Haringey Council

NOTICE OF MEETING

Special Overview and Scrutiny Committee

WEDNESDAY, 20TH OCTOBER, 2010 at 18:00 HRS - HORNSEY HEALTH CENTRE - HORNSEY HEALTH CENTRE - 151 PARK ROAD, LONDON, N8 8JD.

MEMBERS: Councillors Bull (Chair), Browne (Vice-Chair), Alexander, Basu, Ejiofor, Newton and Winskill

Co-Optees: Ms Y. Denny (church representative),1 Church of England vacancy, Ms M Jemide (Parent Governor), Ms S Marsh (Parent Governor), Ms Sandra Young (Parent Governor), Ms H Kania (LINk Representative)

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

Under the Council's Constitution – Part 4 Section B paragraph 17 – no other business shall be considered.

3. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest **and** if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct **and**/**or** if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

5. SUPPORT FUNCTIONS REVIEW (SFR) – POLICY AND PERFORMANCE FUNCTIONS (PAGES 1 - 18)

The report seeks the views of Overview & Scrutiny about the proposals to review the Council's Policy & Performance functions.

6. CARDIOVASCULAR & CANCER SERVICES - PRESENTATION (PAGES 19 - 80)

To receive a brief presentation from NHS Commissioning Support for London, and provide feedback on the cancer and cardiovascular case for change and proposed model of care.

7. CHANGING FOR GOOD (PAGES 81 - 84)

To receive a presentation from the Mental Health Trust (MHT) – Haringey on the development of Mental Health Services.

8. NHS HARINGEY UPDATE (PAGES 85 - 92)

To consider the update from NHS Haringey on matters requested by the Overview & Scrutiny Committee.

9. PRIMARY CARE TRUST MERGERS (PAGES 93 - 94)

To consider the update on Primary Care Trust (PCT) mergers.

Under the Council's Constitution – Part 4 Section B paragraph 17 – no other business shall be considered

Ken Pryor
Deputy Head of Local Democracy and Member Services
River Park House
225 High Road
Wood Green
London N22 8HQ

Natalie Cole
Principal Committee Co-Ordinator
Tel: 020-8489 2919
Fax: 020-8489 2660
Email: Natalie.Cole@haringey.gov.uk

Tuesday 12th October 2010

Agenda Item 5

Haringey Council

Agenda item:

[No.]

Overview & Scrutiny Committee **On 20 October 2010**

Report Title: **Support Functions Review (SFR) – Policy and Performance Functions**

Report of: **Stuart Young, Assistant Chief Executive People and Organisational Development**

Signed :

Contact Officer : Eve Pelekanos, Corporate Head of Policy and Performance

Wards(s) affected: **All**	Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

1.1. This report seeks the views of Overview & Scrutiny about the proposals to review the Council's Policy & Performance functions. It is recognised that staffing reorganisation reports are not ordinarily considered by O&S Committee. However in this instance the functions under review include those that provide support to the Committee. In particular therefore Members of O&S are asked for their views so that these may be included when the matter is considered at General Purposes Committee on 28th October 2010. General Purposes Committee is the appropriate body for determining staffing matters.

1.2. In February 2010 as part of the Support Functions Review (SFR), Chief Executive's Management Board (CEMB) agreed to review the organisation of the policy and performance functions within the Council. Cabinet Members endorsed proposals to create a council wide centralised shared service for the policy and performance functions.

1.3. The attached report is based on that agreement and sets out a proposed model for streamlining these functions. Cabinet Members gave a clear indication that a 50% saving is sought from this review.

2. State link(s) with Council Plan Priorities and actions and /or other Strategies:

2.1. The SFR of Policy and Performance contributes to the Council Plan priority of **'Delivering high quality, efficient services'** by ensuring that these functions are

provided in the most cost effective way.

3. Recommendations

That Members of O&S Committee:

4.1 Provide comments on the proposed centralised model for the policy and performance and the associated efficiencies.

4.2 Bring to the attention of officers any matters that they wish to be considered by the meeting of General Purposes Committee scheduled for 28th October 2010, at which time officers will recommend adoption of the revised staffing and service arrangements.

4.3 Note the timetable for delivery.

4. Reason for recommendation(s)

4.1. The new Strategic Planning and Support Unit will be key in ensuring that the council has a policy framework which meets statutory requirements and enables effective service delivery.

5. Other options considered

5.1. A range of alternate models of delivery were considered.

6. Summary

6.1. The attached report was approved by General Purposes Committee subject to a final report back to their meeting on 28th October 2010. General Purposes Committee is the appropriate body to determine staffing matters.

6.2. A formal period of consultation runs until 14th October 2010 and officers are compiling responses to the matters raised. It is anticipated that a revised set of proposals will be dispatched for the meeting of General Purposes Committee scheduled for 28th October. At the time of this cover report those revised proposals are not known, as the consultation period has yet to close.

6.3. Officers will report verbally to O&S Committee on 20th October 2010 any variations proposed to the attached report.

7. Chief Financial Officer Comments

7.1. As reported on the attached paper

8. Head of Legal Services Comments

8.1. As set out on the attached paper.

9. Head of Procurement Comments

9.1. Not applicable

10. Equalities &Community Cohesion Comments

10.1. As set out on the attached paper.

11. Consultation

11.1. As set out on the attached paper.

12. Service Financial Comments

12.1. not applicable

13. Use of appendices /Tables and photographs

Appendix 1: The proposed model for Policy and Performance

14. Local Government (Access to Information) Act 1985

14.1. Not applicable

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Haringey Council

Agenda item:

[No.]

General Purposes Committee **On 23 September 2010**

Report Title: **Support Functions Review (SFR) – Policy and Performance Functions**

Report of: **Stuart Young, Assistant Chief Executive People and Organisational Development**

Signed :

Contact Officer : Eve Pelekanos, Corporate Head of Policy and Performance

Wards(s) affected: **All**	Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

1.1. In February 2010 as part of the Support Functions Review (SFR), Chief Executive's Management Board (CEMB) agreed to review the organisation of the policy and performance functions within the Council. On 15 July 2010 Cabinet Advisory Board (CAB) endorsed proposals to create a council wide centralised shared service for the policy and performance functions.

1.2. The attached report is based on that agreement and sets out a proposed model for streamlining these functions. At Cabinet Advisory Board Members gave a clear indication that a 50% saving is expected from this review.

1.3. Members to agree the proposed centralised model for the policy and performance and the associated efficiencies.

2. Introduction by Cabinet Member (if necessary)

2.1. [click here to type]

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. The SFR of Policy and Performance contributes to the Council Plan priority of **'Delivering high quality, efficient services'** by ensuring that these functions are provided in the most cost effective way.

4. Recommendations

That Members:

4.1 Consider and agree the proposed centralised model for the policy and performance and the associated efficiencies.

4.2 Delegate authority to the Assistant Chief Executive (People & Organisational Development) to sign off amendments following formal consultation.

4.3 Note the timetable for delivery.

5. Reason for recommendation(s)

5.1. The new Strategic Planning and Support Unit will be key in ensuring that the council has a policy framework which meets statutory requirements and enables effective service delivery.

6. Other options considered

6.1. Not applicable

7. Summary

7.1. In February 2010 as part of the SFR, CEMB agreed to review the organisation of the policy and performance functions within the Council.

7.2. In recognition of the need to respond to the new national and local agendas, make efficiencies and meet the future needs of Haringey, in July CEMB and CAB, agreed that the new model for the Council's policy and performance functions will be a centralised shared service to be known as the Strategic Planning and Support Unit. It will include the functions below:

- **Strategic Planning** – policy, research, cohesion (including equalities), partnerships and scrutiny
- **Business Intelligence** – performance management and systems support, data and needs analyses, data quality and customer insight

7.3. The attached paper is based on that agreement and sets out a proposed model and associated efficiencies for streamlining these functions.

8. Chief Financial Officer Comments

8.1. The Chief Financial Officer has reviewed the proposals in this report with the author.

8.2. The current cost of this service is approximately 94% funded from LBH core and 6% external grant funding; the latter is largely all within PPP&C. Estimated

savings have been made against the current cost of provision regardless of funding source.

8.3. The costing of the proposed structure has been checked and should enable the estimated cost saving to be realised on full implementation however, the actual saving cannot be finalised until the formal consultation is completed.

8.4. The main operating costs (non-salary budget) requirement relates to training, given the need for staff to be up to date on national and regional policy, and some supplies and services in relation to production of statutory documents. A small on-cost per post will be added to the salary budget before the budgets are consolidated to ensure there is sufficient to create a viable service.

8.5. It is currently expected that the one-off costs to achieve the centralised function will be minimal and should be containable within existing budgets

9. Head of Legal Services Comments

9.1. There are no specific legal implications concerning the model to be adopted by the Council for policy and performance functions. The proposals set out in this report are ones that fall within the remit of the Council's policies concerning organisational restructuring and redeployment in respect of the implications for staff employed by the Council. Consideration should be given in order to confirm the proposals for the appropriate pools for redundancy selection and the selection criteria to be adopted. The proposals are at such a stage that statutory consultation under the provisions of Section 188 of the Trade Union and Labour Relations (Consolidation) Act 1992 should be undertaken, in addition to appropriate consultation with the employees affected by the proposals. This consultation should be carried out while the proposals are still at a formative stage and where no final decision has been made.

10. Head of Procurement Comments

10.1. Not applicable

11. Equalities &Community Cohesion Comments

11.1. An Equalities Impact Assessment of the Policy and Performance SFR has been carried out and it found no adverse effects in terms of equalities.

12. Consultation

12.1. Informal consultation has included:

- Three stakeholder workshops held during May and June 2010 to get the views of both senior officers and staff delivering policy and performance functions
- Meetings with Directors and Assistant Directors to get their views
- During the first half of July 2010 meetings with staff working in functions covered

by the scope of the review on the proposed model.

12.2. The feedback from the informal consultation has been used to develop the model described in the attached report.

12.3. Formal consultation will begin in September.

13. Service Financial Comments

13.1. not applicable

14. Use of appendices /Tables and photographs

Appendix 1: The proposed model for Policy and Performance

15. Local Government (Access to Information) Act 1985

15.1. Not applicable

Haringey Council

Appendix 1: Proposed model for policy and performance functions in Haringey

1. Introduction

In February 2010 as part of the Support Functions Review (SFR), Chief Executive's Management Board (CEMB) agreed to review the organisation of the policy and performance functions within the Council. On 15 July 2010 Cabinet Advisory Board (CAB) endorsed proposals to create a council wide centralised shared service for the policy and performance functions. The report below is based on that agreement and sets out a proposed model for streamlining these functions.

2. Background information

2.1 Responding to the new national and local agendas

To maximise our limited resources and deliver the new national and local government agendas, evidenced based strategic planning and delivery of our priorities is crucial. The key issues are:

- The increased focus on very local place shaping which requires robust strategic planning; we are still required to produce a range of evidence based statutory plans and strategies
- Whilst the Comprehensive Area Assessment (CAA) has been abolished, service inspections will continue e.g. this year the Care Quality Commission (CQC) has added additional requirements for adult social care under sections 48 and 54 of the Health and Social Care Act, through an intense programme of special reviews and studies
- There remains a requirement to complete statistical returns, and public services will be required to publish their performance in an accessible and easy to understand way
- The National Indicator Data Set, Local Area Agreements (LAAs) and Local Strategic Partnerships (locally known as the Haringey Strategic Partnership - HSP) remain
- In the last year the range of statutory needs assessments has increased e.g. Local Economic Assessment, Child Poverty Needs Assessment
- There continues to be a strong role for Overview and Scrutiny

2.2 Efficiencies

The Council has identified the need to make significant efficiencies in the period 2011- 2013 to meet an identified funding gap as set out in its Financial Strategy for 2011-2014. At Cabinet Advisory Board (15 July 2010) Members gave a clear indication that a 50% saving is expected from this review.

2.3 Meeting Haringey's future needs

The Council will be going through a number of changes in the coming months which will impact on its structure and functions. Support services will need to be able to respond and enable these changes.

3. Scope of the proposed model

3.1 Determining the scope of the review

i) Defining who does policy and performance

The following steps were taken to get the most accurate picture possible of the numbers of staff carrying out policy and performance activities across the Council:

- Consideration of the initial SFR activity analysis completed for all support functions in 2009
- Discussions were held with Directors/Assistant Directors
- Working knowledge of who undertakes policy and performance was drawn on
- Analysis of the full and most up to date list of employees from SAP to take account of the recent validation exercise

ii) Benchmarking

Research amongst other local authorities showed that the majority have opted or are opting for centralisation. The overall benefits sought are:

- A single view of policy/performance
- Holistic approach to strategic planning for outcomes
- Single point of access for business intelligence
- Flexible capacity to support services through transferable knowledge and skills
- Efficiencies

iii) Initial workshops with key stakeholders

Three stakeholder workshops were held to get the views of both senior officers and staff delivering policy and performance functions. A summary of the key attributes required from policy and performance functions is shown below:

- **Be analytical experts with high levels of capability**
- **Act as internal consultants**
- **Maintain specialist knowledge and be able to fit local service work and statistics into central picture**
- **Provide better business intelligence and analysis for the whole Council**

3.2 The proposed model for policy and performance functions

Following discussions at CAB and CEMB it was agreed that the new model for the Council's policy and performance functions will be a centralised shared service to be known as the **Strategic Planning and Support Unit.**
It will include the functions below:

- **Strategic Planning** – policy, research, cohesion (including equalities), partnerships and scrutiny
- **Business Intelligence** – performance management and systems support, data and needs analyses, data quality and customer insight

3.3 Criteria for functions to be included in the new unit

In deciding which functions should be undertaken by the new unit, a distinction is made between strategic and operational policy.

