

Healthcare for London Consulting the Capital

Response to the Joint Overview and Scrutiny Committee

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Introduction

On behalf of the Joint Committee of Primary Care Trusts (JCPCT) may I thank you for your comprehensive and considered report on *Healthcare for London: Consulting the Capital*.

The JCPCT found your comments to be helpful and insightful and appreciated the positive way that you had addressed the issues in hand. The committee agrees understands and accepts that the NHS has a responsibility to those living in London and the thousands of committed, dedicated professionals working in the NHS. I am sure we will rise to your challenge and not let them down.

The committee was pleased to accept your report at its meeting of 12 June 2008 and I hope we fairly reflected your views in our final documents and decisions.

In the following pages the committee has set out its vision; the agreements that the committee made; and our responses to your recommendations. Where appropriate we have illustrated a point by quoting the JCPCT recommendation to PCTs.

We have repeated a recommendation if it addresses more than one of your points. And conversely, we have omitted some of the recommendations to PCTs if they are not relevant to your report. However the full list can be found in our final report on www.healthcareforlondon.nhs.uk

The JCPCT particularly recognised the concerns the JOSOC has about joint working and accepts entirely that in future, better engagement with councils and Overview and Scrutiny Committees will be essential if we are to truly transform health and social care services together.

I would be grateful if the JOSOC could consider our response in the positive manner it has shown throughout this consultation.

Richard Sumray
Chair of the Joint Committee of PCTs

Summary

The JCPCT was established to ensure *Consulting the Capital* involved and consulted the public in the development of strategic plans for healthcare improvement in London and met the legal requirements of a public consultation. This JCPCT will now cease to exist, unless a referral to the Secretary of State or an application for judicial review is received.

In July 2007 Lord Ara Darzi published his report *Healthcare for London: A Framework for Action*. The report set out a strong case for change, and issued an ambitious challenge to improve health and healthcare in London over the next ten years. The PCTs in London took up the mantle and conducted an extensive consultation, *Consulting the Capital*, with the public and their elected representatives in every borough.

The consultation showed there was widespread support for the Healthcare for London vision:

- ill health is prevented as much as possible;
- primary care is comprehensive, accessible and of excellent quality;
- improvement in care is evidence-based, clinically-driven and patient-led and provided in the most appropriate settings;
- healthcare is focused on individual needs and choices – and is coordinated; and
- improvements are properly resourced, and carefully planned and implemented.

Following the consultation, PCTs now have a clear directive to commission services that meet the needs of patients. The JCPCT expects each PCT will want to utilise the wealth of information produced by the consultation to discuss a programme of implementation with their Overview and Scrutiny Committee before producing plans by November 2008. Proposals will need to be achievable, affordable and demonstrate clear benefits to the community in terms of healthcare provision and health promotion. The SHA will ensure PCTs carry out this work in a consistent and efficient manner providing support and coordination as necessary.

The Healthcare for London programme has responded quickly and grown rapidly in the last year, establishing itself as a credible vehicle to meet the challenge of working with a range of stakeholders to coordinate and improve healthcare. The opportunity exists to make real changes to the health of Londoners that have been beyond the reach of previous organisations.

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". However, we are not complacent – the programme must now consolidate its position and reflect on how it can best achieve its objectives in a way that does justice to the expectations and aspirations of Londoners.

The JCPCT believes that there is a compelling case for change and that proposals are based on a substantial body of evidence. The committee believes that Londoners broadly support the principles, ethos and strategic direction of Healthcare for London. However, we recognise that detailed plans, systems, governance arrangements and financial projections need to be more carefully articulated to inspire confidence that a real step change in London's health can be delivered. The Healthcare for London programme is working with NHS London to ensure strategies (for instance workforce and estates) that will enable us to convert good ideas into high-quality services. These cannot be delivered in isolation and must involve partners from across London.

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The JCPCT recognises that 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 could and should be.

In the longer-term, at a local level, the JCPCT expects PCTs will engage in a process of ongoing dialogue with their OSCs and their local communities, as they take Healthcare for London forward and begin to deliver on its ambitious vision for health and healthcare improvement in the capital.

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.

- **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 polyclinics (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.

Agreements of the Joint Committee of 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.

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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.

Notes:

In the following pages, agreements of the JCPCT are indicated: **The JCPCT agreed that:...** The 19 agreements are listed above. These agreements were consulted upon and the JCPCT has the power to make binding agreements on behalf of the PCTs.

Recommendations of the JCPCT are indicated: **The JCPCT recommended that:...** The numbering refers to the number of the recommendation to be found in the final report of the JCPCT at www.healthcareforlondon.nhs.uk. These recommendations 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.

1 Financing the reforms

Recommendations of the Joint Overview and Scrutiny Committee (JOSC)

We have not heard any evidence that the appropriate resources exist (or have even been identified) to establish and then support the major changes proposed in HfL. Selling under-used estates may help pay for new facilities, but such sales can only take place once the new services are operational. We have not heard whether additional 'pump-priming' resources will be available to solve this dilemma and run the existing services at the same time as pilot pathways are developed and tested.

(a) 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.

(b) 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.

a) Resources for major reform

Consulting the Capital does not recommend specific individual service developments or define changes at organisational level. . Healthcare for London has carried out a high level modelling exercise which demonstrates the proposals set out in *A Framework for Action* are affordable. This exercise made fairly cautious assumptions about funding growth over the next ten years and took account of anticipated increases in demand due, for example, to population growth and disease prevalence. It also revealed that simply continuing with current delivery models will not be affordable. Our proposals therefore yield future benefit not only in terms of quality, safety and patient experience, but also in terms of use of resources and affordability.

The ageing population, an increasingly unhealthy population and increases in people attending NHS services will exert considerable pressure on the NHS.

We expected the NHS in London annual healthcare budget to increase from 11.4 billion a year to 13.1 billion a year in 2016/17. We now anticipate that this is an underestimate. We will focus on the totality of our expenditure not just the increases, to enable the development of new models of care and new services. We will protect services against inflation and develop new services which will deliver better healthcare. Healthcare for London is a 10 year plan and we fully expect that the gradual increase in funding will support a planned approach to reform.

Each PCT will develop detailed Strategic Plans which will outline delivery of the improvements agreed by the JCPCT. A clear requirement will be for PCTs to develop proposals that are affordable within allocated budgets.

We are currently paying attention to the arrangements we need to establish in order to support effective transition to new service models or to introduce new services e.g. double running costs or 'pump priming' investment. We may also introduce new arrangements across clusters of PCTs or pan-London to ensure the existence of funding sources which can be used flexibly to support local developments.

The JCPCT has recommended:

17.12.1 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 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 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 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.

