that Borough and City of London scrutiny functions will want to consider."

Regarding outside London PCTs and their corresponding OSCs, recipients were advised that "PCTs and OSCs outside London may come to the view that the models in A *Framework for Action* would, if implemented, amount to a substantial variation or development for all or part of their population. In this event, PCTs would need to consider agreeing to be part of a Joint Committee for the first-stage consultation and their corresponding OSC would be statutorily required to be party to a Joint Overview and Scrutiny Committee."

An exploratory meeting was held at the offices of NHS London on 2 August 2007, attended by Bill Gillespie, interim Director of Communications for NHS London; Councillor Mary O'Connor and David Coombs of Hillingdon OSC; Dave Burn of Lambeth OSC; Guy Fiegehen of Hillingdon OSC; Dr Fiona Campbell, a consultant engaged by the London Scrutiny Network to write a report on Healthcare for London; and Jane Schofield, Chief Executive of Greenwich PCT.

Guy Fiegehen circulated a briefing note to all London OSC officers on 7 August 2007, inviting them to attend a meeting of the London Scrutiny Network on 10 September 2007 to discuss the arrangements needed for the formation of a JOSC.

Ruth Carnall, Chief Executive of NHS London, attended a meeting of the London Scrutiny Network on 11 October to discuss both A *Framework for Action* and the consultation process.

An informal meeting of Members appointed to the JOSC took place at Islington Town Hall on 30th October 2007. A note of that meeting stated that the first formal JOSC meeting would be held on 30 November 2007. There was general support for examining the following themes: finance, transport, public health, equalities, partners, and sustainability/environment.

7.3 Appointment and responsibilities of key contractors

Director of Communications

An executive search resulted in **Flex Communications** being asked to provide an interim Director of Communications.

Independent analysis of the consultation

A tender was issued to eleven companies on 20 September 2007, seeking an organisation to:

1. Independently assess and critique Healthcare for London communications. In particular ensuring that communications meet the principles.
2. Establish structures that advise the public on the consultation process and record consultees' feedback
    a. Provide a freephone contact (staffed during usual office hours e.g. 8.30 – 5.30pm and on answerphone at other times)
    b. Freepost and email addresses to answer queries and for receipt of consultation responses.
    c. Web presence with facility to receive consultation responses
    d. Liaise with the programme communications manager in order to respond to public queries in a timely, informed way.
3. Assess responses so that the consultation is not only honest and open, but it is **seen** to be honest and open.

(Extract from service specification).

Interviews were held on 10 October 2007 with four companies. The interview panel consisted of the Chief Executive of Barnet PCT, the Chair of the newly formed Patient and Public Advisory Group (PPAG), the Interim Director of Communications, and Outer North East London's Communications Sector Lead. **Ipsos MORI** was appointed to fulfil the role advertised.

There has been very little variance in the delivery of the agreed contract and the Interim Director of Communications expects the final accounts to reflect the original price agreed.

Eliciting the views of traditionally excluded groups

In addition to the consultation and conversations that the PCTs would have with traditionally excluded groups, it was agreed **(Appendix 1l** – Consultation engagement action plan) that a pan-London approach should target specific identified groups.

A tender was issued on 17 October 2007 to seven organisations seeking an organisation to:

1. Identify groups in London that could be classed as traditionally under-represented;
2. Develop a plan to consult with a list of groups. This will need to be agreed with the Healthcare for London programme office to ensure the work does not repeat work currently being carried out in PCTs but rather supplements it – in particular we will be looking at groups that are widely dispersed across London or where it would be easier to engage with pan-London structures;

3. Link with local PCT PPI leads to ensure that all groups are identified, and that the work complements other local events;
4. Engage, inform and consult with these groups on *A Framework for Action*;
5. Encourage these groups to make their views known;
6. Work with consultants preparing an equalities and health inequalities impact assessment of the consultation who may wish to add and/or shape key questions which will be posed to particular groups (for the purposes of the impact assessment); and ensure that if there are different messages, there is proper analysis of why this might be;
7. To share approaches taken and best practice with NHS comms and PPI leads;
8. Prepare a report to inform the LCG and JCPCT of the views of traditionally under-represented groups when they consider the outcomes of consultation.

(Extract from service specification).

Interviews were held on 28 November 2007 with two companies. The interview panel consisted of the Head of Partnerships and Diversity, Ealing Primary Care Trust; a representative appointed by the Patient and Public Advisory Group (PPAG); and the Communications Project Manager for the Healthcare for London Communications Team. **Health Link** was appointed to fulfil the role advertised.

There has been very little variance in the delivery of the agreed contract and the Interim Director of Communications expects the final accounts to reflect the original price agreed. Health Link administered a £10, 000 fund, a sum agreed in advance but outside of their contract, to disburse £200 to each participating organisation.

Roadshow

During early November, expressions of interest were sought from three companies (recommended by PCT communications leads) to provide the roadshow. Communications sector leads considered the bids individually and fed comments back to the Interim Director of Communications. **RS Live** was appointed to fulfil the role based on the value for money offered in their bid, and their positive track record. Additional expenditure over and above the original contract was agreed, in order to support additional roadshows and events in mainline stations, underground stations etc.

Print and design

A tender was issued on 16 October 2007 to seven organisations seeking an organisation to print and design the consultation documents. The companies were invited to submit quotes for the specified work, which included the design and print of the consultation document and summary leaflet. Based on the quotes received, **Raffertys** were appointed on 29 October 2007.

There has been a substantial increase in the amount of print and design required – from increased pagination and print runs (estimates were made prior to PCT requests for documents) and new documentation e.g. a stand-alone questionnaire, additional languages to be translated, to roadshow requirements (which were originally agreed to be the responsibility of the PCTs). The Interim Director of Communications advises the committee the final accounts for print and design have substantially exceeded original estimates but assures the committee that provision has been made through under-expenditure elsewhere in the budget.

8 A Framework for Action

Healthcare for London: A Framework for Action **(Appendix 4)** was commissioned by NHS London and published on 11 July 2007. The publication aimed to offer a compelling vision for the future, based on published evidence (some 250 documents were listed in the report), the views of over 200 clinicians and organisations, and many hundreds of members of the public. Included in the research element was a specially commissioned survey of 7,000 Londoners.

The report reiterated the case for change, analysed the future demands for healthcare, and discussed and made proposals about **how** the NHS could provide care:

- Staying healthy
- Maternity and newborn care
- Mental health
- Acute care
- Planned care
- Long-term conditions
- End-of-life care

and **where** the NHS could provide care.

The report also estimated the costs of these new models of healthcare provision and discussed key drivers of change that would (depending on how they were addressed) turn the vision into a success or see the report gathering dust on a bookshelf like so many other reviews. These drivers were identified as:

- Commissioning
- Partnerships
- Public support
- Clinical leadership
- Training and the workforce
- Patient choice and information
- Funding flows
- Better use of estates

At its board meeting held in public on 8 August 2007, NHS London commended A *Framework for Action* to the PCT Boards and requested that they consult on the recommendations.

9 Developing the consultation and the proposals in *Consulting the Capital*

9.1 Aims of the consultation

A Healthcare for London programme office was established to progress the programme, and work with PCTs to develop a consultation document. The aim was to build on *A Framework for Action* and the response it received, and to develop a consultation that ensured:

- Stakeholders are informed about, and can influence, the proposals;
- The consultation process is timely and legal;
- The resulting recommendations are the best options and include the best ideas from stakeholders;
- The resulting recommendations are supported by as many stakeholders as possible;
- Duplication of effort in consultation is avoided and existing knowledge and services utilised.

(Extract from consultation strategy, **Appendix 1H**)

9.2 Action plan

A Stakeholder Engagement Action Plan **(Appendix 1I)** was developed with PCT communications leads and the Patient and Public Advisory Group. It gave guidance to communications leads on the tasks to be undertaken – for instance meetings, publicity, website promotion and work with traditionally excluded groups, for each of the identified groups of audiences:

- NHS staff and internal stakeholders
- Patients/carers
- Health partners
- Community
- Influencers
- Representatives

Further guidance was issued to communications leads in the form of a handbook – "In the driving seat" …the consultation lead's A-Z of navigating safely and successfully through Healthcare for London.

9.3 The consultation document

Drafting of the full consultation document **(Appendix 5)** involved PCT communications leads, PCT Chief Executives, the London Commissioning Group and PCT representatives on the JCPCT, NHS London staff, the chairs of the original clinical groups on A *Framework for Action* (with the exception of Lord Darzi who was by then a Minister), the Patient and Public Advisory Group, key stakeholders and other clinicians.

The proposals focus on services from a patient's point of view. They look at what needs to change to make services safer and more accessible. And they look at what needs to be done to make Londoners healthier.

The proposals do not simply repeat those of A *Framework for Action*. The proposals were shaped by the engagement of stakeholders and by new evidence. For instance it became clear that it would be better to consider children's services separately (A *Framework for Action* had considered children's services in conjunction with adult services), so the consultation document put all the information regarding children's services in one chapter.

The original chair of each clinical group agreed to introduce each chapter (except for the children's chapter where there was no chair, and the acute chapter where Lord Darzi's place was filled by a member of the group). The document was approved at the JCPCT meeting of 21 November 2008 (with minor amendments, see **Appendix 2B)**

9.4 Developing the questions

For each care pathway, and for the chapter on where care should be provided, questions were devised. In recognition of the fact that the document was very broad in focus and that the PCTs wanted to be open minded about the issues that might be raised, only a limited number of 'closed' questions on specific topics were asked.

A 'free text' question for each chapter, gave respondents the opportunity to comment on any aspect of the proposals, including issues they felt were not covered.

The questions were tested with a small focus group by Ipsos MORI (**Appendix 7A** for details).

10 *Consulting the Capital* – consultation material and activities

10.1 The full document and summary

Approximately 500 full documents were digitally produced in order to have them available at the start of the consultation. These documents were delivered on the 30 November (the start of the consultation) to PCT Chief Executives, to the JOSC (that met on 30 November) and other key stakeholders.

A summary document was produced using information from the full version, giving an indication of the issues that were being consulted upon, and directing people to further information if they were interested.

In all approximately 65,000 full documents were produced (with 58,500 distributed) and 355,000 summary documents produced (with 343,300 distributed).

10.2 Equality of information

The summary document was originally translated into twelve languages but at the request of the JCPCT, Polish and Mandarin were added. During the consultation Somali and Tamil were produced following requests from members of the public.

The summary document was also produced on tape, in Braille and on CD. Large print (18 point and 14 point) versions of the full consultation document were created and made available in hard copy or electronic versions upon request.

The summary and consultation questionnaire were also produced in an easy read version. This was first tested on a group of people with learning disabilities to ensure appropriateness.

The full document, the summary and the translated versions were all made available on the website which, along with the online questionnaire, was designed to be fully accessible (the site exceeds the requirements specified in the NHS website guidelines.)

A subtitled video was placed on the website to help explain how the proposals might work in practice, and a Power Point presentation developed (including notes) and distributed to all PCTs. The PCTs were asked to adapt the presentation to give people an insight as to how the proposals might affect their local community.

10.3 Activities

The Consultation Strategy and Stakeholder Engagement Action Plan were developed by the interim Director of Communications in consultation with PCT communications leads and communications sector leads (five PCT communications leads agreed to support PCTs and co-ordinate work in their sector). Each sector / PCT then developed its own action plan.

The start of consultation was announced in the Evening Standard on 30 November 2007 and a press release issued.

The communications activity report (**Appendix 6**) summarises the broad range of activity overall and in each PCT, over the three month period by:

- Distribution
- Roadshows
- Meetings and Briefings
- Hard to reach groups
- Media

The report shows the very large number of groups that were engaged, the opportunities for members of the public to become involved and the key stakeholders that were informed. We estimate that well over 10, 000 people attended various meetings across the capital.

Additional reports are available e.g.:

- Distribution lists (by the programme office and each PCT);
- Records of key meetings held (these have been supplied to Ipsos MORI);
- Detailed logs of meetings at which Healthcare for London was discussed.

Roadshows

The method of organisation of the roadshows was almost the only variation in the delivery of the agreed Stakeholder Engagement Action Plan. In discussion with PCTs it became clear that in order to achieve maximum quality, consistency of message and best use of resources, it would be best to arrange a pan-London roadshow with local variation, rather than a purely locally developed product.

In consultation with PCT communications leads, the programme office developed a package that could be used across London.

RS Live delivered and set up the roadshow at a minimum of one location in every London borough between the middle of January and late February. This corporate approach ensured that common information was presented at all meetings and roadshows – although presenters were encouraged to give local flavour to presentations.

The package included:

- Web kiosks to enable enquirers to visit the Healthcare for London website, and to complete the online version of the consultation document;
- Branded information boards describing the pathways and places where care could take place;
- Café-style tables and chairs;
- Branded signage and a response box;
- PA system and digital screen to run the video and Power Point presentations that were normally held throughout the day.

Many attendees to the roadshows wanted to take the time to fill in a full response – paper questionnaires were available as well as computer kiosks that could link to the website and the online form. However, attendees could althernatively fill in a comment or two on a post-it note. Many attendees just wanted to talk about the state of the NHS with senior managers, to compliment and to complain. In some instances visitors were able to be directed to appropriate treatments and medicine.

The roadshows were seen as a great success by both visitors and PCT members. Over 4, 200 visitors (an average of over 100 people per event) visited the roadshow.

Roadshows in the South-East London boroughs of Bromley, Bexley, Greenwich and Lewisham were held jointly with the Picture of Health consultation. The two consultations shared the same halls and were introduced as two parts of the same jigsaw, with Healthcare for London providing the strategic overview, and Picture of Health supporting the principles of Healthcare for London and providing the local context. The two consultations were differently branded and located in separate parts of the same hall. The aim was to provide clarity to attendees as to the proposals in both consultations and enable them to consider them as a whole or individually.

Integrated campaign 'Chalk and Cheese'

An integrated campaign - 'Chalk and Cheese' - was developed to highlight health inequalities in London, and the need to change how we provide and use healthcare if we want to see a marked improvement for Londoners. The campaign aimed to provide up to 10million 'opportunities to see'.

The primary objectives were to:

- increase awareness of Healthcare for London among target audiences;
- encourage audiences to find out more – the majority of the campaign aimed to drive audiences to www.healthcareforlondon.nhs.uk, with other access portals as secondary points;
- create dialogue and future engagement platforms with London's youth through the use of bespoke products/channels; and
- to assess the effectiveness of a range of channels and media for ongoing engagement.

The secondary objective of the campaign was to promote participation in the consultation through completion of the online survey or by requesting and completing a paper document.

Target audiences included all London residents and workers, but specifically:

- adults in full-time employment who use inner/greater London train and underground transport networks;
- adults in 'informal' employment contexts or not working, including home-based parents, carers and older people;
- younger adult and 'middle youth' audiences using social networking sites;
- young people under 19 years;
- black and ethnic minority groups; and
- commuters who work in London but live outside the 31 boroughs or in Surrey.

The campaign included:

- a five-page wrap, including front and back covers on the full run (500k copies) of *thelondonpaper (*25 Feb);
- advertisements in *The Voice* and *The Gleaner*; (combined total 330k copies);
- digital signage (TV) in major London stations – a 20-second animated advertisement, running every six minutes from 22-29 February next to the arrivals and departures boards at Victoria, Waterloo, Euston, Kings Cross and Liverpool Street (combined reach: circa 8.3m commuters);
- radio advertisements – LBC London radio and Magic FM;
- print advertisement in *thelondonpaper* (week of 3 March) (500k copies); and

- experiential marketing: exhibitions/roadshows at Victoria, Canary Wharf, Paddington, Oxford Circus, Liverpool Street, Kings Cross, Euston, Waterloo and Bank with estimated visibility and reach to over 700k commuters.

This was supplemented with: marketing promotion activity, involving hand-distribution of around 60k flyers along with branded promotional items (a snack-sized cheese) to commuters passing through Network Rail stations and using the London underground; raising awareness and encouraging visits to the website.

In addition, the campaign incorporated the launch of a youth engagement component. Using digital and viral marketing, four main channels were selected to heighten awareness of the key aims of Healthcare for London, as well as encouraging young Londoners to give their views or share their experiences of healthcare in the capital.

Activity included:

- banner advertisements – *Young Voices* online (the online youth channel of *The Voice*) and digital flyer advertisements on Facebook;
- a web-based 'Ideas river'. This is a bespoke product aimed at younger audiences, which encourages and enables visitors to share and submit their ideas. The focus is on 'staying healthy' and the primary target audience is young people who live and/or work and study in the capital. The target audience is driven to the site through dedicated advertising and 'seeding' (e.g. from *Young Voices* online or from a social networking site;
- groups on social networking sites: Bebo and Facebook; and a
- profile on MySpace.

Take-up was encouraging, with a significant number of young people expressing an interest in engaging beyond consultation.

10.4 The cost of consultation

The budget for the consultation was established at £1.1million. The following breakdown indicates that this would have been sufficient if it had not been for the decision to mount an additional awareness campaign towards the end of the consultation period.

These are un-audited figures based on actual expenditure. They show the proportionate costs of different aspects of the consultation.

The agreed budget of £1.1million approximates to roughly 13 pence expenditure per Londoner, or just over £34,000 per PCT (including Surrey PCT). Based on current payments, expenditure was:

Activity	**Further detail**	**Expenditure in £ 000s**
Administration/Postage		10
Staffing	Seconded staff (including sector leads in PCTs, to backfill senior staff dedicated to consultation)	161
	Staffing and support	140
* Printing and design	Includes production of translated summaries in 15 languages, and in formats including Braille and Easy Read, at a cost of approximately £31K	272
Advertising		27
Legal advice		33
* Consultation, engagement, receipt and analysis of responses, including external consultancy	Includes - *Receipt and analysis of responses - approx £52K *Engagement with traditionally hard to reach groups - approx £84K *Roadshows - approx cost £30K (some roadshow costs also appear in 'Conferences, events and meeting rooms' below)	232
Information systems	Includes website support	5
Conferences, events and meeting rooms	Includes joint working with London Councils	78
Chalk/Cheese campaign		166
TOTAL	(With £142K payments accrued for 07/08)	**1, 124**

* These contracts were subject to competitive tender.

11 Response to consultation

To consider the response to consultation it is necessary to look at three main documents:

- Ipsos MORI consultation analysis of public and organisation responses (**Appendix 7A**) – summarised in 11.2 below.
- Health Link report on traditionally under-represented groups (**Appendix 7B**) – summarised in 11.3 below.
- Report by Joint Overview and Scrutiny Committee (**Appendix 7C**) – summarised in 11.4 below.

and an analysis of the issues raised at meetings (see 11.5 below). In addition to this material, the members of the JCPCT should also consider other sources of information, for instance; their own views from talking to patients, the public and local organisations; the views of their PCT; the response by the Patient and Public Advisory Group and the Clinical Advisory Group.

11.1 The consultation in numbers

- 4,372 individual responses
- 359 organisation responses
- 317 people involved in traditionally under-represented consultation groups
- 20,485 individual visitors to the website
- 4,240 visitors to roadshows
- Over 10,000 people attended meetings arranged by PCTs and the programme office

11.2 Ipsos MORI consultation analysis

(The full report is available in **Appendix 7A**)

Respondents were able to use four channels to respond:

- Email
- Mail
- Telephone
- Online form

In coming to their conclusions Ipsos MORI also examined the meetings/events feedback forms supplied by each PCT and the programme office and the post-it notes filled in at the roadshows.

The following text is extracted from the executive summary, found at the front of the full Ipsos MORI report.

Staying healthy

Respondents were keen to make a number of changes to improve their health, particularly exercising more (58%), reducing stress (46%), losing weight (44%) and improving their diet (42%). Much fewer respondents said that they wanted to reduce their alcohol intake (9%) or

give up smoking (8%). Almost three-quarters (72%) would welcome advice from health professionals about how to stay healthy.

Respondents thought that the NHS could help in a number of ways, particularly by providing NHS exercise facilities and working with other agencies to encourage healthier lifestyles, improving access to support groups, providing early diagnostic testing and screening and making constructive information more widely available. The importance of wider societal change was also mentioned. Others felt that this was a question of individual responsibility alone.

Key stakeholders welcomed the focus on prevention and thought that there was an important role here for a range of healthcare professionals.

Maternity and newborn care

Co-located units (57%), senior doctor presence (46%) and time taken to the place of birth (40%) were considered most important of the range of factors presented to respondents.

Responses to the open questions suggested that safety of the mother and baby was the primary concern for respondents. There were also many comments in relation to the need for greater numbers of midwives.

There was a clear preference for home visits following the birth of a baby. Respondents felt this was easier for the mother and gave opportunities for assessments of the home environment.

Stakeholders emphasised both the importance of choice and the safety of the mother and baby. There was a difference of opinions in relation to the use of midwife-led units in the community, but agreement that greater investment is needed in the numbers and training of midwives. There was agreement that home visits following the birth of a baby were most appropriate.

Children and young people

There was general support amongst respondents for specialised care for children (54%), but with concerns about the extra travel and stress this would cause to families.

Respondents suggested a number of ways to encourage immunisation including increasing access, providing more information, and offering incentives or penalties. A small number were against immunisation for children due to the perceived harmful effects of the vaccines.

Key stakeholders appeared slightly less supportive of specialising paediatric care. They raised the same concerns as the public and were keen for some paediatric services to be maintained in local hospitals.

Mental health

Respondents (from both the general public and key stakeholders) thought that the consultation document contained little detail on this subject. There was a general feeling that there had been insufficient attention paid to mental health care in the past.

There was support for investment in talking therapies, and for most of the points raised in this chapter. However, there was a strong feeling that the numbers of in-patient beds needed to be maintained, if not increased.

Acute care

Respondents were most likely to want an urgent care telephone service to provide general medical advice (44%), be able to transfer callers to healthcare professionals (38%) and to book GP appointments (33%). However, a quarter of respondents would not use this type of service at all (24%).

There was general support for specialised centres for the treatment of trauma (64%), stroke (67%) and complex emergency surgery (65%). There were concerns however over the precise numbers of these centres, particularly due to the transport and traffic in London.

Respondents were generally in favour of direct transfer by ambulance staff (77% of those in agreement with specialised centres), provided they had received appropriate training.

Key stakeholder responses reflected the issues above. They supported the principle of specialised centres, but were not sure about the numbers proposed in the document. Again, they were keen to see a range of services provided at local hospitals.

Planned care

There was support for GP surgeries to offer routine appointments in the evenings and at weekends (80%) but there were a number of concerns, particularly as to how this would affect the quality and continuity of care.

The majority of the key stakeholders commenting here supported extended hours. However, local medical committees and other GP groups raised a number of objections including the unavailability of other services, the impact on staff and whether there was a real need for extended hours.

Long-term conditions

Two-thirds of respondents thought that greater investment should go to community support for long-term conditions (67%). It was thought that this would be more convenient for the patient and allow them to better manage their condition.

Some key stakeholders also thought that GPs were best placed to deal with these patients, although not necessarily for every condition.

End-of-life care

There was some confusion over the proposals in this section. Respondents appeared unclear as to the status of the new end-of-life service providers (ELSPs). They were also unsure about the need for them (33% did not know what impact their introduction would have; but 52% thought it would result in better care). Some respondents thought that care would be improved by investing more in existing providers.

