NHS London

Healthcare for London

Reflections on leadership, lessons and legacy

Hannah Farrar
Alastair Finney
David Griffiths
Christine Kirkpatrick

CONTENTS

1 Introduction 5

2 *Healthcare for London*: Development and Implementation 9

3 Case Studies 40

4 Lessons Learnt 97

5 Conclusion 142

Appendix 1 – Questions 150

Appendix 2 – Biographies 152

References 156

FOREWORD

I FIRST MET ARA DARZI in the summer of 2006, when he had just begun to put ideas together for the review he named *Healthcare for London: A Framework for Action*, which had been commissioned by my predecessor David Nicholson. We put together teams of people and engaged literally hundreds of clinicians in this work, but even so, I don't think either of us realised at the beginning the immense scale of the task at hand. Nor did we realise the level of controversy and conflict we would initiate.

The history of healthcare in London is littered with reviews (the first recorded review was in 1892), many of which have failed, so we approached this challenge with some trepidation. What made this different from its predecessors? First and foremost it was led by a practising clinician with an international reputation who would continue to work in London. Second, the strategic health authority and PCTs in London put significant and sustained resources behind its implementation. Third, its legitimacy was established through the clinical leadership of an extensive consultation and development programme. Fourth, when approaching implementation we insisted on tackling a few priorities properly, rather than taking the easier route of making a half-hearted attempt at everything.

There was a powerful case for change in *Healthcare for London* that continues to have resonance today. There was almost universal support for this case, but of course with significantly divided opinion about what it meant in terms of service change. Nevertheless, a momentum for change was established and improvements began to emerge. Some of these have now achieved widespread recognition through independent evaluation, but just as important to us has been the positive feedback from clinicians and patients across London. This report attempts to describe and reflect on the progress that has been made and the lessons learnt. For me, as the person responsible for healthcare in London, the most challenging point came with the change in Government in May 2010. *Healthcare for London* had become an election topic and, in the heat of political debate, many of the proposals and ideas became badly distorted. It was caricatured as a 'one size fits all top-down plan' and new Secretary of State for Health, Andrew Lansley, wasted no time in bringing all the work on *Healthcare for London* to a halt via an announcement on national television. >>

In my view, it is a measure of the strength of clinical support for change that many of the proposals and recommendations continue to be implemented. But at the time, the Secretary of State's intervention had a powerful effect. Those clinicians and other leaders who had invested time and energy into making change work were angry and frustrated, whilst cynics who never really believed change could happen were in 'I told you so' mode. Those who sought refuge in the status quo either rejoiced in the respite afforded by this decision or derided our efforts as little more than a blueprint in a desk drawer. For my organisation it was a bitter blow, but we were sustained by the many, many clinicians from all sectors who continued to bravely champion *Healthcare for London*. Especially important were the GPs, who were afforded some legitimacy to continue and became our most powerful allies.

What, if anything, has been lost during the past three years, whilst we have been obliged to focus on the mechanics of reform? Was it just another plan or piece of bureaucracy with no cost to London's patients? The fact is that some people continue to have their cancer diagnosed in A&E because of inadequate primary care and diagnostics; people are still admitted as complex emergencies to hospitals with insufficient consultant cover; acutely ill patients admitted at nights and weekends are still more likely to die in hospitals without 24/7 consultant cover; urgent investment is needed in integrated care for people with long term conditions; some maternity units cannot offer the level of care needed for obstetric emergencies. I could cite many more examples and I do not pretend that we could have solved all these problems but measurable progress was being made on all these fronts – progress that was slowed for a time.

It is for our successors to pick up the case for change in London and I have seen for myself how they are aiming to do that in every new clinical commissioning group. I hope this report provides both evidence of improvements to build on and the lessons that can be learnt from mistakes made.

Finally, I would like to thank Ara Darzi, whose total commitment to improving quality was enshrined in *Healthcare for London* and gave meaning and direction to every single one of our working days at NHS London for six years.

DAME RUTH CARNALL

1 INTRODUCTION

IN 2006, only 53% of stroke victims in London were treated on a dedicated stroke ward, less than 1% of patients were offered clot-busting drugs, comprehensive specialist stroke services were rarely available 24/7 and rates of death from stroke in London's hospitals varied considerably. In short, the quality of stroke care in London was poor and deteriorating – stroke was London's second biggest killer and the most significant cause of disability.

However, stroke care in London has since made huge improvements. Twice as many stroke victims as before are taken direct to a specialist stroke unit, with average journey times by ambulance only 14 minutes, and considerably more patients are receiving clot-busting drugs than previously, with the rate of thrombolysis in London now higher than the rest of the country and any large city in the world. 400 extra nurses are also caring for people who have had a stroke. All of this has contributed to over 200 fewer deaths from stroke each year in London and is a direct result of *Healthcare for London*.

This report tells the story of *Healthcare for London* from its inception in 2007 through to 2013, through the voices of those closely involved. It outlines the processes used to turn the vision originally described by Professor the Lord Darzi of Denham into a distinct set of recommendations and describes how some of those recommendations were implemented by the health service.

The term 'healthcare for London' has become synonymous with the overarching strategy for transforming healthcare in London since 2007. It is shorthand for the vision outlined in the report *Healthcare for London: A Framework for Action* and for the programmes of work subsequently undertaken to make that vision a reality, including the changes to stroke, trauma, cardiac and vascular services and for the introduction of polyclinics (or polysystems) in the capital. It also led to a range of guidance and other developments in service areas such as long-term conditions, including diabetes, and urgent care.

Whilst the terms 'success' and 'failure' are too concrete to describe the many changes associated with *Healthcare for London*, there are areas where services have undoubtedly and measurably improved following the introduction of new care pathways based on the report's vision. There are also some areas where the improvements envisaged have not been achieved.

When Secretary of State for Health Andrew Lansley halted the work programmes under the *Healthcare for London* banner in 2010, this reflected the new coalition government's philosophy that central planning of healthcare was inappropriate and greater emphasis should be placed on localism. Since 2010, NHS London – the strategic health authority (SHA) for the capital – therefore focused on making sure the benefits of change undertaken up to that point became embedded, thereby sustaining improvements in health outcomes. Simultaneously, NHS London continued to focus on unwarranted variations in outcomes, supporting clinicians in defining standards of care, publishing data and making the case for change.

Recognising the fundamental challenges that most health service providers in London face, NHS London has also encouraged individual NHS trusts to work more closely with partner organisations, including their new commissioners, to secure the long-term viability of services for London's population so that patients continue to benefit from sustained improvements in quality of healthcare.

As primary care trusts and SHAs finally hand over their responsibilities for the planning and commissioning of health services, the new organisations inherit an NHS in London that has delivered some profound improvements over the past six years. They also inherit an NHS with the scope to do much more in coming years and where there are still unacceptable variations in health outcomes and unacceptable variations in patients' experience of the care they receive.

AIMS OF THE REPORT

The aims of the report include:

- To describe how the *Healthcare for London* vision was created
- To record the lessons learned by healthcare professionals and managers who went through the process and invested vast amounts of time and resources into designing and implementing the vision
- To explore why some clinical changes have been implemented successfully, whilst others have made less progress
- To set out developments that have taken place in London since the implementation of the *Healthcare for London* vision was formally halted in 2010
- To consider next steps, taking into account subsequent and more recent research and analysis, and provide a platform for those responsible for the ongoing improvement of health services in London

While the lessons learnt may be most relevant to those working within the health service in London, many extend to the management of health systems across the UK and internationally and have generic value for anyone involved in change management.

