Notice of Meeting

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

FRIDAY, 24TH OCTOBER, 2008 at 10:00 HRS - LONDON BOROUGH OF ISLINGTON, ISLINGTON TOWN HALL, UPPER STREET, N1 1XR.

Issue date: 16 October 2008
Contact: Rob Mack (rob.mack@haringey.gov.uk) Tel: 020 8489 2921

Committee Membership: attached.

Public Agenda

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. CHAIRMAN'S WELCOME AND INTRODUCTION

4. MINUTES (ATTACHED) (PAGES 1 - 8)

To agree the minutes of the meeting held on 25th April 2008.

5. FORMAL NHS RESPONSE TO THE JOSC REPORT (RESPONSE ATTACHED) (PAGES 9 - 66)

- **Richard Sumray:** *Chair of the Joint Committee of Primary Care Trusts (JCPCT)*
- **Sir Cyril Chantler:** *Chair of the Healthcare for London Clinical Advisory Group*
- **David Sissling:** *Programme Director, Healthcare for London*
- **Don Neame:** *Director of Communications, Healthcare for London*

6. SECOND STAGE CONSULTATIONS - PAN LONDON STROKE AND TRAUMA (PAGES 67 - 94)

7. JOSC FEEDBACK SURVEY: RESULTS (PAGES 95 - 106)

8. ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT (PAGES 107 - 108)

N.B. Business for the day's proceedings has been scheduled to allow the meeting to conclude by around 1.pm.

Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;

(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and

(iii) may, with the consent of the Chairman and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.

Should any such matters arise during the course of discussion of the above items or should the Chairman agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.

9. 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 Ayers
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 Sylvia Scott
Merton - Cllr Gilli Lewis-Lavender
Newham - Cllr Megan Harris Mitchell
Redbridge - Cllr Allan Burgess
Richmond upon Thames - Cllr Nicola Urquhart
Southwark - Cllr Adedokun Lasaki
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. As of 30/11/07 (the first meeting of the JOSC) those authorities who have indicated a preference for participation are as follows:

Out-of-London Local Authorities

Essex – Cllr Christopher Pond
Surrey County Council – Cllr Chris Pitt

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Agenda Item 4
ITEM 4

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 25 APRIL 2008

Royal Borough of Kensington and Chelsea, Council Chamber,
Kensington Town Hall, Hornton Street, W8 7NX

PRESENT:
Cllr Richard Cornelius - London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr David Abrahams – London Borough of Camden
Cllr Ken Ayers - City of London
Cllr Graham Bass - London Borough of Croydon
Cllr Mark Reen - London Borough of Ealing
Cllr Vivien Giladi - London Borough of Enfield
Cllr Janet Gillman - LB Greenwich (main representative)
Cllr Mick Hayes (deputy representative)
Cllr Jonathan McShane – London Borough of Hackney
Cllr Rory Vaughan – London Borough of Hammersmith and Fulham
Cllr Gideon Bull - London Borough of Haringey
Cllr Margaret Davine – London Borough of Harrow
Cllr Ted Eden – London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Meral Ece -LB Islington (Vice-Chairman)
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Megan Harris Mitchell - LB Newham
Cllr Allan Burgess – London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)

ALSO PRESENT:

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Jacqueline Casson – LB Brent
Graham Walton - LB Bromley
Neal Hounsell – Corporation of London
Trevor Harness – LB Croydon
Alain Lodge – LB Greenwich

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Tracey Anderson – LB Hackney
Ben Vinter - LB Hackney
Sue Perrin – LB Hammersmith & Fulham
Rob Mack – LB Haringey
Anthony Clements – LB Havering
Guy Fiegehen – LB Hillingdon
David Coombs – LB Hillingdon
Deepa Patel – LB Hounslow
Sunita Sharma – LB Hounslow
Henry Bewley - RB Kensington & Chelsea
Gavin Wilson – RB Kensington & Chelsea
Elaine Carter - LB Lambeth
Barbara Jarvis - LB Merton
Jonathan Shaw – LB Newham
Satbinder Sanghera- LB Newham
Jilly Mushington - LB Redbridge
Afazul Hoque - LB Tower Hamlets

Others:

Cllr Merrick Cockell - Leader, London Councils (part of meeting)
Kris Hibbert - London Councils

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr Marie West - London Borough of Barking and Dagenham
Cllr Chris Pond - Essex County Council
Cllr Peter Tobias - London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow

2. CHAIRMAN'S WELCOME AND INTRODUCTION

The Chairman (Cllr Mary O'Connor, LB Hillingdon) welcomed members to the meeting and said that she particularly wished to acknowledge the wonderful commitment shown by all participating authorities to the work of the JOSC, which had been undertaken without a dedicated budget, culminating in the final draft report presently before the Joint Committee for agreement.

Councillor Christopher Buckmaster (RB Kensington and Chelsea's representative on the JOSC and Chairman of their Overview and Scrutiny Committee on Health) formally welcomed everyone to the Royal Borough, and provided details of house-keeping arrangements.

The Chairman thanked Councillor Buckmaster for his comments. She then gave a brief outline of the morning's proceedings, referring to comments from the previous meeting having been incorporated in the final draft report, with the intention of providing a clearer format, more precise language, and in places 'toughened' recommendations. She

also stressed that the timescale for finalising the report was extremely short, and it was imperative therefore that the present meeting reached agreement on the final form the report was to take.

2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (London Borough of Bromley) declared that she is an employee of Bromley PCT and a member of the Royal College of Nursing.

4. MINUTES

The minutes of the meeting held on 14 March 2008 were agreed as a correct record.

The minutes of the meeting held on 28 March 2008 were agreed as a correct record, subject to Cllr Judy Ellis (LB Bromley) being shown as present.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

Written submissions from the following were received:

LB Havering's Overview and Scrutiny Committee
LB Lambeth's Health and Adult Services Scrutiny Sub Committee
LB Lewisham's Healthier Communities Select Committee
LB Waltham Forest's Health, Adults and Older Persons Services Overview & Scrutiny Sub-Committee
The Royal Pharmaceutical Society of Great Britain

The Chairman underlined that there would be no further opportunities for submissions to be accepted by the JOSC. She took the opportunity to remind members that the JOSC's final report will be handed over to NHS London on 30 April 2008 followed by a formal presentation at JCPCT meeting on 6 May 2008. She hoped to see as many members of the JOSC present as possible at this event.

6. Final Report of the Joint Overview and Scrutiny Committee

Consideration was given to the final draft report of the JOSC.

Following a suggestion by Cllr Barrie Taylor, (Vice-Chairman, Westminster CC) it was agreed that on page 4 of the report, reference should be made under 'Acknowledgements' to the support provided by officers from LB Hillingdon. It was further agreed that the Centre for Public Scrutiny should be shown as supporting the work of the JOSC. Cllr Taylor also referred to the fact that the work of the JOSC was being nominated for two of the 'good scrutiny' awards from the Centre for

Public Scrutiny, which would be announcing the results of the awards at its annual conference in early June.

At the Chairman's suggestion, it was agreed that the report would be made available electronically or via CD ROM, with Volume II available on request. It would be for each participating authority to distribute the report locally.

The Chairman referred to a number of suggestions for amendments to the Conclusions and Recommendations section of the final draft report, commenting in particular on the substantive changes proposed by LB Hounslow.

Cllr Jon Hardy (LB Hounslow) briefly stated the reasons for proposing extensive and detailed changes to the conclusions and Recommendations at a late stage in the deliberations of the JOSC. Some Members did, however, express concern that the changes proposed had not been brought before the JOSC when detailed consideration had been given to this section of the report at the JOSC's previous meeting.

Following a short discussion on how best to proceed with considering the various amendments before the meeting, detailed attention was given on a sequential basis to the Conclusions and Recommendations on which amendments had been suggested.

It was agreed that, where necessary, the Chairman and Vice-Chairmen (assisted by the 'officer support group') should formulate suitable wording for amended Recommendations to reflect the views of the meeting.

Following the discussion which took place, it was unanimously:

RESOLVED: That the final report, as amended in the light of comments made at meeting, be agreed.

Cllr Merrick Cockell (Leader, London Councils and Leader, Royal Borough of Kensington and Chelsea) briefly joined the meeting. Speaking in his capacity as Leader, London Councils, he said that he looked forward to joining with the JOSC Chairman and Vice-Chairmen in shortly handing over the completed report to NHS London. He admitted to some initial reservations about how effective the process of co-ordinating a London-wide JOSC might be, but said that the emerging end result of a shared, pan-London view was a credit to the membership of the JOSC.

7. The Way Forward

Consideration was given to the tabled paper (copy attached) prepared by the Officer Support Group, 'Progressing the work of the JOSC',

which set out the next steps required to take forward the JOSC's work, and proposed actions to be taken by the Chairman and Vice-Chairmen over the summer period, on behalf of the JOSC or in conjunction with all JOSC members.

Cllr Taylor said there was an intention to convene a further meeting of the JOSC in Autumn 2008 which would consider NHS London's response to the JOSC's report. As well as the work which the Chairman and Vice-Chairmen would be taking forward to promote the JOSC's recommendations, Cllr Taylor emphasised the role which local publicity had to play. A press release on behalf of the JOSC would be issued shortly (embargoed until 00.01 am, 6 May) which it was intended could serve as the basis for local publicity.

It was suggested that the Health OSCs of participating authorities involve newly-formed Local Improvement Networks (LINks) on issues emerging locally from the 'Healthcare for London' proposals.

Cllr Graham Bass (LB Croydon) said that LB Croydon would be pleased to host the proposed meeting of the JOSC in the Autumn. Cllr Megan Harris Mitchell also extended an invitation for the meeting to be held at LB Newham.

RESOLVED: That the actions proposed to be taken by the Chairman and Vice-Chairmen during the summer period, on behalf of the JOSC, or in conjunction with all JOSC members, be agreed.

8. Concluding Remarks

The Chairman again paid tribute to the commitment shown by all members of the JOSC in working together over the past several months, leading to the production of a final report, and said that she hoped that NHS London would give very serious consideration to the JOSC's views.

Cllr Megan Harris Mitchell (LB Newham) proposed a vote of thanks to the Chairman and Vice-Chairmen for their excellent work in steering the work of the JOSC, and this was unanimously supported.

Echoing the sentiments just expressed, Cllr Christopher Buckmaster (RB Kensington and Chelsea) paid tribute to the work of officers who had supported the work of the JOSC, including a considerable role in producing a final report for Members' consideration; these remarks were unanimously endorsed by the meeting.

The meeting finished at 12.58pm.

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Appendix 1

Progressing the work of the JOSC

1. Next Steps

A draft final report of the JOSC will be agreed on 25th April.

The Chairman and Vice Chairmen request your consent to amend the report as agreed at today's meeting and to then make available copies of the Final JOSC Report.

The JOSC report proposes a final meeting of the JOSC take place in autumn 2008 to consider NHS London's response to the JOSC's report.

The Chairman and Vice Chairman propose to promote the work of the JOSC and outcomes as detailed in your report through available forums and media (post GLA elections and receipt by JCPCT – please see separate paper).

The Chairman and Vice Chairman propose to meet in June to discuss obtaining feedback and reflection on the workings of the JOSC and the process undertaken. Any outcomes or proposals will be reported to a final meeting of JOSC in Autumn 2008.

The Chairman and Vice Chairman propose to keep JOSC Members informed and advised of any matters arising during the summer period

2. Proposed Actions from JOSC

The Chairman and Vice Chairman propose to undertake the following activities during the summer period either on your behalf or in conjunction with all JOSC Members and request the JOSC agree to such ACTIONS being undertaken;

Date	Activity	Action
30 April	Final JOSC Report submitted to NHS London	
6 May	JCPCT receives JOSC Report	All
6 May	Press release issued – Chairman and Vice Chairmen to promote to relevant media	
6 May	Press release issued – all JOSC Members to make local efforts to promote outcomes	All
Summer	Chairman and Vice Chairman to promote JOSC report and outcomes to all relevant London and	

	national forums	

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June	Chairman and Vice Chairmen's reflection and onward communication to JOSC Members	
12 June	JCPCT full public meeting to discuss conclusions of HfL	All
July	Date and venue set for Autumn 2008 JOSC meeting and communicated to JOSC Members	
Autumn 2008	Final JOSC meeting convenes	

Healthcare for London

NHS

Healthcare for London
Consulting the Capital

Response to the Joint Overview and Scrutiny Committee

Last Date Revised: 01/08/08

Version: 1.0

Table of Contents

Introduction

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

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

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

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

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

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

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

Richard Sumray
Chair of the Joint Committee of PCTs

Summary

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

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

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

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

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

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

In the words of the Patient and Public Advisory Group, "…the whole process of this consultation has been more comprehensive than any previous one in London". However, we are not complacent – the programme must now consolidate its position and reflect on how it can best achieve its objectives in a way that does justice to the expectations and aspirations of Londoners.

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

The JCPCT recognises that whilst some services are first class, excellence in healthcare is not uniform. There are large inequalities of health outcomes and the quality of patient care is not always as good as it could and should be.

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

Healthcare for London vision

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

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

Patient groups have stressed that much illness is avoidable and the NHS must work with its local authority and other partners and Londoners, to create better and more targeted programmes for health improvement, particularly aimed at sections of the population most at risk and where inequalities are most profound.

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

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

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

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

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

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

- **Improvements are properly resourced.**

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

working with the voluntary sector, local government and many other organisations with an interest in the health of Londoners.

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

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

ITEM 5

Agreements of the Joint Committee of PCTs

The JCPCT:

1. accepts the Ipsos MORI report on consultation responses.

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

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

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

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

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

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

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

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

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

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

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

13 agrees to the proposal to develop some hospitals to provide more specialised care to treat the urgent care needs of patients suffering a stroke (about seven hospitals in London providing 24/7 urgent care, with others providing urgent care during the day). The number and location of these hospitals should be subject to a further consultation by PCTs.

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

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

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

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

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

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

Notes:

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

Recommendations of the JCPCT are indicated: **The JCPCT recommended that:…** The numbering refers to the number of the recommendation to be found in the final report of the JCPCT at www.healthcareforlondon.nhs.uk . These recommendations have been raised as part of the consultation (for instance asking respondents for their views on an issue), or have been raised during the consultation, where the JCPCT felt it was appropriate to express an opinion. However recommendations are not binding on PCTs.

1 Financing the reforms

Recommendations of the Joint Overview and Scrutiny Committee (JOSC)

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

(a) We recommend that NHS London states how and when the money will come from to develop new services in order to address concerns about whether the NHS has the resources available to deliver major reform.

Resources for providing health care are finite. The proposals are likely to lead to primary and social care providing treatment currently undertaken in hospitals.

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

a) Resources for major reform

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

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

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

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

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

The JCPCT has recommended:

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

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

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

17.12.4 PCTs pay particular attention to transitional processes. Detailed and comprehensive plans (including finance and commissioning) need to be developed and it will be critical that there is no deterioration in quality or availability of services as new models of care are introduced.

To support PCTs, Healthcare for London has:

- developed a robust, flexible modelling tool to help PCTs ascertain the costs of operating the different types of polyclinic service model and also to support PCTs to commission polyclinics;

- commissioned a financial modelling tool for local hospitals to ensure they can take advantages of the opportunities presented. Healthcare for London will support trusts undertake scenario planning.

b) Money following the patient

Money currently follows the patient and there is no proposal to change this arrangement. PCTs are allocated money based on their population and they commission services to suit local needs. PCTs must become world class commissioners of services that are affordable, cost-effective, sustainable, of high-quality, and which will reduce inequalities and improve the health of their local population.