Respondents did welcome the efforts to coordinate care better. They supported the right for patients to choose their place of death, but also recognised that families and carers had needs too.

Key stakeholders raised similar concerns about the new ELSPs. They also highlighted the impact on social care services and emphasised the need for greater support and investment.

Where we could provide care

Responses were dominated by the issue of polyclinics. Half of respondents agreed that all or almost all GP practices should be part of a polyclinic (50.5%). They thought that the integrated care would benefit patients.

However, there were strong feelings amongst those who disagreed (29%). They were concerned about the potential impact polyclinics might have on the GP-patient relationship, the perceived loss of continuity of care, and the possible extra travel for patients, especially those with mobility problems. Some also questioned the cost involved, and the governance arrangements – and asked whether the money could be better spent on improving existing services.

Key stakeholders were also divided on this subject for the same reasons. They also raised the impact on other local services such as community pharmacies. Some thought that polyclinics could be beneficial in certain communities, but careful consideration would be needed as to their location and form.

Turning the vision into reality

There was support for the underlying principles (ranging from 72% to 82%), but some respondents questioned whether the evidence was available to show how the proposals would meet the principles.

Similarly, respondents were unsure as to how the proposals would address health inequalities. Just 37% thought the proposals would improve access to health services for people from deprived communities and disadvantaged groups and 29% thought the proposed changes would improve the health of these groups.

Key stakeholder responses were similar and stressed the need for greater partnership working.

11.3 Health Link report on traditionally under-represented groups

(See **Appendix 7B**)

Health Link was commissioned to undertake outreach consultation with groups of people seen as traditionally under-represented in public consultations. This work was supplementary to the local consultation carried out by PCTs. In all, 36 meetings were held with a total of 317 people. Of those who completed a demographic form (284), the following identified themselves against the categories of people (in many cases more than one category) whom we were targeting as traditionally under-represented:

TABLE ONE-NUMBERS SELF REPORTING BY CATEGORY			
CATEGORY	NO.	CATEGORY	NO.
Males (where completed)	123	Females (where completed)	168
Employed 50	Unemployed 75	Retired	91
Alcohol Dependence	30	Mental health service use(outpatient)	22
Carer	17	Non White Ethnic Minority	121
Child	19	Offender	13
Child with special needs	8	Older person	82
Dementia	23	Older frail person living alone	16
Drug Dependence	16	Physical disability	41
HIV positive	14	Prisoner	7
Homelessness	11	Refugee or asylum seeker	10
Hospice patient	11	Religion or belief	177
Learning disability	30	Resident in a care home	30
Lesbian, gay, bisexual, transgender	17	Sensory impaired	18
Living on a low income	72	Traveller	11
Long term medical condition	92	Woman	168
Mental health service use (Inpatient)	10	Young person	19
NON WHITE ETHNIC MINORITY		RELIGION OR BELIEF	
Asian other	*2*	*Buddhist*	*9*
Bangladeshi	*8*	*Christian*	*90*
Black African	*24*	*Hindu*	*32*
Black Caribbean	*24*	*Jewish*	*11*
Black other	*10*	*Muslim*	*21*
Chinese	*18*	*Rastafarian*	*5*
Indian	*44*	*Sikh*	*9*

The following is extracted from Health Link's report summary

Individuals at the following organisations were consulted as part of the Health Link 'conversation':

1. Action Disability Kensington and Chelsea (ADKC)
2. Age Concern Tower Hamlets
3. Alzheimer's Society Enfield Branch
4. Alcohol Recovery Project (ARP)
5. British Thyroid Foundation
6. Camden Chinese Community Centre
7. Camden Lesbian, Gay, Bisexual, Transgender (LGBT) Forum
8. Carers UK
9. Chase Farm Mental Health Unit (Barnet, Enfield & Haringey Mental Health Trust)
10. Day Mer Turkish and Kurdish Community Centre
11. East London Rastafarian Information & Community Services
12. Hackney Libraries Housebound Readers Service
13. Hammersmith and Fulham Refugee Forum
14. Haringey Libraries Special Needs Children's Reading Group
15. Heston House Care Home
16. Her Majesty's Prison Wandsworth
17. International Buddhist Progress Society
18. League of Jewish Women
19. Lohana Social Centre
20. National Association for the Care and Resettlement of Offenders (NACRO)
21. Queens Park Bangladeshi Association
22. Ramgarhia Sikh Association
23. St. Ann's Hospital (Barnet, Enfield & Haringey Mental Health Trust)
24. St Barnabas
25. St Joseph's Hospice
26. St Raphael's
27. St Mungo's, Seven Sisters Road
28. Saheli Enfield Branch
29. Salmon Youth Centre
30. Southwark Travellers Action Group
31. Sutton Mental Health Action Group
32. Terrence Higgins Trust
33. The Shanti Centre
34. United Reform Church
35. United Reform Church Children's Group
36. Walthamstow Deaf Club

The localities of the organisations where we held meetings covered 18 boroughs and a range of deprivation codes from 2 (the most deprived) to 234 (the least deprived) – Index of multiple Deprivation 2007 records.

Although a great deal of intensive work was needed to procure the meetings in the first place, the responses received were detailed and comprehensive and of the 187 who completed evaluation forms (from 25 organisations), 90% found it as easy or easier than they expected to contribute to the meeting and 95% said they would be willing to be involved in the future. This 'consultation capital' can be used by the London PCTs to continue involvement and consultation on the Healthcare for London plans.

> *"Overall, there was broad support for the general approach with reservations about the consequences of applying the model locally and where funding might come*

from. Some suggested that current problems need to be addressed before embarking on such a major review. A significant barrier mentioned by many participants in considering the proposals were the variables in terms of location of any new services, the ease or difficulty of travelling to them and what would happen to existing services."

Staying Healthy

The participants had a number of ideas about what would help them stay healthy, including help with weight loss, healthy cooking classes, free gym membership for older people and those on low incomes and compulsory exercise for children. More information that is more readily available in the community, especially about medication, was also considered important as were general quality improvements in healthcare. It was notable that some of the suggestions about new services are already supposed to exist, such as regular check ups for older people and medication reviews.

Maternity and Newborn care

There was support for a choice of place of birth. Giving birth in a midwife-led unit with a doctor-led unit on the same site was the factor most frequently selected as important. There was some support for home birth, providing the home was assessed as suitable and the mother considered the possibility of complications carefully with the professionals. Help and support for young mothers was cited as an important enhancement to maternity care. The vast majority of participants who discussed this issue felt that the midwife should travel to visit the woman and not the other way round. Reasons cited for this included checking that all was well at home and spotting women at risk of postnatal depression more easily.

Specialist care for children

Views on concentration of specialist services for children were mixed, with recognition of the prime importance of high quality care for children but worries about time taken to travel further in an emergency, the complications for families with other children of travelling greater distances and the stress this would induce, especially for disabled parents. Children in the consultation worried about the unfamiliarity of more distant locations and there was a view that children with mental health needs were better seen locally. Stabilisation of the patient by specialist staff prior to transfer, and support for parents to help with travel and car parking, as well as good parent accommodation, were all cited as important factors for successfully implementing such proposals.

Mental Health

There was some support for direct payments but also confusion about what they could be used for. Pathways of care were broadly welcomed so long as they did not enable police and social services to 'dump' people onto mental health services. There was strong and universal support for talking therapies with many participants outlining the difference this would make to them. The shortcomings of mental health services were also described and concerns expressed about the vulnerability of these services to cuts when funding was required for other services.

Urgent Care Telephone Service

Whilst there was support for this idea, many questioned whether it would duplicate NHS Direct. Participants saw value in the ease and convenience of getting advice on how to treat

illness (particularly for parents of young children) and making the GP appointments system more accessible if it could be done over the telephone. Others felt this would be 'just another pressing buttons nightmare' and did not feel a telephone service was any substitute for face to face contact. If such a service were introduced, it would have to be offered in languages other than English and be staffed by real people who were properly and sensitively trained, and answered promptly. Publicity would be needed so people knew about the service and what it offered.

Specialist care for stroke, trauma and complex surgery

This proposal attracted a mixed response with many seeing the value of the idea but expressing strong reservations. Some participants made it clear that they opposed any hospital closures if this might be the result. The majority recognised the advantages of concentrating specialist equipment for quality of care but they were also concerned that this would reduce access to such care for patients. It was felt that longer travel time for patients in need of urgent care could compromise their recovery. The extra travel for visitors was also seen as a major barrier because older or disabled people might not be able to make such journeys. Patients would need their family close by. Not knowing the actual proposed location of specialist centres made consideration of the question difficult. The selection of the sites should take into account the requirements of those with the greatest needs. A lot depended on the skills of the paramedics in deciding where to take the patient and there was some scepticism about their ability to do this. In some cases, participants considered that local services should be improved to provide the right standard of care instead. Would the concentration of services in the way proposed mean local services would deteriorate? Questions were raised about whether or not these proposals would make waiting times for appointments generally better, as more patients would be going elsewhere.

Extended GP opening hours in the evenings and at weekends

This was the proposal on which there was most unanimity, with most participants supporting the idea. Participants resented having to take time off work or, in the case of children miss school, to attend their GP and it was felt that GPs were paid enough to provide a more accessible service. Even those who did not work supported this proposal, as such a change would help them because they are dependent on employed relatives to take them to the surgery or, for some, provide interpreting during the consultation. Patients would be able to access appointments more easily if the overall number of appointments were increased through longer opening hours. A minority of participants were concerned that if each GP worked longer hours, this would compromise the quality of their work and therefore the quality of care.

End of Life Care

The proposal to offer a choice of where to die attracted strong support, although there were concerns about balancing the needs of the relatives and the patient in the decision. The provision of more hospice places and adequately funded, skilled, 24 hour support for relatives were key success factors. Questions arose as to whether the cost of this service would be free to the patient or treated as social care and therefore charged for. The idea of a single provider to co-ordinate care at the end of life was broadly welcomed. Some questioned whether this should not already be provided by the GP, who was a known person for the family and patient at a time of great distress. Such a service would have to be easy to access, adequately funded and sensitive to cultural and language needs.

Polyclinics

There was strong support for this model but participants found it difficult to conclude that it would work well in practice because they could not be clear on the location. Some considered the 1.5 mile distance for most Londoners cited in the consultation document as too far, especially for older or disabled people. Another strong reservation related to the loss of the relationship with the GP, where this relationship was working well. Subject to these reservations, advantages cited included better access and convenience, greater flexibility in appointments and more accountable GPs. Participants were concerned that this complex service should be well managed and given stable funding, not subject to cuts if a PCT went into deficit. Travel concerns were the overriding issue including time, convenience and cost.

Views on whether GPs should move to a polyclinic depended on participants' current experience of GPs and the accessibility of surgeries. The majority thought that all GPs should be networked to a polyclinic. Any other approach would lead to inequity. Participants were clear that the decision on which GP surgeries should move must not be left to GPs but should be carefully planned and involve the local community. Most participants agreed with the services suggested for inclusion in polyclinics, except that there were mixed views on including social services and leisure services. Many suggestions were also made for other services which could usefully be located in the polyclinics.

Would the plans help improve people's health or their access to healthcare?

There was qualified support for the idea that these plans could improve health and access to healthcare, subject to the various reservations on the individual proposals. However there were concerns that without more staff, changes in infrastructure would be of limited benefit, whilst the funding and skills needed to deliver it all were not guaranteed.

Quality of Healthcare – participants' views

The discussions prompted many comments about the quality of current health services which are described more fully in the report. While some participants had nothing but praise for their GP surgery and valued their personal relationship with him or her, many had negative experiences. The strongest themes on quality of primary care were difficulty in getting appointments, lack of accountability and discriminatory or insensitive attitudes. Poor administration, car parking, infections and lack of cleanliness were concerns expressed about the quality of hospital care.

Equalities and Exclusions

A number of themes emerged about equalities and excluding factors across the NHS generally. These included failure to understand and meet the needs of disabled adults and children, including people with mental health problems. Choice of the gender of doctors was an important priority for personal or cultural reasons, but was not always available. There were complaints of disadvantage for some ethnic groups because of lack of interpreting and translation services, especially in GP surgeries. Some participants complained of stigma on the grounds of their sexual orientation. Among excluding factors which participants complained of were ageism by health service professionals and a failure to understand and meet the needs of carers and those with long term conditions for accessible care. People with basic skills needs reported that they needed extra support to help them cope with medication and written information.

Conclusion

The process of conducting outreach consultation with the target groups was successful in engaging them and they are keen to be involved in the future. In some cases, their personal circumstances give them a range of needs which they are best equipped to describe and plan for. As a starting point, we have developed a Framework of Needs to act as a metric against which to measure any further proposals or local plans. This Framework includes needs arising from discussion on the consultation proposals as well as issues raised by the groups which are not currently reflected in the plans. We recommend further patient and public involvement with similar groups so that the plans are developed in the way that best meets patients' needs and instils public confidence.

Framework of needs identified by participants

EXCLUSION GROUP [x]	Maternity	Children's Specialist Care	Mental Health	Specialist Care	Polyclinics	GP Hours	End of Life	Urgent Care Line
← → *Indicates Services to which Needs are Relevant*								
AGE	← Accessible environment; non-discriminatory, sensitive staff; access to quality care →							
	← Short travel time →							
	← Easy for family and friends to visit →				← Local Care →	← Home Visits →		← Human Answer →
BASIC SKILLS	← Plain English information and support with information →							
CARERS	← Comprehensive Carer Assessments; respect for and flexibility for carers' special needs →							
LONG TERM CONDITION	← Knowledgeable staff and equal access to high quality diagnosis and treatment →							
LOW INCOME	← Free or concessionary travel, car parking and congestion charging →						← Free Service →	← Free Calls →
PRISONERS	← Access to 24 hour care; respectful staff; confidentiality; shorter waiting; complaints advocacy →							
STIGMA	← Respectful staff; accessible services; equal access to services; confidentiality →							
YOUNG PEOPLE	← Respectful staff; confidentiality →				← Access to sexual health services other than via GP →			← Human Answer →

[x] 'EXCLUSION GROUP' meaning groups experiencing factors which can cause inequality in the patients' experience

EQUALITY GROUP*	Maternity	Children's Specialist Care	Mental Health	Specialist Care	Polyclinics	GP Hours	End of Life	Urgent Care Line
← → *Indicates Services to which Needs are Relevant*								
DISABILITY (Inc. physical, sensory, learning disability & mental health)	← Accessible Travel, Environment & Information; Non Discriminatory Staff & Processes →							
	← Sensitive to disabled children and adults →							
	← Short Travel Time →							
	← Easy for family and friends to visit →							← Text or Video →
RACE	← Interpreting; Translation (inc. BSL); Non Discriminatory, Culturally Sensitive Staff/Processes →							
								← Answer in minority langs. →
RELIGION OR BELIEF	← Staff awareness of and respect for requirements of different religions or beliefs →							
	← Access to personnel from religious or belief groups →							
	← Choice of same gender doctor →							
GENDER	← Respect and confidentiality for patients on gender reassignment →							
	← Choice of same gender doctor →							
				← Access to reassignment Treatment →				
SEXUAL ORIENTATION	← Non discriminatory staff and processes →							
					← Access to sexual health services other than via GP →			

11.4 Report by the Joint Overview and Scrutiny Committee

(The following is extracted from the full report which can be found at **Appendix 7C**)

The JOSC welcome the opportunity to comment at this early stage on the models of care outlined in 'Healthcare for London' (HfL). We share Lord Darzi's diagnosis that there is a clear need for London's health services to change in order to meet the demands of the next ten years and beyond.

However, HfL is a vision, not a detailed strategy or plan, and we are deeply concerned about significant gaps in the review. It is not acceptable that mental health and children's services were added as an afterthought. The JOSC expect the same opportunity to analyse proposals for these services as with the services originally included in HfL.

Similarly, we heard that further work is underway on key areas to develop the vision outlined in HfL, including the impact on social care and the implications for NHS estates and finances. As this important information is not yet available, we – the scrutiny Members of London's local authorities and surrounding areas participating in the JOSC – reserve our position to comment on specific proposals when this detail becomes available.

The varying response to the HfL consultation across London demonstrates the NHS must work harder to develop the public's understanding that turning the HfL vision into reality will fundamentally change the way their health services are provided. The NHS must rise to this challenge and deliver meaningful engagement in future discussions on specific changes.

We now present our recommendations in response to the HfL consultation which highlight issues that cause us concern, areas in which further work is required and aspects of the review that we believe are positive. A recurring theme is the need to ensure reforms improve the accessibility of healthcare services and the physical access to facilities where these are provided. We are pleased that NHS London has already accepted the key role that local authorities play in this process, and we look forward to authorities being invited to take part in further detailed considerations on this and all other aspects of Healthcare for London.

The JOSC has unanimously agreed these recommendations, demonstrating the strength of shared feeling across all London's local authorities. In line with health scrutiny legislation we look forward to receiving an appropriate response from the NHS and will reconvene in the autumn to discuss this response and examine NHS London's next steps.

Financing the reforms

1. We recommend that NHS London states how and when the money will come from to develop new services in order to address concerns about whether the NHS has the resources available to deliver major reform. Resources for providing health care are finite. The proposals are likely to lead to primary and social care providing treatment currently undertaken in hospitals.

2. We recommend that the NHS ensures that 'the money follows the patient' and resources are reallocated from acute trusts to primary and social care to reflect changes in the way that patients are treated.

Health and social care for London not 'Healthcare for London'

3. We recommend that London Councils is involved in developing further detailed proposals for London's health services, including fully quantifying the impact on community care services. Partners must have a shared understanding of their required contribution to avoid disputes over 'cost-shunting'.

4. We demand that NHS London outlines how seamless care will be provided in the context of the hugely differing budget increases for health and social care that have sharpened the distinction between universal health services and means-tested social care services. Future funding allocations must give equal weight to health and social care budgets.

Health inequalities

5. We recommend that the NHS focuses resources on communities with greatest health and social care need, and ensures reforms overcome inequalities by improving access to health services. Funding allocations to PCTs must reflect the challenges of providing services to that population.

6. We recommend that NHS in London carries out further health inequalities impact assessments (i) once detailed proposals have been developed, (ii) a year after implementation of each new care pathway to demonstrate that reforms have reduced not increased inequalities, and (iii) on a regular basis to monitor the long term impact of the reforms on health inequalities.

A staged approach to reform

7. We recommend that a staged approach is undertaken to implementing new care pathways with, for example, 'polyclinics' piloted in a selected number of sites. Results from these pilots and existing examples of the proposed care pathways must be evaluated with learning fed into any subsequent roll-out across London. NHS London must also ensure lessons are learnt from work to implement Lord Darzi's vision in the rest of the country. The NHS must be clear and open so that it cannot be accused of implementing the HfL vision in a piecemeal fashion.

8. We recommend that the NHS publish a transparent timetable for implementing the HfL vision which will enable Overview & Scrutiny Committees to hold the NHS to account.

Helping people stay healthy and out of hospital

9. We recommend that NHS London sets a minimum level of expenditure that PCTs must commit to (a) helping people lead healthy lives and (b) helping patients manage their long term conditions. This approach will involve close working with partners such as local authorities.

Carers

10. We recommend that NHS London analyses the impact of the HfL proposals on carers in London, and states the action that the NHS will take to ensure any proposals arising from this consultation will not increase the burden on this often 'hidden army' of dedicated individuals.

Maternity services

11. We recommend that NHS London re-examines the allocation of funding for midwifery and commits expenditure to expand the number of midwives in London (i.e. through improved recruitment and retention).

12. We recommend that NHS London ensures that there is a range of birthing options available to meet varying local need, and reconsiders the proposals for stand-alone midwife-led units given the mixed experience so far.

Children's health

13. We recommend that if specialist care is further centralised then the NHS examines how it will manage the impact on children's families during the treatment at more distant specialist hospitals.

14. We recommend that the NHS works with local authorities to ensure that Children's Centres and Extended Schools are equipped and resourced to provide community health services for our young residents.

Centralising specialist care

15. We recommend that clinicians have a major role in developing proposals, and expect them to be involved in explaining to the public that proposals strive to improve patient care rather than save money.

16. We recommend that the London Ambulance Service (LAS) and Transport for London (TfL) are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS London must work with these organisations to agree a travel plan to underpin any expansion of a hospital's services.

17. We recommend that the NHS adopts a 'hub and spoke' model that involves local hospitals treating less complicated cases of specialist care in the daytime with specialist centres providing treatment out of hours when travel times are shorter.

18. We recommend that any centralisation of specialist care can only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require.

The future of the local hospital

19. We recommend that NHS London provides a firm commitment that reforms arising from HfL will not threaten the concept of local hospitals which must provide a sufficient range of services to make them economically viable. Reforms must be planned as to prevent a 'salami-slicing' of services that create diseconomies of scale.

20. We recommend that NHS London outlines how increased specialisation of hospital care will improve the care for people with multiple health needs (often referred to as 'co-morbidities').

GP services and 'polyclinics'

21. We recommend that the NHS demonstrates that providing complex diagnostic services in new community facilities offers better value than using this funding to expand access to existing services (e.g. greater or improved access to hospital x-ray equipment for primary care patients).

22. We recommend that PCTs, local authorities and other partners are able to decide the appropriate models for providing access to GP and primary care services taking into account specific local circumstances.

23. We recommend that the NHS provides a commitment that reforms will improve access to, and the accessibility of, GPs, and reforms will not undermine the patient/GP relationship that for many is at the heart of the NHS.

24. We recommend that new primary care facilities (i.e. the model referred to as 'polyclinics') can only proceed if the NHS has agreed a travel plan with TfL and the relevant local authority.

Mental health

25. We recommend that NHS London outlines how it will ensure sufficient resources will be allocated to meet the challenges facing London's mental health services, including the establishment of talking therapies and other non-drug based treatments.

End of life care

26. We recommend that NHS London provides a commitment that any reforms to end of life care will not lead to people dying in poor quality housing and/or alone, and that where hospitals provide end of life care this is in an adequate and dignified setting.

27. We recommend that health professionals work with patients at an early stage to help them plan for how and where they would like their end of life care to be delivered.

28. We recommend that NHS London clarifies how it will ensure residents of nursing/care homes are not transferred to a hospital to die when this is driven by the needs and wishes of the care home rather than the individual.

Understanding the cross-border implications

29. We recommend that NHS London works closely with colleagues from the surrounding Strategic Health Authorities to explore the implications of any reforms on patients crossing the Greater London Authority (GLA) boundary.

Workforce

30. We recommend that NHS London publish a workforce strategy that will enable the delivery of any changes to London's health services: resources for workforce development must not be diverted in times of financial difficulty.

ICT: providing the electronic connections

31. We recommend that further work is undertaken to ensure that the appropriate ICT infrastructure is in place to deliver the care pathways arising from this and subsequent consultations. The NHS must state what it has learnt from the recent attempts to implement major ICT projects.

Compatibility with recent reforms to the NHS

32. We recommend that the NHS London provides further reassurance on how the ability of Foundation Trusts to retain resources from the disposal of their estates affects NHS London's proposal to use the sale of underused assets to pay for polyclinics and new community facilities.

Moving forward

33. We recommend that NHS London and PCTs are proactive in approaching local Councillors before and during work to develop local health services: the NHS must have an ongoing dialogue with Overview & Scrutiny Committees (OSCs) to discuss the appropriate level of consultation required.