To support PCTs, Healthcare for London has:

- developed a robust, flexible modelling tool to help PCTs ascertain the costs of operating the different types of polyclinic service model and also to support PCTs to commission polyclinics;
- commissioned a financial modelling tool for local hospitals to ensure they can take advantages of the opportunities presented. Healthcare for London will support trusts undertake scenario planning.

b) Money following the patient

Money currently follows the patient and there is no proposal to change this arrangement. PCTs are allocated money based on their population and they commission services to suit local needs. 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.

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The 'Payment by Results' system ensures providers of services receive an income stream which directly reflects the value and level of services they provide. As commissioners implement their plans to develop increasing volumes of care in primary and community settings, funding will automatically flow to enable and support these changes.

The JCPCT agrees that in future more of the budget will need to be spent on primary care, not just to reflect the way patients are treated, but to ensure the NHS delivers a National Health Service rather than a National Sickness Service.

The JCPCT has agreed:

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.

The JCPCT has recommended:

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

17.9.4 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.

Some funding is allocated directly to acute trusts for education and research and **the JCPCT has recommended:**

17.9.5 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.

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

Conclusions and recommendations of the JOSC

It is unacceptable that local authorities were not part of the original review. The NHS and local authorities must work together in partnership, and steps must be taken to prevent partners working to different (and potentially conflicting) priorities. Disagreements about who pays for which aspects of care can undermine patient well-being.

(a) 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'.

(b) 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.

a) The impact on community care services

We look forward to working with London Councils (and indeed other partners) as we develop detailed plans to improve health and healthcare services. We recognise the need to understand and quantify the impact of new models of care. This is particularly the case as we increase the volume of care being delivered in community settings.

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. Healthcare for London realises we must work with PCTs and councils to assess the impact of changes in healthcare on social care budgets and services, and work in partnership to provide a seamless service. Healthcare for London has recently initiated a joint exercise (with London Councils), drawing on specialist external expertise, to evaluate and 'baseline' the financial interactions between health and social care. This will enable an open and common understanding of the consequences of introducing new delivery models which have a material impact on the health and social care interface. This modelling will be shared with local authorities and OSCs to enable them to better appraise new service proposals. We expect individual PCTs to establish appropriate arrangements with relevant local authorities to model and agree how new models of care can be introduced effectively and affordably. This work is the first in a series of joint programmes that will be undertaken.

The JCPCT has agreed:

- 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.

The JCPCT has recommended:

17.14.2 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.

The JCPCT expects PCTs will share this information with local authorities and OSCs when a change of service is proposed as part of their ongoing relationship.

b) Funding allocations

We are not in a position to directly respond to the statement 'Future funding allocations must give equal weight to health and social care budgets.' The JOSOC will appreciate that neither the JCPCT nor the NHS in London are responsible for funding allocations for health; nor are they responsible for the budgets which local authorities establish for social care. However the committee fully understands the concerns which underpin the JOSOC comments.

Funding of PCTs is determined by the Department of Health based on a number of factors on the basis of the relative needs of their population. Factors include population, age related need, additional need and unavoidable costs – for example the high costs of staff in London.

The NHS should adopt commissioning approaches which enable service change and reconfiguration in a more integrated way. Part of the work to strengthen NHS commissioning focuses on relationships with local authorities at a borough level and across London. Healthcare for London is keen to explore relevant approaches such as integrated planning, joint commissioning and pooled budgets.

The JCPCT believes that expenditure on services must give appropriate weight to the needs of the community, and not be constrained by organisational boundaries

Healthcare for London aims to improve public health, reduce the incidence of ill health, long-term conditions (and delay their onset) and disability and reduce the number of deaths. Achieving these aims would reduce the burden on social care services.

We can assure you that Healthcare for London is keen to work with London Councils and local authorities to ensure seamless services for patients.

The JCPCT has recommended:

17.14.1 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.

3 Health inequalities

Conclusions and recommendations of the JOSOC

Lord Darzi correctly highlights that there are significant inequalities in the health of London's residents. Much of this is due to the way that the location of services has evolved over the years in an unplanned manner.

(a) 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.

Health inequality assessments are key to ensuring this happens, and we therefore welcome the impact assessment undertaken on the broad proposals in HfL. This must not be a one-off piece of work.

(b) 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) Resources targeted on communities with greatest need

The committee agrees with the JOSOC that the NHS must focus resources on communities with greatest need, based on an understanding of how services should be improved to meet their needs..

Funding of PCTs is determined by the Department of Health based on a number of factors on the basis of the relative needs of their population (for instance population, age-related need, additional need and unavoidable costs – such as the high cost of staff in London). The weighted capitation formula is used to determine PCTs' 'target' share of available resources – this target should enable them to commission similar levels of healthcare for populations with similar healthcare needs. London PCTs were on average 4% above 'target' at the end of 2007/08. There were only four PCTs that remained below target (Barking and Dagenham; Tower Hamlets; Newham; and City and Hackney) and Healthcare for London supports the case for these PCTs to reach target.

The London Health Commission (LHC) was contracted to provide independent Health inequalities and equality impact assessments (HIIA and EqIA). The aim of the HIIA/EqIA was to deliver evidence-based recommendations, to inform future development of the strategy and the decision-making process. 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.

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.

The JCPCT believes that by employing staff that reflect all communities within London the NHS could make a positive difference – for instance providing a more appropriate, better service to local communities and improving community cohesion. The committee is also 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 must be taken into account in the planning of future services and health and social care facilities.

The JCPCT has accepted:

- 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.

b) Health Inequality and Equality Impact Assessments

The NHS cannot tackle these issues alone. Only by working in partnership will we be able to meet the challenges head on. The committee has been 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.

PCTs need to ensure 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 unmet need. The SHA will monitor PCT performance and will of course take a particular interest in progress regarding the reduction of health inequalities. The SHA will provide appropriate support and guidance of PCTs which, for whatever reason, are unable to deliver improvements in line with agreed expectations.

The JCPCT has recommended:

17.2.1 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.

4 A staged approach to reform

Conclusions and recommendations of the JOSC

'Big bang' reform can be risky, and 'teething problems' with new health services could have fatal consequences.

(a) 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.

(b) 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.

a) A staged approach

We believe that using evidence should be the hallmark of our processes for planning and implementing new services. We agree that pilots and trials are an excellent way of testing new ideas and that the NHS in London should share knowledge with the rest of the country.

We accept that change needs to be carefully planned. The health economy is complex and has multiple interdependencies. We recognise this and will phase and sequence changes in an appropriate manner. If we wait to be ready to consult upon, and change, every service at the same time then we will never be in a position to make those changes or be able to take advantage of developing knowledge and opportunities. A prime consideration will be good open communication - Londoners have a right to know what changes are planned, what services will be available and where, how they can access them and for their views to be taken into account.