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

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

The JCPCT has agreed:

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

The JCPCT has recommended:

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

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

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

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

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

Conclusions and recommendations of the JOSC

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

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

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

a) The impact on community care services

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

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

The JCPCT has agreed:

- PCTs will need to become better partners in their local community, working with councils, the voluntary sector and others to understand and implement what will deliver the best health of their population, irrespective of economic, social and organisational boundaries.

The JCPCT has recommended:

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

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

b) Funding allocations

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

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

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

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

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

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

The JCPCT has recommended:

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

3 Health inequalities

Conclusions and recommendations of the JOSC

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

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

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

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

a) Resources targeted on communities with greatest need

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

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

The London Health Commission (LHC) was contracted to provide independent Health inequalities and equality impact assessments (HIIA and EqIA). The aim of the HIIA/EqIA was to deliver evidence-based recommendations, to inform future development of the strategy and the decision-making process. The report considers the impact on equality groups: it not only assesses the impact on race, disability and gender equality, as statutorily required, it also assesses the impact on age, faith and sexual orientation equality.

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

The JCPCT believes that by employing staff that reflect all communities within London the NHS could make a positive difference – for instance providing a more appropriate, better service to local communities and improving community cohesion. The committee is also clear from the work by PCTs and Health Link, that improving the health of people from deprived communities and disadvantaged groups will require real dedication, not lip-service. For instance, equitable access for people with a sensory impairment and physical disability must be taken into account in the planning of future services and health and social care facilities.

The JCPCT has accepted:

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

b) Health Inequality and Equality Impact Assessments

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

PCTs need to ensure local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require PCTs to undertake local health equity audits and health inequality impact assessments. Resources and services must then be targeted to meet unmet need. The SHA will monitor PCT performance and will of course take a particular interest in progress regarding the reduction of health inequalities. The SHA will provide appropriate support and guidance of PCTs which, for whatever reason, are unable to deliver improvements in line with agreed expectations.

The JCPCT has recommended:

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

4 A staged approach to reform

Conclusions and recommendations of the JOSC

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

(a) We recommend that a staged approach is undertaken to implementing new care pathways with, for example, 'polyclinics' piloted in a selected number of sites. Results from these pilots and existing examples of the proposed care pathways must be evaluated with learning fed into any subsequent roll-out across London. NHS London must also ensure lessons are learnt from work to implement Lord Darzi's vision in the rest of the country.

The NHS must be clear and open so that it cannot be accused of implementing the HfL vision in a piecemeal fashion.

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

a) A staged approach

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

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

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

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

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

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

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

Early implementer polyclinics will need to be evaluated using an action research framework using a mixed method analysis, collecting data in real time as the project progresses. The starting point will need to be taken as the output of the initial development programme. The evaluation should be designed to define and capture outcomes, identify both problems and solutions. Relevant learning will be disseminated through established management processes and 'bespoke' arrangements e.g. workshops, seminars and learning networks.

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

b) A transparent timetable

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

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

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

The JCPCT has recommended:

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

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

17.17.1

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

5 Helping people stay healthy and out of hospital

Recommendations of the JOSC

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

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

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

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

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

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

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

a) Helping people lead healthy lives

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

The JCPCT has agreed that:

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

The JCPCT has recommended that:

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

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

17.3.3 services and initiatives are delivered:

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

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

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

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

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

17.3.7 PCTs work with local authorities, the GLA, the Mayor and with local voluntary and community organisations to prevent people becoming ill, to address health inequalities and to engage with people who might not otherwise enter the healthcare system. Polyclinics or

wellness centres should help in reaching out to these people, encouraging them to take better care of their health.

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

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

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

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

17.6.1

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

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

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

17.8.1 more surgery should be carried out as day cases, allowing patients to go home the same day. Most patients prefer it, it is more cost-effective, and it reduces the risk of catching an

infection. In 2005, London was the worst-performing region in England, performing far fewer operations as day cases than expected.

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

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

b) Helping people with long-term conditions

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

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

Objectives:

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

Benefits

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

The JCPCT has decided:

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

The JCPCT has recommended that:

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

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

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

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

17.9.4 PCTs work with the voluntary sector. This will be critical to raising standards. The NHS must improve the way it does business with voluntary organisations if patients are going to benefit from their knowledge, expertise, capacity and goodwill.

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

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

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

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

6 Carers

Recommendation of the JOSC

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

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

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

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

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

The JCPCT:

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

The JCPCT has recommended that:

17.6.1 The NHS should set out clearer pathways to care, so that patients, carers, GPs and those who come into contact with people with mental health problems, such as police officers, know how to contact services and what to expect from them; and

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

17.8.3 After an operation, patients need help to recover and return to good health. This is called rehabilitation and the JCPCT recommends it should take place as close to patients' homes as possible – it is what most people want and it is effective. In some cases rehabilitation will be in patients' local hospital or polyclinic, and in many cases in their homes. However, 37 per cent of

pensioners in London live alone, so we will need to work closely with social care agencies to help people return to full and independent lives.

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

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

7 Maternity services

Recommendations of the JOSC

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

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

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

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

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

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

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

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

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

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

a) Midwives

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

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

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

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

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

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

The JCPCT agreed:

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

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

recommended:

17.4.7 further work should be undertaken by Healthcare for London on:

- managed networks of care, their size and configuration, and their possible impact on safety and safe transfers;
- the configuration and impact of services which support the midwife as the first point of access in the community for women;
- the possible configuration of obstetric units given the potential changes in paediatric services (the JCPCT agreed that specialist care for children e.g. high dependency medical or nursing care, or where admission for observation of more than 24 hours is anticipated, should be concentrated in fewer hospitals – the number and location of these hospitals to be subject to further consultation by PCTs); and
- the development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries.

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

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

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

17.13.3 the NHS in London continues to encourage applicants from local areas of deprivation and to reflect the cultural diversity of London.

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

b) Choice

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

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

The Clinical Advisory Group has submitted that with clear and robust selection and transfer protocols many women can give birth perfectly safely in the community. Of course, when exercising choice of where they have their baby, women must be given good information about the advantages and risks of where and how they have their baby.

The JCPCT has recommended:

17.4.1 The JCPCT recommends expectant mothers are offered:

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

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

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

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

8 Children's Health

Recommendations of the JOSC

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

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

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

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

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

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

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

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

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

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

The JCPCT agreed:

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

The JCPCT recommended:

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

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

The JCPCT wholeheartedly agree that the NHS should work closely with local authorities to improve the lives of children. As most children are cared for in the community, the importance of co-operative working and of a multi-agency and multi-disciplinary approach has been stressed throughout the consultation. The JCPCT recognises the need to provide healthcare in a wider variety of settings, for instance Children's Centres and Extended Schools.
PCTs need to strengthen partnership and joint commissioning arrangements. In planning future services for children, PCTs have been encouraged to consider further issues:

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

The JCPCT has recommended:

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

17.5.6 that whilst most urgent care is provided in GP practices and this will continue to be the case, all those who deal with ill children should have the necessary skills and expertise. Where access to GP services is difficult, PCTs need to explore effective alternatives.

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

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

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

9 Centralising specialist care

Recommendations of the JOSC

We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes. However, we will not give blanket approval to all proposals for centralising specialist care at this stage, and expect future consultations to set out prominently the clinical benefits of each particular proposal.

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

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

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

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

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

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

a) Involving clinicians

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

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

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

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

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

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

b) Transport

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

Empowering the public and patients with greater choice is a key part of these improvements in health and healthcare. To realise the power that comes with this responsibility, it is essential that patients have the information they need to make those choices. In a world city such as London this needs constant attention. The main transport organisations and advocacy groups welcomed the consultation's emphasis on accessibility.

TfL said Healthcare for London offered the opportunity to take a proactive approach to planning, and that a comprehensive analysis of the travel implications of the proposals should be undertaken jointly with NHS London. TfL also said it would welcome working with NHS London and PCTs to develop criteria for selecting sites for hospitals, polyclinics and other large-scale facilities, which optimised access.

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

The committee fully accepts Transport for London's suggestions to the consultation as an excellent basis for agreement of a set of joint guidelines and protocols which will be issued alongside marketing the planning tool. These will support PCTs (working in partnership with local communities) to develop transport and accessibility planning into any proposals for new or reconfigured hospitals, polyclinics or major health centres. PCTs would like to work in partnership with TfL to achieve its stated recommendations, including:

- Ensuring reconfiguration or relocation of healthcare services:
    - Help reduce the need to travel, especially by car;
    - Help influence a shift towards more sustainable modes of transport;
    - Encourage access on foot or by bicycle wherever possible; and
    - Reduce inequalities in healthcare.
- Integrating the planning of healthcare services with transport provision.
- Promoting improved health in the capital by producing travel plans for larger developments.
- Designing healthcare sites to give priority to people arriving by foot, by bike or public transport, optimise access by sustainable modes and actively manage parking.

The JCPCT recommended:

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

c) A hub and spoke model

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

The consultation recognised that whilst healthcare will be provided in a variety of places – for instance, schools, pharmacies and community hospitals – most healthcare is likely to be provided in six places: Home; a polyclinic service model (this could be in a network, a same-site or hospital); local hospital; major acute hospital; planned care (elective) hospital; and specialist hospital.

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

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

The JCPCT agreed:

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

The JCPCT recommended:

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

d) The importance of the London Ambulance Service

The consultation proposed the London Ambulance Service (LAS) would take a greater level of responsibility in decision-making on treating and transferring patients. The LAS agreed that changes in their workforce would be required, including improved training for all paramedics. The consultation also recommended investment in training, particular for LAS staff. UNISON specifically supported this proposal.

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

The JCPCT recommended:

17.13.2 the prioritisation of training throughout the NHS, but especially for the London Ambulance Service; and the development of a pan-London workforce strategy. Future work will need to continue to include key partners such as staff, hospitals, PCTs, unions and training and education providers. In addition the London NHS Partnership Forum, bringing together London NHS Unions, employers and NHS London is working to ensure the appropriate involvement and representation of staff. This should involve the establishment of sectoral or other geographic joint arrangements.

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

The committee has also welcomed the LAS' examples of what it could do to improve healthcare for Londoners. For instance:

- Supporting early intervention teams in the identification of mental illness;
- Providing flu vaccination for target groups;
- Undertaking home visits on behalf of GPs;

- For long-term-conditions (LTC) patients:
  - Distribute information to prevent long-term conditions to vulnerable patients
  - Provide immediate access to a patient's wider web of care
  - Undertake opportunistic screening to diagnose LTCs such as diabetes;
- Helping patients access local support groups;
- Training health professionals and members of the public in emergency life support skills;
- Playing a part in ensuring that a patient's wishes are respected on their End-of-Life care.

10 The future of the local hospital

Recommendations of the JOSC

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

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

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

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

a) Enhancing the local hospital

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

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

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

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

However, to balance this it should be noted that:

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

The committee envisages that most local hospitals would have a doctor-led maternity unit and a midwife-led unit, and provide most inpatient emergency care and outpatient services such as kidney dialysis. Patients who needed intensive or specialised treatment at a major or specialist hospital (the hub) would move to their local hospital (the spoke) for rehabilitation as soon as possible. Local hospitals would work in a network to provide these facilities.

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

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

b) Co-morbidities

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

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

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

The Clinical Advisory Group has said “The current physical separation of community mental health centres, general practice and hospital services contributes greatly to problems of missed diagnoses, less effective treatment of co-morbidity and to wider problems of stigma and discrimination. We therefore welcome the core idea of providing a ‘one-stop-shop’ that brings together mental healthcare, primary care and a range of hospital-based services at a local level.”

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

The JCPCT recommended:

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

11 GP services and 'polyclinics'

Recommendations of the JOSC

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

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

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

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

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

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

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

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

a) Diagnostics in the community

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

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

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

- Providing more access points should improve access – the committee accepts that there is a difference between locating the capacity at a new venue and actually using the facility but local solutions need to be found for local communities. The new diagnostic facilities would be nearer to people's homes than a hospital, often diagnostics could be performed whilst the patient was already in the building (for the initial consultation) – again, cutting down travel and reducing the time waiting for an appointment.

- Making primary care clinicians responsible for the service will enable them to better meet the needs of their community – perhaps fast-tracking patients whom they think particularly vulnerable – resulting in a more appropriate service.

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

The JCPCT recommended:

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

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

The committee agrees with the JOSC.

The JCPCT agreed that:

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

- The polyclinic service model should provide improved primary healthcare in London. The nature (for instance networked, single-site, hospital-based), location and precise

services offered should be determined by appropriate local engagement, consultation and decision-making.

The JCPCT recommended:

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

c) Access to GPs and the patient/GP relationship

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

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

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

The JCPCT has recommended:

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

d) A travel plan for polyclinics

Please see the response under 9b (transport).

12 Mental health

Recommendations of the JOSC

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

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

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

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

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

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

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

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

The JCPCT recommended:

17.6.1

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

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

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

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

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

17.6.5 Older people with dementia need early access to services and a care plan that addresses their health and social care needs. The JCPCT recommends PCTs provide support for people

and their carers as close to their own homes as possible but with specialist assessment and treatment units available if necessary.

17.6.7 PCTs and NHS London do more to deliver:

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

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

17.6.9 commissioners of services note the work of The Mental Health Clinical Care Pathway Group (MHCCPG) and use it to build their capability to specify the optimal effective service structures and teams required to deliver better mental healthcare, and to specify the evidence-based care pathways, clinical standards and outcomes to be implemented.

The JCPCT has welcomed the LAS' offer to support early intervention teams in the identification of mental illness.

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

b) Financial challenges

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

The JCPCT has expressed concern regarding changes in funding mechanisms of the Children and Mental Health Service (CAMHS). The implications for CAMHS service delivery are unclear but we are convinced of the value of preventative work and early intervention. PCTs will need to determine how best to ensure sufficient budget is available to maintain, and enhance services.

13 End-of-life care

Recommendations of the JOSC

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

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

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

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

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

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

a) and b) Dignity and choice

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

The JCPCT recommended that:

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

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

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

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

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

c) Nursing and care homes

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

14 Understanding the cross-border implications

Recommendations of the JOSC

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

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

The committee agrees with the JOSC.

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

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

15 Workforce

Recommendations of the JOSC

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

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

The JCPCT agrees with the JOSC.

Introducing these proposals means big changes for NHS staff in London. At the moment, the majority of London's NHS staff are hospital-based (61%). These proposals suggest moving staff out of some hospitals and into the community; making better use of the high levels of skill of staff working in primary care; and introducing new roles and responsibilities. The consultation recognised that staff will need support to move from hospitals into the community.

NHS London is developing a workforce strategy, '*Workforce for London*', working with hospitals, PCTs, staff, unions and training and education providers, which addresses key issues facing staff moving from hospitals to the community, employment flexibility, and the continuing development of a workforce which reflects the diversity of London. The engagement and involvement of staff in delivering service changes will be a key part of the strategy.

Workforce for London is a high-level ten year strategy setting out, for the first time, a holistic view of the shape of the clinical workforce in London's NHS health economy. The strategy sets out the need for a different workforce 'shape', with the right skills working in the right settings to meet the future needs of patients and the public in London. Key messages are:

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

The workforce strategy will be built around 3 strategic themes:

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

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

Through its Social Partnership Forum (the London NHS Partnership Forum), NHS London is supporting employers and trade unions to work together to deliver the changes envisaged in *Workforce for London*. This forum enables partnership working at a strategic level on London wide issues that can be best facilitated by a joint approach. Future work will need to continue to include key partners such as staff, hospitals, PCTs, unions and training and education providers.