This report aims to capture the experience of the people who developed and implemented the *Healthcare for London* vision. It does not attempt to gloss over elements that might have been handled differently. Instead, it makes evidence-based recommendations on how they could or should be handled in future service redesigns. Underpinning this report's findings are the authors' own insights and views, formed over time and based on their experience of working for NHS London.

METHODOLOGY

Approximately 80 individuals closely involved with either the development of the *Healthcare for London* vision or its implementation were interviewed over a period of four months. They ranged from the Chief Executive of the NHS and Lord Darzi, to specialist physicians, GPs, policy experts and senior NHS managers.

An initial interview template featuring a combination of general questions was used to canvass a wide range of opinion on many aspects of *Healthcare for London*. Further questions were put to interviewees closely involved with one or more clinical pathways. The template was adapted accordingly to test specific themes that emerged.

The initial standardised list of questions can be found in Appendix 1.

The fieldwork that has been critical to writing this report was undertaken exclusively by Christine Kirkpatrick and Dr David Griffiths, who dedicated many weeks to researching material, gathering evidence and carrying out interviews. Consequently, much of the content of this report reflects the detail gathered by them. With a small number of exceptions, views are not attributed to individuals so as to encourage interviewees to speak freely.

Reflecting their roles in NHS London, Hannah Farrar and Alastair Finney have been responsible for providing editorial guidance and finalising the report, including using their own experiences and knowledge to describe the work that has been done, capture some lessons learnt and propose further work that might be considered to improve services across the capital.

Author biographies can be found in Appendix 2.

2 *HEALTHCARE FOR LONDON:* DEVELOPMENT AND IMPLEMENTATION

CONTEXT

NHS London was established in July 2006, following the release of *Commissioning a Patient-led NHS*[1] and the consolidation of the 28 SHAs in England into 10. The five SHAs that had previously been responsible for strategic overview and performance management of primary care trusts (PCTs) and NHS trusts in London became NHS London. This was the first time a single health authority had responsibility for services and strategy across the capital and was seen as a catalyst for a large-scale review of London's health services.

At the time, NHS funding was higher than ever before, reaching over £80bn in 2006/07 (almost £10.7 billion in London alone)[2]. However, the period of increased funding associated with the NHS Plan was coming to an end, with future funding increases expected to return to levels that kept pace with inflation. Despite record levels of investment, the NHS in London continued to be challenged financially, with 9 PCTs, 15 NHS trusts and one foundation trust in deficit[3].

Although the performance of the NHS was improving nationally[a], with access to services getting better and waiting times falling dramatically, London was seen as having a slower rate of improvement and was failing to meet key national targets. There were significant challenges due to inequalities in health outcomes and areas of patient dissatisfaction:

> Patient satisfaction was static, despite all the improvements; clinical satisfaction was dropping [and] staff satisfaction rates were dropping.
>
> **– Senior clinician**

There had recently been two major reports on London's health services – Sir Bernard Tomlinson's *Report of the Inquiry into London's Health Service, Medical Education and Research*[4] in 1992 and Lord Turnberg's *Health Services in London: a Strategic Review*[5] in 1997. Both focused in some detail on the future of specific acute sites. Tomlinson recommended the rationalisation of specialist services in inner London – specifically through the merging of Bart's and the London and Guy's and St Thomas' hospitals – and the closure of several others. The Turnberg report focused on wider strategy, recommending large-scale planning for major change, greater involvement of the public in the development of proposals and a future focus on primary and community care, and made specific recommendations in relation to several hospital sites.

Despite these reports, little had subsequently changed in how healthcare was being delivered or services structured in London:

> There had been a couple of very significant reports on health care in London; the Tomlinson and Turnberg reports. And the reality is that those had unfortunately been allowed to gather dust, mainly due to political machinations.
>
> **– Communications expert**

> We had been round this house so many times in London, to try and get things like renal services, cardiac services, cancer services… coordinated.
>
> **– Public health expert**

COMMISSIONING *HEALTHCARE FOR LONDON*

One of the first actions of NHS London, under the leadership of Sir David Nicholson, was to commission a review of health services as a means of determining the issues facing the NHS in the capital and establishing the future strategic vision for healthcare.

Professor Sir Ara Darzi (later Lord Darzi), Chair of Surgery at Imperial College London, was asked to lead the review, a role which, in his words, he "reluctantly accepted". He was chosen because of his senior clinical and academic background, his independence, his national and international reputation, his interest in policy reform, his commitment to health services in London and the confidence that politicians from all parties had in him.

At the time it was commissioned, no-one realised how big the review would become:

> We needed someone independent of the SHA, someone who had a reputation in secondary care but would think wider. So I got him to agree to do it although, I have to say, he didn't quite understand the scale of it when he [started]. Neither did I, to be honest.
>
> **– Sir David Nicholson**

A programme team was established to support Lord Darzi and external management consultancy support was procured to supplement capacity and capabilities. Lord Darzi also established a team at Imperial College that provided additional analytical input.

Both the focus and structure of the review were determined by Lord Darzi and his assembled teams. He was clear that it should centre on quality and improving health outcomes for Londoners and involve as many interested parties as possible. It should avoid focusing on the detail of institutions or bed numbers, as this would distract those involved from the wider issues.

a *For example, cancer waiting times were falling:* http://webarchive.nationalarchives.gov.uk/*/www.performance.doh.gov.uk/cancerwaits/2008/q3/archive.html

THE REVIEW PROCESS

The review began in earnest in December 2006. Sir David Nicholson had left NHS London for the Department of Health but Dame Ruth Carnall, the new Chief Executive of NHS London, continued to see Lord Darzi's review as a major priority.

Early work comprised gathering evidence about the healthcare needs of the population and the performance and productivity of the NHS in London. Clinical working groups were established to examine the evidence and a public engagement process began, so the public's views could be inextricably linked with the academic review process and development of clinical pathways.

Case for Change

The groundwork for *Healthcare for London* was laid with the publication of the *Case for Change* report in March 2007, which was designed to increase awareness of Lord Darzi's review and the challenges it was seeking to address. During a period of sustained and unprecedented investment in the NHS, there were political difficulties in Case for Change stating that existing services needed improvement. Nevertheless, NHS London and Lord Darzi were committed to *Healthcare for London* as a platform for exploring the need for change and published the document as a critical step in encouraging action.

It was clear to Lord Darzi that the evidence of variation in services and clinical outcomes should be presented to the public in order to illustrate that change was necessary.

> The *Case for Change* was vital because [it] was the ammunition to say this is not just unsustainable, it is actually wrong.
>
> **– Lord Darzi**

The academic review, the early engagement with the public and the initial outputs of the clinical working groups resulted in eight reasons to support the proposition that health services in London needed to change. These are summarised below, alongside the views of some of those involved during that period.

The need to improve Londoners' health

London had (and has) specific health needs and challenges[6] due to a younger, more culturally diverse and more transient population than the rest of England. Patterns of illness differed; for example, there were higher rates of HIV and mental ill health, but lower rates of heart disease. This translated into different patterns of access to and provision of healthcare services. For instance, people were more likely to present to A&E in London than elsewhere in the UK[7]. This was partly due to the high numbers of patients in some areas not registered with a GP:

> We have a very disproportionate number of patients who have not registered [with a GP] for a variety of reasons, [such as high levels] of immigration. Access to GPs is difficult for patients who are registered, [and] if you're not registered with the practice it's just impossible.
>
> **– Senior clinician working in an area with high levels of deprivation**[b]

Limited community services meant that more elderly people died in hospital in London than elsewhere[8], whilst pregnant women were more likely to present late to health services in London and there was a higher proportion of pregnancies with associated risk factors:

> Because we do, unfortunately, have a very transient population in London we have a lot of people out there who don't understand antenatal care. And there's your accessibility problem.
>
> **– Local government expert**

In addition, London had significant inequalities in how health varied across the city. This point was starkly illustrated by the fact that by taking the Tube east from Westminster on the Jubilee line, life expectancy dropped one year for every stop[9].

