

Clinical Advisory Group

**Report on Healthcare for London:
Consulting the Capital**

May 2008

Foreword

I am pleased to present the report of the Clinical Advisory Group in response to *Healthcare for London: Consulting the Capital*. The ideas in *A Framework for Action* were based on the expertise and experience of clinicians drawn from across London. This report reflects the agreed views of the members of the Clinical Advisory Group on the proposals for how we can improve healthcare in London over the next 10 years.

In shaping the response to consultation, the Clinical Advisory Group sought to balance clinical expertise and evidence with the views of the public. The mandate for change is clear. The overwhelming majority of people agreed that healthcare in London must change – but, that changes must achieve an improvement in the health and wellbeing of people. Clinical evidence from around the world shows that we can save lives and improve the quality of people's lives if we are prepared to make changes to our healthcare system.

The report of the Clinical Advisory Group presents the evidence we have currently in support of the need for change. Some of this is based on incontrovertible gold standard evidence. In other places, the evidence is less clear. In support of local implementation of Healthcare for London, the Clinical Advisory Group will work with primary care trusts to help commissioners make the distinction between what is opinion and what is fact to ensure that decisions are based on an understanding of the real issues.

Whilst looking at evidence, commissioners of services need to satisfy themselves that proposals are clinically safe, deliverable from a medical workforce perspective, affordable, accessible and would provide a quality of service that was fit for purpose. The financial implications of any changes will also need to be assessed. We stress that local decisions need to be made as to how the proposals are implemented - what fits one place may not fit another.

Working in partnership is absolutely essential if we are going to improve the health of Londoners. We will continue to engage with patient groups, voluntary organisations and professional networks across London to discuss issues and utilise their expertise in developing services. We also will seek to learn from experience as progress is made.

Finally, the Clinical Advisory Group recognises that *A Framework for Action* did not focus on all aspects of healthcare. In developing new services we will need to ensure that such as pathology, radiology and anaesthesia as well as workforce education are addressed.

I wish to thank the members of the Clinical Advisory Group for their continued dedication. Their experience and insight has been invaluable and will help to drive change that really benefits patients.

Sir Cyril Chantler
Chair of the Clinical Advisory Group

13 May 2008

Members of the Clinical Advisory Group

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Staying healthy

Proposals

Healthcare for London: Consulting the Capital proposed:

1. A greater focus on prevention rather than cure:

- Invest more money into preventing ill-health, particularly in the most deprived areas of London;
- Ensure people have opportunities to remain healthy and prevent illness from occurring;
- Encourage people to take responsibility for their own health; and
- Support carers, ensuring they have good information, easily accessible and co-ordinated services.

2. The NHS should help people stay healthy:

- Work in partnerships with local authorities and others; and
- Most health improvement programmes should focus on local issues. Some campaigns could be delivered pan-London.

3. Preventing ill-health must be part of all patient care:

- Health improvement should be delivered by more people in more places; and
- Training for students and professional development should include health improvement.

Responses

Consulting the Capital asked about the areas people wanted to improve their own health and how they thought the NHS could help them. The consultation also questioned whether advice from health professionals on staying healthy was welcomed.

1. Prevention is better than cure

Many stakeholders expressed agreement with the principle of prevention and suggested that increased funding was required, particularly to target poorer areas of London.

Over half of the respondents said they wanted to increase their levels of exercise to improve their health. Reducing stress, losing weight and improving diet were also popular lifestyle changes. Stopping smoking and reducing alcohol intake were mainly concerns for the young.

A significant number of people argued that staying healthy with good lifestyle choices was a personal not a public responsibility. They felt that the NHS had an important role in facilitating healthy lifestyle choices, but that individuals had an equal responsibility in making choices and adapting lifestyles in order to achieve this.

CAG view

It is encouraging that so many people recognise the impact of their lifestyles on their health. A greater focus on prevention would reduce the current strain on some services such as A&E and enable us to invest in services closer to home.

However, targeting interventions based on public opinion has potential flaws. Few would argue against the importance of reducing smoking rates and alcohol intake in some groups. The fact that the public does not identify these as key measures does not necessarily mean that they should not be prioritised.

There is no doubt that lifestyle modifications can produce improvements in health and healthier people use up less NHS resources. The CAG argues that if an intervention can be shown to be cost-effective then it is an appropriate use of public funds. There is a wealth of evidence, described in the NICE guidelines for stepped care models for the management of common mental health conditions, which supports the vital role of lifestyle improvement as a key component of effective treatment, especially of depression. The CAG suggests that local providers should be encouraged to provide new evidence-based services according to local need.

Access to services will be particularly important. For example, provision of appointments outside of office hours improved men's access to services in the Preston model. Similarly, the elderly, who stand to benefit from exercise programmes, may be unable to travel large distances to attend. As a general principle, we need to ensure that it is not difficult or expensive to remain healthy.

2. Helping people stay healthy

2.1 Health interventions

There was an encouraging response to how the NHS could help people change their lifestyle. Some ideas from the public were NHS swimming pools, access to gyms and more constructive information. More help with smoking cessation was also raised.

Many healthcare organisations and voluntary services offered their support in working with the NHS to help people achieve their aims.

Other areas of interest or concern identified by respondents included cancer screening and well man clinics. Respondents suggested the NHS should work to reduce advertising promoting smoking, alcohol and junk food. Several respondents were also keen to see increased availability of alternative therapies including homeopathy and nutritionists.

Other areas of concern to the public included playing fields, cycling lanes, traffic/air pollution and working hours.

CAG view

The CAG strongly supports the principle that the NHS should encourage people to stay healthy including initiatives promoting exercise. Provision of services closer to home (for instance through the polyclinic service model) and a greater focus on promoting and prevention of illness would have a positive impact on the health of Londoners.

Issues for consideration include:

- Logistics - provision of NHS swimming pools as suggested by one respondent would be difficult due to high start up costs;
- Access for those truly in need would need to be ensured; and
- Targeting - would NHS exercise facilities simply provide a cost saving to people who already use gyms or would they truly motivate those who currently don't exercise?

Locally commissioned services might be better able to target those in need, perhaps via person-centred pathways of care or personal budgets. Healthcare services need to be

appropriate for the local community.

The work around polyclinics provides PCTs with an opportunity to build on current services, working closely with health and social care colleagues to open up access to nearby services and commission health promotion teams who could provide clinics.

The CAG is mindful that many members of the public do not agree with privatisation but also aware that, in order to meet some of these expectations, the NHS would have to work with private partners. The provision of facilities for exercise may be one such area and, given that these are not currently widely available under the NHS, may be more palatable to the general public.

Advertising is already a key tool in health improvement. More localised campaigns targeting specific patient groups may be more effective. The importance of outreach using language understood by people in the community is emphasised. There are already excellent examples of health promotion activities, which should be built on and cascaded throughout the NHS. In some areas, local groups are leading healthy living initiatives with support from their PCTs. In terms of controlling advertising of smoking, alcohol and junk food, input from health professionals regarding advertising standards may be appropriate.

The CAG agrees that the future success of enabling people to lead healthy lives and remain at home for longer is dependent on health services working in partnership with social care colleagues and other statutory and non-statutory organisations. Success is dependent on both health and social care agreeing to be committed to joint care pathways and in enabling patients to access services within and out-of-hours. This is happening in many areas, but is an area requiring further development.

2.2 Partnerships with local authorities

The King's Fund welcomed the idea that the NHS in London should work in partnership with local authorities and the Mayor of London to deliver improvements in health through changes in urban and transport planning and public services. Members of the public expressed the view that to achieve its aim of “enabling health rather than treating the sick”, the NHS must work with the Mayor of London and others complement the broader strategies and legislation, for example, pollution, the environment and public health issues.

CAG view

The NHS in London and local authorities need to work together to think about wider issues around staying healthy. The CAG agrees that it is highly appropriate for senior healthcare professionals to be involved in shaping policy and encourages NHS London to push for representation to facilitate this. Local authorities and the Mayor of London should also have an opportunity to use the expertise available to them to inform and influence health strategies and legislation. Joint commissioning of health prevention initiatives should be considered.

2.3 Understanding the system

Respondents wanted a system that was easy to navigate, with good access to health and social care services. Specific patient groups were keen to see an increase in low and medium levels of social care provided at home. They also raised the need for clarity of services. Some groups such as the elderly were concerned that their specific needs had been missed out in the consultation and would not be addressed. Patients want to be actively involved in the decision-making process and to understand how the changes will affect them.

CAG view

The CAG recognises the difficulty that some people have in understanding and navigating the

health system. We believe that the work on achieving a single point of access should improve this, as well as a focus on preventative health and working with the public. This would include working with NHS Direct and others on providing one telephone number for example that patients can ring for advice and support. We welcome the offers of help from voluntary services and partners to become involved in the planning and introduction of new services.

The CAG are also enthusiastic to embrace the need for co-ordinated and seamless care and hope to build on current examples of good practice including case management, care co-ordinators and key workers.

3. Preventing ill-health as part of patient care

The consultation showed that the majority of respondents (72%) wanted advice on staying healthy from healthcare professionals. People under 25 and Asian Londoners were slightly more positive about such advice. This was further elaborated on in terms of how and what this should include. The issues were quite broad ranging from basic healthcare advice to more specialised advice around working environments and conditions. However, specific patient groups and individuals were concerned at the manner in which some healthcare professionals deliver these messages and find them patronising and undermining. In some cases the need to lead by example was noted.

Primary prevention was suggested by stakeholders to be a key priority for both sexual health and cardiovascular disease. The Terence Higgins Trust argued for “*evidence based behavioural and clinical interventions*” to help prevent transmission of STIs and HIV.

The Royal College of Nursing argued that a wider range of health professionals, particularly nurses and allied health professionals should be involved in preventative medicine although no detail was provided as to how this might be realised. GP leaders were anxious to recognise the work already being done to promote prevention in primary care.

Recent health prevention campaigns were viewed positively, but some respondents suggested the NHS should ‘reach out more’ to promote messages in places where local people meet, such as hairdressers or local shops.

Working in partnership with charity and voluntary agencies was highlighted, particularly in accessing some of the hard to reach groups. Respondents urged health care workers to link in with projects such as Health Action Zone.

CAG view

The CAG agrees that providing advice on healthy living is an integral part of healthcare workers' jobs. Concerns about how these messages are delivered must be recognised and addressed if the process is to succeed. If a wide range of professionals are to give patients advice on staying healthy, consideration will need to be given to education for those providing the interventions and quality assurance.

The CAG would like to see access to support services, such as housing and dental health, within current community sites, and an increase in access to clinics that promote health such as well man clinics. However, provision of any new services would need to be critically analysed and formally assessed.

The CAG recognises the excellent work already being done by a wide range of health professionals, not just doctors and nurses, but emphasises that there is much still to be done to improve the general health of the public. Introducing new ways of working by a wider range of professionals should be seen as an opportunity, not as a criticism of, or threat to, current services. The need to continue to support staff working in partnership with the public will form

an integral part of the workforce planning work.

The CAG appreciate the excellent work being provided by charities and other voluntary or statutory providers around London. Where health, social care and community voluntary groups are working in partnership, those areas are seeing benefits. However, the CAG also recognise that the level of partnership working varies across London and will encourage London and PCTs to support and develop successful local initiatives. An incremental approach to introducing new initiatives may be required.

4. Specific issues

4.1 Transport

Some of the concerns raised by respondents focused on the issues around transport and equity of access in order to remain healthy. For some there appeared to be a focus on the “able sick” rather than the “sick, sick” and whilst recognising an individual responsibility in maintaining one’s health, respondents also felt that in order to do so, they should be able to use public transport. There were implications for the cost of remaining healthy – ranging from an individual’s abilities to pay for public transport, parking etc. to an individual’s capacity to travel due to physical conditions such as limited mobility. Some organisations were concerned that, if calling the London Ambulance Service (LAS), they might be taken to the nearest hospital/clinic, rather than the one most suited to meet their needs.

CAG view

The CAG fully recognises the issues around access and transport currently experienced by the public. Relevant transport groups, on responding to the consultation, were also aware of this and keen to work with Healthcare for London in improving this area.

The issue of cost and transport needs to be considered within future work to ensure an equitable service is available to all. The CAG also agrees that patients should be cared for at the place most appropriate for them which might be at a clinic, hospital or another place accessed via a voluntary organisation. We encourage an integrated approach to developing clear pathways that enable patients to be seen by the most appropriate clinician in the most appropriate place. Indeed the LAS, in their response, outlined some exciting new roles and ways of working that could be explored to support people to receive appropriate care nearer to home, such as community engagement officers.

4.2 Medicalisation

Nearly all the professional bodies and union representatives acknowledged the need to recognise all disciplines of clinicians within the future development of the NHS. They and some individual members of the public were concerned that the consultation appeared “medicalised” and very acute focused, with an emphasis on the medical profession only. Respondents were keen to ensure that the very important work carried out by clinicians from all backgrounds in preventing admissions to hospital and supporting people to remain healthy was recognised. They were also concerned that the focus of moving care closer to home wasn’t reflected within the paper which appeared to be acute care focused.

CAG view

The CAG wholeheartedly agrees with this and is committed to ensuring that the patient is central to the decision-making process. This includes ensuring that the person best placed to meet the patient’s needs is identified as care co-ordinator. This might be any member of the healthcare team including physiotherapists, therapists, pharmacists, nurses, support workers or medics. The CAG also agrees that a lot of care traditionally delivered within the acute

hospital setting could be delivered closer or at home by suitably qualified staff or integrated teams. Current examples of good practice and integrated working should inform future work.

Summary

1. Prevention is better than cure

The CAG supports cost-effective NHS pathways to improve public health in every way possible.

The public's concerns about exercise, stress, weight loss and diet should be addressed. Medical knowledge of the benefits of reduced smoking, sensible alcohol use and reduced stress means that these areas should also be high priorities. Our challenge now is to enable individuals and groups to make it happen.

2. Helping people stay healthy

NHS London should help to shape policy in other areas relevant to health.

Access for all, and particularly for those most in need, should be a fundamental part of new services.

