Notice of Meeting

Joint Overview & Scrutiny Committee to review *'Healthcare for London'*

FRIDAY, 30TH NOVEMBER, 2007 at 10:00 HRS - OUTSIDE VENUE.

Council Chamber, Hammersmith Town Hall, King Street, London W6 9JU

Issue date: 22 November 2007
Contact: rob.mack@haringey.gov.uk; tel: 020 8489 2921 or
gavin.wilson@rbkc.gov.uk; tel: 020 7361 2264

Committee Membership: attached.

Public Agenda

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Any Member of the Committee, or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. APPOINTMENT OF CHAIR AND TWO VICE CHAIRS

4. PROPOSED TERMS OF REFERENCE (PAGES 1 - 2)

5. PROPOSED RULES OF PROCEDURE (PAGES 3 - 8)

6. DRAFT PROJECT PLAN (PAGES 9 - 18)

7. PRESENTATION BY RICHARD SUMRAY, CHAIR OF JOINT COMMITTEE OF LONDON PCTS (PAGES 19 - 112)

8. PRESENTATION BY RUTH CARNALL, CHIEF EXECUTIVE, NHS LONDON

9. ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

PARTICIPATING AUTHORITIES:

London Boroughs

Barking and Dagenham - Cllr Marie West
Barnet - Cllr Richard Cornelius
Bexley - Cllr David Hunt
Brent - Chris Leaman
Bromley - Cllr Carole Hubbard
Camden - Cllr David Abrahams
City of London - Cllr Ken Ayres
Croydon - Cllr Graham Bass
Ealing - Cllr Mark Reen
Enfield - Cllr Ann-Marie Pearce
Greenwich - Cllr Janet Gillman
Hackney - tba
Hammersmith and Fulham - Cllr Peter Tobias
Haringey - Cllr Gideon Bull
Harrow - Cllr Vina Mithani
Havering - Cllr Ted Eden
Hillingdon - Cllr Mary O'Connor
Hounslow - Cllr Jon Hardy
Islington - Cllr Meral Ece
Kensington and Chelsea - Cllr Christopher Buckmaster
Kingston upon Thames - Cllr Don Jordan
Lambeth - Cllr Helen O'Malley
Lewisham - Cllr Sylvia Scott
Merton - Cllr Gilli Lewis-Lavender
Newham - Cllr Megan Harris Mitchell
Redbridge - Cllr Allan Burgess
Richmond upon Thames - Cllr Nicola Urquhart
Southwark - Cllr Martin Seaton
Sutton - Cllr Stuart Gordon-Bullock
Tower Hamlets - Cllr Marc Francis
Waltham Forest - Cllr Richard Sweden
Wandsworth - Cllr Ian Hart
Westminster - Cllr Barrie Taylor

Health Scrutiny chairmen for social services authorities covering the areas of all the non-London PCTs to whom NHS London wrote in connection with 'Healthcare for London' were contacted (August 2007) concerning participation in the proposed JOSC. To date, those authorities which have indicated a preference for participation are as follows:

Out-of-London Local Authorities

Bedfordshire
Essex
Surrey County Council - Cllr Chris Pitt
Slough

West Sussex

Agenda Item 4

ITEM 4

JOINT OVERVIEW & SCRUTINY COMMITTEE TO REVIEW *'HEALTHCARE FOR LONDON'*

PROPOSED TERMS OF REFERENCE

1. Consider and respond to the proposals set out in the PCT consultation document *'Healthcare for London: A Framework for Action';*

2. Consider whether the *'Healthcare for London'* proposals are in the interests of the health of local people and will deliver better healthcare for the people of London;

3. Consider the PCT consultation arrangements - including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive.

This page is intentionally left blank

ITEM 5

Joint Overview and Scrutiny Committee to review
'Healthcare for London'.

Proposed Rules of Procedure

PROCEDURES

Chair and Vice-Chair

1. The Committee will appoint a Chair and two Vice Chairs at its first formal meeting to consider filling the three positions from each of the major political parties within London.
2. A separate note on the procedure for electing a Chair and two Vice Chairs at the first formal meeting is attached at Annex 1.

Substitutions

3. Substitutes may attend Committee meetings in lieu of nominated members. Continuity of attendance throughout the review is strongly encouraged however.
4. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure that the officer support group is informed of any changes prior to the meeting.
5. Where a substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting

Quorum

6. The quorum of the meeting of the Joint Committee will be 10 members.

Voting

7. Members of the Joint Committee should endeavour to reach a consensus of views. In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chair of the meeting will have the casting vote.
8. On completion of the scrutiny review by the Joint Committee, it shall produce a single final report, agreed by consensus and reflecting the views of all the local authority committees involved.

Support

9. Administrative and research support will be provided by the officer support group, consisting of one named officer nominated from each of the five London regions.
10. The host Borough for each meeting of the Joint Committee will be responsible for arranging appropriate meeting rooms; ensuring that refreshments are available (including a light lunch); providing spare copies

of agenda papers on the day of the meeting; and producing minutes of the meeting within five working days.

Meetings

11. Meetings of the Joint Committee will normally be held in public and where possible, will take place at venues across each of the five London regions. Accessibility issues may mean that locations in and around Central London are the preferred option.
12. However, there may be occasions on which the Joint Committee may need to meet witnesses or hold visits outside of the formal Committee meeting setting.
13. The Joint Committee may meet informally to discuss and draft its recommendations.
14. Meetings shall commence at 10am and will aim to finish by 4pm, with a one hour break for lunch. The Joint Committee may resolve, by a simple majority, to continue the meeting for a maximum further period of up to 30 minutes.

Agenda

15. The agenda will prepared by the officer support group guided by the Chair and Vice-Chairs. The officer support group will send, by email, the agenda to all members of the Joint Committee (and their support officers) included on a database which will be held centrally by the officer support group.
16. It will then be the responsibility of each Borough to;
    a. Publish official notice of the meeting;
    b. Put the agenda on public deposit;
    c. Make the agenda available on their Council website; and
    d. Make copies of the agenda papers available locally to other members and officers of that Authority and stakeholder groups as they feel appropriate.

Local Overview and Scrutiny Committees

17. The Joint Committee will invite local health overview and scrutiny committees to make known their views on the proposals contained within the consultation.
18. The Joint Committee will consider those views in making its conclusions and comments on the proposals outlined in the consultation document.
19. Local health overview and scrutiny committees will be encouraged to gather views from local NHS bodies and interested parties and advise the Joint Committee of instances where the Joint Committee should take evidence.

Representations

20. The Joint Committee will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders . However as a general principle the committee
    a. Will not consider any written or verbal submissions from individual members of the public. It will however pass written submissions on to the Joint Committee of PCTs carrying out the consultation.

b. Will not consider any written or verbal submissions from interest groups that represent geographical areas that are contained within one local authority area. It will however signpost those groups to the relevant local authority overview and scrutiny committee who may wish to receive those submissions.

21. The Joint Committee will specifically request that the Joint Committee of PCTs considers reviews undertaken by local Overview and Scrutiny Committees. Summaries of the key points from these submissions will be appended to the Joint Committee's final report for submission to the Joint Committee of PCTs.

Timescale

22. This Joint Committee is constituted for a limited period ending when the NHS formally reports to the Joint Committee its decision on the consultation outcome - unless the Joint Committee wishes to refer the service reconfiguration to the Secretary of State. If that is the case, it will remain constituted until such time as the matter is brought to a close.

Annex 1 – Procedure for electing Chair and Vice-Chairs at first meeting

Chairing of the JOSC

- There will be a Chair and two Vice Chairs of the JOSC.
- The informal meeting of the JOSC (30 October 2007) expressed a preference for the Chair and Vice Chairs to be drawn from each of the three main parties in London.
- It is assumed that in addition to chairing meetings of the JOSC these Members will act as a Member steering group for the JOSC

In advance of the meeting

- A list of nominations received prior to the meeting for Chair and Vice Chairs will be sent (by email) the day prior to the meeting to members of the JOSC, and copies tabled on the day of the meeting.
- The list of nominees will display name, party and the borough they are from.
- Nominees can put themselves forward for both the position of Chair or a Vice Chair.
- Self nominations are all that will be considered by the JOSC. i.e. a Councillor may only put themselves forward for nomination.
- Nominations for the position of Chair will be dealt with first. Vice Chairs will follow this process.
- Based on preferences of the JOSC expressed at its informal meeting on 30 November, if the Chair comes from one party then it is automatically presumed that all such shared party nominees for other positions will be excluded from the next stage of the process.

Suggested voting process

- All nominations will need to be seconded to proceed to a vote

- Each seconded nominee will be asked to briefly explain in one minute why they believe they should hold the post.

Voting for a Chair

- A vote (by show of hands) will follow. The supporting officer of the host venue will collate the results.

THE ELECTED CHAIR WILL BE ASKED TO LEAD THE PROCEEDINGS

Voting for Vice Chairs

- Those nominations remaining from the party that holds the Chair will be excluded from the next stage of the process

- The Chair will determine which party position for Vice Chair will next be filled

- A vote (by show of hands) will follow. The supporting officer at the host venue will collate the results.

END - The meeting commences

This page is intentionally left blank

ITEM 6

Joint Overview and Scrutiny Committee to review
'Healthcare for London'.

Draft Project Plan

Issue for Decision – The Joint Overview and Scrutiny Committee is asked to consider and agree its project plan.

1. Developing a Draft Outline Project Plan.

1.1 In order for the Joint Overview and Scrutiny Committee (JOSC) to effectively discharge its functions in considering and responding to the stage one consultation on *'Healthcare for London'*, it will be necessary for the JOSC to agree a project plan.

1.2 In developing a project plan, Members of the JOSC will need to be mindful of the time constraints placed on its scrutiny by the 14 week public consultation period and the many other commitments of the Members participating on the JOSC. This will need to be balanced with a desire to undertake effective and inclusive scrutiny.

1.3 As the JOSC is yet to appoint a chair or its two vice-chairs, an initial draft outline for the project plan has been developed by the officer team supporting the JOSC for Members' consideration. This is attached at appendix A.

1.4 The framework is based on two main sources of information:

1.5 The first is the report prepared by Dr Fiona Campbell for London Boroughs' health overview and scrutiny committees. Dr Fiona Campbell was commissioned by London Councils to prepare a report to look at consultation and scrutiny process issues in relation to the *Healthcare for London* report; to provide a summary and analysis of the report's main proposals, particularly as they might bear on the work of local authorities; and to indicate which proposals might raise questions for further investigation as part of a scrutiny review. Page 9 of the report lists possible evidence and witnesses for a scrutiny review. The list is attached at Appendix B and has been considered and incorporated into the attached draft outline project plan.

1.6 At its informal meeting on 30 October, the JOSC made a number of suggestions for consideration as part of its future work programme. These are attached at Appendix C and are also incorporated into the attached draft outline project plan.

1.7 Consideration has also been given to the *Healthcare for London Consultation Document*, with the intention that the outline project plan

suggested will facilitate the JOSC's consideration and response to the questions asked in the consultation, in line with the draft terms of reference for the JOSC.

1.8 The attached draft outline project plan outlines a timescale for undertaking the review and drafting a response to the consultation, based on current indications on timings from NHS London. The suggested timescale would mean that the JOSC would report its findings as the public consultation ends on 7 March 2008.

1.9 When considering the draft project plan, Members are specifically requested to bear in mind that whilst public consultation will end on 7 March 2008 and meetings of the JOSC will need to complete, at least its evidence gathering, before the purdah for the London Mayoral elections, there may be some flexibility in terms of reporting the conclusions of the scrutiny review.

1.10 NHS London are taking legal advice as to the viability of using the purdah period to allow extensions on reporting arrangements. This would mean that the final report of the JOSC could be drafted and agreed during that period.

1.11 An alternative possible timescale, based on that scenario, is also included *for information* at this stage. It is hoped that NHS London may be able to offer clarification on this issue on 30 November, to enable the JOSC to decide on the best way forward.

2. Themes for Review

2.1 It is suggested that the first two meetings should provide the context for the consultation that is taking place. These sessions will explain the background to and rationale behind the *Healthcare for London* review; how the models of care and delivery proposed in the report were developed; and broadly how it is intended the proposals would be financed. The sessions will also explain how the consultation documents were developed, next steps, and plans for consultation and engagement with stakeholders.

2.2 Given the timescale for collecting evidence and interviewing witnesses, which in both options will need to complete by 7 March 2008, the JOSC officer support team have suggested that subsequent evidence gathering could be centred around four key areas, which could form the basis of future meetings and would enable the JOSC to consider the models of care and delivery set out in the *Healthcare for London* report from a range of perspectives.

2.3 These key areas are:

1. Impact on Local Authorities and Social Services
2. Primary Care

3. Secondary and Specialist Care
4. Health Inequalities

2.4 When collecting evidence, it would then be possible for the JOSC to apply the themes and potential witnesses set out in appendices B and C to the four key areas set out above.

2.5 Because the JOSC is working within a defined timescale for collecting evidence, it will only be possible for the JOSC to interview a limited number of witnesses. The JOSC will therefore need to give consideration as to the key witnesses it wishes to interview.

2.6 The draft outline project plan suggests two sets of witnesses for each of the four key themes set out in paragraph 2.3 above. This would therefore involve eight witness sessions, each of about an hour duration, spread over two meetings.

2.7 The JOSC may also wish to consider other ways to engage with groups and individuals with whom it will not be possible to take oral evidence. Members should also be mindful that key stakeholders are also being consulted on *Healthcare for London* separately, as set out in the Stakeholder Communications and Engagement Framework and Action plan, previously circulated to all Members of the JOSC on 2 November 2007.

3. Conclusion and Next Steps

3.1 The paragraphs above set out the initial development of an outline draft project plan, based on available documents and previous informal discussions of the JOSC. In the absence of an elected Chair or Vice-Chairs, the outline plan has been developed by the JOSC officer support team.

3.2 The JOSC is asked to consider and develop the project plan and to identify possible witnesses and other methods of seeking evidence.

3.3 It may be appropriate to consider the timescale the project plan should follow after the presentation from NHS London during the afternoon session.

Appendix A – Draft Outline Project Plan

Activity	**Intended Outcome**	**Timescale 1**	**Possible Timescale 2** (under consideration by NHS London)
Meeting 1 <u>10 - 12.30pm</u> To agree Chairman/terms of reference/rules of procedure/project plan. <u>1.30 – 3.30pm</u> Presentations from: Ruth Carnall, Chief Executive, NHS London Richard Sumray, Joint Committee of London PCTs	 To agree 'house-keeping' issues and way forward for JOSC. To receive further clarification on the context of the Healthcare for London Review, broadly how it is intended the proposals would be financed, how the consultation documents were developed, next steps, and plans for consultation and engagement with stakeholders.	30 Nov 2007	30 Nov 2007
Meeting 2 <u>10-12.30pm</u> Presentation from representative[s] of Darzi Review Team <u>1.30-4pm</u>	 To receive information on the background to and rationale behind the *Healthcare for London* review and how and why the models of care and delivery proposed in the report were developed	7 Dec 2007	7 Dec 2007

Dr. Fiona Campbell to present the findings of report to London Councils for London Boroughs Health Overview and Scrutiny Committees and to critique morning presentations.	To offer an independent view of the Healthcare for London report and to advise on way forward for the JOSC.		
Meeting 3 <u>10-12.30pm</u> Interviewing of 2 panels of witnesses in connection with 1 of the 4 key themes* <u>1.30-4pm</u> Interviewing of 2 panels of witnesses in connection with 1 of the 4 key themes*	 Evidence gathering and testing of proposals set out in *Healthcare for London* report. Evidence gathering and testing of proposals set out in *Healthcare for London* report.	4 January 2008	Late Jan 2008
Meeting 4 <u>10-12.30pm</u> Interviewing of 2 panels of witnesses in connection with 1 of the 4 key themes* <u>1.30-4pm</u> Interviewing of 2 panels of witnesses in connection with 1 of the 4 key themes*	 Evidence gathering and testing of proposals set out in *Healthcare for London* report. Evidence gathering and testing of proposals set out in *Healthcare for London* report	18 Jan 2008	Feb 2008

Meeting 5 - Final meeting <u>10-12.30pm</u> Consideration of Equalities Impact Assessment and any early feedback on consultation outcomes (if available) <u>1.30 – 4pm</u> Agreement of conclusions and recommendations (paper to be circulated in advance based on previous evidence gathering).	Evidence gathering and testing of proposals set out in *Healthcare for London* report.	1 Feb 2008	Early Mar 2008
Drafting of report		2 – 19 February 2008	April 2008
Draft final report to JOSC Members		20 February 2008	April 2008
JOSC approves final report		28 February 2008	April 2008
Any final amendments made plus final endorsement by Chair		5 March 2008	April 2008
Deadline for Response		7 March 2008	Early May 2008 (TBC)

* The suggested key areas are: 1. Impact on Local Authorities and Social Services; 2. Primary Care; 3. Secondary and Specialist Care; and 4.Health Inequalities.

Appendix B – Evidence and Witnesses for Scrutiny Suggested in Dr Fiona Campbell's Report to London Councils for London Boroughs' Health Overview and Scrutiny Committees.

- Members of the review team
- Members of the Joint Committee of PCTs which will be carrying out the consultation
- Chairs and/or members of the clinical working groups and the working group on mental health
- Directors of adult social services in London and/or cabinet portfolio holders in Boroughs
- Public health professional[s] and expert[s] on health inequalities to understand the potential impact on health improvement and reducing health inequalities
- Health economist[s] to consider the financial implications of the models proposed
- Representatives of voluntary sector organisations to understand the potential impact of the models on their sector and on groups of people on whose behalf they campaign
- Patients' organisations to understand the potential impact on patients in general and on particular categories of patients.

NB. Please note that the evidence and witnesses set out above apply to both parts one and two of the consultation on Healthcare for London.

This draft outline project plan applies only to part one consultation.

Part two will look at the application of the proposals across London and some of the witnesses and evidence suggested above may most appropriately be sought at that stage.

Appendix C – Issues raised by the Joint Overview and Scrutiny Committee at its informal meeting on 30 November 2007.

Themes

- Finance
- Transport
- Public Health
- Accessibility
- Mental Health
- Drugs and Alcohol
- Equalities
- Partners
- Sustainability/Environment

Witnesses

- Dr Fiona Campbell
- Lord Darzi
- NHS London and members of the review team
- Social Services Cabinet members and Directors
- Community and voluntary groups; PPIFs and patients' organisations
- Clinicians not involved in the *Healthcare for London* review
- London Ambulance Service

This page is intentionally left blank

Healthcare for London – Consulting the Capital
Stakeholder Communications & Engagement – Framework and Action Plan
23 Nov 2007

This Framework details the responsibilities of individual PCTs, PCT Sector Leads and the Programme Office Communications Team. It is based on the understanding that the 31 London PCTs and Surrey PCTs will continue to work in collaboration to avoid duplication of effort and ensure the most effective use of professional resources. The timescales indicated are based on the assumption that formal consultation will run for a minimum of 14 weeks from late November 2007 to early March 2008.

