Notice of Meeting

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

Friday, 7th December, 2007 at 10:00 hrs

Council Chamber, Camden Town Hall, Judd Street, London WC1H 9JE

Issue date: 29 November 2007
Contact: gavin.wilson@rbkc.gov.uk; tel: 020 7361 2264

Committee Membership: attached.

Public Agenda

Morning Session

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. PRESENTATION: 'HEALTHCARE FOR LONDON': A FRAMEWORK FOR ACTION

The background and rationale behind the Darzi review, including how and why the proposed models of care and delivery were developed.

Speakers:

Dr Martyn Wake, Joint Medical Director, Sutton and Merton Primary Care Trust (Chair of 'Planned Care' Pathway Clinical Working Group in Darzi Report Review team)

Dr Chris Streather, Medical Director, St Georges Healthcare NHS Trust (member of 'Acute Care' Pathway Clinical Working Group in Darzi Report Review team)

A sandwich lunch will be served at the end of the morning session, at around 12.30 p.m. The afternoon session is scheduled to begin at 1.30 p.m.

Afternoon Session

4. PRESENTATION: 'HEALTHCARE FOR LONDON': REPORT TO LONDON COUNCILS FOR LONDON BOROUGHS' OVERVIEW & SCRUTINY COMMITTEES (PAGES 1 - 54)

Commentary on the main findings and conclusions of the report - looking in particular at the implications of the Darzi review for local authorities, and areas for possible further investigation as part of the joint scrutiny review.

Speaker:

Dr Fiona Campbell (Healthcare Consultant and author of the report commissioned for London Boroughs' Health OSCs)

(N.B. As part of her presentation, Dr Campbell will offer a critique of points made in the presentations in the morning session by the two speakers from the Darzi report review team.)

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

N.B. Business for the day's proceedings has been scheduled to allow the meeting to conclude by around 3.30 pm.

PARTICIPATING AUTHORITIES

London Boroughs

Barking and Dagenham - Cllr Marie West
Barnet - Cllr Richard Cornelius
Bexley - Cllr David Hurt
Brent – Cllr. 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 - Cllr Jonathan McShane
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 Alan Hall
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

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Agenda Item 4

HEALTHCARE FOR LONDON: A FRAMEWORK FOR ACTION

Report to London Councils for London Boroughs' Health Overview and Scrutiny Committees

October 2007

Preface

Following the publication of *Healthcare for London: A Framework for Action*, I was asked by London Councils to prepare this report for London Boroughs' health overview and scrutiny committees. I was asked to look at consultation and scrutiny process issues in relation to the report; to prepare a summary and analysis of its 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.

The context of *Healthcare for London*, as its author, Lord Darzi points out, is that Londoners are not getting the best healthcare they could get and that this needs to improve. It is in the nature of public scrutiny, as a democratic process of holding to account, that it tends to focus on negative aspects of what is being scrutinised. For the purpose of this report, I have concentrated on proposals in *Healthcare for London* which may be problematic and which raise further questions for scrutiny. But I have also briefly tried to indicate where certain themes in the report may be welcomed by overview and scrutiny committees because they reflect a general consensus about what would improve health services for Londoners.

I am grateful to the following for helping me understand the context and implications of the report:

Malcolm Alexander – Chair, London Ambulance Service Patients' Forum
Mark Brangwyn – Head of Health and Social Care, London Councils
Jennifer Dixon – Head of Policy, the King's Fund
Susannah Drury – Scrutiny Manager, London Assembly
John Goldup – Corporate Director of Adults Health and Wellbeing, London Borough of Tower Hamlets
John Hamm - Government Office for London
Steve Iliffe - Professor of Primary Care for Older People, University College London
Elizabeth Manero – Director, Health Link
Bob Sang - Professor of Patient and Public Involvement, South Bank University

and Paul Corrigan, Sue Dutch, Bill Gillespie and colleagues at NHS London.

Fiona Campbell

October 2007

3

HEALTHCARE FOR LONDON: A FRAMEWORK FOR ACTION

Report to London Boroughs' Health Overview and Scrutiny Committees

Contents **Page**

Introduction

Professor Sir Ara (now Lord) Darzi's report, *Healthcare for London: A Framework for Action*, was published on 11 July 2007. It was commissioned in 2006 as a review of London's healthcare by the newly-formed, NHS London, the Strategic Health Authority for London. The creation of a London-wide health authority was seen as an opportunity to take a strategic overview of the capital's healthcare needs – an overview which it was felt had been missing and urgently needed for some time. Lord Darzi refers to the proposals in his report as "a vision for the next ten years".

Healthcare for London proposes radically new models for healthcare and the way it is provided in London. It encompasses all levels of NHS services, from community and primary care to specialist and tertiary care – indeed it questions our existing notions about the hierarchy of these levels. It also ranges across the whole spectrum of health and illness that people may experience in the course of their lives – from "womb to tomb" as has been said. It has massive implications, not only for the NHS, but also for social care and other local government services.

This report is in three sections. The first covers consultation on *Healthcare for London* and matters relating to the scrutiny process. The second contains a summary of its main arguments and proposals and comments on these with particular regard to issues likely to be of interest and concern to the London Boroughs' health overview and scrutiny committees. The third section draws on the summary and analysis in the second section to bring together a list of questions which the overview and scrutiny committees may wish to explore further during the proposed first-stage formal consultation by the NHS. This list is not likely to be exhaustive, as Members will no doubt wish to probe more deeply into areas of special interest to them and to their residents.

Part 1

THE CONSULTATION AND SCRUTINY PROCESS

CONSULTATION PRIOR TO PUBLICATION

In his introduction to *Healthcare for London*, Lord Darzi makes it clear that he was particularly keen to involve clinicians in developing the proposals, as this would help to ensure that the report was implemented. He set up 6 clinical six clinical working groups and also consulted the chief executives of London's mental health trusts to develop proposals in their area. Taken together, these seven groups make proposals "from cradle to grave". A small number of representatives of London boroughs and of voluntary organisations participated in the groups. There was also a full-day clinical conference to highlight good practice around the globe.

Further consultation undertaken in preparing the report included:

- an Opinion Leader deliberative event for voluntary sector organisations and a report from this
- two Opinion Leader deliberative public events with 100 members of the public each and a report
- a paper consultation which received 67 written submissions including 10 from local government and from the Association of Directors of Social Services
- an Ipsos MORI telephone survey of 7,000 London residents
- a number of other meetings and events.

CONSULTATION AFTER PUBLICATION

Primary Care Trusts in London (and the surrounding area) were advised to establish a Joint Committee (JCPCT) to oversee the consultation process. This committee will be based on the existing London PCTs' Commissioning Group (which consists of 2 PCT Chief Executives from each of the previous 5 London Strategic Health Authority areas). A Health Inequalities Impact Assessment will be commissioned by the JCPCT to report in March 2008. The creation of a JCPCT was agreed at PCT board meetings in September.

First stage consultation

A pan-London formal first-stage public consultation period led by the JCPCT is proposed to run from November 2007 through to February or possibly March 2008

(extended from the twelve week norm because of the holiday period). This consultation will be on the models of care and delivery set out in *Healthcare for London*.

Representatives of NHS London have indicated that they believe a two-stage consultation is necessary because only the first-stage consultation will provide an opportunity for comment and discussion on the models as a whole. Later consultation about the detail of implementation of the agreed models is likely to happen at different levels (see below). A consultation document will be approved by the JCPCT. At the end of the consultation period, the JCPCT will take decisions on the models of care and delivery, taking into account the outcome of consultation and Health Inequalities Impact Assessment.

Second stage consultation

Second-stage consultation on the practical application of the models proposed in *Healthcare for London* to services in London would be subject to the outcome of consultation on the models and would follow on from that consultation. It is likely that second-stage consultations would take place at different levels – pan-London, sector level (a cluster of PCTs possibly based on the old Strategic Health Authority areas or on proposed reconfigurations which are currently being discussed), or individual PCT – reflecting the nature of changes being proposed. It is not known what specific proposals will emerge for different sectors or boroughs in advance of the pan-London consultation on the models of care and provision.

Scrutiny by London boroughs' health overview and scrutiny committees

The formal consultation at all stages would require the engagement of a wide range of stakeholders, patients and the public, including the London boroughs.

Under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, the Secretary of State for Health issued a Direction about joint health OSCs in July 2003 relating to consultations by NHS bodies under the Health and Social Care Act 2001 where people from more than one local authority area may be affected by proposed variations or developments to NHS services. In these circumstances, all health OSCs consulted must decide whether they consider the proposals to be "substantial". Those health OSCs that do consider them to be substantial must form a joint health OSC to deal with the consultation and to respond on behalf of their communities.

There is no doubt that proposals arising from the Darzi report would constitute substantial changes to the NHS in London. A joint overview and scrutiny committee (JOSC) composed of members of the London Boroughs' health overview and scrutiny committees (OSCs) would then be required. When a JOSC is formed for the purpose of NHS scrutiny only that JOSC may exercise the scrutiny powers relating to requiring information and the attendance of NHS witnesses at meetings. Individual

OSCs may decide they do not wish to participate in a JOSC. If so, they are not prevented from considering the issues which are the subject of a JOSC review, but they lose their statutory powers of calling for information and witnesses in respect of the particular topic being considered by the JOSC. They do not, however, lose the power to refer the issue to the Secretary of State. As specific practical proposals emerging from the Darzi report are not yet known, it is not clear at what level future consultations would need to be held. However, OSCs should be prepared for the possibility that further joint committees may be necessary – either at a pan-London (and possibly beyond) level, or at a sectoral level, or among a small group of OSCs whose boroughs are particularly affected by certain proposals.

NHS London has proposed to the PCTs forming the JCPCT that the report on the outcome of consultation and the Health Inequalities Impact Assessment are available in March for consideration by PCT Boards, the Professional Executive Committees of PCTs and a joint overview and scrutiny Committee, in advance of the decision-making meeting of the Joint Committee of PCTs. This would mean that a JOSC would see the Health Inequalities Impact Assessment at the end of the first stage of consultation before a decision on the proposals was made by the JCPCT.

It has also been proposed by NHS London that in the event of a joint overview and scrutiny committee being established, the JOSC is asked to consider liaising with the London Assembly's Health and Public Services Committee and London Councils to avoid duplication of scrutiny. The Assembly's Health and Public Services Committee has already held a public session on 13 September 2007 to question representatives of NHS London about the Darzi report.[1] The Committee has indicated that it will not consider the Darzi report again until its meeting in February 2008.

Local government issues arising from the *Healthcare for London*

The London health OSCs will be particularly concerned about the implications of the report for social care and for the role of local government in health improvement. Lord Darzi refers a number of times to these issues and makes clear that he believes his vision of moving to a health service away from a sickness service cannot be implemented without the support of local government and an increased role for social services. However, there is almost no detail given of what that increased role might entail, how it might be funded or resourced, or what the role of local government might be beyond social services. In the analysis of the report that follows, these issues are flagged up where they seem most relevant. However, they appear to be of such fundamental importance that it may be difficult to take a view, during the first stage of consultation, on the desirability or even the feasibility of the Darzi report without a greater understanding of its implications for local government. New models of social care and other local authority provision may be required to match the models of healthcare proposed. Hence, this is not just an issue about the details of delivery for discussion at a later stage. This may mean that a joint overview and

[1] A webcast of this session is available on the Assembly's website: www.london.gov/assembly.

scrutiny committee will wish to hear from cabinet portfolio holders, directors of adult social services and Members and senior officers from other parts of local government, in the course of forming their response during the first stage of consultation.