The JCPCT recognises that it will be impossible to deliver the vision of Healthcare for London if training is not seen as a high priority over the coming years. The committee understands that Workforce for London will be published in September 2008 and will request that NHS London shares the document with the JOSC.

The JCPCT recommended:

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

17.13.2 Staff will be vital to driving improvements to healthcare. As they take on new tasks in new settings it will be important for them to have opportunities for training, and where there are areas of significant change, a transition path will be needed. The JCPCT recommends the prioritisation of training throughout the NHS, but especially for the London Ambulance Service; and the development of a pan-London workforce strategy. Future work will need to continue to

include key partners such as staff, hospitals, PCTs, unions and training and education providers. In addition the London NHS Partnership Forum, bringing together London NHS Unions, employers and NHS London is working to ensure the appropriate involvement and representation of staff. This should involve the establishment of sectoral or other geographic joint arrangements.

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

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

16 ICT: providing the electronic connections

Recommendations of the JOSC

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

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

The NHS will need good information technology to ensure that patients' information is available where and when it is needed, and that it remains secure. This will enable NHS staff to give each patient the best care, especially in an emergency, when having the most up-to-date information is crucial.

Practitioners' access to patient records will also be critical in balancing continuity of care with better access for patients. And if care in people's homes is to be a viable option, then mobile solutions will need to be in place.

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

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

The JCPCT recommended:

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

17 Compatibility with recent reforms to the NHS

Recommendations of the JOSC

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

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

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

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

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

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

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

The JCPCT recommended:

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

- The use of market leading skills and expertise to making best use of the estate entrusted to the NHS, both as a strategic resource and physical space;
- Unlocking the latent value within the NHS estate;
- Ensuring an equitable distribution of this scarce NHS resource for the benefit of all Londoners; and
- Enabling commissioners and providers to focus on the delivery of improved healthcare and not be distracted by the burden of estates management.

NHS London has accepted this recommendation.

18 Moving forward

Recommendations of the JOSC

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

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

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

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

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

a) Ongoing dialogue with local councils

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

The JCPCT recommended:

17.14.1 PCTs become better partners with a range of organisations in their local communities, especially LINks, understanding what will deliver the best health of their population and working

with others to ensure economic, social and organisational boundaries do not obstruct provision of better healthcare.

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

b) Engagement in future consultations

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

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

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

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

The JCPCT recommended:

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

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

Healthcare for London

Improving Stroke and Major Trauma Services in London

Programme Brief for consideration by PCT Boards

September 2008

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Healthcare for London
Southside
105 Victoria Street
London SW1E 6QT
www.healthcareforlondon.nhs.uk

Contents

Section 1 Introduction

Detailed proposals have been developed to significantly improve the care delivered to stroke (essentially a brain attack) and trauma patients across London. These improvements will be enabled by the introduction of new service delivery models and new care pathways. Work has progressed through active processes of clinical, public and patient engagement.

The proposed models of care embrace prevention, diagnosis, specialist acute treatment, acute rehabilitation and long term rehabilitation. This document specifically focuses on the need to conduct a public consultation on the specialist acute phase of care. This reflects the statutory requirement to consult on proposals to substantially vary or develop health services. The content of this document includes a summary of the case for change and a description of key pre-consultation, consultation and post consultation processes.

The proposals will:

- Enable greater prevention of stroke and trauma;
- Ensure the provision of high standards of care in the critical acute periods of treatment;
- Introduce effective processes of rehabilitation and recovery.

We aim to save over 1,000 lives a year, reduce disability and allow thousands of Londoners who experience trauma or a stroke to subsequently realise their full potential.

Section 2 Strategic Context

A Case for Change (March 2007) described how London needs to improve the health of Londoners, to make better use of primary care (for instance in prevention, diagnosis and rehabilitation), to centralise more specialised care, and to better use the NHS workforce and buildings.

Healthcare for London *A Framework for Action* (July 2007) and accompanying clinical pathway reports further developed the case for change and made specific proposals, for instance:

- the development of a stroke strategy and seven hyper-acute stroke centres;
- the development of trauma networks with three major acute centres.

Following *Consulting the Capital* (Nov 2007) the Joint Committee of PCTs accepted the clinical evidence (previously established and further supported by the Clinical Advisory Group (CAG)) and acknowledged the strong patient and public support (64 percent for specialised trauma centres, 67 percent for specialised stroke centres). However in the light of the CAG report it amended the proposed number of major trauma centres. The Committee agreed:

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

- to develop some hospitals to provide more specialised care to treat the urgent care needs of patients suffering a stroke (about seven hospitals in London providing 24/7 urgent care, with others providing urgent care during the day). The number and location of these hospitals should be subject to a further consultation by PCTs.

The proposed model of care for these services was described in *Consulting the Capital.* Patients will be transported to major trauma centres, and for stroke to hyper-acute centres, which have been designated as meeting the necessary clinical criteria.

Rehabilitation (and prevention) for patients is crucial. Both projects will clearly identify the pathway of care following acute admission and treatment. Personalised care plans will play a key role in supporting patients to regain mobility and recover to participate in a healthy life.

Section 3 The Case for Change

The clinical case for change for stroke and major trauma services is well established. The Clinical Advisory Group reviewed the evidence as part of *Consulting the Capital.* The consultation also established there was public support for change and the Joint Committee of PCTs therefore agreed on 12 June 2008 to develop some hospitals to provide more specialised care to treat the urgent care needs of stroke and major trauma patients. This section summarises this case.

3.1 Stroke Services

Stroke is the second most common cause of death and the single most important cause of physical disability in London. In 2007, stroke accounted for well over 4,400 deaths (both in and out of hospital) in the capital, of which nearly 25 percent may have been prevented. Nearly one percent of Londoners have suffered a stroke, and many of these have suffered more than one. The impact on hospital services is huge, with over 11,000 Londoners admitted to hospital with a stroke each year.

Most strokes are age-related. Over 75 percent occur in people over 65 years of age. However, the incidence is higher in black communities and tends to occur at a younger age than among white, European groups. Among London's black population, the incidence of stroke is 60% higher than that of the city's white population.

The poor quality of stroke services in England has been identified for many years, and in 1998 this led to the start of the Sentinel stroke audit. In 2006, figures for London showed that the very best two units in the capital were meeting the 12 key targets only 90 percent of the time. Some units' performance fall well below this benchmark and many figures worsened between 2006 and 2004. This has led to major inequalities in access to, and quality of, services in London.

Although a number of units in London have significantly improved their services since 2006, and more recently in response to the *National Stroke Strategy* and NICE guidelines, pan-London services need a step change improvement if patients are to have equality of access to the highest standard of care across the capital. The 2008 data has been recently published and shows improvement in a number of areas but still indicates that providers are some way off the requirements of the new service specification.

International comparisons of outcome measurements provide compelling evidence of the need for change. Data from the Organisation for Economic and Cooperative Development (OECD) illustrates that the UK has achieved a 23 percent reduction in stroke mortality over a 10 year period. Nevertheless, in spite of this decrease, the UK has the highest proportion of deaths due to stroke when compared with Australia, Germany, Sweden and the US and almost double to the number of deaths compared with our closest neighbour, France.

3.2 Major Trauma Services

It estimated that approximately 3000 people per year suffer a major trauma in London. We are close to getting final results from Healthcare for London analysis which will refine this number.

The standard of care delivered to the majority of trauma patients across the UK (including London) has been shown to be sub-standard in a number of crucial areas including provision of suitably experienced staff and correct clinical decision making. Services are insufficiently co-ordinated to provide the best care for patients. Patients transported directly to the most appropriate hospital (i.e. a trauma centre rather than a local hospital without proper trauma facilities) have been shown to have a mortality of 12 percent, whilst patients initially treated at a local hospital and subsequently transferred have an overall mortality of 19 percent. A network of trauma centres could save over 500 lives a year.

Currently two thirds of severely injured patients have to be transferred between hospitals as their local hospital does not provide the specialist care required. This increase in time to definitive care worsens outcomes for the severely injured.

The Healthcare for London Acute Care Working Group identified overwhelming evidence that severe trauma should be dealt with by a few specialised centres, for example:

- Patients with severe brain injury have their mortality risk reduced by 10 percent when treated in a trauma centre;
- Units with higher volumes of trauma care reduce patient mortality and length of stay, compared to smaller units; and
- Regionalisation of trauma care in Quebec resulted in a reduction in mortality from 52 percent to 19 percent;

Healthcare for London: A Framework for Action observes that the UK is almost alone amongst international comparators in not having a system of regional trauma centres. Data shows that current mortality for severely injured patients who are alive when they reach a hospital is 40 percent higher in the UK than in the US where regional trauma centres exist. The Royal College of Surgeons advocated the development of a systematic approach to trauma in 2000.

Section 4 The proposals – geographical scope

The proposal is that the consultation is run by all 31 London PCTs (each PCT commissions between two and four percent of the total). PCTs in neighbouring SHAs will be invited to join a Joint Committee of PCTs.

Section 5 The proposals – clinical scope

The consultation will cover:

Services for acute trauma care – explicitly the location and coverage of major trauma trauma (e.g. limb amputation, stab and gunshot wounds to the head, neck or chest, open skull fracture) and trauma (e.g. fractured hip or ankle) services in London.

Services for acute stroke care – explicitly the location of hyper-acute services and acute services and coverage in London.

5.2.1 Stroke

The stroke consultation will include configuration of specific hospital sites to provide equality of access to acute stroke services for adults in London. Whilst the documentation will include information on rehabilitation, community care and prevention these services are not being consulted upon. The information will be provided only to enable consultees to be better informed when making comments on acute services. Any local changes relating to these services will be locally managed.

There are three categories of configuration of hospital sites:

1) Hyper acute stroke units (HASU) – which provide the immediate response to a stroke, where the patient is stabilised and receives primary intervention, and where length of stay is typically no longer than 72 hours.
2) Stroke units (SU) – provide multi-therapy rehabilitation and ongoing medical supervision following a patient's stabilisation, where length of stay varies and will last until the patient is well enough for discharge to an acute inpatient setting.
3) Transient Ischaemic Attack (TIA) (mini-stroke) clinics – which provide rapid diagnostic assessment and access to a specialist within 24 hours for high risk patients following a TIA, and within seven days for low risk.

5.2.2 Major trauma

The major trauma consultation will cover the establishment of major trauma networks covering the whole of London. These networks will comprise a major trauma centre linked with a number of trauma centres all of which have proven ability to deliver care through a network-based model.

Major trauma centres will be proposed in specific identified hospitals (as will the trauma centres). They will have demonstrated their ability to provide a major trauma service through a process of evaluation of the quality of their clinical services. The location and coverage will be described in the consultation.

Each trauma network will consist of a major trauma centre, a number of trauma centres and a range of rehabilitation providers. This based on the network model developed and functioning in the United States through the American College of Surgeons.

The consultation will not include burns, prevention or rehabilitation. These will be addressed at a later date either through the Healthcare for London paediatric project or once the London trauma system is established.

The process by which clinical quality and other factors which were used to determine the options for consultation will be made explicit in the consultation document.

Section 6 Benefits of Change

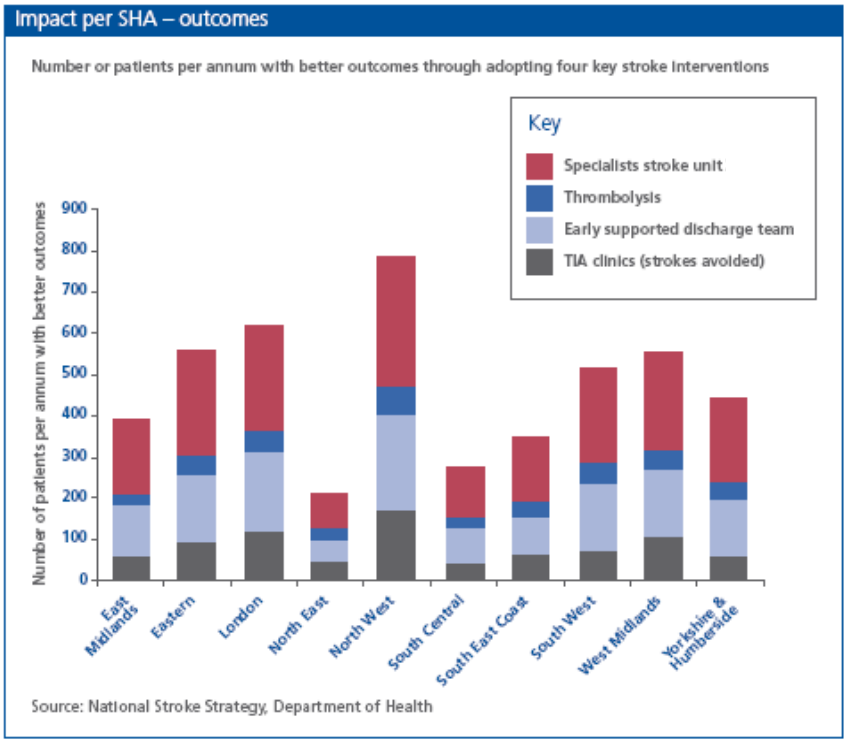
6.1 Stroke

Measures of success are being developed using the detailed service specification that has been developed for the London Ambulance Service / HASU / SU / TIA services. These will give a clear timescale about when they will be achieved.

Measures will need to be developed for the following benefits:

1) Awareness of stroke to increase, resulting in more people being treated urgently following a stroke;
2) Increase in the number of patients able to be thrombolysed by ensuring people get to a specialist hospital as quickly as possible;
3) More patients receiving high dependency care in the first 72 hours following a stroke;
4) More patients receiving thrombolysis following a stroke resulting in more patients having a good outcome (independent or minimal help required) at three months from onset;
5) More patients receiving their total hospital care in a stroke unit, resulting in a greater number of patients having a good outcome at three months from onset;
6) More patients assessed as high risk following a TIA to be assessed by specialist TIA clinic within 24 hours, thus reducing the risk of a major stroke; and
7) Stroke patients to receive earlier assessment from community rehabilitation providers so as to plan transfer into community more effectively.

The graph below shows the benefits for all SHAs of introducing the four key stroke interventions recommended in the *National Stroke Strategy*.



Notes:Transient Ischaemic (lack of blood supply) Attacks (TIA).
Thrombolysis a stroke treatment used to reduce the severity and impact of stroke, increasing potential recovery.

6.2 Major trauma

A trauma system for London would:

- Reduce mortality and disability;
- Improve communication and collaboration between hospitals providing care;
- Provide a higher quality service which is faster, providing the right care, with better clinical outcomes, and improved patient satisfaction; and
- Improve equality of access.

A trauma system would minimise the time to definitive care by delivering patients straight to the most appropriate facility rather than taking them to the nearest hospital and transferring them.

The benefits of introducing a regionalised trauma system reach beyond the improvement of patient outcomes. Whilst not part of this consultation, a system-wide prevention strategy would reduce the number of people suffering severe injury. The majority of injuries are preventable, consisting mainly of motor vehicle accidents and falls. A pan-London approach to prevention has the potential to save a significant number of lives and the burden of injury.

The establishment of a London-wide trauma system made up of networks would facilitate more effective educational programmes for all those involved in trauma care and therefore improve the skills of clinicians and other staff. Rotation of staff between centres would support the retention of skills across the network and encourage a culture of co-operation.

The links and co-operation present in a trauma system would ease the activation and implementation of the Major Incident Plan with hospitals having recognised roles within it. With the introduction of a trauma system the number of people surviving injury and returning to normal social and economic functioning would be increased.

In general, success can be measured by a decrease in mortality and morbidity for major trauma cases across London. Specific success criteria will be established as the trauma system is developed over coming months.