Public dissatisfaction

The engagement strategies described below found significant levels of dissatisfaction with how the NHS was run in London (27% of respondents were dissatisfied, compared with 18% nationally) and with GP services. The public did not feel the NHS in London responded to their needs:

> In the public events, what came out really, really strongly [was] this discussion about how people access services in London. I remember somebody saying, and it was heavily supported by the room, 'Why is it that the NHS always tells us that we have to change our behaviour?...Rather than telling me to go somewhere else, why don't you put what we need where we all turn up?'
>
> **– Senior NHS executive**

b *Note: recent changes to reduce restrictions on GP lists may have helped to address this issue.*

Inequalities in health and healthcare

Areas of extreme deprivation and areas of extreme wealth meant that life expectancy and health status varied widely[10].

> We still have, in London, 40% of kids living in poverty[11]. That is outrageous.
> **– Public health consultant**

There was also great disparity in health outcomes and service provision with, for example, higher numbers of GPs (with higher quality and outcomes framework scores) in wealthier areas[12]. Care did not, however, just vary by geographical area. One of the most striking findings for those involved in the early research was the variation in care received by patients from different providers:

> You can see very clearly in London, you have got the best delivery and the worst delivery in the country, all in one place.
> **– Senior NHS manager**[c]

Lord Darzi made the point that having some very good hospitals did not compensate for poor performance in others:

> [London] had the best hospitals and it had the worst hospitals in the country and when you have these situations of polarity of the best and worst, there is not an average *per se*.
> **– Lord Darzi**

A frustration, however, was obtaining the necessary data to demonstrate this disparity. Data collection at the time was slow and the data itself often impenetrable or was recorded differently in different organisations, making meaningful comparison impossible.

A case for community care

It was becoming clear, particularly from international evidence, that services that could be provided quicker and more conveniently in the community were still being administered in hospital[13]. A lack of facilities outside hospital and limited or inconvenient access to primary care services, particularly out-of-hours, were cited as limiting factors:

> A whole bunch of patients that sit in district general hospitals today should not even be in hospital in the first place. If we treat them better they will [stay] in the community.
> **– Management consultant**

c *This was and is still true.* Dr Foster Hospital Guide 2011.

The need for more specialised care

There was evidence of many centres providing specialist services, such as cancer surgery and stroke, to relatively low numbers of patients. For instance, over 30 trusts were providing stroke services, but not all were offering thrombolysis and very few were offering it 24 hours a day[14]. The evidence suggested that across a range of specialist services a higher volume of patients being treated on fewer sites, backed by greater consultant presence and better equipped departments, would result in better patient outcomes:

> There is good evidence for vascular surgery that someone who is used to doing the operations [is] likely to get better outcomes. Now that strikes one as self evident, but there is evidence for that and [yet] many of our surgical teams are too small. And what's happened with surgery is that it has sub-specialised. I don't want a breast surgeon operating on my colon. You want gut surgeons to do guts, etc.
> **– Senior clinician**

Placing London at the cutting edge of medicine

Thanks to many centres of excellence and a history of pioneering health research, it was realised that the resources were available to secure London as a global hub for health research and innovative practice. Partnerships between providers and universities – which would become academic health science centres (AHSCs) – were seen to be the best means of translating research into clinical practice:

> It was at a time when there were lots of reviews being done in terms of NHS research and development funding… there was a lot happening in the research funding side of things. And also the deaneries and the teaching and all of that, so I think the AHSC was a very clever concept to introduce.
> – **Health policy expert**

> The whole [drive] behind AHSCs is bringing universities and NHS together, but it's not around mediocrity. It's only around excellence.
> **– Acute sector chief executive**

The ineffective use of buildings and workforce

Lord Darzi recognised that the poor utilisation of much of the NHS estate in London constituted an inefficient use of health service resources[15]. Many hospital and primary care premises were old and unfit for purpose and some were unused, which presented a barrier to change:

> A more aggressive approach [is needed]. It is still unclear to me why there is [such] poor utilisation of real estate. I mean, there are a lot of very significant and very expensive pieces of real estate the NHS in London is running without needing to.
>
> **– Management consultant**

> In reality, they (estates) are the major obstacle, [with] people – whether the current users or the local communities or the local politicians – clinging to the bricks and mortar rather than thinking about what service they're getting.
>
> – **Management consultant**

Many people felt that addressing the estate issue was key to improving the efficiency of NHS services in London.

There were also concerns that the NHS in London was not making the best use of its staff and their skills, with productivity 30% lower compared to the rest of England. It was considered critical to unlock the potential in the workforce to improve services[16].

Making better use of taxpayers' money

There was a recognition that the period of growth associated with the NHS Plan was coming to an end and that greater efficiency and improved outcomes would provide value for money:

> I think many people did say if you could redesign services in this way they'd be better value. You could actually deliver things at low cost. So there was quite a strong sense of wanting to ensure value for money.
>
> – **Management consultant**

> I would like to see all the commissioners in London sitting together and discussing what other services should be more focused and really doing this as a joint effort on the grounds that (a) it will save money but (b) it will improve quality of care.
>
> – **Senior clinician**

Taken together, these eight themes painted a vivid picture of why health services in London needed to change and change quickly and why the NHS needed to work in partnership with other organisations, such as local authorities, to address health inequalities. This case for change provided the foundation on which to build proposals that could transform London's healthcare services.

Although there have been improvements since these points were identified, the current economic climate, alongside continuing financial problems at some NHS trusts, makes the argument for improving productivity stronger today than in 2007:

> The underlying position hasn't got any better. If anything, it's got a bit worse, so actually all of the rigour of implementation around *Healthcare for London* is absolutely required.
>
> – **Finance director**

Engagement

Clinical engagement was crucial in both defining the work that needed to be done and moving it forward. Doctors and other healthcare professionals were involved in developing the initial vision, determining ideal models for delivering care and leading implementation.

For Lord Darzi, the language used to communicate with clinicians was vital. A focus on quality rather than targets was employed in order to facilitate engagement and to emphasise the difference between *Healthcare for London* and previous reviews:

> The language of [previous] reforms was very much based on the means rather than the end, and that did not really add up. It [was] all about PFI, targets, waiting times… So, that is why I really drove this quality thing. I think if we can change the language of reform, especially in London, we might be able to achieve the same objectives [against which previous reviews failed to deliver].
>
> **– Lord Darzi**

Clinicians were engaged from the start, both individually and through the Royal Colleges and other professional bodies. A call for evidence elicited responses from both individuals and organisations.

Engagement with patients and the public also started very early in the programme in order to incorporate their ideas about what needed to change and the kind of services that were required. An Ipsos MORI telephone survey of 7,000 people was carried out in January 2007[17] and provided detailed data on the public's perception of London's health services. The themes identified were further explored in two deliberative public events, held in north and south London. Members of the public were paid to participate in order to ensure a representative group.

Lord Darzi also met with MPs from all parties and he and his team attended NHS roadshows and other events.

Engagement also took place on the internet via short films and the *Second Life* virtual world[18], as well as through traditional media sources.