Since the publication of *Healthcare for* London, Lord Darzi - this time as a government minister - is undertaking a national review of the NHS and his interim report suggests that he has not changed his vision of the direction in which the NHS should be heading. It is to be welcomed that the President of the Association of Directors of Social Services (ADASS) has been asked to sit on the Board advising Lord Darzi on primary care aspects of the national review. The need for any consultation to take a "whole systems" approach and include the impact of *Healthcare for London* on social care is summed up in the words of the President and Vice President of ADASS:

> *Social and health care together provide a single bridge between individuals and their broader wellbeing. If one side of that bridge deteriorates so much that it becomes uncrossable, then no matter how much you look after the other side, the crossing will not be completed. Once part of the fabric of a whole system wears thin, the whole edifice is in danger of collapsing.*[2]

Relationship between consultation on *Healthcare for London* and service change engagement/consultation already under way

This timetable means that there is some overlap between this process and consultations on service reconfigurations already under way in several sectors in London. In relation to each of these, NHS London has advised local NHS bodies that they must ensure that their programmes do not, and are seen not to predetermine the outcome of the pan-London consultation in any way. To that end, NHS London has advised bodies involved in local consultations that they should only go ahead with local consultations if:

- There is a local need to carry on with the local consultation without waiting for the outcome of the pan-London consultation. Issues to consider, amongst others, in such circumstances will include impact on the quality of patient care, staff, financial impact and other potential consequences of not carrying on with local consultation, balanced against any potential effect of going ahead such as risking uncertainty or confusion.

- Local consultations do not rely on the recommendations in *A Framework for Action* for decision making, although reliance on a common evidence base is appropriate where relevant.

[2] ADASS press release, 4 October 2007, responding to invitation to ADASS President Anne Williams to sit on Lord Darzi's strategy Board for the national review.

- All decisions are consistent with the open mind that consulting bodies must have, and be seen to have, on the outcome of pan-London consultation.

- All reasonable steps are taken to ensure that consultees understand the points addressed above.

Evidence and witnesses for scrutiny

How any joint committee gathers evidence and talks to witnesses will depend on the format it decides on for its scrutiny review. To get a fully rounded picture of the review and its implications, Members would probably need to hear from at least the following:

- 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
- directors of children's and young people's 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.

If Members decide to visit any healthcare facilities in the course of the review, they might wish to visit some of the facilities referred to in the report as providing examples of good practice, such as the Heart of Hounslow Centre for Health and the Albany midwife-led maternity practice.

Part 2

HEALTHCARE FOR LONDON: THE PROPOSALS

Contents **Page**

Part 2

HEALTHCARE FOR LONDON: THE PROPOSALS

INTRODUCTION

The report begins by making the **case for change** in healthcare across London. It then considers the likely future demand for healthcare in London. Then it discusses the work of the seven working groups which were set up to look at patient pathways - ie the most appropriate **model of healthcare** for people in each group.

Each of these groups was asked to make proposals that would improve health and healthcare in their area of expertise. They were asked to base these proposals on a **set of principles** which have emerged as a common theme from Lord Darzi's discussions with clinicians, NHS managers, patients and the public. Based on these models of healthcare, the report develops **models of provision** for healthcare across London.

THE CASE FOR CHANGE

Lord Darzi identifies eight deficiencies which, taken together, he believes make a strong case for changing healthcare in London. These are listed below. Based on a survey of health scrutiny reviews by London Boroughs listed in the Centre for Public Scrutiny's online reviews library, the information in brackets after some of the items indicates how often they have been the subject of a review by a borough OSC. Out of the 60 reviews listed, 56 are on topics raised in the case for change. Assuming that OSCs carry out reviews of areas where they believe that there is a need for improvement, this suggests that they would be likely to agree with a significant part of the analysis in the case for change. (This is an admittedly unscientific survey, but it does indicate where OSCs' priorities for health appear to lie.)

1. **The need to tackle health challenges that are specific to London:**
   - high rates of HIV, substance abuse, mental health problems, childhood obesity (12 reviews by OSCs)
   - diverse population, 90 ethnic group, 300 languages
   - highly transient population (20%-40% turnover per year in some areas)
   - a larger than average number of single-handed GP practices with unsuitable premises.

Comment

As the first point in the case for change specifically mentions substance abuse and mental health as key London issues, it is perhaps surprising that there was no clinical

working group on mental health. (The working group on mental health was made up of NHS chief executives, including the chief executive of a combined mental health and social care trust.) However, NHS London has made it clear that it is taking advantage of Lord Darzi's national review of the NHS, now under way, to give further consideration to mental health issues.

Similarly, although childhood obesity is identified as a particular issue for London, there was no working group on children's health. (A consultant in adolescent medicine and endocrinology and a director of social services were members of the Staying Healthy working group, but no director of children's services. Some of the other working groups also made recommendations relating to children and young people.) NHS London has said that it will use the national review to look further at children's health issues.

Lord Darzi identifies London's diversity as one of its unique characteristics. Many of those who do not have English as a first language live in the most deprived parts of London. This would suggest that issues of language and communication should be a high priority in tackling health inequalities and improving health. However, there is no mention of the need for a strategic approach to language and communication in the report or of the need to recruit speakers of London's many languages into the NHS workforce.

2. **Londoners' low satisfaction levels with the NHS,** particularly in relation to:
- waiting times for hospital consultants, A&E and operations
- cleanliness of hospitals (5 reviews by OSCs)
- access to GPs and out-of-hours services (2 reviews by OSCs)
- reactive rather than proactive care.

3. **Inequalities in health and healthcare** (6 reviews by OSCs on different health inequalities issues, 16 reviews on health improvement, promotion and prevention)
- difference in life expectancy of 7 years across London
- big differentials in infant mortality and teenage pregnancies across London
- poor health outcomes in deprived areas not matched by inputs (doctor numbers, state-of-the-art facilities or funding per person).

4. **The need to move care into the community away from hospital** (11 reviews by OSCs on intermediate care, continuing care and day care for older people, 3 reviews on care in the home)**:**
- evidence suggests better health outcomes would result for some conditions, eg chronic obstructive pulmonary disease
- modern surgery permits more day cases
- too much use of A&E for non-emergencies
- lack of diagnostic facilities and additional services (eg physiotherapy) at GP practices
- historical divide between consultants and GPs needs to be overcome.

5. **The need to centralise specialist emergency care in fewer hospitals:**
- few London hospitals have dedicated stroke units
- few can provide CT scan within 24 hours (recommendation is within 3 hours)
- more volume would give specialists more experience
- increased access to technology
- increased consultant presence eg in maternity units (1 review by an OSC)
- European Working Time Directive means more consultant cover required.

6. **The need to build on London's historical place at the "cutting edge of medicine":**
- Closer cooperation between hospitals and university research leads to better health outcomes.

7. **The need for the NHS in London to use its workforce and buildings effectively:**
- doctors in London hospitals see 24% fewer patients than nationally
- more need for staff to work flexibly between hospital and community
- huge expense and under-use of NHS estate
- ageing hospitals.

8. **Funding issues require cost effectiveness and reduced hospital stays:**
- funding allocation to London PCTs will slow from April 2008
- rising costs of staff, drugs and technology
- increasing expectations
- reducing hospital stays in London to England average would save over £200 million.

Comment

The report makes a strong case for changes to healthcare and health prevention in London. It should be noted, however, that the case for change does not lead directly to the models of healthcare or the models of delivery discussed below. In fact, some of the issues raised above cannot be addressed by new models of care and delivery. The fact that poor health outcomes in the poorest parts of London are not matched by inputs is partly an issue about funding allocations between areas. It is also partly about the historically uneven spread of hospital provision before the NHS, an unevenness which has been entrenched by the autonomy given to foundation trusts, again not mentioned in the report. This is perhaps not surprising, given Lord Darzi's emphasis on a clinician-led approach. But it is a noticeable gap, given the report's identification of health inequalities as one of the biggest issues for London.

FUTURE DEMANDS ON HEALTHCARE

The report recognises that, as it is seeking to describe a vision for London's healthcare for the next ten years, it will need to make as accurate as possible

predictions of demand over that period and beyond. It lists the major determinants of demand as:

- population size
- population age, composition and ethnicity
- characteristics such as deprivation and lifestyle
- technology
- public expectations

The demographic statistics used to make predictions for the future are taken from a number of sources, including the Greater London Authority, the London School of Economics and the Association of Public Health Observatories.

Demography

The main demographic assumptions are as follows:

- population increase from 7.6 million in 2006 to 8.2 million in 2016, with a further increase to 8.7 million in 2026
- population increase mainly along the Thames Gateway with great disparity in growth rates (eg 40% increase in Tower Hamlets, 3% increase in Bexley)
- the main factor in London's population growth will not be migration but natural increase (ie the birth rate exceeds the death rate) – 114,000 births in 2005/06 rising to 124,000-145,000 per year by 2015/16
- London's comparatively young population (not an increasing fertility rate) is the cause of increasing birth rate
- the fastest growing sections of the population are 40-64 age group and over-85s - the groups with the highest healthcare needs and long-term conditions.

Disease prevalence

The main predictions for disease prevalence to 2016 are:

- rates of coronary heart disease (CHD), and hypertension (high blood pressure) will remain static (although numbers will increase due to population increase)
- rates of chronic obstructive pulmonary disease (COPD) will rise slightly
- rates of diabetes will increase significantly
- sexually transmitted infections are growing sharply
- childhood obesity is a particular problem in London (29% of boys by 2010), although adult obesity is currently lower than the England average.

It is now well established that deprivation is linked to health need. The challenge will be to ensure that, as the population grows, the public health needs of the most deprived areas are being met. The "spearhead boroughs" where health has most to improve have targets to increase life expectancy compared with the average for

England. Some boroughs are on track to succeed in meeting these targets by reducing premature deaths through heart disease, cancer and stroke.

Technology

In the next ten to twenty years there are likely to be considerable breakthroughs in medical technology. Although some new technology can save money, the overall trend is that new technology increases the demand for healthcare by making new interventions and procedures possible.

Growing public demands

The report suggests that rising expectations of health services mean that demands on the NHS will increase and that people will expect NHS services to fit with their lifestyles not the other way round.

Modelling of future healthcare needs

The review team carried out detailed modelling of future healthcare needs. To do this, they broke down all NHS activity in 2005/06 into areas of specialty and treatments and combined this information with the population projections described above. They created three possible scenarios, *low growth, baseline* and *high growth*, making different assumptions for each based on historical growth in patient activity and likely demand due to technology and expectations.

This modelling shows that the greatest growth will occur in A&E, primary/community care and medical admissions (up to 85%, 154% and 63% growth respectively under the high-growth scenario).

Future resources available

The review team also made assumptions about future resources based on London's current healthcare budget of £10.1 billion, growth for 2007/08 of 7.5 based on Department of Health figures and future growth as a proportion of GDP. On these assumptions, resources allocated to London for healthcare in 2016/17 will be £13.1 billion.

This figure of £13.1 billion will fall short of the figures required for both the baseline (the most likely) and the high growth scenarios in the needs analysis described above.

The report concludes from this analysis that the current healthcare system in London is unlikely to be able to meet future demand.