3. Preventing ill-health as part of patient care

Being creative around person-centred pathways of care including both elements of health and illness would provide opportunities about who is most appropriate to provide health improvement initiatives. This could build on the work already being achieved by pharmacists, dentists and opticians for example, who are often the people ideally placed to identify potential health risks and are able to deliver health promotion advice to prevent illness occurring.

Maternity and newborn care

Proposals

Healthcare for London: Consulting the Capital proposed expectant mothers should be offered:

1. **Early assessment by midwife to triage for appropriate care and further assessments during pregnancy.**
2. **Information to enable informed decisions i.e. place of birth and pain relief.**
3. **Antenatal care at local one-stop centres.**
4. **Services to meet their choice for place of birth – home, midwifery unit (stand-alone or co-located), obstetric unit.**
5. **Continuity of care (same team) from early pregnancy to postnatal care whenever possible.**
6. **One-to-one midwifery care during established labour.**
7. **Postnatal care in local one-stop centres as well as at home.**
8. **Improved quality of care:**
 - Greater presence of senior doctors on the labour ward; and
 - All professionals involved in birth to be competent in basic neonatal life-support.
9. **Care provided in the right place:**
 - Slightly fewer doctor-led units which can provide the best quality care for women with complications; and
 - More midwifery units and more support for home births, ensuring mothers can get to a doctor-led maternity unit within a reasonable travel time.

Responses

Consulting the Capital asked what three factors were most important in giving birth. Options included:

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

The consultation also asked about balancing the time midwives spend with mothers after the birth of their baby with the time taken to travel to women's homes.

1. Early assessments

CAG view

In line with respondents, the CAG supports early assessment (before 12 weeks) to triage for further care appropriate to the individual woman.

This is supported by evidence including the Confidential Enquiry into Maternal and Child Health (CEMACH) *Saving Mothers' Lives 2008*, *Maternity Matters* and NICE antenatal care guideline as well as public service agreement (PSA) targets 1, 2 and 3. All stress the importance of early assessment, highlighting the increased morbidity and mortality associated with 'late-bookers' (women who access antenatal care late).

The CEMACH report showed an increased number of deaths in migrant women, so early assessment is crucial in London where many migrant women have had poor access to healthcare in the past and have complex medical problems that need to be recognised early and managed appropriately. These women may require an early medical assessment by an appropriately trained health professional (e.g. GP) as suggested in the key recommendations of the CEMACH 2008 report.

CEMACH *Saving Mothers' Lives* went further to encourage pre-pregnancy assessment in order to tackle problems like obesity and smoking in pregnancy.

"The rise in deaths from cardiac disease highlights the need for hard-hitting health education programmes and pre-conception counselling for those at most risk, including the obese."

CEMACH *Saving Mothers' Lives* 2008

The CAG adds that midwives as the first point of contact should be:

- Available to women throughout the week;
- Able to liaise easily with other community services; and
- Particularly visible to disadvantaged women.

The CAG stresses that it is essential that such community-based midwifery provision is appropriately funded. There is a need to understand the impact of such change in access on GPs and their input into antenatal care.

2. Making informed decisions – place of birth and pain relief

CAG view

The CAG strongly supports that the information that women receive should explain the normal pathway for care and be readily available in a variety of formats and languages.

There should be clarity about the evidence of the benefits and risks associated with all choices especially in relation to place of birth (using the 2009 National Perinatal Epidemiology Unit (NPEU) birthplace study as evidence). The information should stress that maternity services are not provided in isolation, that it is expected that some women will transfer between out-of-hospital birth to hospital birth settings and inform them of the time that this transfer may take. Information should also emphasise that the maternity team works together and that midwives can access support and advice at any time.

3. Antenatal care provided at one-stop centres

CAG view

The CAG supports the view that services should be provided close to home whenever possible and agrees that most women should be able to receive antenatal care in the community.

4. Services to meet patient choice for place of birth

Respondents felt that the most important factors in giving birth were co-located units (57%), senior doctor presence (46%) and the time taken to the place of birth (40%). The overriding concern was the safety of the mother and baby.

CAG view

The CAG agrees that women and their partners should have a choice as to the type of care and place of birth depending on their circumstances and their wishes. Good, clear evidence-based information is needed to enable an informed choice.

It is essential that all professionals involved in maternity care should be competent in basic neonatal resuscitation. Furthermore, obstetric-led services must offer advanced neonatal life support skills 24/7. Maternity facilities must be able to provide continued life support for an unspecified period of time (hours) prior to transfer to a designated neonatal unit.

The CAG agrees that obstetric units should have a co-located midwifery unit. Co-located midwifery units provide women with uncomplicated pregnancies the option of a birth in a home-like and non-clinical environment, with the security of rapid transfer in the event that complications arise. The CAG notes however that the relative safety between stand-alone midwifery units and co-located units is undetermined. Both co-located and stand-alone have advantages, e.g. the advantages of birth in midwifery-led units include a reduction in analgesia and an increase in vaginal birth and intact perineum rates.

Hodnett et al (NPEU birth centre review) shows that co-located birth centres provide women a greater sense of autonomy:

“Women comment on the respect, perceived control and support that they experienced in the birth centres, concepts which mirror the recommendations of page 47 of the Changing Childbirth report (DH 1993).”

NPEU birth centre review

Co-located midwifery units should be actively encouraged to support patient choice.

The CAG agrees that there should always be clear demarcation between obstetric and midwifery units in terms of staffing and services offered whether the midwifery-led units are stand-alone or co-located. It is noted that robust transfer policies will allow speedy transfer from stand-alone midwifery-led units to the nearest obstetric service for pain relief or interventions not immediately available in out-of-hospital care. Excellent team working and seamless services are essential regardless of the model of care.

4.1 Out-of-hospital models

Some concerns were raised about out-of-hospital models.

Safety

Until the Department of Health's birthplace study reports in 2009 we lack evidence as to the

relative safety of hospital-based birth (obstetric unit or co-located midwifery unit) and out-of-hospital birth (stand-alone midwifery unit or homebirth).

Consideration should to be given to:

- Transfer rates: The NPEU birthplace report 2009 may give us a better indication of numbers and reasons for transfer. Out-of-hospital births will need a robust transport network and the impact on the ambulance service will need to be considered.

“When emergencies do occur when delivering at home or in a stand-alone midwifery unit, the transfer time to the hospital is crucial to minimising risks and enhancing safety.”

RCOG statement on NICE Clinical Guideline 55 Intrapartum care - care of healthy women and their babies during childbirth

- Clear selection protocols: The NICE Intrapartum care guideline suggests a list of conditions that would either preclude birth in a midwifery unit or would require serious consideration by a senior member of the maternity team. It is suggested that in view of this it is even more important to ensure we have early assessments of women and improved antenatal care.

The CAG would encourage commissioners to consider transfer times if looking at out-of-hospital models.

Viability

The consultation showed support for choice of place of birth and out-of-hospital models for birth. However looking at the demographics of these respondents, they were mainly white. Consultation of traditionally under-represented groups found that they preferred co-located midwifery units. Their main concern was the lack of ability to predict who will have an uncomplicated birth.

CAG view

We have concerns at this time when there is evidence of inadequate take up of out-of-hospital models in London. There is limited information on the economic viability of stand-alone midwifery units. When considering the potential take up of out-of-hospital models in relation to the financial viability and workforce issues it will be important to assess the demographics of the local population in London and their wishes. For lower-risk women this is an alternative which we should support, provided in areas suitable for the local population.

We need to ensure that midwifery-led units are economically viable and if this is to be the case then we must create models of care which will support women making this choice. We have evidence from service models in south east London that where women get to know their midwife and their midwife is supportive of a midwifery-led model then women will choose it.

4.2 Hospital models

Smaller obstetric units vs travel times

CAG view

We note that respondents see safety as the priority issue in giving birth. The fewer number of deliveries an obstetrics unit has, the more challenging to ensure safety and viability of a unit. The time taken to travel to the place of birth is also important. Out-of-hospital midwifery-led models could be one way of ensuring services for low-risk women.

Safety

CAG view

CAG members support an appropriate increase in consultant cover in obstetric units. The RCOG report '*The future role of the Consultant*' supports 98 hours cover for obstetric units. The benefit of 98 hour consultant cover has not been formally evaluated, but it is agreed that it is a desirable goal.

4.3 Other concerns

Capacity: physical and workforce

Respondents expressed concern as to the ability of London's maternity services to respond to policy direction whilst demand outstrips both the physical capacity and the capacity of the workforce. The workforce is seen to be insufficient both in terms of absolute numbers and in terms of having the competencies to deliver a changed service. Investment is needed both in numbers and in training and development of staff, particularly midwives.

CAG view

This issue needs to be acknowledged and addressed to reduce the pressure on London's maternity services. New models may need time to reach their potential in terms of usage. It will be important that midwifery-led units being established are given time to be fully functioning before changes are made to obstetric units. Similarly, sufficient midwives with the appropriate skills to support out-of-hospital birth and to give one-to-one care to women in labour will need to be in place. The capacity of the London Ambulance Service to provide transfer services also needs to be explored.

Although an absolute increase in midwife numbers and obstetric numbers may be necessary, workforce issues can be addressed in part by some realignment of the current workforce. Maternity support workers and administrative support can be introduced to release skilled midwives for midwifery work and obstetricians' job plans can be realigned in the light of changing needs across gynaecology and obstetric services. Further modelling of workforce changes will be needed as the future pattern of London's maternity services is discussed.

Interdependency with paediatric services

Although the link was not specifically made in the consultation paper, the interdependency of paediatric and obstetric services was raised by some respondents and the implications for the newborn baby if services change. The Royal College of Paediatrics and Child Health (RCPCH) raised the particular issue of the shortage of neonatal intensive care cots in the capital.

CAG view

There are important principles of safe practice that must be adhered to in all circumstances. The first is that all newborn babies need access to individuals who have the ability to offer life support. If a mother's pregnancy has been considered to be low risk, and birth is taking place either at home or in a midwifery-led unit, then basic life support skills are all that the baby should need. It is a requirement that all midwives have such training.

A mother whose pregnancy has been considered to have any risk, or if complications arise in labour, will be advised to deliver in a doctor-led obstetric unit. The newborn baby will require access to individuals who have advanced life support skills. The standards for this service, including the skills required, have been established by the British Association of Perinatal Medicine. This service must be available to mothers in labour within an obstetric unit 24 hours a day.

In the event of any reconfiguration of paediatric and maternity services, these standards must be maintained. A significant increase in numbers of deliveries in London is anticipated. Further work will be required to ensure this need is met. Any planned service re-design should include careful consideration of available options for delivering an advanced neonatal resuscitation service.

With regard to neonatal intensive care provision, the CAG notes that in its recent report, the Children & Young People's Pathway (CYPP) group have identified this as an issue and recommended that there should be an increase in capacity to meet need, which will ensure that the sick newborn receive appropriate standards of care.

5. Continuity of care

CAG view

The CAG agrees that continuity of care throughout pregnancy should be provided. CEMACH reports and *Maternity Matters* have shown how delayed and sporadic access to antenatal services increases the risk to mother and baby. This is especially true for vulnerable populations who find it difficult to navigate what can be a complex system of care. There is an increased risk of maternal death for women with complex social and medical needs falling through gaps in distributed and fragmented services.

“Vulnerable women with socially complex lives who died were far less likely to seek antenatal care early in pregnancy or to stay in regular contact with maternity services.”
CEMACH 2008.

Continuity of care was highlighted as a key component of good maternity care in the Health Committee Second Report: Maternity Services, vol. 1 (1992) (Winterton report), page 95, and further endorsed by the Report of the Expert Maternity Group at the Department of Health (the *Changing Childbirth Report*) (1993). Furthermore, successful partnership working in the community will help address the lack of cross-agency communication highlighted by the CEMACH report. An example of partnership working is, Southampton University Hospitals NHS Trust where the midwifery team worked with local Sure Start Programme.

6. One-to-one midwifery care during established labour

CAG view

The CAG fully supports one-to-one care in established labour. The NICE Intrapartum care guideline recommends supportive one-to-one care in established labour with minimal periods of time when the mother is left alone. This may require an increase in the number of midwives in London; however a realignment of the workforce might reduce this need. The evidence base NICE uses suggests that the one-to-one supporter might not have to be a midwife. More research is needed to evaluate the impact of a standardised training programme for maternity care support workers in the intrapartum period.

7. Postnatal care in local one-stop centres as well as at home

There was a clear preference for home visits following the birth of a baby. Respondents felt this was easier for the mother and gave opportunities for assessments of the home environment.

CAG view

The CAG agrees with respondents in the preference for home visits in the early days after childbirth. There is however a place for postnatal care in local one-stop centres after these early days. It is agreed that women find it difficult to travel in the very early postnatal period and the opportunity for assessment of the home environment for mother, baby and family is important, especially in vulnerable populations. In London there will be people from backgrounds where culturally they are told not to leave the house in the weeks after delivery so would not access the local centres.

To achieve the required standard of postnatal care it may necessitate more investment in services.

8. Other

8.1 The framing of the questions

Concern was raised that the framing of the questions may have resulted in a limited vision of the possible future of London's maternity services.

CAG view

Maternity Matters (DOH 2006) focused on access, continuity, choice and safety. Developing services that meet these principles is complex so we interpret the responses to the consultation with caution.

There is evidence of limitations in user surveys of maternity care being used uncritically to shape the future provision of maternity services because service users tend to value the status quo over innovations of which they have no experience (van Teijlingen 2003, Hundley 2004). This is not in any way to deny the value of user input, rather to put it in context.

There is an additional problem that the most disadvantaged users are the ones who are least likely to respond to consultations. There is a need for improved data and information about women with complex social and medical needs and innovative ways of service provision in order to impact significantly on health inequalities in London.

We believe that the questions in the consultation do not enable the whole picture to emerge and are not able to represent the complexity and trade off in the real exploration of issues that affect a woman's choice of place of birth, e.g. how important is travel time to place of birth against perceived quality of care and resources available?

Equally statements to which responses were sought may be too superficial e.g.