Strategic policies set out a high-level approach to an issue that is designed to deliver change.

Operational policies are defined as those providing a framework for service delivery; they enable the consistent application and interpretation of legislation and strategic policy.

Strategic policies/strategies and high level information analysis will be undertaken by the centralised function whilst operational policies and data input and processing remains within the services.

Following discussions with Directors and Assistant Directors the **criteria** below have been used to compile the list of posts to be included in this review**.**

Inclusions
Those responsible for: • Functions included in the SFR definitions of policy and performance (see Annexe 1) • Strategic statutory plans, strategies and statistical returns • Strategic non statutory plans, strategies and performance e.g. Greenest Borough Strategy and recycling data • Equalities policy and strategy • HSP support **The following areas are also included in the review:** • Information governance – it is proposed that this function is covered by the Feedback Team • Scrutiny support • Social care system development team (Framework-i)
Exclusions
Those responsible for: • The delivery of policies, plans and strategies • Operational policies, strategies and data input e.g. Organisational Development and Human Resources policies, strategies and data; IT strategy; finance • Procurement policies and strategies (as per SFR definitions) • Business Development and other support posts such as those heavily involved in admin or finance (they will be included in future rounds of the SFR) • The Local Area Agreement (LAA) and Area Based Grant monitoring officers who will become part of the Strategy Management Office • Agenda setting for thematic partnership boards – to be led by Directors' Offices as capacity remains within the services

3.4 Issues relating to the scope raised during informal consultation with staff and senior managers

During the first half of July 2010, informal consultation was carried out with staff and management on the proposed model. It has highlighted that adjustments to the scope must be considered if the new function is to work effectively and the efficiencies achieved. The following issues were raised:

- Synergy and close links need to be maintained between the performance function and systems to support the development and improvement of performance reports e.g. Framework-i, OHMS, CRM, and SAP.

  Benchmarking shows that systems support is located with performance and this will fit with the proposal to create a business intelligence capacity for the council. It is proposed that Framework-i development work is incorporated within the new Business Intelligence function as it is closely linked with social care performance management.

- The scope to include the independent investigation stage of complaints in line with the original SFR definition. A review of complaints is being undertaken separately.

- Although the original SFR definition included consultation, it has been decided that a review of this function will be undertaken separately.

4. Functions of the new Unit

The Strategic Planning and Support Unit will actively support front line services and provide the business intelligence to set strategic priorities and agree commissioning intentions. The key functions will be:

4.1 Strategic Planning

- Lead on the development of statutory and key strategic council and partnership documents e.g. Equalities Duty Scheme, Sustainable Community Strategy
- Ensure linkages between policy areas and across thematic partnerships
- Produce the Borough Profile and contribute to statutory and other needs analyses to inform strategic commissioning
- Provide guidance and work with services to ensure the Council meets its Equalities Public Duties
- Provide policy and strategy guidance and support to Directorates on operational policies, strategies and plans
- Ensure that a strategic corporate perspective is integrated within operational policies, strategies and plans
- Assist services in the preparation for inspections and statutory returns
- Provide efficient and effective support to ensure the operation of the HSP and its sub groups
- Co-ordinate research and policy support to Overview and Scrutiny
- Provide support to the Council's research governance framework

4.2 Business Intelligence

- Carry out high level trend analysis and projections to inform needs assessments, policy, commissioning and service delivery
- Establish a customer insight function
- Provide performance information and reports to Directorate Management Teams, CEMB, Members and the HSP through agreed reporting cycles
- Carry out data quality audits and challenge performance and practice where necessary and as a result trigger improvement action
- Carry out systematic and ongoing benchmarking
- Ensure improvement work is undertaken where appropriate and as agreed with services
- Input to inspections and statistical returns for the Council and HSP
- Attend meetings with regulators as required by services
- Publish performance information
- Enable the development of Framework-i to support performance management and social work practice

5. The way of working

To deliver the above functions within a much reduced capacity a different way of working is needed. The new unit will be a council-wide shared resource that will work flexibly across organisational boundaries and within a one council approach.

The key determinants to ensure the success of this approach are to:

- Agree annual Strategic Planning and Business Intelligence work plans at CEMB
- Appoint identified Officers with specialist knowledge to provide close links to services
- Enable officers to be linked to a service but with flexibility to support the Council and HSP as required
- Ensure that resource allocation to services is risk based and directed to where the Council needs to focus its efforts to improve services. The strongest resources will be allocated to the service that needs the highest level of support
- The Head of the Strategic Planning and Support Unit would be answerable to both the relevant Director as well as the Chief Executive

6. Options for consideration

6.1 The proposed model

The table below shows the current number of posts and costs, and those for the proposed model based on the recommendations from Cabinet Advisory Board requiring 50% efficiency.

Function	Current Structure		Proposed Centralised Structure		Change	
	Number of posts	Cost £	Number of posts	Cost £	% posts	% Cost
Policy	36*	1,824,881	14*	803,977	61	56
Performance	40	1,744,889	19	991,865	53	43
Total	**76**	**3,569,770**	**33**	**1,795,842**	**57**	**50**

* Excludes Scrutiny posts

There is a 57% reduction in the number of posts and a 50% reduction in cost between the current and proposed structure. A small on-cost per post will be added to the salary budget before the budgets are consolidated to ensure there is sufficient to create a viable service.

Annexe 2 shows the proposed staffing arrangements. **This shared resource will provide strategic planning and business intelligence support to the whole council and the HSP**. The Scrutiny function is included in the diagram as the resource will contribute to delivering economies of scale.

Annexe 3 provides details of the current staffing levels in each directorate which are included in the review.

6.2 Risks

The proposed model set out in this paper is a much reduced structure which will result in the need to develop and agree a detailed service offer between the Chief Executive's Service and other Directorates. The capacity of the Council to retain specialist knowledge and respond to new national and local agendas as well as ad hoc requests will be diminished. It is therefore proposed that the arrangements are reviewed within a year of implementation.

7. Proposed timetable

7.1 Next steps

An indicative timescale for the implementation of the proposed model is shown below.

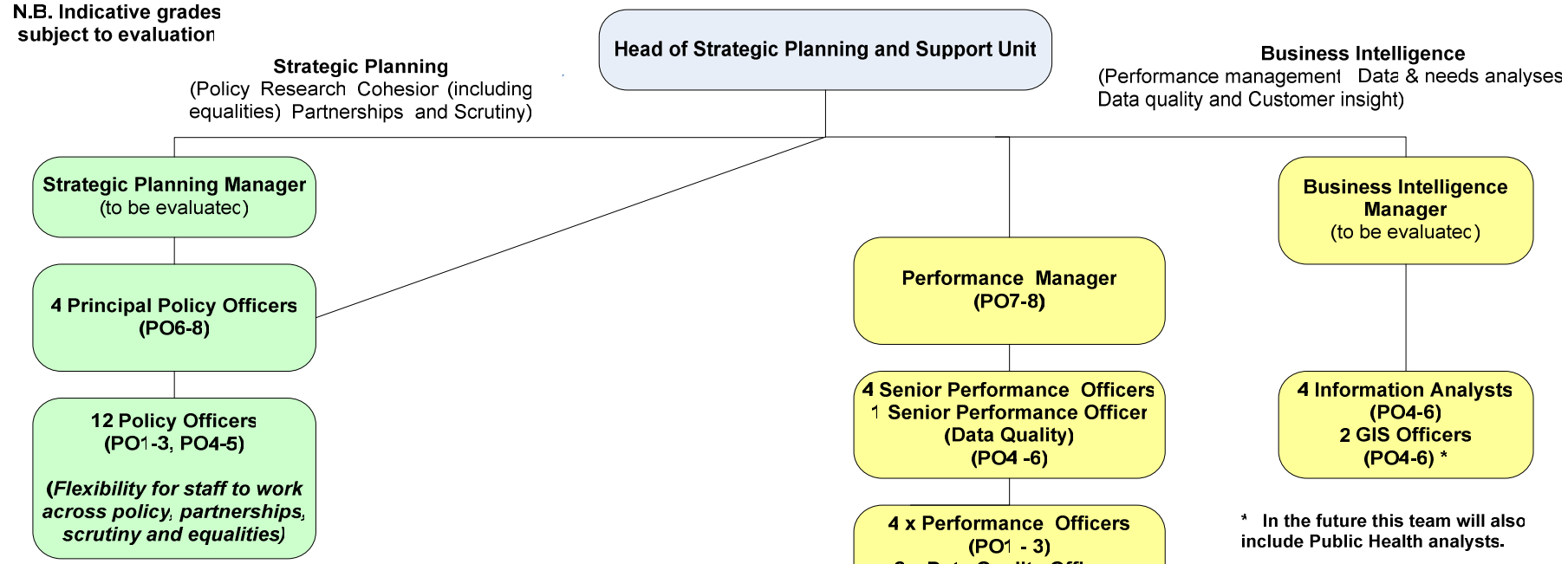
Activity	Timescale
Discussion with Directors and Assistant Directors to finalise the service offer	July – August 2010
An Equalities Impact Assessment carried out	July- September 2010
Formal consultation	From September 2010
General Purposes Committee	23 September 2010
Implementation date	March 2011
First year review of new function	March/April 2012

Annexe1: SFR Activity definitions relating to Policy and Performance

Activity	Definition
Strategy and Policy	Determining the future direction and objectives for the council and the specific policies needed to support achievement of this. Would include strategic planning and policies at a community planning, council and service level.
	Note procurement strategy is under Procurement and Commissioning. Health and Safety Strategy is included under Health and Safety.
Research and Consultation	Undertaking research and consultation activity in support of strategy and policy development.
QA, Performance Management and Improvement	Evaluation, maintenance and development of quality against standards and service performance targets and the initiation of change/improvement activities e.g. Internal process improvement teams (maybe including some internal audit), Actioning customer feedback about services including complaints, Independent reviews of services e.g. Child protection, Care Assessment, Inspection of facilities e.g. swimming pools.
	Identifying Key Performance Indicators (KPIs), Performance reporting, Comprehensive Performance Assessment (CPA)[1] process, Joint Area Review (JAR) process etc. Developing the performance management regime. This does not include staff performance management which is included under Management and Supervision.
Business Information and Reporting	Gathering, analysing, reporting and interpreting business data and performance. Includes the development of any standard / bespoke reports, trend analysis and recommendations. This is the actual collation of data rather than the decision on the information to be collated.

[1] No longer in existence

Annexe 2: Proposed staffing arrangements: Strategic Planning and Support Unit - Strategic Planning & Business Intelligence



Responsible for:

- Working with services and partners to develop cross cutting and key strategic plans and strategies
- Providing guidance and support on policy & strategy development for Council & HSP
- Developing and reviewing Equalities Policy, implementing equalities public duties and promoting cohesion
- Supporting the Haringey Strategic Partnership (HSP)
- Undertaking scrutiny reviews
- Supporting Overview and Scrutiny Committee
- Responding to Councillor Call for Action
- Undertaking Horizon Scanning / Research
- Producing service specific & cross cutting Policy Bulletin / Policy Briefings
- Supporting inspections and preparing statutory returns
- Co-ordinating responses to government consultations
- Supporting the Council's research governance framework

Responsible for:

- Producing projections and trends analyses for service demand
- Producing demographic and GIS information
- Establishing and maintaining the Data observatory
- Analysing customer insight information
- Performance Management & Reporting
- Publication of performance information including the National indicators
- Preparing statutory statistical returns
- Undertaking data quality audits
- Management & maintenance of Covalent & GIS systems
- Independent investigation of Feedback, Complaints, Data Protection, Freedom of Information, Data Governance
- Systems development & improvement of performance reports for Framework-i

Jointly produce needs assessments and Borough Profile information to underpin commissioning

Annexe 3: Current staffing levels in each directorate

	Policy	Performance
Directorate	**Number of posts**	**Number of posts**
Corporate Resources	0	0
Urban Environment	11	8
Adult, Culture and Community Services	4	5
Children and Young People Services	6	14
People and Organisational Development	1	0
Performance, Policy, Partnerships and Communication	15	9
TOTAL	**37**	**36**

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NHS

Commissioning Support for London

London cancer services:
Proposed model of care

Summary

Contents

Foreword from the project board

In some way, cancer will likely touch the lives of every person in London. With around 13,600 deaths from cancer in the capital each year and the number of new cases expected to rise, London needs world-class cancer services to meet this major challenge.

The case for change provides a compelling set of arguments for the need to improve cancer services in London. London's cancer community has developed a proposed model of care that recommends robust, clinically-led solutions to enable improvements to be made in the capital's cancer services. If adopted by London's commissioners, its recommendations would help earlier diagnoses to be made, improve inpatient care, and reduce inequalities in access to and uptake of services, all with the ultimate aims of improving patient experiences and outcomes.

The proposed model of care recommends that high quality care should be delivered by provider networks to allow the sharing of best practice and drive improvements in cancer services. It recommends that commissioners should commission services from provider networks and not necessarily from individual organisations, ensuring that pathways and best practice are standardised.

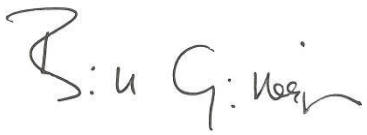
Professor Sir Mike Richards CBE, National Cancer Director has said:

"I commend all those who have been involved in the London cancer services review. The model of care sets out a forward looking approach to the early diagnosis, treatment and aftercare of Londoners with cancer. Collaborative working should be encouraged through the proposed new arrangements for provider networks. Implementation of this model of care would enable

London to acquire the world class services it deserves."