Healthcare for London is developing an evaluation framework to enable the impact of new care models and pathways to be monitored and assessed. We will be working with appropriate specialists in this area and envisage a framework with indicators populating five domains:

- health, improvement, wellbeing and inequalities;
- access to services;
- patient experience;
- clinical outcomes; and
- use of resources.

In regard to polyclinics in particular, **the JCPCT has recommended:**

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 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. Relevant learning will be disseminated through established management processes and 'bespoke' arrangements e.g. workshops, seminars and learning networks.

For instance workshops on polyclinic development have resulted in a series of newsletters for participants. Knowledge gained from recent seminars on patient empowerment and research and development will similarly be disseminated.

b) A transparent timetable

Direct responsibility for change rests with PCTs as commissioners. Different PCTs are at different stages of developing healthcare and different communities require different solutions to local challenges. We expect most future implementation to be carried out at a local level. Therefore we expect each PCT to discuss locally with their OSC a programme of implementation that meets the needs of their community – see recommendation 17.12.3 below. The SHA will ensure PCTs carry out this work in a consistent and efficient manner providing support and co-ordination as necessary.

However we recognise that whilst different PCTs will have different priorities and timetables, there will need to be a certain amount of co-ordination for some services that require network working or are best considered on a regional basis. Healthcare for London will work with NHS London, PCTs, local authorities and OSCs to determine how this timetable for change can best be co-ordinated. We expect that discussion of these plans will form part of regular dialogue between PCTs and OSCs. PCTs are currently embarking on a process of strategic planning to enable the development and agreement of plans by November

In the next year Healthcare for London aims to consult at a pan-London level on the establishment of the hyper-acute section of stroke care (i.e. approximately seven stroke centres agreed in *Consulting the Capital*) and the establishment of trauma centres (three to six) from January 2009. Of course we will be discussing our plans with stakeholders, councils and OSCs during the rest of 2008 to ensure the plans and proposals reflect their views.

The JCPCT has recommended:

17.12.3 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.

However, to oversee the process, **the JCPCT has recommended:**

17.17.1

- The SHA continues to adopt a position of effective strategic leadership;
- 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 Helping people stay healthy and out of hospital

Recommendations of the JOSC

Admission to hospital is not always in the best interest of patients or their families. Staff working in the community (e.g. community matrons) along with pharmacists can help people manage their long-term conditions and prevent the need for emergency hospital admission.

Sufficient resources will be required to fund key professionals such as physiotherapists and occupational therapists who will provide rehabilitation and treatment in the community following the proposed earlier discharge from hospital.

Much of HfL focuses on ensuring patients receive high quality care once they become sick. However intervention 'upstream', e.g. helping people quit smoking, can prevent the need for hospital treatment later.

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.

Healthcare for London's approach will focus on outcomes and outputs. The programme will set ambitious objectives and be rigorous in ensuring they are achieved. Healthcare for London will not set minimum input levels – financial or workforce. Past experience has demonstrated the limitations of focussing on inputs rather than outcomes. Healthcare for London accepts the need to be explicit in setting objectives and ensure they are published.

Whilst it anticipates additional investment in health improvement and long term conditions, the JCPCT also anticipates shifting the balance of expenditure from hospitals to prevention. The JCPCT recognises that many improvements are a consequence of innovation, new working practices and effective leadership.

Partnerships with local authorities and others (for instance the voluntary, charitable, and private sectors) are amongst the most important factors in preventing ill health. The JCPCT believes that each local PCT needs to fund research, service developments and evaluation programmes to ensure it meets the needs of its population. The committee believes it would be difficult to define what 'helping people lead healthy lives' means– for instance it could include patients managing long-term conditions, expenditure on mental health etc. However, the JCPCT does believe that more funding needs to be made available to help people lead healthy lives and manage their long-term conditions. This funding will be a combination of new investment and monies released from traditional care delivery models as we move towards a more community and patient-centred arrangement.

a) Helping people lead healthy lives

Two thirds of respondents to the consultation felt that a greater proportion of spending should be invested in supporting people with long-term conditions to help them stay healthy. The JCPCT agrees.

The JCPCT has agreed 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.

The JCPCT has recommended that:

17.3.1 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 has recommended 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 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 ‘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 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 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 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 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 alternative or complementary medicine could play.

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.

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;
- 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.

17.7.1 To reduce the confusion of having different numbers to call when a patient needs urgent care advice on the telephone 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.

17.8.1 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.

17.8.2 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.

17.11.2 In line with the responses we have received, 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.

b) Helping people with long-term conditions

People with long-term conditions (LTCs) are the most intensive users of health services. Any improvement in LTC care will both benefit a lot of people and have a major impact on the NHS. The JCPCT believes there needs to be more investment in services helping people with LTCs and development of best practice pathways which incorporate prevention and diagnosis, culminating in a web of integrated care centred around the individual.

Out of all of the long term conditions explored in detail in *A Framework for Action*, diabetes is the one that shows a significant predicted significant increase in the prevalence rate as well as an absolute increase in numbers of cases. This is particularly due to an increase in type II diabetes, which is predicted to rise consistently over the next 20 years. The LCG have therefore agreed that work on a diabetes model of care should develop as a priority within the Healthcare for London programme. The lessons learnt from the diabetes project will inform the development of other LTC models of care and pathways due to best practice for LTC management being remarkably similar across the major disease conditions.

Objectives:

- Agreement on the overall pan-London vision for diabetes, centred around the patient.
- Consideration of care pathway development work with PCTs across London, informed by the pan-London vision
- A high level needs assessment of diabetes across London
- Key delivery priorities for commissioning diabetes, including the principles and generic standards for the model and the quality indicators that will be used to measure it

Benefits

- Increase in the identification of people with diabetes at an early stage
- Increase in the number of people with diabetes improving their knowledge, skills, self esteem and capacity to self manage diabetes
- Reduction in number of diabetes patients experiencing healthcare complications as a direct result of their diabetes e.g. blindness, cardiac disease, kidney disease, amputation

The JCPCT has decided:

- 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.

The JCPCT has recommended that:

17.8.5 sometimes specialist care will mean more travel for patients. The JCPCT recommends that PCTs ensure patients 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.

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

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

17.9.3 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 PCTs 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 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 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 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 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.

6 Carers

Recommendation of the JOSC

In addition to impacting on social care, greater care in the community will place additional demands on unpaid carers. According to calculations by Carers UK unpaid carers save the NHS £87 billion a year, more than the annual total spend on the NHS, which stood at £82 billion in 2006/7.

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.

We agree with this recommendation and will ensure we are sensitive to the national carers strategy and of the impact our plans will have on carers.