Each organisation will be expected to produce a local implementation plan, that includes the action outlined for them here plus any other activities that are appropriate, achievable and affordable within local resources and allocations for Communications and Stakeholder engagement.

CONTENTS

The following stakeholder groups mirror the segmentation model described in the consultation strategy:

General Guidance

This document should be read in conjunction with:

- Consultation strategy
- Sector leads' job description
- Distribution list
- Q & As and media protocol for communications staff
- Meeting record sheet
- Q & As

A Patient and Public Advisory Group (PPAG) is being formed (Oct 2007) and a Joint Overview and Scrutiny Committee is likely to be formed prior to the start of consultation. Each will be asked to review this Framework, the consultation strategy, the documentation and individual organisations' action plans and, later, evidence that action plans are being implemented.

If leave is given in the future for judicial review of any decisions taken in relation to a particular borough/geographical area, it will be the responsibility of the sector leads and local PCT(s) to support the programme team and provide detailed evidence of communications and engagement activity.

Tasks

Task	Responsibility	Notes
Planning		
Programme office is responsible for producing an overarching strategy and action plan	Programme office	Programme office will also take responsibility for liaising directly with PCTs outside London that join the JCPCT
Sector Leads are responsible for producing an action plan for their sector	Sector Lead / PCT	Plan should include (but not necessarily in this order or in these headings): • Roles and responsibilities • Key contact details • Key speakers • Organisations to be mailed (and quantities) and events to be held • Budget • Local Q and As • Risk analysis

Events / presentations Sector Leads are responsible for liaising with PCTs and arranging local presentations to local groups. E.g. BME and voluntary communities, OSC and PPI. Sector leads hold a budget for this. Sector Leads are responsible for liaising with PCT comms leads and arranging public meetings. Sector Leads will consider displays at commuter train stations. Sector leads may bid for financial assistance to the programme office Programme office is responsible for arranging pan-London events e.g. all PPI members, Royal Colleges, national charities, JOSC.	Sector Lead / PCT Sector Lead / PCT Programme office	Programme office will provide Powerpoint presentations with optional slides depending on audience, banner panels to brand and consultation documents Ensure you have the necessary equipment and presentation tools e.g. • PA system • PowerPoint projector and screen • Top table if Q&A session • Consultation documents and other products • Banners • Catering/refreshments • Meeting recording form (and someone to fill it in) - to be returned to prog office • Disabled access • Adaptions for visually impaired or deaf people (when necessary - request notification prior to meeting) Programme office wiill hold 5 training sessions for lead speakers to become comfortable with presentation Preference will be to put forward clinicians whenever possible to speak. Programme office will hold details of clinicians available and third party organisations who could bring local or personal flavour to the debate e.g. diabetes UK, Stroke Association Clinicians need good notice to be available – plan ahead with them. Do you need to arrange a pre-meet, especially if different speakers are speaking on different topics? PCTs to liaise with acute trusts to secure events with their staff and users Recommendation is to hold one or two meetings with key audiences prior to Christmas and the rest in January and February Public meetings: The proposal is to hold 'Coffee morning' style events in which the public are invited to come along anytime between 3pm and 8.30pm. A number of execs and clinicians would be available to talk individually to people. There could be a traditional 'talk' every hour or so. Likely to be advertised in local papers with editorial, posters etc. Fairly resource intensive so it is not expected to do morning and evening events. PCTs to inform Programme team of events so that details can be uploaded onto the consultation diary on website and used in pan-London advertisements.

Traditionally excluded groups Sector Leads / PCTs are responsible for ensuring traditionally excluded groups have the opportunity and are encouraged to contribute to the consultation The programme office will contract an organisation to run focus groups with traditionally excluded groups to ensure they are represented in the final analysis	Sector Leads / PCTs	Programme office will ensure any consultation run by the external organisation is in the spirit of the consultation and dovetails with PCTs' own work
Syndicated material The programme office will be responsible for producing newsletters, articles, media releases, case studies, presentations etc Sector leads / PCTs will be responsible for localising syndicated material and issuing in a timely manner	Programme team Sector Leads / PCTs	
Website Everyone should promote the Healthcare for London website. It is impossible for the consultation document to carry every single piece of information, and therefore the website is an active tool for information provision, technical data, case studies, media releases etc. Sector Leads / PCTs are responsible for alerting the programme team of any local information that needs to be updated (especially when dates have been set for events) and for providing local information on their own sites	Programme office Sector Leads / PCTs	

Audience	Communication objectives	Communication & engagement activities	Timescale/ progress	Who
1. NHS STAFF, internal stakeholder groups Includes: • Non Executive Directors • Ambulance Service • PEC members • GPs, GP practice managers, staff and LMCs • Dentists and LDC, Opticians and LOC • Community pharmacists and LPC Types of staff who by purely using traditional communication methods could be missed e.g: • Off-site staff • Learning Disabilities Service • Health Visitors • Staff without a permanent base • Staff without e-mail • Shared staff, Shift workers, part-time and Seconded staff • Absent/ill staff • Staff on maternity leave • Contracted staff • Night staff • Staff who have problems with jargon, literacy or language. • Unions	• To ensure awareness of the aims of the consultation – i.e. to improve and develop services and increase awareness of the main drivers for change. • To provide reassurance that any future proposals will be subject to consultation and scrutiny • The five key principles and models of care and delivery. • To listen to and incorporate staff views in shaping plans. • To enable staff to understand the impact of any proposals on their role. • To demonstrate that all levels of staff have been engaged including those staff who work in patients' homes and don't have access to a computer.	**Planning** The responsibility for engaging with PCT staff, Acute trust staff for whom they are lead commissioners, primary care staff in their area and contractors, is the responsibility of each individual PCT. PCTs to ensure development of a plan (covering all levels of staff) to ensure that staff have the opportunity to become involved and have a clear mechanism for feeding their views into planning. Should include: • joint working between Comms and PPI leads supported by HR • work with staffside/staff and via JSCs – supported by HR **Products** Common, customised presentation training to be devised and delivered to PCT CEs, clinical champions etc in each organisation creating a team of well prepared speakers/presenters who can be deployed at staff events/team briefings locally and in Trusts and MH Trusts Distribution of consultation information primarily by electronic methods, but see audience list opposite. Powerpoint presentation **Practical action** Making consultation document and summary document available as part of staff involvement plan. Syndicated (produced by Programme team) items posted on Intranet and links to H4L website Staff briefings and monthly articles in newsletters (syndicated) Staff to be encouraged to visit the website which will contain an extensive Q & A section that will help them discuss the proposed changes with patients and the public. Letter to individual members of staff – Programme Team will draft a generic letter for local Comms leads to utilise.	Plans complete by 7 Nov Training events in mid Nov Mid Nov 30 Nov Nov onwards Oct onwards Dec onwards 30 Nov	Sector Lead / PCT Programme team Programme team to produce, all to distribute (see list) All Sector Lead / PCTs Sector Lead / PCT Sector Lead / PCT / Programme Team Sector Lead / PCT / Programme team

Audience	Communication Objectives	Communication and engagement activities	Timescale/ progress	Who
2. PATIENTS / CARERS Includes: • HIV +ve people • Mental health users • Disabled people • Drug users • Sensory impaired people • People with a long-term condition • Older frail people or people with dementia • Physically disabled people • PALS and Friends	• To ensure awareness of the overall aims of the consultation i.e. to improve and develop services and increase awareness of the main drivers for change • Consultation is not about specific service change, its about principles and models of care / delivery. • To provide reassurance that any future proposals will be subject to consultation and scrutiny • The five key principles. • To listen to and incorporate views on the options and plans. • To gain understanding of new ways of delivering health care outside large hospitals and demonstrate new approaches to care in community settings. • To be open and create understanding that there are no hidden agenda.	**Planning** As for staff audience, PCTs to ensure development of a plan. Engage with PCT and Trust PPI Forums and Trust heads of comms – on consultation process and communications and engagement plans **Products** Full consultation document and summary. Powerpoint presentations to be developed **Practical action** Send consultation document and summary to all known (pre-engaged) local carer and patient interest groups with offer of speaker for an event. Need to engage trusts to target their users. Distribute summary document via health outlets e.g. Community clinics, outpatient waiting, MIUs, walk in centres, blood test units, A&E, GP and dental surgeries, community pharmacies, sexual health clinics. Send summary to all Expert Patient Programme graduates and current course attenders, PALs and Friends groups. Arrange for consultation proposals to be considered at all regular/planned service planning/redesign group meetings where service users participate. Place feature articles during consultation period in all existing patient/public newsletters. Publicise and promote consultation to patients and carers e.g. repeat prescriptions? Utilise established groups for Long Term conditions and include Mental Health. Provide link from PCT websites to the consultation website. Media activity as per section below	Plans complete by end Oct 30 Nov 1 – 10 Dec 1 – 10 Dec 1 – 10 Dec 1 Dec onwards 1 Dec onwards 1 Dec onwards 30 Nov	Sector Lead / PCT Programme team Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT

Audience	Communication Objectives	Communication and engagement activities	Timescale/ progress	Who
3. HEALTH PARTNERS Includes: • HEIs, Deanery • Private providers • Trusts and PCTs bordering London • Local councils and councils bordering London • Trusts, SHAs outside London • Voluntary and charitable sector • Previously engaged stakeholders and public • Department of Health • Secretary of State • London Ambulance Service • Local partnership groups/boards • Volunteers • NHS Retirement Fellowship	• As 2 above, plus: • To help us encourage informed debate	**Planning** As for staff audience, PCTs to ensure development of a plan. Engage with PCT and Trust PPI Forums and Trust heads of comms – on consultation process and communications and engagement plans **Product** Full consultation document and summary. Powerpoint presentations to be developed Consultation newsletter **Practical action** Encourage all local organisations to adopt link from their website home page to consultation website Encourage all local partner organisations to include information on consultation in their publications/distribution systems Media activity as per section below	Plans complete by end Oct 30 Oct Mid Oct onwards Ongoing Ongoing	Sector Lead / PCT Programme office Programme office All All

Audience	Communication Objectives	Communication and engagement activities	Timescale/ progress	Who
4. COMMUNITY • Public • Commuters Includes community groups: • Schools • Local churches/faith communities and leaders • Residents Associations • Community groups • PPI Forums • Play groups / mother and toddler groups • Sports and social clubs • Youth groups Business representatives: • LDA, CBI • Trade associations • Large employees, Fire service, Met Police etc Traditionally excluded gps e.g: • Alcohol users, BME groups, homeless people, lesbian and gay people, offenders, older people, people on low incomes, prisoners, refugees and asylum seekers, residents of care homes, travellers, women • Unemployed people, housing association tenants	• As 2 above plus: • To build trust in the NHS as caretakers of the nation's health • For the community to better understand how the NHS works and the range of services on offer • For the Healthcare for London team to better understand the needs of the population	**Planning** As for staff audience, PCTs to ensure development of a plan. Engage with PCT and Trust PPI Forums and Trust heads of comms – on consultation process and communications and engagement plans **Product** Arrange to hold open public meetings at "sector" level Purchase paid advertising in local press and consider other local media from launch through consultation period to publicise consultation, timescales, meetings, how to access information etc PCTs to research minority language and BSL and Braille translation requirements and Easy Read Versions documents to be commissioned by Programme Team **Practical** Place consultation document and summaries in all local libraries. Ensure prominent link from home pages of public websites to consultation website. Facilitate link from council/community website home or health pages to consultation website and local NHS sites Target local groups with document and summaries and offer of a speaker for a meeting in consultation period. Consider interpretation services for meetings (minority languages and BSL) - each PCT to access interpreters for local use and liaise with Local Authority on use of in-house resources wherever possible Media activity as per section below	Plans complete by end Oct Jan – Mar 08 Dec 07 – Feb 08 End Oct 1 Dec 1 – 10 Dec 1 – 10 Dec 1 – 10 Dec for document Jan / Feb for meetings Dec onwards	Sector Lead / PCT Sector Lead Programme office and Sector Leads Sector Lead / PCT Programme office Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT Sector Lead / PCT

Audience	Communication Objectives	Communication Activities	Timescale/ progress	Who
5. INFLUENCERS • MPs, MEPs • Media • Clinical Advisory Group Chairs • Campaign Groups • Mayor, GLA • London Assembly	• As 2 above plus:	**Planning** As for staff audience, PCTs to ensure development of a plan.	End- Oct	Sector Lead / PCT
		Product Print copies of consultation documentation, but face to face meetings key for this audience	Oct onwards	All
		Pan-London briefing and media release	Oct onwards	Programme office
		Syndicated press release with opportunity to tailor for local media (to include local issues, quotes from local clinicians etc)	Nov onwards	Programme office to provide template Sector Lead / PCT
		Nominate local spokespeople to receive press and radio media training and presentation training.	1 Nov	Sector Lead / PCT
		Develop positive case studies	Ongoing	All
		Consultation newsletter	Mid Oct onwards	Programme office
		Practical Advance copies of consultation documents, summaries and a briefing to MPs' offices together with information on the planned local comms.	25 Nov	Programme office
		Liaise with MPs' offices and establish meetings - individual - group	Ongoing	Sector Lead / PCT Programme office
		Write to, and meet, the Leader of the local Council	Nov	Sector Lead / PCT
		Provide media with three or four press notices and opportunities for interviews with clinicians – potentially 1 notice prior to consultation and 1 per month during consultation and 1 following closure. - National / London - local - specialist / ethnic	Nov onwards Nov onwards Nov onwards	Programme office Sector Lead / PCT Programme office
		Bid for feature space in council newspapers	Nov onwards	Sector Lead / PCT

Audience	Communication Objectives	Communication activities	Timescale/ progress	Who
6. REPRESENTATIVES • PPIFs • Unions • OSCs • Professional bodies • Patient and Public Advisory Group	• As 2 above • Provide evidence that the views of stakeholders are being sought and are being thoroughly considered by the Joint Committee of PCTs.	**Planning** As for staff audience, PCTs to ensure development of a plan **Product** Establish Patient and Public Advisory Group (PPAG) Consultation documents and Powerpoints Face to Face meetings - Pan London - Local Consultation newsletter **Practical action** The PPAG will be asked to review the strategy and consultation material and monitor and advise the consultation process All PPIF members invited to meeting PCTs expected to meet their local PPIFs Joint OSC meeting to be arranged PCTs expected to present to their local OSCs	Plan by end Oct Mid Oct End Nov Nov onwards Nov onwards Mid Oct onwards	PCTs Programme office Programme office Programme office Sector Lead / PCT Programme office Programme office Programme office Sector Lead / PCT Programme office Sector Lead / PCT

Healthcare for London consultation document

Title:
Healthcare for London: consulting the capital

30 Nov 2007

Originator: Jonathan Street

Last Date Revised: 16/11/07

Version: 0.9

Table of Contents

1 How you can help us achieve excellence

London is one of the greatest cities in the world. We believe Londoners deserve the very best healthcare system in the world and we want to develop a service that meets your needs and expectations. But London is unique. The diversity of its population; its health services and its history all make this a big challenge. We welcome your views on the proposals set out in this document and your help in creating a health service for Londoners of which we can all be proud.

These proposals are about improving the quality, safety and accessibility of healthcare in London. And they are about making Londoners healthier. They are not driven by the need to save money, but by the actual evidence of how to provide the highest quality care. They have been developed by London healthcare professionals and shaped by Londoners. They are about improving how the capital's healthcare service as a whole delivers better patient care.

We are consulting now because we believe these proposals should be discussed locally before any specific service changes are brought forward for further discussion.

We know that some healthcare services in parts of London compare well with the rest of the country and some services are world-class; but there are great variations in quality of care. We also know that setting our sights on providing the best healthcare in the country is not enough. There are many countries in the world that have better survival rates and healthier populations than the UK – this is the gold standard to which we should aim for, and which Londoners deserve.

This document is published on behalf of the 31 Primary Care Trusts (PCTs) in London and Surrey PCT. PCTs buy and provide healthcare for over eight million people living or working in, or visiting, London. PCTs spend over £11 billion a year on services such as hospitals, community nurses, GPs, mental health services, opticians, pharmacists and dentists. So it is important we know what healthcare you need and that we do everything possible to keep you healthy and get the very best health services for you.

Healthcare in London will only be improved by working in partnership with others. We would like to thank Lord Darzi, the doctors, health professionals, colleagues in partner organisations and NHS staff throughout London who contributed to *A Framework for Action*, and in

particular the many Londoners who took part in discussions, events and the opinion survey (available at www.healthcareforlondon.nhs.uk).

We believe the way services are provided, and the services we offer, need to change. We hope that after reading this document, you will too. We look forward to reading your comments.

Signed by the Chairs of all consulting PCTs
Maureen Worby, Barking & Dagenham PCT
Sally Malin, Barnet PCT
Barbara Scott, Bexley PCT
Marcia Saunders, Brent Teaching PCT
Elizabeth Butler, Bromley PCT
John Carrier, Camden PCT
Jane Winder, City & Hackney Teaching PCT
Toni Letts, Croydon PCT
Marion Saunders, Ealing PCT
Carolyn Berkeley, Enfield PCT
Michael Chuter, Greenwich Teaching PCT
Adrian Norridge, Hammersmith & Fulham PCT
Richard Sumray, Haringey Teaching PCT
Gillian Schiller, Harrow PCTw
Len Smith, Havering PCT
Mike Robinson, Hillingdon PCT
Christoper Smallwood, Hounslow PCT
Paula Khan, Islington PCT
Peter Molyneux, Kensington & Chelsea PCT
Neslyn Watson-Druee, Kingston PCT
Caroline Hewitt, Lambeth PCT
Michael Richardson, Lewisham PCT
Marie Gabriel, Newham PCT
Edwin Doyle, Redbridge PCT
Sian Bates, Richmond & Twickenham PCT
Mee Ling Ng, Southwark PCT
Douglas Robertson, Surrey PCT
Kay Sonneborn, Sutton & Merton PCT
Stephen O'Brian CBE, Tower Hamlets PCT
Joan Saddler, Waltham Forest PCT
Ian Reynolds, Wandsworth Teaching PCT
Joe Hegarty, Westminister PCT

30 November 2007

2 About this consultation

This document outlines ways in which health services in London could be really improved over the next ten years. It asks for your views.

The proposals are based on ideas in **Healthcare for London: *A Framework for Action***, written by Professor Lord Darzi and published on 11 July 2007 by NHS London. The proposals focus on services from a patient's point of view. They look at what needs to change to make services safer and more accessible. And they look at what needs to be done to make Londoners healthier.