Ensuring the future availability of world-class cancer services for all Londoners is at the heart of model of care. If it were adopted by commissioners then its implementation will most certainly contribute to improving survival rates to meet the best in Europe and could translate into saving 1,000 Londoners' lives per year. Achieving earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in London and so is deserving of particular attention.

We would like to thank the many individuals and organisations that helped us develop the case for change and proposed model of care for London's cancer services through our work with primary and secondary care professionals, service users, and independent and third sector partners.



Chief Executive, Sutton and Merton Primary Care Trust and Senior Responsible Officer

Professor of Cancer Medicine at Queen Mary, University of London and Clinical Lead

Foreword from the patient panel

The patient panel was formed of patients, carers, relatives and researchers. Its two co-chairs were members of the project board, representing patients' and carers' views and championing their interests. The panel worked to ensure that the overarching issues and principles that dominated their discussions informed the cancer project board when producing the case for change and model of care documents.

Londoners expect the best quality of care. Despite areas of excellence in cancer care across London, the capital still has poorer survival outcomes than most European countries. The cancer case for change and model of care documents have shown that London scores poorly in clinical outcomes and survivorship data compared to other areas of Britain and countries in Europe.

Londoners expect an increased emphasis on public awareness about cancer symptoms and problems associated with delays in early diagnosis. Social marketing and further research should be used to analyse the best methods for engaging patients early in the diagnostic pathway or in screening programmes to improve outcomes.

To help achieve better outcomes, we acknowledge that it will be necessary to consolidate some cancer care in fewer specialist centres. This will increase travelling times for some patients, but it will improve patient care and cancer treatment outcomes. We understand that the ultimate goal is to deliver high quality of care and quality of life.

While we think that the people of London will acknowledge the need to travel further for the best specialist care, they will expect to have transport needs considered. Certain treatments make patients unwell and immunologically compromised and attempts

to alleviate problems encountered due to public transport would be invaluable.

Londoners expect to have a joined up pathway of care throughout their treatment, with care to be delivered closer to their home, where appropriate. Patients should be transferred back for ongoing or follow-up care in local providers or the community as soon as is practicable following care at the specialist centres.

Patients should be informed of all treatment options and outcomes at every stage of their journey to ensure that they are involved in shared and informed decision making.

The people of London expect a holistic approach to their care and for their carers to be acknowledged as partners in their care and to be appropriately supported with communication, information and professional help as needed.

Londoners also expect to have a designated keyworker throughout their journey. Keyworkers, often clinical nurse specialists, are crucial to achieving seamless care for patients, both in the acute setting and importantly when they return home. They prevent feelings of abandonment and act as a contact for advice and reassurance.

The members of the panel consider the invitation to contribute this foreword as an indication of the close working partnership that we have had with the cancer project board and the clinical expert groups. We thank the expert reference groups and the cancer project board members for the opportunity to engage and inform from a patient and public perspective.

We are pleased that a number of our suggestions have led to significant changes in the documents and hope that such input will have a positive impact on the patient experience. We look

forward to improvements in cancer treatment and survival for all in London.

Natalie Teich and Virginia Gorna
Co-chairs of the cancer patient panel

1. London cancer services: a proposed model of care

London's cancer community has come together to propose changes to cancer services in the capital. This document makes both a compelling argument for service change, and sets out an ambitious way forward for cancer services that will deliver better outcomes and a better experience for patients.

Documents

A thorough case for change for cancer services in the capital has been developed as well as a proposed model of care if the case for change was accepted.

The proposed model of care was developed by London's cancer clinicians and is a clinical document. Its recommendations are based on the available literature and evidence from academic sources as well as pilots and innovative initiatives. Where evidence was not available, recommendations are based on the consensus of the nationally and internationally renowned clinicians that London is fortunate to have.

Expert reference groups

Applications for involvement in the process were sought from London's cancer community and 130 were received. Three expert reference groups were formed, one for each of the three workstreams involved: early diagnosis, common cancers and general care, and rarer cancers and specialist care.

Each group consisted of 15-18 individuals from a range of professions and joint chairs were chosen from among its members. The groups met at monthly intervals and were engaged with frequently in between times, both individually and as a group, to provide further evidence and clinical input to the development of the documents.

Expert reference panel

An overarching panel was formed from the six co-chairs of the expert reference groups along with the clinical lead and other senior figures from London's cancer community. This group met monthly following the expert reference group meetings to review progress and ensure that the work of the three groups was closely aligned. Clinical experts from outside of the Greater London area were also asked to comment on the case for change and proposed model of care at intervals throughout the process.

Cancer patient panel

The patient panel included patient representatives from London's five cancer networks and other groups. The patient panel also met on a monthly basis and provided invaluable feedback on, and input into, the two documents. The two co-chairs of the patient panel also sat on the cancer project board.

Project board

The project board was chaired by the senior responsible office and its membership consisted of the clinical lead, the six co-chairs of the expert reference groups, the two patient panel co-chairs, public health and strategic representatives from NHS London, and Commissioning Support for London's executive sponsor.

Engagement

An engagement event was held in November 2009 to share and seek feedback on the draft case for change and emerging model of care. The event was attended by over 120 people, including patients and a range of clinicians and third sector organisations. The feedback from the event was fed into the project documents.

Telephone interviews were held with senior representatives of four leading cancer centres in the USA. The purpose was to gain

insights into their cancer care models, to compare them with the proposals made in this document and to consider whether anything more could be helpfully proposed for London.

2. The nature of the challenge

London's cancer services should meet the highest standards of care. Clinical management in the capital is usually provided by nationally and internationally recognised experts. However, the lack of a planned system for coordinating the delivery of services means that London cannot consistently achieve the excellence achieved in other comparable cities.

London has particular challenges and characteristics in terms of population demographics and cancer services provision.

Patient experience

Londoners have historically reported a poorer experience of cancer care when compared with other regions of England. Differences have particularly related to community and hospital services, and the interface between them.

Inequalities in access and outcomes

There is significant variation in the incidence, survival and mortality rates for cancer patients across London. The risk of being diagnosed with certain cancers is greater among the most deprived families and communities. For the majority of cancers, the most deprived patients have worse survival rates[1]. London has a high level of deprivation with 20% of wards being some of the most deprived in the country[2].

Capacity

London's cancer services provide a significant amount of cancer care, particularly for rarer cancers, to patients living outside London in Kent, Surrey and Sussex, parts of Essex and Hertfordshire, and further afield.

The incidence of cancer nationally is predicted to increase by 33% by 2022, while in London it is only expected to rise by five per cent[3].

However, these patients coming from outside London to receive treatment in the capital come from a growing population and will further increase the demand on London's services.

Workforce

High turnover, high vacancy rates, and lower labour productivity are some of London's unique workforce challenges. London doctors and nurses see relatively fewer patients than those working elsewhere in England.

Fragmentation of services

The spread of London's cancer services is the result of historical development at various hospital sites. This has taken place without a framework to consider how services could fit into an overarching system that can best serve the entire London population.

The provision of specialist services

Insufficient planning across London means services do not make the most efficient use of a limited and highly skilled workforce. As a result, Londoners have not fully benefited from advances in medical care as specialist staff, facilities and patients are spread across too many sites.

Research

The numerous high quality research active providers in London present the opportunity to support local involvement in cancer biomedical research, and increase participation in clinical trials for patients who might otherwise not have ready access to them.

3. Guiding principles of the proposed model of care

Over the last decade, considerable improvements in cancer care have been achieved in London but more needs to be done. A new model of care is needed for London's cancer services in order to improve patient experiences and treatment outcomes.

This model of care is presented to commissioners by London's cancer community as a proposal for how services should be delivered in the future. It will be for commissioners to determine how and from whom they wish to commission services on behalf of their patients.

The proposed model of care is underpinned by ten guiding principles:

1. Services should provide informed choice, quality outcomes and a high quality experience for cancer patients
2. Patients should be at the centre of services, which will be based on patient pathways and will be commissioned to meet their needs
3. Services should aim to exceed national, regional, and local care and quality standards, such as the NICE improving outcomes guidance, and national policies including the Cancer Reform Strategy[4]
4. Health services should be delivered locally where this is clinically appropriate and delivers value for money
5. Healthcare should be delivered close to home and in ambulatory care settings where possible, avoiding or reducing the need for patients to attend or be admitted to hospital
6. Services should be centralised where clinically appropriate
7. Tertiary, secondary, and primary care services should work closely together, with partners such as local authorities, to provide more cohesive and better care for cancer patients
8. Services should deliver improved outcomes for cancer patients while being productive and providing value for money for taxpayers

9. Services should meet the needs of the populations they serve and be innovative and continually evolving
10. Cancer research, both basic and clinical, should be strongly supported and fostered.

4. Networks

Cancer networks in their current form were set up following the publication of the NHS Cancer Plan in 2000[5]. There are currently five London cancer networks.

The strengths of the cancer networks should be consolidated and embedded within commissioning structures. Their weaknesses must be addressed to tackle the issues identified in the case for change.

The case for change

While significant progress has been made since 2000, considerable variation still exists in cancer services across London. Despite the efforts of the existing cancer networks, the constraints of the system in which they operate have prevented them from eliminating this variation.

The role of networks should be redefined to address three critical issues:

- The need to clarify the commissioning role of networks
- The ability of both commissioners and providers to respond to the agenda for cancer services
- The need to work in a way that is more collaborative from an NHS perspective and more coherent from a patient perspective.

To address these issues, London's cancer services should move to a model of clearly delineated commissioning arrangements and provider networks.

Commissioning networks

The role of the existing cancer network management teams should be redefined as 'cancer commissioning networks' and focus solely on supporting the commissioning of high quality services. By refocusing their role to provide support to

commission cancer services of the highest quality, the expertise of the network management teams will not be lost.
To address the problems of fragmentation highlighted in the case for change, cancer commissioning should be on the basis of patient pathways rather than individual organisations. The London Specialised Commissioning Group should continue to drive the commissioning of the rarer cancer services that need to be planned and organised across the whole population.

Provider networks

Provider networks would be groups of providers commissioned collectively to provide a comprehensive cancer service. They should:

- Be clinically led, with a governance board that will comprise representatives from each provider and a commissioning lead
- Have responsibility for delivering the specified care pathways for different tumour sites developed by clinicians and cancer commissioning teams
- Be integrated to include providers at each step of the pathway, including the community
- Function as an integrated, actively managed, single entity, taking responsibility for governance of all cancer patients within the network
- Make clinicians available to advise commissioners at all levels
- Link with high quality cancer research institutions to ensure that research is embedded with patient care.

The proposed model of care does not state the optimum future number of provider networks for the capital. Their configuration should be determined as the model of care's recommendations are implemented, particularly those regarding the consolidation of specialist surgery.

The final number of provider networks will be influenced by a number of factors, including population coverage, cancer activity, and the chance to link with existing collaborative arrangements

such as the three new Health Innovation and Education Clusters. It is expected that this will result in fewer networks than at present.

5. Early diagnosis

The earlier a cancer is diagnosed and treated, the greater a patient's chance of survival and improved quality of life. Evidence suggests that later diagnosis has been a major factor in causing the relative poorer survival rates in England compared with other European countries[6].

Achieving earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in London. Improving survival rates in England[7] to the best in Europe could save an estimated 1,000 lives per year in London.

Population awareness and understanding

Public awareness of the early signs and symptoms of cancer is poor in England. Findings suggest differences between population groups in both the level of awareness of cancer signs and symptoms, and in the public's perceived barriers to care[8].

Late presentation is a contributing factor to a more advanced stage of cancer at the time of diagnosis. Figure 1 shows evidence that patients frequently have symptoms for a considerable period of time before seeking help.

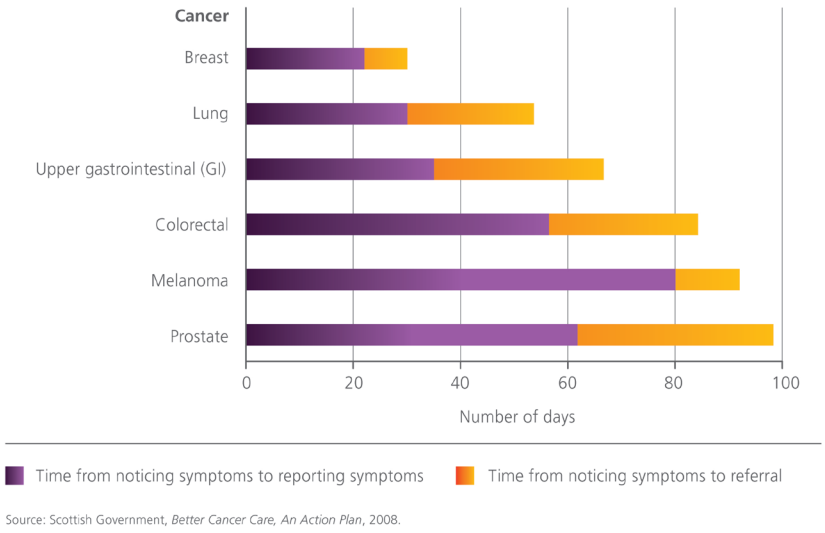
Commissioners should:

- Ensure that the initiatives of the National Awareness and Early Diagnosis Initiative (NAEDI) are implemented
- Use the Cancer Awareness Measure to assess cancer awareness levels in their local population
- Have clear strategies for improving awareness levels amongst the public and increasing early presentation.