The NHS is obliged to carry out regular impact assessments, including the impact of proposals and decisions that might affect carers.

The Health Link report on traditionally excluded groups pointed out that carers need comprehensive carer assessments; respect for and flexibility for carers' special needs; and information about available services and how to access them.

The JCPCT:

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

The JCPCT has recommended that:

17.6.1 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

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.

17.8.3 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 patients' 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

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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.

17.9.7 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.

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

7 Maternity services

Recommendations of the JOSC

We are concerned that HfL is likely to require further midwives at a time when the profession is already under severe strain.

(a) 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).

We support the principle of maternal choice where this is practical, but we have encountered mixed views about stand-alone midwife-led units.

(b) 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.

Shortly after the inception of NHS London, the SHA identified maternity services as a priority area for improvement and commissioned a number of work streams to scope the issues and agree the actions required. Maternity and new born care was therefore included as a priority area within Healthcare for London. In January 2008 the results of the Healthcare Commission (HCC) Review of Maternity Services demonstrated significant challenges in London. In response to the findings, NHS London has worked jointly with the HCC and in January 2008 a pan-London conference took place to discuss the provisional results and actions required.

Each of the 19 Trusts rated as 'least-well' performing and their commissioning PCTs attended seminars with NHS London, the HCC and the Care Services Improvement Partnership to focus on the specific issues uncovered by the review. Each health economy was asked to develop an action plan designed to address those issues which prevented an assessment of 'better performing' for local maternity services in the HCC Review. The action plans have been signed off by NHS London and submitted to the HCC. Progress against the plans will be performance managed by NHS London, this being included in the priorities within the new performance management arrangements. The action plans have been risk rated and key priorities have been identified (including the completion of social and healthcare needs assessment by the end of the 12th completed weeks of pregnancy and 1:1 midwifery care in established labour).

In January 2008 the Secretary of State announced that £330m additional investment funding had been made available over the next three years for the implementation of the national *Maternity Matters* strategy. This resource is expected to be used to modernise options for the place of birth, improve flexibility of maternity services' opening hours, increase workforce capacity within maternity and neonatal services and promote the provision of local easily accessible antenatal care and postnatal services.

This three year commitment equates to £20m in 2008/9 for London. NHS London has therefore written to all PCT Chief Executives to ensure that appropriate investment takes place and they

have been asked to identify how this will be used and what improvements are expected from the additional funding.

Whilst it is recognised that service needs will vary across London, NHS London expects to see sums in the region of £700k per PCT invested and has asked for explanations where this is not planned. Confirmation that Provider Trusts have agreed these allocations and that the money is specifically applied to maternity services is also required.

a) Midwives

The Clinical Advisory Group commented that: 'The midwifery workforce is seen to be insufficient both in terms of absolute numbers and in terms of having the competencies to deliver a changed service. Investment is needed both in numbers and in training and development of staff, particularly midwives.'

There will be an increase in demand for midwifery over the next decade and there is a recognition of the need to redesign maternity services to improve the quality of care and women's experiences. Currently the extent of this demand is still being assessed as birth rate projections in London are being reviewed. There is also a clear role for maternity support assistants who can help free up midwives' time to focus on delivering high quality care.

The JCPCT understands that NHS London has created the post of a Senior Maternity Services Advisor to assist the SHA to move the improvement agenda forward. The post-holder is currently working with SHA colleagues to help improve workforce development plans both to increase student midwife commissions and increase 'Return to Practice' initiatives.

In addition, an increased investment is planned to support staff improve clinical practice supervision and assessment of clinically competent staff so that qualifying midwives are fit for purpose and have an improved experience during training to help reduce attrition rates from courses, thereby maximising the investment spent on education and training.

A Midwifery Support Workers (MSW) competency mapping exercise has also been commissioned to assist in understanding the current position with regard to the efficacy of MSWs thereby assisting in workforce planning for maternity services in the future.

The JCPCT proposed that, following birth mothers could visit a midwife in a one-stop centre (as well as at home). This proposal could free up midwives from travelling and give mothers more time with the midwife. However over 50% of respondents disagreed with this proposal and the JCPCT agreed that PCTs should continue to offer visits to mothers with newborn babies in their homes (see below).

The JCPCT agreed:

- 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.

Therefore, in order to re-address the issues of workforce and training, the **JCPCT**

recommended:

17.4.7 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 (the JCPCT agreed that specialist care for children e.g. high dependency medical or nursing care, or where admission for observation of more than 24 hours is anticipated, should be concentrated in fewer hospitals – the number and location of these hospitals to be subject to further consultation by PCTs); and
- the development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries.

To address the training and development needs, **the JCPCT recommended that:**

17.13.1 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 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 is flexible, sustainable and comprehensive.

b) Choice

The JCPCT agrees with the JOSOC that there should be a range of birthing options available for women. Research has shown a majority of women prefer to give birth in a midwife-led unit with a doctor-led unit on the same hospital site. But this will not always be the case. What is good for one person may not be good for another, especially in maternity and newborn care.

Whilst the JCPCT accepts that there has been mixed success of midwife-led birthing centres in the community, the committee is clear that there have been some very effective developments and we should pursue this model of care.

The Clinical Advisory Group has submitted that with clear and robust selection and transfer protocols many women can give birth perfectly safely in the community. Of course, 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.

The JCPCT has recommended:

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; and
- care following birth in local, one-stop centres as well as at home.

17.4.3 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 appropriate mental health care should be available for women who suffer postnatal depression.

17.4.8 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.

8 Children's Health

Recommendations of the JOSC

We are unable to give a substantive view on how children's health services should develop given the omission of this important area from the original HfL review. We again express our dissatisfaction that children's services were an afterthought in the review: children are not simply 'mini-adults' and have distinct health needs.

(a) 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.

As with adults, hospital treatment should be a last resort for children, and non-NHS community facilities should be used to promote good physical and mental health.

(b) 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.

Children's services were considered by all care pathways in the original *Framework for Action* and specific recommendations were also included. However the JCPCT agrees that children have distinct health needs. Since the publication of the JOSC report, the final report of the London Children and Young People's Pathway Group has been published and was included in the papers for the JCPCT. The Clinical Advisory Group acknowledged the report and concluded that it endorses and builds on the Healthcare for London proposals. It also addresses issues raised during the consultation. As such there is no intention of a formal consultation on the report, rather the JCPCT has recommended it to PCTs to be considered in future planning of services – when the implications will become clearer. The Committee commends it to the JOSC.

