Healthcare for London: A Framework for Action

Introduction

1. The establishment of a single health authority for London has created a unique opportunity to develop an exciting, innovative and coherent vision for health services in the capital. One of the early actions taken on NHS London's formation in July 2006 was to initiate work on a strategy to meet Londoners' health needs over the next five to ten years.

2. Last autumn NHS London commissioned Professor Sir Ara Darzi, Paul Hamlyn Chair of Surgery at Imperial College, London, to undertake a review of London's health services.

3. This review was formally launched in December 2006. The first stage, *The Case for Change*, was published in March 2007. It made a compelling case for why healthcare in London has to change.

4. The final report, *Healthcare for London: A Framework for Action,* was published on 11 July 2007, marking the culmination of nine months of intensive work by Professor Darzi and his team.

5. *Healthcare for London: A Framework for Action* presents a powerful vision of how much better healthcare in London could be - safer, more accessible, higher quality – and of how much healthier Londoners could become. Its recommendations include innovation and challenge in equal measure.

6. This paper invites the Board to formally receive the report and describes proposals for how the NHS in London should respond to it.

The journey so far

The review process

7. The Healthcare for London review was built on a strong programme of engagement. As part of the review process, six clinical working groups were established to make recommendations on ideal care pathways and the future provision of services. These pathways were: maternity and newborn care; staying healthy; acute care; planned care; long-term conditions and end-of-life care. The membership of the clinical working groups was drawn from clinical innovators across London. During the early stages of the review mental health was considered to need a specific focus and the chief executives of London's mental health trusts were involved in drawing up key proposals for this area.

8. The review was informed by the views of 7,000 Londoners, established through an IpsosMORI poll commissioned by NHS London. During the review two all day deliberative events were held with members of the public, each attended by 100 people. These were followed by two further events, to present and seek views on findings and recommendations as work progressed.

9. An all day deliberative event was also held with members of voluntary sector organisations, recognising the important contribution they make, and the experience that voluntary sector organisations have in delivering services to particular communities, including vulnerable groups.

10. Meetings were held to seek views and advice from Royal Colleges, National Clinical Directors and with London-wide bodies including the Greater London Authority and London Councils. Meetings and briefings were also held with London MPs.

11. In addition to this, a wide range of stakeholders were invited to submit written views and evidence and a key clinical conference was held in February 2007 with international contributions. A dedicated website was created and updated as the review progressed. Routine meetings with the NHS, partners and other bodies were well used to brief and report progress.

12. The process involved a substantial review of information and evidence in examining the present state of health and health services in London, in particular to inform the work of the clinical working groups and their recommendations on future service models, to assess future health needs, to consider health delivery models and to consider enablers of change.

13. A huge amount of energy and enthusiasm has gone into this review and preparation of the report. A significant number of people across London who really care about improving the NHS in the capital have contributed their time and knowledge to it and have helped to formulate the recommendations within it.

The report and recommendations – an overview

14. *Healthcare for London: A Framework for Action* covers five key areas: the case for change; future service models; future health needs; health delivery structures; and how the *Framework for Action's* vision could be turned into reality.

15. The case for change identifies eight reasons why healthcare in London needs to change. Opportunities for improvement are indicated in each area. The reasons for change include:

    - the need to improve Londoners' health, with the report citing some specific health challenges in London and the need to meet the needs of London's diverse and mobile population
    - the need to better meet Londoners' expectations
    - the need to tackle stark inequalities in both health and healthcare
    - the need to develop services in settings that better meet requirements for local care and provide the skills and expertise necessary for specialised care
    - the need to develop London's contribution to global research
    - the need to use resources better - healthcare staff, physical assets (such as premises and equipment) and money.

16. The review considered Londoners' health needs over the coming decade to ensure recommendations not only address current challenges but also those of the future. The report sets out projected changes in London's population, which will get bigger and grow older over the next 10 years. Growth and therefore demand for healthcare will not be evenly spread, but will be concentrated in the east of London, mainly along the Thames Gateway. The report considers changes in disease prevalence, in ethnicity and in public health trends and the impact this will have on health and demand for healthcare. This section also considers the impact of future technological changes and rising public expectations. It concludes that our current healthcare system will not be able to meet this demand.