GPs should participate in the primary care national audit of newly-diagnosed cancers to gain an understanding of any pre-diagnostic delays that take place. GPs with an interest in cancer should lead efforts to increase awareness and understanding and

therefore early diagnosis.

Figure 1: TIme from patients noticing and reporting symptoms to GPs and time from patients reporting symptoms to GP referral to secondary care.



Source: Scottish Government, *Better Cancer Care, An Action Plan*, 2008.

Referrals and accessibility of diagnostics

Cancer can be difficult to diagnose in its early stages, particularly as GPs see fewer than ten new cancer cases per year on average[9]. This can potentially lead to delays in GP investigations or referrals to a specialist.

Prompt access to appropriate diagnostics and referral to specialists is fundamental to ensure an early diagnosis of cancer.

The majority of newly diagnosed cancer patients do not come through the two-week referral route. Clear protocols are needed for acting on the receipt of abnormal results for patients who have a low suspicion of cancer.

Inappropriate urgent referrals can lead to cancer services being overloaded, causing delays for patients referred non-urgently who turn out to have cancer.

Allowing GPs rapid access to diagnostics to exclude or confirm a diagnosis of cancer will allow patients to be appropriately and accurately referred to specialist care earlier. Patients should not have long waits for these tests or their results.

The accuracy of referrals to secondary care should be improved and clear protocols for acting on the receipt of abnormal results in secondary care should be established. Specialist cancer diagnostic teams should be strengthened to expedite an accurate diagnosis.

Screening programmes

London has a lower uptake rate of NHS screening programmes than the rest of the country and national minimum targets are largely not met.

Figure 2 illustrates the lack of progress in increasing breast screening uptake in London over recent years. The national minimum target for breast screening uptake is 70%.

Figure 2: Breast screening uptake rates[10]

	2005/06	**2006/07**	**2007/08**
Number invited	271,922	285,808	279,515
Number screened	181,494	184,395	181,606
Uptake rate	61.79%	60.31%	60.54%

The evidence shows that there are a range of factors that contribute to a low uptake of screening in London:

- Lower uptake rates in areas with high levels of deprivation
- A lack of understanding by some people of the benefits of screening

- A significant number of people in hard-to-reach groups are less likely to accept their screening invites
- The transient nature of certain populations has resulted in inflated, conflicting and out-of-date patient lists
- Problems with GP catchment areas result in patients being called to screening services in the wrong borough
- There is no standard IT system to support call and recall centres.

The public should be made more aware of the benefits of cancer screening programmes. Programmes should be expanded and more widely promoted to increase rates of early diagnosis. New technology should also be introduced where appropriate to enhance screening.

Health inequalities

Factors such as age, gender, ethnicity, sexual orientation, learning disabilities and mental health problems can result in inequalities in access to, and outcomes of, cancer care.

The routine collection of patient data by ethnicity, age, gender and disability would enable commissioners to understand the uptake of cancer services. The health inequalities identified can then be addressed locally.

Questions to consider

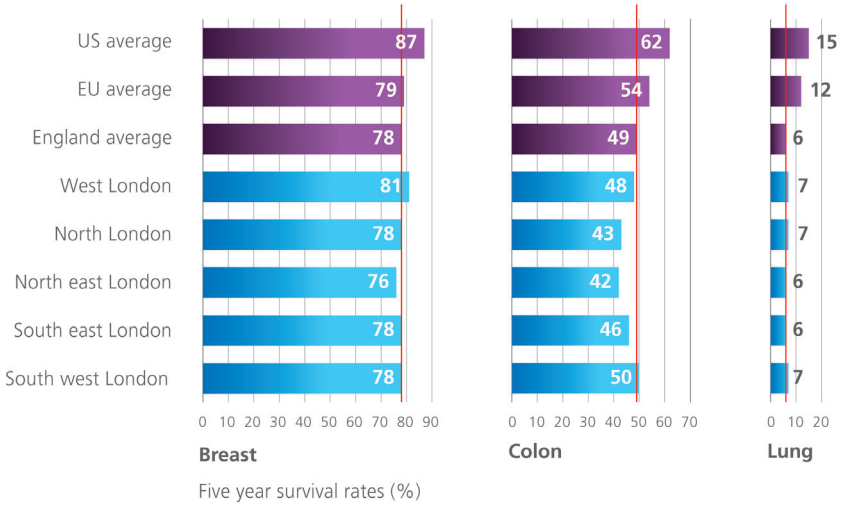
1. Do you agree with the case for change and proposed model of care for early diagnosis?
2. Do you agree that achieving earlier diagnosis has the greatest potential for improving outcomes and survival?
3. Do you have any comments on the proposals?
4. How should the proposed changes be brought about?

6. Common cancers and general care

Survival rates for common cancers in London compare unfavourably with those internationally. There is variation in the quality of care that Londoners receive for common cancers and variation in the quality of the general care that all cancer sufferers receive. This variation is in the treatment that patients receive as well as the length of time that they can expect to spend in hospital. Reducing this variation will improve both outcomes and patient experience.

Relative survival rates for three common cancers, breast, colon and lung, are shown in Figure 3.

Figure 3: London - relative survival rates for three common cancers



Source: National Statistics for Cancers diagnosed 1997-1999 and Eurocare for cancers diagnosed 1996-1999, followed up to 31 December 2004.

Clinical evidence suggests that common cancer care such as chemotherapy and patient follow-up should be provided outside of hospital settings where possible. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. All non-hospital

based services should be integrated with other services in the provider network. This would ensure that services are high quality and as safe as possible.

Common cancer surgery

Number of services

For some common cancers, a large number of London hospitals carry out surgery and the number of procedures that are carried out each year varies widely between hospitals.

An accreditation scheme should be developed that takes into account patient outcomes, the number of procedures carried out annually and other important factors that contribute to the quality of patient care. Only accredited hospitals should be commissioned to provide services.

The proposed model of care does not state an ideal number of services to provide breast and colorectal cancer. The number of providers in the capital will be determined by commissioning and patient choice, informed by cancer quality accounts and the accreditation process.

To ensure that London hospitals see sufficient number of bladder and prostate cancer patients, the number of hospitals commissioned to provide this service should be reduced from the current level of more than ten providers to five. These hospitals should seek to carry out a minimum cumulative total of 100 complex operations a year.

Evidence suggests that the best lung cancer outcomes are achieved in centres performing more than 60 procedures per year[11]. To ensure that London hospitals see sufficient patients to make this possible, the number of hospitals commissioned to provide this service should be reduced from seven to five.

Best practice

Breast cancer surgery can often be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 63% of breast surgery should be as a day case. The case for change showed that the proportion of breast procedures carried out in this way in London hospitals varied from under 20% to over 90%.

To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery. Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

The increased use of laparoscopic surgery in treating colorectal cancers has been approved by NICE but is not widely available in London hospitals, with rates ranging from under 5% to almost 50% of total colon procedures. All colorectal teams should therefore include at least one fully trained laparoscopic surgeon and non-complex colorectal cancer surgery should be available to patients locally.

Haematological and skin cancers

Some London services for patients with high-risk skin cancer, such as malignant melanoma, do not meet NICE guidelines[12]. They should be consolidated to achieve this.

In addition, some GPs undertake the diagnosis and management of low-risk skin cancers when they are not trained to do so.

Providers of care for haematological cancers in London should adopt the recommendations made by the British Society for Haematology, which includes defining the facilities and resources required to deliver haematological care of different levels[13].

Systemic anti-cancer therapy (SACT)

SACT (which includes chemotherapy) is provided predominantly in acute hospitals in London. This means that patients frequently have to travel for treatment, sometimes with considerable travel times and often when feeling unwell.

Guidelines recommend that to provide patient-centred care, inpatient delivery of SACT should be minimised[14]. To do this, satellite services should be set up and linked to a central unit in the provider network to provide more convenient treatment to patients, as long as it is safe and clinically appropriate to do so.

Radiotherapy

London providers have enough radiotherapy capacity if it is used efficiently. Inequalities of access exist, however, with wide variations in the distances that patients are required to travel for care.

There are also variations in the radiotherapy regimen given to patients across the capital and a lower proportion of patients overall receive radiotherapy compared with national recommendations[15].

Furthermore, the London Assembly has reported that waiting times in a third of London's radiotherapy providers exceed national waiting time targets[16].

These issues could be addressed by commissioning radiotherapy services on a pan-London basis. This would ensure that patient flows are managed more efficiently across London and that high safety and quality standards are in place. In this way, treatments, regimens and maximum waiting times could be standardised according to the best clinical evidence.

Multidisciplinary teams

A multidisciplinary team is made up of specialist practitioners who advise on the best care pathway for patients. Reports reveal that a significant number of London multidisciplinary teams are not compliant with NICE guidance on the requirements of these teams[17]. Provider networks should standardise multidisciplinary teams across providers to ensure that they work efficiently and effectively and that clinical time is used appropriately.

Provider networks should also ensure that patient access to a keyworker is always available through the multidisciplinary team. Patient and carer involvement has shown that this role is of vital importance for the quality of the overall patient experience.

Bed days

There is scope for radical improvement in the use of London's cancer beds. Reducing long lengths of stay will improve patient experience and have financial benefits. If all London hospitals had achieved the national average for lengths of stay in 2004/05 for all cancer patients, this would have saved 800,000 bed days or £200m[18].

The amount of time that patients spend in London hospitals after elective cancer surgery varies widely. This variation is caused by a number of factors, including the availability and quality of home and community support, the surgical techniques used, and the individual practice of clinicians.

Programmes to ensure that patients spend no longer than they need in hospital should be used across all elective cancer surgery. Less-invasive surgical techniques should be used where clinically appropriate to improve patient experience and the speed of recovery.

National guidance recommends that hospitals with emergency departments should establish teams to assess cancer patients

presenting as an emergency the moment that they arrive at hospital[19]. Currently not all London emergency departments have such teams. The development of these acute oncology services will prevent unnecessary hospital admissions, improving both patient outcomes and experience.

Follow-up and support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments.

Patients can become ill again between appointments and not feel able to see a specialist until their next scheduled appointment. Londoners should be offered individualised aftercare services based on the emerging survivorship model[20]. This method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across the capital.

Patients should be given relevant information to make an informed choice on their preferred method of follow-up.

Supportive and palliative care

NICE guidance on supportive and palliative care[21] has not yet been fully implemented in London. As a result, Londoners do not have timely access to treatments that ease their symptoms.

NICE guidance on supportive and palliative care[22] should be met across all of London. Commissioners should ensure that:

- Holistic assessments are part of the patient pathway, including an assessment of psychological needs and the support requirements of carers
- Patients are consulted on the development of a rehabilitation care plan prior to treatment
- Palliative care and rehabilitation specialists form part of all multidisciplinary teams
- Complex palliative interventions are performed at specialist centres.

Questions to consider

1. Do you agree with the case for change and proposed model of care for common cancers and general care?
2. Do you agree that some elements of cancer care should be available locally to patients?
3. Do you have any comments on the proposals?
4. How should the proposed changes be brought about?

7. Rarer cancers and specialist care

For some rarer cancers, several London hospitals are providing services for the relatively small number of cases seen in the capital each year. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice.

Improving quality and outcomes

The clinical evidence shows a positive relationship between the volume of patients that cancer services see and the outcomes that they achieve.

Higher patient volumes also improve the research environment, particularly for rarer cancers. There is evidence that cancer patients who participate in clinical trials can have better outcomes. Generally all patients treated in an environment that undertakes clinical research do better, whether or not they are part of a clinical trial.

Most NICE guidance for rarer cancers sets out minimum populations that services should serve or minimum numbers of surgical procedures that should be carried out each year. The guidance also argues that each surgical team should see a minimum number of patients each year to preserve its clinical skills.

In striving to meet this guidance, some concentration of services has occurred in London. The case for confining services to a small number of specialist centres is no longer based only on the volume and outcome relationship. Specialist centres are now seen as vital for the maintenance of a clinical environment that supports the delivery of best practice developments and fully exploits future advances in knowledge and treatments.

In order to achieve world-class services, London services should

serve optimal populations rather than just minimum populations.

Non-surgical treatment for rarer cancers

Just as the evidence suggests that surgeons should perform a minimum number of procedures a year, minimum caseloads should be set for non-surgical specialists for each rarer tumour type to ensure that their expertise is maintained.

For rarer cancers, specialist teams should be responsible for assessing patient needs and recommending care plans. Provider networks should ensure that the different aspects of these care plans can be delivered close to the patient's home where possible.

Upper gastrointestinal cancers

There has been a decline in the number of people requiring upper gastrointestinal procedures in London due to improvements in diagnostic imaging.

Not all hospitals in London are performing the number of pancreatic cancer procedures that the NICE guidelines recommend[23].

Recommendations on minimum surgeon volumes for major oesophago-gastric and hepato-pancreato-biliary (HPB) procedures have been published[24].

As well as meeting minimum surgical volumes, it is essential that all patients with upper gastrointestinal cancer are cared for by highly sophisticated clinical teams beyond surgery alone, who are working in excellent facilities, possess multi-modality cancer expertise, make a strong contribution to national and international research, and offer access to clinical trials for patients.

Primary liver cancer is rare and most liver procedures occur due to the spread of cancer from other sites. The National Liver Plan

recommends that patients with primary liver cancer are managed in centres that offer all treatment options or have appropriate relationships to ensure that there is good local provision[25].