Section 7 Governance of the projects

7.1 Stroke

The Senior Responsible Officer (SRO) for the project is Rachel Tyndall, Chief Executive of Islington PCT. She is accountable to the London Commissioning Group (LCG) for delivery of the project and is supported by a project board of Healthcare for London project officers and a Clinical Director – Chris Streather, Renal Physician, Medical Director and the Director of Strategy at St George's;

The stroke project board is advised by three panels:

- Clinical Expert Panel – comprising healthcare professionals representing the end-to-end stroke pathway – including public health professionals, GPs, stroke physicians, nurses, therapists, social care representatives and the voluntary sector from a range of organisations and hospitals across London.
- Patient Panel – one part of engagement with stroke patients and survivors is through the stroke patient panel. The membership includes representation from the Stroke Association, Connect and Crossroads, and access to their patient and carer groups.
- Commissioning and Finance Panel – comprising commissioning and finance representatives of each of the Collaborative Commissioning Groups (CCG) in London, and cardiac and stroke network leads. This panel meets monthly.

7.2 Major Trauma

The Senior Responsible Officer (SRO) for the project is Simon Robbins, Chief Executive of Bromley PCT. He is accountable to the LCG for delivery of the project and is supported by a project board of Healthcare for London project officers and a Clinical Director – Matt Thompson, Professor of Vascular Surgery at St George's, University of London.

The major trauma project board is advised by three panels:

- Clinical Expert Panel – comprising clinicians from every speciality involved in delivering trauma care and from a range of hospitals across London. E.g. therapies, trauma, rehabilitation, ambulance service, public health, A&E, paediatrics, orthopaedic surgery, neurosurgery, anaesthetics, intensive care, ward and A&E nursing, physiotherapy, radiology, social services, maxillo-facial surgery, blood transfusion, plastic surgery, GP, psychiatry and major incident planning.

- Patient Panel – The major trauma project is engaging with patients via the major trauma project patient panel. Representation includes: British Institute for Brain Injured Children; Brain Injury Rehabilitation Trust; Brain Injury Rehabilitation Trust; Child Brain Injury Trust; Headway; Royal Hospital for Neuro-disability; Spinal Injuries Association; and Healthcare for London Patient and Public Advisory Group member, two major trauma patients and a carer of a major trauma patient.

- Commissioning and Finance Panel – comprising commissioning and finance representatives of each of the Collaborative Commissioning Group (CCGs) in London, as well representation from the London Specialist Commissioning Group and three members from PCTs surrounding London.

Section 8 Developing the Options for Consultation

8.1 Stroke

The project is developing a strategy that covers prevention and awareness, acute care and rehabilitation and community care. This will be issued in early October.

Interested NHS providers will be producing expressions of interest to provide three types of acute stroke care:

1) Hyper acute stroke unit
2) Stroke unit
3) TIA clinics

The acute designation documents will be based on service specifications and performance standards, developed with the projects' various expert panels.

An external panel of clinicians from outside of London will be appointed to evaluate the proposals and produce a long list of potential provider sites for each type of service. Following the initial evaluation, an option or options for configuration of the acute stroke service will be identified.

The stroke project has completed an analysis of the number of patients that are expected to attend London hospitals with a suspected stroke. In addition we have modelled the travel time of patients attending all the hospitals on the fringes of London.

The prevention workstream and the rehabilitation and community care workstream have also been developed with a significant level of engagement with clinicians, commissioners and patient representatives and stroke survivors.

8.2 Major Trauma

Trauma networks are expected to cover a population of between one and a half and three million people (Royal College of Surgeons, Better Care for the Severely Injured 2000). This means that, based on an approximate population of eight million people in London plus patients referred in from neighbouring PCTs, between three and six networks will be required.

A preliminary phase of designation produced five potential trauma networks. These networks have been liaising with providers in neighbouring out-of-London PCTs to ensure that there is joined up trauma care for those patients living around the peripheries of London. We expect bids from each of these networks.

All those trauma networks passing the clinical evaluation stage of the designation process will move to the options evaluation stage. Between November and December 2008, the major trauma project team will conduct options development and evaluation which will involve a comparative analysis of all possible configurations of trauma networks across London.

There will be a workshop run by an external agency in September comprising 20 members of the general public who will be consulted on the eight factors selected for the options evaluation and their relative importance to each other.

Section 9 Consultation – governance and timing

The proposal is to run the consultation in line with Sections 242 and 244 of the NHS Act 2006.

Department of Health guidance for reconfiguration of services recommends that:

- Public and patients need to be reassured that change is necessary and that it will improve the care their receive;
- No major service change should happen except on the basis of need and sound clinical evidence;
- Change should only be initiated when there is clear and strong clinical basis for doing so; consultation should proceed only where there is effective and early engagement with the public, clear evidence of improved outcomes for patients and resources available to enable new facilities to open alongside old ones closing; and
- The case for change should be led by clinicians and subjected to independent clinical assessment prior to consultation.

9.1 The plans

The current project plans allow for public consultation on stroke and trauma to run for 12 weeks, from 5 January 2009 to 30 March 2009. Therefore the consultation should be run 'as if it is one consultation'. This would mean:

- A single set of meetings (reducing administrative burden)
- A single set of consultation materials (reducing costs of roadshows, publications and advertising, minimising confusion to the public and best enabling the public to understand the whole health economy)

However a joint consultation would not mean that the two parts were inextricably linked. So, for instance, a delay in the options appraisal of one part would not necessarily delay the start of consultation for the other. The JCPCT would have the power to direct different specific communications activity for each of the two parts of the consultation.

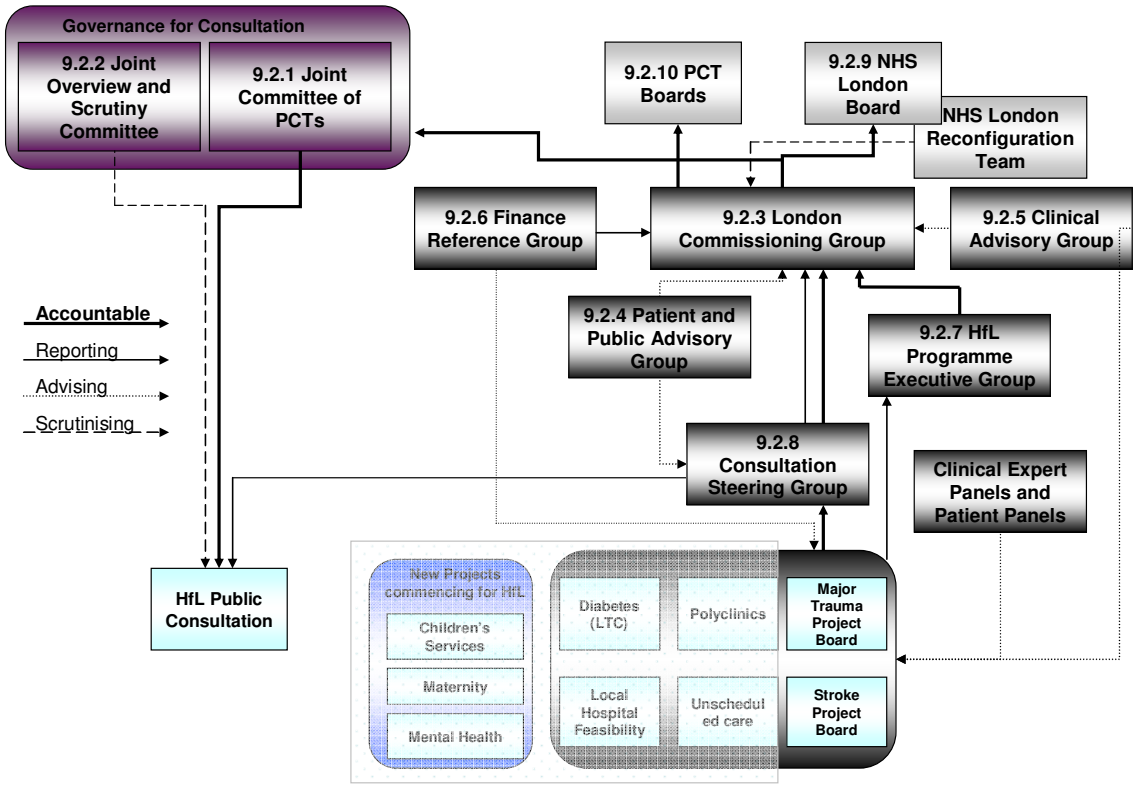
The consultation steering group (with appropriate input from the LCG, CAG, and PPAG) will develop a public consultation document and associated materials that explains the consultation and seek to elicit public views as well as their option preferences.

The consultation steering group will commission various impact assessments e.g. Health, equalities, travel time and environmental. The assessments will be made:

- during the planning and development of proposals but when clinically and financially viable options are established (so as not to waste money on assessments that are otherwise unviable); but
- the results will need to be made available during the consultation period, so that consultees can consider the assessments when making their views known.

9.2 Governance Arrangements

The diagram below shows the proposed governance structure for the consultation. In essence this is the same as for *Consulting the Capital*, with an additional 'Consultation Steering Group' established to coordinate all the strands of the consultation.



9.2.1 Joint Committee of PCTs (JCPCT)

The proposal is to establish a single JCPCT with one member for each constituent London PCT. Members should be voting members of relevant PCT Boards. Places for interested PCTs out of London will be allocated once any interest is known. The JCPCT will:

- Approve the pre-consultation business case and consultation documentation for improving the acute phase of adult services for stroke and major trauma;
- Relate formally to the Joint Overview and Scrutiny Committee which corresponding local authorities would be required to establish;
- Receive the report on the outcome of the consultation;
- Consider the impact assessments and any other relevant material;
- Take decisions on the issues being consulted upon, taking into account the outcome of consultation, the impact assessments and any other relevant material.

9.2.2 Joint Overview and Scrutiny Committee

Healthcare for London will write to London Scrutiny Committees and neighbouring councils' scrutiny committees inviting them to form a Joint Overview and Scrutiny Committee (JOSC).

9.2.3 London Commissioning Group

The consultation will be overseen by the London Commissioning Group (LCG). A review is being conducted as to the fitness for purpose of the LCG to meet the needs of Healthcare for London.

9.2.4 Patient and Public Advisory Group

The Director of Communications and the Stakeholder Manager are currently in discussion with Michael English, the previous Chair of the London Committee of PPIFs, to agree membership of a new PPAG.

9.2.5 Clinical Advisory Group

The Clinical Advisory Group (CAG) was established to advise and support the Healthcare for London programme.

9.2.6 Finance Reference Group

Will provide an external point of reference specifically around the development of the pre-consultation business case.

9.2.7 Programme Executive Group

The Programme Executive Group (PEG) consists of members of the Healthcare for London programme office and project managers. It will be necessary for the PEG to be informed of the progress of the consultation and vice-versa to ensure synergies and opportunities for joint working are exploited.

9.2.8 Consultation Steering Group

The Consultation Steering Group (CSG) will manage the consultation process, for including the development of the pre-consultation business case and consultation materials, commissioning of the impact assessments and implementation of the plan.

The Programme Board will include:

- David Sissling (Programme Director, Healthcare for London), Programme Chair
- Don Neame (Director of Communications, Healthcare for London)
- Nicole Millane (Head of Communications Implementation, Healthcare for London)
- Jo Sheehan (Finance Manager, Healthcare for London)
- Helen Cameron (Programme Manager, Healthcare for London)
- Simon Robbins (Senior Responsible Officer, Major Trauma and Joint SRO for the consultation)
- Professor Matt Thompson (Clinical Lead, Major Trauma)
- Tim Daly / Shaun Danielli (Project Manager, Major Trauma)
- Dr Rachel Tyndall (Senior Responsible Officer, Stroke and Joint SRO for the consultation)
- Chris Streather (Clinical Lead, Stroke)
- Kevin Hunter (Project Manager, Stroke)
- Alastair Finney (NHS London)
- Lisa Anderton (NHS London)

The group will meet at least monthly.

9.2.9 NHS London Reconfiguration Team

NHS London Reconfiguration Lead will need to be satisfied that the organisations involved have the capability and capacity in terms of staff, skills, resources and project management arrangements in place to:

- Develop robust, evidence-based proposals;

- Undertake the process of involvement and consultation;
- Implement their plans (including consultation) within a manageable timeframe;
- Handle communications and media relations; and
- Provide strong leadership

The Reconfiguration Lead has indicated that the consultation will require a Gateway Review, and an independent clinical review.

9.3 Timeframes

High level consultation plan:

Task/Deliverable/Outcome	Date
LCG PCT CEs approve Programme Brief	12 September 2008
Complete first draft consultation document (CD) and pre-consultation business case (PCBC)	29 September 2008
Shadow JCPCT meet to accept remit	29 October 2008
LCG review first draft CD & PCBC	7 October 2008
CAG review first draft CD & PCBC	17 October 2008
SHA Board briefing	w/c 1 Dec or 8 Dec 2008
JCPCT	Mid November (TBC)
JCPCT	26 November 2008
Stroke & Major Trauma options identified	1 December 2008
Present consultation options to CAG	2 December 2008
Stroke & Major Trauma Business Case Complete	8 December 2008
LCG approve final drafts of CD and PCBC	12 December 2008
JCPCT approve CD and PCBC in public	16 December 2008
SHA Board approve CD & PCBC	17 - 21 December 2008
Notify JOSC & key stakeholders of consultation start	18 December 2008
Brief JCPCT of consultation start	5 January 2009
Consultation start date	5 January 2009
Consultation end date	29 March 2008
JCPCT discuss initial responses in private	2 April 2009
Consultation response evaluation end date	16 June 2009
JCPCT discuss final analysis in public	2 July 2009
Options approved	2 July 2009

Additional JCPCTs to be held in private, to monitor and direct the consultation, are expected in February, March, May and June.

9.4 Measures of success

The success of the consultation will be measured by:

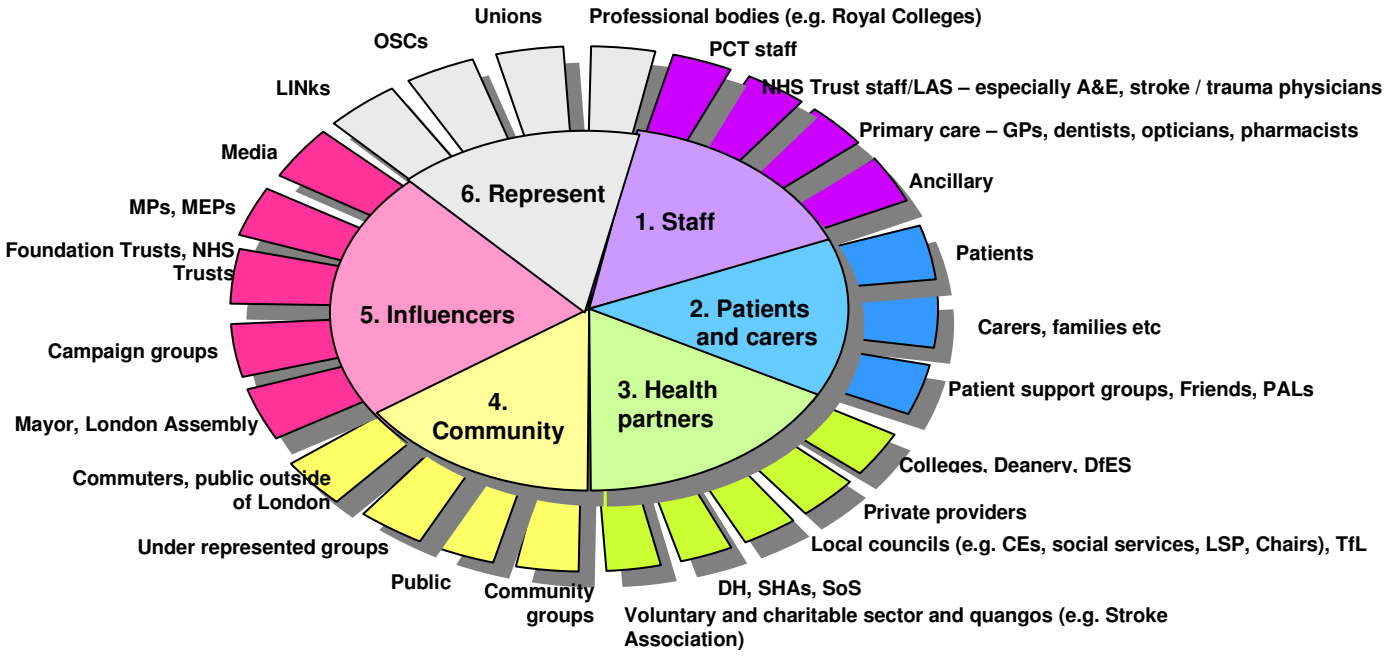
- Number of respondents to the consultation (compared to other consultations);
- Respondents' views on quality of proposals;
- Meeting milestones and time plan and adherence to action plan;
- Engagement with traditionally under-represented groups;
- Public and stakeholder awareness of the issues;
- Positive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

Section 10 Communications

The consultation communications are planned to be managed in a similar way as *Consulting the Capital* – the original consultation on *A Framework for Action.*

The communications aspect of the consultation will be managed by the Director of Communications and staff in the Programme Office, most of whom had experience of managing Consulting the Capital. The team has been strengthened by the addition of a public affairs manager and a media manager.