THE PRINCIPLES

The principles on which the proposals for future healthcare in the report are intended to be based are:

- services focused on individual needs and choices
- localise where possible, centralise where necessary
- truly integrated care and partnership working, maximising the contribution of the entire workforce
- prevention is better than cure
- a focus on health inequalities and diversity

Comment

Most of these principles have already been reflected in Department of Health and NHS policy documents in recent years. For example, "patient choice" has been a key government policy for some years, particularly in relation to the choice of hospital for elective care (although respondents to the early consultation on the issues noted the "potential tension …between patient choice and the trend towards specialisation within hospital [planned] care")[3]. Partnership working between health and local government is encouraged through earlier legislation permitting "flexibilities"[4] in collaboration between health and social services and Local Area Agreements which will be strengthened in forthcoming legislation (the Local Government and Public Involvement in Health Bill). The reports by Sir Derek Wanless on NHS funding and spending, Securing our Future Health and Securing Good Health for the Whole Population, whose recommendations were generally accepted by the Government, placed considerable emphasis on prevention of ill health. And the White Paper, Our Health, Our Care, Our Say, published in January 2006 presents an ambitious vision in which health and social care are closely integrated, community based, and focused on maintaining the health, well-being and independence of service users. It signals future priorities and directions for health and social care with four main goals:

- better prevention and early intervention
- more choice and a stronger voice for individuals and communities in how services are planned and provided
- tackling inequalities and improving access to services
- more support for people with long-term needs and their carers

All these goals line up with Lord Darzi's principles. At this point, it is difficult to say whether the proposals in Lord Darzi's report will build on the principles he outlines, since we do not have a clear picture of how all the proposals will work in practice. For example, the principle, "localise where possible, centralise where necessary" could

[3] *Healthcare for London*: summary of key issues raised in submissions to the review process, http://www.healthcareforlondon.nhs.uk/documents/summary_of_reponses.pdf
[4] Section 31 of the Health Act 1999

be seen to govern the proposals for polyclinics, discussed below, if they are seen as "localising" some care that is currently provided at large acute hospitals. However, it is also proposed that GP services are concentrated in polyclinics, which may be interpreted as a form of centralisation, since most people would have to travel further to see their GP at a polyclinic than they do at a surgery, at present.

The proposals in the report on integrated care, prevention and tackling inequalities brought about by the wider determinants of health are the least well worked out, partly, no doubt, because their success will rely on close collaboration with other agencies, including local government. (There were a small number of local government representatives involved in the clinical working groups, but the remit of the groups was clearly to make proposals for the NHS.) The issue of partnership working is discussed further below.

In relation to bringing about greater equality in access to healthcare, it is again not possible to make a definitive judgement, since much will depend on how successful the proposed reconfigurations of both primary and secondary care are in allocating resources and locating services where they are most needed. It is worth repeating at this point that significant redistribution both of resources and of facilities will be required if the "inverse care law" apparently operating at present is to be reversed. The Darzi report points out that in areas of London with some of the lowest life expectancies in England, average health spending per person is lower than in areas that are considerably less deprived. Furthermore, there are fewer GPs per person in the east and north of London (where health need is greatest), compared with the south and west. In addition, the population projections discussed in the section on future demands on healthcare above, show that population growth will be enormous in some areas and very low in others, thereby increasing inequality between geographical areas in London. The main mechanisms for bringing about the redistribution required to address these discrepancies will be:

- the commissioning role of PCTs, whose success in bringing about changes in patterns of services through creative commissioning has not been notable so far
- the opportunism of NHS Trusts (and, no doubt, new providers in the healthcare market) in identifying opportunities to increase their income by expanding their services into areas of need, which will require collaboration between Trusts and other providers in designing services and a willingness to deliver services in very different ways and in different settings
- the availability of health professionals, including consultants and GPs, willing to work in areas of greatest need and perhaps to be prepared to provide their services in different areas and settings across their medical careers
- the performance management and strategic guidance role of NHS London, which has yet to be tested (and which does not manage the Foundation Trusts, who will have to be key players in all this)
- the role of Government in determining the basis of funding allocations which currently, as the figures above show, are not matched to need.

(The recent announcement by the Health Secretary of additional funding nationally to increase GP numbers may begin to address at least one of the issues highlighted above.)

In summary, most, if not all of the proposals appear to be consistent with the principles outlined by Lord Darzi. A clear picture of how well they will build on the principles and address population issues and inequalities will only emerge when specific proposals about services and infrastructure are made at the next stage of consultation.

THE MODELS OF HEALTHCARE

The seven clinical areas specifically covered in the report are:

- maternity and newborn care
- staying healthy (ie prevention of ill health and health improvement in the general population)
- mental health
- acute care (ie the traditional area of "accident and emergency")
- planned care (ie treatment traditionally known as "elective" which can be planned in advance, such as hip replacement operations)
- long-term conditions (eg diabetes, asthma)
- end-of-life care (issues such as giving people a choice about where they die)

The proposals for each of these areas are outlined and discussed in more detail below.

Maternity and newborn care

Key proposals from the clinical group

- *Early and repeated assessment of women's social and medical needs*
- *Antenatal and postnatal care in local one-stop settings and home*
- *Continuity of care before, during and after birth*
- *Choice of home birth, midwifery unit or obstetric unit*
- *Each obstetrics unit to have an associated midwifery unit*
- *98 hours a week consultant presence in obstetrics units*
- *One-to-one midwifery care in labour*
- *Maternity networks linked with neonatal networks across London*

Comment

The demographic projections discussed above show the number of births in London rising from 115,000 to 125,000 in 2016/17 under the baseline (most likely) scenario

modelled by the review team. At the same time, there is low availability of junior doctors and a projected shortfall of midwives (many of the midwives who train in London, move out of London after training, partly because of housing costs)[5]. This means that demand is outstripping capacity in London. The report argues that the model of healthcare proposed would not only address these problems but would also enable greater variety of provision to respond to social, cultural and clinical need and would give women more choice about how and where they give birth.

The working group for maternity and newborn care proposes that under its model of healthcare, there would be fewer obstetric units but with a greater ratio of consultants, more midwifery units (one for every obstetric unit) and more home births. Midwifery professionals believe that a midwife supporting home births can have the same caseload (approximately 35 births per year) as those supporting births in midwifery units.

An increased proportion of home births might alleviate problems of capacity in bed spaces. However, the figure in the model showing that by 2016/17 50%[6] of women will choose home births or midwife units, compared with 2% who now give birth at home (although many do not have this choice at present), appears to assume a very speedy change in expectations. In any case, it is difficult to see how the model proposed could reduce the demand for midwives, which is likely to increase both because of demography and because the proposed model requires more midwifery units and one-to-one care for women in labour. The report acknowledges that the model would require "more effective use of midwives". One proposal for achieving this is "more use of one-stop community facilities for the provision of antenatal and postnatal care", almost certainly meaning fewer home visits (except for the actual labour period for home births). The polyclinic model discussed below could mean fewer visits to hospital but could mean a net increase in shortish journeys for pregnant women and new mothers and babies, with accompanying transport implications.

The working group envisages that maternity services might become more differentiated between community-based services, led by midwives, and obstetrics-based hospital services. One important aspect of the model is that it proposes much greater choice to women about where and how they give birth, with an assumption that many women will choose home delivery or a midwifery unit rather than hospital. The shift to a less medicalised model of birth is consistent with current policy and with recent NICE evidence that home births and midwife deliveries give rise to fewer medical interventions, such as Caesarean sections. Nonetheless, the model will undoubtedly raise questions about safety in relation to numbers of midwives, risk assessment and guidance on transfer to hospitals arising from complications. This is not to say that midwife-led services cannot be safe – on the contrary, the Albany midwife practice described in the report has 60% home births and very good health outcomes. However, as the report acknowledges, new ways of working would only go

[5] Presentation by Professor Lynne Pacanowski, London Councils, 24 Sept 2007
[6] Presentation by Professor Pacanowski, as above.

part of the way to address the shortage of midwives. It is not clear that current efforts to attract midwives back into the profession and to retain existing midwives in London will be effective enough to support the proposed model.

The report makes it clear that the increased presence of consultants for longer periods would be brought about by reducing the number of obstetrics units. Figures for what this would mean exactly in terms of numbers of units are not given.

The report assumes that resources would be available for social care workers to work closely with midwives in the community, to support vulnerable women ante and postnatally. It is not clear what the resource implications are of this assumption.

In summary, the model proposes a high quality of care before, during and after the birth of children, with a trade-off in the form of fewer obstetrics units and fewer home visits. It is questionable whether there will be capacity in the system over the next ten years to deliver this model to the high standards envisaged. However, demand is outstripping capacity in the current model of maternity care, so there is no doubt that some changes are urgently required.

Staying healthy

Key proposals from the clinical group:

- *The NHS should work "more energetically" with other public services and organisations*
- *More investment in proven health improvement activities*
- *A pan-London campaign for activity and healthy eating linked to the 2012 Olympic and Paralympic Games*
- *All healthcare organisations and staff to be incentivised to promote physical and mental health*
- *A greater focus on health protection especially sexual health, tuberculosis and childhood immunisation services*
- *A greater role in health improvement for the NHS as an employer.*

Comment

The detailed proposals in this section of the report are not quite as vague as the key proposals above might suggest. Nonetheless, this is certainly the weakest section of the report. In one sense, this is perhaps not surprising, given that, as is generally acknowledged, the determinants of health, wellbeing and health inequalities go well beyond the reach of the NHS. The role of the NHS in this area, therefore, depends partly on effective partnerships with other agencies, as the report itself emphasises.

On the one hand, much of what is described in the report under the heading of staying healthy, is not new. Policies and legislation already underpin initiatives such as the development of local authority Sustainable Community Strategies and Local

Area Agreements. PCTs are already working with local authorities to discourage car use, improve facilities for walking and cycling, promote healthy eating and develop urban design that promotes healthy lifestyles and provides high-quality community health facilities. A number of joint health strategies are now in place between PCTs and Local Authorities.

On the other hand, some of the suggestions for new activity have an air of unreality. For example:

"…health improvement services should be delivered through a much broader range of practitioners and settings."

No doubt the report is right about the range of practitioners and settings required and no doubt some of these can be incentivised to carry out preventative activity through contracts, as, for example, dentists have been in their new contract. But there is a limit to how much people such as teachers and environmental health officers can take on beyond their core activities. Only a significant injection of additional resources is likely to kick start the enormous social and cultural shift that will be required to arrive at Sir Derek Wanless' "fully engaged" scenario[7], where, as Lord Darzi puts it, "everything is done to prevent ill health". The Staying Healthy clinical group itself points out that Germany and the Netherlands spend more than three times as much per capita on prevention and health promotion as the UK. The group proposes increasing spending on prevention by:

- shifting expenditure from acute hospital care into prevention
- developing a "menu" of evidence-based preventative interventions
- using programme-budgeting techniques to analyse spending and its impact on outcomes
- using public health researchers to evaluate interventions, develop commissioning tools and monitor outcomes.

Only the first of these proposals is actually about increasing expenditure on prevention and it is notoriously difficult to shift spending out of acute care. This is not to say it should not be attempted: much of the thrust of the report is about making just such a shift. The report outlines a number of ways in which hospital stays could be reduced (and expenditure thereby reduced, it is implied). Examples given are:

- **Post-diagnosis** – a GP "arranging a hostel" for a homeless person with tuberculosis
- **Pre-operation** – smoking cessation advice and support
- **Post-discharge** – taking steps to prevent recurrence of conditions, such as prescribing aspirin for stroke patients and assessing them for an operation to improve blood flow
- **At any stage in care** – holistic care for older people to identify ageing problems eg with hearing, vision, teeth and feet.

[7] Derek Wanless, *Securing our Future Health: Taking a Long-term View*, HM Treasury, 2002

Of course, a good health and social care system could be doing all these things and they would, indeed, reduce hospital stays. But each of them would cost money, some of it to the acute sector itself. And all of them would have to be in place **before** they would begin to have a significant effect on the length and frequency of hospital stays. One of the biggest questions arising from this report is the issue of transitional arrangements. Many of the proposals would require new models of healthcare to operate in parallel with old models before the new models began to have the desired effect.