To create the best clinical environment for upper gastrointestinal cancer patients, London should commission:

- Four oesophago-gastric surgery providers
- Three integrated pancreas and liver (HPB) providers

While transplantation is only an option in a small minority of liver cancer patients, those who may be suitable for a transplant should be referred to a transplant unit as early as possible to be assessed.

Rarer urological cancers

London has the right number of hospitals providing services for testicular and penile cancer and these services meet the NICE requirements[26].

Some services are dependent on too small a number of surgeons. To ensure the best patient outcomes and experience, rarer urological services should have all of the requirements of a high quality service, such as 24-hour access to interventional radiology, appropriate consultant cover, and resident surgical juniors.

Provider networks should ensure that hospitals with general urology services are able to refer patients with complex needs to specialist urology teams promptly.

Head and neck cancers

NICE guidance stipulates that head and neck services should serve populations exceeding one million. All surgery should be provided by a specialist team in a designated centre, and surgeons and their teams should manage a minimum of 100 new cases a year[27].

While services in London have made progress towards these requirements, they have not been met by all hospitals providing a head and neck service.

In order to improve outcomes, and because of the number of different specialties involved in caring for head and neck cancer, the number of hospitals commissioned to provide services in London should reduce from eight to five. These five surgery providers should deal with both upper aero-digestive tract (UAT) and thyroid cancers.

Base of skull and pituitary tumours are rarer than other head and neck cancers. To ensure that teams see the right number of patients to maintain their skills and expertise these services should be provided in two hospitals, both of which should be in the same hospital as a head and neck service.

NICE guidance[28] also states that local community based rehabilitation teams must be provided for head and neck patients. In London, these are in various stages of development and their creation should be expedited to ensure that patients receive the rehabilitation that they require.

Brain and central nervous system (CNS) cancers

Although London's brain and CNS services meet the current NICE requirements, services elsewhere in the country support significantly larger populations. In addition, revised national guidance is expected to increase the recommended populations that should be served.

The number of brain and CNS cancer surgical service providers commissioned should therefore be reduced from seven to four. These should be in a major hospital with acute services including neurosurgery, and neuro-oncology services should also be located on these sites. Two of these hospitals should have specialist spinal cord teams and these should also be collocated

with the two centres that are recommended to provide base of skull and pituitary tumours.

Supportive care and rehabilitation for brain and CNS cancer services are of key importance and are not available across London. Rapid access to appropriate neuro-rehabilitation closer to home should be offered to support patients and aid their recovery.

Gynaecological cancers

While progress has been made in implementing NICE guidance[29], fewer services in London managing higher volumes of patients would allow more effective use of specialist resources. The number of specialist gynaecological surgical services commissioned should therefore be consolidated from six hospitals to five.

There is variation in the average length of stay following gynaecological procedures at hospitals in London and Londoners with gynaecological cancer are not always offered access to supportive care and reproductive medicine consultations. A minimally invasive approach and programmes to reduce unnecessary time in hospital should be offered to patients. Patients should also be offered access to supportive care services, which should address quality of life issues, including preservation of fertility.

Sarcoma

The two sarcoma centres in London see the number of patients a year that is required in the NICE guidance[30] and therefore no change to the number of hospitals is recommended.

The communication between sarcoma services and other teams treating the parts of the body where sarcomas may occur is not always good. This means that patients may not be referred to a sarcoma centre where they would be managed

most appropriately. Protocols should be developed by provider networks to ensure effective links between sarcoma services and these other teams.

Haematopoietic progenitor cell transplantation

Haematopoietic progenitor cell transplantation (a type of bone marrow transplant) is currently delivered by eight providers in London. Some of these hospitals are not seeing sufficient patient numbers and therefore services should be consolidated to five providers, each undertaking a minimum of 100 new cases per year.

Specialist care

To treat the most complex cancer cases, clinicians require a range of diagnostic and treatment equipment to be available in one place. This means locating sophisticated equipment in centres employing experienced staff with all of the relevant expertise. These centres must be set up to see enough patients to justify the technology's cost.

In addition, a centralised commissioning and planning structure should be established in London for specialist radiotherapy, with technologies concentrated in specialist centres where appropriate.

Questions to consider

1. Do you agree with the case for change and proposed model of care for rarer cancers and specialist care?
2. Do you agree that consolidating very specialist, low volume cancer services into fewer hospitals would help achieve high quality patient care and improved outcomes?
3. Do you have any comments on the proposals?
4. How should the proposed changes be brought about?

8. Patient experience

The cancer patient panel proved invaluable in ensuring that the patient experience was kept central to the development of the proposals. The patient panel developed a generic patient pathway diagram to summarise some of the key recommendations of the proposed model of care in an accessible way.

The care pathway diagram in Figure 4 sets out the various parts of the pathway. It outlines some of the key factors that influence patient experience that the patient panel discussed: the centrality of the keyworker and carer support, the survivorship agenda, and care plan assessment. The patient panel felt it was important that patients could exercise choice at each step of the pathway.

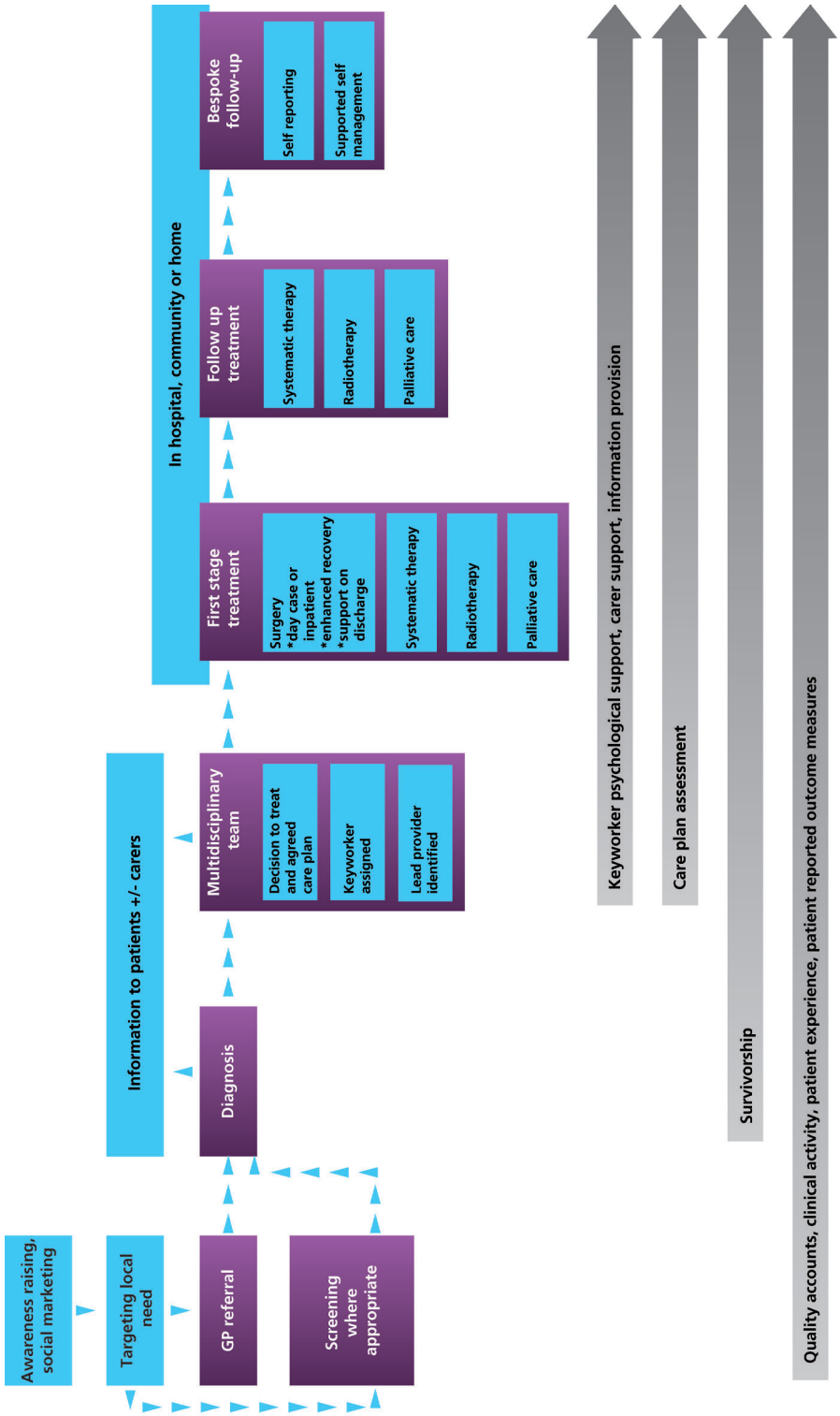


Figure 4: Cancer patient panel pathway diagram

9. Enablers

If it were adopted by commissioners, this proposed model of care would require significant changes in the way that cancer services in London are commissioned and delivered. Implementing it would require the harnessing of a number of enablers for change.

Strong commissioning will be at the core of cancer services in London. Commissioners will commission on the basis of high quality patient pathways. Cancer commissioning will be informed by clinical, patient and carer engagement.

This model would require significant change in commissioning structures and organisational cultures. New contracting arrangements would need to be made to reflect these changes.

Incentives should be in place to foster appropriate collaborative behaviours and shared working. Providers should be encouraged to offer the highest quality care by linking increases in payment to specific quality goals.

The collection and publication of high quality performance information is integral to the success of this proposed model of care. London's provider networks should publish consolidated cancer quality accounts including a wide range of patient satisfaction measures.

London's NHS should use an accreditation process and publication of cancer quality accounts to help implement the recommendations in this proposed model of care, drive up quality, and inform commissioners, patients and the public.

The implementation of this proposed model of care must have the same level of clinical leadership that its development has had.

Provider networks should consider using formal partnership models to support the sharing of learning and standardisation of services.

While some aspects of this proposed model of care are based on collaboration, patient choice and contestability should be retained to drive up quality.

Research should be fully integrated with clinical care to provide the highest quality cancer care possible for Londoners. One of the key roles of the provider networks will be to disseminate best practice where there is innovation in service provision.

Improved information technology will be crucial in ensuring that patients experience seamless services, while being seen in the most appropriate settings within the network.

Commissioners should ensure services are in place to give all patients, families and carers the appropriate support at all stages of the care pathway.

Delivering care in the future in the most appropriate settings will require a programme of disinvestment in current models of care and reinvestment in new ones, together with changes in workforce.

Current providers will need to work together, and across commissioning boundaries, to achieve the optimal and affordable use of estates and facilities.

Implementation should be informed by international best practice. Initial input from four leading centres in the USA shows that they are very much in broad agreement with the proposals made in the proposed model of care.

Questions to consider

- Do you agree that these are the key enablers of the proposed model of care?
- Do you have any comments on the enablers?

10. Cancer co-dependencies

To support the implementation of the recommendations in the proposed model of care, a framework of the co-dependencies between certain cancer services was developed by the clinical expert reference groups.

Consolidating specialist surgery

The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This would ensure that clinical environments are in place to provide high quality care and improved outcomes for Londoners. These recommendations are summarised in Figure 5.

Figure 5: Number of sites recommended for cancer services in London

Specialist cancer service	Proposed number of sites in London
Specialist penile cancer surgery	2
Sarcoma surgery	2
All oesophago-gastric cancer surgery	4
All pancreatic cancer surgery	3 (operating as HPB centres)
Specialist testicular cancer surgery	3
All brain and CNS cancer surgery	4
All liver cancer surgery	3 (operating as HPB centres)
Lung cancer surgery	5
Specialist head and neck cancer surgery	5
Specialist bladder and prostate and renal surgery	5
Specialist gynaecological cancer surgery	5
HPC transplants	5
Colorectal cancer surgery	Undefined number of sites
Breast cancer surgery	Undefined number of sites

Cancer co-dependencies framework

As the proposed model of care makes recommendations for each tumour type as a separate entity, a further piece of work was needed to identify the co-dependencies between services for different cancers.

The purpose of the cancer co-dependencies framework is to establish a clear, clinically agreed and robust statement of the dependencies for specialist cancer services. The full framework

and supporting information is published as a supporting document to the proposed model of care.

The framework looks only at dependencies for specialist cancer surgery and bone marrow transplant. Non-surgical cancer treatment modalities are not included in the framework. However, any commissioning decisions regarding future services should take into account dependencies with these other treatment types.

The co-dependencies framework is intended to assist commissioners in planning any future service configurations. It can also be used by commissioners and providers as a benchmarking tool against the current provision of services.

Developing the framework

The framework identifies the collocation of different services required to achieve world-class care. Two levels of dependency are identified in the framework:

- An optimal service collocation (dependent relationship), where collocation should be on the same hospital site
- A desirable service collocation (moderately dependent relationship), where, if possible, collocation should be on the same hospital site, or otherwise in the same trust

When deciding on the levels of dependency of services the following factors were considered:

- Clinical dependency: is the collocation of services required to deliver a safe service?
- Patient experience: will the collocation of services result in fewer transfers, reduced lengths of stay and improved patient experience?
- Effective use of resource and financial efficiency: will collocation use available resources more effectively, result in economies of scale, and reduce duplication?
- Optimal level of service: will service collocation improve service delivery?