The JCPCT also acknowledges that in spite of considerable work by individual groups and many joint initiatives since the publication of the Children's NSF and Every Child Matters, services for children in London remain fragmented. Key current drivers for change include, amongst others, variable adherence to recognised standards and the sustainability of the current pattern of inpatient units due to medical resource constraints. Development of an integrated service model for children would provide a structure which facilitates care pathways for all aspects of children's and young people's health and social care such that trained professionals can offer timely interventions in appropriate settings.

Whilst it is acknowledged that the issues around children's services are far reaching and complex Healthcare for London has recently established a children's services project to address care pathways and care delivery arrangements in acute community and primary care settings and in particular the interdependencies with maternity services. Further stages of work will be planned as the project develops over time.

a) The impact of centralising specialist care on children's families

The JCPCT agreed with the Clinical Advisory Group that regionalisation of specialist care for children will produce better outcomes.

The JCPCT recognises that if travelling further for care, families will need support. The consultation identified important issues including the need for children to be surrounded by friends and family; the potential stress on the family, particularly if there were siblings; and the difficulty of travel for parents.

The JCPCT agreed:

- 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.

The JCPCT recommended:

17.5.15 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.

b) Working with local authorities to improve the lives of children

The JCPCT wholeheartedly agree that the NHS should work closely with local authorities to improve the lives of children. As most children are cared for in the community, the importance of co-operative working and of a multi-agency and multi-disciplinary approach has been stressed throughout the consultation. The JCPCT recognises the need to provide healthcare in a wider variety of settings, for instance Children's Centres and Extended Schools.

PCTs need to strengthen partnership and joint commissioning arrangements. In planning future services for children, PCTs have been encouraged to consider further issues:

- children in the context of the family structure, and not just as child patients;
- the importance of parenting;
- children who are carers; and
- children looked after by local authorities.

The JCPCT has recommended:

17.5.5 that when children are ill, whether the problem is an urgent one or long-standing, they should, in general, receive 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 that whilst most urgent care is provided in GP practices and this will continue to be the case, all those who deal with ill children should have the necessary skills and expertise. Where access to GP services is difficult, PCTs need to explore effective alternatives.

17.3.5 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 London health organisations and their partners continue to focus on health protection – for instance, improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.

9 Centralising specialist care

Recommendations of the JOSC

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.

(a) 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.

London is a congested city for much of the day. At peak times it may take a long time to travel short distances.

(b) 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.

(c) 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.

Centralisation of specialist care may involve critically ill or injured patients spending longer in ambulances.

(d) 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.

a) Involving clinicians

A good evidence base will be at the heart of all Healthcare for London proposals. Hundreds of clinicians were involved in drawing up the original proposals, many more have scrutinised the recommendations and the responses to the consultation. Clinicians will continue to have a fundamental role in implementing Healthcare for London.

A Clinical Advisory Group (CAG) has been appointed. The CAG will be critical in informing the development of the Healthcare for London programme and will support the London Commissioning Group (LCG) and PCTs in London; helping them commission high quality, evidence-based, clinically-effective services. The 30 CAG members will act as 'clinical champions' of the Healthcare for London programme; engaging with professional networks, communicating the rationale for change and supporting local implementation.

CAG members reviewed all the evidence of Consulting the Capital and the outcomes of the consultation to provide their own report on the proposals. The JCPCT accepted this document and recommended Healthcare for London, NHS London and PCTs take account of the report when developing services.

A clinical director has been appointed to each Healthcare for London project – to be involved in the detailed research and planning of services. Discussion groups have brought together hundreds of clinicians to plan new services e.g. for stroke, major trauma, diabetes or for new models such as polyclinics and local hospitals.

For instance, the Major Trauma Project Board consists of seven people of which four have clinical backgrounds including the Project Clinical Director, a clinical expert for trauma and a clinical expert for rehabilitation. The project board is advised by a clinical expert panel of about 25 clinicians covering all specialties and skills involved in the delivery of trauma services in primary, secondary and tertiary care. During the development of options and design of the London Trauma System the project has used clinicians from the Netherlands and US to advise and ensure international best practice is used. Clinicians will also be involved in the process to assess and decide on the make up of the proposed system. The project is developing the future governance structure for the London trauma system and this will have significant clinical presence.

The JCPCT believes the clinical evidence for regionalising stroke and major trauma is convincing and Healthcare for London is currently preparing proposals for a roadshow to inform clinicians about the decisions taken as part of the consultation and to engage staff in Healthcare for London – specifically the anticipated consultation on stroke and trauma.

b) Transport

The committee accepts that transport will be a key issue and Healthcare for London will need to work with a range of transport organisations, advocacy groups and the London Ambulance Service (LAS) to ensure that places providing care are easily accessible. All business cases to relocate services must consider access to services

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. The main transport organisations and advocacy groups welcomed the consultation's emphasis on accessibility.

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 also 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.

NHS London has been working with TfL to develop a transport planning tool and this is already available on the NHS London website. It will be marketed to PCTs later this summer, along with some joint TfL / NHS guidance (see below) in order to encourage them to use this robust and consistent methodology across London.

The committee fully accepts Transport for London's suggestions to the consultation as an excellent basis for agreement of a set of joint guidelines and protocols which will be issued alongside marketing the planning tool. These will support PCTs (working in partnership with local communities) to develop transport and accessibility 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.

The JCPCT recommended:

17.15.2 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.

c) A hub and spoke model

We agree with the JOSOC that a hub and spoke (or networked) model would benefit the care of patients needing specialist services.

The consultation recognised that whilst healthcare will be provided in a variety of places – for instance, schools, pharmacies and community hospitals – most healthcare is likely to 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.

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.

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 need intensive or specialised treatment at a major or specialist hospital (the hub) would move to their local hospital (the spoke) for rehabilitation as soon as possible. Local hospitals would work in a network to provide these facilities.

The JCPCT agreed:

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

The JCPCT recommended:

17.8.5 that PCTs ensure patients 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.

d) The importance of the London Ambulance Service

The consultation proposed the London Ambulance Service (LAS) would 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. The consultation also recommended investment in training, particular for LAS staff. UNISON specifically supported this proposal.

The JCPCT accepts the proposals may have implications for the LAS and expects PCTs to discuss any recommendations with the LAS at an early stage. This is already happening. For instance, in the recent consultation *A Picture of Health*, the transport modelling indicated that another ambulance (or two - depending on which option was implemented) would be required to support slightly longer journeys and the additional time that ambulances would require to travel back from those hospitals. This was reflected in the business case which identified annual costs of £624 000 (including an additional ambulance and training). This will be funded by PCTs.

The JCPCT recommended:

17.13.2 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.

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

The committee has also welcomed the 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;

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- 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.