A further very important question that arises from the proposals about prevention and shifting care out of hospitals is the demand that will be created for social care. The review team is, of course, aware of this and refer to it throughout the report, stressing the importance of working in close collaboration with local government. Local authorities will need to be satisfied that they will be in a position to respond appropriately to the models of care and delivery proposed. For example, putting significant resources into preventing people entering hospital would mean, given the resources available at present, diverting attention from social services' current concern with enabling people to be discharged quickly. (Recent legislation penalises social services if discharges are delayed for lack of appropriate external arrangements.) Delayed discharge has itself been a serious obstacle to reducing hospital stays and remains an important focus. The issue about the need for transitional arrangements and parallel working while a shift from treatment to prevention is taking place applies as much to social services as it does to health services.

The Staying Healthy section of the report proposes models of prevention and care with which it is difficult to disagree. However, other than an acknowledgement that there are implications for other agencies of this model, the huge extent and the nature of these implications is hardly touched on. The review team might reasonably say that their remit was to focus on NHS services. But given the vital partnership relationships entailed by the models of care, the work cannot really said to be complete until it encompasses a fully worked-out model that encompasses social care and the work of other agencies outside the NHS.

Mental health

Key proposals from the working group

- *Improve "early intervention" services*
- *Make care pathway clearer for service users and partner organisations*
- *Service users should be in control with support for their recovery and social inclusion*
- *More use of "talking" therapies*
- *Develop services for those most at risk: offenders, asylum seekers, refugees, black and minority ethnic population*
- *A more focused remit for community mental health teams.*

Comment

The chief executive of NHS London, in giving evidence to the London Assembly on the report said that, in retrospect, NHS London would have sought to review mental health and children's services differently from the way in which they were reviewed for the *Healthcare for London* report. (The group looking at mental health issues was made up largely of chief executives of Mental Health Trusts rather than clinicians, as the other groups were.) NHS London will be taking advantage of the national NHS review to undertake further consideration of mental health and children's health, including bringing in more senior clinicians. This means that it may be premature to draw conclusions about the section on mental health in the report. The following comments are, therefore, provisional only.

The report points out that Londoners suffer from a higher prevalence of mental illness (18% of people) than nationally (16%); and a higher proportion of the most serious mental ill health (23% of mental health patients have a psychotic diagnosis as compared with 14% nationally). All of the issues listed in the key proposals above have been identified for some time, on the basis of evidence, as essential for improving mental health services. Indeed, this section of the report explicitly seeks to build on and develop the existing policy direction for mental health set out in the National Service Framework. The urgency is even greater for London than for the rest of the country because of the statistics above, because of the pressures of living in London and because of differentials in diagnosis, referral and treatment between ethnic groups.

Much of the development proposed in the report on mental health is about the need to develop clear care pathways across sectoral boundaries (largely between the NHS and local government) to enable both service users and non-mental health professionals to understand where and how to seek help. It is specifically suggested that early intervention will require greater integration of Child and Adolescent Mental Health (CAMHS) services education and health services.

One of the most significant changes proposed (which is welcomed by groups campaigning on behalf of mental health service users) is a shift in balance from drug therapy to "talking" therapies, as recommended by the National Institute for Health and Clinical Excellence (NICE). The report notes that, to enable this shift to happen, a strategic approach to training and supervision is required along with the employment of more graduate mental health workers. Figures are not given in the report to indicate what changes in capacity this would require.

In relation to specialist mental health care, local authorities will be particularly interested in the working group's suggestion that consideration be given to whether inpatient facilities are needed in each borough as inpatient admissions continue to decrease. It is also suggested that centres of excellence and specialisation should be fostered amongst London's ten mental health trusts. This could mean a trade-off

between service users having more specialised care relating to their specific needs and having to travel (along with their families and friends) further to receive treatment. However it should be noted that proposals in this section and elsewhere in the report could mean that mental health service users with less (and perhaps with more) severe illnesses could receive specialist help closer to home, for example by seeing a consultant or specialist GP at a polyclinic (see below).

The report is critical of generic community mental health teams (CMHTs – multidisciplinary teams from health and social services) and suggests that they could become more specialised. It also suggests the creation of community forensic mental health teams to work with offenders on their release from prison. As up to 90% of those in prison are estimated to have at least one mental health problem, this is a significant issue for London. The services involved in supporting this group of people (including social services, housing bodies, court diversion services, voluntary sector organisations) have been highlighting their needs and the potential benefits in reducing re-offending for years. Specific proposals fostering greater integrated community support are likely to be very welcome (although resources will still remain an issue, of course).

Acute care

Key proposals from the working group

- *There should be urgent care centres (as distinct from A&E departments) in hospitals and community settings with doctors on site – those in hospitals to be open 24/7, those in community settings to be open "dependent on local need"*
- *There should be a single point of contact (by telephone) for urgent care (as distinct from emergency 999 calls)*
- *There should be centralisation and networks for major trauma, heart attack and stroke*
- *Dispatch and retrieval protocols for London Ambulance Service (LAS) to be aligned with centralisation*

Comment

The "case for change" suggests that the NHS in London is providing neither accessible urgent care to most people nor high quality specialist emergency to the small numbers who need it (eg the 6,000 Londoners who had a stroke in 2005/06).

The report makes a strong distinction between emergency and urgent care. This distinction may be difficult for lay people to grasp and this may cause difficulties for the model of healthcare proposed.

The acute care group points out that many people are attending A&E who could be better cared for elsewhere. This includes people with minor illnesses and injuries and people with long-term conditions. People often attend A&E departments in London

when a visit to their GP or practice nurse would be more appropriate, either because it is difficult to get a GP appointment or because their illness or injury occurs out of GP hours, or because they are not registered with a GP and/or they are not sure where to seek help. This means that A&E staff are dealing with patients that their departments were not designed to serve and the most seriously ill people are getting a less good service than they should. This problem is so serious in London that some PCTs have made arrangements for GPs to be on call in A&E departments.

To address this issue, the acute care group proposes two ways by which Londoners can access urgent (as opposed to emergency) care – over the phone or face-to-face.

Urgent care by phone

The model for urgent care by phone would mean that "as well as 999 for emergencies, people accessing urgent care would have a well-known number they can ring at any time … They would then access a virtual call-centre hub … [whose staff] would assess and determine the most appropriate course of action, from self-care advice through to transfer to emergency services".

The idea that such a model would divert significant numbers of people away from 999 calls or would vastly improve on NHS Direct appears, prima facie, incredible. First, lay people would have to understand a distinction between "emergency" and "urgent" which the report itself does not define well. Then, the people answering the calls would have to provide a triage and advice service of an exceptionally high quality. The report itself points out that as many as 70% of NHS Direct's calls are currently left unresolved or passed on to another service (which is no doubt partly why people don't ring NHS Direct if they think their situation is urgent). It is suggested that this could be improved by passing on calls to the local urgent care centre (see next section) so that the caller can "speak directly to clinicians, mental health teams, social care etc as required". The call centre would also be able to make appointments for people with their GP or refer them to a nearby pharmacy or urgent care centre. Technology makes this possible in theory, but it is hard to believe that GPs would be happy to relinquish their appointments systems to a call centre or that the teams of people described above would be available to answer the phone 24/7 as well as doing the face-to-face work expected of them.

Urgent care face-to-face

To provide for the large numbers of people who currently attend A&E when they would be better treated elsewhere, the acute care group proposes the establishment of a network of "urgent care centres" both at the "front end" of A&E departments and in community settings. These would be staffed by GPs, nurses, emergency care practitioners, mental health teams and social care workers ("dependent on the availability of staff and local needs"). Part of the role of urgent care centres at A&E departments would be to act as triage centres, determining the most appropriate treatment. Some patients might be directed to the adjacent A&E and all patients brought by ambulance as part of a "category A call" would go directly to A&E (ie some patients brought by ambulance would not go directly to A&E).

Urgent care centres attached to A&E departments would be open 24/7; others' opening hours would depend on local circumstances. They would have diagnostic equipment, basic pathology services and would run GP out of hours services. Ambulance staff would also use them as a local base. They would have suitable facilities for children.

In short, this model of urgent care would be provided through the "polyclinics" discussed in more detail in the next section on models of provision.

Specialist care for the most seriously ill and injured
The report proposes that the model of healthcare for people suffering severe trauma and stroke should follow the model currently used for heart attacks, where people who need specialist treatment to remove a blood clot are taken to one of nine specialist hospitals across London.

For trauma, it is proposed that there should be specialist trauma centres to which the most seriously ill people would be taken directly by ambulance. This would mean that ambulances would bypass the local hospital to take people to a trauma centre. The report points out that a system of this kind in Quebec resulted in mortality dropping from 52% to 19%. It is provisionally suggested that there should be two more trauma centres to complement that already in place at the Royal London Hospital.

Stroke care
For people who have strokes, the evidence is that speed is of the essence in having a CT scan to reveal if the patient requires drugs to dispel blood clots. To provide this diagnosis and treatment, it is suggested that there should be seven specialist stroke sites in London 24/7. Other sites would provide CT scans and interventional treatment during the day.

Emergency surgery
The acute care group points to evidence which indicates that, as for heart attacks, stroke and trauma, centralising emergency surgery improves outcomes (because staff gain experience by carrying out large volumes of work). The group concludes that this evidence, coupled with the need to comply with the European Working Time Directive, means that emergency surgery should not be provided at every hospital with an A&E department. Those without an emergency surgery department would be covered at night by surgeons from other hospitals. The report does not indicate how many emergency surgery departments there should be in all.

Acute care for children
For reasons of volume and capacity, it is also proposed that paediatric acute care is concentrated on fewer sites in London. Other hospitals would retain emergency paediatricians and paediatric assessment units.

Transport
To support the centralisation of care it is proposed that the London Ambulance Service develops a dedicated critical care transport service.

Patients who have been treated and stabilised at specialist centres would be repatriated to their local hospital for inpatient rehabilitation.

There appears to be a consensus among commentators that the evidence for better health outcomes from a centralised model of care for certain conditions is very strong. Added to this is the evidence that Londoners are not well served in relation to these conditions, particularly stroke care. The proposals for concentrating care for stroke, trauma and emergency surgery may, therefore, be the least contentious in the report, at least in relation to models of healthcare. Of course, the implications for other parts of the healthcare system are substantial and these may give rise to much greater controversy. This is discussed further in the section on models of provision below.

Planned care

Key proposals from the working group

- *Improved access to GPs for routine appointments (including Saturdays and at each end of the working day)*
- *Routine diagnostics and outpatients shifted out of large hospitals*
- *Increased use of day case setting for many procedures*
- *Rehabilitation at home wherever possible*
- *Centralisation of specialist care into large hospitals*
- *Development of "London care bundles" for intensive care and hospital-acquired infections.*[8]

Comment

It can be seen that most of these proposals reflect the problems and approaches already highlighted above. The proposals of the unplanned care group are, however, more radical even than those of the acute care group in relation to reducing hospital visits. The unplanned care group proposes that major activity – diagnostics (such as MRI, ultrasound and CT scans) and outpatient care (eg the follow-up visits that people currently make to hospital after an inpatient stay) - could be carried out "as locally as possible". Some of this work would be carried out by GPs, some by visits by consultants to provide outpatient clinics "in the community".

The group believes that moving diagnostics would help to reduce waiting times for elective care, as diagnostic tests are one of the current bottlenecks in the system.

[8] Protocols which identify all the different elements of care needed for a particular condition or procedure.

Similarly, an increase in day surgery, for example, for gynaecological conditions and breast cancer, would be popular with patients and would be cost effective. However, as the report also points out, London has much to do to catch up in this area, let alone forge ahead – in 2004/05 its day case rate was 7.1 per cent less than expected. As the report also points out, more day cases would require better facilities, a consideration which is adduced as one of the arguments for polyclinics, discussed below.