34. We recommend that the NHS in London overcomes this limited awareness and outlines what action it will take to ensure widespread engagement in future consultations.

The JOSC's final message to those running London's health services is *"Please do not let Londoners and those dedicated to our NHS down; working together we can deliver an NHS of which everyone in this great city can be proud."*

11.5 Issues raised at meetings with Londoners

Primary Care Trusts facilitated meetings with over 10, 000 local stakeholders including clinicians, patients, staff, and community and third sector groups. The meetings generated a good level of discussion and comments reflected the broad support for the Healthcare for London proposals. Some key issues raised at meetings included:

1. Meeting attendees spoke of the need to better understand what the changes would mean at the local level, and to avoid a 'one size fits all' approach.

2. There was clear support for improved access to GP services. The feasibility of the polyclinic model was raised. In particular, continuity of care, the location of sites and the impact on patients' travel, concern over privatisation, willingness of GPs to move and the potential duplication of hospital services. More detailed plans would be required prior to local implementation including how PCTs would pay for additional services.

3. The impact of service changes on older people was raised as concern, particularly around accessibility of services. More clarity about end of life care was required.

4. Transport was raised as an issue, both in terms of patients' travelling further to access services and the need for NHS transport for patients receiving services in the community. However, the need to travel further for specialist treatment, on the proviso that patients would receive better quality care, was generally accepted.

5. A greater focus on mental health is needed. In particular attendees considered more attention should be given to mental health promotion, services to support people with mild and moderate mental health needs, and help for people to stay or return to work.

6. There was belief that the proposals would result in increasing demands on the social care sector. However there is a perception that there are insufficient resources available to meet these demands. There were concerns about the impact the proposals will have on unpaid carers.

7. It was considered that there could be better use of partnerships with the third sector in delivering care. Some meetings expressed the need for continued education and training for health professionals.

8. Some meetings suggested that the changes in maternity services were unrealistic due to current low staffing levels of midwives and health visitors. There was a call for more attention to be paid to capacity issues in the delivery of these proposals. It was also considered that home visits by health visitors should continue.

9. Greater clarity of financial models underpinning the proposals was sought and whether future growth and changing demographics had been accurately factored into the proposals. It was also questioned whether the proposed changes were financially driven.

10. The focus on health inequalities was welcomed, especially in improving accessibility of services and language services to diverse groups.

12 Issues arising during or since consultation

12.1 Frequently Asked Questions

A number of questions were raised during the consultation. **Appendix 8A** records some of the more common ones, and the responses.

12.2 Report of the London Children and Young People's Pathway Group

In the original A *Framework for Action*, the health needs of children were considered in all care pathways. However prior to the consultation starting it was decided firstly, to consult specifically on children (so a new children's chapter was constructed – representing the information that had previously been presented in each separate care pathway); and secondly to review the work submitted to *A Framework for Action*. The London Children and Young People's Pathway Group report (**Appendix 8B**) expands on the original work. In essence the report supports the proposals made in *Consulting the Capital.*

The following is an extract of the full report. It concludes:

In spite of a considerable amount of work by individual groups and many joint initiatives since publication of the Children's National Service Framework (NSF) and Every Child Matters (ECM), services for children in London remain fragmented. Implementation of the embodied standards has been variable. As a consequence, health, social and educational outcomes for our children fall short of the world-class outcomes to which we aspire.

This report has provided an overview of the health of London's children, considered current issues in relation to service provision, reflected on barriers to progress, and recommended an integrated care model that could further support the implementation of recommendations arising from the Healthcare for London consultation process.

In summary, the following currently do not exist or could be better in London:

- Equity in health care services and outcomes across all London boroughs
- Integrated commissioning using Joint Strategic Needs Assessment
- Children's Centres and Children's Trusts that are seen as effective for health
- Full implementation of the NSF
- Implementation of the Child Health Promotion Programme
- Managed clinical networks and pathways of services including child protection
- Effective, efficient and equitable access to appropriate care from appropriately trained personnel
- Universal timely access to effective primary and/or first contact care
- Sustainable paediatric assessment units
- Effective close to home facilities providing generalist and specialist planned and unscheduled services
- Training in core competences for all healthcare professionals working with children

The following represent barriers to progress:

- Numerous geographical and organisational boundaries which can affect the same family (hospital v community services v GP v school) or the same street (near neighbouring families getting different care)

- Lack of clarity as to how and when and where to access healthcare services
- Lack of clarity as to whether first contact care should be from a general practitioner, a generalist paediatrician or a specialist
- Lack of formal paediatric training amongst GPs due to short training programme
- Focus on adult targets and remuneration structures such as payment by results
- Inappropriately trained or under-trained workforce
- Too many hospitals with emphasis on 24/7 acute care
- Insufficient medical staff and appropriate posts to be European Working Time Directive (EWTD) or consultant contract compliant in 2009
- Inability to provide trained staff at frontline, particularly out of hours
- Insufficient staff available to provide community based services
- Community paediatricians regarded as too specialised
- Silos of professionals and fixed ways of working
- Insufficient reliable data regarding caseload and case mix
- Poor information systems on public health indices (immunisation rates)
- Inadequate joint commissioning by Health and Local Authorities
- Undefined or unclear pathways and bundles of care
- Insufficient shared care primary/secondary/tertiary and health/social/education
- Lack of systems for transitions (for child and parent) baby/child/young person/adult
- Tension between contestability (Department of Health) and cooperation (Department for Children Schools and Families)
- Professionals working within walls
- Insufficient capacity in specialist centres (e.g. level 3 Neonatal units, level 4 Child and Adolescent Mental Health Service)

The following represent key enablers if a world class service is to be achieved:

- Packages of care which:
    - Are led by capacity to benefit
    - Are jointly costed and funded between relevant providers and commissioners
    - Are jointly regulated
    - Move with child to new borough of residence
    - Include health promotion and tackling inequalities

- A workforce which
    - Is competent to provide generalist and specialist care in primary, secondary and tertiary child health services in hospital and in the community
    - Is sufficiently resourced to provide appropriately trained and experienced personnel at each point in the pathway
    - Is EWTD compliant at all levels
    - Has agreed the respective roles of GPs and paediatricians in providing primary and first contact care to children and young people

- Systems which include:
    - Redesigning the balance between sites that provide acute and long term care Integrated (commissioner, provider, regulator) child and family health centres with generalists and specialists providing planned and unscheduled care, close to home where possible, in specialist centres where necessary
    - Managed clinical networks of services with joint management boards, agreed standards and protocols and agreed referral patterns
    - Cooperation between health, education, social services and the third sector
    - Defined roles for children's centres, schools and special schools
    - Formal interagency working
    - Clinical coordinators (for condition/needs provision) and key workers (for child and family)
    - Quality information for epidemiology, resources and individual management

    - Integrated care records which respect confidentiality, but effective communication between health, social services and education
    - Transport for patients and relatives

- Financial arrangements which can provide:
    - Jointly agreed inclusive packages of care
    - Payment by Results, Practice Based Commissioning and Choice systems which work for children with Long-term conditions

- Leadership in children's services:
    - From paediatricians as clinical and medical directors
    - From other healthcare workers
    - From managers and Chief Executives
    - From directors of children's services and from children's trusts
    - From commissioners at SHA and PCT level
    - From clinical champions for innovation and improvement

- Valuing world class contributions
    - Protecting academic careers through academic fellowships an lectureships
    - Promoting understanding of clinical research amongst CYPP and parents
    - Commissioning and fostering healthcare research

Joint Strategic Needs Assessments (JSNA) will become the process by which PCTs and Local Authorities describe the future health care and well-being needs of local populations, using local and national data on patterns of health and disease.

The NSF also recommends that each health economy develop a Local Clinical Managed Children's Clinical Network to meet the needs of the local population, and that each network should have explicit links to wider services for children provided by other agencies. Networks provide a mechanism for promoting collaborative working, albeit in a climate of competition, and will be key to future service delivery. Real and meaningful clinical engagement is crucial as, given an opportunity to innovate, highly determined managers and clinicians are able to use influence and change practice within local health systems.

There are many examples of networks both nationally and internationally from which lessons can be learnt. There is also an extensive literature on network development and factors which underpin their success or failure. Crucial to success are productive relationships between clinicians and commissioners.

For children's services to function effectively there should be integration at all levels of provision and across all agencies. This can be achieved with strengthened commissioning, productive clinical-commissioning relationships, and strong leadership.

12.3 Report of the Mental Health Clinical Care Pathway Group

In the original *A Framework for Action*, the mental health pathway report was written and researched primarily by mental health trust Chief Executives. Despite many of them having been clinicians, it was felt that a new report, relying on currently practising clinicians, would be beneficial. The Mental Health Clinical Care Pathway Group (MHCCPG) was asked to:

- review an evidence base comprised of a summary of available research studies/evidence; international case studies; and comparative data;
- identify what practice already exists which matches the evidence;
- identify what currently does not exist;
- identify what prevents this happening – structural, organisational, and other issues;
- describe what needs to happen locally and nationally in order to deliver the optimal pathway; and
- review and comment on the recommendations for models of care and delivery set out in *Healthcare for London: A Framework for Action* in light of the group's recommendations.

The MHCCPG report is attached (**Appendix 8C**). It supports and expands on the original working group report summarised in *Consulting the Capital*.

The MHCCPG recommends further work be commissioned to bring the report to a point where it can impact on and improve treatment and care. The group also recommends:

- Investment in a full and sustainable information campaign using modern communication methods to raise public awareness of mental health needs, and to reduce stigma and discrimination;

- Once developed, make information on clinical care pathways easily available to people entering assessment and treatment;

- Give far greater emphasis to the views of service users and carers in identifying needs with advance personal care agreements implemented for all;

- Ensure assessment procedures are substantially redesigned to produce consistency and reduce variation. This requires a new focus on training in expert needs assessment, diagnosis, the routine use of outcome scales, and the related application of competency standards;

- Invest in a system of collaborative benchmarking to raise the standard of care pathway choice;

- Develop a system of care where assessments include an evaluation of physical as well as mental health needs;

- We need to pay attention to the labels we give service pathways selecting these, in consultation with service user groups, ensuring they are meaningful, well understood, and not stigmatising;

- We need investment in the workforce to deliver evidence-based skills, particularly in working with clinical guidelines and protocols which will be nested as components within overall clinical care pathways;

- Where the evidence supports more than one type of intervention at any clinical care pathway stage then these should be offered as choices to service users;

- The model contract for mental health should be developed to positively support clinical care pathway development;

- The interventions delivered to people needing the treatment and care contained within a particular clinical care pathway should be available regardless of where the person lives. This will require a fresh look at the funding formula which varies payments to providers ensuring it more closely reflects actual variations in complex needs on the ground;

- The effective working of clinical care pathways is likely to require formal agreements (more advanced partnerships) between the relevant agencies on what will be delivered, especially from healthcare, social service, housing and criminal justice system service providers;

- Models of care coordination that use regular reviews of needs should be assessed using minimum standards, continually checking the appropriateness of the choice of care pathway. It is important that the potential for exit from a pathway is considered at each review;

- There is a clear need to make exit and re-entry arrangements clearer and easier from the perspective of service users and family members. This approach is sometimes called ‘Easy in-easy out’;

- One fundamental aspect of clinical care pathways is the underlying system of categories applied to clinical casemix groups (which may also be used for Payment by Results and related purposes). There is an immediate need to agree on these categories to avoid the local development of pathway groups that are incompatible between providers or regions. This is likely to require, at an early stage, an initial substantial investment to ensure that: the casemix groups (i) are optimally evidence-based; (ii) are usable in practice for clinical care pathway development and implementation; and (iii) are practicable to support the relevant commissioning and financial arrangements;

- Relatively little is known internationally at present about how to create clinical care pathways in a manner that best supports their implementation and routine use in the long term, so further information needs to be gathered at this; and

- NHS London may benefit from working across the capital with a range of pilot sites on the introduction of a small number of clinical care pathways in the first case with a focus on identifying good practice that enhances clinical engagement and implementation.

12.4 Commentary from PCT Boards

This report (and accompanying appendices) were considered by the Board of each PCT represented on the JCPCT in order to inform the views of their representative. Many PCTs additionally presented the report to their Professional Executive Committee (PEC) to inform their discussions. Each Board was invited, if it wished, to send a commentary to the Healthcare for London programme office. These commentaries were used to identify errors, clarify issues and strengthen the report. The full commentaries received from Boards are attached in **Appendix 8D**.

Responses were received from 25 PCT Boards.

All Boards supported the direction of travel of Healthcare for London, with many being particularly enthusiastic.

The key themes emerging were:

- Although disappointed at the low level of responses, Boards accepted that this was to be expected in a consultation on a strategic vision, and that very large numbers of people had been engaged in the consultation and had the opportunity to respond if they wished;
- Support for the clarity of vision brought by Healthcare for London and appreciation of the flexible approach which would allow PCTs to develop plans to suit their local communities' needs;
- The importance of including social care in taking these proposals forward cannot be under-estimated. Careful consideration of funding and care pathways will need to be made before reconfiguration of any services;
- Partnerships are essential and further attention needs to be paid to the mechanisms required for making partnerships more effective across the NHS, local authorities, the criminal justice system, and the voluntary, charitable and private sectors;
- Recognition that Healthcare for London did not cover every aspect of health and social care. In particular there was concern over the lack of detailed proposals and demonstrable goals surrounding mental health and for young people, addressing long-term care for people with co-morbidities and the needs of people with a learning disability;
- Concern over the means at PCTs' disposal to deliver the recommendations – for instance finance (potentially double running some services); workforce and training (upskilling staff quickly enough or recruiting enough staff); and issues outside PCTs' sphere of influence – for instance under-utilised NHS estates, the economy, IT infrastructure;
- Insufficient focus on child mental health, end-of-life care and health improvement – as opposed to health services;
- Concern that there were no specific recommendations as to how inequalities might be reduced;
- Belief that Healthcare for London was consistent with current PCT plans. PCTs were keen to ensure that future Healthcare for London consultation did not hold up locally agreed developments; and
- The diversity of communities should be recognised more explicitly. This will be essential in taking forward proposals for new pathways.

13 Report of the Clinical Advisory Group

The JCPCT noted the establishment of the Clinical Advisory Group (CAG) at its meeting of 21 November 2008 (**Appendix 1F**).

The CAG was established to advise and support the consultation, development and implementation phases of the programme. It reports, through its chair, to the London Commissioning Group (LCG).

The CAG has approximately 35 members from a broad mix of professions, specialities, care settings and geography to ensure it can speak with authority built on an appropriate breadth of knowledge and expertise.

Members not only bring their particular profession or area of expertise to the group, they also apply their experience and expertise to a wide range of topics. All group members have experience of clinical practice and a good clinical and professional reputation.

Members were selected through interview from over 100 applicants. CAG is co-chaired by Sir Cyril Chantler (Chair of the Board of the Great Ormond Street Hospital and of the King's Fund) and Trish Morris-Thompson (Chief Nurse and Professor of Nursing and Midwifery, NHS London). The full list of members can be found on www.healthcareforlondon.nhs.uk

At its meeting of 20 March 2008 the CAG agreed to prepare a report on its clinical and professional view of the consultation responses – bearing in mind any additional evidence that had come to light during the consultation.

Each member of CAG was assigned to be part of a group and each group looked at a care pathway or 'where we could provide care'. The report was considered on 8 May 2008 at a meeting of the CAG, the PPAG and invited voluntary organisations.

The report (**Appendix 9**) is supportive of the Consulting the Capital proposals. In providing evidence in support of the need for change, the group makes recommendations for each of the patient pathways and provides a steer for how the proposals could be developed and considerations for future implementation.

The report highlights the need for strong evidence to underpin changes to London's healthcare and emphasises the importance of locally tailored solutions to meet local needs. Patient benefit must be the driver of change. Clinicians are clear that in developing high quality services, proposals need to be assessed to ensure they are clinically safe, deliverable from a clinical workforce perspective, affordable, accessible and able to deliver a quality of service that is fit for purpose.

The value of partnership working is another strong theme. The report recommends the continued engagement with patient groups, voluntary organisations and professional networks to develop proposals and learn from experience.

14 Report of the Patient and Public Advisory Group

The Patient and Public Advisory Group (PPAG) was established on 17 October 2007. Its terms of reference (**Appendix 1E**), were noted at the JCPCT on 21 Nov 2007. Essentially its role was to provide advice and guidance throughout the consultation to the Director of Communications and to the London Commissioning Group (LCG) – three members of the PPAG were elected to sit on the LCG.

The group:

- Advised on the construction of the consultation document and approved it;
- Suggested amendments to the consultation strategy; and
- Requested changes to the implementation of the strategy e.g. requested additional advertising in Brent and the inclusion of a Rastafarian group in the traditionally excluded groups consultation by Health Link.

At its meeting of 18 March 2008 the PPAG agreed to prepare a report on its view of the consultation. The report (**Appendix 10**) was drafted by a small group of members at two meetings (with written contribution from another member). It was discussed at a joint meeting of the CAG, the PPAG and voluntary organisations on 8 May 2008.

The report commends the consultation:

> *"We believe that the whole process of this consultation has been more comprehensive than any previous one in London and have already recommended to the Department of Health that it should in turn publicise it to other SHAs as a model of good practice."*

The group highlighted the following issues:

- A number of issues had been omitted from the consultation regarding the prevention of ill health:
    - environmental issues such as atmospheric pollution;
    - problems regarding the seemingly bipartisan political approach to encourage the sale of alcohol; and
    - food additives.
- Health education, not restricted to sex education: The group wish to see all prospective teachers, scientists, engineers and architects taught about their responsibilities towards health. The group wish NHS London to enter into a close discussion with London University on how it can better promote health education throughout London.
- Involvement of the private sector: The group believe that Londoners basically support a public health service funded from taxation and is well aware that such services do not exist in much of the world. However the group acknowledged that "private equals good; public equals bad" is mere ideology and untrue. Either private or public may be good or bad, that is a matter of good administration. So, whilst accepting the private sector had a role to play, the group did not want the basis of the NHS to be eroded.
- Finance: More needs to be spent on mental health and on deprived areas of London – rather than on prosperous areas.
- End-of-life care: Whilst the patient's point of view is of great importance, it needs to be balanced with the wishes of carers and family and the provision of each relevant local authority.
- Immunisation: Immunisations are, in general, desirable; but it is not clear that they are all equally desirable. If immunisations are sufficiently important, parents' choice of method should be available to them.

- Polyclinics: The group welcomed the proposal of ten polyclinics, particularly to investigate governance arrangements and the minimum, optimum and maximum size of practice. However it was concerned if all PCTs were piloting the service, as to have too many pilots would make it difficult to assess them.
- Relationship between patient and GP: It is vital to ensure that responsibility for individual patient care is clear and accountable.
- Academic Health Science Centres: All research should be published openly and applied research should not be limited to one area of the country and specified institutions.

The group additionally wished to point out that the introduction of LINkS to replace Patient Forums was: "…*only one of many NHS examples of sudden administrative change sought too quickly for the processes of legislation and executive action to catch up.*"

The group welcomed Healthcare for London's commissioning of additional reports on children and young people, and on mental health; and the co-operative attitude of Healthcare for London to patient and public involvement.

15 Health Inequalities and Equalities Impact Assessment

Health inequalities and equality impact assessments (HIIA and EqIA) are powerful planning tools that support decision makers. They can help ensure policies, strategies and/or plans are designed in ways to maximise the beneficial effects, and minimise adverse effects, on health and inequalities.

The aim of the HIIA/EqIA is to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process.

London Health Commission (LHC) was contracted to provide an independent HIIA/EqIA which aimed to deliver evidence-based recommendations by:

- scoping the exercise;
- performing a rapid review and appraisal of evidence (**Appendix 11C**);
- establishing a baseline health equity profile (**Appendix 11B**);
- arranging a stakeholder workshop; and
- preparing the HIIA/EqIA report (**Appendix 11A**).

The report considers the impact on equality groups: it not only assesses the impact on race, disability and gender equality, as statutorily required, it also assesses the impact on age, faith and sexual orientation equality.

In particular the LHC noted that:

> *"While the implementation of the proposals in full is likely to improve health outcomes, their partial implementation could further exacerbate health inequalities. For example, a move to earlier discharge after stroke without an improvement in home support could lead to an additional burden on carers, who are themselves a vulnerable group whose health need are often unmet.*
>
> *At this stage the LHC recommends that Healthcare for London increases consideration of health improvement for all Londoners and has particular regard to equality groups."*

15.1 Overall Recommendations

- Ensure the implementation of Healthcare for London reverses the inverse care law. Deprived areas need high quality health services and levels of provision that reflect the higher level of health need their populations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.

- Work throughout the NHS in London to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority. London PCTs should explore with NHS London the possibility of using the QOF system to negotiate a London-wide incentive system to report equalities data as part of their reporting systems. PCTs and NHS London must prioritise improving routine data collection and analysis on the equalities groups.
- Ensure that local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in

the local population and which groups are currently not accessing services. This will require PCTs to undertake local health equity audits and health inequality impact assessments. Resources and services must then be targeted to meet this unmet need.

- Ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.
- Ensure that mainstream services are designed to meet the needs of traditionally-under-represented groups by taking account of low income, stress, social isolation, cultural sensitivities, lack of transport and poor access to exercise facilities.
- Ensure mainstream services are targeted at deprived areas, communities and vulnerable groups. Access is of paramount importance in London as the population is highly mobile: a model of passive service delivery will not reach all equality groups and the HIIA/EqIA recommends service delivery that includes effective outreach.
- Ensure extra funding and incentives are made available to ensure healthcare commissioners and providers do target these groups.
- Ensure that reducing health inequalities is included as an explicit objective in local plans for the implementation. NHS London needs to agree indicators for this objective. The focus of these indicators should be should be on better outcomes for client groups.
- Ensure service infrastructure developments and reconfigurations re-provide existing inadequate and inaccessible premises.
- Ensure planning for accessibility by public transport is included in an early stage of the development of polyclinics. Transport plans should be developed for each polyclinic and other major healthcare facility. Transport for London and NHS London should work together to provide PCTs with guidance on how to do this.
- Ensure that when planning the reconfiguration of services, all Primary Care and NHS Trusts are fully aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000, Section 3 of the Disability Discrimination Act 2005 and Part 4 of the Equality Act 2006.
- Ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

15.2 Recommendations on issues outside the scope of the HIIA/EqIA.

- Ensure that the potential impacts on health and health inequalities of the proposals included in *Healthcare for London: Consulting the Capital* that are outside the scope of this rapid evidence review and appraisal are examined.
- Ensure that proposals relating to child health and development take account of the high rates of child poverty in London and address the health needs of children living in poverty.
- Undertake more detailed modelling to explore the net job loss or gains, which areas they are likely to occur in and which equality groups may be affected.
- Ensure that PCTs undertake local impact assessments on proposed changes to individual services or sites to assess the effects on employment and local economies.

- Ensure that the environmental effects of reconfiguring health services are considered as part of any further impact assessments: transport and biodiversity are key areas of concern.
- Work with the NHS Sustainable Development Unit to identify how the reconfiguration will enable physical, social and environmental sustainability to be a core part of the NHS business case.