Clinicians will present the proposals wherever possible to ensure consultees are clear that the proposals are based on sound clinical arguments.



We expect the cost of the consultation to be less than £1 million, similar to the cost of *Consulting the Capital* – with a more focused consultation agenda, but a wider geographical coverage and potentially more interest and more responses to analyse.

Section 11 Pre-consultation Business Case

The pre-consultation business case will build upon this programme brief and will include the following areas (for both major trauma and stroke):

- The case for change
- The objectives to be achieved
- Description of current model of care
- Proposals – a description of how the options were selected, a description of each option, the case for and against each option, the recommended option – if there is one
- Reference to impact assessments
- Financial analysis of options
- Transition & implementation – timescales to implementation, phasing, implementation arrangements for commissioners etc

11.1 Financial Implications

The business case for both services will identify the current and proposed costs of commissioning these services for each option. In addition, it will also identify potential income changes to current providers on a pan-London basis as services relocate.

The scope of the financial analysis has yet to be finalised. In overall terms, the pre-consultation business case will include an analysis of activity and financial flows of the current acute pathway and the proposed options.

11.1.1 Stroke

The estimated current spend by PCTs on acute stroke services is approx £70m. Based on total PCT allocations of London PCTs of £10bn, this accounts for approx 0.7% of PCT allocations. It is expected that investment will be required to deliver the proposed enhanced service across the acute and rehabilitation part of the care pathway.

11.1.2 Major Trauma

The major trauma project is undertaking work to determine the financial implications of establishing a major trauma system for London. The current spend by London PCTs on acute care is difficult to ascertain as there are no discrete Healthcare Resource Groups (HRGs). Early indications are that PCTs currently spend approx £30 – £40 million on the acute care pathway. This represents 0.3% -0.4% of the total London PCT allocations. It is expected that establishing major trauma networks will require investment by PCTs. This investment will be required to support new acute care services and increased support to patients requiring intensive rehabilitation.

11.2 Workforce Implications

11.2.1 Workforce for London

NHS London is developing a workforce strategy which will be produced on 16 Sept. *Workforce for London* addresses key issues facing staff moving from hospitals to the community, employment flexibility, and the continuing development of a workforce which reflects the diversity of London. The engagement and involvement of staff in delivering service changes will be a key part of the strategy.

This is a high-level ten year strategy setting out, for the first time, a holistic view of the shape of the clinical workforce in London's NHS health economy.

11.2.2 Training

The proposals will affect staff of the London Ambulance Service (LAS) who will be asked to take a greater level of responsibility in decision-making on treating and transferring patients. The LAS has agreed that changes in their workforce would be required, including improved training for all paramedics. *Consulting the Capital* recommended investment in training of LAS staff.

11.2.3 Stroke

A detailed stroke workforce review has commenced which will be aligned with the NHS London workforce strategy. In the meantime the expected workforce requirements for the acute stroke pathway are being modelled and costed. These are detailed in the stroke service specifications (HASU, SU and TIA Clinic). In addition training requirements are being developed for each element of the pathway.

11.2.4 Major Trauma

There will be a positive effect on the workforce through the establishment of a London trauma system. By delivering care through networks there will be increased opportunities for staff to gain skills and experience along the whole patient pathway.

National data indicates that severe injuries comprise a very small percentage (less than 0.1%) of the A&E workload. Thus, the change in workload for each A&E department will be negligible. Based on estimates from the Royal London Hospital, there are approximately 3000 major trauma patients per year across London. Given that there are 34 A&E departments in London, this will see an average of 88 less admissions per A&E department per year – less than two per week.

The workforce implications will be fully scoped to ensure any impact is anticipated and changes are planned. Specifically there may be shortages of some generic and specialist rehabilitation staff.

Specialisation of trauma services will lead to changes in staff roles, and experience will be passed on through a thorough training and development programme involving rotation of staff and training positions as well as formal training developments.

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Healthcare for London

ITEM 6

To: London PCT chief executives
PCT CEs in SHAs bordering London SHA
CEs of SHAs bordering London

Copy to: CEs of London FTs, London NHS Trusts, London Ambulance Service,
Dr Simon Tanner, Regional Director of Public Health for London,
Health Adviser to the Greater London Authority
Mr Matt Tee, CE, NHS Direct
NHS London, chief executive and directors
Mr Boris Johnson, Mayor of London

2 October 2008

Dear PCT chief executive,

Healthcare for London: acute stroke and major trauma services in London

This letter is sent on behalf of the London Commissioning Group (LCG) to all London Primary Care Trusts (PCTs), and to PCTs in neighbouring SHA areas, and sets out a provisional framework for a formal public consultation on acute stroke and major trauma services in London.

The LCG is a stakeholder group that brings together representatives from London PCTs and NHS London and representatives from Unions, the Mayor's office, clinicians, patients and the public, to lead the implementation of Healthcare for London.

Enclosed with this letter is;

- a programme brief for PCT boards, which sets out plans to significantly improve the care delivered to stroke and trauma patients across London
- a template board report
- a powerpoint presentation for use by chairs and chief executives if appropriate
- two pro-formas for completion and return by 17/10/2008 and 28/11/2008

Our proposals follow the consultation *Healthcare for London: Consulting the Capital* which ran from 30 November 2007 to 7 March 2008. The resulting report which was agreed at the Joint Committee of PCTs (JCPCT) meeting on 12 June 2008 can be viewed or downloaded from www.healthcareforlondon.nhs.uk

Timelines

The proposal is for a formal 12-week public consultation period led by PCTs, running from 5 January through to 29 March 2009.

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Page 14 in the enclosed programme brief sets out a provisional overview timetable should PCTs agree to the establishment of a Joint Committee. This deals only with key decision points for boards and the JCPCT.

1. For consideration by PCTs

1.1. PCTs need to ask themselves*: "Could the implementation of the proposals for acute stroke and major trauma services amount to a substantial variation or development for all or part of the population served by my PCT?"*

PCTs should take soundings from their OSC to ensure that they have a shared view. In doing so, PCTs will want to share with their OSC the extent to which their population uses services for which London providers are responsible.

Our current view is that whilst many PCTs in England will wish to be a consultee and will respond to the consultation, there will be very few outside London which will be part of a Joint Committee of PCTs consulting with others.

1.1.2. If the answer to the question in **1.1** is **yes,** PCTs need to consider establishing a Joint Committee (in line with Regulation 10 of NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulation 2002) in order to:

- Approve the pre-consultation business case and consultation document.
- Relate formally to the Joint Overview and Scrutiny Committee which corresponding local authorities would be required to establish
- Receive the report on the outcome of consultation
- Consider the impact assessments and any other relevant information on the proposals for acute stroke and major trauma services
- Take decisions on the proposals taking into account the outcome of consultation and the impact assessments

OR

1.1.3. If the answer the question in **1.1** is **yes,** PCTs can, as an alternative, agree to delegate the exercise of those functions to another PCT. This may be a mechanism which PCTs bordering London wish to consider.

1.2. PCTs joining the JCPCT may wish to consider how the membership as a whole could reflect a mix of non-executive, executive and clinical membership. For London PCTs, we would suggest that this discussion is taken forward at a sector level under the co-ordination of your LCG PCT Chief Executive representatives.

1.3. Boards will want to have made internal arrangements to ensure that Professional Executive Committees (PECs) are fully involved in these discussions.

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1.4. The attached proforma board resolution can be amended and adapted to suit the needs of each individual PCT. In considering the resolutions, boards will need to satisfy themselves that the resolution is permissible within their scheme of delegation. Where it is not, boards will need to amend their scheme of delegation first.

Board meetings to discuss the Healthcare for London proposals for acute stroke and major trauma services must take place by 28 November 2008.

1.5. There may be overlap between this process and other service reconfigurations already underway. In relation to each of these, local NHS bodies 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 bodies involved in local consultations should satisfy themselves:

- 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 outcomes of the proposals for acute stroke and major trauma services for decision making, although reliance on a common evidence base is appropriate where relevant.

- 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 in this section.

1.6 In the event that a JCPCT is established, the LCG will assume operational responsibility for preparing a consultation document and developing a draft pre-consultation business case for consideration by the JCPCT.

1.7 The person you nominate to join the JCPCT needs to be a voting member of your board. The JCPCT member can send a deputy in his/her place, but again he/she should be a voting member of the board.

2. Shadow JCPCT

We advise that any PCT intending, or considering, joining the JCPCT should attend the shadow JCPCT scheduled for **Wednesday 29 October 2008** from 10.30am – 1pm (lunch will be provided). The venue is to be confirmed; it will be in a Central London location, and we will advise as soon as possible.

The intention of the shadow JCPCT meeting would be to ensure that organisations represented on the committee share a common understanding of its function, its decision-making processes, its relationship to PCT boards, the prospective JOSC, the LCG and the consultation process as a whole.

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3. Actions and decisions

We ask PCTs to respond to the LCG on the questions below. In order to facilitate this we have created two electronic pro-formas for completion and return to:

Claire Lynch, Consultation Delivery Manager at claire.lynch@london.nhs.uk

Pro-forma A asks the following questions, and needs to be returned by 17/10/2008:

3a) Please confirm the date when your board will consider the proposal to join a JCPCT or delegate the function to another PCT. Please note that this needs to happen no later than 28 November 2008

3b) (For those PCTs joining, or considering joining, a JCPCT) Please ensure the date for the shadow JCPCT scheduled for Wednesday 29 October is in the diary of a board member.

3c) Please confirm to Claire Lynch the name of the person attending the above meeting.

Pro-forma B asks the following questions, and needs to be returned by 28/11/2008:

3d) Does your board wish to be part of a JCPCT?

3e) Does your board not wish to be part of a JCPCT?

3f) Does your board propose that the exercise of your PCT's functions in this regard is delegated to another PCT (you will need to indicate which PCT)?

3g) Please send a copy of the relevant extract from your scheme of delegation which permits your board to pass the resolution it is being asked to consider.

3h) Please note the draft timetable, and make provision for your board to consider the outcome of consultation and the impact assessments in the first half of June 2009 in advance of the JCPCT decision-making meeting. While this can only be a provisional timetable, we ask PCTs that are likely to agree to the establishment of a JCPCT to plan for the possibility of a board (and PEC if appropriate) meeting during this period.

3i) Please confirm the name and contact details of the person we should be liaising with on future communications on the consultation process, as well as contact details for the nominated JCPCT member.

3j) Send a copy of your board paper and minutes agreeing to your joining the JCPCT and to the matters addressed in the template board report

Please note: PCTs considering being part of a JCPCT will need to incorporate the attached board template in their board papers.

If we do not hear from you by 28 November 2008, we will assume you do not want to join the JCPCT.

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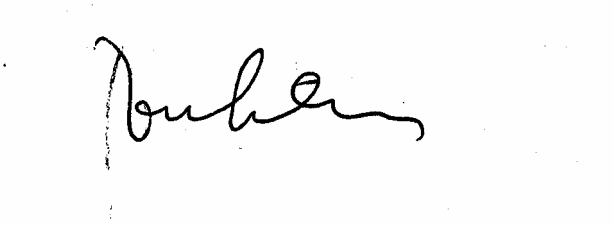
We would be grateful if you could share this letter with your Local Involvement Network (LINk). In parallel with this workstream on governance and decision-making, there are ongoing discussions underway to establish a public and patient advisory group for the consultation.

We have written today to chief executives of London Boroughs, the Common Council for the City of London and chief executives of Social Services Authorities in SHAs neighbouring London in relation to the role of scrutiny in the proposed consultation and will copy you into this letter.

We would be grateful if SHAs bordering London could share this letter with local providers who may have an interest in the consultation.

If you have any queries on the contents of this letter, please e-mail claire.lynch@london.nhs.uk

Yours sincerely,



Tom Easterling of the London Commissioning Group

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Healthcare for London

ITEM 6

To: All health OSCs and/or lead scrutiny officers in London
All health OSCs and/or lead scrutiny officers in Authorities surrounding London
Chief Executives of all Local Authorities in London and surrounding areas
Copy: Chief Executive, Greater London Authority
Mr Boris Johnson, Mayor of London
Mr Alex Bax, Senior Adviser, Mayor's Office
Chief Executive, London Councils
PCT CEs in London and surrounding SHA areas
CEs in SHAs surrounding London
Members of the London Commissioning Group
NHS London Reconfiguration Team

7 October, 2008

Dear Sir or Madam,

Re: Proposed public consultation on acute stroke and major trauma services in London

Please ensure this is passed to your health scrutiny chairman and/or lead scrutiny officer

I enclose a copy of a letter to PCT Chief Executives in London and surrounding areas from the London Commissioning Group (LCG). This sets out a provisional framework for a formal consultation on acute stroke and major trauma services in London. I also enclose a copy of the programme brief.

The LCG is a stakeholder group that brings together representatives from London PCTs, NHS London (the Strategic Health Authority for London) and representatives from unions, the mayor's office, clinicians, patients and the public, to lead the implementation of Healthcare for London. My purpose in writing is to invite relevant local authorities to establish a Joint Overview and Scrutiny Committee to consider and respond to the proposed consultation. This is in line with Directions from the Secretary of State issued in July 2003.

Our current view is that whilst many PCTs in England will wish to be a consultee and will respond to the consultation, a few outside London may wish to be part of the Joint Committee of PCTs.

Summary
The framework for the proposed consultation builds on *Healthcare for London: Consulting the Capital*. For more details please see the attached programme brief. The key points are:

- PCTs for whom the implementation of the models proposed for stroke and major trauma might amount to a substantial variation or development for part or all of their population establish a Joint Committee in October 2008.

- A formal 12-week public consultation period will take place from 5 January through to 29 March 2009.