Collocation of services

As well as a large number of desirable service collocations, the following optimal service collocations are identified:

- All specialist cancer services with the general service for that body part (for example, specialist lung cancer surgery has a dependency with thoracic surgery)
- Liver cancer surgery with pancreatic surgery
- Pancreatic cancer surgery with liver surgery
- Specialist gynaecological cancer surgery with bladder and prostate surgery
- Soft tissue sarcoma (for the provider of retroperitoneal sarcoma surgery only) with oesophago-gastric surgery, bladder and prostate and renal surgery (specialist urology)

Considering the optimal service dependencies in the cancer co-dependencies framework and the recommendations of the proposed model of care, there are three groups of services where collocation is recommended:

- Service grouping 1: specialist gynaecological, and specialist prostate and bladder and renal cancer surgery (where the model of care recommendation to confine management of renal cancer to prostate and bladder specialist teams is implemented)
- Service grouping 2: liver cancer surgery and pancreatic cancer surgery
- Service grouping 3: specialist UAT cancer surgery, base of skull and pituitary cancer surgery, brain and CNS surgery, and spinal cord surgery (where the model of care recommendation to have specialist UAT teams manage malignant thyroid tumours is implemented).

Several specialist services then have moderate dependencies with services in more than one of the above groupings.
For example, soft tissue sarcoma surgery has a moderate dependency with colorectal, gynaecology and UAT surgery.

Therefore, where possible, these three groupings of services could be helpfully collocated with each other.

Taking into account all the moderate service dependencies, with the exception of breast cancer surgery, skin cancer surgery, penile cancer surgery, and HPC transplants where there are no service dependencies identified in the framework, all specialist services listed would benefit from collocation.

Implications of the framework

The cancer co-dependencies framework is a clear, clinically agreed and robust statement of the dependencies for specialist cancer surgery services. It establishes that as far as is possible, these services should be collocated on the same hospital site.

Configuration of specialist services in London to meet just the optimal dependencies identified would result in some consolidation of services, but fragmentation would remain with multiple sites delivering specialist surgery services across the capital.

Configuration to meet both optimal and moderate co-dependencies would result in the creation of a small number of comprehensive cancer centres, a model that is used internationally to provide the best possible outcomes for patients.

11. Financial assessment

Improving early diagnosis will require a limited investment from commissioners. The level of this investment will reflect the success in raising awareness of cancer symptoms, improving the effectiveness of screening programmes, and improving referrals and access to diagnostics.

The recommended changes to care pathways will reduce the time that patients spend in hospital and improve follow-up care, reducing costs to commissioners.

The complexities of identifying cancer-related costs preclude the full costing of each item in the proposed model of care. The financial assessments that have been made are therefore intended to indicate the cost or saving that would result from the changes proposed. The high-level analysis is published as a supporting document to the full model of care.

The proposed model of care reemphasises a number of recommendations made in the Cancer Reform Strategy[31] and other national recommendations so the costs do not result solely from the implementation of the model of care.

The proposed model of care emphasises that the achievement of earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in London. Investment in this area has the potential to increase the early detection of cancer and save the lives of 1,000 Londoners a year. To offset this investment, savings can be made through the commissioning of best practice pathways.

In summary, Figure 6 outlines the pan-London financial impacts of the proposed model of care.

Figure 6: Impact of the proposed model of care

Year 1	Commissioners			Providers		
	Low	Medium	High	Low	Medium	High
	£m	£m	£m	£m	£m	£m
Provider networks	0.0	0.0	0.0	-0.6	-1.2	-1.8
Early diagnosis	-3.0	-8.9	-14.8	3.0	8.9	14.8
Providers marginal costs	0.0	0.0	0.0	-2.1	-6.2	-10.4
Screening costs	-0.3	-0.5	-0.8	-0.8	-1.2	-1.7
Common and rare cancers	0.0	0.0	0.0	0.0	0.0	0.0
Non-surgical treatments and general care	1.6	2.9	4.2	-0.5	1.1	2.7
Total	-1.7	-6.5	-11.4	-1.0	1.4	3.7

Year 2	Commissioners			Providers		
	Low	Medium	High	Low	Medium	High
	£m	£m	£m	£m	£m	£m
Provider networks	0.0	0.0	0.0	-0.6	-1.2	-1.8
Early diagnosis	-1.5	-5.9	-10.3	1.5	5.9	10.3
Providers marginal costs	0.0	0.0	0.0	-1.1	-4.1	-7.2
Screening costs	-0.3	-0.5	-0.8	-0.8	-1.2	-1.7
Common and rare cancers	0.0	0.0	0.0	0.0	0.0	0.0
Non-surgical treatments and general care	1.6	2.9	4.2	-0.5	1.1	2.7
Total	-0.2	-3.5	-6.9	-1.4	0.5	2.3

12. A new way of delivering care

With around 13,600 deaths from cancer in the capital each year and the number of new cases expected to rise, London needs world-class cancer services to meet this major challenge.

London's cancer community has built a compelling case for change, and now puts forward this proposal for a future model of care to London's commissioners.

Achieving the recommendations for earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in London. It will go some way to improve survival rates to meet the best in Europe and could translate into saving 1,000 Londoners' lives per year.

The case for change provides a compelling argument for the improvement of cancer services in London. The proposed model of care outlines robust, clinically-led solutions that would ensure that improvements are made in London's cancer services. These improvements would enable earlier diagnoses to be made, improve inpatient care and reduce inequalities in access to and uptake of services.

Commissioning for cancer should be on the basis of care pathways. High quality care should be delivered by networks of providers to allow the sharing of best practice and drive improvements in cancer services. If they were adopted by commissioners, the implementation of these changes will challenge many aspects of the way the NHS has worked in recent years. Success would largely depend on the willingness of the individuals and organisations in London to make these arrangements work.

Acknowledgements

Project board members

- Bill Gillespie (Chair), Chief Executive – Sutton and Merton PCT, Senior Responsible Officer – Commissioning Support for London Cancer Project
- Dr Andy Mitchell, Medical Director – NHS London
- Hannah Farrar, Director of Strategy and System Management – NHS London
- Jane Moore, Associate Regional Director of Public Health – NHS London
- Other project board members denoted by * below

Expert reference panel

- John Toy (Chair), Professor of Cancer Medicine – Institute of Cancer, Queen Mary, University of London, Clinical Lead*
- Mike Bellamy, Director of the cancer peer review programme for London, National Cancer Action Team
- Adrian Brown, Public Health Consultant – NHS Westminster. Co-chair of the early diagnosis expert reference group*
- Shelley Dolan, Chief Nurse – The Royal Marsden NHS Foundation Trust. Co-chair of the rarer cancers expert reference group*
- Martin Gore, Medical Director – The Royal Marsden NHS Foundation Trust, Professor of Cancer Medicine – The Institute of Cancer Research, London
- Nigel Heaton, Consultant Liver Transplant and HPB Surgeon – King's College Hospital NHS Foundation Trust, Professor of Liver Transplant, Hepato-biliary and Pancreatic Surgery – King's College, London. Co-chair of the rarer cancers expert reference group*
- Celia Ingham-Clark, Consultant Colorectal Surgeon and Medical Director – The Whittington Hospital NHS Trust
- Alison Jones, Consultant Medical Oncologist – University College London Hospitals NHS Foundation Trust and Royal Free Hampstead NHS Trust. Co-chair of the common cancers

expert reference group*
- Adrian Newland CBE, Professor of Haematology – Queen Mary, University of London, Medical Director – North East London Cancer Network. Co-chair of the common cancers expert reference group*
- Sarah Vinnicombe, Consultant Radiologist – Barts and the London NHS Trust, Director – Central and East London Breast Screening Service. Co-chair of the early diagnosis expert reference group*

Expert reference group for early diagnosis
- Adrian Brown (Co-chair), Public Health Consultant – NHS Westminster
- Sarah Vinnicombe (Co-chair), Consultant Radiologist – Barts and the London NHS Trust, Director – Central and East London Breast Screening Service
- Nigel Beharry, Consultant Radiologist – St George's NHS Healthcare NHS Trust
- Cathy Burton, General Practitioner – Guy's and St Thomas' NHS Foundation Trust / South East London Cancer Network
- Ian Fentiman, Professor of Surgical Oncology – Guy's and St Thomas' NHS Foundation Trust
- Jessica Hancox, Lead Cancer Nurse – Imperial College Healthcare NHS Trust
- Iona Heath CBE, General Practitioner – Camden PCT, President of the Royal College of General Practitioners
- Tuck-Kay Loke, Consultant Respiratory Physician – Mayday Healthcare NHS Trust
- Cyprian Okoro, Consultant in Public Health Medicine – NHS Ealing, Honorary Senior Lecturer – Imperial College Medical School
- Evelyn Smith, Clinical Nurse Specialist – South West London Breast Screening Service, St George's Healthcare NHS Trust
- Ian Smith, Consultant Medical Oncologist – The Royal Marsden NHS Foundation Trust, Professor of Cancer Medicine – The Institute for Cancer Research, London

- Philip Wilson, Consultant Histopathologist and Clinical Director for Diagnostics – St George's Healthcare NHS Trust
- Robin Wilson, Consultant Breast Radiologist – The Royal Marsden NHS Foundation Trust

Expert reference group for common cancers and general care

- Adrian Newland (Co-chair), Professor of Haematology – Queen Mary, University of London, Medical Director – North East London Cancer Network
- Alison Jones (Co-chair), Consultant Medical Oncologist – University College London Hospitals NHS Foundation Trust and Royal Free Hampstead NHS Trust
- Muti Abulafi, Consultant Colorectal Surgeon – Mayday Healthcare NHS Trust
- Tony Brzezicki, General Practitioner – Croydon PCT
- Lallita Carbello, Nurse Director – North London Cancer Network
- David Cunningham, Professor of Cancer Medicine – Institute of Cancer Research, Consultant Medical Oncologist – The Royal Marsden NHS Foundation Trust
- Mark Emberton, Consultant Urologist and Clinical Director for Cancer Services – University College London Hospitals NHS Foundation Trust
- Ian Grant, Consultant Haematologist and Lead Clinician for Cancer Services – Barking, Havering and Redbridge University Hospitals NHS Trust
- Jane Head, Head of Radiotherapy – Barts and the London NHS Trust
- Elizabeth Hadley, Consultant Physician, Respiratory and General Medicine – Barking, Havering and Redbridge University Hospitals NHS Trust
- Majiid Kazmi, Consultant Haematologist and Deputy Clinical Director, Oncology and Haematology – Guy's and St Thomas' NHS Foundation Trust
- Jane Maher, Consultant Clinical Oncologist – Hillingdon

Hospital NHS Trust and Mount Vernon Cancer Centre, NHS Improvement Lead for Cancer Survivorship
- Jan Morrison, Macmillan Lead Cancer Nurse and Breast Care Nurse – Kingston Hospital NHS Trust
- Clare Phillips, Consultant Physician in Palliative Care – Barts and the London NHS Trust, Clinical Lead for Cancer – Newham University Hospital NHS Trust
- Arnie Purushotham, Professor of Breast Cancer – King's College London, Director Integrated Cancer Centre – Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust
- Anne Rigg, Consultant Medical Oncologist – Guy's and St Thomas' NHS Foundation Trust
- Jacky Turner, Lead Network Oncology Pharmacist – Guy's and St Thomas' NHS Foundation Trust and South East London Cancer Network

Expert reference group for rarer cancers and specialist care
- Nigel Heaton (Co-chair), Consultant Liver Transplant and HPB Surgeon – King's College Hospital NHS Foundation Trust, Professor of Liver Transplant, Hepatobiliary and Pancreatic Surgery – King's College, London
- Shelley Dolan (Co-chair), Chief Nurse – The Royal Marsden NHS Foundation Trust
- Kim Ainsworth, Allied Health Lead – North East London Cancer Network
- Keyoumars Ashkan, Consultant Neurosurgeon – King's College Hospital NHS Foundation Trust
- Sian Davies, Consultant Clinical Oncologist – North Middlesex University Hospital NHS Trust
- Claire Dearden, Consultant Haemato-oncologist – Royal Marsden NHS Foundation Trust, Director – South West London Cancer Network
- Mark Glaser, Consultant Clinical Oncologist and Chief of Service for Clinical and Medical Oncology – Imperial College Healthcare NHS Trust

- George Hanna, Professor of Surgical Sciences and Consultant Oesophago-gastric Cancer Surgeon – Imperial College Healthcare NHS Trust
- Suzanne Harrow, Head of Radiotherapy – Imperial College Healthcare NHS Trust
- Sarah Henderson, Urology Clinical Nurse Specialist – St George's Healthcare NHS Trust
- Nicholas Hyde, Consultant Maxillofacial/Head and Neck Surgeon – St George's Healthcare NHS Trust
- Fiona Lofts, Consultant Medical Oncologist and Care Group Lead – St George's Healthcare NHS Trust
- Adeola Olaitan, Consultant Gynaecological Oncologist (Surgical) – University College London Hospitals NHS Foundation Trust

Cancer patient panel

- Natalie Teich (Co-chair), Representative – Commissioning Support for London Patient and Public Advisory Group*
- Virginia Gorna (Co-chair), Patient representative – West London Cancer Network*
- Barbara Gallagher, Patient representative – South West London cancer network
- Bonnie Green, Representative – Commissioning Support for London Patient and Public Advisory Group
- Mary McNulty, Representative – Commissioning Support for London Patient and Public Advisory Group
- Beryl Pankhurst, Representative – Commissioning Support for London Patient and Public Advisory Group
- Carole Rawlinson, Patient representative – North London Cancer Network
- Mary Sexton, Representative – Commissioning Support for London Patient and Public Advisory Group