"Evidence suggests that senior doctors are less likely than junior doctors to recommend caesarean births; and their presence and influence results in less distress for unborn babies. Distress can result in the disability or even death of a baby." * The future role of the consultant; RCOG, December 2005
Consulting the Capital, page 18*

This statement has not been qualified to inform women that the majority of women will not experience foetal distress and that obstetric care is only required where a problem has been identified. This means that the result of the consultation should be seen in the light of all the information that is currently available to us about maternity services.

8.2 The management of services

Respondents in their free text addressed the question of how maternity services could be best

managed. There was support for the importance of clear lines of referral, good communication between maternity professionals and between other disciplines. Respondents stressed the need to ensure ease of access, choice, continuity and safety and supported both in hospital and out-of-hospital birth. They supported the concept of managed networks of care and of maternity services being commissioned as part of a managed clinical network.

CAG view

The CAG supports these sentiments entirely. The concept of maternity networks was a key proposal in *A Framework for Action* and the CAG wish to re-stress their importance. As healthcare provision becomes increasingly complex there is evidence that patient journeys through the healthcare system (especially for vulnerable users) can be problematic. This is especially true at the boundaries of organisations and professional responsibility – potentially resulting in failures in referral, handover and transfer. This can affect patient safety and quality of care, particularly in areas of care where critical incidents are frequent.

Fragmented and unevenly distributed nature of healthcare leads to disadvantaged populations, such as those found throughout London, falling through gaps in services. There is evidence that increasing professional collaboration/continuity improves outcomes (Zwarenstein 2000).

Further work is needed to clarify the optimum arrangements for maternity networks and to ensure alignment with neonatal networks in particular. The CAG notes that current means of payment for maternity services may not be supportive of a managed maternity network. Further consideration needs to be given to this issue.

Further work

Further work should be undertaken on:

- Managed networks of care and their size and configuration, and their possible impact on safety and safe transfers;
- The configuration and impact of services which support the midwife as the first point of access in the community for women;
- The possible configuration of obstetric units given the potential changes in paediatric services;
- The development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries; and
- Information and data collection on hard to reach groups. This will require gap analysis.

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Children and young people

Proposals

Healthcare for London: Consulting the Capital proposed:

1. Co-ordinated working and improved wellbeing of children:

- Improve understanding of how to lead healthy lives and create secure environments for children;
- Improve equal opportunities to access services for children;
- Promote breastfeeding;
- Place more emphasis on preventing emerging problems, for example obesity and behavioural conditions;
- Ensure that all those who manage children have the rights skills to do so. Where access to GP services is difficult, explore effective alternatives;
- Ensure hospitals caring for children meet the National Service Framework standards and have the right staff available day and night to meet children's needs; and
- Improved co-ordination for children with life limiting or life-threatening illness.

2. Prioritise immunisation through co-ordinated efforts:

- Improve information giving by health professionals to parents, and support those coordinating and managing local programmes.

3. Specialisation of care:

- Care close to home where possible and suitable.
- Improved clarity for parents and carers on how to access the right care.
- Specialist care concentrated in fewer sites following the Royal College of Paediatric and Child Health view.

Responses

Consulting the Capital asked about the concept of care being provided locally for the majority of cases, including urgent care, but specialist care for children concentrated in hospitals with specialist child care. This may mean specialist care is provided further away from home.

Fifty-four percent of people agreed with this proposal. In particular those working within the NHS were more in favour (60% to 50%). Organisations were slightly less likely to support the proposals than the public.

The consultation also asked what could be done to encourage parents to immunise their children. On this second issue of immunisation, stakeholders and the general public were in tune.

1. Co-ordinated care and improved wellbeing of children

Many organisations expressed the view that the *Framework for Action* pathway groups should have been more inclusive of social care. Within the same theme of co-operative working, respondents emphasised the importance of developing services within extended schools and children's centres. The importance of health promotion, illness prevention and early identification was stressed by many respondents.

CAG view

The CAG acknowledges recent publication of the Children & Young People's Pathway (CYPP) report. The recommendations of the CYPP not only endorse and build on the Healthcare for London proposals, but also address issues raised during the consultation.

From the outset the co-chairs of the CYPP group recognised the importance of a multi-agency and multi-disciplinary approach, incorporating the principles of *Every Child Matters* (ECM) and *the National Service Framework for Children, Young People and Maternity Services* (Children's NSF). This was reflected in the group's constitution and recommendations.

The CAG acknowledges the importance of integrated service provision. The CYPP report proposed that schools and centres become part of a networked arrangement with dedicated facilities for children within community healthcare centres. An arrangement such as this would have the advantage of offering health promotion and illness prevention activity, enable earlier identification of children's problems, and provide prompt access to specialist services including a range of therapies. There would also be improved access to services for children with urgent care needs. Co-location of staff would achieve better integration between primary, secondary healthcare, social care and education. Agreement between PCTs and local authorities would need to be reached and joint commissioning is desirable.

The CAG fully supports health promotion, illness prevention and early identification as a priority area for investment, and holds the view that much can be achieved by:

- Full implementation of the recently revised *Child Health Promotion Plan*;
- A greater focus on parenting skills;
- Promotion of mental health; and
- Early identification of vulnerable families in the ante-natal period so that programmes of support such as the Family Nurse Partnership can be offered.

To achieve this, a joint commissioning framework would be required, underpinned by joint strategic needs assessment.

2. Immunisation

There was general acknowledgment of the importance of immunisation and the need to improve immunisation rates in London. Many commented on how immunisation might be made available on a more opportunistic basis, to enhance uptake.

"Make it easier to get immunisation e.g. go to the baby and toddler groups, swimming pools, children's entertainment etc."

Female, aged 45-54

A small number of respondents expressed the view that immunisation should be a private matter for parents, and that choice should be offered over immunisation schedules.

CAG view

Immunisation is the most effective preventive measure available. Failure to immunise exposes children to potential disability and death from a range of serious illnesses. Public uncertainty persists following the MMR scare and it is evident that there is still a great deal of work to do in order to regain public confidence. The greatest improvement in immunisation rates will most likely be achieved by convincing sceptical parents of the safety of the programme and encouraging them to attend at scheduled times.

The CYPP report promotes opportunistic immunisation in a range of areas, including acute healthcare settings, at primary and secondary school entry, in Sure Start facilities and extended schools. However, it must be emphasised that having accurate data on a child's

immunisation status will be essential if opportunistic immunisation is to be offered. Universal use of the parent held child health record would be invaluable in such circumstances. It will also be necessary to capture immunisation data, with professional access to up-to-date information systems. Mechanisms for achieving access and maintenance of the database will require further work. Opportunistic immunisation will make co-ordination of the schedule more problematic; it should only be offered if accurate information is available. Furthermore other linked proposals may improve the situation, such as altered GP opening hours. It should be incumbent on all staff working with children to raise the awareness of the importance of immunisation.

With regard to 'choice' in accepting immunisation, it remains government policy that immunisation is not mandatory before nursery or school entry for example. It is important, however, that parents are aware of the significant risks of failure to immunise their child, and receive appropriate professional advice if they have concerns about risks of immunisation. Choice should be fully informed. Single immunisations cannot be recommended because of serious doubts about effectiveness, and will not become optional.

3. Specialisation of care

Although the consultation document emphasised that most urgent and acute care for children could and would be provided close to home, it proposed that in order to meet the needs of children who were more sick and needing in-patient care safely, there should be fewer in-patient units where such specialist care could be provided.

Some respondents called for specialised treatment to be provided in all local hospitals, but there was also general acceptance that this was neither practical nor possible, and many respondents supported the concept of 'specialisation' with the belief that well-resourced expert care outweighed the need for treatment to be provided locally.

"Highly trained specialist care is more of a priority than convenience in my mind."
Female 45-54

A significant minority thought that it was more important for the ill child to be closer to home, particularly as they thought that being surrounded by family and friends would aid recovery. There was also an emphasis on stress, and support for families in terms of travel and accommodation, particularly for those on lower incomes.

"It can cause huge difficulties if you have children at home trying to arrange care for longer periods of time."
Female 45-54

CAG view

The CAG supports the proposal that there should be fewer in-patient paediatric units, but in reflecting on the question posed in the consultation document, consider that the concept of 'specialist care' and the proposed pathway for ill children needs clarification. The question lacks precision, and this was highlighted in some of the responses. 'Specialist' care may have been inappropriately used in this context. There is not a clear division between specialist and general care, rather it is a continuum. Therefore it is the degree of specialist practice that is needed along a continuum or pathway that should determine where the child is treated. A focus on competence rather than profession is key.

Most children with acute illness can be managed in community settings with supportive advice from primary care services, and other agencies, without the need for attendance at A&E services or admission to hospital. A&Es are not always appropriate places for provision of children's urgent care. Changes to GP working hours ought to result in fewer children attending A&E as access to primary care services will be improved, and community children's

nursing teams can be very effective in providing support for ill children in the home. Provision of urgent care within community healthcare clinics is also envisaged.

There are groups of children who require periods of observation or treatment, without formal admission to hospital, before safe clinical decisions can be made about continuing care at home. This can be undertaken in paediatric assessment units, and all local and major acute hospitals should have, or will retain this facility. Most acute care for children, therefore, can be provided close to home.

Many children who are observed in paediatric assessment units can be discharged home within relatively short periods of time. There are children who need a more prolonged stay in hospital because of the nature of their illness, which may be more severe, and which requires a higher dependency of medical and nursing care. The numbers of such children are reducing, due for example, to earlier detection of illness and improved preventive practice. This is leading to a dilution of the skills needed to deal with such illness. There are benefits to children in having expertise concentrated in a smaller number of inpatient units. In addition, the CAG acknowledges that financial issues are a factor; money spent in maintaining paediatric units with low bed occupancy may be more wisely spent on health promotion and preventive practice.

There are small numbers of children who need either very high dependency or intensive care, or access to a range of other highly specialised services. These are currently provided in an even smaller number of major acute or specialist hospitals. Such services have very complex inter-relationships, and work has recently been undertaken by the Department of Health and the Royal Colleges recommending how these should be configured to ensure safe practice. The CAG acknowledges that some such services have been subject to review in recent years, and recommendations made have not acted upon, i.e. despite acceptance for the need for change, such change has been slow to occur in practice. The example of paediatric cardiac surgery was raised by a respondent. The new framework of interdependency has provided the opportunity for commissioners to reconsider this situation in particular.

Transport for sick children is a key issue. Should a unit be re-designed so that it provides short stay observation beds only? Dedicated transport links to a linked major acute hospital should be commissioned.

It is interesting and important to note that 77% of respondents agreed that there should be specialist centres for trauma and stroke, compared to 54% for children. This may highlight variation in interpretation of evidence, and or insufficient communication with the public on the case for change in paediatrics compared to other specialities.

In order to make the system work effectively networked arrangements will be necessary. This will involve different hospitals working together to ensure that safe practice is maintained.

4. Other

4.1 Interdependency with paediatric services

Although the link was not specifically made in the consultation paper, the interdependency of paediatric and obstetric services was raised by some respondents and the implications for the newborn baby if services change. The Royal College of Paediatrics and Child Health (RCPCH) raised the issue of shortage of neonatal intensive care cots in the capital.

CAG view

There are important principles of safe practice that must be adhered to in all circumstances.

The first is that all newborn babies need access to individuals who have the ability to offer life support. If a mother's pregnancy has been considered to be low risk, and birth is taking place either at home or in a midwifery-led unit, then basic life support skills are all that the baby should need. It is a requirement that all midwives have such training.

A mother whose pregnancy has been considered to have any risk, or if complications arise in labour, will be advised to deliver in a doctor-led obstetric unit. The newborn baby will require access to individuals who have advanced life support skills. The standards for this service, including the skills required, have been established by the British Association of Perinatal Medicine. This service must be available to mothers in labour within an obstetric unit 24 hours a day.

In the event of any reconfiguration of paediatric and maternity services, these standards must be maintained. A significant increase in numbers of deliveries in London is anticipated. Further work will be required to ensure this need is met. Any planned service re-design should include careful consideration of available options for delivering an advanced neonatal resuscitation service.

With regard to neonatal intensive care provision, the CAG notes that in its recent report, the Children & Young People's Pathway (CYPP) group have identified this as an issue and recommended that there should be an increase in capacity to meet need, which will ensure that the sick newborn receive appropriate standards of care.

Summary

1. Co-ordinated care and improved wellbeing of children

The importance of co-ordinated care and networked arrangements was stressed by all.

2. Immunisation

Immunisation is imperative. The current mechanism to improve compliance should be exploited. Any changes to current system, particularly introduction of opportunistic immunisation, will require investment in data capture. The CAG stresses the need to first optimise current strategies, and not to change mechanisms without good data systems. Furthermore it is incumbent of professionals to educate about immunisations at every opportunity, allowing carers and parents to make fully informed choices.

3. Specialisation of care

Caring for children requires a spectrum of options. Enhancing local care, e.g. through improved access to primary care, will facilitate care close to home. However, services which cater for children with high level needs, either acutely or on a longer-term basis will still be required. As the number of children with high-level care needs is lowering, it is safer and more efficient for this type of care to be provided in dedicated centres. Issues of transportation and co-ordination of care need addressing. Both stakeholders and the public accept the need for specialised services. The CAG supports this view, but stresses the need for location of care to match the spectrum of need. Furthermore to underpin safe care for children at all sites, professionals must have appropriate training and hospitals caring for children should meet the NSF recommendations.

Communication with public and stakeholders concerning the need for change is required.

Mental health

Proposals

Healthcare for London: Consulting the Capital proposed:

1. Develop existing mental health services:

- Young people between 14 and 25 with emerging mental health problems should get help quickly;
- Reduce fear of services, particularly in communities where it is less culturally acceptable to seek help;
- Set out clearer pathways to care to ensure anyone coming into contact with people with mental health problems know how to contact services and what to expect; and
- Greater use of cognitive behaviour therapy and other 'talking therapies'.

2. More choice:

- Service users should have more choice over the service or treatment they receive.

3. Services should meet the needs of individuals:

- Services should address the needs of minority groups, offenders, and people with dementia.

4. New ways of working:

- Clearer focus for generalist community mental health teams (CHMTs); and
- Vision for specialist inpatient mental healthcare.