> Lord Darzi is an internationally respected surgeon. He holds the Paul Hamlyn Chair of Surgery at the Royal Marsden Hospitals NHS Foundation Trust and the Chair of Surgery at Imperial College, London. Lord Darzi completed *Healthcare for London* before he became a Minister in the Government's health team. In writing his report he drew on medical and social research, surveys and meetings with patients, the public and NHS staff. Seven working groups with front-line professionals and representatives from partner organisations also provided valuable assistance and guidance.

This consultation is not about any individual service or building. If proposals to change a service are put forward in the future they will be subject to a separate discussion, consultation and scrutiny.

The booklet does not repeat every recommendation and option considered in A *Framework for Action*, the technical paper and the clinical working group reviews. Nor does this booklet list the 250 pieces of information listed in the full report. If you would like more background information to help you comment, please visit our website www.healthcareforlondon.nhs.uk or call 0800 XXXXXXX or write to us at Freepost, Consulting the Capital.

We welcome your views on how healthcare in London could be organised and delivered. You will find a number of questions in this booklet that will help us develop our ideas. However, you do not have to answer any of them. If you prefer to make other comments, then please do so.

There is a questionnaire at the end of this booklet or you can use the form on our website www.healthcareforlondon.nhs.uk

The deadline for responding to this consultation is 7 March 2008.

Background

This document aims to inform you about our understanding of healthcare in London and explain how we think services need to improve. We then ask for your views.

We know there are lots of changes that have been made, and are being made, in the NHS. So we need to focus our attention on those that most need our attention. When partner organisations, working groups and members of the public came up with ideas, they were asked to think:

- Will it improve quality of care and safety?
- Will it improve access?
- Will it tackle health inequalities and help people to stay healthy?

So every recommendation in this document should help meet one of these aims.

Where we are doing well…

Recently there has been a big growth in funding the NHS. The NHS in London now spends £11.4 billion a year on healthcare, up from £5.5 billion in 2000. The NHS now spends more per person than most developed countries. Investment in new and existing community-based centres and hospitals has made many buildings more pleasant, more economical to run and cleaner and easier for staff to deliver better standards of care.

Staff across London are working hard to improve care for everyone. GPs offer their patients more services than ever before and nurses and therapists are taking on more roles in the community, GP practices and hospitals.

Because of the effort made by staff throughout the NHS, waiting times for operations have fallen dramatically. New methods, new technology and treatments are saving many more lives.

…and not so well

Despite this, London's NHS is not performing as well as it could do. Whilst some services in London are the best in the country, many do not compare well. And we see many news reports showing the UK is falling behind other countries in the quality of care we give to patients, the access to care and the cleanliness of our hospitals.

The NHS in London is not providing easily accessible high-quality urgent care* for most of the population, nor the best quality specialist care for the small number of people who need it.

*** In this booklet 'urgent care' means care that is needed immediately or within the next day or two.**

Where we are…

London is very different from other parts of the country. It has a very diverse community and big differences in health and care. It has greater challenges than the rest of the country on issues such as mental and sexual health but it also has some centres of excellence that are amongst the best in the world. Demands on services and the costs of new technologies, drugs and techniques are all increasing so we must make the best use of the finances available.

A Framework for Action examines new evidence and ideas, but it also looks at recent national and local patient and public surveys. We know that people would like to have improved out-of-hours access for urgent care. We know that people would like more money spent on preventative care and a more joined-up approach to end-of-life care. Some parts of this document should feel very familiar – as a great many patients and members of the public have contributed to them.

…and where we are going

Following the consultation, all your comments will be summarised by Ipsos MORI, who are our independent analysts. Ipsos MORI will comment on whether the consultation was carried out correctly and will publish a report that fully and fairly reflects the views made in the consultation. This report will be made available to consulting PCTs to help them plan future services and we will publish it on www.healthcareforlondon.nhs.uk

In summer 2008, a committee of PCTs will consider the report and take it into account, with all other relevant information, before making decisions on the issues being consulted upon.

Based on these decisions, each PCT (or group of PCTs) will then develop detailed proposals on services – starting with those that are in most urgent need of improvement. These proposals will be subject to

proper discussion, scrutiny and consultation with patients, the public, staff, and anyone with an interest in healthcare in London.

In parts of London some PCTs are consulting, or are preparing to consult, on specific service changes. We have tried to avoid holding consultations at the same time. However, we believe it is reasonable to consult in some cases where there is a pressing need. For instance when:

- not starting or carrying on a consultation would badly affect the quality or safety of patient care, the staff, finances or other key factors – even though there may be a risk of uncertainty or confusion.

- a local consultation does not rely on the recommendations in *A Framework for Action* for decision making

- decisions are consistent with the open mind that consulting bodies have on the outcome of this consultation

- all reasonable steps are taken to ensure that consultees understand the differences between consultations and the reasons for the consultations going ahead

Where consultations have not met this guidance, they have been delayed.

3 A summary of the proposals

During Lord Darzi's talks with patients, public, staff and partner organisations on how to deliver healthcare that is better, safer, more accessible and helps people stay healthier, five principles emerged:

1. Services should be focused on individual needs and choices
2. Services should be localised where possible, regionalised where that improves the quality of care
3. There should be joined-up care and partnership working, maximising the contribution of the entire workforce
4. Prevention is better than cure
5. There must be a focus on reducing differences in health and healthcare across London

In this chapter we give examples of what that might mean to services in London.

Principle 1. Services should be focused on individual needs and choices

Patients should feel in control of their care and be able to make informed choices.

What does that mean?

People should be able to have simple tests in local facilities rather than having to go to hospital for simple tests and they should be able to see a doctor for routine appointments in the evenings and at weekends.

Women should be offered better information about maternity care and greater choice of where they have their baby.

People who are nearing the end of their life should have an end-of-life care plan and be able to choose the place where they die.

Principle 2. Services should be localised where possible and regionalised where that improves the quality of care

Routine healthcare should take place as close to home as possible. The most complex care should be regionalised to ensure it is carried out by the most skilled professionals with the most modern equipment.

What does that mean?

We want to make better use of the high levels of skill and experience of GPs, midwives, therapists and other healthcare staff working in the community. We will need to provide larger community healthcare teams, more equipment (for instance for tests), larger facilities in which to house the greater range of services and we want to see more hospital specialists providing clinics in the community.

When facilities aren't available in the community, local hospitals would provide all but the most complex services.

When very specialist care is needed, for instance for people suffering a stroke or a major injury – they should be taken to one of a small number of specialist hospitals. This already happens for people suffering a heart attack.

Principle 3.There should be joined-up care and partnership working, maximising the contribution of the entire workforce

Better communication and co-operation is needed between community services and hospitals, between different teams working in the same buildings and between the NHS and local government and voluntary organisations.

What does that mean?

If we co-ordinate care for people with long-term conditions such as diabetes, heart disease, mental health problems, asthma and lung disease, they will be able to manage their condition more effectively and avoid unnecessary emergency admissions to hospital.

Patients should not have to tell each doctor or healthcare professional they meet their personal details, the conditions and symptoms they have and the treatments they receive. This information should be held securely, and available to the healthcare professional treating the patient.

Older people, people with a physical or learning disability, those with a long-term-condition or nearing the end of their life often have a wide range of needs that need services provided by different health professionals. We need to get better at co-ordinating these services.

Because staying healthy is not just about NHS services we should work better with central and local government, the Greater London Authority and voluntary organisations to help people stay mentally and physically healthy.

What does that mean?

Immunisation of children is safe and cost-effective but it needs to be seen as a high priority amongst parents and staff concerned with the care of children.

Helping people take more exercise or stop smoking, providing services to reduce the number of unwanted pregnancies and making sure all health professionals advise people on how to live healthier lives will all improve the health of the community.

Many people aren't having basic tests or check-ups that would enable healthcare professionals working in the community prevent a condition becoming worse. If GPs had better access to tests then we could keep people healthier.

We know that if we diagnose and treat those suffering from mental health problems earlier this will lead to better results.

Principle 5. There must be a focus on reducing differences in health and healthcare

The most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare. Improvements also need to take into account London's ethnic and cultural diversity.

What does that mean?

Mental health problems are greatest in the most deprived areas of London. The different mental health needs of migrants, offenders and the black and minority ethnic community need to be met.

Some of the most deprived areas of London also have the fewest GPs, the highest infant death rates and the shortest life expectancy. We need to consider how we can address these issues in everything that we do.

4 Why London's healthcare needs to change

The NHS has made major improvements over the last 20 years in a period when science and medicine have developed in ways that could not have been foreseen.

Since the 1950s, groundbreaking discoveries have included DNA, the link between smoking and cancer, advances in organ transplantation and keyhole surgery. All these developments have revolutionised the way healthcare services are provided to patients.

Over the next ten to 20 years we expect further major breakthroughs, for instance in:

- molecular genetics – as scientists find more genes affecting conditions such as cystic fibrosis and heart disease
- bioengineering – to produce artificial body parts and organs which could replace transplantation within 30 years
- keyhole surgery – half of all operations could be performed using keyhole surgery, reducing the time patients spend recovering in hospital and cutting the risk of infection.

But today our NHS in London is not performing as well as it could and should. Millions of Londoners have illnesses which are not life-threatening but need quick and convenient treatment. A much smaller number suffer from more serious illness, such as stroke or heart attack, or have a major injury. The NHS is not serving either of these groups as well as it could.

We need to use our workforce in better, more flexible ways. The European Working Time Directive is helping make sure most doctors are less likely to be tired when treating patients – by limiting their working hours. This means each doctor works fewer hours, so more staff are needed to provide cover.

We believe there are eight main reasons why change is needed.

1. The need to improve Londoners' health
2. The NHS is not meeting Londoners' expectations
3. One city, but big inequalities in health and healthcare
4. Hospital is not always the answer
5. The need for more specialised care
6. London should be at the cutting edge of medicine

7. Our workforce and buildings are not being used effectively
8. Making best use of taxpayers' money

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

Reason Two – the NHS is not meeting Londoners' expectations
27 per cent of Londoners are dissatisfied with the running of the NHS, compared to 18 per cent nationally.

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

Also around 60 per cent of 7,000 Londoners questioned in a poll said improvement was needed in cleanliness in hospitals, and in waiting times to see consultants in A&E and for routine operations.

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

For instance:

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

Reason Four – the hospital is not always the answer
Londoners have told us they want more care to take place nearer their homes. The vast majority of patients do not need hospital care, but we have a long way to go to make alternatives a reality. Minor surgery and

tests often do not need to be done in hospitals and people with long-term conditions like diabetes can be supported to stay at home.

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

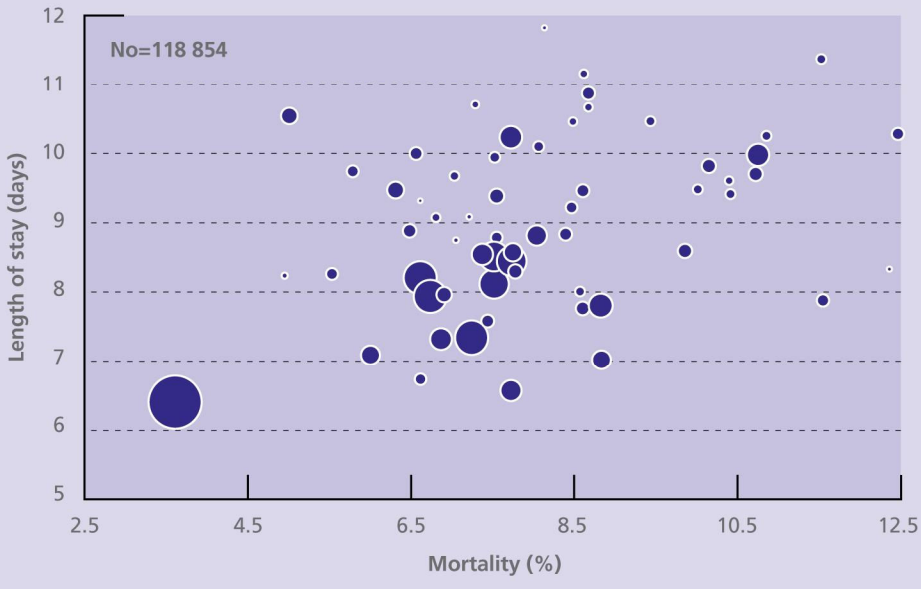
We believe many people go to A&E departments because they are dissatisfied with the availability of services outside working hours. This is far from ideal. Patients are seen by junior doctors in hospitals rather than by GPs, who are better skilled at treating minor illness and injury.

Reason Five – the need for more specialised care

The most seriously ill patients need specialist care. We need to develop, and take advantage of, exciting clinical and technical advancements. And we need to concentrate specialist equipment and expert staff in centres with enough patients being treated by each specialty to ensure the service provides the best quality of care.

Specialisation can lead to lower cost and better outcomes: cancer example

The circles on the graph are hospitals in New York. The size of the circle shows the number of patients treated. The nearer the circle to the bottom left hand corner, the better. The graph shows that, in general, hospitals that treat the most patients have the lowest rate of death (mortality) and the shortest length of stay for patients – which is good for patients, and saves money.



Risk-adjusted mortality from cancer against length of stay for institutions in New York State. Adapted from ©2005 BMJ Publishing Group Ltd.

Reason Six – London should be at the cutting edge of medicine
London is the leading centre for health research in the UK. Fifty per cent of the UK's biomedical research is carried out in the capital and 30 per cent of healthcare students are educated here.

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

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

Reason Seven – not using our staff and buildings effectively
The NHS's staff are its greatest asset, but their abilities are not always fully used. There needs to be more support for staff to work flexibly to deliver the best care.

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

Reason Eight – making the best use of taxpayers' money
Although some trusts are still overspent, in 2005/06 the NHS in London made a surplus of over £90million. This money can be used to improve healthcare in the capital. Over the next few years, PCTs will continue to receive growth in their budgets above inflation. But any money spent inefficiently on one aspect of healthcare is money that could be used to save lives elsewhere. The money spent by the NHS in London is very considerable - £10.1 billion in 2005/06, or £27.7 million a day.

But London's population is growing - and living longer. New technologies can help treat more and more people. The rising cost of drugs, new technology and treatments will challenge the NHS. Demand for services is only going to grow. Our 'most likely' forecast, comparing the cost of

services with funding in ten years time, shows that if we carry on without making any changes we will not be able to afford the kinds of improvements in quality of care and new technology which have the potential to improve health for Londoners.

5 How we could provide care: the journey through life

Here we look at how health services perform in London, from the perspective of the patient. The detailed reports that support these chapters, from each of the seven working groups set up by Lord Darzi, can be found at www.healthcareforlondon.nhs.uk. Background information regarding the children's section can be found within each of the working group reports.

5.1 Staying healthy

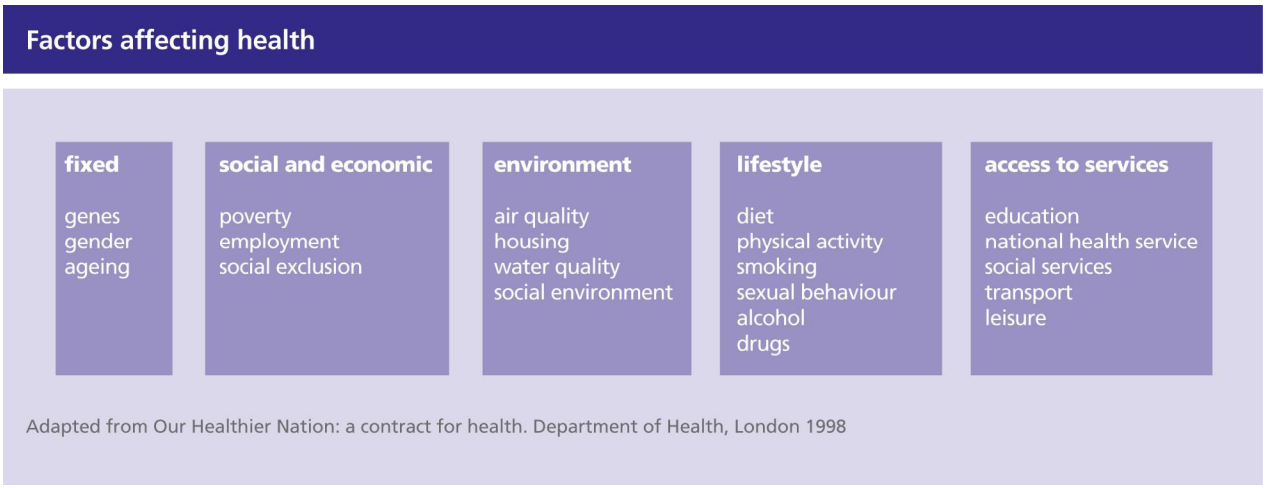
*"*Prevention is definitely better than cure, but we tend to spend much more of the NHS budget on hospital care – treating the illness – than preventing it in the first place. Finding ways to help people stay healthy is best for Londoners. It will also reduce the strain on the services described on the following pages, from mental health and Accident and Emergency (A&E) to the management of long-term conditions."
Dr Maggie Barker, Deputy Regional Director of Public Health, London and Working Group Chair, Healthcare for London.

Dr Barker has held posts at Great Ormond Street Hospital for Children and Camden and Islington Health Authority, and has advised the Department of Health on a range of task forces. She holds honorary senior lectureships at University College London.

A snapshot

Staying mentally and physically healthy is not just about healthcare services. Social, economic, environmental and lifestyle factors are the cause of much ill-health and these are issues over which the NHS has little direct control. For instance 184,000 homes in London are judged to be unfit to live in and 41 per cent of children live in households that are below the poverty line.

There are large numbers of unplanned teenage pregnancies in London compared to elsewhere in the country. The capital also has very high levels of sexually transmitted disease, again particularly amongst young people. Preventing obesity, helping people stop smoking and reducing substance misuse will all be challenges over the coming years.



What are we recommending?

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

We wish to work with the Mayor of London to address the priorities he sets out in *Reducing health inequalities – issues for London and priorities for action*. You can view this at www.london.gov.uk/mayor/health/strategy

MRSA and Clostridium difficile

Good hygiene practices, education and training to promote clinical skill will help reduce the number of cases of healthcare associated infections. For instance we need to ensure staff are able to undertake aseptic techniques. Many of the proposals in this document also help people stay healthy by reducing infections. For instance:

- Moving care out of hospitals and into the community and people's homes
- Separating emergency and booked operations and different specialisms.

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

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

- Shifting the balance of expenditure from hospitals to prevention as recommended by *Our health, our care, our say*

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/index.htm

- Analysing where money is having the greatest impact on preventing ill-health and concentrating our efforts in these areas.

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

Preventing ill-health must be part of all patient care

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

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

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

Smoking is the main cause of preventable death in the UK. Stop smoking aids and education are needed to help people give up smoking. We also need to work with partners to reduce people's exposure to second-hand smoke.

Smokers should be encouraged to stop before they have an operation. This would prevent between 2,500 and 5,300 complications a year after operations. Avoiding having to put these problems right would be better for patients and mean the NHS in London would have between £1.5 million and £4 million per year more to spend on other services.