A pathway approach underpinned by analysis

Lord Darzi was clear that a clinical pathway approach should form the basis for service redesign. Six 'cradle to grave' categories were initially defined by Dr Maggie Barker, then Deputy Regional Director of Public Health in London, in a workshop held early in the programme. These were:

- Maternity and newborn care
- Staying healthy
- Acute care
- Planned care
- Long-term conditions
- End-of-life care

Whilst this approach has now been adopted as common practice across the NHS, at the time it was groundbreaking. It shifted thinking from a focus on organisations to one of examining the model of care through the journey of the patient.

Lord Darzi believed that mental health should form an integral part of all clinical pathways and therefore was not originally included as a separate category. However, a body of opinion emerged that felt mental health would not be adequately covered with this approach, so a separate group, comprising the chief executives of all mental health trusts in London, was established to examine this area. The membership of this group meant, however, that it could not be considered a clinical working group in the same way as those described below.

The clinical working groups, which mainly comprised senior clinicians from related fields, were set up to examine the six pathway areas listed above. The groups evaluated the evidence base and developed key principles for high-level care pathways. Once these were established, the care models needed to deliver the pathways were defined. The groups then made recommendations on how to achieve that vision:

> **We did not tell them anything about delivery models. We just said, 'look at your pathways of care. You have got the evidence base, what are you doing at the moment, what is the evidence base, and what do you need to do in the future?'**
>
> **– Lord Darzi**

The groups met, on average, three times each. They were each facilitated by an independent management consultant, who also provided research support to the groups before and during the process. The need for strong facilitation was highlighted, as well as highly skilled technical back up:

> **[You need] good facilitation [from] a very senior person who can hold this group to account, who can flood this group with challenging analysis and data, and so on, who can say: 'What are you going to do about it? What are your four key recommendations?'**
>
> **– Senior management consultant**

The methodology of the groups was praised by interviewees:

> **The preparation by the support team was so fantastic that we had information beforehand for the first one, and then it was written up, and further information researched after the second one, and by the time [of the third meeting], we'd assimilated all the evidence to support the clinical assertions that were made.**
>
> **– Clinical working group chair**

The work on clinical pathways was underpinned by a technical analysis put together by a group of experts established to collect and interpret information in a way that would support the work of the *Healthcare for London* programme.

After *Healthcare for London: A Framework for Action* was completed, Lord Darzi was asked to lead a national review, which was published as *High Quality Care for All*. This was broken down into eight pathways, including a dedicated focus on both mental health and children's services. *Healthcare for London* had not looked at these areas separately, arguing that they were covered within the six 'cradle to grave' pathways. However, in response to criticism of this decision and the publication of *High Quality Care for All*, dedicated clinical working groups for mental health and children's services in London were established. This helped to cement all eight pathways and aligned London with other English regions.

However, it was the six original pathways of care developed by the clinical working groups that had been used to generate the delivery models proposed in a *Framework for Action*. These delivery models were descriptions of where care should be delivered and what form the necessary facilities should take. This part of the work was orientated towards the institution in which the delivery of care should be located, recognising that these models had to have coherence in order for care pathways to be deliverable. The fact that outputs from these two additional groups in London were never fully integrated into the *Healthcare for London* delivery models was perhaps a missed opportunity.

A FRAMEWORK FOR ACTION

Healthcare for London: A Framework for Action built upon the *Case for Change* and set out the principles that should underpin the design of future health services:

- Service focused on individual needs and choices
- Localisation where possible, centralisation where necessary
- Truly integrated care and partnership designed to maximise the contribution of the entire workforce
- Prevention being better than cure
- A focus on health inequalities and diversity

Clinical pathways

The report also laid out recommendations for each of the clinical pathways examined by the clinical working groups:

- **Maternity and newborn care** – Needs should be assessed early, care should be provided in one-stop settings; continuity of care and choice should be provided; there should be a higher consultant presence on labour wards; more midwife-led units should be established.
- **Staying healthy** – There should be greater investment in health promotion (including within the NHS itself) and more links between the NHS and other public bodies, alongside a greater focus on health protection.
- **Mental health** – Improvements needed in early intervention services and inpatient care, alongside greater clarity of care pathways. Service users should have greater control, with a particular focus on those most at risk. There should be greater availability of psychological therapies in the community.
- **Acute care** – Access should be improved, with a single point of telephone contact for urgent care. Some specialised services should be centralised, with associated ambulance protocols.
- **Planned care** – Access to GPs should improve and care should move out of hospitals where appropriate, but specialist care should be consolidated at large hospitals. There should be a focus on improving intensive care and reducing rates of healthcare-associated infections.
- **Long-term conditions** – There should be a greater focus on prevention and action to reduce emergency admissions and length of stay. Greater integration of care should be provided and best practice pathways developed.
- **End-of-life care** – Best practice guidelines should be met and dedicated service providers should be commissioned to ensure more coordinated care. Electronic care plans should be recorded for patients and there should be greater support for those wanting to die at home.

Delivery models

Analysis based on affordable and accessible modes of addressing these pathway recommendations led to the report proposing seven delivery models:

- Care in the home, particularly at the start and end of life and for those with long-term conditions, should be an option for many more patients. Providers should focus on improving processes and facilities to enable this, including working more closely with social services.
- Polyclinics should be developed to provide a wide range of services appropriate for delivery in the community, including diagnostics, psychological therapies, ante and post-natal care and dentistry in addition to existing GP services. Outpatient care should move away from hospitals into the community.
- Local hospitals should provide most inpatient care, plus a 24-hour accident and emergency service. Inpatient rehabilitation and most emergency care should be provided, but complex cases could go elsewhere.
- Elective centres should provide most routine, high-throughput surgical procedures, such as hip and knee replacements and cataract removal.
- Major acute hospitals should handle the most complex treatments, with consultants present 24/7, caring for sufficient volumes of patients to ensure the best outcomes.
- Specialist hospitals should be encouraged, and more developed, in order to provide the highest quality specialist services.
- AHSCs should be established as centres of clinical, educational and research excellence, with a focus on translating research into improvements in patient care.

Enablers

Lord Darzi acknowledged that previous attempts at implementing strategic change programmes in London had not succeeded, partly because of the failure to mobilise the right people to make change a reality and the failure to identify the key drivers for change. To maintain the momentum of such a large programme, *A Framework for Action* identified eight criteria for enabling change:

- Strengthening commissioning, so that London's PCTs (which were responsible for commissioning most of London's healthcare) would have the capacity, capability and necessary clinical input to purchase services to meet the *Healthcare for London* quality criteria.
- Recognising that health and healthcare were not the responsibility of the NHS alone, therefore developing and nurturing relationships with key partner organisations in local government, the voluntary and private sectors.
- Strengthening engagement with patients, the public and their representatives so that, even when recommendations might affect a local service provider, the case for change and proposals for change would be well understood and supported.

- Strengthening clinical leadership and developing clinical champions to communicate the evidence base for change in a way that confronted and assuaged any anxieties.
- Initiating a strategy for developing and training a culturally diverse workforce, to deliver the new models of care, particularly working more in the community. Key priorities included developing the London Ambulance Service workforce, a greater focus on the training for non-doctor clinicians and continual training for all clinical staff in addressing healthcare inequalities.
- Enabling patients to make choices about the healthcare they receive by providing them with high quality information about local services and how to manage self-care. Improvements to IT systems were recognised as a key requirement in this process.
- Changing funding flows, to act as an incentive for doing things differently and better.
- Development of a comprehensive strategy to rationalise utilisation of the enormous NHS estate in London.