17. The largest chapter in the report sets out the recommendations to improve care pathways in the seven areas previously mentioned (paragraph 7). The chapter opens with five principles for the provision of future healthcare. These emerged as the most commonly raised themes from stakeholder meetings and events and the report's recommendations are based on them. The five principles are:

- Services focused on individual needs and choices
- Services should be localised where possible, centralised where necessary
- Services should be based on truly integrated care and partnership working, maximising the contribution of the entire workforce
- Prevention is better than cure – health improvement should be imbedded in everything the NHS does
- A focus on health inequalities and diversity – the most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare.

18. The main report contains a great deal of material setting out the thinking and recommendations of each clinical working group. In all there are 40 key proposals across the 7 pathways (the full report from each group is available on the Healthcare for London website - see paragraph 29). The recommendations cover three main themes: improving access; quality and safety and staying healthy. Some of the key recommendations related to each theme are:

Improving access
- Around the clock to meet out-of-hours and urgent needs
- A single point of contact (by telephone) for urgent care
- More routine surgery, diagnostics and outpatients done locally
- Develop community-based, midwife-led maternity services
- 1:1 midwife-led care should be provided during labour

Quality and safety
- Centres of excellence in stroke, heart attack and trauma that patients go directly to
- Specialised inpatient care (e.g. complex cancer surgery) should be centralised
- All organisations must meet end-of-life care best practice

Staying healthy

- More should be invested in proven health improvement programmes
- All health professionals should be incentivised to improve health at each interaction
- Need for more partnership working to help people stay healthy

19. The report states that at present London does not have the infrastructure and facilities to provide the ideal care outlined by the clinical working groups and proposes that new models of provision will be required to deliver the kind of high-quality care Londoners need and deserve. Two stark needs are identified:

    - To provide a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital
    - To develop hospitals that are more specialist, delivering excellent outcomes in complex cases, some linking directly into universities to foster research and development.

20. These two needs lead to seven models of provision being proposed for the future. Each model is fully described in the report:

    - **Home** – where more healthcare should be provided
    - **Polyclinics** – these new facilities should be developed to offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals
    - **Local hospitals** – should provide the majority of inpatient care
    - **Elective centres** – should provide most high-throughput surgery
    - **Major acute hospitals** – some hospitals should be designated as major acute hospitals and handle the most complex treatments
    - **Specialist hospitals** – existing specialised hospitals should be valued and other hospitals should be encouraged to specialise
    - **Academic Health Science Centres** – should be developed in London to be centres of clinical and research excellence.

21. The report outlines the detailed feasibility modelling carried out to test the extent to which the proposed future models of healthcare provision would meet Londoner's health needs as assessed by the review. This takes account of the future predicted demand for healthcare and future predicted funding. The conclusion is the proposed new model of care is necessary not just to improve services for people, but in order for future activity to be affordable. The detailed report on the modelling is available as supporting information on the Healthcare for London website (see paragraph 29).

22. The final chapter of the report considers how the vision proposed could be turned into reality. This chapter identifies eight enablers, or drivers, of change. These are:

- commissioning
- partnerships to improve health
- public support
- clinical leadership
- training and the workforce
- patient choice and information
- how funding flows
- better use of NHS estate.

23. The report concludes with a challenge. Professor Darzi identifies four immediate short-term activities that he believes are necessary for the NHS in London to show that it is serious about improving healthcare:

- Provide some early examples of how polyclinics will work by developing five to ten polyclinic pilots by April 2009
- Undertake a London-wide configuration of stroke services, proposed as an urgent activity given the evidence presented in the report
- Undertake a London-wide configuration of trauma services
- Rapid work to further improve the skill and capacity of the London Ambulance Service.

24. One of the main themes in *Healthcare for London: A Framework for Action* is the importance of reducing health inequalities by improving access to the best possible care for everyone. The proposals in the report have undergone a preliminary inequalities impact review. A full inequalities impact assessment will be commissioned as part of the next stage of this process (see paragraph 35). The preliminary review indicated that the way in which the *Framework* is implemented will be the most important factor in reducing inequalities. Each PCT area/borough will need a detailed understanding of the baseline position from which its health economy starts, with systematic use of health inequalities impact assessments to ensure improvements are helping the most disadvantaged. The report emphasises that progress on reducing health inequalities will depend upon close working with local stakeholders and communities.

25. The Board is invited to formally receive *Healthcare for London: A Framework for Action,* the report of the review into London's health services commissioned from Professor Sir Ara Darzi.