Isle of Dogs networked polyclinic

Four GP practices serving 31,000 people on the Isle of Dogs in Tower Hamlets are working together in a network to bring more services out of hospital and closer to local people.

The network includes primary and community health care teams, pharmacists, voluntary and community organisations, schools and Registered Social Landlords.

The network means minor surgery is available on the island, provided by a team drawn from the four practices. A multi-agency team is now offering young people's sexual health and healthy lifestyle services. And local pharmacists are piloting a "Know your Risk Factors" campaign for men over 40 who have not had their blood pressure or blood glucose taken in the last year.

In December one of the network practices moves into a new £12 million centre, bringing together a birthing centre, community dentists, mental health staff, diagnostics and a children's centre for the benefit of local people

Local GP Dr Mike Fitchett said "working together to pool expertise and to provide more services is common sense and is good for patients"

Sexual health

London has 57 per cent of England's cases of HIV and the highest rates in the country for new diagnosis of chlamydia, gonorrhoea and syphilis. We believe we need to tackle the rising rates of sexually transmitted infections by:

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

Health protection

We believe London health organisations need to continue to work with other partners to maintain a firm focus on health protection – for instance improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.

Questions for you…

Question 1a

Looking at the list below, which of the following changes, if any, would you like to make in the future to improve your health? Please choose up to 4.

Improve your diet
Increase your level of exercise
Lose weight
Give up smoking
Improve your sexual health
Reduce your stress
Reduce your alcohol intake
None of these
Other

Question 1b

How could the NHS in London best help you to make these changes?

Question 1c

What else could the NHS in London do to help you stay healthy?

Question 2

To what extent do you agree or disagree with the following statement… "I would welcome advice on staying healthy when I come into contact with healthcare professionals (for example, advice on losing weight or stopping smoking)".

Question 3

Please tell us any other comments you might have on the proposals in this section.

5.2 Maternity and newborn care

*"*The challenge for the NHS is to meet the growing demand for maternity services, improve access and offer more choice to pregnant women. The small number of midwifery units and the lack of resources and priority given to home births means that at present the only realistic option for most women is an obstetric (doctor-led) unit."
Professor Cathy Warwick, General Manager of Women and Children's Services and Director of Midwifery, King's College Hospital NHS Foundation Trust and Working Group Chair, Healthcare for London.

Professor Warwick trained as a nurse and midwife. She is Visiting Professor of Midwifery at King's College and has advised on the development of midwifery services in Northern Ireland, South Africa and Hong Kong.

A snapshot

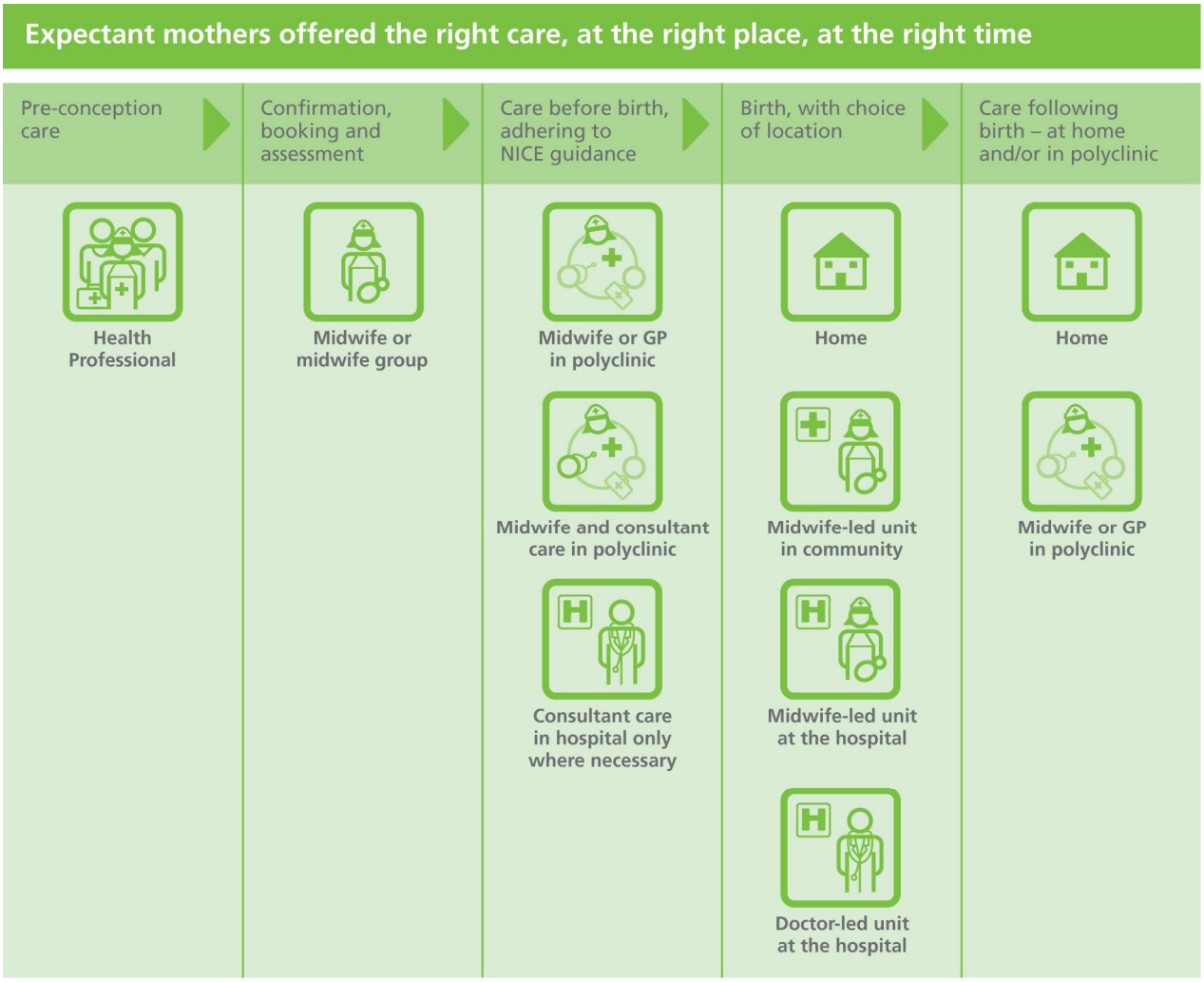
In 2006/07 there were over 120,000 births in London and that figure is expected to rise to between 124,000 and 145,000 by 2015/16.
At the moment 97 per cent of births in London take place in obstetric (doctor-led) units or the midwifery units found in about a third of hospitals. Around two per cent of births take place at home and half a per cent in London's two stand-alone midwifery units.

A recent national study showed that 56 per cent of women were left alone for periods during their labour whilst women consistently say one-to-one care is the most important thing for them.

What are we recommending?

Expectant mothers should be offered:

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



Improving the quality of care

Evidence suggests that senior doctors are less likely than junior doctors to recommend caesarean births and their presence results in less distress for unborn babies. This distress can result in the disability or even death of a baby.

High quality doctor-led care requires senior doctors to be on the labour ward, not just to manage issues when they are there, but to train others and to put in place good systems for when they are not available.

At the moment, guidance requires that a senior doctor should be present on the ward for a minimum of 40 hours per week (all London maternity trusts meet this minimum and some already do better than this). However, the Royal College of Obstetricians and Gynaecologists

suggests units delivering over 4, 000 babies a year should have a senior doctor present for 98 hours a week. Taking into account the Royal College guidance, the anticipated increase in births in London over the next 10 years, and the concentration of population in the capital, we believe we should be able to provide mothers with an excellent service whilst still ensuring a reasonable travel time to a doctor-led maternity unit.

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

Where care should be provided

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

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

Care following birth should be provided at home and in local one-stop settings such as drop-in clinics, which can provide a range of support to parents. Mental health care should be available for those women who suffer from postnatal depression.

Prolonged care for seriously ill babies will require a neonatal intensive care unit (NICU).

Albany Midwifery Group

The group operates in Peckham and is made up of six midwives. The midwives offer one-to-one care during pregnancy and labour, delivering either at home (46 per cent of births in 2006) or in hospital. Care before birth and some care after birth is provided in the local leisure centre. The group takes all women, not just those who are low risk, and achieves high rates of breastfeeding. The midwives work nine months of the year and cover each other's holiday, sick and training leave. They achieve a workload of 36 deliveries per midwife per year (one of the highest rates in London). The group is supported by an obstetrician and neonatologist at King's College London.

Questions for you…

Question 4

We are trying to balance a number of different factors when developing proposals for maternity care in London. We would like to know what **three** factors are most important to you:

- Giving birth in a doctor-led unit in a hospital
- Giving birth in a midwife-led unit in the community
- Giving birth in a midwife-led unit with a doctor-led unit on the same hospital site
- Being given a choice of a home birth
- Time taken to travel to the place where you will give birth
- Having a senior doctor present on the unit where you will give birth

Question 5

To be able to give high quality care, we need to balance the time that midwives can spend with mothers after the birth of their baby, with the time taken to travel to women's homes. Which of these options would you prefer?

a) as now, midwives seeing women at home for appointments after the birth of their baby

b) most women travelling to a GP or health clinic for appointments following the birth of their baby, and midwives having more time to spend with them. (There would be home visits available to women when necessary)

c) don't know

Question 6

Please tell us any other comments you might have about the proposals in this section.

5.3 Children and young people*

Children's services were discussed by all the *Framework for Action* working groups. However, during recent talks with interested groups it has become clear that it would be better to consider children's services separately. So, we have put all the information in the original report into this new section and have set up a working group to re-examine the health issues specific to children. To find out more about this work visit www.healthcareforlondon.nhs.uk

*In this context, young people includes those up to the age of 18

A snapshot

A recent UNICEF report considering the well-being of children ranked England among the lowest in Europe, below a number of east European countries. Children's health is worse in deprived areas of London.

Children in the UK have an increasing problem with obesity which will affect their long term health, and London's children have higher rates of obesity than the rest of the country.

Too many of our teenagers abuse alcohol and substances. This will have a negative effect on their long term health. Our teenage girls also have very high rates of pregnancy. We know that they are anxious about coming forward to get the help they need.

We know that our children and young people have problems with their mental health and well-being. In spite of there having been an increase in resources in recent years most young people still do not receive the specialised help they need

Immunisation can keep in check many of the major illnesses that affect children, and has virtually eliminated some. But children in the capital remain at risk from conditions such as measles, mumps and rubella because, in the last quarter of 2006, only 73 per cent of children were immunised against them. In some parts of London this figure is as low as 49 per cent, compared to the England average of 85 per cent. Last year the number of cases of measles was the highest number ever recorded and this year looks set to follow that trend. This year a third of all cases of measles in the UK have been in London. We are failing to protect our children and leaving them vulnerable to death and disability.

Nor do we offer our children the best service when they are ill. Both in A&E departments and in care in the community they may be treated by professionals who have little or no training in children's illnesses.

However, figures show that where specialist care is concentrated and provided to large numbers of children, there are many benefits. For instance, compared with smaller units, 28 per cent fewer babies die in children's heart surgery units that perform over 100 operations a year. And 33 per cent fewer babies die if they are operated on by surgeons who do more than 75 operations a year.

What are we recommending for the future?

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

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

We also believe that more effort should be made to promote breastfeeding because of the proven benefit to infants' well-being and development.

More emphasis should be placed on preventing the emerging problems that children are facing, for example obesity and behavioural disorders.

Childhood immunisation is one of the safest, most cost-effective, evidence-based interventions, yet many parents do not immunise their children. We believe a high priority should be given 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 local immunisation leads in their efforts to co-ordinate local programmes.

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

We know that most urgent care is provided in GP practices. This will continue to be the case, but we are recommending that all those who

deal with ill children have the necessary skills and expertise. Where access to GP services is difficult we will be exploring effective alternatives.

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

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

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

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

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

Further recommendations aimed to improve the health and welfare of children and young people will emerge from the children’s pathway group in the New Year.

Questions for you…

Question 7

The majority of care for children, including urgent care, will continue to be provided locally. We are proposing that specialist care for children will be concentrated in hospitals with specialist child care. This may mean that they are further away from your home. Do you agree or disagree with this proposal?

Question 8

What, if anything, could we do to encourage more parents to immunise their children?

Question 9

Please tell us any other comments you might have about the proposals in this section.

5.4 Mental health

"England's mental health services are amongst the best in the world. But services in London are under severe pressure due to higher levels of mental illness than the rest of the country. As with many other healthcare problems, the levels of mental illness are highest in the more deprived parts of London, a situation that needs to be urgently addressed."
Stephen Firn, Chief Executive, Oxleas NHS Foundation Trust, Working Group Co-Chair.

Mr Firn joined the NHS 26 years ago as a Health Care Assistant. He trained as a Mental Health Nurse and worked with adults and elderly people. He has since worked as a lecturer and researcher and held advisory roles at the Royal College of Nursing and the Department of Health.)

Following discussions with interested groups over the past few months it is clear that there are advantages in establishing a new mental health working group with greater clinical and user representation to take forward the work of the original group which supported Lord Darzi, and to report back to PCTs. To find out more about this work visit www.healthcareforlondon.nhs.uk

A snapshot

Eighteen per cent of Londoners suffer from a common mental health problem. Mental illness is estimated to cost the capital £5 billion a year, when the cost of services, lost earnings and benefits are taken into account.

Twenty three per cent of mental health inpatients (people needing an overnight stay) have the most serious mental illness compared with 14 per cent nationally. This higher rate of serious mental illness creates a more volatile, disturbed environment on mental health wards. But the need to focus resources on the most severely ill can mean people with moderate illness are less likely to be able to access services than those in other parts of the country.

Thirty years ago, care was provided in very large mental hospitals offering only limited outpatient services. Now it is accepted that mental health care is best delivered to people in their own homes, with medical and other staff working in multidisciplinary teams in the local community. This has resulted in big reductions in admissions to hospitals and

currently 90 per cent of people with mental health problems receive their care in a community setting.

However, too often care is focused on anti-depressant drugs. Ninety three per cent of GPs have said they have prescribed anti-depressants because of a lack of alternatives.

London's diverse population has vastly differing needs, attitudes to accessing care and patterns of service use. High rates of offending, substance misuse and homelessness all present particular challenges.

For instance:

- diagnosis of serious mental illness in people from Black African-Caribbean communities is five times greater than among white British people. People from these communities are also less likely to seek help than others
- up to 90 per cent of prisoners are estimated to be suffering from at least one mental health disorder.

And with more and more people living beyond 80 we expect a significant rise in the number of people with dementia.

What are we recommending for the future?

The following proposals aim to develop existing mental health services:

- 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

- Further efforts should be made to reduce the fear of services, with special measures taken in communities where it is culturally less acceptable to seek help

- Clearer pathways should be developed 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 they can expect from them

- Cognitive behaviour therapy and other `talking therapies' could be used extensively but, where they exist, waits for these services in many parts of London are long. More graduate mental health workers could be employed to deliver talking therapies. Other

therapies should also be explored, including exercise, reading and walking.

More choice

A London Assembly survey found that only 50 per cent of mental health service users felt they had a choice over the service or treatment they received. People could be given more control over their lives by:

- Greater use of payments to patients so that they can buy their own services

- Better access to opportunities such as housing and employment. Around 40 per cent of benefit claimants are on incapacity benefit because of mental health problems, but the vast majority of these people want to work

- Encouraging mental health services to work in partnership with local organisations including physical health providers, social care, housing and employment agencies, black and minority ethnic communities, local businesses and faith communities to help people lead full lives as part of their local community.

Individual services

Mental health services must meet the needs of minority groups. In some cases assertive outreach (a system where community professionals go out to the homes of patients who are reluctant to come in to be seen) should be used. 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.

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

Older people with dementia need to have early access to services and a care plan which addresses their health and social care needs. The aim is to provide support for people and their carers as close to their own home as possible but with specialist assessment and treatment units available if necessary.

New ways of working

In recent years a range of specialist mental health teams have been developed. But more generalist community mental health teams (CMHTs) need a clearer focus, perhaps on providing assessment and co-ordinating support, recovery or therapies.

Whilst community services are improved, London needs to develop a vision for specialist inpatient mental health care, involving:

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

A question for you…

Question 10

We have established a new mental health working group with greater clinical representation. The results of this work will be published in summer 2008. In the meantime, we welcome your views on the recommendations shown in this section, to help us with the more detailed work.

5.5 Acute care

"Each year millions of Londoners have short-term illnesses or health problems that are not life-threatening, such as a chest or bladder infection, but for which they need quick and convenient treatment. A much smaller number suffer from serious illness, such as a stroke or heart attack, or have a major injury. These patients need highly skilled specialist care to give them the best chance of recovery. The NHS in London is providing neither accessible, high-quality urgent care for the bulk of the population, nor the best quality specialist care for the small number of people who need it."
Dr Chris Streather, Renal Physician, Director of Strategy and Medical Director at St George's and member of the Adult Care Working Group, Healthcare for London.

Dr Streather was a National Kidney Research Fund Training Fellow at King's College and has a particular interest in cardiovascular risk in renal disease.

A snapshot

*** In this booklet 'urgent care' means care that is needed immediately or within the next day or two.**

Most people with an urgent care* need will ring their GP practice for an appointment. But people can also call a number of other organisations – for instance the London Ambulance Service, NHS Direct, emergency dental services or their local GP's out-of-hours provider. People are often unclear as to which number to ring.

- Almost three million people attended London A&E services in 2005/06
- Many of these people attend A&E with a minor injury or illness
- 40 per cent of those taken to hospital by ambulance could be treated and cared for in the community

Often, someone attending A&E for a minor illness may be getting treatment from a junior doctor rather than the ideal - an experienced GP. However, people go to A&E because they see it as providing expert care and solutions to all healthcare problems and, of course, it is open all day, every day.

At the other end of the scale, the services for more complex, specialist care are simply not good enough. Some hospitals simply do not have the specialist staff, equipment, or number of patients needed to ensure care of the highest quality can be provided 24 hours a day, seven days a week.

Stroke care – specialist care is best

In 2005/06 over 6,000 Londoners suffered a stroke (a 'brain attack' similar to a heart attack).

Best urgent care for a stroke patient means:

- rapid assessment by ambulance staff
- access to a CT scan (a sophisticated x-ray) to determine the cause of the stroke
- early treatment using clot-busting drugs if the scan shows it is appropriate. The scan is essential as the drugs could worsen some patients' condition

Patients who receive this treatment within 90 minutes of the attack are twice as likely to survive or have less disability than those that don't.

Not every hospital can provide the specialist multidisciplinary teams and the equipment to deliver this level and speed of care all the time. At the moment many people are not even having the initial scan within 24 hours. In 2006 no hospital trust in London gave at least 90 per cent of stroke patients a scan in the less-than-ideal benchmark of 24 hours.

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

What are we recommending for the future?