REACTION

Interest in *Healthcare for London* was already widespread before the launch of *A Framework for Action*, with Lord Darzi carrying out individual briefings with journalists to explain his proposals in detail, as well outlining his early thoughts and the challenges faced in an Evening Standard article entitled 'The Capital Needs Better GPs and Fewer Hospitals'[19]. Lord Darzi also appeared alongside Dame Ruth Carnall on BBC1's The Politics Show to outline the challenges London faced[20].

From the outset, professional and media responses were divided. The immediate press response following the launch of *A Framework for Action* included much positive comment, for example 'Hold Your Breath: Nothing's Sacred'[21] and 'A Radical Plan for London's NHS'[22]. There was some negative comment, particularly stemming from GPs' reaction to polyclinics, such as 'Polyclinics Plan Will Kill off Local GPs, Claim Tories'[23].

While it was welcomed by many people, particularly clinicians, there were reportedly questions about potential political ramifications and the association with Lord Darzi:

> "[Politicians] were all terrified of London politically, so we had that political crossroads that we had to deal with at some stage. Even towards the end, in May and June, I was not sure that they would actually let us even publish it.
>
> **– Lord Darzi**

ECONOMIC MODELLING

A Framework for Action was underpinned by a financial model that demonstrated for the first time the consequences of not changing health services in London, alongside the potential financial benefits of new delivery models[24]. In addition to the cost of delivering the recommended models of care, the likely increase in future levels of activity associated with demographic changes and changes in disease prevalence were considered. Associated staffing costs and the implications for capacity were also analysed.

This financial analysis was published one day after the main report in an accompanying *Technical Paper*, but was not fully articulated in the main report itself. This was due to the fact that the principal driver of Lord Darzi's review was improving quality and clinical need at a time when the NHS was benefitting from unprecedented investment. The economic argument was therefore not the primary focus of the initial case for change and there was little effort to engage with the public or the wider NHS on this basis:

> There was underpinning financial stuff [but] it wasn't very visible… It didn't start off [as] a strategy which had a complete financial infrastructure to it… alongside the clinical infrastructure, and certainly not one that was widely owned.
>
> **– Finance director**

> Given the importance of the launch and the framework, remarkably little time in NHS London was given to testing, understanding, ensuring there was a corporate understanding of the economic model that underpinned *Healthcare for London*.
>
> **– Communications lead**

There was, reportedly, a widely-held view amongst those involved in *Healthcare for London* that the changes associated with the programme, including greater efficiency and better use of staff and resources, would lead to savings and increased productivity. However, the lack of focus on the financial side was a cause of concern for some. If nothing else, it allowed opponents of the policy to argue against it on grounds of cost and this was felt to be an obstacle by some:

> Getting information out about what the cost would be of delivering a hyper acute stroke unit and stroke unit care and then dividing out those costs was hard.
>
> **– PCT CEO**

As the economic climate in England worsened, it became clear that the financial benefits of the changes needed to be formally illustrated:

> **We got to a point in 2008 where we needed the demonstration that this was financially beneficial and affordable.**
>
> **– Finance director**

Further work was undertaken to develop the financial model and clearly demonstrate that *Healthcare for London* was affordable and implementation of the strategy as a whole would save money. An affordability analysis published in 2009 examined the impact of doing nothing compared with implementation of the *Healthcare for London* plans, taking into account likely levels of funding and possible differences in the pace of implementation. It found that the current system of healthcare in London was not affordable in the medium to long-term, even after allowing for a stretching target of 4% yearly efficiency improvements by hospitals. It was shown that maintaining the status quo, whilst allowing for projected levels of NHS funding, would leave commissioners facing a funding gap of between £1.4 billion and £2.7 billion by 2016/17[25].

Efforts were made to engage commissioners with the financial model, to persuade them that implementing *Healthcare for London* would lead to both clinical and financial improvements in services:

> **We took PCTs as they then were – sectors [a consolidation of PCT management teams] as they were beginning to emerge – through the economics of it all, got them to understand the model and got a large amount of buy-in into it. So we'd finally got to the point where people not only accepted the clinical arguments, accepted the difficult things that needed to be done, but also accepted the economics of it.**
>
> **– Finance director**

Since 2009, the insights from the affordability analysis have been built into the development of commissioners' strategy plans and more detailed financial modelling has been carried out as part of individual programmes of implementation – both London-wide programmes and more local reconfiguration programmes, which are discussed later.

The affordability analysis also highlighted that change would place acute hospitals in London under considerable financial strain through having to respond to both a 4% efficiency challenge and the loss of income resulting from commissioners acting to increase the delivery of care in community settings as opposed to hospitals. Some hospitals would also lose income from the concentration of more specialised services on fewer sites. In 2008/09, five NHS trusts were already in deficit, although this was a considerable improvement from the 15 NHS trusts and one foundation trust in deficit in 2005/06.

Therefore, a reconfiguration of acute hospital services would be required to deliver the *Healthcare for London* vision. Whilst broadly accepted in the NHS in London, this caused difficulties due to the political controversy that surrounds all proposed service reconfigurations – a situation that is perhaps even more acute in London. NHS London subsequently completed a further piece of financial analysis designed to define the issues facing individual trusts as opposed to the sector as a whole. Published in February 2012, it concluded that realising efficiency opportunities alone was insufficient to secure the viability of the majority of NHS trusts, with structural changes (service and/or organisational) also necessary in many cases to secure service sustainability[26].

Arguably, London would have made quicker progress from a more through economic assessment and greater engagement during the development of *A Framework for Action* itself. Nevertheless, constant assessment and updating of the economics have been essential to the progress that has been made and has highlighted the actual financial benefits of delivery, thereby strengthening the health system's understanding of how to facilitate change.

The economic modelling for *Healthcare for London* was groundbreaking in showing that delivery model changes could deliver reductions in cost in an unprecedented manner, but many felt that, although the situation was later rectified, this was not done early or comprehensively enough.

Lessons learnt from the interviews undertaken in relation to economic modelling suggest the following key points:

- Undertake financial analysis early
- Ensure it is integral to the overall plan
- Work harder to ensure effective engagement on the economic arguments with clinicians and the public
- Make clear that improving services can also deliver economic benefits

LORD DARZI'S DEPARTURE

In July 2007, just before the publication of *A Framework for Action*, Lord Darzi was asked to join Gordon Brown's government as a junior health minister, becoming a member of the House of Lords. His remit was to carry out a review similar to *Healthcare for London*, but on a national scale. As a member of the Government, he was no longer able to be directly involved with *A Framework for Action* or any future plans for the NHS in London.

His departure had a temporarily destabilising effect on the teams at Imperial and NHS London:

> I went from having a colleague that I spoke to or saw every single day of the week, not just Monday to Friday. I mean every single day of the week we would talk about what we were doing, why we were doing it… and we would meet several times a week to think about how we are going to turn this thing into action, and [it] stopped like that.
>
> **– Senior NHS executive**

Lord Darzi's departure also had the perceived effect of politicising the strategy. This theme is discussed in more detail in Chapter 4.

PUBLIC CONSULTATION

Following the publication of *A Framework for Action*, there was debate as to how the vision could best be taken forward. NHS London, after taking legal advice, decided to recommend to London's PCTs that they should consult on its findings. Some interviewees recalled being keen to start implementation straight away:

> My overall feeling at that time was 'we are spending months and months on consultation and bureaucracy and joint committees of PCTs and this that and the other, and absolutely nothing is happening. If we are not careful, we will spend two years talking about it, never do anything, and everybody will have forgotten about what it was for'.
>
> **– Senior NHS executive**

Others saw the value in gauging public opinion:

> My view, having been involved in quite complicated service reconfigurations elsewhere, was that it was better to do a two-stage process where you consulted on the conceptual models – the polyclinic, the stroke standards – and tested out views on those. Once you'd done that, and hopefully got sign-up to the models, you could then move to actually say 'this is what we're going to do'.
>
> **– Communications expert**

It was decided that a formal public consultation should be undertaken as soon as possible to enable Londoners to comment on the proposals in *A Framework for Action*. If the plans were approved, it would then be possible to draw a line in the sand and concentrate on, for example, the actual number and location of hyper-acute stroke units (HASUs), rather than the rationale for change.