London cancer network leads

- Alastair Whitington, Network Director – South East London Cancer Network*

- Timothy Jackson, Nurse Director – South East London Cancer Network
- Charlotte Joll, Network Director – South West London Cancer Network
- Jo Champness, Associate Director – South West London Cancer Network
- Karen Gaunt, Associate Director – South West London Cancer Network
- Alison Hill, Nurse Director – South West London Cancer Network
- Fiona Bonas, Network Director – West London Cancer Network
- Carolyn Garritt, Deputy Director – West London Cancer Network
- Josephine Archer, Nurse Director – West London Cancer Network
- Chris Ward, Network Director – North London Cancer Network
- Lallita Carbello, Nurse Director – North London Cancer Network
- Bob Park, Network Director – North East London Cancer Network
- Paul Trevatt, Nurse Director – North East London Cancer Network
- Ursula Peaple, Acting Lead Rare Cancers – London Specialised Commissioning Group, Programme Manager Young People with Cancer – London and South East Coast Specialised Commissioning Groups

Other contributors

- Alan Burnett, Professor of Haematology – Cardiff University School of Medicine
- Kathie Binysh, Medical Director – West London Cancer Network
- Richard Charnley, Consultant Hepatobiliary and Pancreatic Surgeon – The Newcastle upon Tyne Hospitals NHS

Foundation Trust
- Peter Clark, Professor of Medical Oncology – Clatterbridge Centre for Oncology NHS Foundation Trust, Co-chair of the National Chemotherapy Advisory Group (NCAG)
- Jessica Corner, Head of School of Health Sciences – University of Southampton
- Sean Duffy, Medical Director – Yorkshire Cancer Network
- Paul Finan, Consultant Colorectal Surgeon – Leeds Teaching Hospitals NHS Trust
- Michael Griffin, Consultant Surgeon – Newcastle upon Tyne Hospitals NHS Foundation Trust, Professor of Gastrointestinal Surgery – University of Newcastle upon Tyne
- Peter Johnson, Professor of Medical Oncology – University of Southampton, Chief Clinician – Cancer Research UK
- Nora Kearney, Professor of Nursing and Cancer Care – University of Dundee
- Martin Lee, Consultant Surgeon – University Hospitals Coventry and Warwickshire NHS Trust, President of the Association of Breast Surgery at BASO
- David Luesley, Professor of Gynaecological Oncology – University of Birmingham, Consultant Gynaecologist – City Hospital NHS Trust, Birmingham
- Toni Mathie , Greater Manchester and Cheshire Cancer Network Programme Director
- Teresa Moss, Director – National Specialised Commissioning, NHS London
- Julietta Patnick CBE, Director – NHS Cancer Screening Programmes
- Michael Peake, Consultant Respiratory Physician and Lead for Lung Cancer – University Hospitals of Leicester NHS Trust, National Clinical Lead for Lung Cancer – NHS Cancer Improvement, Clinical Lead – National Cancer Intelligence Network
- Sir Michael Richards CBE, National Clinical Director for Cancer
- Greg Rubin, Professor of General Practice and Primary Care

– Durham University
- Michael Williams, Consultant Clinical Oncologist – Cambridge University Hospitals NHS Foundation Trust
- Dana-Farber Cancer Institute, Boston
- Memorial Sloan Kettering Cancer Center, New York
- Sidney Kimmel Comprehensive Cancer Centre at Johns Hopkins, Baltimore
- Stanford Cancer Center, California

Glossary

Cancer Awareness Measure- a tool that has been designed to measure cancer symptom awareness among the general public

Cancer Reform Strategy- a Department of Health cancer strategy published in 2007

Chemotherapy- treatment of cancer using specific chemical agents or drugs that are selectively destructive to malignant cells and tissues

Colorectal- relating to the large bowel (colon and rectum)

Gynaecological- relating to the female reproductive system

Haematological- relating to the blood and blood-forming organs

Haematopoietic progenitor cell transplantation- the transplantation of blood stem cells derived from the bone marrow or blood

Health Innovation and Education Clusters- government funded networks aimed at delivering high quality patient care through better trained clinicians and faster translation and adoption of research and innovation

Hepato-pancreato-biliary- relating to the liver, pancreas and biliary tract

Improving outcomes guidance- service guidance produced by NICE on improving outcomes for patients

Keyworker- a person who, with the patient's consent and agreement, takes a key role in coordinating and promoting continuity of the patient's care, ensuring the patient knows who to

access for information and advice

Laparoscopic surgery- a surgical technique in which operations are performed through small incisions, also called minimally invasive surgery and keyhole surgery

London Specialised Commissioning Group- a joint committee of London PCTs that commissions specialised services collaboratively for all of London

Multidisciplinary team- a group of doctors, nurses and other health care professionals who come together to provide comprehensive assessment of possible and confirmed cancer cases

National Awareness and Early Detection Initiative- Department of Health initiative to co-ordinate and support activities that promote the early diagnosis and treatment of cancer

Neuro-oncology- the branch of medicine dealing with tumours of the nervous system

NHS Cancer Plan- Department of Health cancer strategy published in 2000

NICE (National Institute for Health and Clinical Excellence)- an independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health

Oesophago-gastric- pertaining to the oesophagus and stomach

Palliative- medical care or treatment that concentrates on reducing the severity of disease symptoms

Pancreatectomy- removal of all or part of the pancreas

Pancreatic- relating to the pancreas

Pituitary- relating to the pituitary gland

Radiotherapy- the medical use of ionizing radiation as part of cancer treatment to control malignant cells

Sarcoma- a malignant tumour arising in tissue such as connective tissue, bone, cartilage, or striated muscle that spreads by extension into neighbouring tissue or by way of the bloodstream

Systemic anti-cancer therapy (SACT)- A group of therapies including chemotherapy, endocrine therapy, and hormonal therapy used to kill or slow the growth of cancer cells

Thoracic- relating to the region of the body extending from the neck to the diaphragm, not including the upper limbs

Thyroid- relating to the thyroid gland

Upper aero-digestive tract- the region of the body comprised of the ear, nasal cavity, mouth, pharynx, and larynx

Upper gastrointestinal- relating to the oesophagus, stomach and duodenum (small bowel)

Urological- relating to the urinary tracts of males and females, and the reproductive system of males

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Changing for Good

The development of mental health services 2010 to 2015

Update to Haringey OSC
20 October 2010

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Introduction

- This is part of our ongoing discussions with a wide range of stakeholders on the future of our services
- Two 'Changing for Good' discussion papers produced outlining the need for changes – in October 2009 and March 2010
- Series of meetings held with service users, carers, NHS partners, local authorities, OSCs / HSPs and others over the last year
- These views have helped to shape the Trust's plans for the future
- This brief presentation aims to update HSP members, particularly in the light of the new NHS White Paper

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Where are we now - 1

Trust has made a lot of progress recently:

- Achievement of 'Excellent' and 'Good' ratings from CQC for last two years
- Full Registration under new CQC Regulatory Framework
- Achieved financial targets for last two years
- Delivered very challenging cost improvement programme for last two years
- Appointed preferred partner for Enfield Community Services, due to transfer to MHT on 1 January 2011

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Where are we now - 2

Despite considerable achievements, there is still a lot to do:

- Keep improving our services, to match rising expectations and increasing demand
- Maintain full CQC Registration
- Keep delivering on financial and cost improvement targets, within a very challenged local health economy
- Successfully manage the transfer of Enfield Community Services
- Move forward with our service development plans, in collaboration with all our key stakeholders
- Move forward with our plans to become an NHS Foundation Trust by October 2011

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Recent developments

- New NHS White Paper signals significant changes in way NHS services are commissioned and planned, which impact on our plans
- New Government has signalled that NHS needs to continue to modernise and improve quality – with significantly reduced resources
- However, change process needs to be more bottom up, driven by patients, carers, local people, partners, NHS staff and, increasingly, GPs as commissioners
- New Government has set four tests for assessing plans for future service changes:
  - Support from GP commissioners
  - Strengthened public and patient engagement
  - Clear clinical evidence
  - Consistent with promoting patient choice

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Summary of our latest plans - 1

We have summarised our plans for the future into six key clinical service development areas:

- **Transfer and integration of Enfield Community Services**
  - Transfer of Enfield Community Services from NHS Enfield by early 2011
  - Integration of physical and mental health services, building on strong clinical synergies to develop more holistic services
- **Transforming Inpatient Care**
  - Reducing our use of inpatient mental health beds through developing further alternatives to inpatient care
    - Recovery Centres in each borough
    - Strengthening the Home Treatment Teams
  - Consolidation of our remaining inpatient facilities into fewer units to maximise clinical and cost effectiveness
- **Transforming Community Care and embedding services into Primary Care**
  - Developing services in primary care and providing more support to primary care
  - Focusing current generic CMHT case workers into specialist areas, to improve quality and efficiency

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Implications for BEH-MHT

- The Trust's future strategy focuses on the promotion of more holistic services, the prevention of ill health and active recovery, delivered as close to service user's homes as possible
- In the future, the Trust will be delivering a broader range of services, in different ways, in different locations
  - Transfer of Enfield Community Services is a big step in developing our services, bringing together physical and mental health services
- There are a series of major changes planned, which have been discussed at high level over the last year, which we now need to start moving forward on
- We are clear, however, that this must be done in collaboration with service users, carers, our partners and our staf, if it is to be successful

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Summary of our latest plans - 2

- **Transforming Child and Adolescent Services**
  - Developing a range of community based alternatives to inpatient care – so there is no need to separate young people from their families
- **Transforming Dementia services**
  - Responding the National Dementia Strategy and the overall increase in numbers of older people
  - Expanding home treatment for people with dementia
  - Expanding memory treatment services
  - Supporting dementia care in acute hospitals
- **Transforming Forensic Services**
  - Changing the way Forensic patients are managed and developing more clinically effective alternatives
  - Maximising the focus on recovery, e.g. support for employment

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Summary of our latest plans - 3

Our six key clinical service developments are supported by two key enablers:

- **Modernising our Estate**
  - As more services are provided in or close to people's homes, our need for building and facilities will change
  - We want to focus our resources on services, not maintaining lots of buildings
  - We see the size of our estate reducing over time, with better usage and more sharing of space with other partners e.g. local authorities
  - We want to improve the quality of our remaining estate, so it meets the expectations of service users and staff
- **Improving our Information Systems**
  - Our current IT and information systems are poor and do not meet our needs
  - We are currently reviewing what we need for the future and how best to improve our IT

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Mental Health NHS Trust

Next Steps

- New Government has made it clear NHS planning needs to be more bottom up, with more engagement of patients, staff and other stakeholders
- We have already been doing a lot of this through our 'Changing for Good' programme, which is all about working with all our stakeholders to plan for the future
- Over the next few months we will be developing more specific proposals for changes to our services and sharing these widely

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

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NHS Haringey

BRIEFING FOR HARINGEY COUNCIL OVERVIEW AND SCRUTINY COMMITTEE HEARING ON HEALTH – WEDNESDAY 20 OCTOBER HORNSEY NEIGHBOURHOOD HEALTH CENTRE

This paper gives a brief overview of the issues the Overview and Scrutiny Committee wishes to discuss with NHS Haringey at the special health hearing.

Camidoc/Out of Hours Service

After winning a competitive tender process for the new contract, Camidoc alerted the Consortium of Camden, Islington, Haringey and City and Hackney PCTs to problems regarding its financial status. With the agreement and co-operation of Camidoc, the Consortium commissioned an independent business review which confirmed the seriousness and ongoing nature of the problem. It was clear that Camidoc was technically insolvent and that this could compromise future service delivery in both the short and longer term.

Taking all of this into consideration, the consortium concluded that it could not confidently and safely ensure continuity of the out of hours service by entering into a new contract with Camidoc.

An emergency provider has been appointed for a nine month period to provide an out of hours service while a reprocurement exercise is undertaken. The consortium appointed Harmoni, which already provides out of hours care to people across eight London PCTs.

Harmoni has similar origins to Camidoc as a GP cooperative. Both organisations state that they believe in delivering a local GP led, clinically safe service to the patients. Harmoni was started in 1996 as a GP co-operative in Harrow, West London. The two founding GPs, Dr David Lloyd and Dr Nizar Meralli, are still active within the company today. It now provides services to over nine million patients in England on behalf of over 20 PCTs, handling up to 70,000 calls per month. Within London, Harmoni already deliver out of hours care to approximately two million patients across eight PCTs.

Section 242 of the NHS Act 2006 was complied with when setting the service specification for the new contract for which Camidoc was the preferred provider.

Harmoni is providing cover for this contract on an interim basis for a period of nine months. The service delivery remains the same, e.g. there are no changes to the location of delivery, hours of service, methods of contact or even the service telephone number. Legal advice has confirmed that there is no obligation to consult under section 242 off the NHS Act as there is no change in service provision between Camidoc and Harmoni.

All decisions regarding the appointment of an alternative provider and the selection of that provider were taken by the Consortium Board with the full support of the individual PCTs. Local clinical leaders have been kept informed and GP and LINks representatives from each PCT have been invited onto service mobilisation groups

The PCTs have an obligation to ensure that value for money is demonstrated across all services. Furthermore, the duty of the Consortium is to ensure a safe and consistent out of hours service is provided, irrespective of any actual or perceived differences in organisational form or ideology.

The service set-up costs are being paid to Harmoni, on an open book basis, in recognition of the short term nature of the contract. With longer term contracts these costs would be expected to be recovered by the provider over the contract period.

Set-up costs for this short term contract have been estimated at £50k per PCT. The monthly cost of the Harmoni service is comparable to that of the Camidoc service.