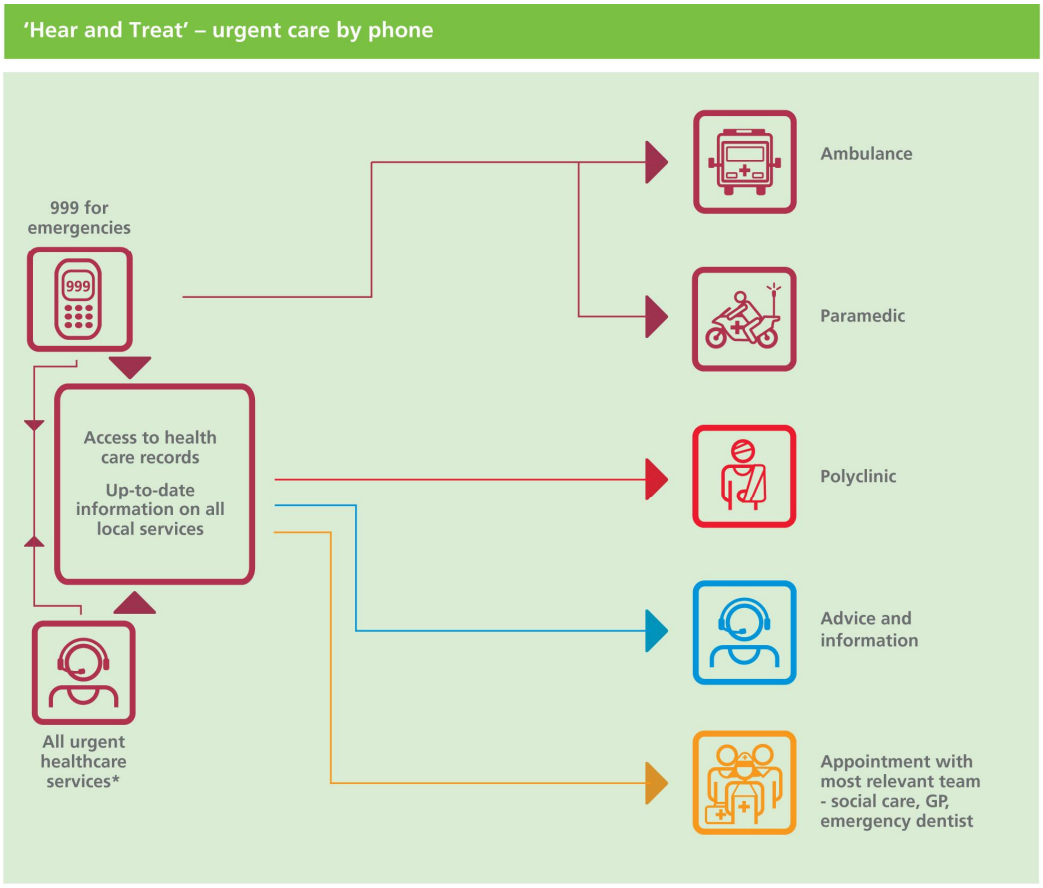
When people need – or think they need – urgent care they should expect consistent and thorough assessment 24 hours a day, seven days a week.

Telephone advice

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

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

Call-handlers would be able to respond quickly to callers' needs rather than the caller having to find their way through the system. This is shown below.



* Further work needs to be done to see if NHS Direct could provide all these services in future, or some of the services – for instance advice and information.

Face-to-face care

GPs will continue to provide most face-to-face urgent care for patients through the appointments system. Those people whose needs are more pressing should have the choice of:

- attending a same-site polyclinic or the hub of a network polyclinic in the community. Polyclinics would be open for extended hours and could house GPs, nurses, emergency care practitioners, mental health crisis resolution teams and social care workers. Staff would be able to help patients with substance or alcohol problems and have access to testing equipment including x-ray, ultrasound, heart checks and blood tests

- attending a polyclinic attached to an A&E. These would be led by GPs and other healthcare professionals experienced in working in the community. They would have similar facilities to a community-based centre and be open all day, every day

- admission to the nearest local hospital A&E or major acute hospital's A&E – these would be open all day, every day. Most ambulance admissions will be to the nearest hospital as we recognise that for many conditions such as severe asthma attacks, and choking, speed of treatment is the most important issue

- admission to the nearest hospital with specialist facilities.

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

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

When ambulance staff arrive at a patient suffering a suspected heart attack, they use a 12-lead electro-cardiogram to see if this is the problem. If it is, they can now take the patient directly to one of nine specialist centres in London. This means the patient can benefit from a technique known as angioplasty, where a balloon is inserted and inflated into the blocked artery. It is too early to provide figures on the impact on survival in London. But we know that in America, 92% of patients receiving angioplasty are alive after a year compared to 84% of patients receiving the previous 'gold standard' treatment. We expect to see a similar rise in survival in London.

At present there is one severe injury centre in London, at the Royal London Hospital in Whitechapel. The Royal London treats 950 severely injured patients a year and its results are impressive. In 2006 it recorded 28 per cent fewer deaths in the most severely injured patients compared to the national average. We believe there should be approximately three severe injury centres in London, including the one at the Royal London. This is based on the recommendations of the Royal College of Surgeons that these centres should serve between one and three million people. These severe injury centres would not replace A&E departments at other hospitals, which would still provide the majority of emergency care.

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

Questions for you…

Question 11

If there was a telephone service to treat your urgent care needs, what facilities would you like it to have? (Please choose all that apply)

A. Provide general medical advice

B. Book an appointment with GP

C. Book an appointment with another healthcare professional

D. Transfer callers to emergency services (999)

E. Transfer callers to a specific healthcare professional

F. Give directions to a polyclinic, pharmacy or hospital

H. I would not use a telephone service for the treatment of urgent care needs

Question 12

We propose developing some hospitals to provide more specialised care to treat urgent care needs of the following conditions. These would probably be further from your home than your local hospital. If these proposals are adopted, the number and locations will be subject to later consultation:

- Trauma (severe injury) - approximately 3 hospitals in London
- Stroke - approximately 7 hospitals in London providing 24/7 urgent care, with others providing urgent care during the day – and rehabilitation
- Complex emergency surgery needs – further work will need to be carried out to propose a number

Do you agree or disagree with the proposals to create more specialised centres for the treatment of severe injury, stroke and complex emergency surgery needs

Question 13

If you agree that there should be specialist centres for the treatment of trauma, stroke and complex surgery, do you agree or disagree that ambulance staff should take seriously ill and injured patients directly to these specialist centres, even if there is another hospital nearby?

Question 14

Please tell us any other comments you might have on the proposals in this section.

5.6 Planned care

"Each year in London there are over eight million hospital outpatient appointments. We know that many of these are not necessary and GPs and nurses could carry out a lot of these appointments closer to people's homes. When specialist outpatient care is needed this should happen as locally as possible, with hospital consultants and other clinicians coming to local clinics, avoiding the need for patients to travel to specialist hospitals."
Dr Martyn Wake, GP and Joint Medical Director, Sutton and Merton Primary Care Trust. Working Group Chair, Healthcare for London.

Dr Wake has worked as a GP in South West London for 25 years. He is involved in developing extended primary care particularly in the management of diabetes, cardiovascular and respiratory disease. He has a special interest in stroke and cancer care, mental health and learning disability.

A snapshot

Access to diagnostic tests in hospitals, in particular Magnetic Resonance Imaging (MRI), ultrasound and Computerised Tomography (CT) scans, is slow compared to other parts of the country. The bottleneck is putting lives at risk. Over 70 per cent of tests are performed on outpatients who have to travel to hospital just for a test.

In 2005/06, 800,000 Londoners had planned surgery or medical treatment needing an overnight stay. These people deserve the best possible care, but the way existing services are provided and organised is not meeting their needs.

When specialist care is needed it is not good enough. Cancer care is a good example. The National Institute for Health and Clinical Excellence (NICE) sets standards for high quality cancer care. Level one standard is essential to the delivery of a satisfactory service, but none of the five London cancer networks achieve this level.

What are we recommending for the future?

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

More surgery should be carried out as day cases, allowing patients to go home the same day. Patients prefer it, it is more cost-effective and it

reduces the risk of catching an infection. In 2005, London was the worst performing region in England, performing far fewer operations as day cases than expected.

More local care

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

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

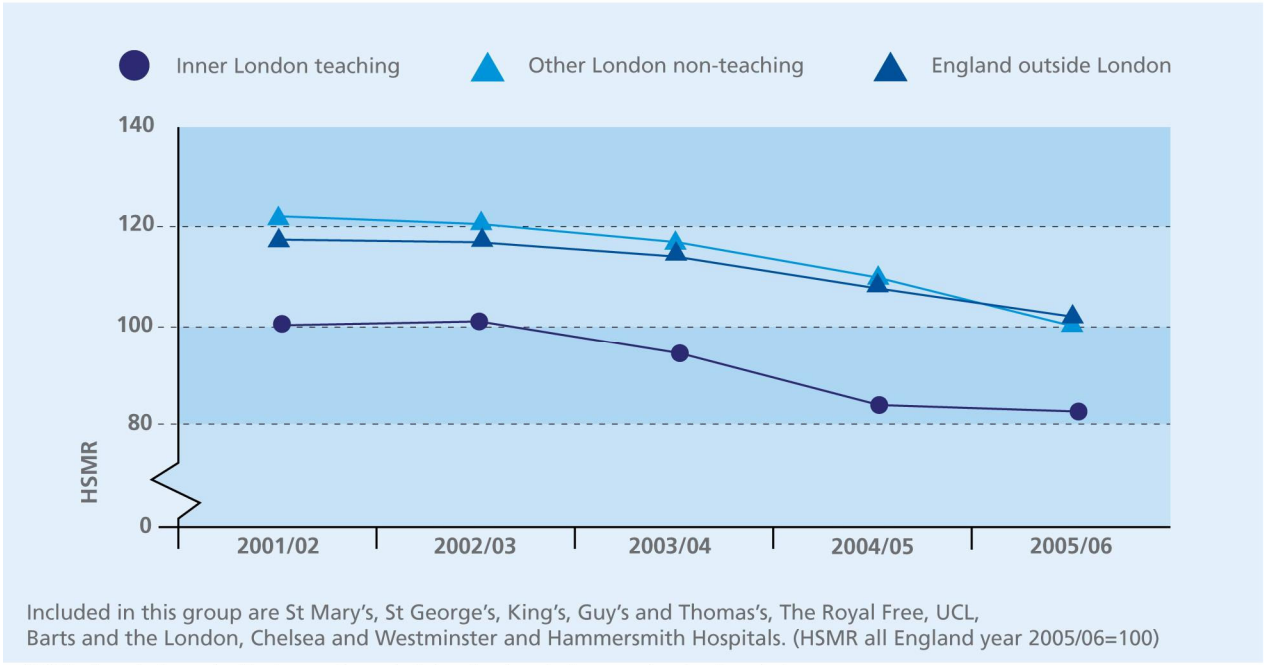
More specialist care

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

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

We recognise that there will be times when specialist care means more travel for a patient. We will need to work hard to ensure patients only come to the hospital when necessary. For instance tests could be done close to a patient's 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 at other hospitals.

Comparing death rates of large inner London hospitals with other London and England hospitals. A lower score means that more people survive.



Included in this group are St Mary's, St George's, King's, Guy's and Thomas's, The Royal Free, UCL, Barts and the London, Chelsea and Westminster and Hammersmith Hospitals. (HSMR all England year 2005/06=100)

HMSRs (hospital standardised mortality ratios): London hospitals vs non-London hospitals.
Source: Hospital reported HSMR scores

Questions for you…

Question 15

How useful, if at all, would you find it for GP surgeries to be open for appointments in the evenings and at weekends?

Question 16

Please tell us any other comments you might have on the proposals in this section.

Telemedicine

Every two minutes, someone in the UK has a heart attack and early death from heart disease is higher in London than England as a whole.

New techniques and technology can be used to detect changes in the heart rhythm or other problems of patients, before they start feeling unwell.

Patients either monitor themselves at home or go to a local GP surgery. Data can then be sent electronically to a specialist team, constantly available and trained in reading the results. The team look at the data and advise the patient, nurse or GP on the best course of action.

The results are impressive. Patients using this type of telemedicine, who used to regularly attend hospital because they felt chest sensations or were worried, now rarely have to do so because they feel confident in the tests.

Of course this peace of mind and avoidance of unnecessary trips to a hospital also saves money. We ought to be making more use of this type of technology for a wider range of conditions.

5.7 Long-term conditions

"Patients with long-term conditions are the biggest users of healthcare. Good management of diabetes, arthritis, heart failure, asthma, obesity, lung disease and some cancers can mean patients lead a full and active life in the community without the need for hospitalisation and emergency care. People with long-term conditions should be in control of their care, making informed decisions about the care they can access."
Dr Tom Coffey, GP and Professional Executive Committee Chair, Wandsworth Primary Care Trust. Working Group Chair

Dr Coffey has been a GP partner in south-west London for ten years. He is chair of the Tooting Healthy Living Centre and medical advisor to Tooting Walk-in Centre, Clinical Assistant in A&E at Charing Cross Hospital and a Tutor at St George's Medical School.

A snapshot

The number of people with long-term conditions is likely to grow. There are clear links between lifestyle and the incidence of some long-term conditions. For instance smoking increases the likelihood of cancer, and obesity increases the chances of suffering from type II diabetes.

Many people with long-term conditions have yet to be diagnosed. It is estimated that up to a third of people with diabetes may be undiagnosed,

putting them at risk of blindness and amputation. Forty per cent of people with lung disease are undiagnosed and only a third of people with dementia are ever formally diagnosed, denying them access to drugs that could improve their lives.

What are we recommending for the future?

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

GPs, practice nurses and social care staff should be supported to develop effective ways of 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.

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

Giving control to patients

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

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

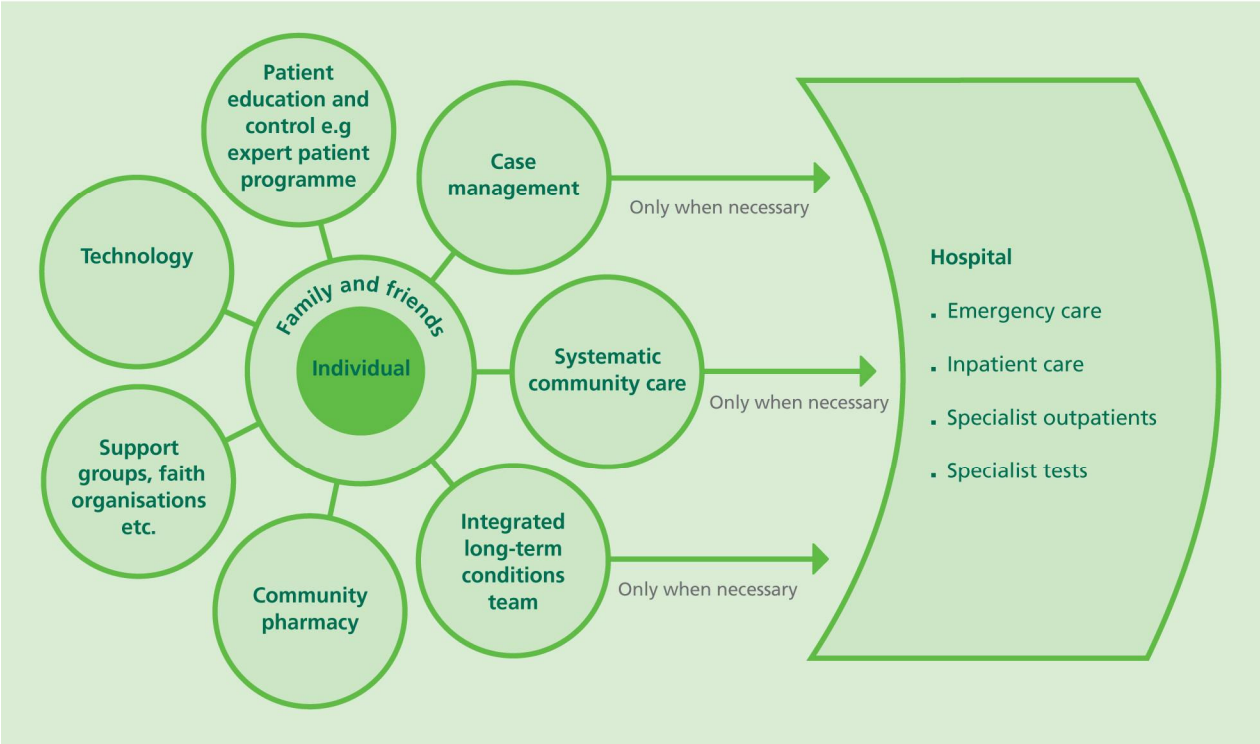
- the expert patient programme which is a course giving people the confidence, skills and knowledge to manage their condition better and be more in control of their lives
- information prescriptions, which tell people where they can get further information and advice.

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

All these recommendations will keep people healthier, reduce the need for hospital care and reduce unnecessary emergency admissions.

However, it will require considerable investment to support patients in this way, rather than the hospital-based care we are all used to.

Proposals will create a web of care with the individual at the centre



Questions for you…

Question 17

Thinking about how the NHS in London is balancing the resources it spends on long-term conditions, (e.g. asthma, diabetes), do you think:

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

b) the current balance of investment between hospitals and community support for people with long-term conditions is about right

c) a greater proportion of spending should go to supporting people with long-term conditions through investing in hospital care

Please explain your reasons.

Question 18

Please tell us any other comments you might have on the proposals in this section.

Partnerships putting patients first

Many patients, after they have been diagnosed with a terminal illness, have the chance to talk with their GP or their nurse about where they want to die. Most people decide that they would prefer to be at home when the end comes. But sometimes it is very hard for a family to just let that happen, and often they will call an ambulance.

In the past the ambulance crew arrived and – with no knowledge that the patient has decided they would like to die at home – they followed their training and did all they could to save the patient's life, and then took them into hospital. Although they were doing their best, the person often died in hospital, against their previously expressed wishes and without their family around them.

The ambulance service is trying to address this. When someone knows they are dying, they can agree that their GP sends a letter to the ambulance service asking for their details to be registered. It means that if an ambulance is called to them, the staff will know that they are going to a patient who has expressed their wishes about where they want to die. If death can't be avoided, the ambulance crew can provide pain relief and support to the patient and their family, and ensure that the patient's wishes are respected.

The same principle could apply to patients who are not dying, but living with long term conditions. For instance long-term lung disease is condition of the lungs which means patients often suffer from breathlessness and low oxygen levels in their blood. Ambulance crews will often take patients to A&E unnecessarily because they don't know the patient has lung disease and would be expected to have lower than 'normal' oxygen levels.

If ambulance staff know that the patient they are going to has lung disease then they can provide enough oxygen to bring the patient up to normal levels for that patient and then contact the right person (the district nurse, community matron or GP for example) to make sure the patient gets a follow-up call.