The consultation took place between November 2007 and March 2008. Despite the perceived delay in implementation most interviewees felt, in retrospect, that the consultation had been worthwhile. It demonstrated the benefits of engagement more broadly, particularly with vulnerable groups. It increased ownership of *Healthcare for London* by PCTs and provided a blueprint for subsequent consultations. Importantly, it also established consensus on the principles for change:

> On reflection, I think it gave us a much stronger platform than I realised: a platform for change, and a set of principles that were quite difficult to back away from, having consulted on them. So on reflection I think it was valuable.
>
> **– Senior NHS executive**

Over 5,000 individuals and organisations responded to the consultation, with 72-82% support for the underlying principles of *Healthcare for London*. Responses were used to help determine which elements were taken forward first. For example, there was general support for specialised centres for the treatment of trauma (64%) and stroke (67%). Two-thirds of respondents thought that greater investment should go to community support for long-term conditions (67%) and just over 50% of respondents were in favour of GP surgeries being amalgamated into polyclinics. Those who were not in favour of polyclinics were strongly concerned about damage to the doctor-patient relationship[27].

A joint committee of PCTs, set up in November 2007 to oversee the public consultation, considered the responses to consultation in June 2008 and agreed with respondents that the strategies outlined should be taken forward. A London-wide Joint Overview and Scrutiny Committee (JOSC) was also set up to examine the aims and methods of the consultation and seek evidence from patients, carers, professionals and politicians. The JOSC welcomed *Healthcare for London* and recognised it was needed but wanted further work in some areas, including mental health, children's services, and the financial impact on areas such as social care. Understandably, the JOSC reserved final judgement until the specifics of implementation were spelt out[28].

MOVING TO IMPLEMENTATION

Commissioners and the leadership of NHS London wanted to focus on delivery. All the elements of *Healthcare for London* were felt to be important and all the clinical working groups had created the energy and enthusiasm for change. However, the NHS in London (and nationally) remained sceptical about the ability to deliver change.

The consultation process had enabled a shift in the governance and leadership of the *Healthcare for London* programme. It was no longer an independent review sponsored and facilitated by NHS London; it was, instead, the agreed strategy for London, jointly owned by NHS London and London's 31 PCTs. The London Commissioning Group (LCG) – originally established for another purpose, but by then a means of agreeing London-wide commissioning decisions – had its membership and authority extended to maintain oversight of *Healthcare for London*, incorporate its priorities across all commissioning bodies and ensure that the changes envisaged were implemented in an integrated fashion. The group comprised the chief executives of 10 PCTs, the chief executive and directors of NHS London, representatives from the Mayor's Office, local authorities, the Patient and Public Involvement Group, and a clinical lead.

In February 2008, a new clinical advisory group (CAG) was established to ensure that clinical leadership and expertise continued to underpin all elements of *Healthcare for London*, initially by shaping the response to the consultation and providing advice to the Joint Committee of PCTs. The CAG was co-chaired by Sir Cyril Chantler, Chair of the Board of the Great Ormond Street Hospital for Children NHS Trust and of the King's Fund, and Professor Trish Morris-Thompson, Chief Nurse at NHS London. Over 100 clinicians from across London applied for posts on the CAG, with an eventual membership of around 30 that balanced both coverage of the different clinical professions and geographical spread.

A Framework for Action had concluded by signalling changes that could be undertaken in the relative short term. Lord Darzi and NHS London believed that forging ahead with delivery would counter much of the scepticism by showing that transformational change was possible, thereby generating the necessary momentum to achieve this change.

Through strengthening the governance of the *Healthcare for London* programme, and following public consultation, stroke and trauma were identified as clinical priorities for immediate action. This was due to the strong evidence base for change and the desire and commitment to address these areas that had been generated by the *Healthcare for London* process itself. Changes to the London Ambulance Service were also identified as necessary to support the changes to stroke and trauma services. There was subsequently significant investment in workforce training and development, as well as implementation of new ambulance transport protocols.

There was also a strong desire to improve out-of-hospital services. Following public consultation, commissioners collectively agreed to press ahead with implementation of the polyclinic model across London, despite a level of scepticism remaining about whether it was possible to deliver the vision set out in *A Framework for Action*.

Improving the care for people with long-term conditions, in particular diabetes, was determined as a further priority and it was also decided that more thinking was needed on improving unscheduled care and on a future model for local hospitals. Both of these areas were difficult, requiring locally sensitive change across multiple pathways. PCT engagement was a particular challenge and the implications of changing an area as complex as unscheduled care was later commented on:

> **"Stroke and trauma are close enough to specialist commissioning that you could sort of carve off the top and say, we're going to do that separately. Similarly, cancer and cardiac… [but] unscheduled care is the core of what a hospital does and so that is an inherent challenge – if you're going to try and monkey with that, you're monkeying with the whole health system.**
>
> **– Management consultant**

A substantial investment was made by PCTs and NHS London to take this work forward. The team working on *Healthcare for London* was expanded and organised in such a way as to enable the delivery of priority implementation programmes. A dedicated programme director was appointed and the team was hosted by a PCT instead of NHS London.

Three priority programmes – trauma, stroke and the polyclinic model – are case studied in chapter 3. The stroke programme has been recognised as a success, both nationally and internationally, and the NHS in London is rightly proud of this achievement, particularly as it was complex and difficult to deliver. The work on polyclinics was even more complex and difficult, with numerous changes of course necessary in trying to secure the improvements envisaged. Today, the NHS in London would describe the same endeavour in the language of integrated care and the transformation of primary care.

NHS London itself began to focus on Lord Darzi's enablers of change, with varying degrees of success in what it could control and influence. The *Workforce for London* strategy recognised that the quality of the NHS workforce in London was the single most important factor in making implementation of *Healthcare for London* a success. It set up a new approach to the planning, educating, training and, where necessary, re-training of the workforce, in a way that was integrated with both London-wide and local service planning. Backed by significant resources, it was a strategy for improving the quality of healthcare through better, higher quality education and professional development, thus creating the freedom for frontline staff to innovate and create real improvements for patients. This was all supported by an investment in leadership development.

Commissioning was strengthened by PCT management teams coming together in geographical sectors. This was intended to make the most of the high calibre of commissioning that existed in some of London's PCTs, but which was not replicated across all of them. NHS London succeeded in part in making the case to local government representatives who, for the most part, were uncomfortable about losing their coterminous working relationships with PCTs and had successfully argued against rationalising the number of London PCTs in 2005.

NHS London was less successful in other areas. First, very little progress was made in developing a strategy for optimising the use of the NHS estate in London, which reflected the nature and scale of the challenge across secondary, primary and community sectors. Second, mainly because of the number and complex nature of the various organisations involved in the provision of NHS healthcare, NHS London failed to realise the benefits that developments in IT could bring to more integrated working, which was identified early on as critical to the success of implementing the polyclinics model across London. Finally, little progress was made in changing funding flows to act as an incentive for change.