The report launch and dissemination

26. *Healthcare for London: A Framework for Action* report was formally published on 11 July 2007 at a conference attended by over 400 stakeholders from across London and beyond. At the conference Professor Darzi and chairs of the clinical working groups presented the key findings and recommendations for improving healthcare and health services in London. The event included

presentations by two international speakers whose work had informed the review and a contribution from the Chief Executive of the NHS.

27. The report has been proactively promoted to ensure that it reaches as many organisations and people as possible. Copies were widely disseminated to stakeholders across London on the 11 and 12 July 2007 and have been sent to interested bodies outside of London. A summary leaflet has also been published and circulated alongside the report. Arrangements have been put in place to supply additional hard copies and alternative formats on request (a second edition of the report has already been produced).

28. A DVD containing six stand-alone films to help explain some of the proposals for patient pathways has also been produced and circulated (these consider maternity and newborn care; staying healthy; acute care; planned care; long-term care and mental health).

29. The Healthcare for London web-site (www.healthcareforlondon.nhs.uk) has been updated and refreshed, with the following information available:

- The full Healthcare for London report downloadable by chapter
- A PDF of the summary leaflet
- Supporting material referred to in the Healthcare for London report
    i. All clinical working groups' reports on patient pathways
    ii. The IpsosMORI report on attitudes of Londoners to the NHS
    iii. A summary of the themes from submissions to the review
    iv. Opinion Leader reports on:
        a. two large deliberative events with members of the public
        b. a deliberative event with the voluntary sector
    v. A technical paper on the finance and activity modelling which informed Healthcare for London
- The six patient pathway films referred to above (paragraph 28)
- A short film of one of the public events
- A 20-minute power point presentation and supplementary slides dealing with particular sections of the report in more detail:
    i. Case for change
    ii. Patient pathways
    iii. Delivery models
    iv. Financial and activity modelling
    v. Enablers

The next stage in the process - proposals for consultation

30. The terms of reference for this review asked for advice on how to develop a world-class health service for London. In *Healthcare for London: A Framework for Action* Professor Darzi paints a powerful picture of how much better healthcare in London could be - safer, more accessible, higher quality – and of how much healthier Londoners could become.

31. The recommendations in *Healthcare for London: A Framework for Action* are far reaching. They imply significant and challenging change, but equally they hold the promise of significant gain. The Board is invited to note the scale of ambition in the report and the opportunities it identifies to improve health and health services in London.

32. A process now needs to put in place to enable everyone who has an interest in health and healthcare in London to consider and debate the recommendations and give their views. It is crucial that this is a robust and transparent process with a clear outcome so that at the end of it the NHS in London is able to take some firm decisions to move forward and deliver real improvements with the public, with patients, and with key partners.

33. The Board is therefore invited to commend the report to PCTs in London and to ask PCTs, in accordance with section 242 of the NHS Act 2006, to consider formally consulting on the models of care and delivery that *Healthcare for London: A Framework for Action* recommends. The proposed formal consultation will be about the models of care and delivery models only. Subject to the outcome of this consultation, decisions on implementation, and if necessary subsequent consultation on the application of the models, would follow.

Consultation process

34. There should be a single consultation exercise with arrangements put in place to enable PCTs to make decisions collectively. PCTs in London and also PCTs 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) will be asked to 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). The remit of this joint committee would primarily be to:

- Approve the consultation document
- Relate formally to the Joint Overview and Scrutiny Committee (JOSC) 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 – see paragraph 35)
- Take decisions on the models of care and delivery models taking into account the outcome of consultation and the HIIA.

35. It is intended that a formal HIIA of *Healthcare for London: A Framework for Action* will be carried out. It is proposed that this is commissioned from the London Health Commission, in accordance with the timetable set out below. Preliminary enquiries have confirmed that this can be achieved.

Proposed timetable

36. The provisional timetable envisages the consultation running from November 2007 to February 2008. A formal fourteen-week public consultation is proposed, two weeks longer than the required twelve-week consultation to take account of the festive period. This timetable is subject to further discussion with JOSC councillors and officers. A detailed timetable including, amongst other actions, development of consultation materials, stakeholder engagement and the commissioning and completion of a HIIA will also need to be developed.