5.8 End-of-life care

"People at the end of life often need support and care from a number of different services, but there is no consistent approach to organising this complex care. Too often services react slowly to a patient's needs that could easily have been predicted. Better planning is needed to ensure help arrives at the right time to provide comfort and services that the patient has chosen."
Cyril Chantler, Chair of Great Ormond Street Hospital for Children and the King's Fund. End-of-Life Working Group Chair, Healthcare for London.

Sir Cyril has been Dean of the Guy's, King's College and St Thomas' Hospitals' Medical and Dental School, where he was the Children Nationwide Medical Research Fund Professor of Paediatric Nephrology until his retirement in 2000. He has also held posts as Principal of the United Medical and Dental School of Guy's and St Thomas's Hospitals, President of the British Association of Medical Managers and was also a Member of the General Medical Council , where he was Chairman of the Standards Committee.

A snapshot

Almost 53,000 people died in London in 2005. Care for people in their last weeks and months often involves intensive support by the NHS.

In a recent poll, 77 per cent of people who had experienced the death of a loved one in the last five years were fairly or very happy with the care given. However, 54 per cent of all complaints about hospitals received by the Healthcare Commission are about end-of-life care.

Whilst 57 per cent of people say they would prefer to die in their own home, in London just 20 per cent actually die at home.

Best practice techniques in end-of-life care are used by over 90 per cent of GP practices in some parts of the country. These techniques are used by fewer than 25 per cent of GP practices in London, nor are they being used by all hospitals.

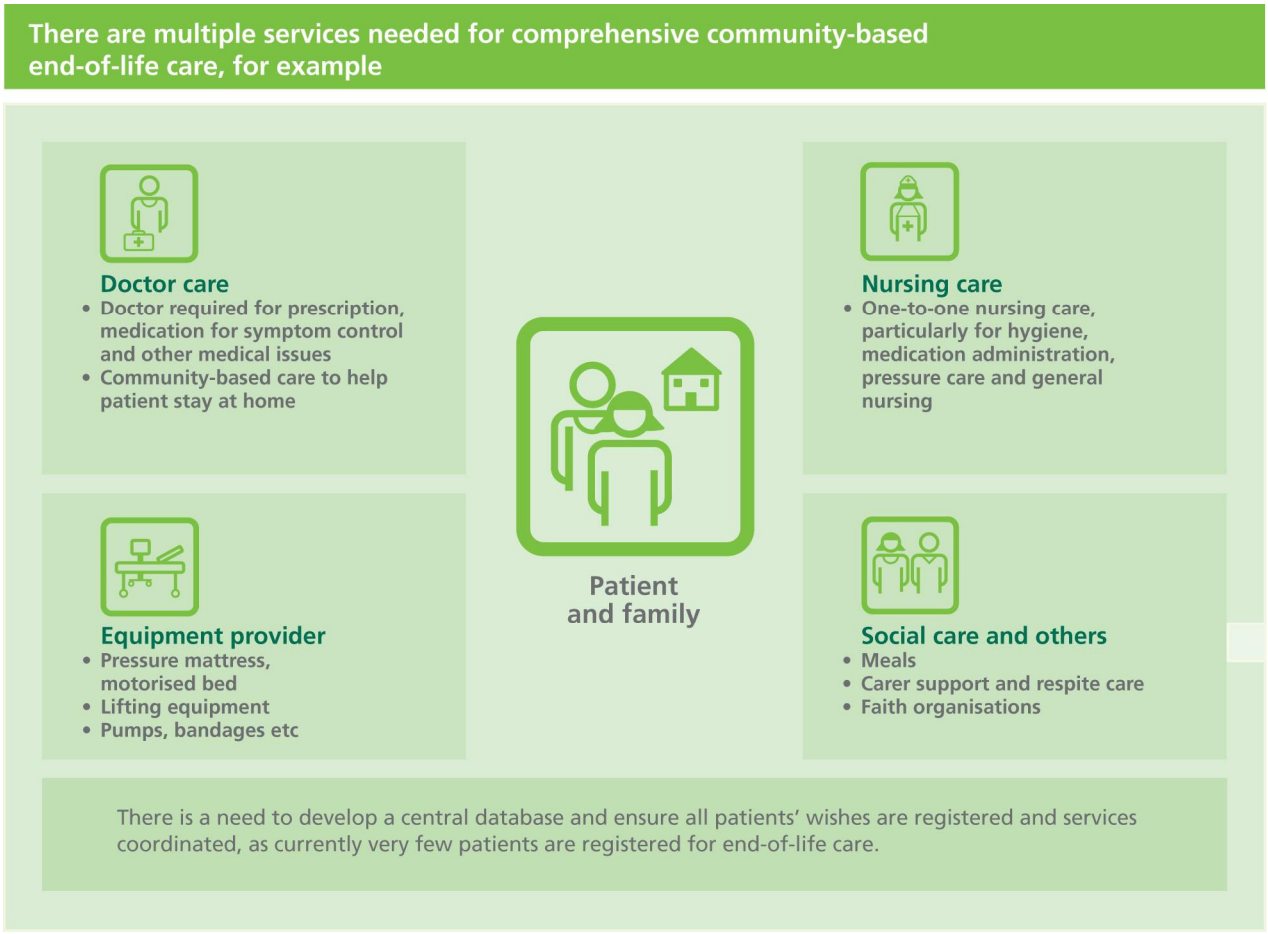
What are we recommending for the future?

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

There should be new End-of-Life Service Providers (ELSPs) co-ordinating care for patients. Patients with an advanced progressive illness who are identified as nearing the end of their life should be offered

the opportunity to have their needs assessed and to identify their preferred place of death. The end-of-life service provider would then be responsible for arranging a package of care.

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



Questions for you…

Question 19

Do you think that new end-of-life service providers responsible for co-ordinating end-of-life care will result in better or worse care for patients than the current arrangement?

Question 20

Please tell us any other comments you might have on the proposals in this section.

6 Where we could provide care

This consultation document has concentrated on the way care is provided to patients and how that care can be improved. This section looks at the organisations and places that provide care and makes recommendations for a new approach. This would be based on evidence of best practice, clinical effectiveness and the needs and wishes of Londoners.

Please note that the analytical work that underpins this section can be found in the technical paper at www.healthcareforlondon.nhs.uk or by requesting the printed version from 0800 XXXXXXXXX

6.1 A snapshot

A national survey by the British Medical Association (BMA) found that 75 per cent of GP practices felt their premises were not suitable for future needs and over a third of practices cannot be adapted to meet all the disabled access requirements of the Disability Discrimination Act – we expect this reflects the picture in London. This limits the ability of the NHS to provide services such as physiotherapy and basic blood tests closer to people's homes.

Many hospitals, both acute and mental health units, operate on multiple sites, spread over a large and poorly designed set of buildings that are not used effectively.

The 32 hospital trusts in London cannot all try to provide every kind of specialised care, each treating only a small number of patients.

6.2 Our recommendations

The proposals set out where we could provide safe and expert services in the most convenient place for the patient. There are three key needs. First is to make sure where existing services are working well that any changes really are improvements. We wish to improve services at GP practices and local hospitals. Secondly to provide a new kind of community-based care at a level that is between the current GP practice and traditional hospitals, and thirdly to develop a small number of more specialised hospitals focused on providing better quality care for some conditions.

Whilst we recognise that healthcare will be provided in a variety of places, for instance schools, pharmacies and community hospitals, we think most healthcare will take place in six places:

- Home
- Polyclinic*
- Local hospital
- Major acute hospital
- Planned care (elective) centre
- Specialist hospital

* This could be in a networked polyclinic – where existing GP practices link together and to a local ‘hub’, a same-site polyclinic – where many GP practices come together under one roof, or a hospital polyclinic. See page x for more details.

Flexible care

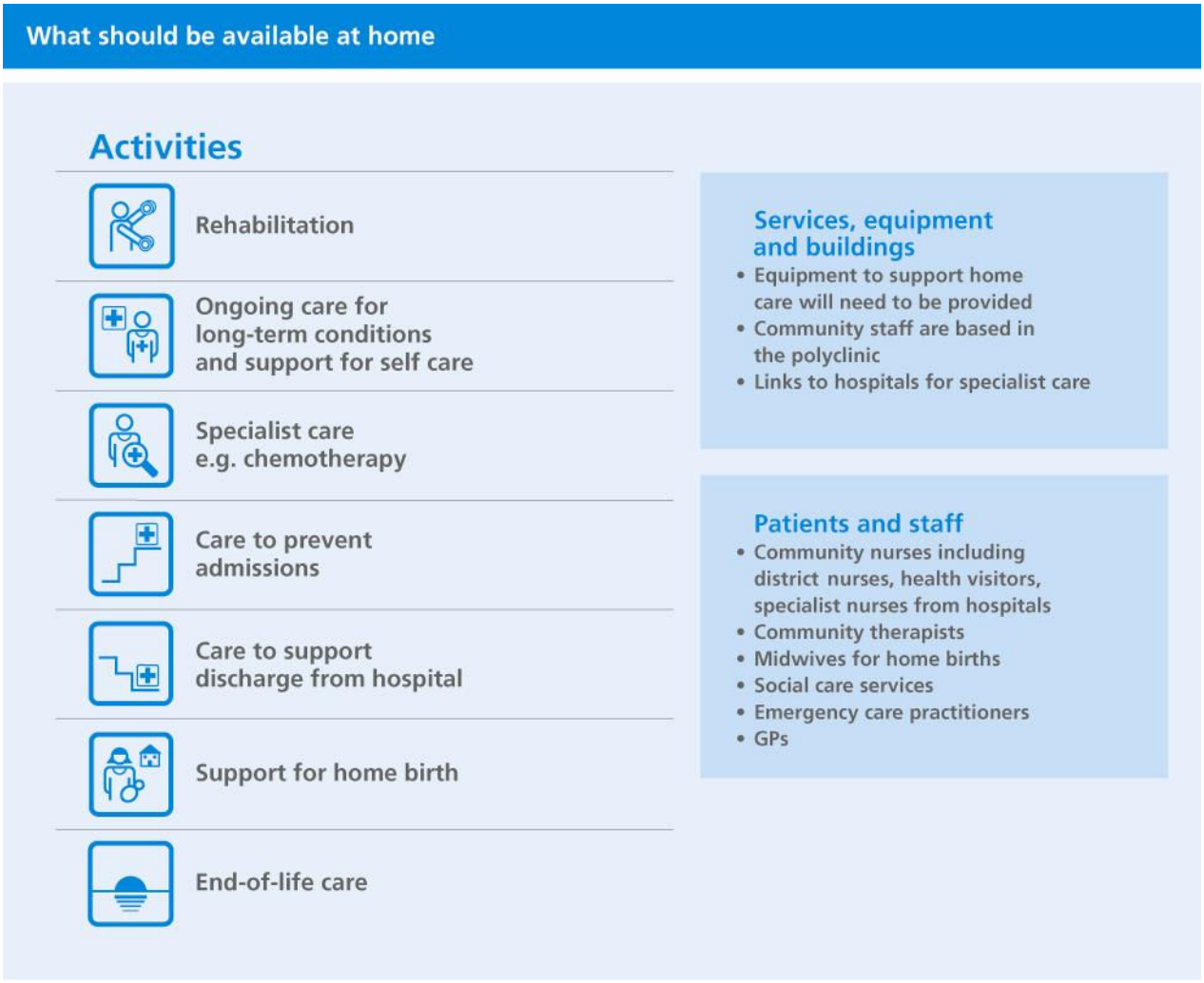
The following pages show the health activities that could be provided at each of those locations – they do not describe exactly what will be delivered in each location – this will depend on local needs and circumstances. None of the locations would work on their own. All the locations would need to work together in networks that ensured patients were provided with the right care, in the right place, at the right time. And the places might be called different names, for instance ‘multi-care centres’, ‘health centres’ and healthy living centres are all names that have been applied to polyclinic-style models.

Some services may be on the same site, for instance there would always be a polyclinic on the same site as a local hospital, and an elective centre could share the same site as a local or major acute hospital.

The proposals set out where we could provide safe and expert services in the most convenient place for the patient.

Home

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



Polyclinic

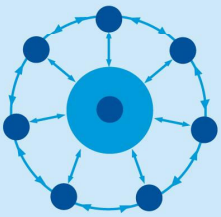
Polyclinics could provide part of the solution to providing a much wider range of high-quality services, for extended hours, into the community – reducing the need to visit hospitals and other services. The location and design of each polyclinic would need to meet the needs of each community, but the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

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

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

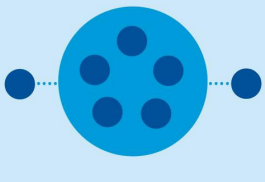
Different types of polyclinic

Polyclinics exist in other cities in the world and there are plenty of examples of large health centres and GP practices in London that are well on the way to becoming polyclinics. Polyclinics could help GPs offer more extended opening hours and services. Each polyclinic would house or network about 25 GPs.



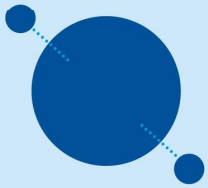
A NETWORKED POLYCLINIC

Existing GP practices would link to a local 'hub' for specialist clinics and services such as blood tests, scanning and plaster facilities. The 'hub' could be developed from an existing GP or other provider or a new building

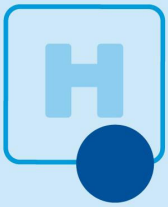


SAME-SITE POLYCLINICS

GP practices could come together under one roof, sharing many services but being run as different practices, perhaps linking with some other practices



GPs could merge into one large practice, again linking with other practices not on the same site.



HOSPITAL POLYCLINICS

Based at the `front door' of local hospitals. These would provide the local population with the same range of services and staff as other polyclinics but be open 24/7.

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

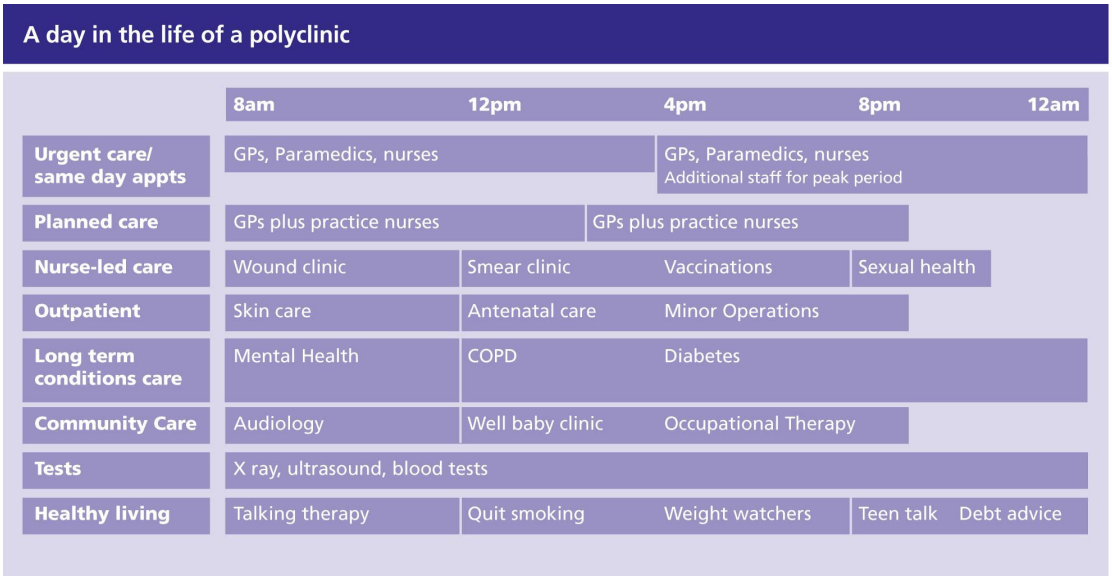
Every hospital A&E would have a polyclinic as its `front entrance' so that patients who did not need to go to A&E or be admitted to a bed could receive care there.

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

Addressing concerns

Many patients are keen to retain a relationship with a doctor and we are keen to ensure this happens – the family doctor relationship can be maintained in a polyclinic. But if an urgent appointment with a doctor is needed the proposed extended opening hours of polyclinics would make this easier. And if patients wanted to see a GP whilst their own doctor was unavailable, attend before-birth classes or use other health facilities, this would be possible too.

We recognise that some people will be concerned about having to travel further to see their GP. Of course in a networked polyclinic there would be no additional distance for patients to travel because GP practices would remain where they are. However high-level modelling suggests that, even if all GPs in an area wanted to relocate to the same building, the vast majority of Londoners would be within 1.5 miles of a polyclinic. Because polyclinics would have far more services provided over extended hours, the need to attend a hospital would be reduced.



What a polyclinic should provide

Activities	Hours open per day
General practice services	12
Community services	12
Most outpatient appointments (including antenatal/postnatal care)	12
Minor procedures	12
Urgent care	12-24
Tests e.g x-ray, ultrasound	18-24
Interactive health information services including healthy living classes	18-24
Pharmacy	18-24
Other health professionals, e.g. optician, dentist	12

Services, equipment and buildings

- Dedicated child-friendly facilities
- Base for other services such as district nurses, radiology
- Healthy living/information centre
- Co-located local authority services in some e.g. social services
- Co-located leisure facilities in some, e.g. swimming pool
- Co-located ambulance
- Open 18-24/7

Patients and staff

- Serve population of approximately 50,000
- Staff would typically include:
  - Approx 25 GP's (in a networked polyclinic some GP's would be based in the 'hub' and some in linked general practices)
  - Consultant specialists
  - Nurses
  - Dentists, opticians, therapists
  - Emergency care practitioners
  - Mental health workers
  - Midwives, health visitors
  - Social workers
  - Ambulance staff

Local hospital

Local hospitals would include a 24/7 polyclinic as their '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. Working in a network, local hospitals would provide rehabilitation facilities for patients whose complex condition had required a visit to a major acute hospital.