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Next steps
I would like to invite local authorities to liaise with their PCT about involvement in a Joint Overview and Scrutiny Committee (JOSC). Healthcare for London has discussed these proposals with Cllr Mary O'Connor (Chairman of the JOSC established during *Healthcare for London: Consulting the Capital*) and Cllr Barrie Taylor (Vice-Chairman of the JOSC established during *Healthcare for London: Consulting the Capital)* who have also commented upon the brief.

Cllr O'Connor has proposed that discussion regarding the establishment of a new JOSC for the stroke and major trauma consultation take place at the final meeting of the current JOSC (established to scrutinise *Consulting the Capital*) which takes place in public on 24 October 2008. OSCs that are not members of the current JOSC are welcome to attend the meeting. It is expected that the London Scrutiny Network will organise an Officer Support Group for the new JOSC. In the meantime, can you please express your interest by responding to Guy Fiegehen (Head of Scrutiny & Members' Services, London Borough of Hillingdon) so that your details can be forwarded to the new Officer Support Group. Guy can be contacted on gfiegehen@hillingdon.gov.uk or 01895 277 733.

Sharing this information with your OSCs
I have asked the Officer Support Group of the current JOSC to forward this to the Members and Scrutiny officers in participating authorities; I would be grateful if all Chief Executives could likewise forward this letter onto their respective OSC chairmen

Please see Attachment A for information on issues for Local Authorities to consider.

If you need further clarification on any of the issues set out in this letter, please contact Claire Lynch, Consultation Delivery Manager on claire.lynch@london.nhs.uk or 020 7932 3801.

Yours sincerely,

Tom Easterling on behalf of the London Commissioning Group

Encs:
Copy of letter to PCT Chief Executives in London and surrounding areas
Programme brief for improving stroke and major trauma services in London

Attachment A

Issues for Local Authorities in London
We anticipate that all PCT boards in London will agree to the establishment of a Joint Committee of PCTs at their board meetings in Autumn 2008. Were that to be the case, there would be a statutory requirement on London boroughs and the Common Council of the City of London to form a Joint Overview and Scrutiny Committee (JOSC). The composition of that committee, arrangements for chairing the JOSC and supporting it, will be matters that borough and City of London scrutiny functions will want to consider.

From a PCT perspective, the earlier that there is clarity about councillors and officers with authority to liaise with on scrutiny even if only on a “shadow” or “designate” basis, the better.

While the statutory responsibility for scrutiny on the consultation sits with London boroughs, the Common Council of the City of London and, where relevant, social services authorities outside London, the JOSC may also want to consider the scope for any liaison with the London Assembly.

Issues for Social Services Authorities outside London
We have asked PCTs in SHAs adjoining London to ask themselves: “Could the implementation of the models of care and delivery proposed for acute stroke and major trauma services amount to a substantial variation or development for all or part of the population served by my PCT?”

PCTs and OSCs outside London may come to the view that the proposals for **stroke services, or major trauma services, or both stroke and major trauma services** if implemented, amount to a substantial variation or development for all or part of their population.

In any of these events, PCTs would need to consider agreeing to be part of a Joint Committee for the consultation and their corresponding OSC would be statutorily required to be party to a Joint Overview and Scrutiny Committee.

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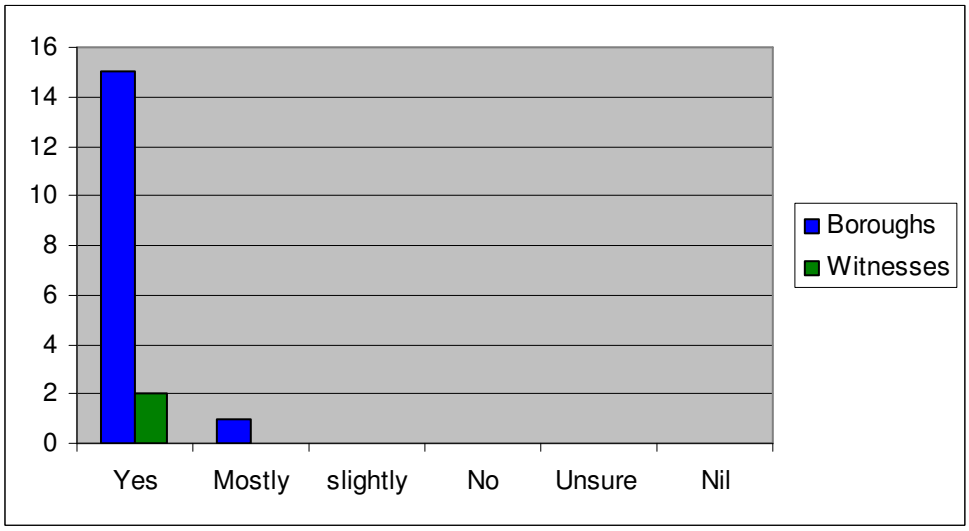
HfL Consultation JOSC 2007/8 - Feedback

A Joint Overview and Scrutiny Committee (JOSC) (all 33 London Boroughs including two outer London Boroughs Essex and Surrey) for London was formed for the first time in November 2007 to respond to NHS London's proposals for change to the NHS Services across London.

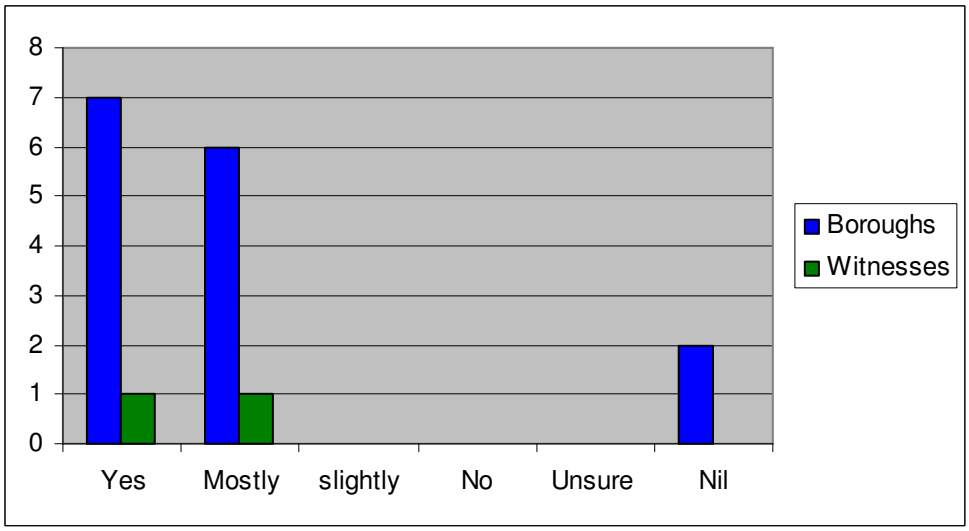
Following this historic experience all the participating Councillors, supporting officers and expert witnesses were sent a questionnaire to provide feedback about the review and to allow analysis of the process. The questionnaire was sent to 70 Members (Councillors and supporting officers) and all expert witnesses called to give evidence to the JOSC. 21 questionnaires were returned and analysis of the responses (below) show the feedback received as at the 31st August 2008. The break down being 19 JOSC Members / Officer and 2 from expert witnesses.

JOSC Process and Membership

1.2.1 Was the process for setting up the JOSC clearly outlined to you?



1.2.2 Did you find the size of the JOSC membership manageable?



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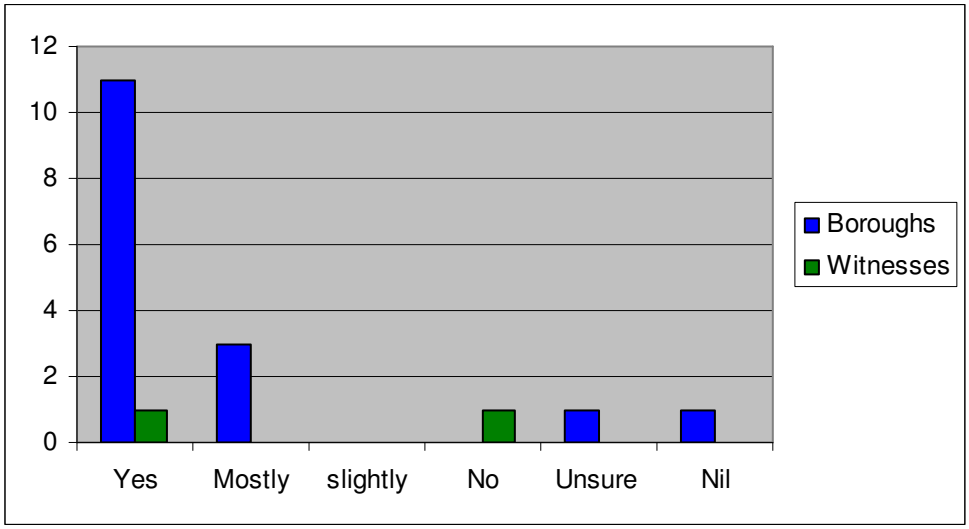
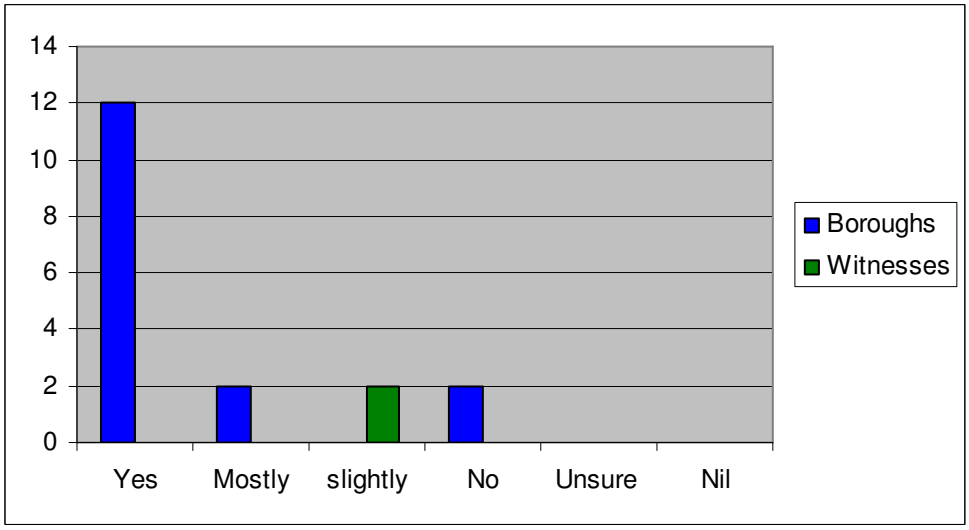
1.2.3 Did you think the arrangements for the JOSC officer support group worked well?



1.2.4 Has your understanding of the JOSC process improved as a result of this review?



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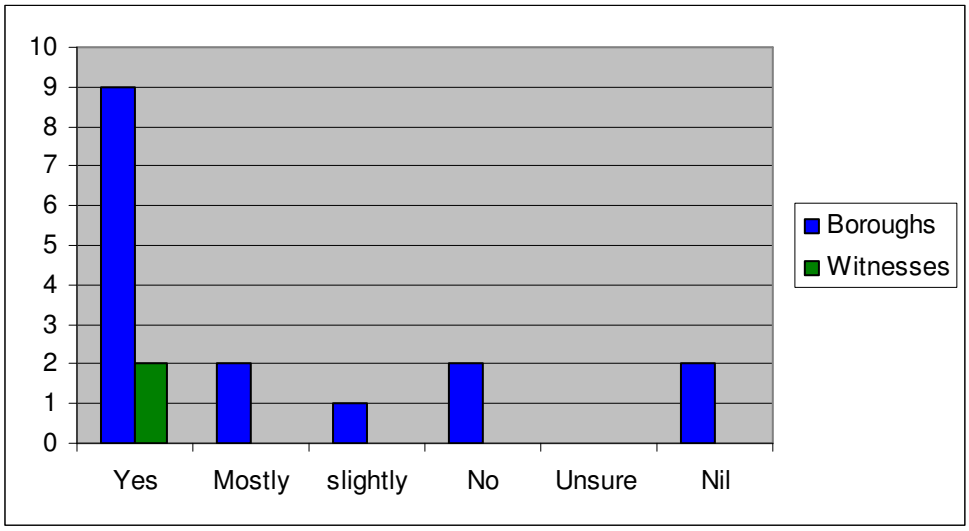
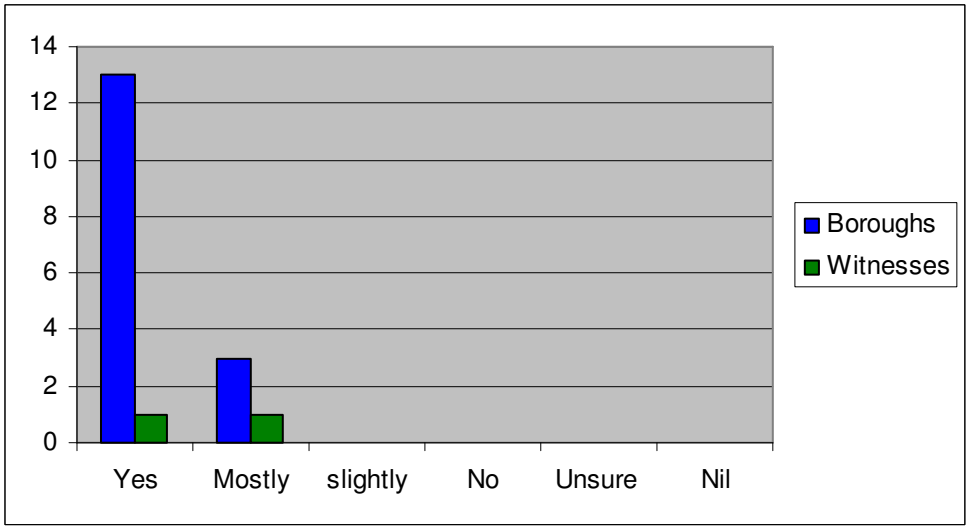
1.3 Aims and issues

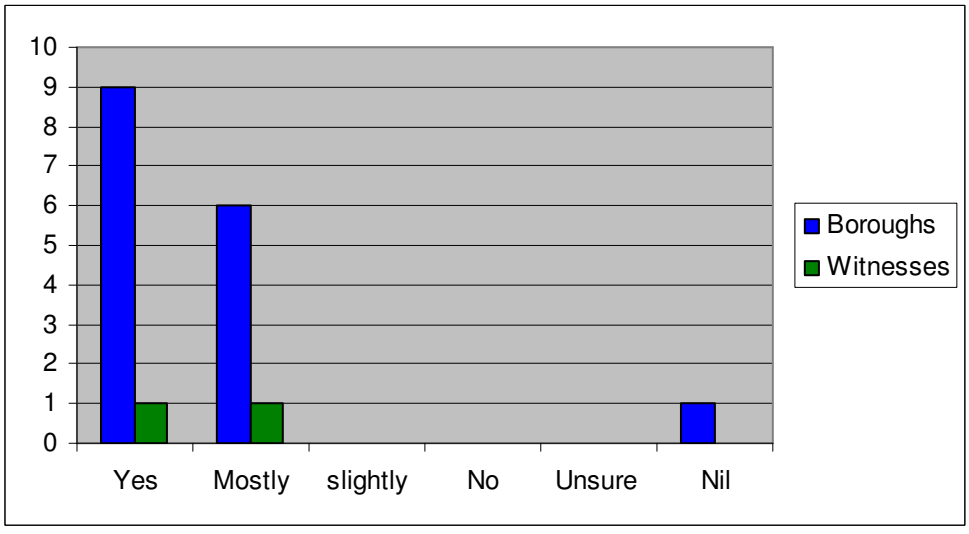
1.3.1 Were the main aims of the review made clear to you?