10 The future of the local hospital

Recommendations of the JOSC

The proposals could lead to local hospitals (often referred to as District General Hospitals or 'DGHs') losing services either to specialist centres or to polyclinics providing more general care. However, sufficient beds will be required in local hospitals to enable discharge from specialist centres once the initial treatment has been provided, as well as continuing to deliver the majority of hospital treatment that does not need to be undertaken at a specialist centre.

(a) 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.

Specialisation must not undermine care for patients who have several health problems (e.g. the elderly).

(b) 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').

a) Enhancing the local hospital

The JCPCT agrees that local hospitals will continue to be where most secondary care will be provided for the local community.

A local hospital would generally include a primary care led 24/7 polyclinic as its 'front door' to ensure more appropriate care for people needing urgent primary care.

The proposed reforms will reduce demands on local hospitals. For instance:

- Because of a lack, or perceived lack, of alternatives, many people present to A&E in a local hospital when a GP would be better able to diagnose and treat the condition. We expect these attendances to be in an alternative urgent care location (which might be a polyclinic) in future.
- More specialised care in major acute hospitals will mean that local hospitals need to treat less trauma, stroke and emergency complex surgery patients and less children needing specialist care

However, to balance this it should be noted that:

- Healthcare for London estimates stroke and trauma cases together account for less than one per cent of a typical local hospital's A&E casework.
- Forecasts show an approximate 60% increase in the demand for attendances by 2016/17 (an ageing population, more long-term conditions etc), so unless changes occur local hospitals will not be able to cope with the additional volumes of work.

The committee envisages that most local hospitals would 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 (the hub) would move to their local hospital (the spoke) for rehabilitation as soon as possible. Local hospitals would work in a network to provide these facilities.

While more outpatient care, minor procedures and tests are proposed to be provided in the community, a good proportion of this work could be carried out by clinicians from the local hospital – thereby reducing ‘diseconomies of scale’.

Increased specialisation for certain conditions results in better outcomes and the JCPCT is clear that better patient care should be the driver for change. However the committee recognises that improvements to acute care cannot be undertaken in isolation. The JCPCT is aware of the work being carried out by Healthcare for London in respect of the local hospital model as described in *Consulting the Capital*. This work is demonstrating a sustainable future for these hospitals with opportunities to enhance quality and provide an appropriate range of responsive services. The work underlines the JOSC observation that the development of local hospitals will require careful planning. It also indicates the future importance of clinical networks to enable local hospitals to play a full role in new care pathways. The JCPCT understands that the local hospital model report will be available in August and have requested Healthcare for London forward it to the JOSC when it becomes available.

b) Co-morbidities

The phrase ‘increased specialisation of hospital care’ needs to be set within the totality of the Healthcare for London plans. We do anticipate some hospitals being able to respond very effectively to patients who require very specialised acute care. However this care will be provided as part of a defined care pathway – which describes care from prevention to rehabilitation. Our plans envisage an equally effective response to less complex and multiple health needs. This will require an integrated approach – drawing together specialist, generalist and multi-disciplinary teams. Care for such patients will be provided in a range of settings including home, polyclinic, community and local hospitals (N.B. Healthcare for London recognised a role for community hospitals as well as local, major acute, specialist hospitals and elective centres. However, the consultation was clear that what would be delivered at each hospital would depend on local needs and circumstances. The JCPCT expects that community hospitals would provide a larger range of services than a polyclinic, but with beds – compared to a local hospital (which would usually include an A&E, emergency non-complex surgery, doctor-led and midwife-led maternity units etc).

Increased specialisation of care may, or may not, improve the care for people with multiple health needs – a good care pathway is what is essential. Clearly, better outcomes for a specific condition (such as a stroke or major trauma) are an excellent first step. However, since most other secondary care will be carried out in a local hospital we see no reason why this should be detrimental to caring for people with co-morbidities.

Other proposals in *Consulting the Capital* are aimed at improving the care for people with co-morbidities. For instance, the use of clinical nurse specialists in the community for the management of long-term conditions reduces mortality, morbidity and the frequency of emergency admissions.

The Clinical Advisory Group has said “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. We therefore welcome the core idea of providing a ‘one-stop-shop’ that brings together mental healthcare, primary care and a range of hospital-based services at a local level.”

Of course there are many other proposals in Healthcare for London that aim to improve the care for people with co-morbidities. For instance:

The JCPCT recommended:

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.

11 GP services and ‘polyclinics’

Recommendations of the JOSC

We agree that Londoners could benefit from the provision of a broader range of services in the community. It is unacceptable to expect people to travel to a hospital to have a routine blood test, for example. However, it is expensive to provide certain diagnostic services and resources must not be duplicated with polyclinics becoming ‘mini-hospitals’.

(a) 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).

There has been much debate in our meetings about the proposal for polyclinics. We do not believe ‘one size fits all’. Partners such as local authorities must be fully involved in providing services in pilot polyclinics in order to realise the potential of these as holistic ‘well-being’ centres.

(b) 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.

It will be vital to balance benefits of a greater range of services with the importance of ensuring GP services are accessible.

(c) 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.

The NHS must ensure reforms take account of the fact that many GP patients do not have access to a car.

(d) 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.

a) Diagnostics in the community

There is considerable evidence that many patient visits to hospital could be avoided if capacity, particularly diagnostic services were established in community and primary care settings.

In planning all service development in community settings PCTs will need to produce business plans and business cases. These will examine the benefits of investing in new service models, for example, enhanced diagnostics. Specific development options will be assessed including improvements in existing facilities.

The current waiting time for diagnostics in London is unacceptable and compares unfavourably with other parts of England. There is a lack of capacity and more facilities need to be provided. Of course it would be possible to fund an expansion of existing, hospital-based services. Clearly the level of complexity and investment in each location would need individual consideration. Some diagnostics are not complex, nor do they require high capital investment. Where a complex piece of equipment is proposed it should be to meet a specific need. For instance, a location serving a fairly immobile local population with a high level of need for the diagnostic and where the nearest hospital is not easily accessible (due to distance or poor transport links) could be an entirely suitable place for investment.

- Providing more access points should improve access – the committee accepts that there is a difference between locating the capacity at a new venue and actually using the facility but local solutions need to be found for local communities. The new diagnostic facilities would be nearer to people's homes than a hospital, often diagnostics could be performed whilst the patient was already in the building (for the initial consultation) – again, cutting down travel and reducing the time waiting for an appointment.
- Making primary care clinicians responsible for the service will enable them to better meet the needs of their community – perhaps fast-tracking patients whom they think particularly vulnerable – resulting in a more appropriate service.

The JCPCT wishes to ensure that there is careful planning of services so that expensive equipment is well utilised and clinicians' time well spent. It should be noted that there are considerable potential savings in the acute sector as well as costs – for instance, savings associated with prevention and early diagnosis and avoidance of attendance and admission into a hospital.