Responses

Consulting the Capital stated that a new mental health working group with clinical representation had been established with results expected to be published in the summer 2008. People were asked for their views on the recommendations to help inform the working group.

CAG view

The CAG agrees that mental health should be 'everybody's business', from managing stress through to care for severe long-term conditions. Most people should have their mental health needs met outside the health sector – in schools, in their employment and in their community. Many mental health problems are caused or aggravated by problems in these arenas. A key challenge therefore is to work across organisational boundaries, with local authorities, criminal justice agencies, and the voluntary sector in order to best provide the complex array of interventions necessary for prevention, treatment, rehabilitation and recovery. Ensuring that people and their families are well informed and treated as key partners in understanding and managing their difficulties is the basis of a modern society.

1. Develop existing mental health services

1.1 Prevention and health promotion

A significant percentage of replies to the consultation mentioned the need for readily available help and advice to manage stress and to reduce alcohol consumption and illicit drug abuse. Forty-six percent of respondents wanted help to reduce stress, not just through the health service but through working with their employers and the government to reduce advertising and promotion of alcohol, tobacco and junk food and to increase their levels of exercise and lead a healthy lifestyle – which in turn lead to good mental as well as physical health. The Patient and Public Advisory Group to Healthcare for London also pointed to the need for initiatives to address isolation, particularly amongst the elderly, to prevent depression and anxiety.

CAG view

Prevention and health promotion is vital in mental health as well as physical health. While the CAG fully endorse the importance of prevention, the challenge will be to develop and fund an appropriately skilled workforce. This cannot be delivered by the health service alone as it requires attention to the social conditions in which people live including access to quality housing, education, employment and leisure facilities.

We encourage the involvement of the NHS in working alongside local authorities and the Mayor of London to improve the quality of local services that have a direct bearing on mental wellbeing and to establish cultural and spiritual supports.

As many mental health problems begin in childhood and adolescence, it will be particularly important to focus this preventive work from an early age. Initiatives such as those being developed through the National Academy for Parenting Practitioners will be needed to support the training of a range of practitioners to deliver this agenda across health, social care and youth justice agencies. The importance of local school and youth community initiatives will be imperative.

The public health benefits to wellbeing and health; of smoking cessation, sensible eating and drinking, and a more active lifestyle through sports and leisure activities are well understood. The Royal College of Nursing (RCN) London sees possibilities to further strengthen the contribution of nursing and allied health professionals in these areas.

An information campaign could help to raise public awareness of mental health needs, reduce stigma and discrimination and maximise effective education, and improve to access help.

1.2 Improvements in the management of crises

In mental health there is significant expertise in developing home treatment and community services with affordable, sustainable skill-mixes based on the optimal use of resources, e.g. nurse-led memory and other clinics. The introduction of assertive outreach and crisis home treatment teams has accelerated the move to reduce reliance on inpatient care and there has been a progressive reduction in the numbers of mental health hospital inpatient beds over many years.

Inpatient care

In their response, the King's Fund highlights that mental health admissions have been rising since 2004 and inpatient bed occupancy in London continues to be over 100%, despite continuing efforts to manage ever more disorders in the community.

CAG view

In this context it is essential to review the focus on the function and quality of inpatient care. Greater attention needs to be given to improving the safety and quality of the inpatient experience – including attention to social and recreational activities on wards to assist recovery.

Home treatment

Though welcomed, crisis home treatment is poorly developed in the evidence-based practice use, with large variations in implementation across the capital including some sites (according to consultation responses) where it is not available 24/7. If crisis home care is to be an effective alternative to hospital care, it needs to be adequately staffed by experienced clinicians using evidence-based care pathways and available around the clock. This is supported by findings of recent major national studies on the functioning and capacity of crisis home treatment teams and the availability of alternatives to hospital admissions such as respite and crisis supported accommodation.

The quality of social care infrastructure is key to the success of providing affordable models of home treatment to reduce hospitalisation. For home treatment to be successful, practical support systems and a home of adequate condition is essential. Protracted stays in hospital are often due to simple problems with utilities (plumbing, electricity etc) or rent arrears. Home care has to consider an affordable, sustainable team skill mix which includes sufficient support staff to make this viable.

1.3 Greater use of cognitive behaviour therapy and other ‘talking therapies’

Calls for improved access to talking therapy was by far the most common issue raised in the consultation with acknowledgement of the need for access in primary and acute care, as well as specialist mental health services.

CAG view

While the CAG fully endorse the need for an expansion in the availability of talking treatments, the major challenge lies in the development of the skilled, affordable workforce needed to deliver the range of modern evidence-based interventions and the capacity to offer choice where more than one intervention is needed. These interventions should be available regardless of where the service user lives. The Improving Access to Psychological Therapies (IAPT) programme will be one vehicle for the dissemination of evidence-based therapies such as cognitive behaviour therapy. Given the expense of training and implementing all talking therapies, priority will have to be given to those with the strongest evidence base and this may mean difficult choices for some agencies with an investment in less well-evidenced therapies.

The current availability of therapies is very variable and there will be a need to ensure that in all developments, e.g. polyclinics and local hospitals, access to these approaches are considered and at the very least, clear pathways to access this expertise are provided.

1.4 The need to integrate mental health assessment into care pathways

In settings where the focus is on people with physical health problems, it is important to recognise that those with a current long-term condition such as diabetes, ischaemic heart disease and cancer are:

- At greater risk of mental health problems such as depression and anxiety that exacerbate the condition;
- Increase healthcare consumption; and
- Reduce positive physical health outcomes.

There are also patients who are consulting with physical symptoms that are of mental rather than physical origin, often only identified after extensive, costly physical investigations have been undertaken. For these individuals, the likelihood of a successful outcome is poor right from the start.

In many services, from community agencies through primary and acute care, staff are not sufficiently supported with psychological training or commissioned talking therapies and thus fail to consider the underlying psychological symptoms.

CAG view

It is important that mental health is incorporated into physical care pathway approaches, and that all staff are trained in screening and assessment. It may be safer to treat these problems with psychological approaches than with antidepressants that can adversely affect their physical condition or interact with other drug treatments.

Initiatives to improve assessment and recognition of the causes of physical presentations will improve outcomes and deliver greater NHS efficiency. Staff need to be appropriately trained and would benefit from an agreed set of assessment and diagnosis tools to assist them.

1.5 Substance use (alcohol and illicit drugs)

In addition to responses on the public health consequences of alcohol policy and illicit drug use (see above), there were a number of comments concerning the need for improved access to substance misuse specialist services. One issue that will be a concern of the forthcoming report of the mental health working group report is the availability of services for people who have both severe mental illness and a substance use problem.

CAG view

As a group these patients are among the highest consumers of mental health services, and have very high levels of morbidity and mortality arising from physical health consequences of nutritional neglect, substance abuse and self-harm. These are complex problems that often lead to multi-agency involvement including housing, social care and criminal justice. Early detection is essential and should include an assessment of the significance of behavioural problems, substance misuse and psychotic symptoms. In the early stages of adolescence, these can be particularly difficult to distinguish from more benign or transitory states. We endorse the call for improved training in the detection and management of these disorders. At present few of the existing workforce has the necessary range of skills to provide the models of integrated care, i.e. substance use and mental healthcare provided by one team.

2. More choice

2.1 The need for greater availability of choice and personalised care

A number of responses indicated support for more personalised care, with the need to develop self management approaches for longer term conditions. There was support in principle for direct payments as a way to expedite personalised care, but concern about the level of speed and complexity in currently accessing such arrangements. A number of respondents called for greater availability of alternative medicine, e.g. homeopathy.

CAG view

The CAG support the implementation of the strong evidence base which finds that where service users, families and carers are supported with information and self-management approaches, relapse rates are reduced, readmission decreased and outcomes improved. A review of the extent to which accessible flexible budgets to support personalised care

packages can provide improved outcomes is important. The CAG acknowledges that some patients find 'alternative therapy' approaches helpful, but urges caution that the first priority should be to deliver evidence-based self management approaches and talking therapies where these are of proven scientific efficacy for specific conditions.

3. Services that meet the needs of individuals

3.1 Traditionally hard to reach groups

The response to the consultation included a good representation from minority communities. A focus on health inequalities is needed as well as development of care pathway and service models which ensure that services are accessible and target those most in need and those who are least likely to seek help through health service provision. There is a need to provide information in a variety of formats and languages and for translation services. This is particularly important in mental health as there is evidence that some mental health problems may have a greater incidence in these populations while they are also less likely to receive talking treatments. Services must address varying cultural and spiritual needs.

3.2 People with learning disabilities

CAG view

Care pathways should be mapped out from the point of view of people with learning disabilities, as well as other disadvantaged groups, to ensure their unique and often complex needs are met. Recommendations include:

- Map out each care pathway to consider the impact for a person with a learning disability, including primary care;
- Support the current NHS choices and Department of Health information prescriptions processes to provide accessible information for their care group, particularly provision of information in more visual formats; and
- Extend each care pathway group to include a learning disability clinician. A commitment from the clinician to help the pathway group work on implementing the pathway would be needed.

4. New ways of working

4.1 Polyclinics

Approximately 40% of all consultations at general practice and at least as many in ambulatory hospital settings involve mental health problems (as a primary diagnosis or presenting with physical symptoms or as a co-occurring condition). Similarly, many long-term mental disorders are associated with greatly increased risks of serious physical ill health. The current physical separation of community mental health centres, general practice and hospital services contributes greatly to problems of missed diagnoses, less effective treatment of co-morbidity and to wider problems of stigma and discrimination. We therefore welcome the core idea of providing a 'one-stop-shop' that brings together mental healthcare, primary care and a range of hospital-based services at a local level.

This could involve being the co-located base for a community mental health team, and the expansion of practice-based psychological therapies, particularly CBT. Aligning access to crisis home treatment teams, with their role in preventing admission to hospital beds for those with severe mental health problems, and in expediting discharge was also advocated. Specialist nurse-led clinics, including those for people with memory impairment and perinatal

conditions could be integrated. There was also strong support to further develop the role of child and adolescent mental health services with primary and acute care partners. Mental health prevention work could also be a part of the key work of a polyclinic.

Networked practices where different clinicians may be aligned or co-located with diagnostic services easily available could aid development of new and innovative services for patients.

It seems likely that the precise polyclinic model will vary depending on local circumstance. We also recognise that co-working does not necessarily follow automatically from co-location and that such models may actually prove to be more expensive than the present arrangement. Nevertheless, we are keen to support pilot sites and models and wish to see mental health incorporated into the planning and execution of these.

4.2 The vital role of commissioning

The Patient and Public Advisory Group to Healthcare for London noted the need for services to be commissioned based on outcomes, and for better co-ordination of services. Differences in mental health spending across London was also raised as a concern, though increased spend has not been assessed for efficacy.

CAG view

A great deal of knowledge has been gained from the nine years of implementing the national service framework. It is often clear which effective structures need to be commissioned, and in many areas great progress has been made. Similarly, the growing development of public and practitioner supported regulatory and provider standards has helped improve quality.

However there is now a need for commissioners to be supported in commissioning services which not only specify the optimal effective service structures and teams, but in addition specify the evidence-based care pathways, clinical standards and outcomes to be implemented. Based on these very helpful consultation responses and the forthcoming care pathways publication, the CAG would wish to support health and social care commissioners integrate these crucial elements into future commissioning.

5. Other

5.1 Maternity

For high-risk women with mental health conditions, the National Institute for Clinical Evidence (NICE) found that clinical networks are essential to achieve safe improved care.

Clinical networks should be established for perinatal mental health services, managed by a co-ordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- A specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams;
- Access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding;
- Clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental disorders, to ensure effective transfer of information and continuity of care;
- Pathways of care for service users, with defined roles and competencies for all professional groups involved.

Acute care

Overview

Consulting the Capital and a *Framework for Action* described the current situation in acute care in some detail. At one end of the scale three million people attend London A&E services, and many of these have minor illnesses or injuries that could more appropriately have been treated in the community. Up to 40% of ambulance cases might be cared for in this way. At the other end services for more complex diseases are simply not good enough. The difference in outcomes between the best stroke and trauma units and the majority of hospitals are stark.

Proposals

Healthcare for London: Consulting the Capital proposed:

- 1. A single telephone number for urgent care advice.**
- 2. Specialist care for heart attacks, severe injury, stroke and complex emergency surgery.**

Responses

1. Single telephone number

Consulting the Capital asked about a telephone service to treat urgent care needs, and what facilities this service should have, e.g. provide general medical advice, book appointments with GPs or other health professional, or transfer calls to emergency services.

There is widespread support for the concept from stakeholders, but some important negative comment. Broad support outweighs opposition or disinterest by three to one and this is important. The London Medical Committees (LMCs), pan-London and Surrey and Sussex are generally supportive, London more so, but with an important reservation about the telephone service being used to directly access appointments. They feel that this may be inferior to a really good local service that benefits from the relationships many patients develop with their own surgery. The London Ambulance Service (LAS) response is very detailed in this area and includes some well developed proposals on a pilot scheme in partnership with NHS Direct which is worthy of further attention.

The need for simplification, and better signposting is universally accepted, and the public are most interested in straightforward access to someone who can give them meaningful clinical advice or direction. A lot of the negativity is focused on the practicalities of implementation, for instance IT, rather than on the concept. Dislike for automated telephone answering services was also raised by some respondents. This whole area was not a particularly big issue in the consultation responses. This could be interpreted in two ways, either it is not important or possibly because it is not controversial.

CAG view

The CAG has worked with stakeholders, a general practice Healthcare for London sounding board, the polyclinic reference group and an unscheduled care stakeholder workshop. There is

an emerging theme from respondents that a London-wide solution is desirable, but that the telephone service, although a key enabler, is only a component of that. There also needs to be urgent primary care centres, both in the community, and at the front end of A&E departments and the potential of practice based commissioning needs to be realised to repatriate demand from acute hospitals. In the transitional period this may need some double running. There are also estates and workforce issues that will need addressing in more detail.

2. Regionalisation of some services

The consultation also proposed providing more specialised care to treat the urgent care needs for trauma, stroke and complex emergency surgery. People who agreed with this proposal were asked whether ambulance staff should take seriously ill and injured patients directly to these specialist centres, even if another hospital was located nearby.