37. This is a challenging but achievable timetable. The limited slippage within it and management capacity to deliver the process have been identified as the key risk areas. The establishment of a programme office to manage the process is critical to minimising these risks (see paragraphs 53 and 54).

Structure and governance arrangements for moving forward

Role of the London Commissioning Group

38. Previous strategic frameworks for improving the NHS in London have created excellent arguments for change, but have resulted in little or no implementation. *Healthcare for London: A Framework for Action* reinforces the importance of having levers for change and confirms that commissioning is the key enabler for improvement in healthcare delivery. Given the importance of PCTs to implementation it is proposed that the London Commissioning Group (LCG) should be the leadership body responsible for delivering the *Framework for Action* work programme. This requires an enhanced role (that of steering the process) and membership for the LCG.

39. The LCG was established in January 2007, bringing together representatives from London PCTs and NHS London to lead the implementation of the London commissioning model. Its main roles are to develop and co-ordinate the strategy, planning and policy direction for London commissioning and to provide leadership to those commissioning issues and processes which should be transacted once across London. The LCG is accountable to all London PCTs and to NHS London.

40. To date, the LCG has played an important role in coordinating PCT commissioning and contracting activities and has taken significant steps to strengthen PCT commissioning. While the existing terms of reference remain broadly appropriate, the authority and membership of the LCG and the infrastructure that supports it all need to be augmented to enable the LCG to lead delivery of the *Framework for Action* work programme and management of related processes.

41. Whilst the governance of the decision making about the consultation is the responsibility of PCTs the LCG will need authority from PCTs and NHS London to *manage* the consultation process (e.g. preparing consultation documentation, organising consultation activities). It will also have to begin to structure those actions to be undertaken at London, sector and PCT-level that could flow from the framework for London that results post consultation.

Membership of the LCG

42. It is proposed that the LCG's membership should be as shown below (new membership in italics):

    - 10 London PCT Chief Executives (2 per sector, including the chairs of the 5 Collaborative Commissioning Groups)
    - NHS London Chief Executive (chair of LCG)
    - NHS London Director of Strategy & Commissioning
    - NHS London Director of Public Health
    - *GLA representative*
    - *Local Authority representative* (which London Councils will be invited to nominate)
    - *Clinical lead(s)* - chair of clinical leadership group (to be established)
    - *Patient representative(s)* - to be nominated by PPI group (to be established)
    - *Programme Director*
    - [*Out of London PCT representation*]

43. As the LCG will be taking on a significantly enhanced role, it is proposed that the PCT Chief Executives are given the opportunity to re-confirm the Chief Executives who will serve on the LCG.

Accountability

44. The LCG will continue to be accountable to both PCTs and NHS London for delivery of its functions. The revised LCG terms of reference will be presented to the NHS London Board and PCT Boards for endorsement in September.

45. It is proposed that the LCG will prepare regular updates and publish an annual summary of progress. There should also be a formal annual review and Boards should be asked to renew the LCG's mandate and budget for the year ahead.

46. As part of these arrangements the LCG will report routinely to the NHS London Board and to the Strategy Steering Committee.

Decision-making

47. The LCG will seek to operate by consensus. Contentious issues will need to be worked through in order that an acceptable way forward can be agreed between all stakeholders. However, it will be necessary to develop clear arrangements for decision-making that can be used when consensus cannot be achieved.

48. PCTs will remain legally responsible for making the decisions about the consultation process and responsible for making decisions about the results of that consultation process (hence the requirement for the JPCT Committee).

49. PCTs will remain individually accountable to NHS London for strategy, operations and capital, including the delivery of actions related to *Healthcare for London: A Framework for Action*.

50. The LCG's terms of reference will need to be kept under review. It is envisaged that the LCG may need greater authority to act on behalf of PCTs as work progresses.

Resourcing the work programme

51. Preliminary work has been carried out to identify and consider key elements of the work programme that will be necessary to prepare for and deliver a consultation process across London. This work has also identified activities required to better understand the implications of some of the *Framework for Action* recommendations and, pending the outcome of consultation and an amended framework, potential workstreams over the next 12-18 months. This includes consideration of the areas that Professor Darzi identifies as requiring early attention (see paragraph 23).

52. The work programme will be substantial and complex. The Board is asked to note that NHS London has agreed with PCT Chief Executives to allocate £15M non-recurrently from the central budget devolved to the SHA to pump-prime this programme.