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

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

What a local hospital should provide

Activities	Hours open per day
Rehabilitation with full range of community services	12
A&E	24
Emergency non-complex surgery	12
Urgent care	24
Outpatient services	12
Regular attendees, e.g. renal dialysis	12
Children's assessment unit	18
Doctor-led unit with a Midwife-led Unit and level 1/2 Neonatal Intensive Care Unit *(in some local hospitals)*	24
Tests e.g x-ray, ultrasound	24**

Services, equipment and buildings

- High Dependency Unit (but not Intensive Care Unit)
- Acute admissions unit
- Overnight beds
- Pathology satellite laboratory*
- Test imaging
- Open 24/7

Patients and staff

- Serve a population of around 200,000-250,000
- Have a similar staff composition to current district general hospitals

*Pathology satellite laboratories provide rapid test results needed by A&Es and other local hospital services.
**Core Services only

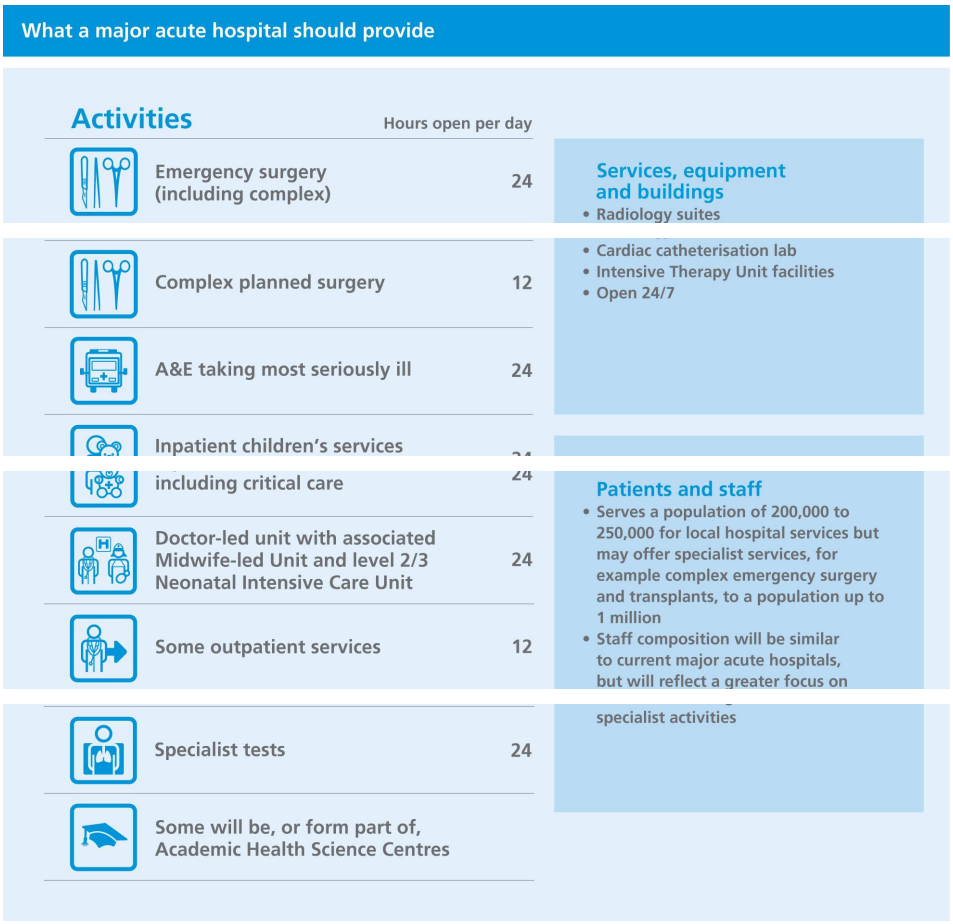
Major acute hospital

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

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

In addition:

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



Planned care (elective) centres

Elective centres would focus on particular types of high-volume planned surgery such as knee and hip replacements and cataract operations. This work will be separated out from emergency surgery to achieve better results and productivity and reduce the risk of cancellations and cross-infection. Elective centres could be on a hospital site or separate.

Elective centres are already being used in London, for example the South West London Elective Orthopaedic Centre is an NHS treatment centre on the Epsom General Hospital site. It performs nearly 3,000 hip, knee and shoulder replacements a year.

What an elective centre should provide

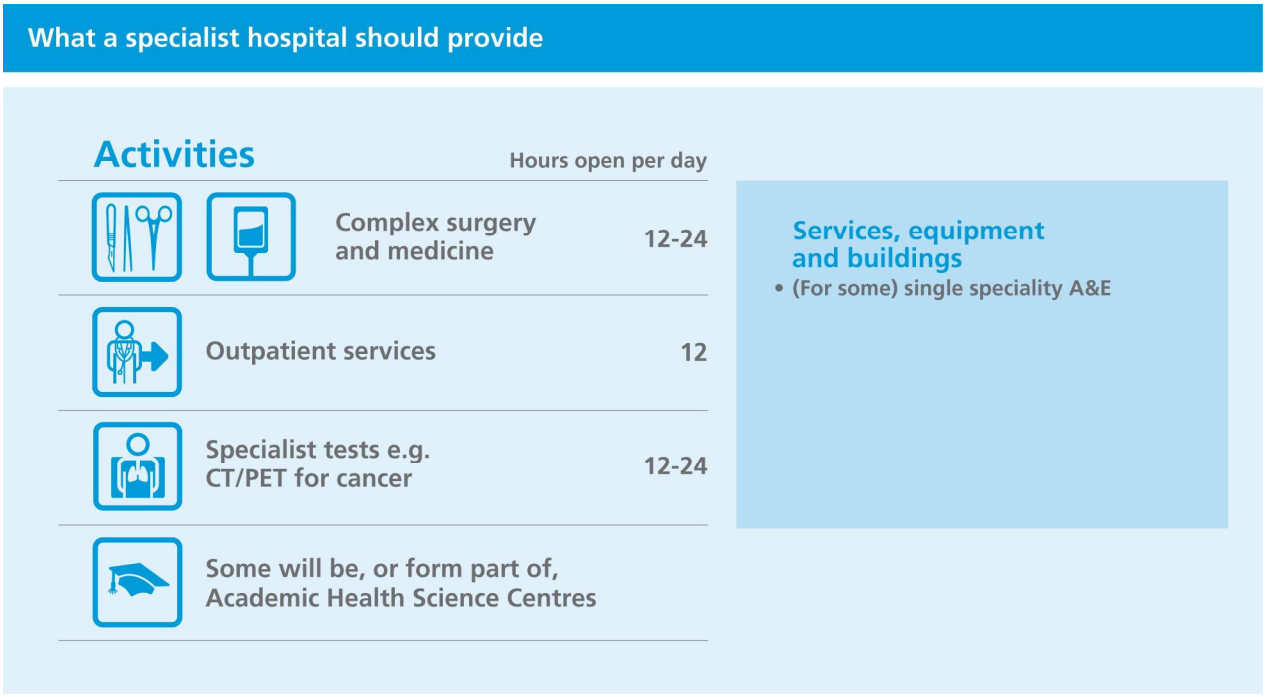
Activities	Hours open per day
Planned surgery, some centres may sub-specialise	12
Simple day case procedures (such as endoscopy)	12
Outpatient consultations	12
Pre-admission clinic and facility for pre-operation workups	12
Tests	12

Services, equipment and buildings

- Day case unit
- Children's wing
- Open 24/7, although surgery only during the day

Specialist hospital

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



Questions for you…

Question 21

The proposed polyclinics will have a number of features. We would like to know what five factors are most important to you:

- GP services
- Social services
- Leisure services (for example a gym or a swimming pool)
- Outpatient appointments (including before birth / care following birth)
- Minor procedures
- Urgent care
- Tests – blood tests, scans, radiology
- Healthy living classes
- Proactive management of long-term conditions
- Pharmacy
- Optician
- Dentist

Question 22

Do you agree or disagree that almost all GP practices in London should be part of a polyclinic, either networked or same-site (see diagram)?

Question 23

We are proposing moving the treatment of some conditions (e.g. trauma, stroke and complex emergency surgery) to specialist hospitals and providing more outpatient care, minor procedures and tests in the community. Local hospitals will continue to provide most other types of care as they do now. Which of these statements most closely fits your view:

a) Hospitals should continue to provide services in the same way as now, with most hospitals providing most services.
b) The treatment of a few conditions (e.g. trauma, stroke and complex emergency surgery) should be moved to specialist hospitals, and local hospitals should continue to provide other care as they do now.
c) More outpatient care, minor procedures and tests should be provided in the community and local hospitals should continue to provide other care as they do now.

Question 24

Please tell us any other comments you might have on the proposals in this section.

7 The costs

We estimate that by 2016/17 the London PCT healthcare budget will have risen to £13.1 billion. This is a rise from £5.5 billion in 2000 and from the current figure of £11.4 billion a year. So these proposals are not about healthcare 'cuts' or driven by the need to save money, they are aimed at providing the best healthcare system possible within a budget which will continue to grow substantially.

Forecasts have been made of how demand for health services in London will change and where, if these recommendations were implemented, different operations and procedures would be performed in ten years time.

Clearly these estimates are just that - estimates. So many things can change over a decade which would affect the calculations. However, if we make the changes recommended in Healthcare for London, we believe we can deliver safer, higher quality, more accessible care. These changes also enable services to be run more efficiently. By combining some services on the same site (for example in polyclinics) we can provide a better service to patients who can receive more treatments at the same time and in the same place. This is better for the patient and is a more efficient use of space and resources. Our most likely forecast is that services will cost £13.1 billion – the same as the estimated budget.

We will need to make sure we put in place, and strengthen, financial arrangements that allow these changes to occur. For instance, enabling hospital-based clinicians to work in the community and GPs to offer more services to their patients. But we believe this is achievable.

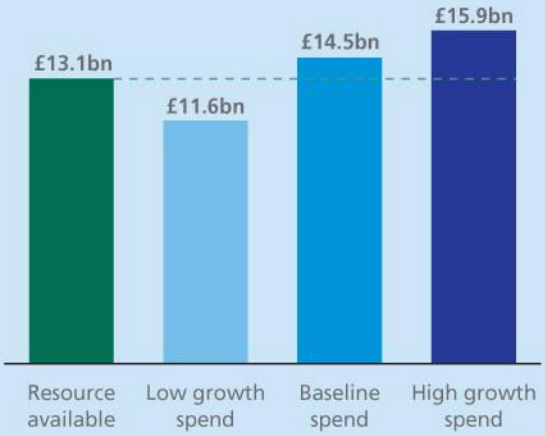
If we continue to provide services the way we do now the current weaknesses in quality and accessibility of care will not be tackled. In other words, a bigger budget would not be spent efficiently or effectively.

The work that supports this section can be found in the technical paper at www.healthcareforlondon.nhs.uk or by calling 0800 XXXXXXXXXX for a copy.

Cost of delivery models against projected commissioning resources available in 2016/17

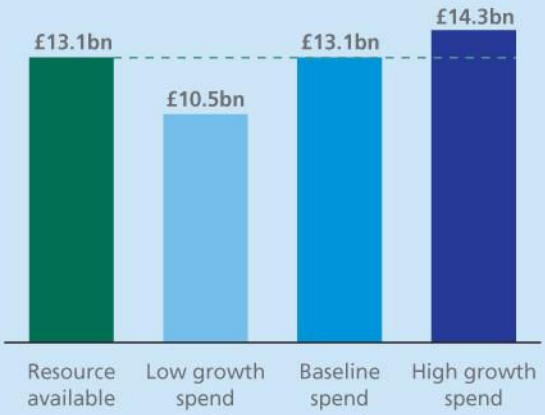
Delivery models

No change in delivery model



No step change in quality, safety and access in any of the scenarios. Two of the scenarios unaffordable.

Proposed delivery model



Step change in quality, safety and access in all scenarios. Low growth and baseline growth scenarios affordable. Over-run on resources available in high growth scenario.

Source: Outcomes of PCT allocation projections and activity and spend forecasts

Patient activity scenarios

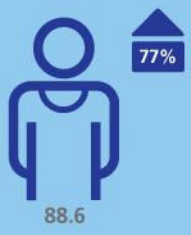
Patient activity: spells/attendances (millions)

% Percentage increase against 2005/06 actual

2005/06 Actual

2016/17
Low growth scenario
Growth in line with demographics and impact of changing prevalence rates for selected long-term conditions

2016/17
Baseline scenario
Historical growth rates over and above demographics and changing prevalence rates except for A&E



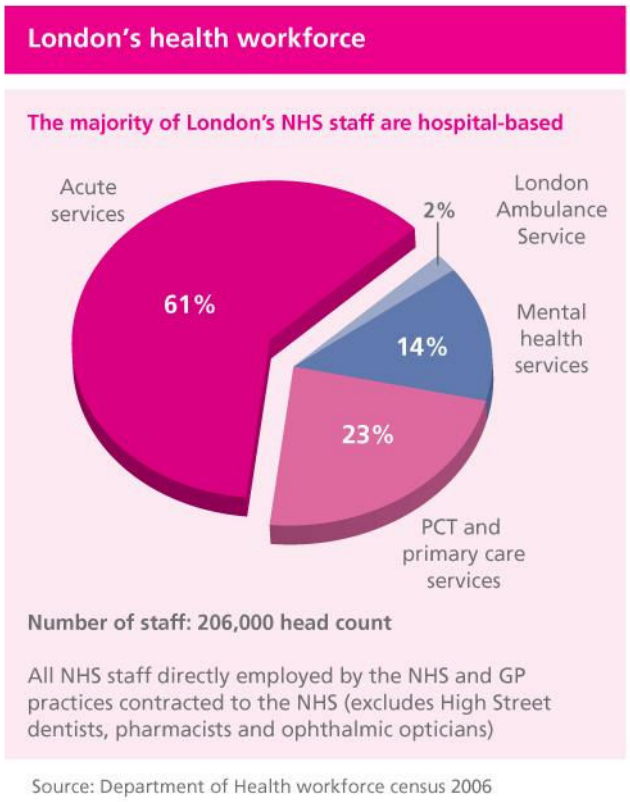
2016/17
High growth scenario
Growth rates higher than demographics, changing prevalence rates and historical due to improved access and pace of technological development

Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians

8 Turning the vision into reality

Making change happen in a service as complex as the NHS takes a lot of time and effort and there are some key issues to get right if we are to succeed:

8.1 Workforce



Over 200, 000 NHS staff work together, in London, to provide high quality healthcare 24 hours a day, 365 days of the year. They do so in an often challenging environment with professionalism, commitment and compassion. We need to support them in their efforts to improve services and keep Londoners healthy.

Introducing these proposals would mean big changes for NHS staff in London. We will require staff with different skills and capacities. We will need leaders from both clinical and non-clinical backgrounds. We will need to recruit and retain the right people at the right times. To do so we need to look at the number of staff required, the types of jobs available, how much travel will be needed and the types of teams that are created.

Our proposals also suggest moving staff out of some hospitals and into the community – and we recognise that staff will need to be supported to make this change.

The NHS is a major employer and we need to continue to encourage applicants from local areas of deprivation and ensure that the NHS reflects the cultural diversity of London.

All these ideas will require early, open and informed discussion with unions, staff, education and training providers and others. To address all these issues, NHS London will be developing a workforce strategy from which local workforce planning can happen.

8.2 Training

Training needs to be given a high priority and be linked to the workforce strategy. NHS London needs to explore how training and education can best be organised and provided to meet the future workforce needs of London and to support its role as a world-class centre for education and innovation.

Continued attention needs to be given to the contracts for training nurses, health professionals and medical students as well as other staff training, to ensure that NHS staff stay up-to-date in their understanding of inequalities and the needs of vulnerable groups.

There is the potential for developing exciting new roles, such as GPs with a special interest in emergency medicine or paediatrics, and we will need more staff in existing roles such as specialist long-term condition nurses. We will need to plan how we can train these people.

Of all London's healthcare providers, the London Ambulance Service (LAS) receives the least funding for education. LAS staff have a growing role in diagnosing serious illness and injury and need resourcing to improve the skills of its staff and procedures.

8.3 Buying services

Primary Care Trusts (PCTs) buy, on behalf of the public, almost all health services. At the moment some PCTs do not have some of the skills needed to be able to buy high quality, easy accessible services that result in the best possible health and well-being of residents.

To raise the standard of buying services we need to develop London-wide guidelines, provide better training and involve more clinicians and other partners, for instance local authorities.

8.4 Partnerships

To turn this vision into a reality will need the involvement of everybody who works in the NHS. Everyone will need to be actively involved in developing improvements to ensure that healthcare in London is the best it can be.

The NHS will need to improve how it works in partnership with local authorities, the voluntary sector – which has a vast wealth of expertise – higher education, the private sector, health providers and other organisations.

We know that transport will be a key issue and we need to work with a range of organisations to ensure care is provided in places that are easily accessible.

8.5 Public support

For these proposals to succeed both the public and politicians need to be convinced that it will improve healthcare. Many people remain attached to the services that are provided at the moment without being aware that there may be better ways of providing these services.

Clinicians must have a central role in explaining the clinical benefits of new ideas to the public.

8.6 Patient choice and information

From 2008, Londoners will be able to choose any approved provider of healthcare for planned treatment. This is likely to change where patients go to have their treatment, with providers that are popular with patients increasing their services to meet demand. Improved information is vital if people are to make informed choices. Patients need to know what they should expect from services and how to access information.

8.7 Information Technology

We will need good information technology to ensure that your information is available where and when it is needed, and that it remains secure. This will enable NHS staff to give you the best care, especially in an emergency, when having the most up-to-date information - for instance on your allergies - is crucial. Ensuring that you have access to your information is also important.

Questions for you…

Question 25

In the front of this booklet we described five principles. Now that you have seen how these principles will be applied throughout the proposals, please tell us whether you agree or disagree with each of these principles?

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

Question 26

What, if any, other principles do you think there should be?

We need to make sure that our proposals do not unintentionally disadvantage some people or groups of the community and have a positive effect on people who are most in need of better health.

We have asked a number of organisations to work with groups of traditionally under-represented and disadvantaged groups to look at how the proposals may affect them. An Equalities and Health Inequalities Impact Assessment on the consultation will be made available to the Joint Committee of PCTs when they consider the responses to consultation. We would also like your views.

Question 27

To what extent do ou agree or disagree with the following statements?

a) the proposed changes to healthcare services in London will **improve access to health services** for people from deprived communities and disadvantaged equalities groups.

b) the proposed changes to healthcare services in London will **improve the health** of people from deprived communities and disadvantaged groups.

* Equalities groups include: people from black, Asian and minority ethnic groups; children and young people; disabled people; people from faith groups; lesbian, gay and bi-sexual people; older people; women and other vulnerable, disadvantaged, and marginalized groups in London.

Question 28

What else could be done to improve access to health services and improve the health of deprived communities and disadvantaged groups.

Question 27

Please tell us any other comments you might have on how health services in London could be improved over the next ten years.

9 How to give us your comments

We believe that the people of London deserve the very best healthcare system in the world and we want to develop a healthcare service that meets the needs and expectations of all Londoners. We would welcome your views on our proposals.

Whatever your age, sex, ethnicity, sexuality, faith, job, or your current health, if you live or work in London this proposal affects you.