The whole concept of regionalisation is almost universally endorsed by key organisations. This includes LMCs, the charity sector (Stroke Association), acute trusts, secondary and tertiary hospitals, and more diverse stakeholders including the King's Fund, British Homeopathic Association and Faculty of Homeopathy. One organisation, an east London LMC, was uniformly negative but not accompanied by detail or examples of evidence for their view.

There were obviously a number of significant reservations in this chorus of approval. Some of these might be principled and some practical. These issues are addressed below.

2.1 Trauma services

Some of the individual responses to the consultation questioned whether three trauma centres was sufficient. The King's Fund endorsed the principles and wanted to emphasise how commissioning was the key to implementation, that quality must be the driver and that the outcomes should be patient not institution-based.

CAG view

A Framework for Action provisionally suggested that there should be centralisation and networks for major trauma for London based around three trauma centres. This figure came from the Royal College of Surgeons' recommendation that trauma centres should serve between one and three million people depending on population density. At the time of consultation, it was felt that London's high population density would mean London's trauma system would operate at the upper end of that range. The responses to the consultation are largely in support for setting up a regionalised trauma system.

Our analysis suggests that the number of trauma centres that the system would need may be more than three (although unlikely to be more than six). This is because the programme would need to agree how many of London's patients would use the system with neighbouring SHAs and the resulting changes to patient travel times - hence the population base and density may be different. Other considerations, including the degree to which paediatric and burns patients are part of the trauma system, may also affect the final number. When reaching the final number of trauma centres, we would ensure that each received the critical mass of patients needed to deliver the improved outcomes intended by *A Framework for Action*.

2.2 Future role of hospitals

Specialist providers were unanimously supportive of the approach but consistent in highlighting the need to put in safeguards to ensure the viability of all hospitals. District general hospital respondents too drew attention to this issue. There were sensible proposals about redrawing the relationships between acute providers and primary care. Another response

commented on the positive example of the role of networks in the implementation of primary angioplasty for heart attack.

CAG view

The endorsement of the centralisation of a small number of services driven by clear evidence of advantages in the delivery of high quality care is welcomed. The Royal College of Physicians (RCP) acute medicine task force in 2007 acknowledged that the majority of care will remain in what are currently district general hospitals. It is important that the local hospital project team of Healthcare for London continue to work closely with district hospitals to ensure that the movement of small numbers of highly specialised patients does not impact on the majority of patients with less complex needs. Taking stroke as an example, a typical acute hospital sees around one a day, but will see more like 250-300 patients in A&E. The central flow of the stroke patients should not be allowed to influence that of the bulk of the A&E attendees. In its September 2007 report, the Academy of Royal Colleges suggested that “*the facilities and services for urgent and emergency care should be part of a co-ordinated system*” and that this should include all tiers of the health delivery system from general practice through community hospitals, district hospitals and highly specialised centres. Co-operation and effective networking between acute providers will be a necessary element of the future configuration of the capital’s services.

2.3 Paediatric services

Uncertainty about paediatric services was a common theme from providers, and there was a request to develop more clarity on the direction of travel for these services.

CAG view

There is a need to develop more clarity about plans for inpatient paediatric care. It is clear however that the outcomes for children in the UK have fallen short of European comparators and the Academy of Medical Colleges also highlighted this in their 2007 report. They made special note of the better outcomes for children with solid tumours, diabetes or prematurity and said that the configuration of acute services for children needs the fundamental review that is now taking place under the auspices of Healthcare for London.

2.4 Stroke care

The public, stakeholder and health service response to the question about the focusing of 24-hour stroke care in a smaller number of hospitals was strongly endorsed.

CAG view

There is incontrovertible evidence from the RCP sentinel audits of 2004 and 2006 that stroke care in the capital is not good enough, did not significantly improve over that period and is patchy. The precise number of 24-hour stroke centres in London that would best meet the needs of Londoners, where each centre would have sufficient critical mass to maintain high quality care, and travel times would be kept to a limit that didn’t create new inequalities, has yet to be decided. But the approximate figure of seven in the *Consulting the Capital* still makes sense. Whether these are supported by other centres that provide some daytime care, the model recently chosen by Manchester, will need further analysis and work with stakeholders, but must absolutely focus on outcomes and clinical quality. Equality of access, particularly geographical equality, would need to be ensured and any future service changes would require further consultation. It is imperative that any service changes consider training and education for paramedics to ensure that front line ambulance services are highly skilled to recognise conditions including stroke.

2.5 Patient journeys

The practicalities and the funding of the increased number of patient movements worried a number of stakeholders. These included the LAS, GPs and hospital trusts. GPs in particular were worried about the patient pathway lengthening when it might be delivered across acute providers and might involve a non-urgent journey part way through. There were also concerns about how funding/tariff might be apportioned across new pathways and where extra funding for new journeys might come from.

CAG view

The 'Sheffield report' in the Emergency Medicine Journal in August 2007 identified a relationship between distance from hospital and outcome. Conditions where an increase in travel distance might be detrimental to patients were: choking, drowning, anaphylactic shock and acute asthma attacks. As proposed in *Healthcare for London*, care for these conditions would continue to be provided at a local hospital. Furthermore, the associations described in the Sheffield report were applicable from 1997-2001, but because of changes in pre-hospital care the LAS do not believe these results are transferable to London in 2008. The report also clearly states that for some groups of emergency patients, specifically primary angioplasty, acute myocardial infarction and major trauma, care provided at specialist centres improves outcomes:

"With appropriate pre-hospital care and at distances typical in the UK, the benefits of specialist care, which is only available in certain centres, would outweigh any detriments resulting from increased travel distances to the centres."

Sheffield report

Studies in Scotland and East Anglia in trauma and in Sussex of outcomes in aneurysm show no relationship between journey time and mortality. Improved outcomes for heart attack patients travelling further for primary angioplasty, here in London, and in well-run studies in New England and Denmark support this view. The Academy of Medical Colleges also highlights the improved outcomes for children in other European countries with more centralised inpatient facilities. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) also in 2007 provided strong evidence for the concentration of major trauma in a smaller number of centres, identifying sub-optimal care in 60% of cases, recommending consultant delivered care and a minimum case load of 20 per week. There are mixed views about travel services; however this is dependent on a very skilled front line ambulances service, with a focus on training and education.

Summary

Overall there was a great deal of consistency and positivity, across healthcare and other sectors, and a number of very constructive inputs and detailed responses.

Planned care

Proposals

Healthcare for London: Consulting the Capital proposed:

1. **Better access to GPs for routine appointments before 9am, in the evenings and at weekends.**
2. **More outpatient services in the community and more surgery carried out as day cases.**
3. **Access to test facilities in the community to reduce waiting times and save patients unnecessary trips to hospital**
4. **Rehabilitation services provided closer to home, either at a local hospital, polyclinic, or in many cases, in the patient's home.**
5. **More specialist inpatient care should be centralised into large hospitals.**

Responses

1. Better access to GP services out-of-hours

Consulting the Capital asked how useful people would find it for GP surgeries to open for appointments in the evenings and at weekends. Eighty per cent of respondents thought it would be useful if GP surgeries were open for routine appointments in the evenings and at weekends. Sixty per cent of respondents thought that this would be very useful. Age was a factor in these responses with 86% of younger people being in favour of extending opening hours. There was a general feeling that GP opening hours would help access to healthcare for those people who found it difficult to take time off work during the day.

Another theme was that easier access to healthcare outside of the working week might facilitate a preventive approach to managing healthcare. From NHS respondents, one key theme was that extending GP services might ease the burden on the A&E departments within the capital. In contrast to the general support for extended opening hours, some respondents were concerned that increasing access to GP surgeries out-of-hours might lead to a less efficient service unless other aspects of the surgery were also open namely diagnostic, blood tests, nursing services and physiotherapy. There was also some concern that some GPs are already over-stretched and that extending the opening hours may exacerbate this problem.

Responses from GP surgeries were in general less supportive. One particular theme identified was a lack of continuity of care for patients with long-term conditions.

CAG view

The CAG recognises that the vast majority of respondents in the planned care consultation wanted GP practices to be open for longer and extended hours. There did appear to be a difference with regard to the age of respondents.

Clearly, a balance needs to be struck between access to GPs surgeries and continuity of care. One solution might be to provide different services to different groups of the community. For

example, patients who value out-of-hours routine care could register with a larger GP surgery or polyclinic slightly further from home. Other groups such as the elderly, young mothers and the chronically ill may prefer to continue with smaller, local practices open at more conventional times. Of course smaller practices that network together could provide an 'out-of-hours' service.

Extending the hours of GP practices could provide better patient care and relieve some of the pressure on providers of unscheduled care, in particular, the workload on local A&E departments. It should be possible to provide extended opening hours in large GP practices, or in polyclinics. However, it is possible that increasing access hours will simply increase demand and this should be studied before changes to practice are made.

The CAG recognises that extended working hours for GP surgeries will require that other services are also open and available on site. This will particularly include practice nurses, phlebotomy and access to routine investigations. In addition, there will undoubtedly be some manpower issues, and therefore robust and effective quality control of services provided out of the traditional working hours should be ensured. Extending the working hours of GP surgeries, may be a prelude to delivering more specialist care locally with the provision of specialist clinics outside of traditional working hours.

The suggestion by some patients that they be allowed to register with two practices deserves further consideration. There are considerable logistical issues here, particularly around communication, information transfer, record keeping and confidentiality. However, in the current system, walk-in centres, and indeed A&E departments, already provide care to patients registered at distant practices so lessons could be learned from current experience.

2. More outpatient services in the community and more surgery carried out as day cases

Advances in surgical technology mean that many procedures are now less invasive which should allow more procedures to be performed in short-stay or day-care settings.

CAG view

The transfer of outpatient services to the community is a sensible approach. If clinical and cost-effectiveness can be proved for local services, provision of services by primary care specialists is an appropriate plan. Likewise, outreach clinics by specialists, which are long-standing outside of London, are a good use of resources. The CAG is concerned however that patient choice be maintained: if a patient wants to attend a specific service or location then that should continue to be possible.

Where evidence shows a procedure is safely performed in the day-care setting it *may* be appropriate to transfer the service into the community. The CAG is concerned that there are risks attached to any procedure and for the tiny proportion of patients who suffer complications, such as reactions to general anaesthetic, a lack of access to emergency care could be dangerous. Robust safety data will be needed *before* transfer of services and collection should continue as part of clinical governance. Furthermore, safety equipment and provision for rapid emergency transfer would be required at any site providing surgical services. This will affect cost. There are also issues of manpower and training provision which will need to be considered in more detail.

Other elective services may also be appropriate for local provision, such as chemo and radiotherapy.

Finally, there is the question of who should be performing procedures in the community:

traditional NHS or independent providers? The CAG is aware of public concerns regarding privatisation of the NHS but is generally supportive of the use of the private sector where they can be shown to provide a service to at least the same standard and cost-effectiveness of the NHS. The CAG is concerned that any new contracts should constitute a good deal for NHS London.

3. More diagnostic services in the community

The current long waits for diagnostic services was highlighted as a major problem.

CAG view

There is no doubt that more timely access to diagnostics could improve the patient experience. There are a number of other theoretical benefits such as earlier diagnosis, improved outcomes and reduced referral rates but these should be evidence based. As always, there is a danger that increased supply may lead to increased demand and, potentially, to inappropriate referrals. Any new system will need to address this issue.

The CAG recognises that some areas already have some rapid access diagnostic services and it would be useful to discover how successful these have been. This is a prime area for practice based commissioning to help target services to local needs. Innovative solutions such as mobile scanners may also have a part to play.

4. Rehabilitation provided closer to home

CAG view

The CAG is supportive of this proposal providing standards of care are subject to appropriate scrutiny. Concerns exist however around the management of late complications; there will need to be sufficiently skilled personnel at community sites to ensure patient safety. Other issues are logistical: any such system will succeed or fail based on the ability to move patients between sites in a timely fashion. This system adds in an extra transfer compared with the current patient journey so effective transport and bed management will be paramount and will need careful planning. The CAG has some reservations based on current experience of bed availability in London.

5. More specialist care

More specialised inpatient care should be centralised into large hospitals. Recent data has suggested that there is a clear relationship between the number of complex procedures performed, and the outcome of such procedures. Along with other arguments such as centralisation of expensive technology and diagnostics, there is a case for service reconfiguration of specialised surgical services. It is proposed that such services might be delivered by centralisation of care, and utilising a hub and spoke network approach. This model would allow consultation, diagnosis and surgical planning to take place locally. Complex surgery however would be centralised, and rehabilitation from these procedures would take place either locally or at home. It was also envisaged that specialised providers of complex surgery should be able to offer care on other hospital sites to ensure that services remain local.

CAG view

The CAG is in agreement with this proposal.

Summary

1. Access to GPs

Access to GP services for routine appointments should be improved. Primary care should be provided at a wider range of times, although the exact system by which this should be accomplished needs further consideration.

2. More outpatient services in the community and more surgery carried out as day cases

Increased use should be made of the day care setting for many procedures. Some long-term conditions should be managed in primary care and others should be managed by specialists in outreach clinics.

3. More diagnostic services in the community

Some diagnostic services should be moved to the community setting.

4. Rehabilitation provided closer to home

Rehabilitation from major illness or surgery should be done at home, or close to home wherever possible.

5. More specialist care

More specialised inpatient care should be centralised into large hospitals.

Long-term conditions

Proposals

Healthcare for London: Consulting the Capital proposed:

- 1. Prevent long-term conditions by promoting healthy living.**
- 2. Increased care in the community:**
 - GPs, practice nurses and social care staff should be supported to develop effective ways of diagnosis and finding undiagnosed people who do not present to the healthcare system;
 - Encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills; and
 - Community pharmacies can support people with long-term conditions.
- 3. Giving control to patients:**
 - Full range of support so that patients can manage their own condition with professional help;
 - Patients should make informed decisions about the support they need through expert patient programme and information prescriptions;
 - London-wide guidelines should be developed; and
 - Greater use of community healthcare professionals or specialist nurses working in the community.