The report also points to evidence in support of early discharge from hospital and rehabilitation at home, which is what most patients prefer. However, as the report also acknowledges, "to achieve such home-based rehabilitation will require greater use of social care". Social services staff in London are already very hard pressed to make adequate and timely provision for people – especially older people – on discharge from hospital. A significant increase in numbers, along with the higher dependency that rehabilitation at home may entail would require social care capacity to increase by the level of magnitude that hospital stays would decrease. The planned care group suggests that "resources freed up from more day cases may need to be re-invested into social care support". A measure of this kind would certainly be essential and local authorities will want to understand how it would work in practice. But a post-hoc investment in social care would not be enough. As the summary of submissions to the review team, puts it:

> *[T]he transfer of activity from a hospital to a community setting needs to be well managed to allay public and clinical concerns and this may need to involve primary and community based services being developed in advance of any changes in the hospital sector.*

Like its colleagues in the acute care group, the planned care group is proposing more centralisation of specialist care which it argues is safest for the most complex cases (for example cancer care in which London is not meeting NICE quality guidance).The group argues that a concentration of cases into a smaller number of specialist centres (the exact number is not specified) "should achieve a critical mass of expertise and skills, improving patient safety and the quality of care". To implement this, a "hub and spoke" model is proposed. For instance a diagnostic test could be undertaken locally and reviewed by a specialist at a large specialist hospital.

This group makes its view quite clear that "The days of the district general hospital seeking to provide all services to a high enough standard are over".

Long-term conditions

Key proposals from the working group

- *Long-term conditions (LTCs) should be prevented where possible by outreach and tailored advice to the most deprived*
- *People with LTCs to be at the centre of a "web of care"*

- *More pro-active community care to reduce emergency admissions*
- *Integration should be improved between GPs and hospital specialists and between health and social care*
- *Best practice care pathways to be developed (eg for diabetes, chronic obstructive pulmonary disease, coronary heart disease and asthma)*

Comment

The report highlights the fact that people with LTCs are the biggest users of healthcare and demographic projections suggest that the incidence of LTCs is likely to increase in London, especially in the most deprived areas with high BME populations.

The proposals on prevention of LTCs should be read in the light of the comments made above on the Staying Healthy working group. They require targeted efforts across health and social care and, as such, will also be heavily resource-intensive. Preventative activity among the most deprived groups would, as the LTC group points out, assist in reducing inequalities and no-one is likely to disagree with the proposal that this should be attempted. However, policy documents have been making this same point for many years without a noticeable shift towards prevention by the NHS. This is understandable, given the enormous pressures on the NHS as a sickness service. For it to become a real health service will require investment of resources, new incentives and support for partnership with other agencies that goes beyond existing provision.

Existing pressures are not likely to be relieved by the LTC working group's understandable insistence on diagnosis and case finding (the latter in collaboration with social care staff). The group points out that up to 33% of people with diabetes may be undiagnosed and up to 41% with chronic obstructive pulmonary disease. Finding and working with people in danger of or already having these conditions could undoubtedly improve the lives of many people and make savings on healthcare in the future. The problem with this, as with many of the proposals in the report, is that they require an "invest to save" approach which has not so far operated on the non-acute side of the NHS.

For example, the LTC working group suggests a significantly increased routine of primary care appointments each year for people with LTCs. It estimates that this would require approximately 175 more GPs and 350 specialist nurses in London. The group points out that "this increase would be offset by a reduction in urgent care appointments due to better planning and management of LTCs in the community and a reduction in emergency admissions to hospital". However, the increase in primary care would need to happen before the reduction in demand for secondary care took place. This will require commitment, leadership, the right kind of incentives in the system and the kind of flexibility in resource allocation between secondary care, primary and social services which is not yet present.

End of life care

Key proposals of the working group

- *Commissioning of end-of-life service providers to co-ordinate end-of-life care*
- *Electronic registration of people's end-of-life care plans, including preferences on place of death*
- *All organisations to meet existing good practice guidelines*
- *Greater investment to support people to die at home.*

Comment

The proposals in this section relate mainly to people with an advanced progressive illness who are identified as nearing the end of their life. The overarching proposal is for the commissioning of a new kind of service provider – an End-of-life service provider (ELSP) - which, the working group suggests, could be a voluntary, public or private sector organisation. It is suggested that ELSPs should be commissioned at sector level (ie at the level of the 5 previous London strategic health authorities) to enable expertise in commissioning and economies of scale. It is proposed that there should be pan-London specialised commissioning of children's palliative care. ELSPs would co-ordinate the complex array of care from different agencies that is often required and would provide a clear contact point for each person and their family/carers.

The report points out that 54% of complaints to the Healthcare Commission about hospitals are about end-of-life care and that people are not able to die in their preferred location. In the majority of cases, people would prefer to die at home which is why the one of the key proposals supports this. It would also be important, in the light of London's culturally diverse population, to recognise that cultural differences affect people's views of the end of life and their choice of where to die. This is not mentioned in the report.

THE MODELS OF PROVISION

The report proposes 7 types of healthcare provision as the best way of adhering to the principles, addressing London's particular needs and challenges and delivering the models of healthcare described above. The proposed 7 types of provision are:

- home – the models of healthcare described above require significantly more healthcare to be provided at home (7.9% of all current healthcare by 2016/17 under the most likely scenario)
- polyclinic - these would be new facilities, described as at "a level that falls between the current GP practice and the traditional district general hospital" (59.8% of all current healthcare by 2016/17 under the most likely scenario, with 18.4% being carried out by GPs "linked to polyclinics")
- local hospital – to provide the majority of inpatient care (29% by 2016/17)

- elective centre – to provide "high throughput surgery" eg hip replacements (20% of inpatient care by 20/16/17)
- major acute hospital – to handle "the most complex" treatments (major acute and specialist hospitals to provide 41% of inpatient care between them by 2016/17)
- specialist hospital – more hospitals to be encouraged to specialise
- Academic Health Science Centre - based on teaching hospital/university/research collaboration

Each of these models of provision is discussion in more detail below.

Healthcare at home

The proposed activities that would take place at home are:

- rehabilitation
- ongoing care for long-term conditions and support for self care
- specialist care eg chemotherapy
- "step-up" care to prevent admissions
- "step-down" care to support discharge from hospital
- support for home birth
- end-of-life care.

This list gives an indication of the amount of home visits by NHS staff that would be required. In a brief paragraph, almost an aside, surprising for a report about London with all its congestion and parking problems, transport is mentioned.

> "*Providing more care at home will have transport implications for NHS and social care staff, who will need to be able to travel quickly and (where travelling by car) park easily."*

The transport implications of all the proposals in the report need some serious unpacking and this is highlighted below in the section on issues for scrutiny.

Of great interest and importance to local authorities is the proposal in the report that:

> "*The need for increasing support from social care and the associated costs of this should be considered as part of NHS commissioning, with NHS resources being used, where appropriate, to commission social care."*

At present, there is statutory provision for the pooling of parts of NHS and social services budgets.[9] It may be that these mechanisms are sufficient for what is being proposed here. But local authorities will wish to understand this proposal in more detail before taking a view on its implications.

[9] Through Section 31 of the Health Act 1999

Polyclinics

The proposal to set up polyclinics across London is one of the most controversial aspects of the report, in terms of provision. It will be important for overview and scrutiny committees to understand in some detail what the concept of polyclinics entails. The report gives a list of what a polyclinic should provide:

- general practice services
- community services
- most outpatient appointments (including antenatal/postnatal care)
- minor procedures
- urgent care
- diagnostics – point of care pathology and radiology
- interactive health information services including healthy living classes
- proactive management of long-term conditions
- pharmacy
- other health professionals, eg optician, dentist

Thus a polyclinic is something like what we currently think of as a hospital, except without overnight beds, something like a health centre housing several GP practices, something like a leisure centre and something like a health-focused mini shopping mall. At the moment, there is no community facility in London that has all these elements, although there are some large health centres, such as the Heart of Hounslow Centre for Health, that have many of them. It should be noted that the list of services to be provided in a polyclinic does not mention social care which would surely be fundamental to the concept of more seamless access to provision that polyclinics are (partly) designed to address.

It is proposed that all hospitals with A&E departments would be co-located with a polyclinic, which, beside its other functions, would have an urgent care centre acting as a “front door” or triage centre for A&E, as discussed in the section on acute care above. There would also be free-standing polyclinics “in the community”.

The report says that over time polyclinics will become the site of most GP care. GP practices could merge into one large practice, remain separate but co-located with a polyclinic, or remain initially in their own premises while using a polyclinic’s facilities.

It is suggested that there should be one polyclinic to serve a population of 50,000 people. That means just over 150 would be needed for London’s current population, ie approximately 4 – 5 polyclinics per borough (although this is, of course, a notional figure, as they might not be evenly spread across the city). The report indicates that “the vast majority of Londoners would be within one to two kilometres of a polyclinic” and adds that “Public transport links and … population distribution will be important in choosing polyclinic sites”.

The models proposed in the report, if they were all implemented, would mean that most people would probably have to travel less far for diagnostic tests, minor surgery,

follow-up and outpatients appointments. But they would probably have to travel further to see a GP or a practice nurse or for any of the activities that currently take place in GPs' surgeries. On the other hand, NHS clinical staff and social care staff would be expected to do considerably more home visits (although they might be based at a local polyclinic rather than a more distant hospital) and to run many sessions in polyclinics rather than in hospitals. No modelling of the likely impact on transport and parking has yet been published and this will be a major concern for local authorities.

The report acknowledges that GPs might have particular concerns about the polyclinic model, and indeed this is what has happened. The Royal College of General Practitioners accepts that the "organisational development of general practice must be increased". It also notes that GPs are hampered in providing the "best clinical care through a lack of access to diagnostics, many of which are only available through consultant referral".[10] However, the College prefers a model based on collaborative groupings or federations of GP practices which it believes is, "essential to counter the challenges of a 'market' approach in the NHS". The College specifically cautions against "the development of 'polyclinics' that focus purely on diseases and technical care but commends the value of co-location of services to reduce fragmentation of patient experience". By collaborating in federations, the College claims, practices, "may be able to provide enhanced services such as extended chronic disease management and ambulatory care. … They could be virtual and/or operate diagnostics and more specialised services from community hospitals." This recent report from the RCGP has been quoted at some length because it seems to offer an alternative model of provision that could deliver at least some of the models of improved healthcare laid out in the Darzi report.

The British Medical Association (BMA) supports the concept of GPs working together in larger groups to provide a wider range of services "where the clinicians concerned believe it is in the best interest of their patients". However, the BMA says that "[c]oercing services into polyclinics, however, is not the way forward", pointing out that "it is unclear whether the clinics would be staffed by doctors employed by NHS Trusts or private organisations holding APMS [Alternative Provider Medical Services] or other such contracts".[11]

On the other hand, the proposals for polyclinics has been welcomed by the London Ambulance Service, saying "For those patients who are not very sick or injured, it makes much more sense that we can take them for treatment closer to home, and the idea of polyclinics or 'super surgeries' with their range of services will help to meet this need."[12]

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[10] Royal College of General Practitioners, *The Future Direction of General Practice: a roadmap*, RCGP, 2007.
[11] BMA, *Polyclinics could threaten NHS services, warns BMA*, press release, 11 July 2007.
[12] LAS, *London Ambulance Services supports proposals for capital's future healthcare services*, press release, 11 July 2007.

NHS London has indicated that the polyclinic model could be a flexible one, with perhaps 70% of primary care delivered from polyclinics and 30% from GP practices, depending on local circumstances. In giving evidence to the London Assembly's Health and Public Services Committee, the Chief Executive of NHS London, Ruth Carnall, made it clear that there was "no intention to force people, eg GPs into a pre-determined model". But she also made it clear that where the proposals in the report were opposed that NHS London would be "much more assertive" in requiring improved alternative models of healthcare "and less tolerant of poor practice".[13]

There will no doubt be extensive further debate on the issue of polyclinics.