15.3 Priority issues and actions

Issue and action	Indicative Milestone
Priorities and resources 1.1 In the service reconfiguration associated with implementation of Healthcare for London (HfL), resource allocation and redistribution should be strongly needs-led and reflect the higher levels of need in deprived communities and equality groups.	Resource allocation and redistribution to reverse the 'inverse care law', to reduce health inequalities and towards health improvement and prevention services, identified as a key feature of world class commissioning for the NHS in London.
1.2 Increase mainstream investment to ensure mainstream provision of preventive services and health promotion as an explicit strand throughout each model of care and care pathway; and targeting those with greatest needs.	HfL and PCTs to develop clear and robust plans to increase mainstream investment in prevention and health promotion.
1.3 Provision of services that prevent ill health and promote good physical and mental health for equality groups should be strongly incentivised.	New incentives identified in further development and implementation plans for HfL.
1.4 Health improvement services to take account of the wider, social determinants of health, and work with target communities and groups to develop appropriate health improvement programmes.	Increase in investment in 'community-led' models for health improvement based on community perceived needs and evidence-based (or evaluated) solutions.
Assessing and meeting (diverse) needs 2.1 The local NHS to take proactive steps to identify and include the (unmet) needs of equality and vulnerable groups in decision making, planning and implementation of HfL.	Needs and unmet needs of equality and vulnerable groups prioritised within further development and implementation plans for HfL.

2.2 Identification of, and action to meet, unmet needs to become an ongoing priority in routine planning and commissioning processes.	Mechanisms for identifying unmet needs of equality and other vulnerable groups explicit within mainstream planning and commissioning processes. All NHS services subject to regular Health Equity Audit.
2.3 Joint Strategic Needs Assessments (JSNAs), which are informed by public and patient experience, should specifically include the experience of equality and vulnerable groups.	Experience of equality and other vulnerable groups is explicit within all JSNAs.
2.4 Increase investment in awareness and capacity building programmes to ensure that all NHS Trusts are fully aware of, compliant with, and proactively develop capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000, Section 3 of the Disability Discrimination Act 2005 and Part 4 of the Equality Act 2006.	All NHS Trusts in London fully compliant with RRA, DDA and EA.
Monitoring and evaluation 3.1 NHS London should establish a set of routinely collected outcome indicators for PCTs to monitor improvements in health and well-being, and reduction in health inequalities, of equality groups. PCTs performance managed against these improvements. Mechanisms to be found to make better use of existing data; eg GP data (beyond QOF requirements).	Agreed indicator set and regular accessible reporting as part of PCT performance management.
3.2 NHS commissioners should require all providers of NHS commissioned care to collect, evaluate and report, accurate and comprehensive equalities data.	This requirement embedded in all contracts with service providers.
3.3 Process of health inequalities and equalities impact assessment to be undertaken on all aspects of HfL; this should include, as first priority, the proposed new models of care relating to mental health and to children's services. HIIA and EqIA must be ongoing at all stages and levels of development and implementation of all aspects of Healthcare for London and beyond.	HIIA/EqIA to be completed on the proposals for mental health and for children's services when they are published. Coordinated programme of HIIA and EqIA to be agreed for the different stages and at the different levels. N.B. LHC can advise on this forward programme of impact assessment.

Geographic proximity to services versus access to an increased range, more specialised and/or better quality services. 4.1 E.g. In relation to polyclinics, PCTs should identify who gains and who loses from the trade-off between geographic proximity to primary care versus access to an increased range of services and how this is managed to ensure equity and equality of access.	Consideration of these issues/trade-offs to be explicit in the plans for further development implementation of HfL.
Workforce Skills and Capacity 5.1 Prioritise innovative workforce development plans to support delivery of the HfL service strategies at pan–London and local levels. Existing and new workforce and skills to be distributed across London according to health need. E.g. to improve access to primary care in disadvantaged communities. Local workforce plans designed to secure workforce which is reflective of the diversity in local populations and sensitive to their care and wider social and cultural needs.	Health inequalities and equality issues explicitly addressed in workforce development plans that are sustainable, can be monitored, and have clear lines of accountability.
Joint working with social services 6.1 Acknowledge the impacts of HfL reforms on families, carers, community and social care services, particularly for equality groups, other disadvantaged and vulnerable groups. 6.2 Proactively seek to ensure that adequate NHS resources are in place to enable good quality care in the community. 6.3 Maximise the opportunity to align with the social care reform agenda.	Impact assessment and ongoing monitoring and evaluation to include consideration of impact on other local services.
Service accessibility 7.1 All NHS funded care to be accessible to equality groups: including, but not limited to, physical access requirements, language support services and the needs of those with sight and hearing restrictions.	HfL to go beyond the minimum statutory requirements for access and to set high standards for service accessibility for ALL disadvantaged and equality groups. London PCTS and NHS Trusts to collectively sign up to and invest in the London Language Support Services Strategy (a cross public sector strategy developed by LHC).

7.2 Provide incentives and invest in outreach activity that: proactively seek to increase access for the most disadvantaged and for all equality groups; engages people from these groups in initiatives that promote health; and identify and respond earlier to health risks.	Mainstream models of outreach for key services (to reach equality and other disadvantaged groups) in place as part of implementation of HfL.
7.3 Work in partnership with other agencies to provide effective outreach services.	

16 The Healthcare for London vision

Having listened to the views expressed in the consultation, we believe that health and healthcare in London must be improved. Our vision is a health service where:

- **Ill health is prevented as much as possible.**

Patient groups have stressed that much illness is avoidable and the NHS must work with its local authority and other partners and Londoners, to create better and more targeted programmes for health improvement, particularly aimed at sections of the population most at risk and where inequalities are most profound. The NHS must play its part and ensure that a healthy environment where people can be treated. Facilities should be clean, seen to be clean, pleasant to visit and environmentally friendly.

- **Primary care is comprehensive, accessible and of excellent quality.**

There is some excellent primary care in London but standards are variable and there is patchy access. We need to put primary care at the core of the NHS in London, delivering more services closer to people's homes. We recognise that the improvement in primary care will be developed differently in different parts of London and agree that one form of primary care will not fit every part of the city. In line with the responses we have received we will be developing different ways of providing polyclinic models (including networked) according to local circumstances and will ensure that continuity of care is there for those patients who wish it.

- **Improvement in care is evidence-based, clinically-driven and patient-led and provided in the most appropriate settings.**

Medicine is dynamic. Science and technology provide real opportunities for improvement; as do new working practices, better training and new partnerships. In the last ten years survival rates from heart attacks have improved dramatically. Now, many people who would have died because of their head injury, can survive. A world city such as London should be able to provide the specialist services in appropriate settings that ensures Londoners' health care is at the cutting edge of medicine. This change must be led by clinicians and patients. Services must be localised wherever possible, but regionalised where necessary.

- **Healthcare is focused on individual needs and choices – and is coordinated.**

Consulting the Capital proposed a coherent approach to the improvement of health care. Responses from Londoners argued that there are vital interdependencies between services. Individual PCTs need to develop service plans for improvement in their localities ensuring that they consider the effect on both local and regional health economies. This is especially important in the development of joint approaches by the NHS and its partners.

- **Improvements are properly resourced.**

Each development needs to demonstrate how it can work in the planned financial resources for the NHS, and demonstrate in a clear way how these resources play a part in the overall NHS financial planning in London. None of these improvements in health and healthcare will take place without the hard work of NHS staff; they are often at the front of arguments for improvement. All future plans must recognise that any move from services based within the acute sector into the primary sector will involve changes in the way in which many thousands of staff work. Their active involvement in the implementation of these improvements will be vital. To maximise the contribution of the entire workforce there must be better partnership working with the voluntary sector, local government and many other organisations with an interest in the health of Londoners.

- **Changes are carefully planned and implemented.**

The scale and nature of the changes we are seeking demands meticulous planning and careful implementation. We will ensure that the transition from existing to new delivery models does not result in even a temporary reduction in service availability or quality. We will need to recognise the complexity of the issues and interdependencies whilst still working at an appropriate pace. We will involve our staff, our stakeholders and services users in all our processes for change.

17 Decisions and recommendations

This chapter:

A Considers the consultation processes, the main reports to be considered by the JCPCT to inform its decisions and the principles of Healthcare for London.

B Discusses the case for change and how we might improve the health of those most in need.

C Considers each of the care pathways and 'where we could provide care' as described in *Consulting the Capital* by:

- Presenting the original recommendations;
- Summarising some of the key issues from a range of sources including;
    i. The consultation (individual and organisational responses, Health Link report into traditionally under-represented groups, meeting reports);
    ii. The Joint Overview and Scrutiny Committee;
    iii. The London Health Commission's Health Inequalities and Equalities Impact Assessment; and
    iv. Healthcare for London's Clinical Advisory Group and the Public and Patient Advisory Group report;
- Drawing together some conclusions; and
- Proposing issues for decision or recommendation.

D Considers how we might turn the vision into reality. Again presenting the original remarks, summarising some of the issues for the JCPCT to consider and drawing together conclusions and recommendations or decisions.

Please note, as stated at the front of this document, "the use of quotes throughout the document is to illustrate points, they do not necessarily reflect a balance of all opinions or signify that Healthcare for London supports their sentiment". Quotes are included to give a 'taste' of diverse views expressed.

We obtained a broad range of information and perspectives and a large diversity of experience in terms of: age, gender, ethnicity, religion, socioeconomic status, experience of healthcare and participants' locality within London. Some responses were made by 'ticking a box' to make a difference to a percentage, others were carefully considered and crafted responses by eminent organisations. All were welcomed. Responses were analysed through an iterative process of comparison that identified issues that participants pinpointed as important. The purpose of analysis was to provide explanations, highlight influences, and discover contributing factors. Some views were explicit, with clearly presented reasoning in the response. Others were implicit – and constructed by considering interweaving, the absence of something which was present in other accounts, logic, common sense or evidence.

Different readers may draw different conclusions from the evidence presented – all of which is available online at www.healthcareforlondon.nhs.uk

A – The consultation process, the reports to be considered by the JCPCT and the principles of Healthcare for London

This report (in particular chapters 6 – 15) and accompanying appendices, detail the extent of the consultation. The consultation included hundreds of meetings with members of the public, patient groups and NHS staff and their London representatives. Responses were received from over 350 groups and 4, 300 individuals as well as over 300 responses to enable Health Link to compile its report. Meetings were held with over 10, 000 people and over 20, 000 people logged onto the Healthcare for London website.

The consultation has produced a wealth of information. For instance, the Ipsos MORI analysis by PCT alone runs to 300 pages. The Health Link report breaks new ground in its consideration of traditionally excluded groups. We particularly commend the Framework of Needs (described in Chapter 11.3) to PCTs to inform their future commissioning of services.

The recommendations and priorities described in the Health Inequalities and Equalities Impact Assessment provide excellent guidance to commissioners of services and we commend in particular the recommendations in Chapter 15 of this report.

These reports should be working documents that are referenced by all those interested in building better health services for Londoners.

We recognise that Healthcare for London does not, and cannot, discuss all health provision in the capital. For instance, the Patient and Public Advisory Group drew attention to lack of discussion on issues such as the environment; the sale of alcohol, food additives; and health education (other than sexual health). Others highlighted the lack of a specific chapter on the needs of older people:

> *"Given that older people are the biggest group of NHS users, we see a distinct lack of explicit reference to their needs."*
>
> Counsel and Care

Some respondents also questioned the lack of discussion regarding bureaucracy; reducing waiting times; improving cleanliness; ending the 'postcode lottery'; and maintaining the provision of services within the NHS (both health related and others such as cleaning and maintenance.

Conclusions

Overall, tremendous effort was made into ensuring the consultation was stimulating, open and honest. Preceding chapters evidence the thoroughness of the consultation and the quality of the responses made. The consultation achieved its aims, namely that:

- stakeholders were informed about, and could influence the proposals;
- the consultation process was timely and legal;
- the resulting recommendations are the best options and include the best ideas from stakeholders;
- the resulting recommendations are supported by as many stakeholders as possible; and
- duplication of effort in consultation has been avoided and existing knowledge and services utilised.

We believe that the consultation has led the way in innovative ideas to engage with communities. The 'Chalk and Cheese' campaign, the work by Health Link into the needs of

under-represented group and the use of roadshows have all played a part in making the consultation such a success. We hope that future consultations are as innovative and engaging as *Consulting the Capital*.

For decision

The JCPCT:

1) accepts the Ipsos MORI report on consultation responses.
2) accepts the Health Link report on traditionally under-represented groups.
3) accepts the Joint Overview and Scrutiny report and commissions Healthcare for London to prepare a response.
4) accepts the London Health Commission's Health Inequalities and Equalities Impact Assessment and recommends that Healthcare for London, NHS London and PCTs take into account its findings and actively work to reduce inequalities when developing services.
5) accepts the report of the Clinical Advisory Group and recommends Healthcare for London, NHS London and PCTs take account of the report when developing services.
6) accepts the report of the Patient and Public Advisory Group and recommends Healthcare for London, NHS London and PCTs take account of the report when developing services.
7) accepts the consultation process was appropriate and met all the requirements of a valid consultation.

17.1 The principles of Healthcare for London

The majority of respondents agreed with the five principles:

- Prevention is better than cure;
- Reduce health inequalities;
- A focus on individual needs and choices;
- Joined-up care and partnership working, maximise the contribution of the entire workforce; and
- Localise where possible, regionalise where necessary.

Some respondents, whilst supporting the focus on individual needs felt that societal needs should override individual needs, whilst others pointed out that there is a difference between 'choice' and 'need'.

And some respondents questioned whether the evidence was available to show how the proposals would meet the principles or meet health inequalities.

> *"Agree with principles – no evidence of how this will work in reality."*
>
> Female, aged 35 – 44

A minority felt that sustainability and the environment should also be considered in all that the NHS does – something that the JCPCT would support.

Other suggestions were; a focus on best value; use of resources and quality; use of an evidence base for decision-making; and involving patients and partners.

For decision

The JCPCT:

8) agrees that the principles of Healthcare for London, and the vision described in this document, should drive the ethos of the programme and underpin its development. In particular, PCTs will need to become better partners in their local community, working with councils, the voluntary sector and others to understand and implement what will deliver the best health of their population, irrespective of economic, social and organisational boundaries.

B – The case for change

Healthcare for London: Consulting the Capital accepted Lord Darzi's report *A Case for Change* and its proposal that there are eight main reasons why the NHS in London has to change.

The consultation drew overwhelming support for this view and a belief that change in London's NHS is long overdue. The public, stakeholders, Joint Overview and Scrutiny Committee and clinicians saw the need to reform services and deliver lasting change.

> *"UNISON supports the five common principles…of the report and the need for current provision to improve to meet the health needs and expectations of Londoners over the next 10-15 years."*
>
> UNISON

> *"There is over-whelming support for change."*
>
> Royal College of Nursing

> *"Lord Darzi presents a compelling case why London's health services must change."*
>
> Joint Overview and Scrutiny Committee

However a note of caution was made in the HIIA/*EqIA,"While the implementation of the proposals in full is likely to improve health outcomes, their partial implementation could further exacerbate health inequalities…"* and a small number of respondents objected to the changes, or felt that change was happening too fast.

> *"Stop messing with the system and allow a period of consolidation without constant change."*
>
> Male, aged 65+

Issues for the JCPCT to consider

Whilst it is noted that partial implementation could further exacerbate health inequalities, the Joint Overview and Scrutiny Committee recommended *"… a staged approach is undertaken to implementing new care pathways with, for example, 'polyclinics' piloted in a number of sites." and "The NHS must be clear and open so that it cannot be accused of implementing the HfL vision in a piecemeal fashion."*

Overall, respondents were concerned about the capacity of the NHS to deliver change in a timely and well-planned way.

Some respondents felt that change didn't go far enough, and there were other areas of healthcare that needed similar attention. For instance, dental committees expressed their concern over the lack of people attending for NHS dental treatment and urged PCTs to encourage dentists to treat children and disadvantaged groups.

> *"Dentistry should be a priority for the NHS, and adequate resources should be available to fund this."*
>
> The London Regional Group of Local Dental Committees

Conclusions and new recommendations

Whilst the JCPCT recognises that there is good support for change, it is also acutely aware that the NHS has not always been good at changing for the better.

For these proposals to succeed, the public and politicians need to be convinced that they will improve healthcare. Many people remain attached to the services provided at the moment, without being aware that there may be better and safer ways of providing them. Clinicians must have a central role in explaining the clinical benefits of new ideas to the public.

We recognise that we will need to involve and work with everyone with an interest in the NHS (and that should be all Londoners) to ensure that change is a positive experience and advances healthcare in the capital, not hinders it.

We also recognise that Healthcare for London does not tackle all the issues that might need to be changed. For instance we believe that Primary Care Trusts in most areas of London report very few complaints from people unable to find an NHS dentist and general availability of NHS dentists across London compares favourably to England as a whole. However we understand that there is an inequitable distribution of resources, caused by the historical decisions of dentists, who were free to set up practice in an area of their choice, rather than where the need was greatest. The new dental contract allows PCTs to commission services in line with local need.

Whilst accepting the need for change, the JCPCT is clear that the use of evidence in arguing for improvements should continue to be the hallmark of planning and implementation of improvements. It is also important that every aspect of these improvements is evaluated in a clear and transparent way and that issues of sustainability are carefully considered. However, we do not wish to stifle creativity and innovation and accept that in cases where evidence is lacking, piloting, robust processes of evaluation and continuous learning may well be a good solution.

17.1.1 The JCPCT recommends PCTs improve their capacity for data collection and analysis, and ensure providers of care regularly collect, evaluate and report accurate data. Monitoring the efficacy, effectiveness and efficiency of services and the health and well-being of the population is a key component to ensuring continuous improvement.

The consultation has built up both interest and expectation. We must not lose that excitement in changing the NHS. Organisations and individuals that have engaged with the consultation should be encouraged to continue to be involved in planning and considering changes in health services.

17.1.2 The JCPCT recommends an innovative campaign is launched to disseminate the recommendations of this consultation. The public must continue to be involved in processes to shape and implement future service developments.

For decision

The JCPCT:

9) accepts the case for change, and is clear that the use of evidence in arguing for improvements should continue to be the hallmark of planning and implementing services.

17.2 Improving the health of people from deprived communities* and disadvantaged groups, and their access to health services

* Deprived communities or disadvantaged groups included: people from black, Asian and minority ethnic groups; children and young people; disabled people; people from faith groups; lesbian, gay and bi-sexual people; older people; women and other vulnerable, disadvantaged, and marginalised groups in London.

Reducing health inequalities was a key theme of the consultation and a key reason why change is needed. However, many consultees were either unconvinced or not sure that the proposals would improve the health of deprived communities and disadvantaged groups, or their access to services.

> *"We recommend that NHS in London carries out further health inequalities impact assessments i) once detailed proposals have been developed, ii) a year after implementation of each new care pathway to demonstrate that reforms have reduced not increased inequalities, and iii) on a regular basis to monitor the long term impact of the reforms on inequalities."*
>
> *"We recommend that PCTs, local authorities and other partners are able to decide the appropriate models for providing access to GP and primary care services taking into account specific local circumstances.*
>
> *"We recommend that the NHS provides a commitment that reforms will improve access to and the accessibility of GPs, and reforms will not undermine the patient/GP relationship that for many is at the heart of the NHS."*
>
> Joint Overview and Scrutiny Committee
>
> *"VCS organisations that work with and advocate for the most disadvantaged communities are in an ideal position to provide the type of information to their clients that will help them to make an informed choice about the healthcare services they use."*
>
> London Voluntary Services Council
>
> *"A number of themes emerged about equalities and excluding factors across the NHS generally. These included failure to understand and meet the needs of disabled adults and children, including people with mental health problems. Choice of the gender of doctors was an important priority for personal or cultural reasons, but was not always available. There were complaints of disadvantage for some ethnic groups because of lack of interpreting and translation services, especially in GP surgeries. Some participants complained of stigma on the grounds of their sexual orientation. Among excluding factors which participants complained of were ageism by health service professionals and a failure to understand and meet the needs of carers and those with long term conditions for accessible care. People with basic skills needs reported that they needed extra support to help them cope with medication and written information."*
>
> Health Link report on traditionally excluded groups
>
> *"At this stage the LHC recommends that Healthcare for London increases consideration of health improvement for all Londoners and has particular regard to equality groups."*
>
> Health Inequalities and Equalities Impact Assessment

Conclusions and new recommendations

We know that the most deprived areas of London have the greatest health needs and need better access to healthcare. We know that some of the most deprived areas on London have the fewest GPs, the highest infant mortality death rates and the shortest life expectancy. Yet we have not shown to the public's satisfaction that the proposals in Healthcare for London will improve access for deprived communities and reduce inequalities.

In fact just 37% thought the proposals would improve access to health services for people from deprived communities and disadvantaged groups and 29% thought the proposed changes would improve the health of these groups.

Many respondents felt that the key to improving access to health services was related to education about health issues and breaking down cultural and language barriers.

The JCPCT agrees with respondents that employing staff that reflect all communities within London could make a positive difference.

The London Health Commission's HIIA/EqIA shows there is much to be done both to address current issues and future needs. The list of recommendations is challenging, from improving data collection and analysis to shifting resources to focus on deprived areas.

We are clear from the work by PCTs and Health Link, that improving the health of people from deprived communities and disadvantaged groups will require real dedication, not lip-service. For instance, equitable access for people with a sensory impairment and physical disability should be taken into account in the planning of future services and health and social care facilities.

> *"It was notable that some of the suggestions about new services are already supposed to exist, such as regular check ups for older people and medication reviews."*
>
> Health Link report on traditionally excluded groups

The NHS cannot tackle these issues alone. Only by working in partnership will we be able to meet the challenges head on. We are therefore encouraged by the number of organisations that expressed their willingness to work with the NHS to address these issues. Healthcare for London will continue to work with the London Health Commission to reduce the inequalities that are so clearly apparent.

17.2.1 The JCPCT recommends PCTs commission further health equalities and inequalities impact assessments when considering future service changes and redouble their efforts to reduce inequalities to ensure a sustained improvement in the health of the most deprived and disadvantaged individuals and communities.

C – Care pathways and where we could provide care

17.3 Preventing ill health*

* Whilst the original chapter in Consulting the Capital was 'Staying Healthy', it has been pointed out during the consultation that some people never have the opportunity to stay healthy as they are born with, or quickly develop, ill health.

What did we recommend in *Consulting the Capital*?

Partnership with local authorities and others is the most important factor in helping people stay healthy. For instance, we need to make sure that people with a manageable disease do not have to give up work, that new housing encourages a healthy lifestyle, and that people walk and cycle more. We need to encourage people to take responsibility for their own health and help them to do so.

We wish to work with the Mayor of London to address the priorities he set out in *Reducing Health Inequalities – Issues for London and Priorities for Action.***

We need to help carers in the valuable role they play, and ensure they are supported. Carers need good information, easily accessible and co-ordinated services, and the opportunity to live their own lives.

More money needs to be spent on preventing ill-health, particularly in the most deprived areas of London.

This could be done by:

- shifting the balance of expenditure from hospitals to prevention, as recommended by *Our health, Our care, Our say*; and
- analysing where funding is proving most effective in preventing ill-health and concentrating our efforts in these areas.