Responses

Consulting the Capital asked about how the NHS in London is balancing resources in long-term conditions. In particular, whether a greater proportion of future spending should be invested in community support, in hospital care or whether the current balance of investment was about right.

There was a clear preference for investment in community support for long-term conditions. Two thirds of respondents thought that a greater proportion of future spending should be invested in GPs, specialist nurses and other health professionals. This view was shared by clinical organisations, patient organisations and councils.

1. Health promotion

There was agreement that money should be spent on health promotion and that this would decrease the burden of long-term conditions.

CAG view

Whilst the CAG supports this argument, it is imperative that there is recognition of the difficulties in changing behaviour and the amount of resources needed to enable change. There are many examples in London of innovative projects to promote health. There are also many examples where projects to promote health have failed. Rigorous evaluation of health promotion methods is essential for all projects to ensure delivery, particularly on reduction of health inequality.

It is salutary that the National Institute for Clinical Evidence promotes some solutions for health promotion that have NO evidence in fact (e.g. recommending primary care invest resources helping people to lose weight using methods that have not been shown to produce the desired outcome which is *long-term* maintenance of lower weight. Although this is the outcome we desire, we still have no clear evidence of how to help people do this). Health promotion should not be seen as 'politically correct' and an ingredient to be added to any pie without thought and resources.

Addressing health inequalities requires thinking that includes more than just healthcare. Since economics is the main cause of health inequalities, thinking needs to address this also.

2. Care in the community

2.1 Expanding community care

Many respondents talked with enthusiasm about the advantages of increasing spending on community care.

"GPs and nurses can provide a more 'personal' service and develop a relationship with people and hopefully make it easier to persuade them to change."

Female aged 55-64

Some respondents commented on the fact that some GPs seem unable to cope. There were concerns expressed about the quality of care.

"Moving too much into community can result in reduction in quality of care – and before you say 'skill mix' I have seen what can happen when skills spread too thinly."

Male age 55 -64

Some felt it important to emphasise joint working.

"I think the combination (specialist / community) is very important."

Female 45 -54

The design of primary and specialist interaction was considered important.

"Most studies of consultant outreach services have failed to show clinical or cost benefits."

Londonwide LMCs

CAG view

The CAG agrees that investment in community services is important. It is imperative that primary care is supported in providing the high quality care to patients that is needed, both by investment, and by being able to work more closely with specialist colleagues. There is good evidence of the benefits of employing more community staff to help care for long-term conditions – particularly of skilled nurses working in the community decreasing the number of admissions.

However, it is vitally important that primary and specialist care for patients with chronic illness evidence is linked and co-ordinated (Rothman AA, Wagner EH. Chronic illness management: what is the role of primary care? *Ann Intern Med* 2003; 138: 256-61). There is evidence that closer integration of primary and specialist care improves healthcare for patients on an individual and population basis (McCulloch DK, Price MJ, Hindmarsh M, Wagner EH. A

population-based approach to diabetes management in a primary care setting: early results and lessons learned. *Effective Clin Pract* 1998; 1: 12-22.).

Closer integration does not, however, simply mean moving specialists into community settings – it means a properly integrated primary and specialist care service developing pathways, establishing core competencies, promoting and delivering staff and patient education and as a resource to turn to in more complex cases. [See comments on best use of consultant and specialist nurse expertise in CAG response to ‘Where we could provide care’.]

It is important that all facets of a multi-disciplinary healthcare team should be in place in the community – speech and language therapists, dieticians, specialist nurses in nutrition and physiotherapists for stroke patients, for example – in order to avoid unnecessary admissions to, or long stays in hospital.

There will need to be local ‘needs assessments’ and care provision in order to reach those groups that are traditionally ‘hard to reach’ and services will need to meet local, cultural and language needs for this reason.

Moving care into the community will require consideration of how it will integrate with social services, including costs and education.

2.2 Finances

Several respondents commented that providing more care in the community would result in savings which could be invested in secondary care. There was concern, however, that an ageing population will place ever-increasing demands on already stretched community resources.

“To what extent can the NHS or local authorities ‘invest to save’ in the context of an increase in the number of older, frail, adults? Alternatively, can we afford not to ‘invest to save’ given the ever increasing costs of caring for an ageing population?”
Croydon Council

*“For instance, Darzi recommends preventative healthcare, but most local authorities have already cut “low” and “medium” criteria for care, leaving only the “substantial” and “critical” criteria. This means that hundreds of thousands of old people are refused help with bathing, house-cleaning, bed-making, laundry, shopping etc. The effect is loneliness, stress and increased health problems. Many local authorities are now planning to cut “substantial” care with potentially even more disastrous results. “Throughout the review Darzi proposes services, e.g. early intervention, community and inpatient care which **should** be put in place, and many of these we would welcome. However nowhere in the review are there proposals about how “should” can be translated into ‘will!’”*
National Pensioners Convention, Greater London

CAG view

Investment in community/primary care services should not be seen as the ‘cheap’ option. Care will have to be provided for the increasing number of people living longer. Cost effectiveness may improve but total costs are likely to rise.

Furthermore, to reduce health inequalities there will have to be an unequal distribution of increased spending. Health inequalities of the size we see across London occur, not because of good or poor doctors, but because of poverty and deprivation, a point made by several patient organisations. Healthcare for London cannot alter this. It can recognise that some people need more spent on them than others and ensure that the funding reflects the need.

2.3 Primary care capacity

Some respondents commented on the fact that some GPs seem unable to cope.

CAG view

It is imperative that primary care is supported in providing the high quality care to patients that is needed both by investment and by being able to work more closely with specialist colleagues. This does not mean merely moving specialists into community settings – it means a properly integrated primary and specialist care service developing pathways, establishing core competencies, promoting and delivering staff and patient education and as a resource to turn to in more complex cases.

“The same comments apply to the proposal (p.120, para 52) to consider creating ‘consultants in the community’, particularly when most studies of consultant outreach services have failed to show clinical or cost benefits”
Londonwide LMCs

2.4 Financing education and research

CAG view

To better understand how to reduce health inequalities for those with long-term conditions, education of healthcare professionals will be crucial. To ensure adequate exposure of undergraduates to patients with long-term conditions more of their education will have to take place in primary care and a greater proportion of undergraduate and postgraduate healthcare professional education will need to occur in community settings. This will have to be funded adequately and will require facilities and teachers. At present, the vast majority of education money is spent in secondary care. This will have to change. Similarly, research funding will need to be made available if we are to learn better how to reduce inequalities, particularly in hard to reach populations.

2.5 Continuity of care

There is some evidence that personal continuity of care is of more benefit than organisational continuity.

“There is persuasive evidence to support the hypothesis that continuity of care remains an essential element of modern general practice, and is a pre-requisite for high-quality consultations and effective management. There is also some evidence that personal continuity, as opposed to organisational continuity, is associated with greater patient satisfaction with care and more efficient use of resources. This is likely to be further enhanced, particularly in terms of inter-organisational continuity, by the use of a shared electronic patient record.”
Londonwide LMCs

CAG view

It will be important to ensure that as community teams enlarge, patients with long-term conditions do not have more fragmented care. We agree with the importance of personal continuity and the role that a shared electronic patient record may contribute.

3. Giving control to patients

3.1 Self management

Some respondents felt that increased spending should go towards supporting non-healthcare professionals.

“Whilst we support Option A above the other options. This may mean investment in non-healthcare professionals who can support individuals to take control of their own conditions or facilitate peer support and information exchange. We strongly believe that supporting self management/expert patient approaches is key to reducing the harm caused by long-term conditions.”

Hammersmith and Fulham Council

“Older people must be enabled and supported to choose and access the services they need. Information, advice and advocacy support is essential.”

Age Concern

CAG view

The CAG fully supports the need to promote self-management and believe that non-healthcare professionals have an important role to play. Schemes to promote self-help need to be carefully implemented, as benefits are not demonstrated with all schemes (Griffiths C, Foster G, Ramsay J, Eldridge S, Taylor S. *How effective are expert patient (lay led) education programmes for chronic disease?* BMJ 2007; 334:1254-1256). There is a danger that populations most at need will benefit least from these approaches. To reduce this danger, the setting, timing and delivery of these programmes needs to be researched locally to be sensitive to the local population if they are to be successful in addressing health inequalities. To achieve maximum benefit they need to be well supported and rigorously evaluated. This is particularly important in communities considered as hard to reach: people who do not access either primary or specialist care and frequently present as emergencies.

In addition, translating and advocacy services will need investment. Properly funded translation services should not be seen as optional for primary care – and offering English classes is not a practical solution for many elderly non-English-speaking patients who have been in this country for many years. Inequalities in health occur because non-English speaking patients find it harder to access services.

3.2. London-wide guidelines

CAG view

The CAG believes that care pathways can be very valuable in helping primary care clinicians improve the care they offer their patients. It is unclear why London-wide best practice care pathways need to be developed (as suggested in *Consulting the Capital*) when there are already national care pathways. Developing London-wide pathways will *not* decrease health inequalities. Indeed, implementing London-wide pathways could have the opposite effect if resources are invested implementing pathways in communities that already have better outcomes. It is essential that any care pathway is tailored to the local health community. For example, what works in Westminster may not work in Richmond or Newham. The ‘map-of-medicine’ offers an excellent way of taking national care pathways and tailoring them to local needs without losing the clinically evidenced actions that all clinicians should be following. (The ‘map of medicine’ is a database of best practice pathways for common conditions. Pathways can be amended locally - www.mapofmedicine.com.) Finally, sharing good practice must not deflect from considering the needs and wants of the individual.

Summary

1. Health promotion

The CAG agrees with the aim of preventing long-term conditions by promoting healthy living. Evaluation of health promotion methods is essential to ensure efficacy.

2. Community care

The CAG agrees that:

- GPs, practice nurses and social care staff should be supported to develop effective ways of diagnosis and finding undiagnosed people who do not present to the healthcare system; and
- There should be greater use of community healthcare professionals or specialist nurses working in the community.

There is a need for close integration of primary and specialist care. It is not necessarily true that encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills.

Although investment in community/primary care services may be the most cost effective option for long-term conditions, adequate funding is essential and costs are likely to rise for demographic reasons.

Funding should be directed according to need and to reduce inequity of healthcare provision. Funding for education and research will have to move into the community along with care of long-term conditions.

A shared electronic patient record may help prevent fragmentation of patient care as teams enlarge. Personal continuity of care is important.

3. Giving control to patients

The CAG supports the need to promote self-management and believes that non-healthcare professionals have an important role to play.

The CAG does not agree that London-wide guidelines should be developed. Instead, national best practice pathways can be adapted to local needs.

End-of-life care

Proposals

Healthcare for London: Consulting the Capital proposed:

- 1. All organisations involved in end-of-life care need to meet existing best-practice guidelines.**
- 2. There should be new end-of-life service providers (ELSPs) to co-ordinate care. Voluntary, charitable, public and private sector organisations could all be ELSPs.**
- 3. Patients near the end-of-life should be offered the opportunity to have their needs assessed and to identify their preferred place of death.**

Responses

Consulting the Capital asked whether new end-of-life providers responsible for co-ordinating end-of-life care would result in better or worse care for patients than the current arrangement.

Just over half of respondents thought that new end-of-life service providers (ELSPs), as described in the consultation document, would result in better care for patients than the current arrangement. But responses to the open question demonstrated confusion about the precise role and status of ELSPs. There was unequivocal support for increased co-ordination of end-of-life care and communication between the various providers involved.

There was strong support for patient involvement in end-of-life planning, and in particular for the right to choose place of death. Respondents also supported measures to improve equity of access to care (such as through provision of interpreters) and to ensure 24-hour availability of support.

1. Meeting best-practice

1.1 Training and implementation of best evidence-based practice

Respondents expressed concerns about:

- Variability of training and skills of healthcare professionals;
- General reduction in training budgets in response to recent financial pressures; and
- A well-recognised 'retirement bulge' in the specialist nursing palliative care workforce.

CAG view

This is the first time that end-of-life care has featured explicitly in both regional and National Health Service reform and strategy. At last, there is recognition of the widespread legacy of bad death in the population and steps are being taken to engage the problem. Whilst there are NICE guidelines for the provision of palliative care, education and training in even the basics of end-of-life care are not core competencies for many practitioners who routinely look after the dying.

The CAG shares the view that education, training *and* continued support are of paramount importance, not just of healthcare professionals but those working in social care and any residential facility caring for the chronically sick and dying. It is of considerable concern that continued education is an early casualty in times of financial pressure. This is a false economy since poor training and support is well known as a catalyst of burnout and staff attrition. The

CAG would wish to ensure that services commissioned to deliver end-of-life care at any level had training and education as part of their specification in ensuring that staff operate to the competencies requisite to their roles.

The consultation demonstrated sufficient support for the general concept of a co-ordinated end-of-life care pathway to justify examining and addressing the practical challenges of developing this across London.

There are already a number of initiatives, frameworks and tools that offer support to the development and delivery of a care pathway for London's diverse population:

- The End-of-life Care Programme (EoLC) - www.endoflifecare.nhs.uk
"To offer all adult patients nearing the end-of-life, regardless of their diagnosis, the choice and access to high quality end-of-life care". All Strategic Health Authorities (SHAs) have appointed a lead person to implement the EoLC Programme in their area. The EoLC Programme is co-ordinated by a national director who together with national leads will support the 28 SHAs in England to improve the choice, equity and responsiveness for all adult patients nearing the end-of-life.
- The End-of-life Strategy
A Department of Health national plan is due for publication at the end of June 2008. Every PCT in England has contributed baseline data to inform it. The CAG expects to follow its guidance on the broad themes important for care at the end-of-life, which will then be adapted to suit local circumstances.
- Advanced Care Planning - www.endoflifecare.nhs.uk/eolc/eolcpublications/
Advance Care Planning (ACP) is a process of discussion between an individual and their care provider(s) irrespective of discipline. If the individual wishes, their family and friends may be included. With the individual's agreement, this discussion should be documented, regularly reviewed and communicated to key persons involved in their care.
- SHA Involvement
Progress in the rollout of end-of-life care models/tools has been measured by the SHAs at six monthly intervals (end-of-life care programme – summary of SHA rollout of end-of-life care models/tools Jan 05 – Dec 06).