In addition to the London-wide programmes, PCTs worked increasingly collaboratively in their five geographical sectors – North East London, North Central London, North West London, South West London and South East London. The intention was to develop and take forward service reconfiguration proposals aimed at addressing the clinical and financial challenges of hospitals in each area in a holistic way and re-invest resources in community-based services. Because it wanted a coherent London-wide approach to service change, NHS London halted what were close to a hundred service change programmes shortly after it was set up, with only a handful of exceptions. Local PCTs consulted on service reconfiguration proposals under the *Barnet, Enfield and Haringey Clinical Strategy* and *A Picture of Health* in south east London, both of which would lay the foundations for further change under *Healthcare for London*.

Proposals continued to be worked up in north east London and north west London but, for different reasons, they stalled. Following *Consulting the Capital*, the PCTs developed revised proposals for consultation service change – *Health for North East London* in 2009 and *Shaping a Healthier Future* in north west London in 2012. Proposals for change by PCTs in south west London have proved more difficult to bring forward, with *Healthcare for South West London* abandoned in early 2010 and, subsequently, proposals under *Better Services, Better Value* not yet finalised for consultation. All service change proposals are founded in *Healthcare for London*, although since 2010 nothing has been explicitly linked back to it. However, the principles outlined in *A Framework for Action* are being taken forward. As it was an evidence-based clinically-led analysis, it is unsurprising that clinicians looking at the evidence and analysis again drew similar conclusions.

These service change programmes, both local and London-wide (including stroke), arguably led to the criticism of implementation being 'top-down'. However, the context of planning services for a large population – eight million across London and upwards of one million for each of the geographical sectors described above – in an environment of financial and workforce constraints has to be considered. It is not feasible, given all the service improvements envisaged in *A Framework for Action*, either to adopt a market-type approach or to pursue the many different priorities for service change all at the same time. Instead, what is required to enable change, as has been the case with *Healthcare for London*, is careful and skilful management and sound planning around agreed priorities, drawing on the expertise of clinicians and their leaders and the broad engagement of patients and the public.

HEALTHCARE FOR LONDON HALTED

In May 2010, Andrew Lansley halted site-specific changes to London's health services that were associated with *Healthcare for London*. He stated that it was time to call a halt to NHS London's reconfiguration of NHS services, and that a top-down, one-size fits all approach should be replaced with the devolution of responsibility to clinicians and the public, with an improved focus on quality."[29]

He also instigated a moratorium on changes that were under way and required they should meet four key criteria before being allowed to progress, He stated that: "First, there must be clarity about the clinical evidence base underpinning the proposals. Second, they must have the support of the GP commissioners involved. Third, they must genuinely promote choice for their patients. Fourth, the process must have genuinely engaged the public, patients and local authorities."[30]

For those leading the changes, Andrew Lansley's decision generated a range of reactions, ranging from resignation, to frustration, to outright anger. For some, it had a paralysing effect – it prompted Sir Richard Sykes to resign as Chair of the NHS London Board, along with four non-executive directors. Sir Richard exposed his frustration in his resignation letter, writing that: "I have reflected on what you [Andrew Lansley] said and concluded that our visions of healthcare delivery bear so little in common that it would make no sense for me to continue in this role."

All of this gave strength to the opponents of *Healthcare for London*. For those who disagreed with the proposals set out in *A Framework for Action* and wished to maintain the status quo, Andrew Lansley's decision meant they now had the ammunition to obstruct change. Similarly, those sceptics who, irrespective of whether they believed in the case and proposals for change or not, did not believe the NHS in London had the will and/or capability to take forward the changes, were now able to argue that their cynicism was not misplaced. However, despite opposition and scepticism it was too late to turn back the clock on some of the strategic change programmes already being delivered, although the momentum for realising the rest of the *Healthcare for London* vision was slowed.

PROGRESS SINCE MAY 2010

Although no longer able to describe the programmes of change under the *Healthcare for London* banner, momentum was so powerful that London's clinical leadership was clear that none of the service transformation programmes under way should be abandoned. The clinical programmes indentified as priorities for implementation as part of *Healthcare for London* continued to progress throughout 2010 and beyond as part of a rolling programme of change, with further workstreams initiated. Reconfiguration programmes stalled, but the issues they were seeking to resolve were still very real. Clinicians and managers regrouped and programmes were rebranded and taken forward once more.

Delivering these changes and realising the full benefits envisaged in *Healthcare for London* have had varying degrees of success. The coalition government's reform programme, including the introduction of clinical commissioning groups and the planned abolition of PCTs and SHAs, has meant a change of focus among commissioners in London. This has been unfortunate as, arguably, it has distracted the NHS in London from transforming services in the way and at the pace envisaged in *Healthcare for London*, even though the evidence-based vision is still as valid today. The case for change remains the same as ever, whilst any updated affordability analysis would show the financial picture to be more challenging today than when the original analysis was undertaken.

Clinical areas that have continued or been initiated since May 2010 include specific clinical pathways (including cardiovascular, cancer, mental health, maternity and paediatric services), a cross-cutting effort on quality and safety, especially related to hospital emergency services, a focus on integrated care and primary care, and holistic reviews of clinical services in defined geographic areas. These are outlined below:

Specific clinical pathways

A London-wide review of cardiovascular services was carried out in a very similar way to those of stroke and trauma. The review covered vascular services, cardiac surgery and cardiology. It aimed to improve outcomes as well as reducing delays for patients awaiting surgery, shortening the time they spent in hospital after surgery and improving overall experience. For example, in 2008 data showed that at 8% the UK had the worst mortality rates in the developed world following arterial vascular surgery, in comparison to some nations achieving rates as low as around 2%. It was estimated that around 180 lives each year could be saved if London became the best in the world.

The review highlighted a clear link between volumes and outcomes. Consequently, significant consolidation of vascular surgery has taken place to achieve appropriate volumes at hospitals. Although further consolidation may be necessary, London now has one of the best mortality rates in England for this type of surgery, with the highest hospital mortality rate of just 3.7% in 2012, compared to a rate of 8.5% found at one hospital in 2008.

The model of care was published in December 2010 and handed over to the London cardiovascular and stroke networks for implementation. Working with each of the five sectors, networks of care have since been established that improve outcomes through streamlined pathways and the use of risk stratification that accelerates the delivery of care. Surgery is carried out in high volume by specialist teams with access to the latest technology and techniques.

Patient involvement was maintained through the London Patient Panel and implementation was completed in March 2012. Ongoing performance is monitored through the Pan-London Cardiovascular and Stroke Network Board and a London Cardiovascular Leadership Advisory Group, made up of clinical leaders from across the capital, which has been established to ensure the continued evaluation and improvement of services.

A review of cancer services has been completed that highlights significant inequalities in access to care and outcomes, for which late diagnosis is also a major factor. Raising survival rates in England to match the best in Europe could save approximately 1,000 lives per year in London. In August 2010 the model of care was agreed, which seeks to treat patients closer to home where possible and to consolidate specialist services within an integrated cancer system (ICS). The specification of these systems was completed in May 2011 and London's two ICSs went live from April 2012.

Work has continued, with a pathway approach to commissioning cancer services being undertaken. Output specifications for breast, lung, colorectal, and brain cancers, with supporting best practice pathways and commissioning metrics, have been drafted and the process for agreeing clinical input with both ICSs is under way. Work is also taking place to ensure prompt referral and access to diagnostics in both primary and secondary care, as well as increasing population awareness of the signs and symptoms of cancer.

A review of mental health services has taken place, focusing on services for people with long-term mental health conditions and those in crisis. This was driven by considerable variation in lengths of stay, models of provision and investment and a desire by commissioners to have some best practice information on what constituted 'excellent' provision, in order to add value to negotiations and joint working with providers. There was also the need to consider what care should be provided by specialist mental health providers and what could better be managed within primary care, particularly in the context of a growing emphasis on commissioning a recovery model. This has subsequently been emphasised in the cross-government strategy No health without mental health.