You can make your views known by contacting the independent consultants:

- Completing the comments form on the consultation website www.healthcareforlondon.nhs.uk
- Using the form in the centre pages or writing a letter to: FREEPOST CONSULTING THE CAPITAL
- Freephone: 0800 XXXXX
- Email: XXXX
- Attending one of the consultation meetings. For details you can look at the website or phone 0800 XXXXX

All comments must be received by 7 March 2008

10 Inside back cover

The partner PCTs would like to thank all the staff and stakeholders who have generously assisted in the preparation of this document including:

- The members of the Joint Committee of PCTs

Barking & Dagenham Primary Care Trust	Angela Todd	Non Executive Director
Barnet Primary Care Trust	Philippa Curran	Chair, Professional Executive Committee
Bexley Care Trust	Alison Barnett	Director of Public Health
Brent Teaching Primary Care Trust	Sarah Thompson	Director of Strategic Commissioning
Bromley Primary Care Trust	Elizabeth Butler	Chair
Camden Primary Care Trust	John Carrier	Chair
City & Hackney Teaching Primary Care Trust	May Cahill	Chair, Professional Executive Committee
Croydon Primary Care Trust	Stephen O'Brien	Deputy Chief Executive
Ealing Primary Care Trust	Tim Hughes	Non Executive Director (Vice Chair)
Enfield Primary Care Trust	Kristy Leach	Director of Nursing and Corporate Services

Greenwich Teaching Primary Care Trust	Michael Chuter	Chair
Hammersmith & Fulham Primary Care Trust	Mike Wood	Chief Executive
Haringey Teaching Primary Care Trust	Richard Sumray	Chair
Harrow Primary Care Trust	David Slegg	Interim Chief Executive
Havering Primary Care Trust	Ian Humberstone	Professional Executive Committee member
Hillingdon Primary Care Trust	Mike Robinson	Chair
Hounslow Primary Care Trust	Christopher Smallwood	Chair
Islington Primary Care Trust	Paula Kahn	Chair
Kensington & Chelsea Primary Care Trust	Diana Middleditch	Chief Executive
Kingston Primary Care Trust	Neslyn Watson-Druee	Chair
Lambeth Primary Care Trust	Andrew Eyres	Acting Chief Executive
Lewisham Primary Care Trust	Faruk Majid	Professional Executive Committee member
Newham Primary Care Trust	Melanie Walker	Chief Executive
Redbridge Primary Care Trust	Edwin Doyle	Chair
Richmond & Twickenham Primary Care Trust	Sian Bates	Chair
Southwark Primary Care Trust	Malcolm Hines	Deputy Chief Executive
Sutton & Merton Primary Care Trust	Howard Freeman	Chair, Professional Executive Committee & Medical Director
Tower Hamlets Primary Care Trust	Caroline Alexander	Director of Nursing & Therapies
Waltham Forest Primary Care Trust	Joan Saddler	Chair
Wandsworth Teaching Primary Care Trust	Ann Radmore	Chief Executive
Westminster Primary Care Trust	Joe Hegarty	Chair
Surrey Primary Care Trust	Chris Butler	Chief Executive

- The members of the Patient and Public Advisory Group (list names)

Complaints

If you have a complaint about this document or the consultation process you can contact: Complaints, Healthcare for London, Southside, London SW1E 6QT.

11 Other formats and languages (Back cover)

For a large print, Braille, CD or audio-tape version of this document, please contact Ipsos MORI at:

- Freepost, Consulting the Capital
- Telephone: XXXXXX
- Minicom: XXXXXX
- Email:

You will need to supply the title of this booklet “Consulting the capital”, your name, your address and the format you require.

If you would like a summary of this document in your language, please phone xxxx or contact us at the address above.

Translate above sentence to:

- Chinese
- Vietnamese
- Greek
- Turkish
- Punjabi
- Hindi
- Bengali
- Urdu
- Arabic
- Gujarati

If you do not see your language listed above, please call us to discuss your needs.

12 Document Information

Document Owner: Don Neame

Document Author: Jonathan Street
Date Created: 24/08/07
Current Status: Draft
Location/Branding

13 Version History

Version	Date Updated	Updated By	Reason
0.1	24/08/07	J Street	First draft requiring input
0.2	29/08/07	J Street	Comments from D Neame, D Mason, B Gillespie
0.3	13/09/07	D Neame	Comments from J Robinson, D Mason etc. Feedback from JCPCT meet
0.4	18/09/07	J Street	Amends to current draft, mainly on style
0.5	28/09/07	D Neame	Comments from team and P Dash
0.6	12/10/07	D Neame	DN input and BG
0.7	14/10/07	D Neame	Comments from LCG, NHS London Exec and PCT Comms
0.8	29/10/07	D Neame	Comments from JCPCT
0.9	15/11/07	D Neame	Comments from JCPCT, NHS London Board, OSCs, PCTs, key stakeholders, legal advice and Ipsos MORI

(12500 words)

Healthcare for London
Consulting the Capital

Consultation Strategy

Author: Don Neame
Last Date Revised: 23/11/07
Version: 1.0

Table of Contents

1 Executive Summary

This strategy is a 'blueprint' for the Healthcare for London consultation with stakeholders on *A Framework for Action*. The strategy follows good communications practice and focuses on what will be **meaningful to our stakeholders**, as opposed to the production and promotion of project outputs.

The consultation will be led by PCTs.

2 Background

The partner organisations (the PCTs leading the consultation) recognise that the views of the community will be helpful in developing the proposals for future healthcare in London.

2.1 What will success look like?

This strategy aims to ensure:

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

2.2 Scope

The strategy is intended to be part of a suite of documents that will include: an action plan; Q&As; press releases, case studies, a website, advertising, a consultation document and leaflet, translated versions etc.

The consultation strategy aims to utilise resources from the partner organisations and dovetail into their own communications strategies.

The consultation is on a framework and not on changes in specific services.

This consultation will be considered by a Joint Committee of PCTs (JCPCT). PCTs will then, individually or in partnership with one another, consult on service reconfiguration when appropriate.

2.3 Communication principles

In order for the PCTs, through the JCPCT, to meet their communications objectives, consultation activity must be based on a clear set of principles:

- The hallmark of success is that people understand and act on what is being communicated, not simply that they have been informed.
- Communications are stimulating, open, concise, targeted and purposeful.
- Communication is a two-way process. It is about engaging with people and listening to them, as much as informing them. Consultation will improve the Healthcare for London proposals.
- Communications will be appropriate to the target groups' needs and preferences.
- We will take account of people's differences (e.g. languages, cultures, abilities, learning styles and disabilities).
- We are committed to openness and accountability.
- Stakeholders do not feel burdened by excessive information.
- Specific, measurable, achievable, realistic targets (SMART) will be set and research used to evaluate effectiveness.
- Communications will be reviewed throughout the consultation.

3 Management and responsibilities

The consultation will be led by PCTs.

Each Primary Care Trust (PCT) that is part of the consultation (all London PCTs and Surrey PCT) has nominated a representative to sit on a Joint Committee of Primary Care Trusts (JCPCT). Strategic decisions will be taken at this committee. This strategy (as well as an action plan and the consultation document) will be approved by the JCPCT.

For operational matters the Communications Director will report to the Programme Director, Healthcare for London. There will also be two lead Chief Executives on consultation identified in the London Commissioning Group (LCG).

The communications aspect of the consultation will be managed by the Communications Director and staff in the Programme Office. The Programme Office will co-ordinate the production of materials, arrange pan-London events (e.g. with London LMC's, Greater London Association of Older People), arrange a Patient and Public Advisory Group, support ambassadors, lead the overall strategy etc (See Framework / Action Plan).

Two representatives from the Patient and Public Advisory Group (PPAG) will also attend the LCG.

PCT Sector Leads, will oversee the communications in each of five sectors:

- North-West: Hillingdon, Harrow, Brent, Ealing, Hounslow, Hammersmith, K&C, Westminster
- North-Central: Enfield, Barnet, Haringey, Camden, Islington, Tower Hamlets, Newham, Hackney and City
- North-East: Havering, Redbridge, Waltham Forest, Barking
- South-West: Richmond, Kingston, Sutton and Merton, Croydon, Wandsworth
- South-East: Bromley, Lewisham, Bexley, Greenwich, Southwark, Lambeth

Sector Leads will be backfilled for 0.4 of a post. They will support the Programme Office and PCT Communications Leads, take the lead for public events, help ensure consistency of consultation across their sector and pan-London and hold the budget for sector communications work

PCT Communications Leads will be responsible for communications in their PCT area, for instance distributing documentation to primary care, voluntary organisations, councils, staff etc, arranging presentations to interested groups in their area, placing articles in local papers and engaging with local groups.

3.1 Monitoring

Please also see Framework and Action Plan

- PCT Communications Leads will report progress to, and be advised by, the Sector Leads,
- Sector Leads will report on progress to the Programme Office
- The Programme Office will report on progress to, and be advised by, the two CEs on LCG on operational aspects; and via the London Commissioning Group representatives to the JCPCT on strategic issues

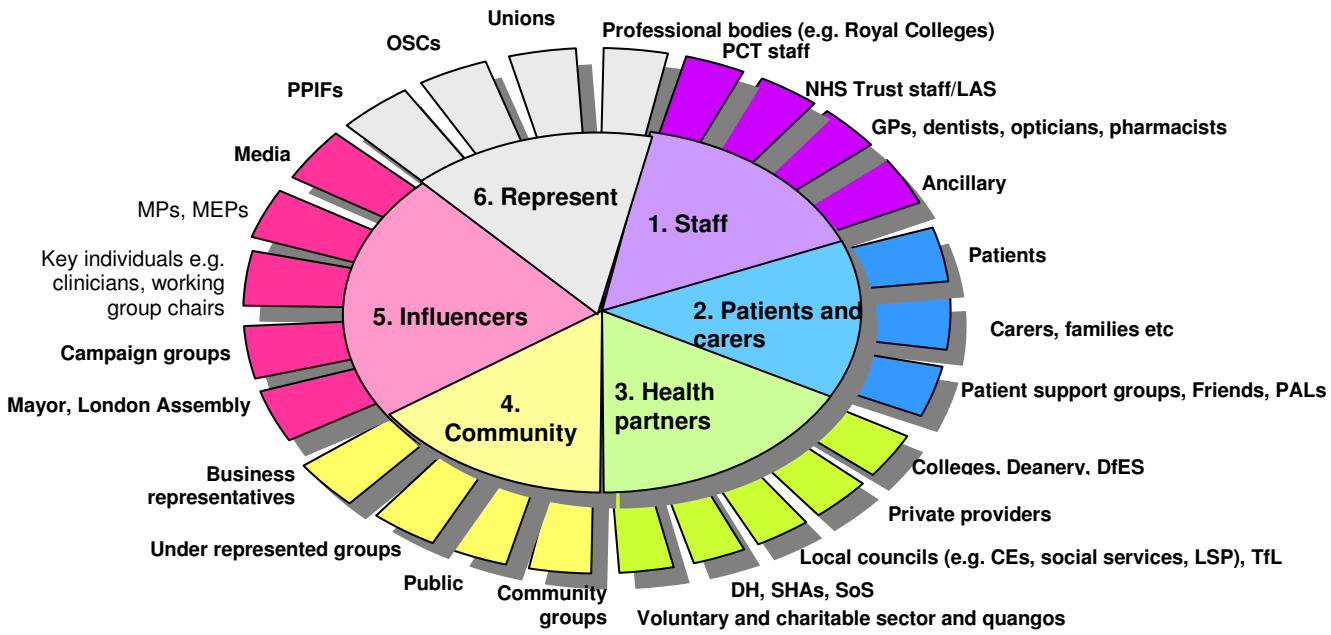
4 Stakeholder Analysis

A stakeholder analysis is used to ensure that communications are appropriate to the needs of different stakeholders.

The stakeholder analysis first segments the key stakeholders. Not by how we might envisage them, but by what is important to them. So, for instance, Overview and Scrutiny Committees (part of a local council) have been placed in segment 6, 'Representation'. They will be most concerned with 'How will this affect our residents?' and 'Is this a fair and transparent process to which everyone can contribute?' NHS staff will be most concerned with how the proposals will affect their role.

In considering this segmentation it is useful to refer both to the communications channel and key messages (see following sections).

4.1 Stakeholder Segmentation



Stakeholders are not a homogeneous mass. The diagram above gives an illustration of the groups of people with whom Healthcare for London needs to engage. Particular attention will be given to hard-to-reach groups such as traditionally under-represented groups e.g. asylum seekers, people with learning disabilities, night workers, unemployed people, Black and Minority Ethnic communities etc.

All partner organisation staff are potential ambassadors of Healthcare for London. They will be approached by a variety of stakeholders for their views and must be seen as a key audience.

4.2 Communication Channels

Clinicians will present the proposals wherever possible to ensure consultees are clear about the clinical aspects of the proposals.

Third party distribution vehicles should be used wherever possible e.g. articles for voluntary sector and local council magazines; Overview and Scrutiny Councils' and PPI Forum events

Advertising space will need to be bought e.g. to announce the issue for consultation, the start and end dates and the opportunities to comment.

Opportunities for traditionally under-represented groups to make their voice known need to be considered, and all literature should be offered in alternative languages. We are investigating commissioning consultants to consult with under-represented groups to support the work that PCTs will be doing.

Open days/evenings will be organised in every PCT. These will have a continuous rolling programme of presentations and a range of staffed displays designed to give members of the public the opportunity to focus on what is of interest to them.

Focus groups, a citizen's panel, perception or patient surveys will assist in informing the consultation process.

4.3 Key messages

Key messages need to be developed from what is important to PCTs to communicate to enable stakeholders to make an informed decision and, more critically, what is important to the stakeholder.

The following four key messages will be **appropriate for all audiences**:

HOW WE GOT HERE

1. **Delivering safe, accessible health care means changes need to be made in health services.**

Lord Darzi identified 8 reasons why we have to change.

1. Need to improve Londoners' health
2. NHS not meeting Londoners' expectations
3. Big inequalities of care across the city
4. Hospital not always the answer
5. Need for more specialised care
6. London should be at the cutting edge of healthcare
7. Workforce and buildings are not being used effectively
8. Need to demonstrate best use of taxpayers' money

WHERE WE ARE

2. **We are consulting on five key principles, which need to be translated into tangible examples:**

- Services focused on individual needs and choices. *Examples in maternity and end-of-life*
- Localise where possible, centralise where necessary. *Examples in children and acute*
- Truly integrated care and partnership working, maximising the contribution of the entire workforce. *Examples in mental health and long-term conditions*
- Prevention is better than cure. *Examples in staying healthy*
- A focus on health inequalities and diversity. *Examples in planned care and polyclinics*

3. **This consultation is supported by many clinicians and is evidence-based. It describes a vision for healthcare in London that:**

- Improves quality and safety of healthcare
- Improves access to healthcare
- Tackles health inequalities

THE FUTURE

4. **The consultation is on principles and models of care and delivery. It does not propose specific service changes.**

The outcome of this consultation will shape consultation on a range of specific proposals in the future.

There are no proposals in this document that advocate the closure of any hospital or A&E.

The partner PCTs **do** expect this consultation to lead to proposals that will change the services that are provided. If, and when, these proposals are developed they will be subject to the legally required discussion, consultation and scrutiny.

5 Key deliverables

Products

- Aim is for a 48 page consultation document for general distribution
- Letters to consultees.
- Short leaflet for NHS Trust and other staff, libraries, primary and secondary care settings
- Easy read consultation document (mainly in pictures), Makaton etc
- Translated consultation document (1/3 A4 flyer in 10 most common languages with offer to translate into others)
- Braille, CD and tape versions
- A4 posters
- Case studies
- Presentations and speakers' notes
- Newspaper advertisements
- Media releases (announcing start of consultation and bringing public meeting to the attention of public, and as a countdown to end of consultation)
- Website (including response mechanism)
- Newsletters

Meetings

- Presentations for PCT staff, stakeholders and public
- Public meetings and local stakeholder meetings (e.g. JOSC, OSC and PPIs)
- MP meetings
- Briefings to journalists
- Citizens panel
- Meetings for specific groups e.g.; patients with long-term conditions; women who have had a child in the past year.

Support

- Freephone, freepost communications and online forms on website

6 Issues

6.1 Timing

- We wish to finish consultation prior to purdah starting (18 March) for the Mayoral elections.
- To finish consultation prior to 18 March consultation must start at the latest on 11 Dec (for a 14 week consultation.)
- It is therefore proposed that we run a 14 week consultation (rather than 12 weeks – to allow for a 2-week Christmas break) starting on the 30 Nov.
- PPIFs are to be dissolved in April 08 and be replaced by LINks. As LINks are unlikely to be properly up and running from 1 April scrutiny of recommendations will need to be with PPIF members (without their constituted organisation) and the public. We will keep this under review.
- Any delay will delay the introduction of better healthcare in London.
- Where parallel consultations are underway, or likely to be underway e.g.; A Picture of Health in South East London or the Mayor's consultation on Health Inequalities Strategy, every effort will be made to coordinate consultation programmes.

6.2 Other issues

- Ipsos Mori have been engaged to receive and analyse consultation responses and to develop the questions. All questions will be tested with healthcare professionals and members of the public.
- A Patient and Public Advisory Group has been established. It comprises the London PPI Executive and ten members of the public who attended *Framework for Action* events and agreed to further involvement, to offer advice on the consultation process and information before, during and after the consultation.
- In November we will run a series of briefings for managers and clinicians (e.g. PPI leads, communications leads, CEs, Chairs of PCTs, PEC Chairs) to ensure they are fully briefed regarding all aspects of the mechanics of the consultation and the issues

7 Risks

Communications risk	Action to mitigate risk
Dovetailing with other major consultations means that not only do the partners need to agree timescales, but there is likely to be concerted effort to find aspects of each consultation that do not accord with one another.	The lead for PoH will manage the sectoral consultation for Healthcare for London in his area
Partners have different agenda and requirements. Therefore there is a likelihood of mixed messages.	Agree key messages and collateral at regular intervals. Ensure a protocol is agreed on how to coordinated responses to questions.

The process becomes caught up in changing national or local political and policy agenda	Ensure buy-in from all parties via comprehensive public affairs programme designed to inform key policy influencers and provide early warning intelligence of potential change
The consultation becomes inextricably linked with specific service reconfigurations	Clear communications information and Q&As
Loss of key staff	Establish good sharing of knowledge and filing protocols
Inadequate consultation by one PCT leaves the whole process open to judicial review	Specify communications requirements and support PCTs in their consultation.

8 Evaluation

The success of the consultation will be measured by:

- Number of respondents to the consultation (compared to other consultations)
- Respondents' views on quality of proposals
- Meeting milestones and time plan and adherence to action plan
- Engagement with traditionally under-represented groups
- Public and stakeholder awareness of the issues
- Positive engagement with questions posed - relevance of views expressed and the improvements they have on the recommendations
- No grounds for judicial review

9 Document Information

Document Owner: Don Neame
Document Author: Don Neame
Date Created: 17/09/07
Current Status: Draft
Location/Branding

10 Version History

Version	Date Updated	Updated By	Reason
0.1	01/10/07	D Neame	First draft requiring input
0.2	08/10/07	D Neame	Comments from PCT Comms leads and BG
0.3	22/10/07	D Neame	Comments from JCPCT
0.4	02/11/07	C Lynch	Comments from Bill Gillespie
1.0	23/11/04	D Neame	Comments from JCPCT

This page is intentionally left blank