Establishing a programme office

53. The work programme needs to be appropriately resourced. It will need senior leadership of the highest quality, including clinical leadership, with dedicated time for this task. The establishment of a programme office to plan and coordinate the work, accountable to the LCG, has been identified as an early and urgent requirement.

54. Key staff posts in the programme office have been identified as a programme director, a programme manager, a communications director and an administrator. Given the proposed timetable (paragraph 36) recruitment to these posts and the appointment of a Clinical Advisory Group, should start immediately, led by the LCG and supported by the Strategy and Commissioning Directorate of NHS London.

Links to NHS London and PCTs' planning processes

55. NHS London's existing business plan and current work programmes include a significant amount of activity relevant to the enablers of change that the *Framework for Action* identifies. In particular these include work to develop commissioning, workforce and education strategies and a review of NHS estate. As they develop there will be increasing alignment of these components of strategic planning and NHS London will have a lead role in their coordination and delivery.

56. A central requirement of the NHS London Commissioning Framework is for every PCT to develop a commissioning strategy plan for the next three years. It is also the case that each geographical sector is expected to develop collaborative commissioning initiatives. Developing a strategic approach to commissioning is a core responsibility of every PCT in London, and work on these plans is progressing.

57. As the intention is to consult on the *Healthcare for London: A Framework for Action* report, PCTs are not in a position to base their strategies on this document. To do so would be to pre-empt the results of the consultation. PCTs should use the available clinical evidence to develop their strategies. PCTs should have a strategic approach to their commissioning and it is important that this work continues. The outcome of the consultation on the *Framework for Action* should inform the refresh of strategies that will need to take place next year.

58. PCTs and NHS London must continue to make decisions about the investment of new resources. Some of this decision-making is urgent and cannot wait for the *Framework for Action* consultation process to be completed. Again it is important to note that these decisions cannot be made on the basis of simply accepting *A Framework for Action* since this would undermine the consultation process. But neither can it be the case that all decisions are put off until the middle of next year. Urgency should be assessed on a case by case basis but relates predominantly to the safety and sustainability of current services.

59. The same is true of urgent service change proposals being developed in some parts of London. NHS bodies involved in local consultations must ensure that:

- There is a local need to carry on with the local consultation without waiting for the outcome of the pan-London consultation. Issues to consider, amongst others, in such circumstances will include impact on the quality of patient care, staff, financial impact and other potential consequences of not carrying on with local consultation, balanced against any potential adverse effect of going ahead such as risking uncertainty or confusion
- Local consultations do not rely on the recommendations in *A Framework for Action* for decision-making, although reliance on a common evidence base is appropriate where relevant
- All decisions are consistent with an open mind that consulting bodies must have on the outcome of the *Framework for Action* consultation
- All reasonable steps are taken to ensure that consultees understand the points addressed in this section.

Recommendations

60. In summary, the Board is asked to:

    i. Formally receive the report, *Healthcare for London: A Framework for Action.*

    ii. Note the scale of ambition set out in the report and the opportunities it identifies to improve health and health services in London.

    iii. Commend the report to PCTs in London and ask PCTs to consider formally consulting on the models of care and delivery models that *Healthcare for London: A Framework for Action* recommends.

    iv. Note that this will involve PCTs agreeing to establish a joint committee of PCTs with delegated authority as the vehicle for joint decision-making on the outcome of consultation. The London Commissioning Group will also invite PCTs bordering London to consider whether or not they wish to be party to the consultation.

    v. Note the proposed timetable of activities over the coming months and the assessment of risk areas.

    vi. Note the intention to commission a formal health inequalities impact assessment as part of this process.

    vii. Whilst PCTs clearly have the governance responsibility for decision-making note that the London Commissioning Group (LCG), with revised membership and governance, will be the body responsible for delivering the work programme, and that the LCG will report routinely to the NHS London Board and to the Strategy Steering Committee.

    viii. To note the agreement to allocate £15M from the 2007/08 devolved central budget received by NHS London to support delivery of this substantial work programme.

    ix. Note that a programme office, accountable to the LCG, will be established as an early priority.

    x. Note the programme of work on enablers, their importance as components of strategic planning and NHS London’s role in leading these workstreams

    xi. Note the need to continue with urgent investment and reconfiguration proposals and issues that need to be considered in such circumstances.