Local hospitals

The proposed activities for local hospitals are:

- inpatient bed-based community rehabilitation with full range of community services
- A&E, acute non-complex medicine, emergency non-complex surgery
- urgent care
- outpatient services requiring hospital infrastructure
- High Dependency Unit for non-ventilated patients, facility for intubation and transfer of patients
- regular attendees, eg renal dialysis
- paediatric assessment unit
- obstetric unit with a midwife-led unit and level ½ NICU (neonatal intensive care unit) in some local hospitals
- diagnostics including CT

The local hospital appears to be the future transformation of a district general hospital, although the report makes clear that it is quite different from the current DGH. There is an impression from the report that the local hospital is at least partly defined by what it is not: it is not a specialist centre, it is not a centre for elective procedures, it is not a trauma centre, although "local hospitals will be able to provide most inpatient emergency care" (except at night), it will not have a fully staffed intensive care unit, although it will provide a minimum of intensive and high dependency care. The report points to the Brent Emergency Care and Diagnostic Centre at the Central Middlesex Hospital as an example of the future local hospital.

From the description of activities given, it would seem that there will be a high level of transfer of patients out of local hospitals into more specialised centres such as paediatric units and major acute hospitals, and a high level of transfer of patients into local hospitals for rehabilitation and non-intensive inpatient care. The report makes proposals for changes in the ambulance service to deal with this. The issue of

[13] London Assembly, Health and Public Services Committee, meeting of 13 September 2007.

emergency care at night seems to be unclear if the local hospitals are going to do most emergency care, but only during the day.

One question that is raised by the proposed centralisation of specialist care and decentralisation of many of the current functions of DGHs to polyclinics, is whether local hospitals would have sufficient volume and throughput to support the necessary infrastructure, skilled staff and technology. There is a suggestion in the report that patient care might be overseen by intensive care staff from a remote site through monitoring devices and two-way care. NHS London is proposing to carry out a feasibility study of the local hospital concept which may provide some answers.

The report does not state how many local hospitals might be appropriate for London to fit in with the other models of provision.

Elective centre

The proposed activities for elective centres are:

- high throughput elective surgery, some centres may sub-specialise
- simple day case medical interventions (such as endoscopy)
- outpatient consultations
- pre-admission clinic and facility for pre-op workups
- diagnostics

Elective centres as envisaged in the report are similar to the Independent Sector Treatment Centres (and some NHS treatment centres) already set up to carry out mainly orthopaedic and cataract surgery across the country. The report suggests that more of these are needed in London (it does not propose a specific number) and that close working with local authorities to ensure appropriate community support following discharge will be crucial to their success. Local authorities will wish to understand what additional demand might be created for their services by new elective centres.

Major acute hospital

Major acute hospitals would be created by designating some of London's 32 acute trusts (ie it is not proposed that new hospitals are built). They would provide specialised health services "to the highest critical standards". Between them, they would provide the centralised services proposed in the models of healthcare outlined above, such as trauma centres and comprehensive 24/7 stroke care. The activities proposed for major acute hospitals are:

- emergency surgery (including complex)
- complex elective surgery
- non-complex elective surgery for patients with comorbidities (more than one medical condition)

- complex medicine (acute and elective)
- A&E departments taking the most seriously ill patients
- inpatient paediatrics including critical care
- obstetric unit with associated midwife-led unit and level 2/3 neonatal intensive care unit (ie for the most seriously ill babies)
- some outpatient services
- specialist diagnostics
- some will be or form part of Academic Health Science Centres.

It is suggested that relatively few people will need to be cared for in a major acute hospital, as they will provide the most complex care. They would serve a population of 0.5 – 1 million, but offer some specialist services for up to 5m population. The criteria for NHS London and the PCTs to designate a group of existing Trusts as major acute hospitals should be:

- current clinical outcomes
- providing cover for both outer and inner London
- ensuring good transport links

Specialist centres

There are currently 6 specialist hospitals in London (Moorfields Eye Hospital, Royal National Orthopaedic Hospital, Great Ormond Street, Royal Brompton (heart and lung disease), Royal Marsden (cancer care) and South London and the Maudsley (mental health))and the report encourages the creation of more of these and of other specialist facilities. It suggests that these would be of particular benefit to some vulnerable and disadvantaged groups who have higher rates of particular health problems such as HIV/AIDS, TB, mental health problems. The activities they would undertake are:

- complex surgery
- complex medicine
- related outpatients services
- specialist diagnostics
- some would have single specialty A&E
- some will form part of Academic Health Science Centres (see below)

Academic Health Science Centres

This concept is intended to bring together university research, teaching hospitals and patient care. It is believed that they would attract the best international talent by providing a high-quality clinical environment for research.

On 1 October 2007, Hammersmith Hospitals NHS Trust and St Mary's NHS Trust came together with Imperial College London to form the UK's first Academic Health

Science Centre. The new Trust is made up of five hospitals – Charing Cross, Queen Charlotte's and Chelsea, Hammersmith, St Mary's and the Western Eye together with Imperial College London. It has an annual turnover of £760 million and employs 9,700 staff. It offers more than 50 clinical specialties.

The report proposes that both polyclinics and local hospitals be linked to AHSCs or even be a part of them. The latter would involve some form of integrated governance.

FUNDING AND AFFORDABILITY

The review team carried out a detailed piece of feasibility modelling, looking at where they would expect different kinds of healthcare to be provided in future[14]. They then calculated how much it would cost to provide the main types of activity in each setting, using the Payment by Results tariffs and making bottom-up calculations for the cost of primary and community care.

On the basis of these and other forecasts outlined in the report, the following predictions are made:

Allocation to London PCTs by 2016/17	£13.1bn
Cost by 2016/17 on current models of care and provision	£14.6 bn
Cost by 2016/17 on Darzi proposed models of care and provision	£13.1bn

The costs above are running costs and do not include start-up capital expenditure or capital repayments over the life of any contract. Since there are no polyclinics in London at the moment and since they alone would presumably require major investment in infrastructure (even if some existing infrastructure is used), this is a fairly substantial omission. The report points out the importance of auditing and making better use of NHS estates. NHS London chief executive, Ruth Carnall, has indicated that she would expect much of the additional investment required to move to the new models to come out of NHS estates.[15] Until extensive mapping and auditing is carried out, the position of assets now belonging to NHS Foundation Trusts is clarified, and proposals are made for converting to new uses or disposing of existing NHS infrastructure, it will be difficult to take a view on how realistic this proposal is. In its response to the report, the British Medical Association commented:

> *"The proposals detailed in the review would require a considerable 'up front' investment …. Commitment to invest in the right type and amount of resources, including finances, staff and premises, are needed to achieve change of this scale and we have serious doubts over whether such investment would be seen. To date, no development of the NHS has been accompanied by such support."*[16]

[14] Details of this are given in the Technical Paper published with the main report.
[15] Seminar at London Councils, 24 September 2007
[16] http://www.bma.org.uk/ap.nsf/Content/LordDarziReview

There are currently 9 large Local Improvement Finance Trust (LIFT) public private partnership building projects under way in London on 19 sites, to improve primary care infrastructure. Most of the projects have some local authority involvement. Their total capital costs to date are £337.54 million and the NHS and other public sector partners are committed to 20-year contracts .[17] It is not clear from the Darzi report what would happen to these sites with a move to polyclinics. Presumably, at least some of them could form the basis of a polyclinic, but would require further modification and extension to become fully-fledged polyclinics.

Nor, as far as it is possible to ascertain, do the review team's calculations include the cost of running services in parallel or making the transition to new models of delivery. The report proposes that NHS London, the Strategic Health Authority establishes a "double-running" or "pump-priming" fund. This could well assist with some of the concerns that are likely to be raised about transition to new models. The report does not indicate an optimal size for this fund or where it would come from.

The report does not indicate how financial incentives in the system would have to change to encourage and facilitate the new delivery models proposed, although it does acknowledge that such changes would be necessary. As the summary of submissions to the review teams points out, "[t]he Payment by Results tariff is not sufficiently refined to adequately fund specialist care and is a potential barrier to further centralisation of specialist services". In addition, submissions suggested that financial incentives in the system would need to be re-aligned to support re-designed care pathways, for example to encourage outpatient attendance at polyclinics or to encourage more day surgery. Some work is going on at the moment to "unbundle" the Payment by Results tariffs to facilitate shared care between different settings, but the radical nature of the proposed new models suggests that funding mechanisms would need to be significantly rethought. This is particularly the case since primary care, in which considerably more NHS activity would take place under the proposed models, is currently funded on a capitation (per registered patient) basis, whereas secondary care is funded on activity (number and type of operations etc).

Furthermore, the Government has made it clear that it expects a significant proportion of funding to be channeled through the mechanism of Practice-based Commissioning (PBC), that is, commissioning by GP practices or consortia of practices. This means that many of the changes in service provision advocated by Lord Darzi would depend on innovative commissioning by GPs. There may very well be groups of entrepreneurial and energetic GPs who embrace the Darzi vision wholeheartedly, but at the moment, there is probably insufficient evidence to say in what direction PBC will take commissioned services. Additional incentives may be necessary at the level of PBC. Without an understanding about what these might be or whether they will be introduced, it is difficult to take a view on how likely it is that PBC would act as a lever for the Darzi vision.

[17] Department of Health, "All LIFT projects – progress to date – updated 19 September, 2007": http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm

WHAT WOULD IT BE LIKE?

The following examples have been constructed from the proposals to give OSC Members some idea of how the experience of some of their residents might differ from the present under the new models of care and provision.

What would it be like …

… for a woman having a child?

Prior to conception, she would have had healthy lifestyle advice from her GP practice. This might be located in a polyclinic requiring her to travel further than she does now to see her GP. If overweight and trying to conceive, she might have attended an exercise class at a polyclinic or been advised by a nurse specialist. If she had diabetes or epilepsy, she should have received information from her GP about the risks associated with pregnancy.

On becoming pregnant, she would be able to choose a midwife or group of midwives and book directly with them without having to be referred first by her GP. She would receive antenatal care locally (either closer to home or to her place of work). This might be in a polyclinic or a children's centre (with ultrasound and phlebotomy (taking blood) on site) requiring her to travel less far than she does now to a local hospital. If she had complications with her pregnancy she might be able to see a consultant at a polyclinic, rather than a hospital. She might be put in touch with other expectant mothers from her local community, enabling her to be involved in local support networks.

She would be offered an informed choice between a home birth, birth in a midwifery unit and birth in an obstetric unit. She would be able to choose from more midwifery units and fewer obstetrics units than at present (the ideal number of each is not specified in the report). During labour and birth she would receive one-to-one midwifery care. If she was giving birth at home or in a midwifery unit and had to be transferred to an obstetrics unit, this might mean further travel, as there would be fewer obstetrics units. Or the midwifery unit might be co-located with an obstetrics unit on the same site. At the obstetrics unit, there would be more likelihood of a consultant being present than there is now, and less likelihood that she would be attended by a junior doctor.

Postnatal care might be available at home, but she might have to attend a clinic, either in a polyclinic or in a children's centre. This might mean more travelling with her baby than at present, but it might also give her the opportunity to meet other mothers. If she was assessed as having "high social needs" (for example if she was a lone teenage mother) her midwife would work with social care staff to give her additional support.

… for a working mother of young children?