The PCTs, based on financial information previously provided by Camidoc were able to estimate likely costs of Camidoc providing the service for the nine month period. These costs were deemed likely to be approximately 20 per cent higher than the current monthly contract value. This would be more than the contract value agreed with Harmoni. In fact it would have been inappropriate for the PCTs to contract with Camidoc for the nine month period for the same reasons that caused the abandonment of the original procurement.

Patient safety and sound clinical governance are of paramount importance to the PCTs and the service provider. The PCTs, as part of the temporary provider selection process, sought assurances as to the robustness and appropriateness of proposed arrangements.

The performance framework set out within the contract will allow ongoing monitoring of the delivery of the service. Local GP representatives are also involved in overseeing the transition and Governance arrangements.

Local knowledge is recognised as being key to the effective delivery of the service. Eligible staff, including current call centre staff, drivers and GP roster/shift coordinators, have the right to have their employment transferred to Harmoni under TUPE on the same terms and conditions. Harmoni have confirmed that they are committed to continuing to work with local GP's in the delivery of the service.

8 till 8 Service at Hornsey

NHS Haringey commissioned the pilot walk in service in April 2010 for people who required access to primary care services outside of GP normal working hours and at weekends. The pilot scheme finished on 1 September.

It was always our intention to review the service after completion of the pilot phase, to see how it complemented the other ways of accessing care including NHS Direct, our out of hours services and extended GP opening hours.

Our original projected demand at the time of commissioning the pilot was that it should see 30 patients per day, 900 patients per month. The service started slowly but in July saw approximately 700 patients.

The vast majority of GPs in the West of the borough already provide extended opening hours, and it was clear that the walk in service was being used by some patients as an alternative to routine GP appointments, which is not an appropriate use of the service.

NHS Haringey put in place a communications plan to inform the public that the service is no longer available, and signposting them to the other ways that people obtain medical advice and treatment.

We are now actively evaluating the pilot whilst we do that we have suspended the pilot from September 2010 to April 2011. This has been necessitated due to other changes in the provision of out of hours services and the need to have a more streamlined approach towards unscheduled care that is cost effective and efficient, taking into account how best we can ensure people can access services outside of normal GP hours.

NHS Haringey is committed to ensuring that Hornsey neighbourhood health centre is a key community asset for the provision of medical services in the area. Services that are already provided at the centre include physiotherapy, foot health and midwifery clinics, and we are working very closely with the Whittington Hospital to provide new clinical services including treatments for diabetes and dermatology.

NHS Haringey will continue to work with the practice at Hornsey and other stakeholders to evaluate how all primary care services, including NHS Direct, our out of hours services and extended GP opening hours work together to deliver a comprehensive service for patients ensuring the best use of NHS resources.

Buses to Hornsey

One challenge for community based health facilities is the provision of public transport links. Major hospitals are usually situated near public transport hubs, while neighbourhood health centres are based in the community, and not always near major public transport routes. The Hornsey neighbourhood health centre is on the W7 bus route, and is near to the W5 and W3 routes. That said, there have been calls for better public transport access, and NHS Haringey has discussed the issue regularly with Transport for London. TfL do review routes, but will want to see significant unmet passenger demand before changing routes.

Recently NHS Haringey met with Haringey Bus Watch to discuss options for improving transport access to the Hornsey health centre. It was recognised that unless there was significant demand for access to the centre from people who had mobility issues, it would difficult to persuade TfL to increase access to the centre. NHS Haringey is currently looking at what the current and projected services are for Hornsey which may be for people with mobility issues. If there are not significant numbers, then we will investigate alternative transport arrangements such as encouraging volunteers to pick up patients and take them to the centre, and arrangement which many acute hospitals provide.

NE Tottenham Health Centre

Tottenham, one of the most deprived areas of the borough and the need to develop a substantial presence for health in this area has long been a priority for both Haringey and Enfield.

The opportunity to develop a flagship polyclinic in Tottenham, adjacent to the Spurs stadium redevelopment is a unique opportunity to address the needs of the poorest population in London. Spur planning for stadium has been approved, we have developed proposals with Elevate, our property management partners, but have no money available at the moment to take this project forward. We want to provide good quality healthcare from this site but have to be realistic about the financial position,

which means securing the necessary funding will be difficult in the current financial climate.

The Laurels

Services at the centre are provided under an APMS (alternative personal medical services) contract by a partnership between LHS Ltd (a consortium of two Haringey GP practices) and Camidoc.

LHS Ltd have now informed us that because of uncertainty around Camidoc's financial situation, they are no longer in a position to continue to provide their service at The Laurels. They therefore wish to hand the contract back to the PCT on 15th September 2010.

We are currently negotiating with the medical director at the Laurels to continue to provide services until 30 September. This will allow us to put in place appropriate communication and contingency plans.

In order to ensure patient safety and continuity for the patients registered at the practice, NHS Haringey is putting in place a temporary emergency APMS contract until March 2011 at the earliest. The APMS contract will be for core GP services run by a local GP.

Under the APMS contract, an 8-8 seven days a week walk in service was also provided. However, information from the Laurels Healthy Living Centre shows that it was used by a small number of local patients, most of which were already registered with the practice or neighbouring practices.

We have therefore decided that because we are agreeing new temporary arrangements, we will no longer provide the 8-8 and the walk in service for the rest of the financial year. It is our intention to consult and commission the provision of a walk in service from next year under a new APMS contract.

In the meantime we will be informing patients at the practice that the walk in service is currently suspended, and that if they do have an urgent medical need, they should either contact our out of hours provider, NHS Direct or go to their nearest A&E centre.

Pharmacy provision in the Laurels Healthy Living Centre

In January 2010 NHS Haringey received an application from the Bridge Renewal Services to open a pharmacy in the Laurels. We considered the application under the regulatory test of whether a pharmacy would be necessary or expedient in order to secure adequate pharmaceutical services in a particular neighbourhood. The PCT received many letters of support, including local residents, two Haringey Councillors and the local MP. There were also many letters from local pharmacies opposing the application. The application was declined on the grounds that there were already sufficient pharmacies in the neighbourhood.

In May 2010 we received a second application for a pharmacy to open under an exemption category whereby a pharmacy opening for more than 100 hours per week is exempt from the regulatory test described above. We had no grounds to refuse this application which was approved in September 2010.

NHS Haringey financial update report for 2010/11

NHS Haringey faces a number of major pressures on its resources for 2010/11, which means it estimates it is heading toward a significant deficit on its budget. This note sets out what these pressures are, and what NHS Haringey is doing to address them in order to minimise any overspend.

Budgetary pressures

Low income growth: NHS Haringey's income grew by only £3.6m for 2010/11.

Significant growth in acute expenditure: In the last two years there has been £24m growth in acute expenditure. Reasons for this increase in expenditure include an eight per cent increase in recorded activity per annum which represents £14m of the £24m total; high cost drug usage and newly recorded procedures; and an increase in emergency procedures. This, and other reasons has resulted in NHS Haringey's growth in acute spend being the highest in the north central London sector. This situation has been compounded by the Government's changes to the funding formulae for how much PCTs pay for secondary care services, which has meant we now have to pay more. This means there has been an increase in the demand for secondary care services, and an increase in the amount we pay for secondary care services.

Other pressures: There has been an increase in forensic mental health patient numbers; the cost of providing continuing care has increased; and a growth in our expenditure on prescription drugs.

Savings

NHS Haringey has looked at all aspects of its operation to see where savings can be made in order to reduce the level of any end of year overspend. Each year we have always been required to make efficiency savings, but this year because of the pressure on our budget, the scale of the savings is significantly higher. Originally we hoped to achieve these savings by transferring appropriate services out of acute hospitals and into our community facilities such as Hornsey health centre, and through other efficiency and productivity gains.

However, although we have transferred some services into our health centres, the shift has not been sufficient to meet the savings targets, and neither have the productivity and efficiency gains. The NHS Haringey board therefore agreed to an additional savings plan, which we estimate will save us £12m over the course of the year. However, we continue to explore all opportunities to achieve additional savings.

As a consequence of these pressures, NHS Haringey currently estimates that it faces a significant deficit at the end of this financial year.

Healthcare support for adults living in care homes

NHS Haringey provides a full range of healthcare support to all residents of the borough who are registered with a General Practitioner (GP). This support includes servicing the needs of those residents who live in multiple occupancy accommodation and specifically nursing and residential care homes.

The majority of GPs aligned to Nursing Care homes manage to provide the appropriate level of healthcare support. However, in 2008 NHS Haringey introduced a Locally Enhanced Service (LES) that provided further support in the form of additional payment to GPs for the provision of healthcare to the residents of the Nursing Care Homes. This was taken up by GPs covering four Nursing Homes out of the 17 in Haringey, three of which come under Haringey Council's direct management.

As part of the 2010/11 quality and efficiency review, NHS Haringey took the view that such a service was neither equitable, as it covered only four nursing homes, nor appropriate as the main healthcare needs of these residents should be covered by the GPs under the contractual obligations. The PCT therefore gave notice to the four GPs receiving the LES payment. Subsequent to this GPS providing services under the LES to two of the care homes notified us that they no longer wished to provide care to the clients in these care homes.

NHS Haringey has therefore made arrangements for appropriate healthcare support to be maintained at these four homes. Our Practice & Practitioner Service (PPS) Manager wrote to the GP surgeries, patients and care homes on the 28th September to confirm the new allocations and advising the care homes how to register patients with the new GPs. An email with patient allocations was sent to the care home managers on the 28th and 29th September.

NHS Haringey has recently recruited a new Community Matron for Care Homes, who is also a nurse prescriber. We are arranging for them to be registered locally and to work closely with the appointed GPs and Care Home staff and managers. As part of her work, the community matron has started with the two care homes where we have reallocated clients to new GPs and in addition NHS Haringey will provide a simple contact guide to each home to ensure there is no disruption to services from October onwards.

NHS Haringey is committed to ensuring that all residents in the care homes in Haringey receive good quality primary care services.

Report of the clinical panel on their review of the Barnet, Enfield and Haringey clinical strategy

Since 2006, Barnet, Enfield and Haringey PCTs, together with the hospitals at Barnet, Chase Farm and North Middlesex, have been working together to plan safer and stronger healthcare services locally.

Following an extensive consultation process and agreement by the then Secretary of State for Health, the programme to provide better healthcare services began to be implemented last year.

This work was halted by the Health Secretary, Andrew Lansley, in May 2010 pending the outcome of a review of the planned changes against four tests. He outlined his vision to ensure that patient outcomes and clinical evidence are at the heart of any changes to health services, stating that all service changes must be led by clinicians and patients, not driven from the top down.

The Secretary of State requires reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement, including local authorities;

- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

As part of the assessment of the support from GP commissioners, the BEH clinical strategy team put together a panel of clinicians from across the three boroughs to review the clinical arguments that underpin the BEH strategy. Dr Jatin Pandya represented Haringey on this panel, which met from 27 September to 1 October.

The purpose of the clinical review group is to:

- Review the clinical evidence for the service change envisaged in the BEH Strategy - assessing separately Women's services, Children's services, Urgent Care, Primary Care, Planned Care
- ascertain whether any change in circumstance or evidence has taken place in the three years since the original consultation
- Engage wider GP body in each PCT area
- Provide a digest of the evidence and advice to the Strategic Review Group in each local authority area.

The Group will produce a summary report by 6th October 2010. This report will be available to the Strategic Review Groups, wider body of GPs, LINks and Local Authorities and be posted on the PCTs' web sites.

Duncan Stroud
Associate Director – Communications and Engagement
NHS Haringey
11 October 2010

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NHS Haringey

PCT mergers and transition arrangements

There are three major drivers for change in the NHS at present:

- The NHS is required to make £15bn efficiency savings over three years, at a time when demand for the use of NHS services continues to rise with consequential pressures on budgets. This means the NHS must find ways to do things more efficiently and more effectively, with less money.

- The Government proposes to devolve commissioning of services to new GP consortia from 2013. GPs will need to develop new skills and resources to deliver this. It will also mean the abolition of the 151 PCTs across the country and 10 strategic health authorities. These have been billed as the biggest changes to the NHS in 40 years.

- The NHS has been required to reduce its management costs by 50 per cent.

In discussion with their own boards and NHS London, the five PCTs that make up NHS North Central London (NCL) – Barnet, Camden, Enfield, Haringey and Islington – are working together to put in transition arrangements that will support the move to GP commissioning and deliver the 50 per cent management savings. The key elements of these changes are:

- Create a single transition team across the five PCTs, with teams in each PCT reporting along a single line of accountability to the CEO for NCL.

- Determine what can be done locally and what can be done centrally. Central functions will typically be corporate ones including human resources, communications and acute commissioning. Local functions will be liaison with local authorities, support for emerging GP consortia and specific quality assurance and governance – eg safeguarding. We recognise that maintain a strong local presence will be essential moving forward with the transition arrangements.

- Decide how the five PCTs can be restructured to deliver the required 50 per cent management savings. If possible, NHS London want us to deliver the 50 per cent savings by April 2011, subject to discussion with them and the individual PCT boards. This will release money in 2011/12 to be invested into GP commissioning

We recognise that there are many issues that need to be addressed, and that we are only at the start of this process. But given the need to resolve these issues as quickly as possible, close working and discussion with all our partner organisations including local authorities and clinicians is going to be vital in order to deliver a smooth transition to the new working arrangements, and deliver the new ways of working and efficiency savings the NHS is required to make.

Duncan Stroud
Associate Director – Communications and Engagement
NHS Haringey
11 October 2010