17.3.1 While most health improvement programmes should focus on local issues, there is a place for pan-London campaigns. For example, linked to the 2012 Games, London should lead an initiative focused on healthy eating and physical activity. And if the NHS expects the public to live healthy lives it should help and support its staff to do so.

Preventing ill-health must be part of all patient care

17.3.2 Health improvement should be part of the course for all students training to become health professionals and it should be an important part of professional development. This would help and encourage them to become more involved in improving the health of their patients. Older people with the common problems of ageing – poor hearing, eyesight, teeth and feet – should be given good advice and services to put the problems right, whichever health professional they visit. We could help make this happen by locating opticians, dentists, and hearing-aid services in the same place, for example in a polyclinic.

** Please note that this is an extract from *Healthcare for London: Consulting the Capital* and refers to the previous Mayor of London's report.

17.3.3 Health improvement initiatives also need to reach people who are not ill. So they should be delivered by more people:

- for instance, pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, or health visitors; and
- working in more places – for instance in schools, leisure facilities, the workplace or prisons.

17.3.4 Smoking is the main cause of preventable death in the UK. 'Stop smoking' aids and education are needed to help people give up smoking. We also need to work with partners to reduce people's exposure to second-hand smoke. Smokers should be encouraged to stop before they have an operation.

Sexual health

17.3.5 We believe we need to tackle the rising rates of sexually transmitted infections by:

- encouraging more people to use contraception and condoms;
- improving information about healthy living and the services available;
- improving access to services (for instance, longer opening hours); and
- improving the services themselves.

Health protection

17.3.6 We believe London health organisations and their partners need to continue focusing on health protection – for instance, improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.

Responses to consultation and key issues for the JCPCT to consider

Individual respondents to the consultation welcomed the focus on prevention and were keen to make a number of changes to improve their health, particularly exercising more, reducing stress, losing weight and improving their diet.

Almost three-quarters of respondents would welcome advice from health professionals about how to stay healthy. Younger members of the community and those from Asian ethnic groups were most likely to agree they would welcome advice when they come into contact with healthcare professionals.

Advice on giving up smoking, reducing alcohol intake or improving sexual health were not seen as priorities by respondents. Well-man clinics were suggested to engage men – who are a notoriously reticent group.

Respondents thought that the NHS could help in a number of ways including:

- providing or working with others to provide exercise facilities e.g. swimming pools, playing fields, gyms;
- working with organisations to encourage healthier lifestyles e.g. cycle lanes, improving working conditions, reducing pollution and advertising of unhealthy lifestyles;
- providing early diagnostic testing and screening; and
- making constructive information available (although respondents were clear that this must not be patronising). Many respondents said they knew what would make them healthier, they needed advice on **how** to make those changes.

"I need to lose a few pounds. I don't need advice that I need to lose a few pounds."

Male, aged 45 – 54

The importance of wider societal change (e.g. housing, poverty and education) was also mentioned and the value of alternative or complementary medicine. Encouragement to better recognise the part that complementary medicine can play was a theme through many of the care pathways – particularly in staying healthy and long-term conditions.

However some people felt that it is the responsibility of an individual to look after their own health.

"LMCs were strongly supportive of measures aimed at smoking cessation, weight loss and increasing exercise levels, through the provision of exercise referral schemes, subsidised gym membership and measures to facilitate the use of bicycles."

Londonwide Local Medical Committees

"In the cardiac and stroke arena a greater emphasis on primary prevention is needed."

NCL Cardiac and Stoke Network

"We recommend that NHS London sets a minimum level of expenditure that PCTs must commit to a) helping people lead healthy lives and b) helping patients manage their long-term conditions. This will involve close working with partners such as local authorities."

Joint Overview and Scrutiny Committee

Key stakeholders focused on the importance of partnerships and the significant role that could be played by a wide range of healthcare professionals.

"We therefore welcome the idea that the NHS at all levels in London will advise, support and work alongside local authorities and the Mayor of London, who have direct responsibility for services such as public transport, urban planning and leisure facilities, to ensure that they deliver improvements in health."

King's Fund

Conclusions and further recommendations

It is encouraging that so many people recognise the importance of lifestyle on their health – but it is another matter to persuade people to do something about it. Access to information and services, provided by the right person, in the right way, at the right time with support from a variety of organisations will be essential if we are to improve the health of Londoners. And designing initiatives that encourage lifestyle changes will be a particular challenge.

Partnerships with local authorities and others (for instance the voluntary, charitable, and private sectors) was proposed as the most important factor in preventing ill health – there appears to be little argument against this.

17.3.7 The JCPCT recommends PCTs work with local authorities, the GLA, the Mayor and with local voluntary and community organisations to prevent people becoming ill, to address health inequalities and to engage with people who might not otherwise enter the healthcare system. Polyclinics or wellness centres may help in reaching out to these people, encouraging them to take better care of their health.

Sustained investment is needed to make a difference, especially in areas of greatest need. We also highlight the need for proper evaluation of projects, and sharing of knowledge of what works and what doesn't – so that each PCT can build on the work of others.

In order to bring about results we recognise the need to shift the emphasis of NHS expenditure to prevent people from becoming ill, and provide more cost-effective services. As a general principle we must ensure that it is not difficult or expensive to remain healthy.

We recognise childhood obesity as a very important issue which has the potential to have a huge impact on healthcare services in years to come.

17.3.8 The JCPCT recommends PCTs consider the responses to the questions in the Staying Healthy chapter of *Consulting the Capital* when planning future services, in particular the value that evidence-based alternative or complementary medicine could play.

17.4 Maternity and newborn care

What did we recommend in *Consulting the Capital*?

17.4.1 Expectant mothers should be offered:

- an early assessment by a midwife to ensure their care is right for them; and further assessments during the course of the pregnancy;
- information to enable them to make informed choices, for instance, about the relative benefits and risks of different locations to have their baby and about pain relief;
- care before birth provided at local one-stop centres;
- services that meet their choice of where they give birth – for instance, at home, in a midwifery unit, or in an obstetric (doctor-led unit);
- care with the same team from early pregnancy until after the birth whenever possible;
- one-to-one midwifery care during established labour;
- care following birth in local, one-stop centres as well as at home.

Taking into account the Royal College guidance, the expected increase in births in London over the next ten years, and the concentration of population in the capital, we believe we should be able to provide mothers with an excellent service while still ensuring they can get to a doctor-led maternity unit within a reasonable travel time.

17.4.2 All professionals involved in birth should be competent in basic newborn (neonatal) life-support skills.

Where care should be provided

Staff who are experienced in dealing with difficult births can provide the best quality care for women with complications. To ensure units have experienced staff and are affordable, we think we will need slightly fewer doctor-led units in London than we do now. We cannot say precisely how many fewer at this stage because detailed examination of specific services is needed.

17.4.3 To balance this change there should be more midwife-led units and more support for home births. All doctor-led units should have a partner midwifery unit at the hospital or in the community.

Care after birth should be given at home and in local one-stop settings such as drop-in clinics, which can offer parents a range of support.

17.4.4 Mental health care should be available for women who suffer postnatal depression.

17.4.5 Prolonged care for seriously ill babies will require a neonatal intensive care unit.

Responses to consultation and key issues for the JCPCT to consider

There is a need to plan services together, not just children's and adult services, but also services for young children e.g. maternity and newborn care.

> *"…we remain concerned that the interdependencies between services have not been fully recognised. If localities have a consultant-led obstetric unit, on-site neonatal provision will be required."*
>
> Royal College of Paediatrics and Child Health

The safety of the mother and baby was the primary concern for respondents to the consultation. This was given as a reason by some stakeholders for their support of co-located obstetric and midwifery-led units. However the Royal College of Midwives said:

> *"There is no evidence that free-standing birth centres are a less clinically effective environment than other settings. There is a danger of co-located centres being used as overflow areas for usual labour ward activities."*
>
> Royal College of Midwives

> *"The Royal College of Obstetricians and Gynaecologists supports the option of home birth or stand alone midwifery unit births for women with uncomplicated pregnancies."*
>
> Royal College of Obstetricians and Gynaecologists

Respondents (including organisations) emphasised the importance of choice for a mother when deciding where to have her baby.

All groups, particularly health bodies and professional bodies, emphasised the centrality of midwives. However there was serious concern expressed as to the ability of London's maternity services to cope. The workforce is seen to be insufficient both in terms of absolute numbers and in terms of having the competencies to deliver a changed service.

> *"We also support increased use of maternity support workers which would enable midwives to provide more specialised midwifery care."*
>
> Royal College of Obstetricians and Gynaecologists

There was a view amongst stakeholders and the public that home appointments should continue to be offered to women following the birth of their baby (56% agreed). Home appointments offer the opportunity for a welfare assessment, whereas a visit to a clinic may cause women difficulty (particularly if they have had a caesarean section) or undue stress for mother and baby. However there was some support for both patient choice and acknowledgment of the advantages for mothers attending a clinic for some subsequent meetings with a midwife.

Conclusions and further recommendations

Safety of a mother and her baby was the primary concern for respondents. For many women the preferred place to give birth will be in a midwife-led unit with a doctor-led unit on the same hospital site. But this will not always be the case. Nowhere is the belief that what is good for one person may not be good for another more true than in maternity and newborn care. With clear and robust selection and transfer protocols many women can give birth perfectly safely in the community.

However, when exercising choice of where they have their baby, women must be given good information about the advantages and risks of where and how they have their baby and there must be clear and robust protocols in place (not just a belief that they should be in place).

17.4.6 The JCPCT recognises the clear message of the interdependency between obstetrics and paediatrics and recommends that those planning these services engage with clinicians of both specialties to ensure proper consideration of all the issues. The JCPCT also notes the importance of good communication between midwifery and health visiting services. It is the health visitor who will provide ongoing support to families after their discharge from maternity services.

17.4.7 The JCPCT agrees with the CAG and recommends that further work should be undertaken by Healthcare for London on:

- managed networks of care, their size and configuration, and their possible impact on safety and safe transfers;
- the configuration and impact of services which support the midwife as the first point of access in the community for women;
- the possible configuration of obstetric units given the potential changes in paediatric services; and
- the development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries.

A managed network with overarching clinical governance arrangements could, in particular, help ensure that all maternity service provision was delivered in accordance with national standards and guidance.

17.4.8 The JCPCT recommends that when developing maternity services, PCTs and acute trusts should consider the public and organisation responses made to this consultation regarding the three factors most important to them (Giving birth in a midwife-led unit with a doctor-led unit on the same hospital site; having a senior doctor present on the unit where you will give birth; time taken to travel to the place where you will give birth). Safety of the mother and baby was considered to be the primary concern for respondents.

17.4.9 The JCPCT recommends that PCTs take note of the Royal College of Obstetricians and Gynaecologists' recommendation that units delivering over 4, 000 births a year should have a senior doctor present for 98 hours a week.

We have heard what respondents have said and we are clear that women would prefer home visits from midwives following the birth of their baby, at least in the early days of a child's life. There were concerns from mothers that they would find it difficult to attend a clinic in the days after the birth of their baby, and keenness from stakeholder and the public that midwives need to ensure the home environment is suitable.

For decision

The JCPCT:

10) agrees that midwives should continue to visit mothers with newborn babies in their homes and PCTs should investigate whether care in local, one-stop settings, (where mothers could see a midwife and other health or social care professional) following early home visits, would be appropriate in their community.

17.5 Children and young people

What did we recommend in *Consulting the Capital*?

We need to help children, their parents and carers understand how to live healthy lives and create an environment where children will feel happy and secure.

17.5.1 We recommend a greater effort to provide equal opportunity for children, young people and their families so that they can access services when they are needed.

17.5.2 We also believe we should try harder to promote breastfeeding because of the proven benefit to infants' well-being and development.

17.5.3 We should place more emphasis on preventing the emerging problems that children are facing, for example obesity and behavioural disorders.

17.5.4 Childhood immunisation is one of the safest, most cost-effective, evidence-based interventions, yet many parents do not immunise their children. We believe we should give high priority to ensuring that all children are immunised, with a London-wide co-ordinated effort. All health professionals who deal with children should know about and be able to offer accurate advice to parents. We need to support healthcare professionals who are trying to promote and co-ordinate local programmes of immunisation.

17.5.5 When children are ill, whether the problem is an urgent one or long-standing, they should receive care close to their home, perhaps at home, in a children's centre, at school or in hospital, and parents and carers should know how to gain access to the right people.

17.5.6 We know that most urgent care is provided in GP practices. This will continue to be the case, but we are recommending that all those who deal with ill children have the necessary skills and expertise. Where access to GP services is difficult we will be exploring effective alternatives.

17.5.7 Hospitals that care for children need to be able to guarantee that their services meet National Service Framework (NSF) standards.

17.5.8 Some hospitals will continue to provide the whole range of care that children need, including inpatient care if they are very sick. We want to ensure that they have staff available through day and night with the skills and ability to meet children's needs.

17.5.9 Other hospitals will not have inpatient facilities for children. Even so they will need doctors and nurses with the same training in children's illnesses, who can assess and treat children in specially designed units. Many children who come to A&E departments can be managed in this way without needing admission to hospital. Where the paediatric staff believe an admission is necessary, arrangements must be in place with the ambulance service to transfer the child safely.

We have listened to the view of the Royal College of Paediatrics and Child Health. They have said that: *"…the current children's healthcare workforce cannot safely sustain the number of existing inpatient and acute children's services.*" So we are recommending that specialist care for children is concentrated on fewer sites.

17.5.10 Unfortunately, some children are born with, or develop, a life-limiting or life-threatening illness. For these children we are recommending better co-ordination of services. And if we are to provide the best possible care, we will have to work in partnerships across the whole of London.

Responses to consultation and key issues for the JCPCT to consider

There was general support amongst respondents for specialised care for children (54% strongly agreed or tended to agree), but with concerns about the extra travel and stress this would cause to families. For instance:

> *"We currently have a local hospital with an excellent children's ward with full paediatric support. Under the reconfiguration plans presented to us, the majority of care will, in our view, not be provided locally and our children will be travelling further for their care."*
>
> Save Chase Farm Group

> *"We recommend that if specialist care is further centralised then the NHS examines how it will manage the impact on children's families during the treatment at more distant specialist hospitals."*
>
> Joint Overview and Scrutiny Committee

Respondents suggested a number of ways to encourage immunisation including increasing access e.g. in health clinics, schools, mother and baby groups and leisure centres, providing more and better information and offering incentives or penalties. There was a minority of respondents who felt that children should not be immunised due to perceived harmful effects or that more choice would be beneficial.

> *"…GPs have been given financial incentives to perform immunisations in the way desired by the NHS, which may not be the way desired by the parents. We believe that , if the immunisation is sufficiently important, the parent's choice of method should be available to them. It may also be that immunisations should be given at school to encourage high take up."*
>
> Patient and Public Advisory Group

The importance of health promotion, illness prevention and early identification of illness was stressed by many stakeholders and members of the public.

> *"We recommend that the NHS work with local authorities to ensure that Children's Centres and Extended Schools are equipped and resourced to provide community health services for our young residents."*
>
> Joint Overview and Scrutiny Committee

In planning future services for children, PCTs were encouraged to consider a wider range of issues, including:

- children in the context of the family structure, and not just as child patients;
- the importance of parenting;
- children who are carers (see also section on long-term conditions); and
- children looked after by local authorities.

Conclusions and further recommendations

17.5.11 As most children are cared for in the community, the importance of co-operative working and of a multi-agency and multi-disciplinary approach was stressed by many respondents. The JCPCT recommends PCTs strengthen partnership and joint commissioning arrangements. In particular, caring for vulnerable children requires an integrated approach between health and local authority services.

17.5.12 The interdependency of paediatric and obstetric services and the implications for the newborn baby were also a key focus of attention. The JCPCT agrees with these sentiments and recommends greater incorporation of the principles of Every Child Matters and the National Service Framework for Children, Young People and Maternity Services into current and future services.

17.5.13 The public and organisation responses to how the NHS could encourage more parents to immunise their children are warmly welcomed. The JCPCT is very clear that immunisation is a critical public health priority and believes that current mechanisms to improve compliance should be exploited, particularly focusing on encouraging healthcare professionals to educate the public and parents about immunisation. The JCPCT recommends PCTs consider responses to the consultation when planning campaigns to improve immunisation in their localities. The JCPCT is interested in the concept of opportunistic immunisation, but because it will make co-ordination of the schedule more difficult, it recommends it should only be offered if accurate information is available. The committee agrees with the CAG and PECs, that single vaccines for Mumps, Measles and Rubella should not be supported – on grounds of doubt over clinical effectiveness. However the committee would be interested in seeing plans for the development of clinically established, effective and successful vaccinations such as Hepatitis B.

17.5.14 The report of the London Children and Young People's Pathway Group is welcomed and recommended to PCTs to be considered in future planning of services. In particular we note the concerns the group has that many basic requirements of good healthcare for children (for instance full implementation of the Child Health Promotion Programme) are not a feature of current provision. The group also expressed concern regarding changes in funding mechanisms of the Children and Mental Health Service (CAMHS). The implications for CAMHS service delivery are unclear but we are convinced of the value of preventative work and early intervention. PCTs will need to determine how best to ensure sufficient budget is available to maintain, and enhance services.

The majority of respondents supported the concept of specialised care which could be further from a child's home – although the support was not as great as for stroke, trauma and emergency surgery. Stated concerns were that children needed to be surrounded by friends and family; the stress of the family, particularly if there were siblings; and the difficulty of travel for parents. It may also be that respondents were unable to visualise the type of specialist care that is proposed. The JCPCT recognises these concerns. In essence, the type of specialised care the consultation document proposes providing on fewer sites is high dependency medical or nursing care, or where admission for observation of more than 24 hrs is anticipated.

17.5.15 The JCPCT recommends PCTs commission further work to identify the reconfiguration required for specialised care for children and the key issues for families, such as how transport might be provided.

17.5.16 The JCPCT recognises the view of the London Children and Young People's Pathway Group that there is a shortage of neonatal intensive care cots in the capital and recommends further work be carried out to ensure an appropriate increase in capacity to meet this need.

These recommendations and the following proposal were clinically-driven and the clinical case for change remains. The majority of respondents supported the proposal although there were some concerns about the impact of those changes on patients and families.

For decision

The JCPCT:

11) agrees that specialist care (e.g. high dependency medical or nursing care, or where admission for observation of more than 24 hrs is anticipated) for children should be concentrated in fewer hospitals with specialist child care. The number and location of these hospitals should be subject to further consultation by PCTs.

17.6 Mental health

What did we recommend in *Consulting the Capital*?

17.6.1

- Young people between 14 and 25 with emerging mental health problems need to be able to get help quickly. We know this improves care, reduces time in hospital and leads to fewer admissions to hospital involving the police;
- We should make further efforts to reduce the fear of services, taking special measures in communities where it is culturally less acceptable to seek help;
- We should set out clearer pathways to care, so that patients, carers, GPs and those who come into contact with people with mental health problems, such as police officers, know how to contact services and what to expect from them; and
- Cognitive behaviour therapy and other `talking therapies' should be used extensively – but accessing these services is a problem and people in many parts of London face long waits for these services. More mental health workers should be employed to deliver talking therapies. Other therapies should also be explored, including exercise, reading and walking.

More choice

17.6.2 People could be given more control over their lives by:

- greater use of payments to patients so that they could buy their own services;
- better access to opportunities such as housing and employment. Around 40 per cent of benefit claimants are on incapacity benefit because of mental health problems, but nearly all these people want to work; and
- encouraging mental health services to work in partnership with local organisations, including physical health providers, social care, housing and employment agencies, black and minority ethnic communities, local businesses and faith communities, to help people lead full lives as part of their local community.

Individual services

17.6.3 Mental health services must meet the needs of minority groups. In some cases they should use assertive outreach (a system where community professionals go out to the homes of patients who are reluctant to come in for appointments). Health services, local authorities, community development workers and, in particular, the black voluntary sector need to work together to break down barriers between mental health services and minority ethnic communities.

17.6.4 Mental health services also need to work with London's prisons, probation services and others, to develop a pan-London strategy for delivering more effective mental health services to offenders.

17.6.5 Older people with dementia need early access to services and a care plan that addresses their health and social care needs. We should aim to provide support for people and their carers as close to their own homes as possible but with specialist assessment and treatment units available if necessary.

New ways of working

More generalist community mental health teams (CMHTs) need a clearer focus, perhaps on providing assessment and co-ordinating support, recovery or therapies.

17.6.6 While improving community services, London also needs to develop a vision for specialist inpatient mental health care, involving:

- discussion of whether, as admissions to mental health units decrease, inpatient beds are needed in every borough;
- improving the quality of inpatient care, from the environment where treatments are given to the quality and range of treatments; and
- encouraging centres of specialisation amongst London's ten mental health trusts.

Responses to consultation and key issues for the JCPCT to consider

Public respondents to this section were well-informed, often provided extensive comments and generally supported the proposals.

Some respondents thought that there was little detail regarding mental health in the consultation and that insufficient attention and financing had been paid to mental health care in the past.

There was significant support for investment in alternatives to medication such as cognitive behaviour therapy and talking therapies – although it is recognised that cognitive behaviour therapy has its limitations. There was a strong feeling that the numbers of inpatient beds needed to be maintained, if not increased.

> *"We need to stop the closure of in-patient beds and develop community and half way homes as well as 'crisis' and respite accommodation."*
>
> Various UNISON branches

> *"Broad support for everything in this section, especially the importance of working with other agencies to address the isolation which individuals with mental health problems can face – a real barrier to continuing health."*
>
> Male, aged 55-64

There was scepticism around the subject of personal budgets. Some questioned whether this policy would prove to be an effective way of ensuring mental health service users received the correct care.

Conclusions and further recommendations

Mental health should be 'everybody's business', from managing stress through to care for severe long-term conditions. Most people should have their mental health needs met outside the health sector – in schools, in their employment and in their community. Many mental health problems are caused or aggravated by problems in these arenas. For instance, the link between unemployment and mental health is well documented.

17.6.7 The JCPCT agrees with the CAG and recommends that PCTs and NHS London do more to deliver:

- readily available help and advice to manage stress and to reduce alcohol consumption and illicit drug abuse; and improved access to substance misuse specialist services; and
- a skilled, affordable workforce to deliver the range of modern evidence-based interventions and the capacity to offer choice where more than one intervention is needed.

We recognise the contribution that nursing and allied health professionals could offer. We understand that the current physical separation of community mental health centres, general practice and hospital services contributes greatly to problems of missed diagnoses, less effective treatment of co-morbidity and to wider problems of stigma and discrimination and that the core idea of providing a 'one-stop-shop' that brings together mental health care, primary care and a range of hospital-based outpatient services at a local level would be welcomed. This concept is discussed further in the section 'Where we could provided care'.

17.6.8 The JCPCT recommends that there should be increased investment in evidence-based alternatives to medication such as cognitive behaviour therapy and talking therapies.

17.6.9 The Mental Health Clinical Care Pathway Group (MHCCPG) supports and expands upon the work of *A Framework for Action* and *Consulting the Capital* (see chapter 12). The JCPCT recommends that commissioners of services note the work of the group and use it to build their capability to specify the optimal effective service structures and teams required to deliver better mental healthcare, and to specify the evidence-based care pathways, clinical standards and outcomes to be implemented.

The recommendations in this chapter were clinically-led and the clinical case for change remains. The majority of respondents supported the proposals.