The JCPCT recommended:

17.11.3 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.

b) Models for GP and primary care services – one size does not fit all

The committee agrees with the JOSOC.

The JCPCT agreed 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.
- 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.

The JCPCT recommended:

17.11.2 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.

c) Access to GPs and the patient/GP relationship

In almost every part of London, patients rate accessibility to their GP lower than the national average. This has got to change.

By working in a federated way, GP surgeries can provide services for extended hours without increasing the burden on GPs (or damaging the patient/GP relationship) – for instance a GP might wish to return to work part-time in the evenings or an additional GP could be employed by a number of surgeries to cover evenings or weekends.

The committee agrees that continuity of care is an important factor for many people when seeing 'their' GP. However the committee sees no reason why the patient/GP relationship should be any different in a polyclinic than in the current model. If patients want to see their GP then that will be entirely possible. However if people want to see a GP early in the morning, in the evening or at weekends and just want to see a GP, then this will be possible too. 80% of respondents to the consultation said they would like this option.

The JCPCT has recommended:

17.11.4 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).

d) A travel plan for polyclinics

Please see the response under 9b (transport).

12 Mental health

Recommendations of the JOSC

Mental health services must not be the forgotten or neglected aspect of the NHS in London. Again, we express our deep dissatisfaction that mental health (one of the largest services in the NHS) was excluded from the original HfL review, and we wish to hear how the NHS will develop services for the majority of mental health service users that do not require in-patient treatment.

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.

Mental health was not excluded from the original review. The committee wishes to express its concern that the JOSC has made no acknowledgement of the chapter on mental health in *A Framework for Action* or the supporting technical paper, or in *Consulting the Capital*.

Because of the agreed importance of mental health, Healthcare for London commissioned an additional piece of work. This new report, by the Mental Health Clinical Care Pathway Group (MHCCPG), supports the direction of travel of the original report and expands upon it. The report was included in the papers for the JCPCT to inform their decision. The JCPCT accepted the report and recommends it to the JOSC.

Healthcare for London has recently established a project to undertake further in-depth work to support the development of a commissioning framework which describes the capabilities, expertise, skills and partnerships necessary to enable efficient commissioning of mental health across London. Specifically, the overall project will focus on:

- Undertaking a needs-based analysis across London to identify relevant patterns, clusters and levels of demand;
- Developing detailed care pathways focusing in particular on those three described in the report by the Mental Health Clinical Care Pathway Group;
- Providing guidance in respect of the efficient implementation of these pathways giving attention to matters including:
 - Workforce
 - Settings for care delivery
 - Finance
 - Timescales
 - Patient engagement
- Specifying actions which will in relation to mental health and mental illness, improve the health status of the population of London and reduce inequalities;

a) Developing services for users that do not require in-patient treatment

The JCPCT agrees with the JOSc that the majority of mental health patients do not require in-patient treatment. The JCPCT has made a series of recommendations based on firm clinical research (and supported by the work of the MHCCPG) regarding prevention, early identification of patients needing help, greater choice, new models of care and care pathways, more care in community settings and greater support for those groups most in need. We believe these proposals will substantially improve already high-quality services for mental health patients.

The JCPCT recommended:

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;
- 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 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 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.

17.6.7 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 there should be increased investment in evidence-based alternatives to medication such as cognitive behaviour therapy and talking therapies.

17.6.9 commissioners of services note the work of The Mental Health Clinical Care Pathway Group (MHCCPG) 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 JCPCT has welcomed the LAS' offer to support early intervention teams in the identification of mental illness.

Polyclinic models have tremendous potential to identify and treat mental illness in patients at an early stage and prevent inappropriate presentations at A&E. The committee expects PCTs to engage positively with mental health teams when planning any polyclinic service model.

b) Financial challenges

Each PCT is responsible for reflecting the impact of changes to services in their future plans. The JCPCT has recommended that all detailed proposals are fully costed and within available resources. The overall budget for the NHS in London will increase by £1.7 billion in the next ten years. The JCPCT agrees it is essential that sufficient resources need to be directed to mental health services.

The JCPCT has 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.

13 End-of-life care

Recommendations of the JOSC

Again, 'one size does not fit all' and end of life services must be tailored to individual need, circumstances and preferences. This will require NHS professionals to undertake sensitive conversations with patients diagnosed with a terminal illness. Improvements to end of life care will require joint working across health, housing and social care organisations in the public, private and voluntary sectors.

(a) 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.

(b) 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.

Nursing/care homes are people's homes and proposals for improved end of life care must reflect this.

(c) 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.

Healthcare for London's clinical advisers on end-of-life care recognise that many projects designed to improve care at the end of life are already underway and these will produce findings which may be transferable to other localities and settings. The clinicians will be pleased to involve London Councils and local authorities in determining how health services can identify best practice and disseminate it widely in order to meet the expressed choices of patients and their families.

a) and b) Dignity and choice

Every person has a different idea of what would precisely constitute a good death but the recently published End-of-Life Care Strategy acknowledges that being treated as an individual, with dignity and respect and being in familiar surroundings is key. In recognition of the fact that it is not always possible for a person to achieve their choice of place of death, hospitals and nursing homes should provide appropriate settings to ensure that patients and their families receive individualised and sensitive care. Extra funding will be available to develop the core competencies required to deliver end-of-life care in these settings. Healthcare for London will support PCTs in developing their plans to strengthen the provision of end-of-life care in the community which will be facilitated by recently announced additional funding.

The JCPCT recommended that:

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

17.10.2 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, PCTs should give consideration to the wishes of carers and families.

17.10.4 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 PCTs should work collectively to commission adult services, and potentially pan-London to commission children's services.

c) Nursing and care homes

We will seek to adopt an approach which is effective irrespective of setting. However, we will pay attention to the distinctive circumstances of those in residential and nursing homes. Our staff will work closely with the homes in question and, of course local authorities and patients, to ensure end-of-life arrangements are determined by the needs of the individual.

14 Understanding the cross-border implications

Recommendations of the JOSC

London is not a self-contained entity, and patients travel in either direction across the London boundary to receive NHS care.

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.

The committee agrees with the JOSC.

Healthcare for London invited surrounding PCTs from surrounding areas of London to join *Consulting the Capital* if they wished. We agree that any further discussions and consultations should repeat this invitation. We believe that for major trauma, where the nearest other units are as far away as Oxford, Cambridge, Southampton and, in the future, Brighton, PCTs outside of London will be particularly interested in joining a JCPCT.

The 'Chalk and Cheese' campaign run during the consultation did focus on people commuting in from surrounding SHA areas and we would expect further pan-London consultations to continue this trend.