She might have to travel further than she does at the moment to see her GP at the local polyclinic. This might mean a bus journey with the children instead of going on foot. She could make an appointment with her regular GP and most routine tests her GP required could be carried out on site, so she might be able to get the results more quickly and have medication prescribed and dispensed at the same time. She could see the GP before or after office hours or on a Saturday morning. There might also be a polyclinic near to her office which she could attend in her lunch hour.

If she needed to see a GP without an appointment, she could go to the polyclinic but might not be able to see her regular GP. If a member of the family became ill outside of normal GP surgery hours, they could go to the urgent care centre at the polyclinic where they could see a GP or nurse, probably not their regular one. Diagnostic procedures, such as x-rays could be carried out at the polyclinic and they might be treated or, if necessary, transferred to A&E, which might or might not be co-located.

If one of her children had a long-term condition like diabetes, they could see a specialist who might have a regular session at the polyclinic, or a local hospital. Her child could also see a nurse regularly at the polyclinic throughout the year and perhaps attend an exercise class there. Also, at the polyclinic, she could get advice from a nutritionist about her son's diet. If he developed complications, she might have to take him to a specialist paediatric unit, further away than her local hospital. She could get his medication either from the pharmacy at the polyclinic or at a high-street pharmacy, whichever was more convenient. She could have routine cervical screening and mammograms at the polyclinic without having to go to a hospital.

If she unfortunately developed cancer, she might receive initial treatment at a specialist cancer centre which could be anywhere in London. She might be able to have follow-up treatment and check ups at a polyclinic.

… for an older person with chronic obstructive pulmonary disease (COPD)?

He would have made an appointment with his regular GP at his local polyclinic because of wheezing and coughing. (This appointment might have been prompted by a visit from a case-finding social care manager who regularly phones all people over 80 living alone. This kind of activity would depend on extra funding for social services.) He would have had to go by bus or tube or get a lift rather than walking to his GP as he does now. (If he had a car, would he have been able to park free at the polyclinic? Probably not, to go by current trends at hospital car parks.)

His GP would have arranged for chest x-rays at the polyclinic immediately after his appointment, so he would not have had to go to a hospital for these. He could have picked up any medication prescribed by his GP at the polyclinic pharmacy. He could have attended an Expert Patient Programme run at the polyclinic by other people

with COPD to learn to understand and live with the condition. He would have had a couple of pre-arranged appointments with the practice nurse at the polyclinic each year while his condition was not too serious.

If it became worse, he would see a specialist nurse there several times a year, who might have been able to help manage his condition so that he did not have to have so many spells in hospital as he might now. If his condition became severe, he would see his GP and the specialist nurse more frequently, sometimes at home. The specialist nurse would liaise with the social services staff at the polyclinic to provide any necessary support (such as a stair lift and “meals on wheels”). He would also have seen his local pharmacist in a private consulting room several times a year to review his medication.

If his condition got really bad, and he developed other chronic conditions of old age, he might have had a case manager, who would have co-ordinated all the care he needed, including nursing and personal care at home.

Part 3

ISSUES FOR SCRUTINY

INTRODUCTION

Based on the summary and analysis above, the following areas summarise some possible topics for further investigation by the London health overview and scrutiny committees before reaching a conclusion on the proposed models of care and provision. (The summaries below should be read in conjunction with the analysis above which may suggest further issues to OSC Members and officers arising form their own knowledge, experience and local concerns.)

NHS London has made it clear that, during the first stage of formal consultation, it will itself be exploring further the feasibility of some of the models of provision proposed. It is setting up workstreams with members drawn from the London PCTs on the following topics:

- polyclinics
- stroke
- major trauma
- unscheduled care
- local hospital feasibility

There will also be work going on in relation to mental health and children's health in London in line with the national review work being led by Lord Darzi. Further work may also be undertaken during the consultation period on other topics, such as care pathways for certain long-term conditions. It is also proposed to commission a Health Inequalities Impact Assessment of the report. This means that, as the consultation period progresses, NHS London may have a clearer and more detailed idea of the implications of the models of healthcare and provision proposed in the report. Reports emerging from these workstreams may make some of the questions suggested below redundant.

It should also be borne in mind that Lord Darzi, as a Government Minister, is currently conducting a review of the NHS nationally. He has produced an interim report as part of this review[18]. This interim report appears to endorse the same principles and models as the London review, but the final conclusions may, of course, have implications for London as well as for the rest of the country.

As the first stage of consultation by NHS London will be on the proposed models of healthcare and provision, the issues raised below are confined, as far as possible to the models. However, it is not possible to disentangle the models

[18] *Our NHS, Our Future*, Department of Health, October 2007

entirely from practical considerations. Indeed, it is sometimes difficult to understand the models without thinking about the specifics of delivery in relation to London as a congested, populous city, with people of many cultures living side by side but also separated by huge divisions of wealth and opportunity. This is understood by the review team, which has produced a model of provison of health services for London and its people, not for an abstract notional citizenry. Some of the issues raised below, therefore, inevitably touch on practical matters in very general terms.

ISSUES FOR FURTHER EXPLORATION

General

The models of healthcare and the proposed models of delivery are each presented in the report as an interconnecting whole.

How interdependent are the different elements of the models on each other? For example would the models for centralising specialist and acute care only be viable if non-emergency and long-term care were "localised" as is proposed? It would be helpful to know for each of the proposed models of care and delivery, how dependent its success is on the other models being in place.

How dependent are the proposed models on improved information technology, such as shared electronic patient records? Is it envisaged that the appropriate technology to share records between hospitals and GPs would have to be in place before any polyclinics are set up?

Patient and public involvement

Consultation on the report which is proposed to begin in November 2007 will be formal public consultation.

What are the mechanisms for stage 1 to consult patients and the public aside from consultation of London Boroughs through their overview and scrutiny function? How are patients and the public being involved in the further development of proposals arising from the report? For example, what involvement of patients, their representatives and voluntary sector organisations is there in the workstreams set up by NHS London and listed in the introduction to this section?

The report proposes that "care bundles"[19] and care pathways are developed and act as guidance for clinical responses to various medical conditions, both urgent and long term.

[19] Protocols which identify all the different elements of care needed for a particular condition or procedure.

Are patients and/or patients' groups involved in any of these that are currently being developed?

Throughout the report, it is recommended that various clinical networks are strengthened.

What is the scope for involving patients in these networks?

Older people are the biggest users of health and social services and therefore likely to be disproportionately affected by the proposed models in the report.

What evidence is there that the models in the report are welcomed by older people and that older people and organisations representing them are confident that there will be sufficient safeguards for their care at the health and social care interface?

Equality and inequality

One of the main issues that the Darzi report is designed to address is the inequalities in provision and health outcomes across London.

How will the proposals in the report address the problem of "under-doctored" areas of London which contributes to existing and increasing health inequalities? Does NHS London propose to use any levers or incentives to "redistribute" the proportions of GPs in particular, to provide greater access in the most deprived areas?

Will any of the proposals have an impact on the inequalities in funding per person in London? For example, the report notes that whilst North East London contains several deprived boroughs with some of the lowest life expectancies in England, in 2004/5, spending per person was £1,090 compared with the North West London figure of £1,311 (p19). Will any of the proposals address this issue?

The Technical paper accompanying *Healthcare for London* states that, "[a] number of polyclinics will be located on hospital sites – likely at least one to two per site – in order to support financial viability of local hospitals".

How will this method of planning the location of polyclinics address the issue of locating healthcare facilities according to need?

The Government's GLA Bill would give the Mayor of London new duties to promote a reduction in health inequalities and prepare a statutory health

inequalities strategy, in addition to his existing duty to promote health. The Mayor is currently preparing a health inequalities strategy.

To what extent have the Mayor's health advisers been involved in preparation of the Darzi report? How confident are the PCTs that the models for preventing ill health and tackling inequalities will dovetail with the GLA's activities?

In light of the diversity of London's population and the inequalities highlighted in the report, what information is available on the ethnic make-up of the NHS workforce at different levels and within clinical specialties? What steps are being taken to ensure that the workforce is more representative of local communities, particularly given the proposals for many more services in and closer to people's homes?

Given the 300 languages spoken London and the fact that many of the most deprived London residents speak a first language other than English, how would this issue be addressed within the proposed models of care and provision? Do the proposals for concentration of specialist services and dispersal or "localisation" of other services have implications for language and communication services? How well do the translation and interpretation services available to the NHS in London meet the population's needs? In particular, how well served is the London Ambulance Service by the available language and communication services, in light of the increasing demands on the LAS that the report envisages? How representative is the LAS workforce itself of the many languages spoken in London? Is there scope for a London-wide NHS language and communication service which would offer economies of scale and volume?

The role of and impact on social services and local government

The overwhelming direction of the proposed models of care and provision is towards significantly greater prevention, care and rehabilitation based in people's homes. The report recognises that there will be substantial implications for social care and other local government services.

To what extent have directors of adult and children's services been involved either in developing the proposals or in analysing their potential impact on social care? Is there any work being undertaken at the moment on a model of social care that mirrors the proposals for healthcare in London?

The report emphasises the importance of a whole systems/holistic understanding of people's health needs.

How far do the models of care and the care pathways envisaged in the report support this understanding by extending to social care? (Another way of considering this question might be to ask, are they medical or social models?) Is

there any high-level or detailed analysis of the potential impact of the proposed models on social care?

The NHS is a universal service free (more or less) at the point of delivery. Social services are targeted, means tested and subject to eligibility thresholds, which in London have been steadily getting tighter with the result that fewer people are receiving care. That is, the movement in social services in recent years has been towards more intensive services for a smaller number of people. The models of care in the Darzi report imply that many more people will need to receive a broader range of personal care and advice as well as health care.

How are these contradictions to be addressed?

Maternity services

It is proposed that the number of obstetrics units be reduced and the number of midwife-led units be increased.

Has any modelling been done to indicate how many units of each would be required? What do predictions for the workforce indicate about the likely availability of midwives to lead the proposed units? Will existing workforce strategies ensure that the capacity to implement the model is there?

Is it possible at this stage to say what the implications are for social services of supporting more women in home and community births and in providing additional support to vulnerable women ante and postnatally?

Children's health

NHS London has said that it is using Lord Darzi's national review to explore further models of care and provision for children's heatlh.

Is there any indication yet, of what further proposals might arise from this?

The report proposes that some healthcare for children might be available at children's centres. It also suggests that the possibility of co-locating children's centres with polyclinics should be explored.

What kind of children's services are envisaged in these proposals? How would children's health services in children's centres and polyclinics relate to the greater concentration of specialist care for children in specialist units? For example, is it envisaged that specialist paediatricians and paediatric nurses would have the facilities to provide some services in children's centres? Could mental health services for children and young people be provided at children's centres and/or polyclinics?

What kind of preventative measures would the review team like to see being instituted in relation to children's health? What do they see as the role of schools in the proposed models - for example, in relation to obesity?

The touchstone for improved children's care services must surely be that a case like that of Victoria Climbié would be less likely to happen.[20]

Would the proposed new models help to reduce the likelihood of another death like that of Victoria Climbié? If so, how?

Older people's health

Older people are most likely to be affected by the changes proposed in the report, as they are the heaviest users of health services.

What would be the most significant changes that an older person would notice in the proposed new models of care?

Transport is likely to be one of the biggest issues for older people. It is suggested that they, like other patients, would have to travel less far for certain diagnostic and treatment services currently provided in hospital and for outpatient services, and would have to travel further to see a GP or practice nurse at a polyclinic. Travelling one or two kilometres to a polyclinic could mean the difference between being able to walk to the surgery and having to get public or other transport.

Is it envisaged that older people would have to travel to a polyclinic on occasions on which they would now visit their GP's practice and see other primary care staff such as practice nurses and podiatrists? Or would home visits be made? If the latter, how would this be resourced?