17.7 Acute care

What did we recommend in *Consulting the Capital*?

When you need – or think you might need – urgent care, you should expect consistent and thorough assessment available 24 hours a day, seven days a week.

Telephone advice

17.7.1 To reduce the confusion of having different numbers to call when you need urgent care advice on the telephone we think there should be two points of contact – the existing 999 number for emergencies and a new service. The new service could, for instance:

- provide advice. Professionally trained healthcare advisers would have access to up-to date information and advice, tailored to your address;
- book you an appointment with your GP or other healthcare professional such as a nurse or a mental health worker;
- transfer you to a polyclinic, so you could speak to a healthcare professional such as a GP or community nurse;
- give directions to a polyclinic close to your home or workplace, a nearby pharmacy, or a hospital; or
- transfer you to emergency services.

Call-handlers would be able to respond quickly to your needs rather than you having to find your way through the system.

Face-to-face care

GPs will continue to provide most face-to-face urgent care through the appointments system. For more pressing needs you should have the choice of:

- attending a same-site polyclinic or the hub of a network polyclinic in the community. Polyclinics would be open for extended hours and could house GPs, nurses, emergency care practitioners, mental health crisis-resolution teams, and social care workers. Staff would be able to help with substance or alcohol problems and have access to testing equipment including x-ray and ultrasound; and be able to do heart checks and blood tests;
- attending a polyclinic attached to an A&E. These would be led by GPs and other healthcare professionals experienced in working in the community. They would have similar facilities to a community-based centre and be open all day, every day;
- admission to the nearest local hospital A&E or major acute hospital's A&E – these would be open all day, every day. Most ambulance admissions will be to the nearest hospital as we recognise that for many conditions such as severe asthma attacks and choking, speed of treatment is the most important issue; or
- admission to the nearest hospital with specialist facilities.

Ambulance staff could take 999 patients to any of these places, depending on what is right for their needs.

Specialist care for heart attacks, severe injury, stroke and complex emergency surgery

We believe there should be about three severe injury centres in London, including the one at the Royal London. This is based on the recommendation of the Royal College of

Surgeons that these centres should each serve between one and three million people. These severe injury centres would not replace A&E departments at other hospitals, which would still provide the majority of emergency care.

The evidence for stroke and complex emergency surgery is just as convincing. With arrangements in place to take patients straight to specialist centres instead of the nearest hospital, many more lives could be saved and many more patients could avoid disability. For these conditions it is better to get to the right hospital with the right team of specialists than go to the nearest hospital. Rehabilitation would take place at home or in the patient's local hospital.

We recommend that approximately seven hospitals should provide 24/7 care supported by full neuroscience expertise. Other hospitals could provide treatment during the day and rehabilitation services closer to people's homes. To decide on the best location of these specialist units we think a London-wide stroke strategy is needed.

Responses to consultation and key issues for the JCPCT to consider

Respondents were most likely to want an urgent care telephone service to provide general medical advice (44%), be able to transfer callers to healthcare professionals (38%) and to book GP appointments (33%). However a quarter of respondents would not use this type of service at all and most Local Medical Committees did not wish a telephone service to include booking of GP appointments.

> *"Whilst there was support for this idea, many questioned whether it would duplicate NHS Direct. Participants saw value in the ease and convenience of getting advice on how to treat illness (particularly for parents of young children) and making the GP appointments system more accessible if it could be done over the telephone. Others felt this would be 'just another pressing buttons nightmare' and did not feel a telephone service was any substitute for face to face contact. If such a service were introduced, it would have to be offered in languages other than English and be staffed by real people who were properly and sensitively trained, and answered promptly. Publicity would be needed so people knew about the service and what it offered."*
>
> Health Link report on traditionally excluded groups

> *"There was strong support for telephone services for urgent care needs being linked to a transfer system to health professionals. However most LMCs did not want the services to have the facility for direct booking of GP or other health care professionals – concern that this would not help those patients personally known by practice staff or for the GP advocating on behalf of their patient/carer."*
>
> Londonwide Local Medical Committees

There was strong support for specialised centres for the treatment of trauma (64% strongly or tended to agree), stroke (67% strongly or tended to agree) and complex emergency surgery (65% strongly or tended to agree). However there were concerns over the numbers of these centres, particularly due to the transport and traffic in London.

> *"The Stroke Association welcomes "A Framework for Action and its recognition that London's stroke services are in need of urgent improvement…If implemented these proposals could achieve dramatic improvements in mortality rates, in levels of disability, in reducing the overall cost of stroke care and, most importantly, in improving the quality of life for the thousands of people who have their lives shattered by stroke in London every year.*
>
> The Stroke Association

"Three centres would be putting all eggs in one basket approach, should a major fire or incident occur at the centre, a third of the capital's resources would be disabled."

Male aged 45-54

"We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes. However, we will not give blanket approval to all proposals for centralising specialist care at this stage, and expect future consultations to set out prominently the clinical benefits of each particular proposal. We recommend that clinicians have a major role in developing proposals, and expect them to be involved in explaining to the public that proposals strive to improve patient care rather than save money."

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Respondents were also concerned about how regionalisation would affect local hospitals and services (see also 'where we could provide care').

"We endorse the recommendations on the further centralisation of complex trauma and stroke…complex emergency surgery and intensive care are potentially more difficult issues as they beg questions about what is a viable local hospital, what staffing skills are required throughout the day and night, and the safety of transferring acutely ill patients."

St George's Healthcare NHS Trust

Three quarters of respondents were in favour of direct transfer by ambulance staff, provided they had received appropriate training.

Conclusions and further recommendations

Whilst the committee is clear that increased specialisation for certain conditions is an excellent concept, we also recognise that improvements to acute care cannot be undertaken in isolation. For instance, the development of local hospitals, polyclinics, care pathways, primary care provision and better information to the public will all play a part in improving acute care provision; reducing unnecessary admissions to hospital and ensuring patients are able to access the right clinician, in the right place at the right time.

Whilst a quarter of respondents said that they would not use an urgent care telephone service, many welcomed the idea, particularly to give general medical advice – although some questioned how this would be better than NHS Direct. Most people are interested in straightforward access to someone who can give them meaningful clinical advice or direction.

Some traditionally excluded groups were extremely keen on an urgent care telephone service (perhaps because they have difficulty in accessing traditional face-to-face methods). However they made it clear that the facility must be available in different languages and there must be a facility for deaf people. The London Ambulance Service (LAS) stressed the need to consider better co-ordination of services between current providers (e.g. LAS, NHS Direct, GP out of hours service) before establishing a new service.

17.7.2 The JCPCT has similar reservations to the public regarding a telephone service – would the system just frustrate people in 'push-button hell'; and how much would the IT systems cost – would it be effective? However if these obstacles could be overcome the JCPCT can see the benefits in providing a solution. The JCPCT recommends that the comments regarding a new telephone service are carefully taken into account when a telephone service is considered.

The evidence for regionalising some specialist care was strong in the original *Framework for Action* and the public and stakeholders have consistently supported the idea through their responses and discussions at meetings.

Current clinical analysis by the CAG suggests that the number of trauma centres that the system would need may be more than three (although unlikely to be more than six). This is because the programme would need to agree how many out of London patients would use the system with neighbouring SHAs and the resulting changes to patient travel times - hence the population base and density may be different. Other considerations, including the degree to which paediatric and burns patients are part of the trauma system, may also affect the final number. The need for more trauma units was supported by respondents.

The precise number of 24 hour stroke centres in London that would best meet the needs of Londoners, where each of these would have sufficient critical mass to maintain high quality care, and travel times would be kept to a limit that didn't create new inequalities has yet to be decided. The approximate figure of seven in the *Consulting the Capital* has support from the public and organisations. Whether these are supported by other centres that provide some daytime care will need further analysis and work with stakeholders, but must absolutely focus on outcomes and clinical quality.

When reaching the final number of specialised centres (and daytime units), the JCPCT would still wish to ensure that each trauma or stroke centre received the critical mass of patients needed to deliver the improved outcomes intended by A *Framework for Action*.

All the following proposals were clinically-led and the clinical case for change remains. The majority of respondents supported the proposals although there were some concerns that the number of trauma centres was too small. In light of these concerns and the clinical view provided by CAG that the number of trauma centres might need to be more – between three and six – the JCPCT has agreed that the number of hospitals providing more specialised care to treat the urgent care needs of trauma will probably be between three and six hospitals.

All specialised centres (stroke, trauma or complex emergency surgery) would need to operate as part of a defined pathway of care.

For decision

The JCPCT:

12) agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of trauma (severe injury) patients – probably between three and six hospitals. The number and location of these hospitals should be subject to a further consultation by PCTs.
13) agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of patients suffering a stroke (about seven hospitals in London providing 24/7 urgent care, with others providing urgent care during the day). The number and location of these hospitals should be subject to a further consultation by PCTs.
14) agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of patients needing complex emergency surgery. The number and location of these hospitals should be subject to a further consultation by PCTs.
15) agrees that ambulance staff should take seriously ill and injured patients directly to designated specialist centres, when appropriate, even if there is another hospital nearby.

17.8 Planned care

What did we recommend in *Consulting the Capital*?

We think people should be offered better access to a GP for routine appointments before 9am, in the evenings and at weekends.

17.8.1 More surgery should be carried out as day cases, allowing patients to go home the same day. Most patients prefer it, it is more cost-effective, and it reduces the risk of catching an infection. In 2005, London was the worst-performing region in England, performing far fewer operations as day cases than expected.

More local care

17.8.2 GPs should have access to test facilities in the community to reduce waiting times and save patients unnecessary trips to hospitals. Hospitals should keep their test facilities – providing services for the hospital and local patients.

17.8.3 After an operation, patients need help to recover and return to good health. This is called rehabilitation and it should take place as close to their homes as possible – it is what most people want and it is effective. In some cases rehabilitation will be in patients' local hospital or polyclinic, and in many cases in their homes. However, 37 per cent of pensioners in London live alone, so we will need to work closely with social care agencies to help people return to full and independent lives.

More specialist care

Evidence shows that hospitals providing complex care to lots of people have the best outcomes for patients. Even if money were no object and it were possible to equip and staff specialist centres in every hospital, it would be better to transport patients to teams that regularly perform the procedures.

17.8.4 For the best care, more hospitals need to specialise in particular aspects of healthcare. The days of a general hospital trying to provide all services to all patients, to a high enough standard, are over.

17.8.5 We recognise that sometimes specialist care will mean more travel for patients. We will need to ensure they only go to hospital when necessary. For instance, tests could be done close to their home and reviewed by a specialist at the hospital, who could give an opinion remotely – without the patient having to visit. Or the specialist hospital might provide care teams to visit other hospitals.

Responses to consultation and key issues for the JCPCT to consider

There was general support for extended GP practice opening hours, with 80% of respondents saying they would find this fairly or very useful. But there were a number of concerns; particularly as to how this would affect the quality and continuity of care; over-burdening of GPs; the affordability of other services if finances were diverted to extend opening hours; and the availability of other services such as blood tests during the extended hours.

Extended hours were also considered to be helpful in easing the burden on A&E (although this is more relevant to acute care). Some respondents suggested there was a need to allow patients to register at more than one practice.

> *"Unfortunately, illness and modern life no longer fall into a tradition pattern and the NHS services should evolve to meet modern needs."*
>
> Female, aged 25-34

> *"This (extended GP opening hours in the evenings and at weekends) was the proposal on which there was most unanimity, with most participants supporting the idea."*
>
> Health Link report on traditionally excluded groups

However local medical committees and other GP groups in particular raised a number of objections including the possible unavailability of other services, the impact on staff and whether there was a real need for longer opening hours.

> *"All LMCs commented on this and the main areas of concern were that extended opening hours would mean that continuity of care would suffer; that there was not enough demand for this, with many quoting the national survey which showed 86% of patients indicated that they were happy with access to their GP surgery; that others services, such as diagnostics, would not be available and; a number of LMCs also had concerns over the safety of staff working extended hours and that the hours would not be family friendly for practice staff."*
>
> Londonwide LMCs

Some individual respondents were also concerned that longer opening hours pandered to 'the working well' and 'the worried well'. However others felt that more accessible GPs would encourage a preventative approach to managing health and perhaps lead to earlier diagnosis.

In PCT Board meetings some respondents also referenced the national GP patient survey quoted by the LMCs (see above) showing a large proportion of patients were happy with access to their GP surgery. It should be noted:

- Those surveyed had all been to see a GP within the last six months;
- Nationally, although 86% of patients were able to get an appointment within 48 hours, the response for all PCTs in London (with the exception of Kingston and Harrow) were less than this average; and
- Nationally, although 84% of patients were satisfied with the opening times of their GP surgery, the response for all PCTs in London (with the exception of Bexley) failed to meet this national average.

What is clear is that, to achieve real time extension of hours, PCTs will need to look at primary care as a whole, at teamwork, appropriate settings and support services not just at GP services. And PCTs will need to consider how best to meet patient expectations not just 'out of hours', but at all times.

Opening hours was the key area for discussion in this chapter. However, access to test facilities in the community was broadly welcomed and the principle that rehabilitation should take place as close to people's homes was not questioned. More specialisation of hospital services also drew little comment.

Conclusions

The JCPCT supports the key recommendations regarding planned care, namely that:

- more outpatient services should be provided in the community;
- there should be more use made of the day care setting for many procedures;
- more diagnostic services should be made available in the community; and
- rehabilitation should be as close to people's homes as possible.

We acknowledge the concern of GPs and the public regarding limiting any additional burden on GPs, and ensuring continuity of care for those who want it, and whether diagnostics could be provided during extended hours. We also recognise that some members of the public (particularly younger people and those who wish to stay healthy in their busy lives) do not have the same need for continuity of care as do, for instance, elderly people, people with a long-term condition or young mothers.

However there is an evidenced desire and a perceived need for extended hours. We also believe that there are a number of solutions that would enable GP practices to offer extended hours without prejudicing continuity of care for those that want it, or overburdening GPs. For instance, practices working in a federated way could provide an extended service between them – either by one partner taking responsibility for evening work – with his or her own patient list of people who prefer to see a GP in the evening, or by working a roster. It will be important for the proposed polyclinic pilots (see 'Where we could provide care') to consider the needs of those patients wanting better access to a GP, and to test how continuity of care could be provided in this service model.

The JCPCT wishes to avoid new equipment being provided in GP surgeries to carry out diagnostics without proper consideration of the issues. How can current equipment be best utilised? How can new equipment be shared? Are there appropriate care pathways in place and accredited clinicians available to ensure best value for money? These are all questions that need to be answered if we are to provide better care for patients.

The following proposal is aimed at increasing patient choice and helping people stay healthy. The majority of respondents, including traditionally excluded groups interviewed by Health Link, supported the proposal, although there were some concerns over the impact on GPs and whether continuity of care with a GP could be maintained for those that wanted it. The recommendation has been amended from the original proposal to acknowledge the views of respondents that it is access to primary care and not just to a GP that is important to patients.

For decision

The JCPCT:

16) agrees that people should be offered better access to a GP and primary healthcare services, especially before 9am, in the evenings and at weekends. The extent of such provision should be determined by individual PCTs in consultation with local communities.

17.9 Long-term conditions

What did we recommend in *Consulting the Capital*?

17.9.1 Every effort should be made to prevent long-term conditions by promoting healthy living.

17.9.2 The JCPCT recommends GPs, practice nurses and social care staff should be supported to develop effective mechanisms for finding undiagnosed people who do not present themselves to the healthcare system and for undertaking assessments. Encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills.

Community pharmacies can support people with long-term conditions too, by helping them with their medication. Problems with taking medicine are estimated to cause as many as 15 per cent of hospital admissions.

Giving control to patients

17.9.3 People with long-term conditions should be able to access the full range of support for their condition so that they can manage it more effectively, with professional help.

Individual patients should be making informed decisions about the support they need. There are many good examples of this type of work, for instance:

- the expert patient programme, which is a course giving people the confidence, skills and knowledge to manage their condition better and be more in control of their lives;
- information prescriptions, which tell people where they can get further information and advice.

London-wide guidelines and standards should be developed so that patients know if their care is up to the standard they should expect, and we should make much greater use of regular appointments with community healthcare professionals and specialist nurses working in the community.

All these recommendations will keep people healthier, reduce the need for hospital care and reduce unnecessary emergency admissions. However, it will require considerable investment to support patients in this way, rather than the hospital-based care we are all used to.

Responses to consultation and key issues for the JCPCT to consider

There was a clear preference for investment in community support for long-term conditions. Two thirds of respondents thought that a greater proportion of future spending should be invested in GPs, specialist nurses and other health professionals. This view was shared by clinical organisations, patient organisations and councils. There was recognition that investment in the community for long-term conditions was a more cost effective option than investment in hospital-based services and would free up secondary care to concentrate on specialist areas. However some respondents urged caution in taking resources from hospitals.

> *"That is utopia and will never happen. Don't drain the local district general hospital of its specialist nurses."*

Female, aged 55 – 64

"People with long term conditions live at home, and should be helped where they are, rather than having to go to hospital. Most people understand their condition and can manage it with support – relying on health professionals all the time can stop them trusting themselves."

Female, aged 45 – 54

There should be a greater focus on research and education in primary care. Education and research providers should be involved in the planning of this shift in emphasis.

There was a general view that GPs were best placed to help people with long-term conditions, although not necessarily for every condition (e.g.HIV). But of course integrated services would be more convenient for patients.

"Long-term condition management should involve an integrated treatment pathway from prevention through to treatment and care. A person living with HIV should be able to present to a community-based clinic for a routine appointment and be able to access additional care, for example smoking cessation advice, in the same setting as their check-up. Many patients go to a HIV clinic to receive prescriptions for HIV medications but are told to go to their GP for other healthcare needs. If a GP was available in a HIV clinic several days a week, patients could access the care they need in a single visit. GPs could also work with voluntary organisations to bring health and social care together in one location

Terrence Higgins Trust

Additional comments highlighted the fact that care pathways need to be carefully considered and properly resourced, with the right care being delivered by the right professional at the right time. Clinical guidelines must be evidence-based and used appropriately – not as a means of rationing care.

The Clinical Advisory Group commented on the development of care pathways:

"It is unclear why London-wide best practice care pathways need to be developed… when there are already national care pathways. Developing London-wide pathways will not decrease health inequalities. Indeed, implementing London-wide pathways could have the opposite effect if resources are invested implementing pathways in communities that already have better outcomes. It is essential that any care pathway is tailored to the local health community. For example, what works in Westminster may not work in Richmond or Newham. The 'map-of-medicine' offers an excellent way of taking national care pathways and tailoring them to local needs without losing the clinically evidenced actions that all clinicians should be following.

Clinical Advisory Group

The views of respondents who advocated the benefits of complementary medicine were particularly prevalent here.

Carers

The essential role of carers was particularly recognised in this section.

"We recommend that NHS London analyses the impact of the HfL proposals on carers in London, and states the action that the NHS will take to ensure any proposals arising from this consultation will not increase the burden on this often 'hidden army' of dedicated individuals."

Joint Overview and Scrutiny Committee

Conclusions and further recommendations

Whilst two thirds of respondents agreed that a greater proportion of future spending should go to supporting people by investing in more GPs, specialist nurses and other health professionals (as opposed to more investment in hospital care), the challenge will be to ensure that investment is well spent and evaluated. It is all too easy to measure and compare the benefits of hospital-based care – it is much more difficult to prove (over the short-term) that prevention and community treatment are cost effective.

17.9.4 Whilst accepting that more resources need to be directed to supporting people in investing in more GPs, specialist nurses and other health professionals, the JCPCT also accepts that working with the voluntary sector will be critical to raising standards. The NHS must improve the way it does business with voluntary organisations if patients are going to benefit from their knowledge, expertise, capacity and goodwill.

17.9.5 The JCPCT recommends that appropriate funding for education and research should follow the movement of treatment of long-term conditions into the community – in essence, a greater focus on research and education in primary care.

17.9.6 The JCPCT recommends that in each PCT, funding should be directed according to need and to reduce inequity of healthcare provision, but also recognises that partnership working to facilitate access to the features of life that most people take for granted, such as transport and recreation, social care and good housing, will be key to better outcomes.

The message that personal continuity of care is important came across very clearly in this section and the fact that, whilst GPs are best placed to manage long-term conditions, non-healthcare professionals have an important part to play.

And whilst encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills, we accept this is not the only solution to integrating primary and specialist care.

17.9.7 The needs of carers were emphasised in relation to long-term conditions. As PCTs develop their plans they must recognise the importance of continuity of a carer and ensure that any changes in service support the needs of carers (including child carers and occasional carers). The JCPCT recommends PCTs also take into account the recommendations of the emerging national strategy (which is subject to a separate consultation). In the long term, carers' requirements will be addressed in a number of specific workstreams, especially mental health, long-term conditions, stroke and polyclinics.

17.9.8 The JCPCT agrees with the CAG view and recommends that PCTs tailor national best practice pathways to the needs of their local communities (for instance using the map of medicine database), rather than developing London-wide guidelines so that patients receive better quality care and can judge if their care is up to the standard they should expect.

For decision

The JCPCT:

17) agrees that a greater proportion of future spending should go to help people with long-term conditions stay as healthy as possible, by investing in more GPs, specialist nurses and other health professionals and the services they provide.

17.10 End-of-life care

What did we recommend in the *Consulting the Capital*?

17.10.1 We believe that all organisations involved in end-of-life care need to meet existing best-practice guidelines.

There should be new end-of-life service providers (ELSPs) co-ordinating care for patients. Patients with advanced progressive illnesses who are identified as nearing the end of their life should be offered the opportunity to have their needs assessed and to identify their preferred place of death. The end-of-life service provider would then be responsible for arranging a package of care.

Voluntary, charitable, public and private-sector organisations could all be ELSPs, contracted to provide care for a group of PCTs. ELSPs will need to cover quite a large area so that they can become expert in buying services and take advantage of economies of scale.

Responses to consultation and key issues for the JCPCT to consider

Just over half of respondents to the consultation thought that new end-of-life service providers responsible for co-ordinating end-of-life care would result in better care than current arrangements.

However there was some confusion over the proposals in this section. Respondents appeared unclear as to the status of the providers. In addition, although the consultation document stated that "There should be new end-of-life service providers (ELSPs) co-ordinating care for patients…Voluntary, charitable, public and private-sector organisations could all be ELSPs, contracted to provide care for a group of PCTs", it did not make it clear that it was the end-of-life service provider idea that was **'new'** and this could include **existing** organisations already involved in end-of-life care.

> *"I'm not sure that bringing in another organisation will help people, as it might just lead to confusion – better to co-ordinate existing services better. Macmillan and Marie Curie and the hospices do a great job – we just need to make sure that those in need have easier access."*
>
> Female, aged 45-54

There was good support for any proposals which were aimed at providing more choice to patients as to their proposed care and place of death, though it was noted that the wishes of carers and the support needed by families should be considered.

> *"We wish to point out that whilst the patient's view is of great importance, it needs to be balanced against the wishes of carers and family and the provision (which varies) that the relevant local authority makes to support them."*
>
> Healthcare for London Patient and Public Advisory Group

> *"The discussion on end-of-life care is welcome. We entirely support the aspirations of the report to improve and co-ordinate palliative and terminal care and to ensure that these services are properly integrated. We are concerned, however, about the concept of 'end of life service providers' to co-ordinate care. This function for many years has been appropriately and effectively discharged by primary care teams working closely with community nursing, social services, palliative care nurses and specialists."*
>
> Londonwide LMCs

There was a strong sense that enhanced end-of-life care will require partnership working. The PCT's role in commissioning joined-up services should not be underestimated.