15 Workforce

Recommendations of the JOSC

The major changes proposed in HfL will require professionals to acquire new skills and work differently; notably up to a third of current hospital nurses could be required to transfer to the community setting. This is perhaps the greatest challenge facing implementation of HfL: reforms cannot proceed if the workforce is not in place. Different teams of professionals must work together to achieve seamless care.

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.

The JCPCT agrees with the JOSC.

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 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.

Workforce for London 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. The strategy sets out the need for a different workforce 'shape', with the right skills working in the right settings to meet the future needs of patients and the public in London. Key messages are:

- Current trajectory will lead to a workforce unable to provide the quality of care required – major potential oversupply in some key roles (e.g., A&E doctors); undersupply in others (e.g., GPs); need for new roles (e.g., advanced practitioners) productivity gap; basic quality issues (e.g., in nursing);
- Clinical leadership is a fundamental cornerstone for service improvement but there is an acute shortage across London;
- Many other workforce issues which will underpin improvements in patient care are unaddressed (e.g., incentives and investment aligned with shift to new models of care)

The workforce strategy will be built around 3 strategic themes:

- Developing a world-class workforce with the skills, competencies and expertise to deliver high-quality care, meeting the changing needs of Londoners
- Building robust and diverse leadership capabilities throughout the workforce
- Enabling the workforce to deliver high-quality patient care across care pathways

These will be set out in detail with the actions that NHS London needs to take to implement them, with the support of key partners and stakeholders.

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. Future work will need to continue to include key partners such as staff, hospitals, PCTs, unions and training and education providers.

The JCPCT recognises 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. The committee understands that *Workforce for London* will be published in September 2008 and will request that NHS London shares the document with the JOSC.

The JCPCT recommended:

17.13.1 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 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

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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.

16 ICT: providing the electronic connections

Recommendations of the JOSC

Providing seamless health and social care services will also require the ability for different parts of the health and social care economy to be able to communicate electronically.

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.

The NHS 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.

Practitioners' access to patient records will also 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.

Healthcare for London is working with the London Programme for IT (LPfIT) both at a programme level and on individual workstreams to ensure that the IT requirements and both considered and delivered as part of the overall solution and care pathway.

Specifically a workstream has been set up to enable the NHS to learn from recent IT implementations, and to promote sharing of best practice.

The JCPCT recommended:

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 Compatibility with recent reforms to the NHS

Recommendations of the JOSC

The NHS has undergone significant reform in recent years including the introduction of Payment by Results and the creation of Foundation Trusts. We are concerned that Payment by Results may encourage competition between acute trusts rather than the cooperation required to establish specialist centres, while the freedoms for Foundation Trusts may complicate the proposed shift to greater care in the community.

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.

The Healthcare for London Programme will be driven forward by PCTs as commissioners. They will work with NHS Trusts, Foundation Trusts and the community, voluntary and independent sectors as appropriate, to ensure the needs of patients are consistently met. There may need to be some refinement to the payment by results system to provide the necessary enablement of new models of care. We will work with the Department of Health in this area. Commissioners will ensure the right balance of competition, contestability and co-operation to ensure standards, quality and access to care is improved.

We are developing a comprehensive estates strategy which takes account of Foundation Trusts. The SHA and PCTs will ensure there is a viable capital investment strategy in place to support the creation of new community facilities.

The JCPCT understands the concerns of the JOSC. Payment by Results encourages Acute Trusts (including Foundations Trusts) to provide high-quality, cost-efficient services in order to succeed in a market that is led by patient choice. It is likely that a combination of managed strategic reconfiguration and harnessing the developing market as an enabler of change will be vital to the successful delivery of this ambitious vision.

The JCPCT also recognises the importance of acute trusts working in clinical networks, ensuring that each hospital becomes world-class in its service provision – whilst still providing patients with the opportunity to access the widest possible range of services.

A number of Foundation Trusts have expressed an interest in supporting polyclinics and new community facilities. Trusts will have the opportunity to contribute to the shift to greater care in the community as part of the implementation of Healthcare for London. Proposals by Trusts could complement any potential use of underused NHS assets.

The JCPCT recommended:

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

- The use of market leading skills and expertise to 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 the benefit of all Londoners; and
- Enabling commissioners and providers to focus on the delivery of improved healthcare and not be distracted by the burden of estates management.

NHS London has accepted this recommendation.

18 Moving forward

Recommendations of the JOSC

This Committee demonstrates the value of the unelected NHS talking to local Councillors who are elected to represent and speak up on behalf of local communities. This does not happen enough and engagement of local Councillors must not be limited to formal participation in Overview & Scrutiny Committees to respond to consultations.

(a) 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.

We do not believe that Londoners, including those working in the NHS, appreciate the impact that the reforms proposed in HfL could have on existing services.

(b) 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 JCPCT appreciates the time and effort that councillors have invested in the JOSC and accepts the value of the NHS in talking to local councillors. The committee agrees that discussion should not be limited to formal involvement with OSCs but should be part of an ongoing debate on how, jointly, we can provide better health and social care for Londoners.

a) Ongoing dialogue with local councils

The JCPCT agrees that the NHS must have an ongoing dialogue with OSCs and with local councils more generally.

The JCPCT recommended:

17.14.1 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 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.

b) Engagement in future consultations

Whilst the JCPCT accepts that there needs to be better engagement of the public in future consultations, the committee would like to highlight that a Londonwide Local Medical Committee survey showed that 30% of Londoners knew about Healthcare for London (approximately 2.4 million people), over 20, 000 people visited the Healthcare for London website, over 15, 000 people visited meetings or roadshows and over 5, 000 people responded to the consultation.

The Patient and Public Advisory Group has stated that "...the whole process of this consultation has been more comprehensive than any previous one in London." The JCPCT believes that PCTs have raised the bar for what constitutes good engagement and consultation with stakeholders.

Many PCTs entered into discussion with local groups for the first time. A feedback leaflet has been produced to inform members of the public of the decisions and a feedback event held on the 2 July (to which all respondents to the consultation – whose address was known – were invited) was attended by 300 people. Individually PCTs are also engaging with interested parties – for instance Ealing PCT's recent celebration event attracted 200 staff and public. The Healthcare for London team will continue to support PCTs in their communications activity.

Roadshows (which were highly praised during the consultation) will again be a key element of the proposed campaign to raise public and patient understanding of the issues. A greater focus will need to be directed towards staff – particularly those in acute trusts – who have the greatest stake in the proposed reconfiguration of stroke and major trauma.

The JCPCT recommended:

17.1.2 that an innovative campaign is launched to disseminate the recommendations of *Consulting the Capital*. The public must continue to be involved in processes to shape and implement future service developments.

17.15.1 that each future 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.