There are also a number of tools to support the development of core competencies in staff and the provision of high quality care at the end-of-life. NICE recommends the use of three that cover the areas most in need of attention – continuity of care, facilitating patient choice and dealing with the last few days of life:

- The Gold Standards Framework (GSF) - www.goldstandardsframework.nhs.uk
GSF was developed over five years with a multidisciplinary reference group and pilot projects. It aims to improve palliative care provided by the whole primary care team and is currently being used by 1,000 practices in all cancer networks. It enables those approaching the end-of-life to be identified, their care needs assessed, and a plan of care with all relevant agencies to be in place. The framework focuses on optimising continuity of care, teamwork, advanced planning (including out-of-hours), symptom control and patient carer and staff support. Although developed for use in primary care it can and is being used in care homes to assist and consolidate training and core competencies in end-of-life care for residents from all disease groups. An audit of the use of the Gold Standards Framework by GPs in Shropshire, Telford and Wrekin shows the number of patients dying at home is now almost twice as many as before it was introduced. (<http://www.endoflifecareforadults.nhs.uk/eolc/eolc/current/CS203.htm>)

- Preferred Place of Care (PPC) an example of Advanced Care Planning (ACP) - www.cancerlancashire.org.uk
PPC helps patients and carers decide where they wish to be cared for at the end-of-life and begins to offer a means for individualised expressions of a person's wishes and their social context. In other words, a patient begins to be empowered to evaluate their choices and articulate, formulate and record what they consider at the time to be their best interests. Concerns to promote these aspects of care were raised by a number of patient representatives. PPC comprises a patient held record, which records the patient's wishes, the socio-economic circumstances of the family, the services being accessed, reasons for change in the care, and a needs assessment that documents care on an ongoing basis. It has been used in the home and is being trialled in care homes with older people. It is of particular value in guiding care should a patient lose the capacity to express their wishes. With training, paid carers come to understand and gain confidence in communicating, promoting and facilitating patients' autonomy and dignity and seeing individuals holistically – all core competencies key to developing and delivering excellent care.
- The Liverpool Care Pathway for the Dying Patient (LCP) - www.mcpcil.org.uk
This is a tool to assist practitioners to deliver good and appropriate care to their patients in the last days of life. LCP was developed for use in hospitals but has been adapted for use in primary care and in care homes. The training is led by the specialist palliative care teams for LCP. It provides a care pathway, confidence and guidelines to facilitate communication with the patient and loved ones, symptom control and other basic aspects of good care for those in the active phase of dying. Whilst developed in cancer, it is a generic model and can be transferred to non-cancer patients. An education programme has been devised by the Liverpool team.

Whilst the CAG supports the use of these or similar tools which achieve an equivalent outcome, we emphasise that they are neither ends in themselves, nor do they support themselves. They are meaningless when used by staff without the requisite competencies. They require a full programme of education, support and appropriate resources to achieve their goals to facilitate excellence in care.

1.2 Impact on partner agencies

There were clear calls for the NHS to work more closely with other partners, including the voluntary sector and social care services. Respondents emphasised the need to acknowledge, develop and extend the work of the voluntary sector, particularly in hospices.

CAG view

CAG strongly supports this position. Close working with partner agencies will facilitate locally tailored solutions, based upon agreed standards and competencies through a comprehensive and detailed commissioning process, and is the wise way forward to ensure equality, equity and effectiveness across the capital.

2. End-of-life service providers

Both the general public and stakeholders expressed confusion as to who ELSPs would be. Both groups questioned the need for another tier of organisation. Concerns about additional bureaucracy and complexity and issues of governance were raised.

“Not more bureaucracy.”
Female, aged 45-54

“We are concerned, however, about the concept of ‘end-of-life service providers’ (ELSPs) (p.80, paras 239-241) to co-ordinate this care. This function for many years has been appropriately and effectively discharged by primary care teams working closely with community nursing, social services, palliative care nurses and specialists.”

Londonwide LMCs

“This would fragment care at a critical time. Gold standard end-of-life care with GPs works well alongside supporting services such as Macmillan nursing. This needs resourcing rather than developing new providers.”

Newham LMC

“It remains unclear however whether the method of achieving greater coordination necessarily requires wholly new organisations to be established.”

Help the Hospices

CAG view

The CAG recognises that the discussion on ELSPs was ambiguous and has led to some confusion. To be clear, in common with many respondents, the CAG does not envisage or propose the introduction of a new or additional layer of administration nor does it expect existing services to be swept away by a new breed of provider. However, we wish to emphasise that with explicit commissioning of an ELSP must come responsibility and accountability for the organisation and delivery of services that the PCT commissions. In other words, it is also an End-of-life Care Organiser. Furthermore, the necessary collaborations across health and social care, primary care and the voluntary sector may involve organisational leadership being taken by any of the stakeholders.

When end-of-life care was not given the prominence or status that it deserved in healthcare commissioning, various models of palliative care and services delivery developed through visionaries that responded to local needs with local initiatives such as day care, community palliative care teams and hospices. Many have been in the voluntary/charitable sectors and have often been generated out of the experiences and needs of service users whose continued voluntary and financial support speaks for itself. This has also led to a huge repository of skill and expertise in end-of-life care across the capital. It is worth noting that the UK has and continues to lead the world in the development of hospice and palliative care, and several of the pioneer services are in London. Nevertheless, local inequalities remain in access, consistency and quality. Virtually all of the work streams have to engage with the needs of those at the end-of-life in various ways and to varying degrees: patients will continue to deteriorate and die in all settings, what is new is that their needs are now being identified. The challenge is to ensure that excellence in care is available to all and to direct it to the right place at the right time and in an appropriate way. Current specialist palliative care services, as examples of excellence, are therefore the natural starting point for the development of extended models of provision and are what we consider to be London’s end-of-life care providers.

The CAG seeks to support and strengthen coherent and effective development and dissemination of excellence across the relevant professions and disciplines and all care settings. These necessarily raise significant challenges to current providers, most of whom are at capacity, that will need new alliances, collaborations and partnerships as:

- Services grow to embrace the needs of historically marginalised groups such as the disabled, frail care home residents or those with neurodisability;
- Services expand and adapt to cater for the wide spectrum of needs particular to BME

- communities;
- Services are required to offer 24-hour access to specialist support; and
- Educational demands, joint working and specialist support stretch specialist services.

The CAG also emphasises that end-of-life care is extremely complex because, amongst other things:

- Dying is not just a physical phenomenon – social, cultural and religious needs have equal prominence and ask a great deal of the practitioner and the service, especially in ethnically diverse areas;
- The needs of carers cannot be divorced from those of the patient;
- There are frequently several specialists involved in management that requires co-ordination and relationships, in real time, across services; and
- Natural alliances and service configurations currently reflect patient flows between services and centres, or even effective public transport rather than geographical or organisational boundaries.

The CAG neither suggests that one size fits all, nor that big is best. London is too complex and services must reflect local need. An open discussion about commissioning across a sector will encourage services to look creatively at the benefits of partnership working, and ensure that there is consistency and equity in commissioning to engage both the general and local complexities of service delivery. For example:

- Many existing services pool resources already to offer 24-hour access to specialist support;
- Collaborations already extend educational programmes;
- By being shared across services, specific skills or expertise can achieve critical mass for those smaller, local providers who might otherwise be unable to offer such support to their local population. Translation and advocacy services might fall into this category as may periodical, but particular needs of a minority group such as their religious needs during the dying process and ethical analysis of particularly complex cases; and
- Certain elements of co-ordination and triage, such as a single number access point may also benefit from drawing on a partner that already has such an infrastructure, but does not traditionally provide end-of-life care exclusively. As an example, models exist for the mutual support and collaboration of out-of-hours GP services and specialist palliative care.

Effective co-ordination and operational integration across organisations and care sectors has been central to many of the most successful models to date. This should be extended to ensuring consistency and effectiveness of practice and provision.

Further consultations with stakeholders have confirmed that, with this clarification of ELSP, there is support for such collaborative models that will ensure both critical mass and local responsiveness.

3. Assessing and identifying patient needs

3.1 Care pathways and recording of care preferences

CAG view

Successful co-ordination and delivery of end-of-life care requires:

- Identification of people approaching the end-of-life;
- Identification and documentation of their preferences about care;

- Communication of a care plan to all individuals involved in providing care;
- Facilitation of patient movement between care settings; and
- Provision of high quality care in a variety of care settings.

Any end-of-life care pathway should be flexible enough to be integrated with the pathways for managing long-term conditions, rather than being a stand-alone segment of care. A patient would have the choice of opting into a care plan.

The registering of preferences for end-of-life care – and the idea that there may be entitlements to that care – presents significant challenges to clinicians. Service development must be mindful that different cultures and communities handle death and dying in different ways and that what is entirely routine or normal for one group may cause significant distress or offence in another. However, it is also clearly impossible to offer choices and effective communication and collaboration between service providers without knowledge of and access to a patient or family's view of their illness and preferences. Furthermore, the *Mental Capacity Act 2007* now gives a statutory framework and places obligations upon services to know and address the wishes of patients. Services are required to discuss future possibilities along a disease journey with tools such as the PPC and to engage actively in advance care planning. Advance decisions to refuse treatments (what was known historically as a living will) now also have statutory force.

Consequently, further work is required to enable the diverse views and anxieties that patients from different cultures express about the end-of-life to be incorporated into the care they receive. Local solutions for end-of-life care planning should be guided by nationally available frameworks (ACP/GSF) as outlined above. Documentation is important for practitioners to act properly on patient preferences, and to enable care to be transferable or co-ordinated effectively. Whilst recognising important local cultural and social issues is essential, this cannot trump the need for adequate and appropriate means to ensure continuity of care between providers.

The CAG also recommends that a record of the management plan should be accessible to all health and social care professionals who interact with the patient. The GSF registers may well offer a means to explore the idea of such documentation.

The consultation did not address questions of IT and record keeping, but these are evident as issues of concern to both users and providers of end-of-life care and will need to be addressed.

3.2. User involvement

CAG view

The consultation received a low number of replies to the specific end-of-life question and to the request for any other comments. For obvious reasons, the nature of end-of-life care can make user involvement in service design and user feedback more difficult than in other areas. Nevertheless, since users' views of care and quality are known to become increasingly plastic as they approach the end-of-life, the CAG is anxious to ensure that, however difficult, there is continuous testing of innovations in end-of-life care as they are developed, with reference to service users, rather than the well or able sick.

3.3. Families and carers

Some respondents commented on:

- The pressures on families and informal carers; and
- Lack of suitable housing at the end-of-life.

CAG view

This is a fundamental area of concern, since patients' social and health needs and indeed those of any carers become increasingly difficult to distinguish as health deteriorates. Poor support for carers is a major determinant of where a person is able to receive care or to die. Serving the best interest of patients entails the best interest of their carers, many of whom have their own health and social care needs. The desire to deliver patients' preferences will only become a reality when carers receive the support that they deserve.

- It is vital that some mechanisms of joint funding or flexibility are introduced between health and social care if there is to be a genuine commitment to help people die at home. This challenge is not insurmountable: operationally integrated, jointly funded models have been introduced successfully in one or two localities; and
- Twenty-four hour district nursing, supported by specialist palliative care, is a fundamental building block to patients being able to die safely and peacefully at home. This is not available to many of London's residents.

4. Other

Comments in response to other questions in the consultation with relevance to care at the end-of-life, included:

- Proposals were aimed at the 'able sick' rather than the 'sick sick';
- London Ambulance Service proposals for telephone assessment advice lines triggered by a 999 call, alternatives to taking people to A&E, and access to the register of preferred place of care; and
- Specialist out-reach services may be more expensive and less efficient than hospital based services.

Summary

1. Meeting best-practice

There was strong support for the proposal that all organisations involved in end-of-life care need to meet existing best-practice guidelines.

Education, training *and* continued support are of paramount importance, not just of healthcare professionals but those working in social care and any residential facility caring for the chronically sick and dying.

2. End-of-life service providers

Effective co-ordination and operational integration across organisations and care sectors has been central to many of the most successful service models to date and this must not be lost, but extended to secure the consistency and effectiveness of practice as it is made available to those who are entitled to the best of care, but have historically been denied it.

With this clarification that ELSPs already exist, there is support for collaborative models that will ensure critical mass on the one hand and local responsiveness on the other.

Tools are already available that may help existing agencies deliver high quality end-of-life care, though the successful use of such tools requires adequate resources for training and implementation.

Specific tools or care pathways should be tailored to local needs.

3. Identifying and assessing patient needs

There was strong support for the proposals that:

- Patients near the end-of-life should be offered the opportunity to have their needs assessed and to identify their preferred place of death and that this should include the needs and support of carers; and
- Service configurations and partnerships must cater for the particular needs of different cultural groups whose perceptions of the end-of-life are frequently integral to their identity. These must be part of local service provision reflecting local need.

Social care is a fundamental area of concern, since patients' social and health needs, and indeed those of any carers, become increasingly difficult to distinguish as health deteriorates. Poor support for carers is a major determinant of where a person is able to receive care or to die.

- It is vital that some mechanisms of joint funding or flexibility are introduced between health and social care if there is to be a genuine commitment to help people die at home.
- Twenty-four hour district nursing, supported by specialist palliative care, is a fundamental building block to patients being able to die safely and peacefully at home. This is not available to many of London's residents.

Where we could provide care

Overview

Healthcare for London: Consulting the Capital set out where we could provide safe and expert services in the most convenient place for patients.

It considered that most healthcare would occur in six places:

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

** This could be in a networked polyclinic where existing GP practices link together and to a local 'hub'; a same-site polyclinic where many GP practices come together under one roof; or a hospital polyclinic. Use of existing facilities such as extended schools could be considered as part of a polyclinic model.*

Consulting the Capital and *A Framework for Action* described how people find it difficult to access the right services at the right time, how GPs feel their premises are unsuitable for current and future needs, and how over a third of practices cannot be adapted to meet all the disabled access requirements of the *Disability Discrimination Act* access. Many hospitals are poorly designed and spread over large areas.