Many respondents raised the importance of appropriately trained and experienced staff to care for patients at the end of their life. There was concern that many NHS staff are not adequately trained for this role and joint working will need to be strengthened.

> *"The expansion of both rehabilitation and end-of-life care at home will have an impact on social care services and carers. Successful implementation will require strong partnerships and joint working with social care commissioners/providers and carers."*
>
> The Royal Borough of Kensington and Chelsea

> *"We recommend that NHS London provides a commitment that any reforms to end of life care will not lead to people dying in poor quality housing and/or alone, and that where hospitals provide end of life care this is in an adequate and dignified setting.*
>
> *"We recommend that health professionals work with patients at an early stage to help them plan for how and where they would like their end of life care to be delivered.*
>
> *"We recommend that NHS London clarifies how it will ensure residents of nursing/care homes are not transferred to a hospital to die when this is driven by the needs and wishes of the care home rather than the individual."*
>
> Joint Overview and Scrutiny Committee

Conclusions and further recommendations

Whilst there was general agreement in this section regarding most of the proposals there was some confusion over the status of the proposed ELSPs (even though 52% of respondents felt that their introduction would result in better care for patients).

When end-of-life care was not given the prominence or status that it deserved in healthcare commissioning, various models of palliative care and services delivery developed through visionaries and local initiatives that responded to local needs such as day care, community teams and hospices. Many have been in the voluntary/charitable sectors and have often been generated out of the experiences and needs of service users whose continued voluntary and financial support speaks for itself. This has also led to a huge repository of skill and expertise in end-of-life care across the capital. The UK leads the world (and continues to do so) in the development of hospice and palliative care, and several of the pioneer services are in London.

Nevertheless, local inequalities remain in access, consistency and quality. Virtually all of the workstreams have to engage with the needs of those at the end-of-life in various ways and to varying degrees. The challenge is to ensure that excellence in care is available to all and to direct it to the right place at the right time and in an appropriate way.

17.10.2 The JCPCT recommends that patients with advanced progressive illnesses who are identified as nearing the end of their life should be offered the opportunity to have their needs assessed and to identify their preferred place of death.

17.10.3 Whilst PCTs should aim to provide more choice to patients as to their proposed care and place of death, the JCPCT recommends that PCTs give consideration to the wishes of carers and families.

17.10.4 The JCPCT recommends that PCTs support and strengthen coherent and effective development and dissemination of excellence across the relevant professions, disciplines and care settings, and better co-ordinate care for people nearing their end-of-life. This could properly be done by acting upon local baseline reviews and designating end-of-life service providers.

17.10.5 In order to become expert at commissioning high quality end-of-life services and taking advantage of economies of scale, the JCPCT recommends that PCTs work collectively to commission adult services and potentially pan-London to commission children's services.

17.11 Where we could provide care

What did we recommend in Consulting the Capital?

To make sure, where existing services are working well, that any changes really are improvements. We wish to improve services at GP practices and local hospitals.

We should provide a new kind of community-based care at a level that is between the current GP practice and traditional hospitals.

We should develop a few more specialised hospitals focused on providing better- quality care for some conditions.

17.11.1 While we recognise that healthcare will be provided in a variety of places – for instance, schools, pharmacies and community hospitals – we think most healthcare will occur in six places:

1.	Home	**2.**	Polyclinic*
3.	Local hospital	**4.**	Major acute hospital
5.	Planned care (elective) centre	**6.**	Specialist hospital

* This could be in a networked polyclinic where existing GP practices link together and to a local 'hub'; a same-site polyclinic where many GP practices come together under one roof; or a hospital polyclinic.

None of the locations would work on its own. All would need to work together in networks that provided people with the right care in the right place at the right time.

Some services may be on the same site. For instance, there would always be a polyclinic on the same site as a local hospital, and an elective centre could share the same site as a local or major acute hospital. The proposals set out where we could provide safe and expert services in the most convenient place for patients.

Home

We believe more services should be provided in people's homes or in more local settings where this is suitable and patients want it. We want to make better use of the high levels of skill and experience of GPs and other healthcare staff – for instance, community matrons, therapists and ambulance staff – working in the community. Giving more care closer to people's homes will need larger community healthcare teams, more hospital specialists giving clinics in the community, more equipment (for instance to do tests) and buildings large enough to house the greater range of services.

Polyclinic

Polyclinics could provide part of the solution by offering a much wider range of high-quality services, over extended hours, to the community – reducing the need for patients to visit hospitals and other services. The location and design of each polyclinic would need to meet the needs of each community, but the idea is flexible enough to suit different needs across London. The benefits are:

- moving a wide range of services out of hospitals and into the community (some of these services could be provided by hospital staff working in polyclinics);
- providing a one-stop shop to access GP services, clinical specialists, community services, urgent care, healthy living classes, and other health professionals;
- extended hours. Polyclinics based at hospitals would be open 24 hours a day; those in the community would meet the needs of their neighbourhood.

In addition, services that would be under-used and uneconomical for one GP practice would be fully used in bigger settings. For instance, staff could be available to meet the needs of people with learning disabilities or mental illnesses or those with language or cultural barriers.

The networked model could be suitable in parts of London where the population is relatively spread out. The same-site model would be more suitable where the population is concentrated and existing GP practices are too small or there are not enough doctors.

Every hospital A&E would have a polyclinic as its 'front entrance' so that patients who did not need to go to A&E or be admitted to a bed could receive care there.

We are recommending the development of ten pilot polyclinics, but in ten years there could be 150 across London.

Local hospital

A local hospital would include a 24/7 polyclinic as its 'front door'. Most would also have a doctor-led maternity unit and a midwife-led unit, and provide most inpatient emergency care and outpatient services such as kidney dialysis. Patients who needed intensive or specialised treatment at a major or specialist hospital would move to their local hospital for rehabilitation as soon as possible. Local hospitals would work in a network to provide these facilities.

A 24/7 A&E department would treat people with urgent needs such as choking, diabetic complications, asthma attacks and fractures. For safety and quality reasons a local hospital A&E department would not perform complex emergency surgery. Non-complex emergency surgery would be provided during the day. Arrangements for emergency surgery at night would need to be discussed by hospitals in a particular area. The London Ambulance Service would need clear support and guidance to ensure patients were taken to the most appropriate hospital.

All A&E departments would have access to senior medical decision-makers 24/7 and someone who could give a surgical opinion quickly.

Major acute hospital

A major acute hospital would include a 24/7 polyclinic and would usually provide all the services of a local hospital – but also have teams in a range of specialties for the more complex work. They would treat sufficient numbers of patients to maintain their specialised skills, make best use of high-technology equipment and deliver the best results for patients. In a serious emergency, the ambulance service would bring patients here rather than take them to their nearest hospital if it didn't have the most appropriate facilities.

Major acute hospitals would take maternity emergencies, as would those local hospitals with a doctor-led maternity unit. Children needing emergency inpatient care would go to the most suitable major acute hospital. In addition:

- some of these hospitals (we are proposing around three) would take the most severely injured patients;
- some of these hospitals (we are proposing around seven) would take stroke patients 24/7, with other hospitals providing the same level of care to stroke patients during day time hours.

Planned care (elective) centre

Elective centres would focus on particular types of high-volume planned surgery such as knee and hip replacements and cataract operations. This work will be separated out from emergency surgery to achieve better results and productivity and reduce the risk of cancellations and cross-infection. Elective centres could be on a hospital site or separate. Elective centres are already being used in London, for example the South West London Elective Orthopaedic Centre is an NHS treatment centre on the Epsom General Hospital site. It performs nearly 3,000 hip, knee and shoulder replacements a year.

Specialist hospital

London has several specialist units that form part of another hospital trust, and seven specialist hospitals (Moorfields Eye Hospital, Royal National Orthopaedic Hospital, Great Ormond Street, Royal Brompton, Royal Marsden, Tavistock and Portman and the Maudsley) treating patients with conditions ranging from eye problems to mental health and cancer.

Responses to consultation and key issues for the JCPCT to consider

Respondents to the consultation agreed that reconfigurations should not be made to services that are already working well. The consultation proposed that improvements to GP practices, primary care and local hospitals were necessary, but care needed to be taken to ensure changes would actually deliver improvements, and not just be change for change's sake. Good clinical evidence was seen as critical.

Work being undertaken by the Healthcare for London workstreams will build on the existing clinical, financial and other evidence, and evaluating and testing proposed new models of care will ensure a sound basis for any future implementation.

The polyclinic service model

Responses to this section were dominated by the issue of polyclinics and opinion was divided. Half of respondents (50.5%) agreed that all or almost all GP practices should be part of a polyclinic – they thought that the integrated care it would provide would benefit patients.

Those that disagreed (29.5%) were concerned about the impact on the GP-patient relationship, the loss of continuity of care, privatisation of the health service, the impact on local services such as community pharmacies and the extra travel for patients, especially for those with mobility problems. Some also questioned the cost involved and the evidence base.

There was substantial support for the networked polyclinic – respondents who disagreed with the polyclinic idea were primarily against a same-site model.

> *"The proposals (on polyclinics) included in the report are interesting and UNISON believes that the concept should be developed further…we particularly welcome the inclusion of mental health services in any polyclinic setting as we believe this will help de-stigmatise mental illness as well as bring these services closer to the community and will ensure earlier intervention."*
>
> UNISON

> *"In sizing up primary care provision, RCN London's view is there is great scope for*

specialist nurses to have a much greater role in providing appropriate referrals to secondary care but only if the acute sector stranglehold on ordering diagnostics procedures is loosened. At present the systems seeks to reduce access to limited resources but access or more likely speed of service will only be increased through mass investment or dare we say independent sector involvement and allowing clinicians other than the GP to order and respond to investigations within agreed clinical pathways."

Royal College of Nursing

"We recommend that the NHS demonstrates that providing complex diagnostic services in new community facilities offers better value than using this funding to expand access to existing services (e.g. greater or improved access to hospital X-ray equipment for primary care patients)."

Joint Overview and Scrutiny Committee

"The proposed model of 'polyclinics' could work excellently to provide an integrated local health centre delivering a range of health, social care, preventative and quality of life services to older people, flexibly and in partnership with local organisations…The practical outcome will be influenced however by a whole range of factors including where the polyclinic is sited, transport links and how older people physically access it, the local health and social care economy and the culture of the PCT and local authority."

Age Concern London

"The evidence for shifting GP services to polyclinics is currently weak – there is a case to proceed with pilots that can be monitored and evaluated accordingly."

King's Fund

A number of respondents requested that social services, housing services, welfare advice, back-to-work advice schemes and leisure services should be based in a polyclinic.

Local Pharmaceutical Committees, whilst broadly positive about the benefits of federated or networked polyclinics, were concerned about the effects that very large polyclinics that involved the movement of GP surgeries might have on the distribution of community pharmacies.

"PCTs will also have to accept that locating a community pharmacy within a polyclinic needs careful planning. Pharmacists can play a useful role in the polyclinic activities outside the dispensing process and, for patients on acute visits, obtaining their medication during the visit may also be convenient. For these reasons installing a community pharmacy is acceptable but if it is only located there to generate a considerable rental fee it is totally unacceptable."

Bexley, Bromley and Greenwich Local Pharmaceutical Committee

"The Middlesex LPCs have long held the view that there will be benefit in pharmacies working collaboratively on NHS services via a 'virtual group practice' and we are now getting to the point where developments in technology can support that model."

Middlesex Local Pharmaceutical Committee

Developing more community-based care and specialised hospitals

There was positive support (40%) for moving the treatment of some conditions into specialist hospitals and providing more outpatient care, minor procedures/tests in the community; with local hospitals continuing to provide other care. A further 20% supported moving the treatment of some conditions into specialist hospitals (without moving some outpatient care into the community).

There was concern that, with the outflow of work from hospitals to the community and to specialist hospitals, local hospitals would become unviable. However, as the CAG report points out, a local A&E will deal with upwards of 300 cases a day, only one or two of which will be a stroke patient. Outflow to the community may be more significant, but of course many of these services may be run by specialists employed by the hospital. The current Healthcare for London workstream on local hospital feasibility aims to model the different options.

> *"We recommend that the NHS adopts a 'hub and spoke' model that involves local hospitals treating less complicated cases of specialist care in the daytime with specialist centres providing treatment out of hours when travel times are shorter.*
>
> *"We recommend that any centralisation of specialist care can only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require.*
>
> *"We recommend that NHS London provides a firm commitment that reforms arising from HfL will not threaten the concept of local hospitals which must provide a sufficient range of services to make them economically viable. Reforms must be planned so as to prevent a 'salami-slicing' of services that create diseconomies of scale.*
>
> *"We recommend that NHS London outlines how increased specialisation of hospital care will improve the care for people with multiple health needs (often referred to as 'co-morbidities').*
>
> Joint Overview and Scrutiny Committee

Conclusions and further recommendations

The argument that more services need to be directly provided from primary care settings putting GP-led care at the core of the NHS in London was well received. We recognise that the improvement in primary care will be developed differently in different parts of London and agree that one form of primary care will not fit every part of the city.

The JCPCT welcomes the development of the polyclinic concept by Healthcare for London as a service model rather than a specific building. Partnership working between GPs, primary care providers, hospitals, London councils and others to establish excellent quality care pathways will be just as important to improving patient care and outcomes as ensuring a building is fit for purpose.

17.11.2 In line with the responses we have received, the JCPCT recommends PCTs develop polyclinic models to meet the distinctive needs of their local populations. Whilst all polyclinic models will have to meet defined standards in respect of range of services, access and quality, the proposed approach will enable appropriate flexibility and diversity. We do not wish to limit enthusiasm for better primary care across London. Therefore, whilst the development of polyclinic models should be driven by local needs and considered by, amongst others, local people, local GPs and other healthcare professionals, we recommend that Healthcare for London takes responsibility for ensuring that there is a programme of support and continuous learning for PCTs so that different models can be explored and each new development can learn from previous good practice.
.

17.11.3 The JCPCT recommends PCTs should note and take into account the consultation responses if pursuing proposals for any polyclinic models based on a single-site. PCTs

should ensure that continuity of care is there for those patients who wish it alongside the easier access to a wider range of better services.

Early implementer polyclinics will need to be evaluated using an action research framework using a mixed method analysis, collecting data in real time as the project progresses. The starting point will need to be taken as the output of the initial development programme. The evaluation should be designed to define and capture outcomes, identify both problems and solutions and disseminate learning.

We will need to work with primary care providers – and welcome Healthcare for London's recent establishment of a Londonwide pharmacy group. The discussions now underway with community pharmacists will need to consolidate the work already done to assess opportunities and risks. The new pharmacy framework for England should be considered as a way of supporting the delivery of Healthcare for London.

Mental health services were not originally identified as a key element of a polyclinic service. However, there was strong support in the narrative responses for mental health services to be an integral part of a polyclinic. This could involve being the co-located base for a community mental health team and the expansion of practice-based psychological therapies, particularly cognitive behavioural therapies or talking therapies. Aligning access to crisis home treatment teams, with their role in preventing admission to hospital beds for those with severe mental health problems, and in expediting discharge was also advocated. There was strong support to further develop the role of child and adolescent mental health services and mental health prevention could also be a part of the work of a polyclinic.

A combined model of primary and mental health care could held to 'destigmatise' mental health patients and encourage access to services. Similarly responses from traditionally hard to reach groups and carers demonstrated strong support for integrated care. Of course it would be for local decision as to whether these services could add value to a particular polyclinic.

17.11.4 The JCPCT recommends that PCTs, when considering polyclinic models, consider the consultation responses regarding the types of services that could be provided (the three most important factors were GP services, tests and minor procedures).

The case for the right number of specialised units in secondary care where staff can gain the necessary expertise to deliver the high quality care to save lives in stroke and trauma services is compelling and is discussed in the section on acute care. The patient pathways that need to be developed before and after these acute events have taken place in specialised settings will need to involve local hospitals, primary and social care providers.

However we believe that local hospitals will form the backbone of secondary care for Londoners. Local hospitals will need to deal with the vast majority of secondary care for a particular community, both medical and surgical care, and they may receive those who have had specialised care for their initial rehabilitation. Nevertheless, the JCPCT recognises that the direction of travel – to provide more services in the community and some specialist services in specialist centres – has implications for the funding of local hospitals and the training of medical students. The JCPCT supports the workstream investigating the implications of Healthcare for London on local hospitals.

These proposals are clinically-led and the clinical case for change remains. The majority of respondents supported the proposals although there were concerns over the concept of polyclinics – particularly if they were large buildings into which all GPs would be 'herded'.

For decision

The JCPCT:

18) agrees that more outpatient care, minor procedures and tests should be provided in the community. Local hospitals should continue to provide most other types of secondary care.

19) agrees that the polyclinic service model should provide improved primary healthcare in London. The nature (for instance networked, single-site, hospital-based), location and precise services offered should be determined by appropriate local engagement, consultation and decision-making.

D – Turning the vision into reality

Throughout this consultation respondents have stressed the importance of 'Turning the vision into reality' (Chapter 9: *Consulting the Capital*). We have been told loud and clear that good clinical plans for new services will fail to improve the health of Londoners if they cannot access them, if staff are not properly trained, or we do not have the finances to implement them.

The following sections describe some of the key challenges that PCTs will need to overcome if they are to deliver truly world-class services for their populations.

Making change happen

PCTs, in planning service change, must carry out careful modelling to understand the impact of proposals. Full assessment and consideration of all key revenue, capital, capacity, workforce and other enabling factors must be undertaken. Where necessary, business cases must be produced and approved.

Rigorous project planning capabilities must be utilised by PCTs as they implement change. This will require appropriate skills and expertise. Particular attention should be given to transitional phases as existing models of care are phased out and new ones introduced. Generally, the existing model will not be ceased until the new model is operating in a robust, proven manner.

PCTs will need to engage with their local populations as they plan and implement change. They will seek to develop a particularly close relationship with the Overview and Scrutiny Committees, discussing proposals as early as possible. Where necessary a full public consultation will be undertaken.

Many of the new models of care which have been the subject of consultation require planning and care delivery arrangements along a defined patient care pathway. Often these will necessitate the development or strengthening of clinical networks. These networks will play a significant role in defining standards, recommending resource deployment and ensuring coherent, consistent delivery. There are many examples of effective clinical networks across London. Steps must be taken to build on these and learn from acknowledged good practice.

Whilst acknowledging the need to enhance commissioning capability, there may also be a requirement to develop the commissioning system. New incentives and new financial arrangements may need to be introduced to enable an appropriate focus on quality and patient experience.

We also recognise that the UK has a proud history of research and development. As stated in *A Case for Change*, 'London should be at the cutting edge of medicine'. Currently London is in danger of losing that competitive advantage. We welcome the establishment of the Academic Health Science Centre around Imperial College Healthcare NHS Trust and hope that research and development – which is so essential in driving innovation in healthcare, gains the recognition it deserves to ensure Londoners can benefit from truly world-class services.

17.12 Finance and commissioning services

What did we say in *Consulting the Capital*?

We estimated that by 2016/17 the London PCT healthcare budget will have risen to £13.1 billion. This is a rise from the current figure of £11.4 billion a year. We stated that we had estimated projected costs and believed that if we carried on providing services as we do now, we wouldn't tackle the current weaknesses in quality and accessibility of care and would spend £14.5 billion. Our best forecast of spending if we make the changes recommended in Healthcare for London is £13.1 billion.

Primary Care Trusts (PCTs) buy, on behalf of the public, almost all health services. At the moment some PCTs lack some of the skills needed to buy high quality, easily accessible services that result in the best possible health and wellbeing of residents.

To raise the standard of buying services, we need to develop London-wide guidelines, provide better training and involve more clinicians and other partners, like local authorities.

Responses to consultation and issues for the JCPCT to consider

Many stakeholders questioned how a bigger budget could be used more effectively and efficiently or wanted to see more accurate budgets.

> *"We recommend that NHS London states how and when the money will come from to develop new services in order to address concerns over whether the NHS has the resources available to deliver major reform."*
>
> Joint Overview and Scrutiny Committee

It needs to be recognised that A *Framework for Action* and *Consulting the Capital* are strategic documents. They do not recommend specific individual services or buildings.

However we are clear that efficiencies can be made, for instance:

a) hospitals are expensive places to run in order to perform fairly simple outpatient treatments;
b) care pathways can be made to be more efficient;
c) better training can increase productivity;
d) reconfiguration of services can bring economies e.g. the use of elective centres which reduce cancellations due to A&E suddenly diverting resources;
e) good surgery/procedures cost less than poor surgery e.g. if major trauma, cancer or stroke care is in specialist centres then there will be fewer complications, less readmissions; and
f) better prevention means lower cost of treatment. Creating a National Health Service rather than a National Sickness Service.

Healthcare for London is set up as a **commissioning** programme, so the pathway projects – Stroke, Major Trauma, Unscheduled Care and Diabetes that have been given priority are looking at service users, their needs, population changes and future commissioning proposals. The programme is working from the PCT perspective - identifying needs, pathways and what is best for patients. There needs to be an assessment of the overall impact of changes on hospital trusts to ensure the whole system remains viable, but the impact on individual organisations will be assessed by that organisation. PCTs have no way of knowing what the financial impact will be on individual organisations, particularly

Foundation Trusts. PCTs will need to work with providers of services to discuss any proposed changes in patterns of service.

"NHS London must strengthen local commissioning so that services can be delivered where they are needed most, rather than looking for a 'one size fits all' solution."

Royal College of Nursing

Some professional bodies and pressure groups raised concerns that the proposals may pave the way for privatisation or outsourcing of essential NHS services.

> *"The threat – of transactional fragmentation and commercial distortion of care – could be noticeably reduced by recognition by government that involvement of market mechanisms including the private sector in any such development plans is totally incompatible with the conditions of mutual support, trust and co-operation that are necessary to attain these new levels of NHS performance and achievement."*
>
> Keep our NHS public

Conclusions

Many respondents were concerned about the lack of financial planning for Healthcare for London, whilst others challenged the assumptions – in particular the efficiencies that could be made. However it should be recognised that *Consulting the Capital* is a strategic document and the finance figures are estimates.

Local implementation of decisions will mean very different challenges to each PCT. Is the PCT financially stable? What is the current configuration of services? How will they be configured to align with new proposals? What are the needs of the local population? These are all questions that need to be asked to assess the local cost of delivery.

To assist PCTs in their planning, significant work needs to be undertaken:

1. Local Hospitals – Healthcare for London must test the feasibility of the model as described in *Consulting the Capital* to assess the financial and clinical viability of a hospital trust if more work is to be carried out in the community and there is more specialisation in acute trusts.

2. Polyclinics – A robust but flexible modelling tool will be needed to help PCTs ascertain the costs of operating all the different types of polyclinic service model and also to support PCTs to commission polyclinics.

The role of PCTs is at the core of all of these improvements in health and healthcare. How PCTs commission these improvements will determine how fast healthcare for Londoners will improve. The Department of Health has set a goal for all PCTs to improve their skills to become world class commissioners. PCTs must become world class commissioners of services that are affordable, cost-effective, sustainable, of high-quality, and which will reduce inequalities and improve the health of their local population.