How would primary care for older people living in residential accommodation be commissioned? Would the new models mean that there would be an increased or decreased likelihood of being visited by familiar doctors and other healthcare workers?

Mental health

The proposal to move to greater use of "talking" therapies and away from drug therapies and to give patients greater choice on these matters will be welcomed. But it does have implications for training and recruitment.

Has any work been done to calculate what the capacity issues may be for the mental health workforce of the proposals? Does current workforce planning

[20] In February 2000 8-year old Victoria Climbié died as the result of severe physical abuse and neglect that had spanned several months. During the months leading to her death, Victoria was known to 12 different services including health and social care.

indicate how the shift will be made and what numbers of additional graduate mental health workers will be required? What are the relative costs of drug versus talking therapies?

The report suggests that inpatient mental health facilities may not be needed in each borough as more people receive treatment and care outside hospital.

Has any modelling been done to suggest how many inpatient units may be required in London in ten years?

New forensic mental health teams are proposed to support offenders with mental health problems.

Which agencies would be involved in these teams and how would they be resourced?

The report proposes "greater integration of CAMHS [child and adolescent mental health services] with education and health".

How would this be achieved?

Acute care

How would people know whether to phone a new "urgent care" phone number or the existing 999 emergency number? How would the experience of phoning each number be different?

What reason is there to believe that a new urgent care number would be able to provide a better service than NHS Direct (where as many as 70% of calls are left unresolved or passed on to another service)?

Specialist care and local hospitals

It is suggested that 3 specialist trauma centres and 7 specialist stroke centres should be provided in London. It is also suggested that not every A&E department should carry out emergency surgery and that those without an emergency surgery department would be covered at night by surgeons from other hospitals.

How would this system of night-time cover work and how many specialist emergency surgery departments should there be across London?

The models proposed in the report entail significant centralisation of specialist care and decentralisations of many of the current functions of district general hospitals.

Given this reduction in their core functions, will local hospitals have sufficient volume and throughput to support the necessary infrastructure, skilled staff and technology required for their remaining functions? Is there a danger that they might come to be thought of as "sinks" or "second best" for both staff and patients, particularly older patients who do not require specialist or intensive care elsewhere but are not well enough to go home?

Won't the co-existence of more specialist centres, urgent care centres, local hospitals and polyclinics with overlapping functions such as diagnostics mean either considerable duplication or gaps in technology, skills and resources across the whole nexus of services?

The BMA has said that the review fails to make a case for why some hospitals should be able to provide 24 hour emergency medical, but not surgical care and that the proposals would lead to unnecessary and perhaps harmful inter-hospital transfers. Although the BMA agrees that for some groups of patients, specialist centred care would outweigh any detriments from increased travel, it says that recent evidence shows that increased journey times lead to increased mortality for some conditions. Therefore local A&E departments should not be downgraded in the process of creating more specialist centres.

Is the NHS in London satisfied that the proposed division of labour between local and specialist hospitals will lead to the best health outcomes? How much of the move towards concentration of care in specialist centres is due to evidence of improved clinical quality and how much is due to other factors? For example:

- *the trend towards specialisation and sub-specialisation among clinicians*
- *financial pressures to merge and rationalise services*
- *the European Working Time Directive which requires the reduction of the working hours of junior doctors to a maximum of 48 hours a week?*

Elective centres

The recently-created Independent Sector Treatment Centres along with some NHS treatment centres are the model for elective centres. The use of Independent Sector Treatment Centres has been controversial. In some areas it has been suggested that they undermine the viability of general hospitals and in some that they are under-utilised.

How will the need for elective centres to provide extra capacity across London be assessed? Is there a risk that, if large numbers of certain procedures are delegated to elective centres, this will reduce the availability of expertise and the capacity for skills development in local hospitals? Has any work been carried out on the likely additional demand on social services created by high throughput, early discharge elective centres? What would be the governance model for elective centres?

Polyclinics

The proposals for polyclinics have given rise to the greatest controversy so far. They will, presumably, require considerable capital investment (see section on funding and affordability below).

How confident is the NHS in London that polyclinics offer a sufficiently flexible model of healthcare to cope with the fast pace of change in medicine, surgery, diagnostics and treatment and the likely changing health needs of London's population, referred to in the report? Is the concept of a polyclinic a physical one, requiring new infrastructure to support it, or could there be virtual polyclinics performing the functions described in the report, but based on existing institutions and premises?

GPs' representatives appear to be particularly unhappy about the concept of polyclinics, partly because they believe that they may be "disease focused" rather than person-centred, partly because they believe their independent contractor status will be threatened and partly because they believe that polyclinics are a recipe for the wholesale takeover of primary care by foundation trusts and/or the private sector.[21] It has been suggested that the proposals in the Darzi report spell the end of general practice as we know it, and that the polyclinics proposal will "depend on private companies – which may or may not have any experience of providing healthcare".[22]

Are any changes in the employment status of GPs envisaged in a move to polyclinics? To what extent might new providers be expected to enter the primary care field in the new model? What would happen to GPs' individual lists in the polyclinic model? Could GPs set up their own polyclinics? If so, would there be conflicts of interest as GPs are also commissioners of care? What would be the governance model(s) for polyclinics?

The British Medical Association has suggested that the following questions should be considered in assessing whether it is appropriate for any specialist service such as diagnostics to be moved out of hospitals:

- *What improvements will there be to patient care?*
- *What back-up services are required and can they be efficiently and safely provided in the new setting?*
- *Will there be sufficient workload to make effective and efficient use of consultant and specialist time?*

[21] These points are made by the Royal College of General Practitioners and by the BMA in their responses to the Darzi report on their websites.
[22] Dr Kailash Chand, *Pulse*, 7 October 2007.

- *What impact will the move have on regional and super-specialist services, and other services that continue to be provided in a hospital setting and primary care facilities?*
- *Do the changes fit in with the plans of local practice based commissioners?*
- *What impact will the changes have on education, teaching and research activities?*

(These questions may also be helpful to overview and scrutiny committees in considering specific proposals during the second stage consultation.)

End of life care

The main proposal in the report is that new End-of-life service providers should be commissioned at a sector level in London.

Would commissioning at this level enable appropriate account to be taken of different cultural attitudes to death and dying across London's many different ethnic communities?

Workforce issues

Over half of the written submissions received by the review team highlighted workforce challenges as a key issue that the review need to confront. The polyclinic model appears to require considerable duplication between polyclinics and hospitals and between local hospitals and specialist/major acute hospitals, particularly in diagnostics and various clinical skills areas (eg radiography, physiotherapy). There are also proposals that would seem to require additional staff from certain groups (eg midwives, health visitors, specialist nurses). The report also proposes an enhanced role for the London Ambulance Service (or the creation of additional patient transport services). The proposed models of care also imply greater flexibility and versatility across traditional healthcare roles, for example in being organised around care pathways.

Is there capacity in numbers and skills in the NHS workforce in London to support the proposed models of care? What are the levels of vacancies in the various clinical and other workforce areas across London? In what ways might the proposed models assist in reducing these vacancies? How confident is the NHS in London that it could recruit and retain the necessary qualified staff to support the delivery models?

The models appear to demand fewer consultants and more GPs with greater skills (such as surgical skills).

Does workforce planning suggest that there will be capacity for this shift and that a significant number of GPs will want to develop special interests?

The report suggests that training budgets have come to be seen as available as part of core budgets (ie they are not always used for training). It suggests that this situation needs to change to enable the skills training that the new models require.

How realistic is this and what would be the likely effects on core budgets?

Commissioning

How will commissioning manage the need for local, sectoral and London-wide strategic planning of services? Do the proposals mean that NHS London needs to take a bigger role in commissioning?

What balance will be needed between Practice-based and PCT-based commissioning to ensure that strategic planning can take place through commissioning? Now that Practice-based commissioning is a key conduit for funding of healthcare, what reason is there to believe that it will be used as a lever to shift provision in the way that the Darzi report recommends?

Do all PCTs know where their budgets are going in relation to their most deprived communities? Will any of the proposals assist them in this analysis?

Funding and investment

The issue of funding raises some of the biggest questions in the report. It envisages a transformation of services to the high quality, seamless health and social care, delivered to people in or near their homes that almost everyone would aspire to. However, if there is not proper investment in the models of provision, there is a real danger that services could be made worse, because the models depend so heavily on excellent community facilities *as well as* excellent centralised specialist facilities. Inadequate funding could lead to enormous pressures on social services and informal unpaid carers.

How is it possible to estimate the affordability of the proposed models without having the results of the current audit of NHS estates in London, or any estimate of the capital costs of the Healthcare for London *models?*

How confident is the NHS in London that both capital and revenue funding will be available to support the models of care and provision proposed? In particular:

- *How confident is NHS London that funding can be found from better use of and disposal of NHS Estates?*
- *What is the position of NHS Foundation Trusts – is their estate available for pooling either for use or for raising capital?*
- *How much scope would there be to build on the current 19 LIFT projects in London (total capital costs £337.54m) as the bases for polyclinics or the*

other community facilities proposed in the report? How much of the current LIFT infrastructure will be fit for purpose in the new models?

What do NHS London and the PCTs think of the report's proposal for a "double-running" or "pump-priming" fund to assist in making the transition to new models of delivery? Where would such a fund come from (eg top slicing from the PCTs' allocations or another source)? Might it or a similar fund also be available to social services to assist them in a transition to more preventative work, pre-hospital support, support for more care in the home and case finding?

The report suggests that financial incentives would have to change to encourage and facilitate the delivery models proposed. At the moment, financial incentives tend to disaggregate care, whereas the new models propose a holistic, seamless and integrated approach to care. New incentives would need to support:

- more shared care
- more care in the community and the home
- a shift from acute care to prevention, including a greater role for pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, health visitors etc working in a variety of settings school, leisure, workplace, prison, etc
- more joint commissioning between health and social services
- closer and more flexible working with social services and other local government services
- care that is much more integrated vertically across the current different hierarchy of "levels" (primary, secondary, social services etc).

Have any proposals been formulated about new funding (or other) incentives that would galvanise the NHS and other public services into the enormous change in culture and provision suggested in the report?

The biggest budget issue for local authorities in London, as elsewhere, is the escalating cost of social care. The models of care in *Healthcare for London* entail a very substantial increase in social care.

However good a model of quality they provide, how realistic are they on the basis of the current funding regimes?

The report suggests that the NHS should be able to commission and fund social care where this would support the new models of healthcare. The argument for this is that it would ultimately lead to better care and to cost savings.

But is the NHS in London currently in a position to subsidise social care in the widespread way that appears to be required by the proposals? Would this involve new definitions of "personal" and "health" care and new legislation or are there existing mechanisms under which this could be done?

Transport and travel

If the proposed delivery models are implemented, the assumption of the report is that people might have to travel further for very specialised care, but that they would have to travel less far than they do now for some forms of specialist care. However, they would have to travel further to see a GP. This has implications both for the NHS transport services – the London Ambulance Service and other forms of hospital transport - and for personal travel by patients.

Has any high level modelling been done to show how the proposed models would impact on the number and length of journeys for the London Ambulance Service and other hospital transport services? Has any modelling been done to show the likely impact on number of journeys and distance travelled for healthcare purposes for different groups of people, including pregnant women, older people, people with different medical conditions? Has Transport for London been involved in any discussions about the likely impact (either negative or positive) of the proposals?

The proposals in the report also make it clear that NHS staff will be expected to do considerably more home and locality visiting, for example to provide diagnostic and other services in polyclinics. The report also suggests that staff should be able to travel quickly and park near to where they are providing services where necessary.

Has any work been done to estimate the net effect of the proposals on the amount of travelling and the parking facilities that will be required for staff?