1.3.2 Were the issues you considered to be significant raised?



1.3.3 Were the issues you considered to be significant addressed to your satisfaction?



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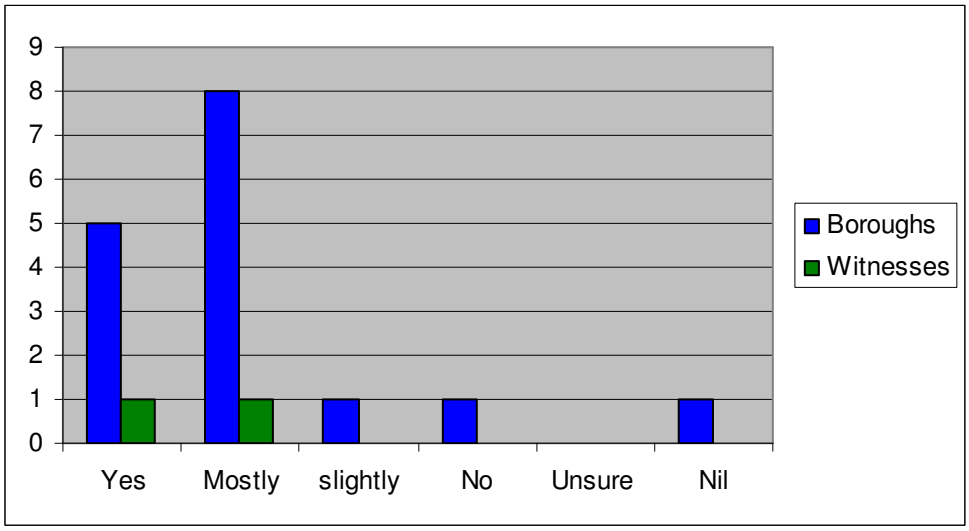
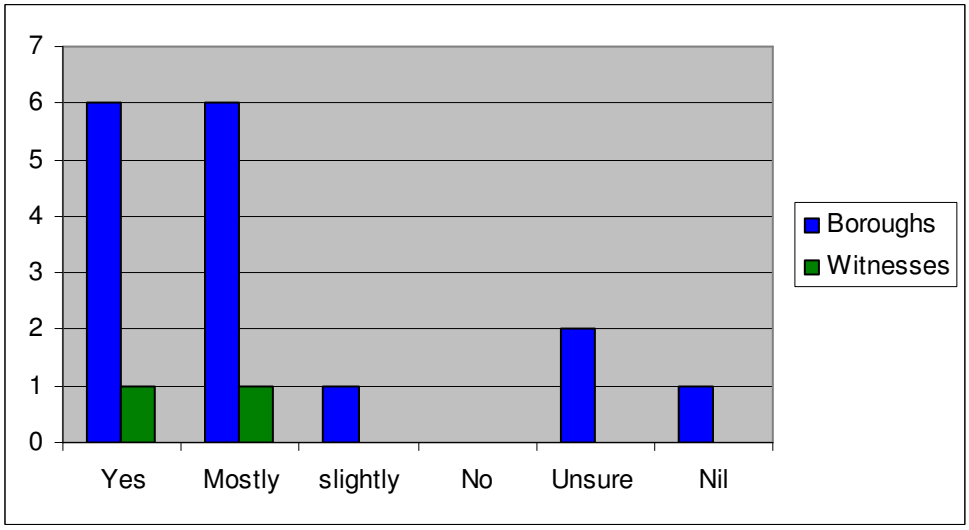
1.3.4 Did the review meet the original specifications of the Terms of Reference and/or work Programme established?



1.3.5 Did the review stick to the agreed programme and meet the agreed deadlines?



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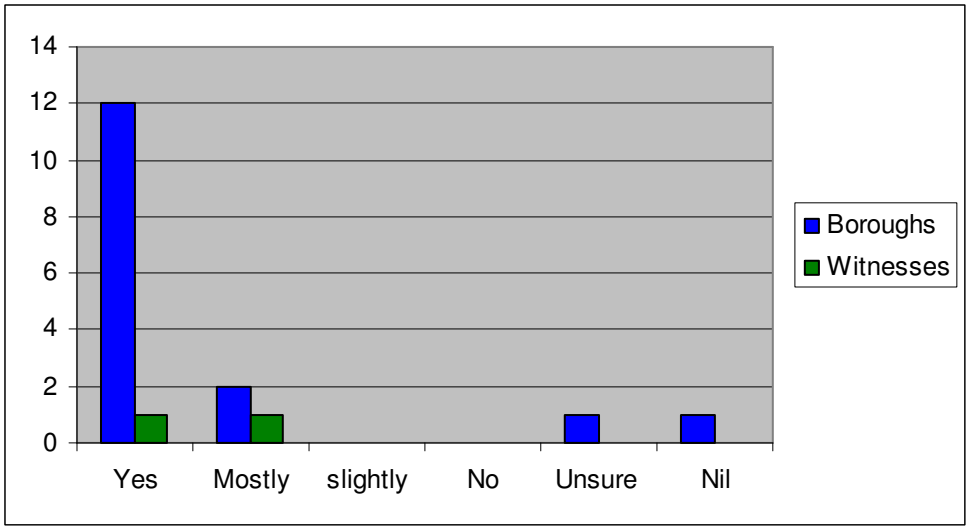
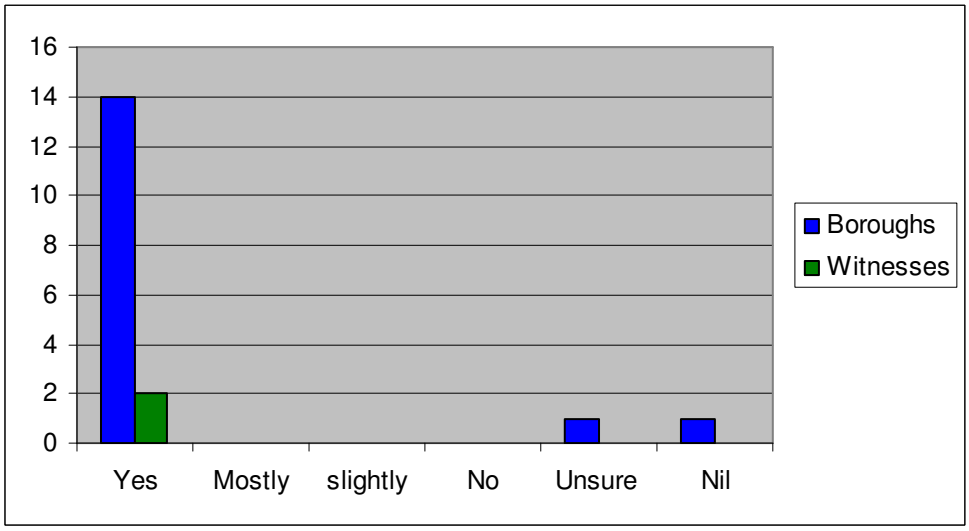
1.4 Contributions to discussion

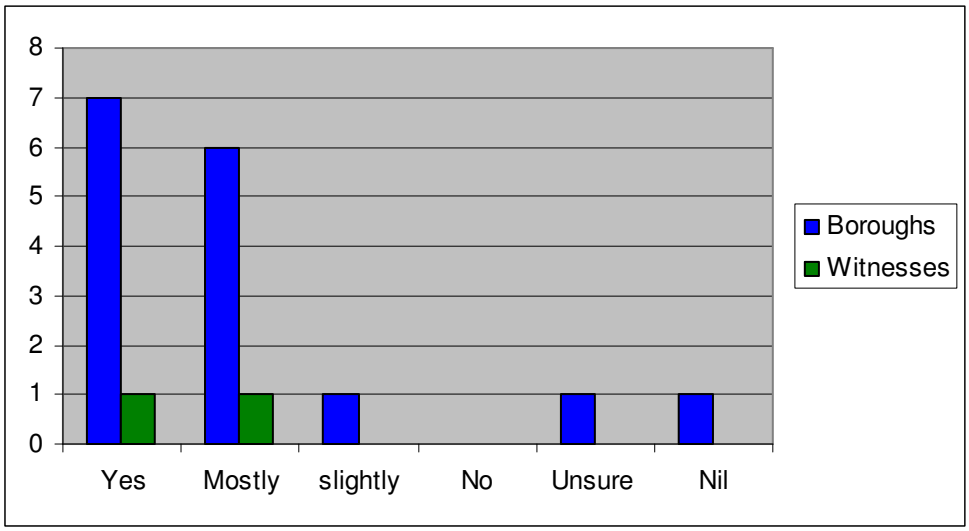
1.4.1 Did the JOSC take contributions from representatives of a variety of interested parties working in partnership with the NHS or Councils sufficiently into account?



1.4.2 If external 'expert witnesses' were called in, did you feel that the JOSC took their views into account?

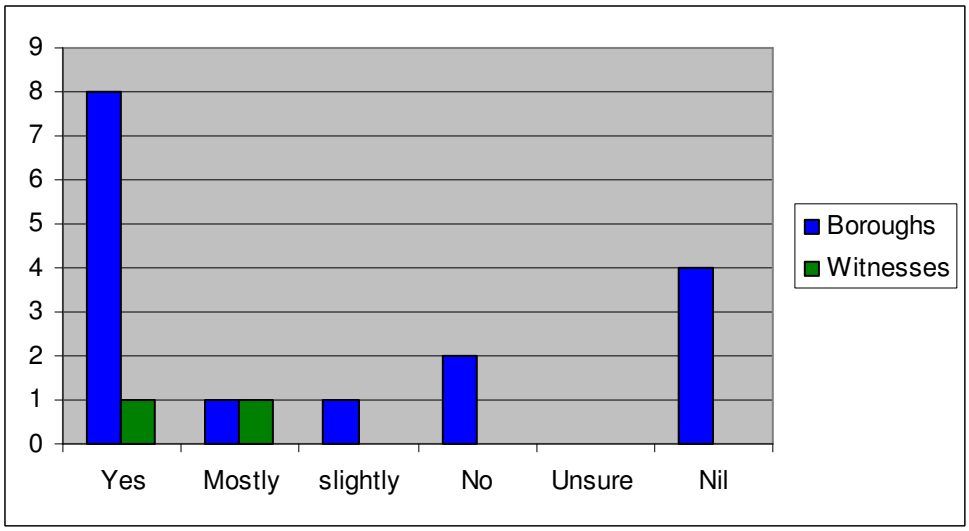


1.4.3 Were you personally given the chance to participate in the public meetings as much as you wished?

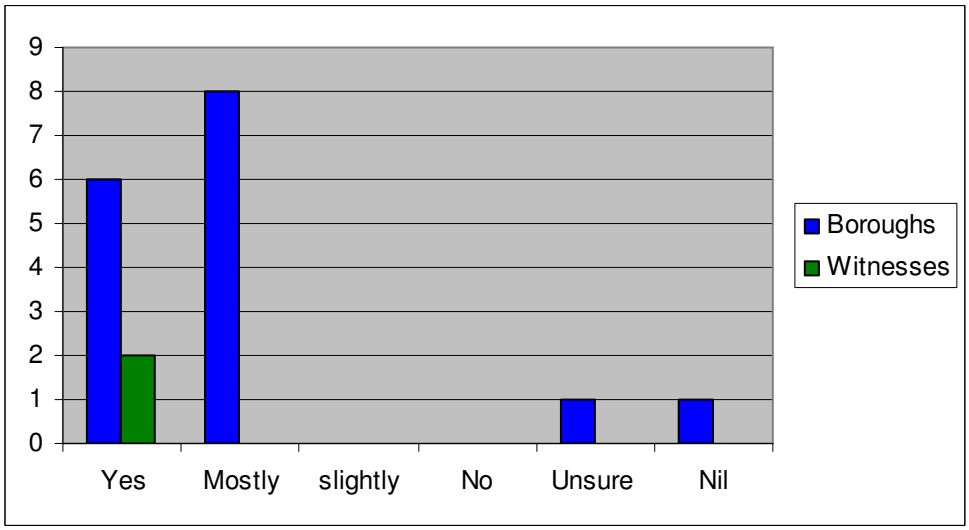


1.5 Encouragement of public involvement in the scrutiny process

1.5.1 Were the venues and room layout (e.g. seating arrangements and set up) good, accessible and evenly spread around London?



1.5.2 Was there a good provision of facilities for the public (e.g. Disabled access)?



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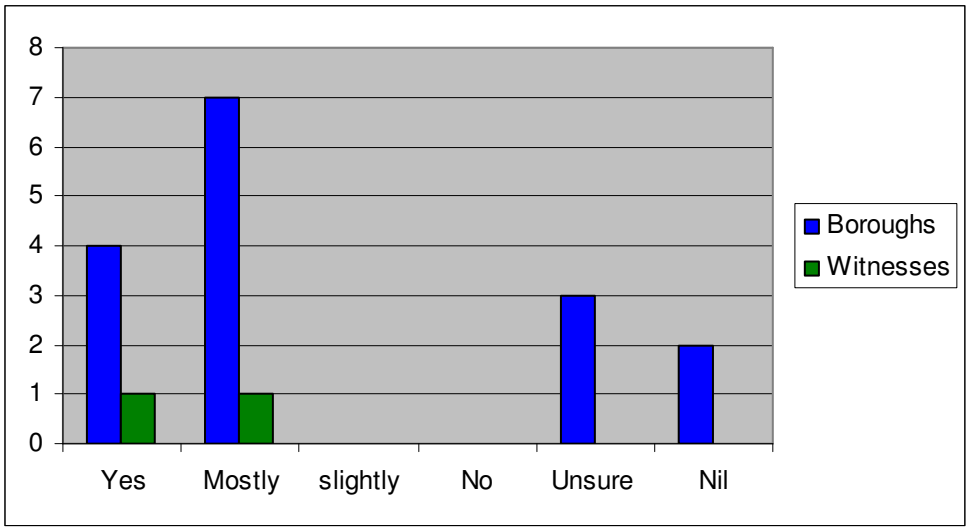
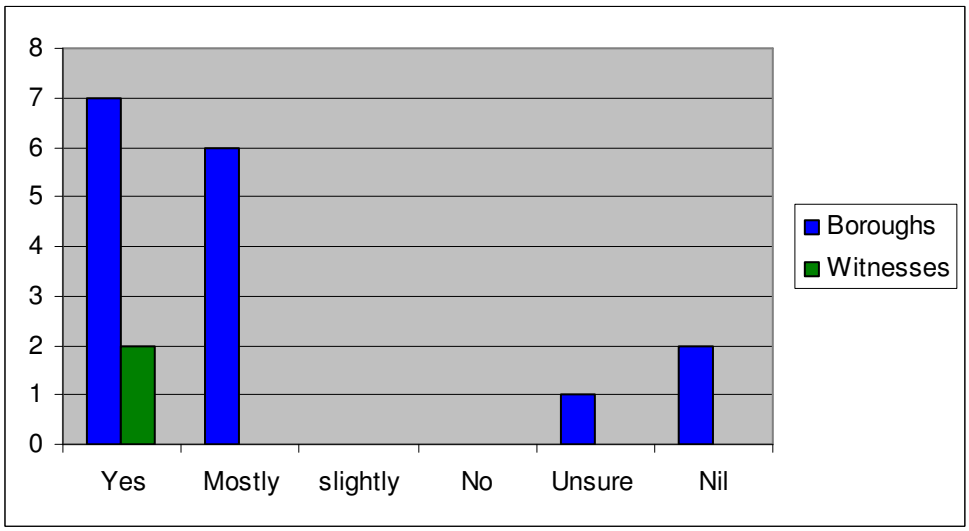
1.5.3 Were Members of the Committee and other witnesses clearly identified?