Growth in A&E attendances, long waits for treatment, and poor outcomes for stroke, major trauma, myocardial infarction and cancer all point to the fact that healthcare in London has to change. The problems are clear.

Proposals

Healthcare for London: Consulting the Capital proposed:

- 1. Where existing services worked well, any changes must be improvements. Improvements to services at GP practices and local hospitals should be made.**
- 2. A new kind of community-based care at a level that is between current GP practice and traditional hospitals should be provided**
- 3. A few more specialised hospitals focused on providing better-quality care for some conditions should be developed.**

Responses

'*Consulting the Capital*' asked what factors were most important to people when thinking about they types of services that could be available in the proposed polyclinics. It asked whether people agreed or disagreed that almost all GP practices in London should be part of a polyclinic, either networked or same-site.

There was support from respondents for almost all GP practices in London being part of a polyclinic, either networked or same site. 51% were in favour, 12% neither agreeing nor disagreeing and 29% opposing. The written responses supported the federated model, with a central hub and a set of spokes. Those who disagreed with the model, who gave a written view, disagreed significantly with the same-site model. The CAG supports the hub and spoke model but feels the opportunities for same-site models in London would be more limited.

Whilst acknowledging the need for change, the case for polyclinics is, as yet, unproven in this country. The CAG supports the recommendation to pilot a number of polyclinics.

The consultation also asked whether the treatment of some conditions (trauma, stroke and complex emergency surgery) should move to specialist hospitals while more outpatient care such as minor procedures and test should be provided in the community, with local hospitals continuing to provide most other types of care as they do now.

The proposed movement of the treatment of some conditions to specialised hospitals was widely supported (approximately 60% of respondents to the closed questions). This is supported by the wider clinical community view which relies on good peer-reviewed evidence.

1. Improvements to GP practices and local hospitals

Respondents to the consultation agreed that changes should not be made to services that are already working well. *Healthcare for London: Consulting the Capital* proposed that any changes should be improvements to services, and that improvements to GP practices and local hospitals were necessary. Changes must be based on good clinical evidence. A critical component of the work being undertaken by the Healthcare for London workstreams will be building on the existing clinical, financial and other evidence. Furthermore, evaluating and testing proposed models through piloting projects will ensure a sound basis for any future implementation.

2. Community-based care – polyclinic service model

As described above, 51% of respondents gave support for almost all GP practices in London being part of a polyclinic, either networked or same-site. Respondents raised various issues which are addressed below.

2.1 Continuity of care

There was strong support for the continuity of care between the patient and primary care providers (GPs, pharmacies etc.). There was anxiety, especially among the traditionally unrepresented groups, that this may be affected by moving to a larger polyclinic-style model.

CAG view

The federated polyclinic model would maintain the relationship with the patient's GP and the local pharmacist. The development of a polyclinic would need to ensure that the spokes were properly supported (finance, estate, human resources). A number of practices could move into the hub of a federated polyclinic; there should be no forced move to merge these practices. The Royal College of General Practitioners have produced a document called "*The Future Direction of General Practice – A Road Map*" which outlines many of the principles embraced by the polyclinic model of primary healthcare. The proposed pilot polyclinics need to evaluate the impact on continuity of care. All pilots would also need to perform and publish an Equality Impact Assessment (EIA).

2.2 Travel

Patients expressed concerned that there would be greater travelling distances for specialised care for patients, their carers and visitors – and also to the polyclinic hub.

CAG view

The movement of diagnostics, unscheduled primary care, long-term condition management and integrated social care into one setting may well mean shorter distances to travel compared with previous dispersed locations.

If a hub and spoke (or federated) polyclinic model is adopted, there should be no significant increase in travel for patients attending their GP as practices would be by and large stay where they are. Wherever there is a proposal to move a practice or develop a hub, there needs to be improved transport links to make sure that patients and their carers/visitors are not disadvantaged. Pilots need to evaluate the impact on travelling. Same-site polyclinics would need significantly more consideration of travel times and of transport links.

2.3 Integration with social care and mental health

A number of respondents requested that social services, housing services, welfare advice, back-to-work advice schemes and leisure services should be based in a polyclinic.

Mental health services were not identified in the initial consultation. However, there was strong support in the narrative responses for mental health services to be an integral part of a polyclinic. This could involve being the co-located base for a community mental health team and the expansion of practice-based psychological therapies, particularly cognitive behavioural therapies or talking therapies. Aligning access to crisis home treatment teams, with their role in preventing admission to hospital beds for those with severe mental health problems, and in expediting discharge was also advocated. There was strong support to further develop the role of child and adolescent mental health services and mental health prevention could also be a part of the key work of a polyclinic.

CAG view

The use of a polyclinic as a means of offering integration with the hospital needs to work hand-in-hand with integration with other community services and, thus, would support the horizontal integration to improve patient care. The evidence to support integrated care for people with long-term conditions is extensive. Heart failure specialist nurses reduce emergency admissions by 58% (BMJ Randomised controlled trial of specialist nurses intervention, 2001;323;715-8) and primary care case management reduces diabetes admissions by 25% (DH Cochrane compendium 2004).

2.4 Evidence to support the model of larger practices

The Picker Institute research shows that small practices are more popular. The Department of Health 2007/08 access survey showed that small practices offered access equal to that of larger practices. The 2006/07 Quality & Outcome Framework for General Practice showed that small practices performed slightly better than large practices. The Patient and Public Advisory Group to Healthcare for London expressed a preference for smaller practices, however wanted longer and more flexible GP opening hours.

CAG view

Smaller practices may perform better on the Quality and Outcome Framework. However this is not a measure of access to diagnostics, access for urgent care or joint working with secondary care all of which would be better in a polyclinic. And if current **larger practices** offer no better

access than small practices, then all the more reason to ensure that **polyclinics** DO improve access. A polyclinic would be able to share services (or work together), to provide more services and to improve access further.

There was also a clear request for evening surgeries and Saturday morning surgeries, which are much more likely to be offered by practices working together thereby improving access.

2.5 Costing of proposed models

The King's Fund and many other respondents identified the lack of costing to the models proposed.

CAG view

A key part of all pilots should involve the financial analysis on the re-provision of services.

2.6 Need for interpreting services

The traditionally under-represented groups highlighted a need for better interpreting services.

CAG view

A polyclinic would allow interpreting services to be shared and used effectively.

2.7 Out-of-hours care

Respondents identified the present unclear system of accessing primary care out-of-hours and felt that they would like to see a GP in the evenings and at weekends.

CAG view

We are aware that A&E has become the default point of entry for many integrated healthcare systems. The polyclinic service model may serve to address these issues, either by being a front-end to an A&E department or by extending hours of access and providing a greater range of services, seven days a week, within a community polyclinic. The compromise for having seven days-a-week access to GPs, 16 hours a day is the lack of guarantee that it will be your own GP that you see 'out-of-hours'.

The CAG also feels that a polyclinic hub would offer great opportunities to the London Ambulance Service (LAS), as long as polyclinics have agreed opening times for unscheduled care and agreed acceptance protocols to receive patients from the LAS. The hub could also become a base for ambulances and their staff – the LAS could assist transport to and from the hub for patient-visiting, for diagnostic and outpatient-type facilities.

There is good evidence to support GPs being effective assessors of urgent primary care (Dale J, *Cost effectiveness of treating primary care patients in A&E*, BMJ 1996; 312; 1340-1344).

2.8 Integrating systems

There is understandable concern that new pathways may become muddled and there would not be true integration between community, general practice and secondary care.

CAG view

Increasing moves to pass the majority of commissioning budget to practice based commissioning (PBC) (PBC Universal Coverage Jan 2006, *PBC, Budget setting, Governance* DH Dec 2007) suggests that PBC should take the lead on the commissioning of services for polyclinics. Payment by results (PbR) may also inhibit true integration of care and unbundling of payment packages should be investigated.

2.9 The privatisation of the health service

There was significant concern that any new entrants into the health markets would only be private providers.

CAG view

- a) There needs to be a transparent system of developing business cases and tendering processes;
- b) The quality of service needs to be the driver for new services, not the cost;
- c) The process of selecting organisations that will win new contracts needs to be simpler. The present process is too complicated and is an obstacle to new entrants into the market who are smaller or do not have the back-office support to prepare complex bids (e.g. voluntary sector and social enterprises); and
- d) The pilots need to test out how networked practices can work together to provide extended hours and unscheduled care. The placing of a new GP-led health centre at the hub would only allow APMS providers a role for combined extended and unscheduled care. A GP-led health centre as a spoke, in an area of population growth, will meet a local capacity need and prevent critics from describing polyclinics as a Trojan horse for the “Privatisation of the NHS”. Thus, pilots need to reflect models which encourage engagement of the existing high quality practices.

2.10 Health inequalities

There was concern that the formation of a large same-site polyclinic would worsen health inequalities as it moved services away from vulnerable communities.

CAG view

The hub and spoke or federated model would make sure that travelling distances and the positioning of health facilities within communities would be maintained. This could only be done if there was active support for the spokes as well as the hubs of a new polyclinic. As noted above, the risk of increasing inequalities would appear to be greater for proposals for a same-site model. However, with good transport links, the co-location of multiple services could improve access.

2.11 Medical nursing and Associated Healthcare Professional (AHP) education facilities

Fifteen per cent of clinical education now takes place in general practice and community settings. To deliver high quality teaching in general practice, dedicated space is needed for students and post-graduate trainees to observe consultations, carry out their own consultations and to access information through libraries and from electronic sources.

CAG view

The polyclinic could effectively become the campus facility in the community to educate graduate and post-graduate health professionals.

2.12 Outpatient services

Thirty-nine per cent of respondents felt that outpatient services were an essential part of polyclinics.

CAG view

The movement of outpatient services to a polyclinic hub would improve convenience for the patient but may increase cost and would not normally change clinical outcome. It is more likely to be effective if one focuses on high volume/low technology specialities like dermatology,

rheumatology and gynaecology. The only real clinical benefit is where the outpatient consultation is in relation to a long-term condition and services redesign occurs.

2.13 Long-term conditions

Forty-three per cent of respondents felt that long-term condition management should be part of a polyclinic.

CAG view

There is strong evidence for the use of clinical nurse specialists in the management of long-term conditions; they reduce mortality, morbidity and the frequency of emergency admissions. Outreach consultant work tends to only improve outcomes if the model of care is very different and focuses on developing expert patients, educates primary care staff and acts as a specialist resource.

2.14 Diagnostics

Seventy-five percent of respondents felt diagnostics should be part of the polyclinic hub.

CAG view

The location of diagnostics in the community improves patient convenience and access. However, it may also encourage patients to attend clinics. There is also a case for GPs to be able to perform pre-referral investigations – in many cases avoiding the need for patients to attend a hospital at all. However diagnostics in community settings are unlikely to reduce costs. The location of diagnostics in polyclinics is supported and the CAG would recommend that polyclinic hubs had x-ray, ultrasound, spirometry, ECG and phlebotomy facilities as key diagnostic provisions.

2.15 Hospital polyclinic

One of the benefits of a polyclinic in the community is improved access to a range of services. However, this is clearly not the case for hospital-based polyclinics.

For these polyclinics advantages include:

- Better triaging for patients attending A&E. This is an extremely complex task that involves good partnership working between primary and secondary care (whilst recognising the specific skills of A&E triage staff); and
- Primary care management of unscheduled care, particularly for patients attending who are unregistered.

3. Treatment of some conditions in specialised hospitals

The consultation sought views about the location and organisation of services currently provided in district general hospitals. Public support for moving some treatments to specialist hospitals was relatively high, with 60% of respondents expressing support for this proposal. Support for moving services into the community was high but 16% of respondents expressed the wish to see services remain as they are now and 20% supported a more limited movement of services from local hospitals into community settings.

The professional response reflected some of this pattern. The following themes emerged from the responses:

There was a high degree of support for the principles laid out in the consultation document and also for the treatment of trauma, strokes and heart attacks in specialist centres. Barts and

the London, St George's, North West London Trust and the King's Fund are amongst those responding positively on these points:

"We strongly support the proposals to centralise key services where there is clear evidence that this will improve clinical outcomes."

Barts and the London

The need for clinical networks, working across organisations was emphasised by many of the trusts responding to the consultation, referred to by the West Middlesex, Barnet and Chase Farm and Whipps Cross. The importance of effective governance arrangements for networks was also highlighted, as was the need to work closely with the London Ambulance Service on implementing changes.

Some issues emerge from the responses about the impact of the cumulative changes on existing general hospitals that move towards becoming local hospitals. The need to make this change evidence-based and flexible to reflect local circumstances is made in a number of responses. For example, Whipps Cross suggests polyclinics could readily be provided in hospitals if that suits local circumstances. Chelsea and Westminster Trust want to ensure that, where services produce very good outcomes, they continue to function in their current locations.

The safety of the local hospital service and its ability to manage different patient conditions is an issue raised, including the question of the nature of critical care support required:

"... it may well be appropriate to retain critical care not just HDU facilities in local hospitals."

North West London Trust

Linked to this, the point is made that staff skills need to be maintained in order to ensure a safe and effective service in the local hospital.

Generally, the responses express support for the principles and the proposals for the location of services, but with the need to understand the potential impact of changes to where services are provided. This should include the clinical and financial impact of any proposed changes. Local flexibility on how services are developed was also sought. In order to deliver change, truly expert commissioning will be required.

Recommendations

The CAG recommends the following decisions and actions:

- Support the centralisation of services where there is evidence of improved clinical outcomes, whilst retaining a focus on the safety of services that are affected by any changes;
- Commission work to develop proposals for the effective management of clinical networks for different specialties;
- Ensure that, in managing any changes, the requirement to retain appropriate skills in the workforce in all locations is essential;
- Note the wish to see both an evidence-based approach to change and local flexibility in its implementation;
- Ensure that the LAS is fully engaged in changes and has the information to support decisions on where to take patients;
- Review the information that comes from the local hospital project to assess the scope and impact of changes and to inform how they proceed with the implementation of changes to where services are provided; and
- Ensure the viability of local hospitals that lose services to primary care and specialist hospitals.