To achieve this goal, all London PCTs will be going through an assurance process, judged against an agreed list of competencies. This will lead to board development programmes that strengthen their commissioning capabilities in support of Healthcare for London. Development programmes will include leadership to deliver world class commissioning; ownership of a meaningful strategic plan for commissioning – and financial, operating and development plans; ability to understand and procure the delivery of improvements in health outcomes; Key Performance Indicators and performance management information to

measure improvements in health outcomes; networking and relationship-building skills and board controls and processes.

Recommendations

17.12.1 The JCPCT recommends PCTs consider the impact of changes to services and reflect them in future Strategic Plans and accompanying analysis. PCTs will need to get better at self assessment, critically analysing their own plans, to ensure that healthcare is affordable, fit for purpose and does not adversely impact on other parts of the health economy.

17.12.2 The JCPCT recommends all detailed proposals are fully costed, within available resources, procured from the most cost-effective providers and include contingency plans should funding or activity levels vary. This will require comprehensive, robust business plans.

17.12.3 The JCPCT recommends that Healthcare for London decisions become an integral part of PCT Commissioning Plans. It is essential that changes in commissioning costs are reflected in PCT annual and medium term plans, rather than be seen as part of a separate commissioning plan.

17.12.4 The JCPCT recommends PCTs pay particular attention to transitional processes. Detailed and comprehensive plans (including finance and commissioning) need to be developed and it will be critical that there is no deterioration in quality or availability of services as new models of care are introduced.

17.13 Workforce and training

What did we say in the consultation?

Introducing these proposals means big changes for NHS staff in London. At the moment, the majority of London's NHS staff are hospital-based (61%). These proposals suggest moving staff out of some hospitals and into the community; making better use of the high levels of skill of staff working in primary care; and introducing new roles and responsibilities. The consultation recognised that staff will need support to move from hospitals into the community.

NHS London plans to develop a workforce strategy which will support local workforce planning. The NHS is a major employer and needs to continue to encourage applicants from local areas of deprivation and to reflect the cultural diversity of London.

All these ideas will require early, open and informed discussion with staff, unions, education and training providers, and others.

NHS London needs to explore how training and education can best be organised and provided to meet the future workforce needs of London and to support its role as a world-class centre for education and innovation. Training needs to be given a high priority and to be linked to the workforce strategy.

There is potential for developing exciting new roles, such as GPs with a special interest in emergency medicine or paediatrics – and we will need more staff in existing roles, such as specialist long-term condition nurses. NHS London will need to plan how we can train these people.

Of all London's healthcare providers, the London Ambulance Services (LAS) receives the least funding for education. LAS staff have a growing role in diagnosing serious illness and injury and need resourcing to improve their skills and procedures.

Responses to consultation and issues for the JCPCT to consider

Many respondents raised the need for more investment in the health workforce. Hospitals, including North West London Hospitals NHS Trust and Barts and The London NHS Trust, called for more flexibility of employment between hospitals and community care, and between health and social care. They also said staff should be involved in the detailed planning and development of new services.

> *"RCN London recommends that higher priority be given to the contribution of nurses, nursing, midwives and allied health professionals in terms of improving patient outcomes, tackling public health, improving cost effectiveness and delivering innovation in service provision."*
>
> Royal College of Nursing

The Royal College of Nursing (RCN) said its members acknowledged the shift of staff from hospitals to the community but felt it would be difficult without significant investment in training and re-education. The RCN and UNISON called for more investment in workforce planning systems and processes.

The HIIA/EqIA called for workforce development plans to be prioritised and the JOSC said:

"We recommend that NHS London publish a workforce strategy that will enable the delivery of any changes to London's health services."

Joint Overview and Scrutiny Committee

The proposals suggested a further increase of medical staff would be required and many respondents (e.g. the JOSC, traditionally under-represented groups and local authorities) said it should be acknowledged that some local health authorities were already experiencing difficulties recruiting and retaining staff. They questioned whether the NHS has the capacity or ability to provide the extra staffing that will be required.

Workforce strategy

NHS London is developing a workforce strategy, '*Workforce for London*', working with hospitals, PCTs, staff, unions and training and education providers, which addresses key issues facing staff moving from hospitals to the community, employment flexibility, and the continuing development of a workforce which reflects the diversity of London. The engagement and involvement of staff in delivering service changes will be a key part of the strategy.

This is a high-level ten year strategy setting out, for the first time, a holistic view of the shape of the clinical workforce in London's NHS health economy.

Key themes of the strategy are:

- the shape of the future clinical workforce to support the new vision;
- the implications for new and existing roles; and
- the implications for investing in and developing new skills

The development of *Workforce for London* is underpinned by a number of projects that will examine in detail, areas of the workforce where significant change is likely to be required to deliver the services envisaged in Healthcare for London. These include:

- a framework to implement incentives and levers to promote productivity;
- greater need for community-based care setting out the vision for an out-of-hospital workforce in 10 years' time; and steps needed to build a multi-disciplinary workforce to deliver this vision; and
- an analysis of the existing medical workforce that will be reviewed against the emerging service strategies. This is to ensure training and investment plans reflect future needs in terms of what is required for London - nationally and internationally.

Through its Social Partnership Forum (the London NHS Partnership Forum), NHS London is supporting employers and trade unions to work together to deliver the changes envisaged in 'Workforce for London'. This forum enables partnership working at a strategic level on London wide issues that can be best facilitated by a joint approach.

Training

Many respondents raised the need for better training of NHS staff. Hospitals, professional organisations and unions welcomed the commitment to training and education and called for more investment. Several hospitals commented that their own training systems could be developed to support the proposed changes, both within their own organisations and across other organisations.

There were also calls to develop the capacity and capability of the NHS to commission high-quality training.

"…resources for workforce development must not be diverted in times of financial difficulty."

Joint Overview and Scrutiny Committee

"At present, the vast majority of education money is spent in secondary care. This will have to change. Similarly, research funding will need to be made available if we are to learn better how to reduce inequalities, particularly in "hard to reach" populations."

Healthcare for London Clinical Advisory Group

The London Medical Committees (LMCs), representing London General Practice, said that education and training should be at the centre of implementing change, and raised the need to increase both the funding of, and physical capacity for, GP training. Although LMCs also questioned the principle of specialisation for GPs.

"Although the pursuit of individual interests and the development of expertise within group practices is not only inevitable but desirable, any further fragmentation of services, particularly those suggested by the range of new roles for GPs proposed at various stages in the report, are likely to have a serious de-skilling effect on GPs."

Londonwide LMCs

There was widespread agreement on the proposal for London Ambulance Service (LAS) to take a greater level of responsibility in decision-making on treating and transferring patients. The LAS agreed that changes in their workforce would be required, including improved training for all paramedics. Several hospitals commented on the need for training to ensure the LAS could fulfil this role, particularly in dealing with complex cases. UNISON specifically supported the proposal to invest in training LAS staff.

Conclusions

Training budgets are often targets for savings in times of budget constraints. We recognise that it will be impossible to deliver the vision of Healthcare for London if training is not seen as a high priority over the coming years.

We urge NHS London to take the lead in organising and providing a world-class training regime and supporting PCTs in planning, contracting, quality-assuring and managing training that will ensure the London health workforce is second to none.

NHS London has a responsibility to ensure, with NHS Boards locally, that the leaders who manage NHS services within London are of the highest calibre. Poor leadership will result in poor services for Londoners. We therefore wholeheartedly approve of the programme of work, 'Leading for Health', which has been initiated to support NHS organisations to develop current and future leaders in both clinical and management roles.

Whilst efforts to recruit highly skilled staff should be prioritised, it should be remembered that the majority of the workforce that will be employed in 2018 are current NHS employees. It is essential that existing staff and unions contribute to the detailed planning and reconfiguration of services, are involved in developing new ways of working, and are supported to meet the challenges of the Healthcare for London programme. A dialogue with employers will be required to be clear as to the role they should play, whilst service commissioners will want to consider what incentives they can put in the system to encourage employers.

In order for NHS London to deliver world class education it is essential the commissioning process with education and training providers (e.g. Higher Education Institutions (HEIs) and NHS Trusts), is aligned to best practice. NHS London must develop a new commissioning process to take a 'value for money' approach and meet the workforce needs of the service.

The development of a workforce strategy is essential and must take into account the new ideas and concepts contained in Healthcare for London to ensure proper consideration of new ways of working, and potential new roles. It must also make allowance for, and consider, the different challenges facing different parts of London, and that there is no one-size-fits-all solution. As well as solutions being flexible, they must also be sustainable.

Of course it is well documented that the attitude of staff is high on the list of changes the public would like to see – and this doesn't need to be costly.

Recommendations

17.13.1 The JCPCT recommends that NHS London takes the lead in organising and providing a world-class training regime and supporting PCTs and other organisations in planning, contracting, quality-assuring and managing training that will ensure the London health workforce is second to none.

17.13.2 NHS staff will be vital to driving improvements to healthcare. As they take on new tasks in new settings it will be important for them to have opportunities for training, and where there are areas of significant change, a transition path will be needed. The JCPCT recommends the prioritisation of training throughout the NHS, but especially for the London Ambulance Service; and the development of a pan-London workforce strategy. Future work will need to continue to include key partners such as staff, hospitals, PCTs, unions and training and education providers. In addition the London NHS Partnership Forum, bringing together London NHS Unions, employers and NHS London is working to ensure the appropriate involvement and representation of staff. This should involve the establishment of sectoral or other geographic joint arrangements.

17.13.3 The NHS is a major employer. The JCPCT recommends the NHS in London continues to encourage applicants from local areas of deprivation and to reflect the cultural diversity of London.

17.13.4 The proposed workforce strategy being developed by NHS London must be flexible, sustainable and comprehensive.

17.14 Partnerships and social care

What did we say in *Consulting the Capital*?

To turn the Healthcare for London vision into a reality will need the involvement of everybody who works in the NHS. Everyone will need to be actively involved in developing improvements to ensure that healthcare in London is the best it can be.

The NHS will need to improve how it works in partnership with local authorities, the voluntary sector, higher education, the private sector, health providers and other organisations.

Specifically, we proposed that health and social care staff should be supported to develop effective ways of diagnosing people with long-term conditions and finding people who do not present to the healthcare system.

Responses to consultation and issues for the JCPCT to consider

NHS respondents to the consultation highlighted that working in partnership across their local health economy is already a key foundation of their business and strategic planning, but that external forces were making this increasingly difficult, not easier to deliver. The NHS will need to find solutions to this conundrum.

> *"With an increasing emphasis on competition and autonomy of providers of NHS services, as well as the complex relationships between primary care provision and commissioning, this will need careful handling."*
>
> St George's Healthcare NHS Trust

Many respondents raised the importance of partnership working with local authorities. Stakeholders felt that this was crucial for improving the delivery of healthcare and identified key priority areas, such as better co-ordination of health and social care, encouraging people to lead healthier lifestyles and addressing inequalities.

Responses from local authorities raised the potential for more joint commissioning arrangements and even closer partnership working to tackle health inequalities and improve public health.

> *"We recommend that NHS London and PCTs are proactive in approaching local Councillors before and during work to develop local health services: the NHS must have an ongoing dialogue with Overview & Scrutiny Committees (OSCs) to discuss the appropriate level of consultation."*
>
> Joint Overview and Scrutiny Committee

The King's Fund said Local Strategic Partnerships and Local Area Agreements would provide a framework for ensuring better co-ordination between PCTs and local authorities, as well as other partners.

> *"We therefore welcome the idea that the NHS at all levels in London will advise, support and work alongside local authorities and the Mayor of London, who have direct responsibility for services such as public transport, urban planning and leisure facilities, to ensure that they deliver improvements in health."*
>
> King's Fund

There was a widely-held view that the proposals would result in increasing demands on the social care sector. Some stakeholders, particularly from local government, expressed dismay that social care had not been more involved in the review process. Many said there had been no modelling of potential additional demand and no attempt to quantify the impact on social care.

For instance, the Royal Borough of Kensington and Chelsea said the planning and implementation of change should be jointly carried out across the health and social economy in London, and a unified financial model developed for the provision of health and social care in the community.

> *"We recommend that London Councils is involved in developing further detailed proposals for London's health services, including fully quantifying the impact on community care services. Partners must have a shared understanding of their required contribution to avoid disputes over 'cost-shunting'.*
>
> *"We demand that NHS London outlines how seamless care will be provided in the context of the hugely differing budget increases for health and social care that have sharpened the distinction between universal health services and means-tested social care services. Future funding allocations must give equal weight to health and social care budgets."*
>
> Joint Overview and Scrutiny Committee

Conclusions

To improve health and healthcare, PCTs must work in very close partnership with London Councils generally, and with the Mayor – to reduce health inequalities. Throughout the consultation, local government has been at the heart of this process of health and health care improvement and it is vital that this remains the case as plans become more detailed.

This partnership between PCTs and local government will form the core of other relationships with voluntary and community organisations, other public services and the private sector. These partnerships need to drive improvement on a London-wide basis as well as within each local health economy. And the relationships will need to extend further than the social care field (for example caring for people with long-term conditions or rehabilitation of stroke patients) into other, equally important areas, for instance the prevention of ill-health.

The NHS in London needs to become a full partner in supporting Local Strategic Partnerships and Local Area Agreements, working closely with local partners on developing and supporting new arrangements, including joint commissioning, Joint Strategic Needs Assessments, and new scrutiny arrangements.

Whilst social care has been at the heart of the consultation and planning process to date we recognise that an understanding of the impact of changes in the NHS on social care is essential if patients are to receive a joined-up care package with individuals at the centre of a web of care. The JCPCT welcomes the work by Healthcare for London and London Councils that is already investigating the interdependencies between health and social care. As service plans become more detailed and are implemented it is vital that health and social care commissioners develop a genuinely joint assessment of needs for each patient pathway.

However we do not accept that Healthcare for London will automatically burden social care budgets. Better stroke care will reduce disability of patients; better prevention of ill-health

will reduce the incidence of long-term conditions and delay their onset until later in life for many people; better care pathways for children could result in greater efficiencies. For this reason we believe future funding allocations must give appropriate weight to the needs of the community, not to artificial institutional boundaries.

Joint working between the NHS and partner organisations is to be encouraged. The JCPCT welcomes the enthusiasm of organisations to work with the NHS, and encourages all those responsible for commissioning and developing services in the NHS to channel that enthusiasm into fruitful partnerships.

We also welcome the London Ambulance Service's (LAS) examples of what it could do to improve healthcare for Londoners. For instance:

- Supporting early intervention teams in the identification of mental illness;
- Providing flu vaccination for target groups;
- Undertaking home visits on behalf of GPs;
- For long-term-conditions (LTC) patients:
  - Distribute information to prevent long-term conditions to vulnerable patients
  - Provide immediate access to a patient's wider web of care
  - Undertake opportunistic screening to diagnose LTCs such as diabetes;
- Helping patients access local support groups;
- Training health professionals and members of the public in emergency life support skills;
- Playing a part in ensuring that a patient's wishes are respected on their End-of-Life care.

Recommendations

17.14.1 The JCPCT recommends PCTs become better partners with a range of organisations in their local communities, especially LINks, understanding what will deliver the best health of their population and working with others to ensure economic, social and organisational boundaries do not obstruct provision of better healthcare.

17.14.2 The JCPCT recommends PCTs work with London councils and the Mayor to tackle the challenge of improving the health and social care of Londoners, and reduce health inequalities. PCTs and NHS London must quantify the impact of changes in healthcare on social care budgets and services and work in partnership to provide a seamless service.

17.15 Patient choice and transport

What did we say in *Consulting the Capital*?

From 2008, patients will be able to choose any approved provider of healthcare for planned treatment. This is likely to mean you change the places you go for treatment, so popular providers will increase their services to meet demand. You must have better information if you are to make informed choices. You need to know what to expect from services and how to access information.

We know that transport will be a key issue and we need to work with a range of organisations to ensure that places providing care are easily accessible.

Responses to consultation and issues for the JCPCT to consider

The need for clearer patient information and better signposting of services, particularly for disadvantaged groups, was a common theme.

The need for better information was highlighted by the LMCs, the King's Fund, the Health Link consultation with traditionally under-represented groups, and a number of hospitals, who said patients needed help to navigate through an increasingly complex health and social care system.

Some respondents felt that wider social changes would be needed to reduce inequalities. Many felt that advocacy and recognition of the need for language services was imperative, whilst others reiterated the importance of partnership working, for example with local councils and with voluntary and community sector (VCS) organisations.

But, as Transport for London said:

> *"In seeking to facilitate individual choice, the question of how people are able to access healthcare must form an integral part of the planning and delivery process."*
>
> Transport for London

The implications the proposals will have on transport services need to be considered fully, prior to implementation – and at the earliest possible planning stage. There were concerns that travelling time to specialised services and re-configured primary care will increase for some patients and this might have a negative impact on the accessibility of services.

> *"World-class healthcare will remain an aspiration for many Londoners if they cannot reasonably get to the sites from which those services are provided. We therefore believe it is paramount that the accessibility of any new, or reconfigured facility should be considered at the earliest possible planning stage, giving particular regard to travelling by public transport, bicycle and on foot. … too many hospitals have been relocated to places remote from public transport on the assumption that the transport provider, often TfL buses, will be able to introduce new routes or divert others. Often this is not the case."*
>
> London Travel Watch

The main transport organisations and advocacy groups welcomed the consultation's emphasis on accessibility.

Transport for London (TfL) said Healthcare for London offered the opportunity to take a proactive approach to planning, and that a comprehensive analysis of the travel implications of the proposals should be undertaken jointly with NHS London. TfL said it would welcome working with NHS London and PCTs to develop criteria for selecting sites for hospitals, polyclinics and other large-scale facilities, which optimised access.

Meetings with residents and service-users hosted by PCTs, and the Health Link consultation with traditionally under-represented groups, raised concerns about the impact of the proposals on transport services. These included travelling extra distances to polyclinics for older or disabled people, or to specialist care for children, particularly for disabled parents.

> *"We recommend that the London Ambulance Service (LAS) and Transport for London (TfL) are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS London must work with these organisations to agree a travel plan to underpin any expansion of a hospital's services.*
>
> *"We recommend that new primary care facilities (i.e. the model referred to as 'polyclinics') can only proceed if the NHS has agreed a travel plan with TfL and the relevant local authority."*
>
> Joint Overview and Scrutiny Committee

London boroughs, including the City of London also expressed an interest in being involved in transport planning around these proposals.

The Healthcare for London programme has recognised the importance of transport issues in the commissioning of health services and has established a clear working relationship with NHS London and Transport for London to ensure links are strengthened and practical improvements made. A travel model is being developed to be used by PCTs as a tool for increasing their understanding of challenges and opportunities relating to particular service changes. Work is also ongoing to look at relaunching the London wide NHS travel group to bring together the various agencies and ensure that communication, and therefore planning, is improved.

Conclusions

Empowering the public and patients with greater choice is a key part of these improvements in health and healthcare. To realise the power that comes with this responsibility, it is essential that patients have the information they need to make those choices. In a world city such as London this needs constant attention.

We fully accept Transport for London's recommendations as an excellent basis for agreement of a set of guidelines and protocols. These could support PCTs (working in partnership with local communities) to develop transport planning into any proposals for new or reconfigured hospitals, polyclinics or major health centres. PCTs would like to work in partnership with TfL to achieve its stated recommendations, including:

- Ensuring reconfiguration or relocation of healthcare services:
    - Help reduce the need to travel, especially by car;
    - Help influence a shift towards more sustainable modes of transport;
    - Encourage access on foot or by bicycle wherever possible; and
    - Reduce inequalities in healthcare.
- Integrating the planning of healthcare services with transport provision.
- Promoting improved health in the capital by producing travel plans for larger developments.

- Designing healthcare sites to give priority to people arriving by foot, by bike or public transport, optimise access by sustainable modes and actively manage parking.

Recommendations

17.15.1 The JCPCT recommends that each strand of detailed planning and implementation demonstrates how it will better inform patients and the public across the capital so that Londoners are empowered to choose the type and location of high-quality services that is most suitable for them..

17.15.2 The JCPCT recommends NHS London works in partnership with Healthcare for London, TfL, the London Ambulance Service and others (such as community transport organisations, the GLA and councils) to develop the TfL recommendations into more comprehensive guidance that could be used when PCTs consider any service reconfigurations.

17.16 Capital investment – information technology and estates

What did we say in *Consulting the Capital*?

We will need good information technology to ensure that patients' information is available where and when it is needed, and that it remains secure. This will enable NHS staff to give each patient the best care, especially in an emergency, when having the most up-to-date information is crucial. Ensuring patients have access to their own information is also important.

Responses and issues for the JCPCT to consider

> *"We recommend that the NHS London provides further reassurance on how the ability of Foundation Trusts to retain resources from the disposal of their estates affects NHS London's proposal to use the sale of underused assets to pay for polyclinics and new community facilities."*
>
> *"We recommend that further work is undertaken to ensure that the appropriate ICT infrastructure is in place to deliver the care pathways arising from this and subsequent consultations. The NHS must state what it has learnt from the recent attempts to implement major ICT projects."*
>
> Joint Overview and Scrutiny Committee

Newham University Hospital NHS Trust commented that further work was needed to consider the implications of the proposals on areas like technology and the availability of information; and the Royal College of Nursing said a major factor in the successful delivery of change proposals would be the ability of IT systems to interact. Some of their members expressed concerns about the IT capacity of the NHS.

Conclusions

Improving the flexibility and adaptability of the NHS estate in London, as well as unlocking the value of that estate, is critical to the successful delivery of Healthcare for London. The existing estate has an important part to play in the delivery of new models of care although it must be less constrained in order to do so to its full potential.

Practitioners' access to patient records will be critical in balancing continuity of care with better access for patients. And if care in people's homes is to be a viable option, then mobile solutions will need to be in place.

Recommendations

17.16.1 The JCPCT recommends NHS health organisations in London deploy and support IT systems which ensure that patient information is available where and when it is needed; and ensure policies on access to medical records are up-to-date – and that staff are well-versed in them.

17.16.2 In order to catalyse the scale of transformation of services and facilities contemplated in Healthcare for London the JCPCT recommends that NHS London develops a pan-London estates strategy. This should focus on:

- Making best use of the estate entrusted to the NHS, both as a strategic resource and physical space;
- Unlocking the latent value within the NHS estate;
- Ensuring an equitable distribution of this scarce NHS resource for all Londoners; and
- Enabling commissioners and providers to deliver improved healthcare.

We would also like to see how the estates strategy could, and would, translate into local strategies.

17.17 A coherent approach to implementation

17.17.1 We have established a compelling case for change. We have raised expectations. We have and will continue to adopt an open and inclusive approach as we plan and implement improvements. We must deliver. To enable this, the JCPCT recommends:

- The SHA continues to adopt a position of effective strategic leadership;
- Direct responsibility for change rests with PCTs as commissioners;
- A dedicated resource – the Healthcare for London programme team – supports PCTs in planning and implementing change;
- A London Commissioning Group maintains responsibility for planning and overseeing the programme. It is important that implementation is carefully monitored; and
- A committee of PCTs be established where there are London-wide issues to be consulted upon.