1.6 Outcomes

1.6.1 On balance, are you in favour of the recommendations put forward by the JOSC?



1.6.2 Do you believe this scrutiny review has had positive effects?

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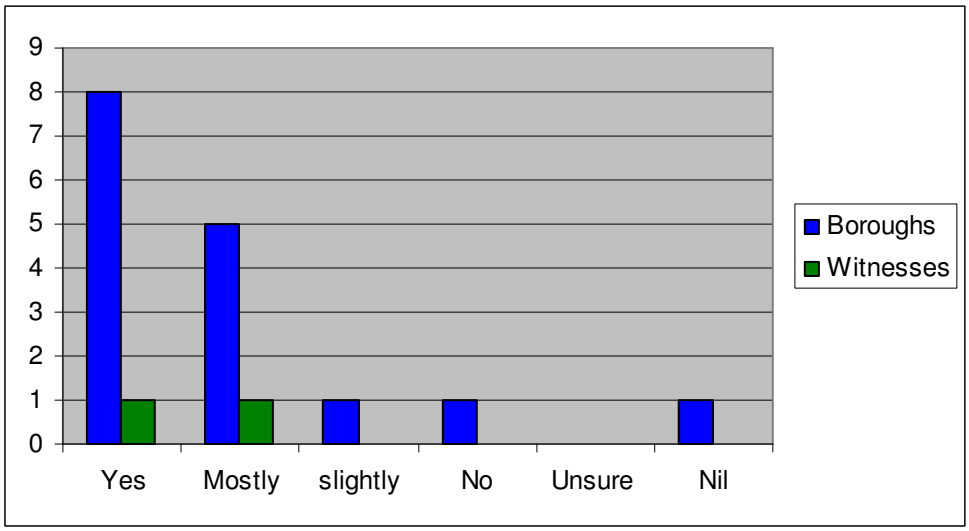
9
8
7
6
5
4
3
2
1
0
Yes
Mostly
slightly
No
Unsure
Nil
Boroughs
Witnesses

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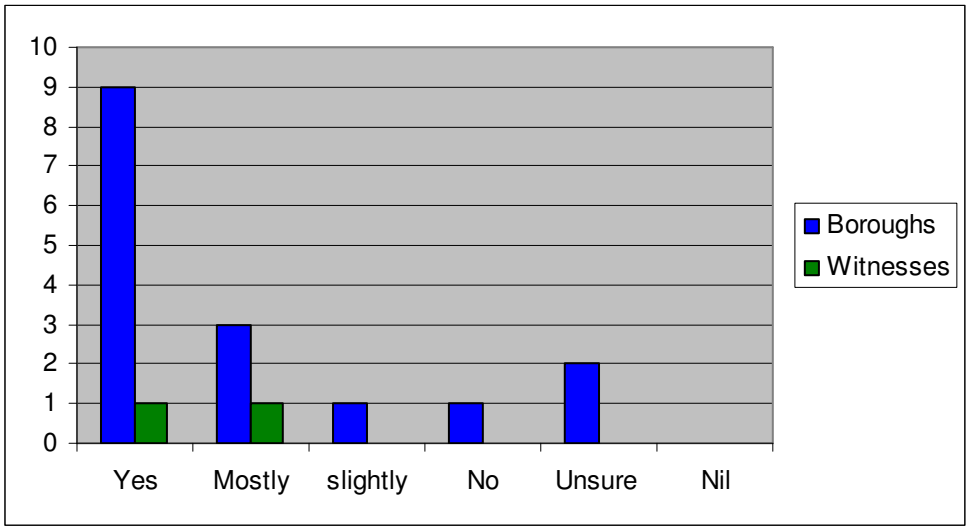
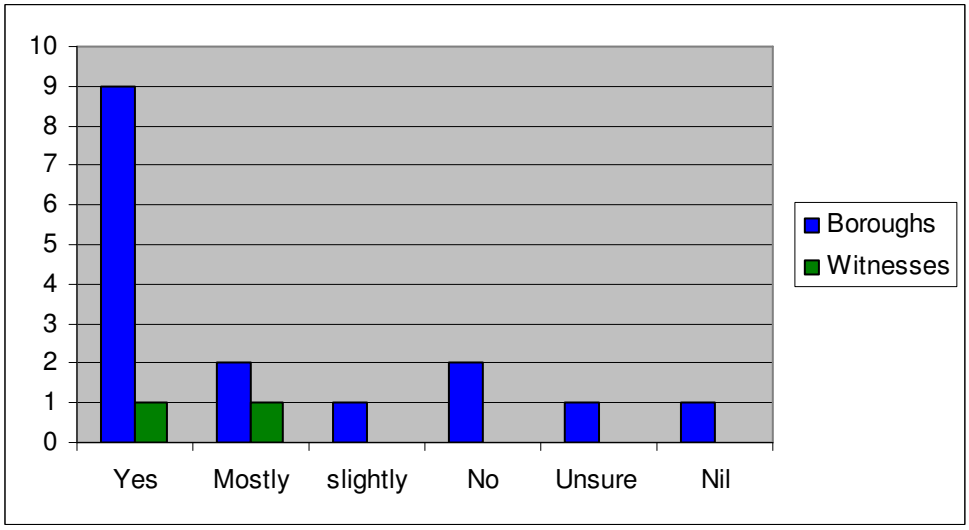
2. The Review

2.1.1 Do you believe you were given appropriate time to prepare for your attendance at the meeting?



2.1.2 Were you adequately briefed about the purpose for your attending the meeting?



2.1.3 Do you feel that you received the necessary support to participate effectively in this review?

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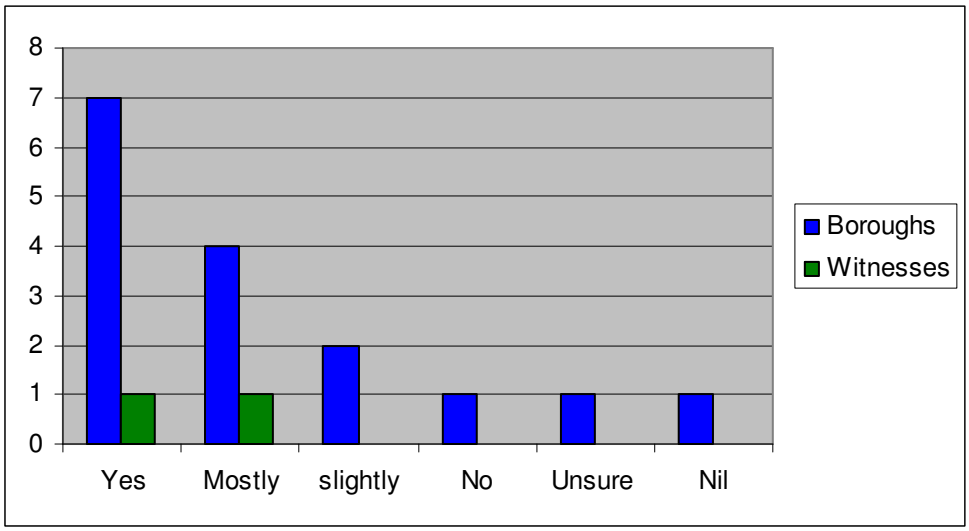
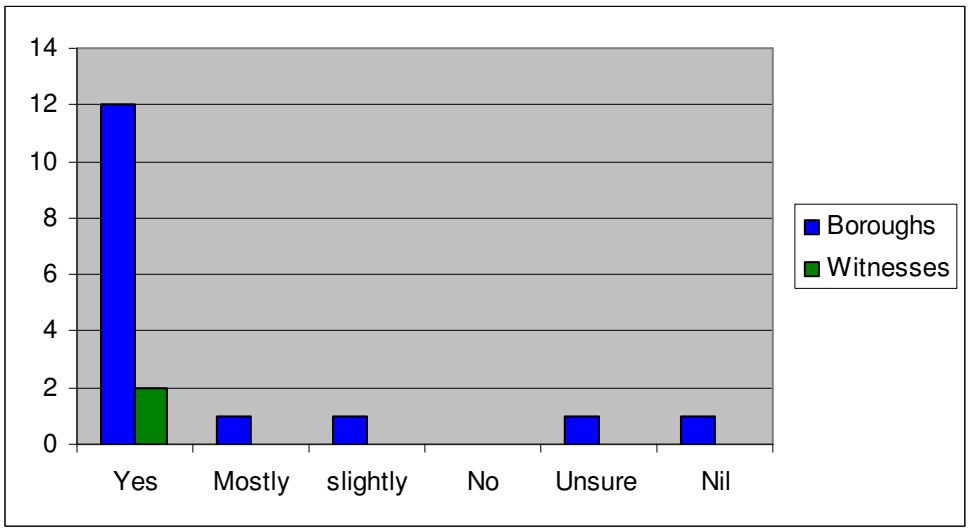
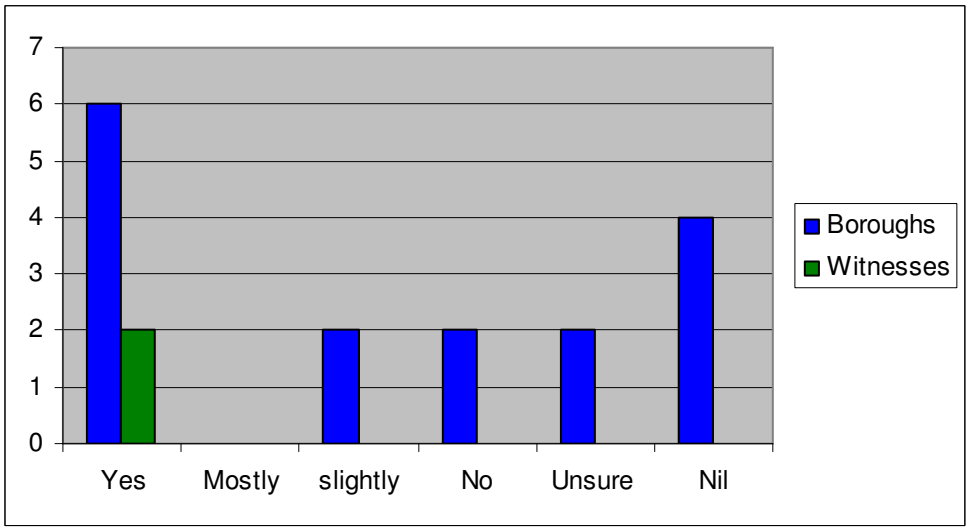


2.1.4 Do you believe that your service area was sufficiently challenged by scrutiny?



2.1.5 Do you feel like your participation in the review added value?



Overall the Chairman and Vice Chairmen consider the first Pan London Joint Health Scrutiny was a success and the feedback received was largely positive with some positive criticisms to be taken forward for the next JOSC when the

second stage of the Darzi review goes out for consultation and second Pan London JOSC is established.

A selection of some specific comments received were:

> *"Given our concerns at the outset about the logistical difficulties of setting up and running such a huge JOSC (and on a set of principles rather than actual proposed service changes) the JOSC ran remarkably smoothly. The chairing, cross-party working and officer support arrangements ran well thanks to a huge amount of goodwill from all parties concerned."*
>
> *"A very positive experience throughout."*
>
> *"Because the JOSC officer support swapped from meeting to meeting it was difficult to ensure that we received the minutes of the JOSC meeting that our expert witness attended and that we were added to the circulation list for papers and could contact the correct person to receive further information."*
>
> *"There should have been back up support to those providing lead support. There should have been more research, analysis experience into the skills mix."*
>
> *"Showed that local authorities from across London can work together. Showed to the NHS that local authorities can be constructive and not confrontational."*
>
> *"Established precedent for pan-London and hopefully durable Joint Health Scrutiny Committee. Reinforced credibility of Scrutiny on major Health issues"*

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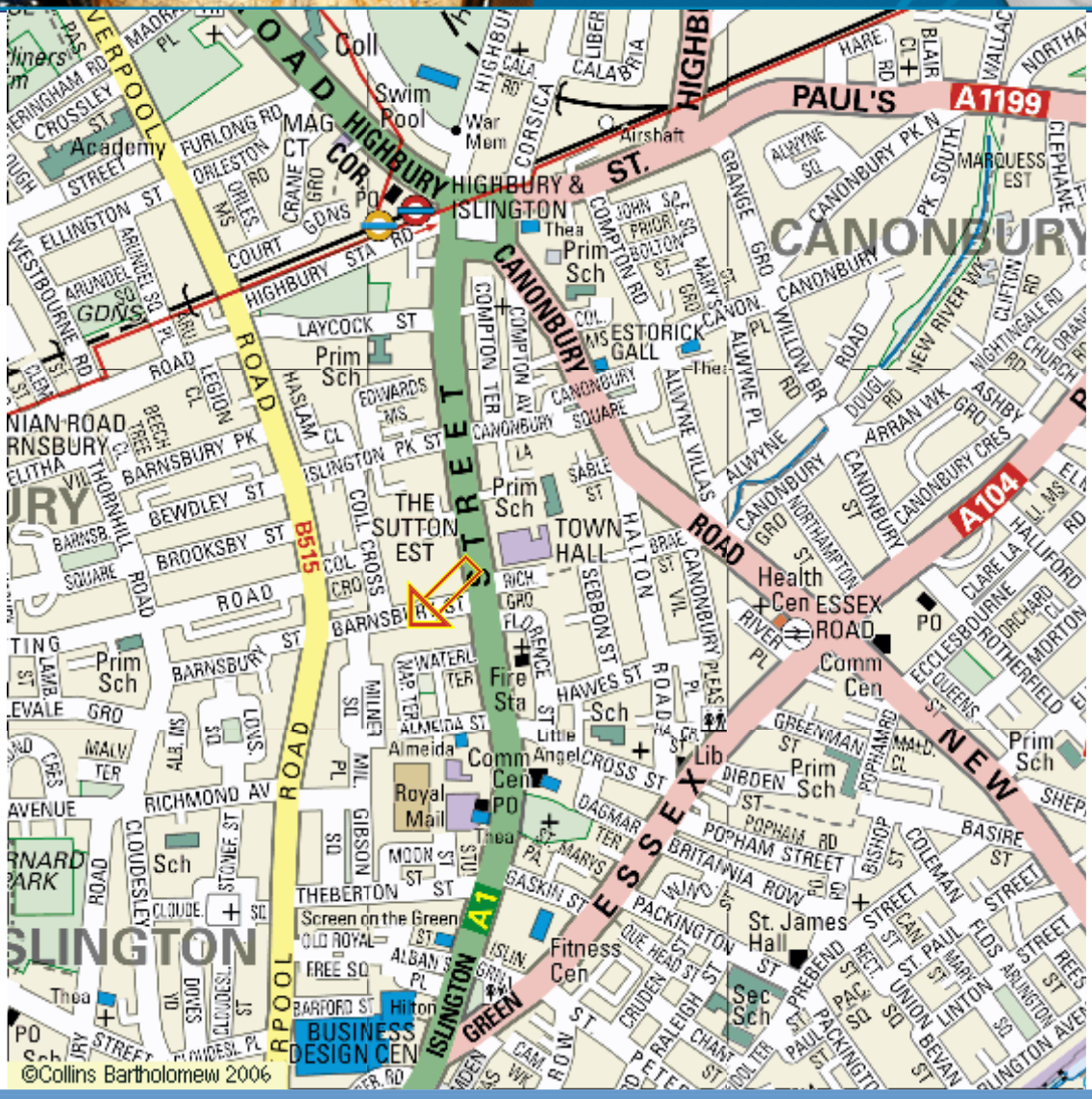
Agenda Item 8



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