The resultant model for people with long-term mental health conditions was built around shared care between secondary and primary care and has been manifested in a number of ways across London. Implementation is being undertaken at a local level, as this was felt more appropriate in order to ensure local ownership and reflect differing needs and configurations of services. However, this has meant that there has been no centralised

collection of data or outcome findings. The introduction of mental health payment by results and the outcomes framework will enable this work to be undertaken in the coming years and enable meaningful comparison across London.

While specialised children's services in London are, in many instances, provided by hospitals with nationally and internationally recognised experts, fragmentation of these services is widespread and service provision is largely unplanned. Fragmentation, in the context of a limited, highly skilled workforce, also means that 'critical mass' is not always achieved, which raised concerns about the safety and sustainability of some specialised children's services. In March 2011, following extensive public engagement and consideration by an expert clinical panel, a new model for tertiary paediatric care was agreed that aimed to address these issues. In April that year, implementation began on a two-network model, which has now been established in north London and south London, with integrated care system boards that meet regularly.

Nine clinical pathway groups have been established, with London-wide clinical representation from the main providers of tertiary care. The paediatric intensive care and paediatric trauma groups are well established, with pathways and collaborative networks developed and the remainder are working together to develop the same. The Royal College of Paediatrics and Child Health is leading the process of patient and public engagement.

Cross-cutting focus on quality and safety

In 2011, the Quality and Safety Programme developed a case for change and associated London quality standards for adult acute emergency medicine and emergency general surgery. These were in response to significant evidence that demonstrated a variation in outcomes for patients depending on the time and day of the week they attended an emergency department, or were admitted to hospital as an emergency. This suggested a minimum of 500 lives in London could be saved every year if mortality rates for patients admitted at the weekend were the same for patients admitted during the week.

These variations in outcomes have been associated with a lack of immediate access to senior medical personnel in the assessment and management of acutely ill patients, as well as a lack of timely access to diagnostics and consultant reporting and insufficient input from multi-disciplinary teams, particularly outside normal working hours. The aim of London's quality standards is to ensure the assessment and subsequent treatment and care of patients attending or admitted to an emergency department will be consultant-delivered, available seven days a week and consistent across all service providers.

The Quality and Safety Programme was expanded in 2012 to address further areas of need:

- For patients with a fractured neck-of-femur, timely operations have a significant positive impact upon mortality and complication rates, yet almost a third of hospitals in London are below the national average for the time to operation and have at least 20% of operations taking place more than two days after admission. Scotland is currently outperforming London, with 84% of all operations taking place within 24 hours.
- London's maternity services do not perform uniformly well, with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity and patient experience. A 2012 study found that the maternal death rate in London was twice the rate of the rest of the UK. Data also demonstrated that women in London were found to be the least satisfied in the country with the care they received during labour.
- London also has a higher mortality rate for paediatric emergency admissions when compared to the rest of the country and this is increasing in comparison to mortality rates for other age groups.

In light of the above, further standards have been developed in the areas of emergency department, critical care, fractured neck-of-femur pathway, paediatric and maternity services.

An audit of all acute hospitals took place between May 2012 and January 2013 to ascertain the current status of London hospitals against the quality standards for adult acute medicine and emergency general surgery. The results, along with the programme's work, have been made publically available as part of the drive for transparency and availability of information and commissioners continue to work with providers in their efforts to achieve the quality standards.

Integrated care and out-of-hospital care

In 2010, parts of the NHS in London shifted emphasis away from the *Healthcare for London* polyclinic/polysystem model towards integrated care, recognising the need to improve aspects of coordinated care for the frail elderly and an ageing population with increasing incidence of long-term conditions. NHS London sponsored three integrated care pilots aligned to London's AHSCs. The pilots have helped in defining an integrated care system, which has seven core components delivered by multi-disciplinary groups and is dependant on five critical enablers for success – clinical leadership and culture development, information sharing, aligned incentives, patient engagement and accountability and joint decision-making.

NHS London recognised the need to support the diffusion of the benefits of integrated care systems more widely, so undertook analysis of the potential economic impact and showed that implementation across London could save commissioners up to £474 million.

Integrated care systems have now emerged across London and the benefits are becoming clearer. For example, the integrated care pilot in north west London is showing that all emergency (medical and surgical) admissions are growing at a lesser rate for the pilot population compared to the non-pilot population. Alongside the decision to reconfigure acute hospital services, the NHS in north west London is developing a fully integrated system, supported by clinical commissioning groups, out-of-hospital strategies and community investment.

A key element of London's reforms in integrating urgent and emergency systems is the new NHS 111 telephone number, supported by a capacity management system directory of services. London-wide coverage was completed by 31 March 2013 and will give the public better access to urgent healthcare services, driving improvements in the way the NHS commissions and delivers care. Whilst this was a national initiative with national drive and focus, a single point of access was a key proposal in *A Framework for Action*.

A new electronic patient care planner for end-of-life patients, Coordinate My Care, is being rolled out in line with NHS 111 across London. Coordinate My Care allows health professionals from primary, secondary and community care to develop a plan with patients that outlines their wishes and preferences for their place of treatment and death and ensures this is honoured, even when instinct may be to elevate to an unwanted level of care. In London to date, over 5,000 patients have a Coordinate My Care plan, of which 1,339 have died. Of the patients who have died and expressed a preference, 78% have died in their preferred place and only 21% died in hospital, compared to 59% nationally. Coordinate My Care enables the clear majority of patients to die in their preferred place in the community and has been well received by care homes, where many patients spend their last year of life:

> **Coordinate My Care is a fantastic idea to have a central port for such important data… especially useful for out-of-hours doctors who do not know the resident who needs a visit.**
>
> **– Nursing Home, Hounslow**

More than 90% of all healthcare contacts in England – 300 million consultations annually – occur in primary care. In 2010, NHS London launched a programme of work to support the transformation of primary care across the capital, acknowledging that whilst excellence in primary care exists, there is significant variation in the quality of services being delivered across London – for example, across 31 PCTs, the NHS in London had 26 different approaches to support the assessment of general practice provision.

NHS London worked in collaboration with GP leaders, London-wide LMCs, PCT clusters and patient representative groups, with input from over 150 other professionals across 70 organisations, to develop *The Pan London General Practice Outcome Standards and Framework*. The framework includes a suite of 28 outcome standards, grouped and aligned to the five overarching domains of the *NHS Outcomes Framework*, which form part of a triangulated picture to begin to establish an overall assessment of risk to quality and patient safety. Data on GPs was shared with them prior to publication, to provide the opportunity to review and, if necessary, challenge. This further strengthened the validity of the data, the process and the ongoing support and collaboration with the profession and its representatives. In November 2011, the outcome standards were published on the myhealthlondon website (www.myhealth.london.nhs.uk), allowing the public to view them ahead of choosing services.

Since the introduction of *The Pan London General Practice Outcome Standards and Framework*, there have been demonstrable improvements in data quality and completeness, quality of service provision and reductions in variation across London. In 2012, the work won the *Health Service Journal* award for enhancing care with data and information management. The outcome standards and framework's web interface has since been adopted by the NHS Commissioning Board and is being rolled out across England.

Holistic reviews in specific geographic areas

Programmes of major service change have been taken forward across London, aimed at delivering better health and patient outcomes by improving the quality of, and equality of access to, healthcare. With the inherent link between quality and efficiency and the overarching economic climate, these programmes have also been a means of addressing issues of financial viability of commissioners and providers.

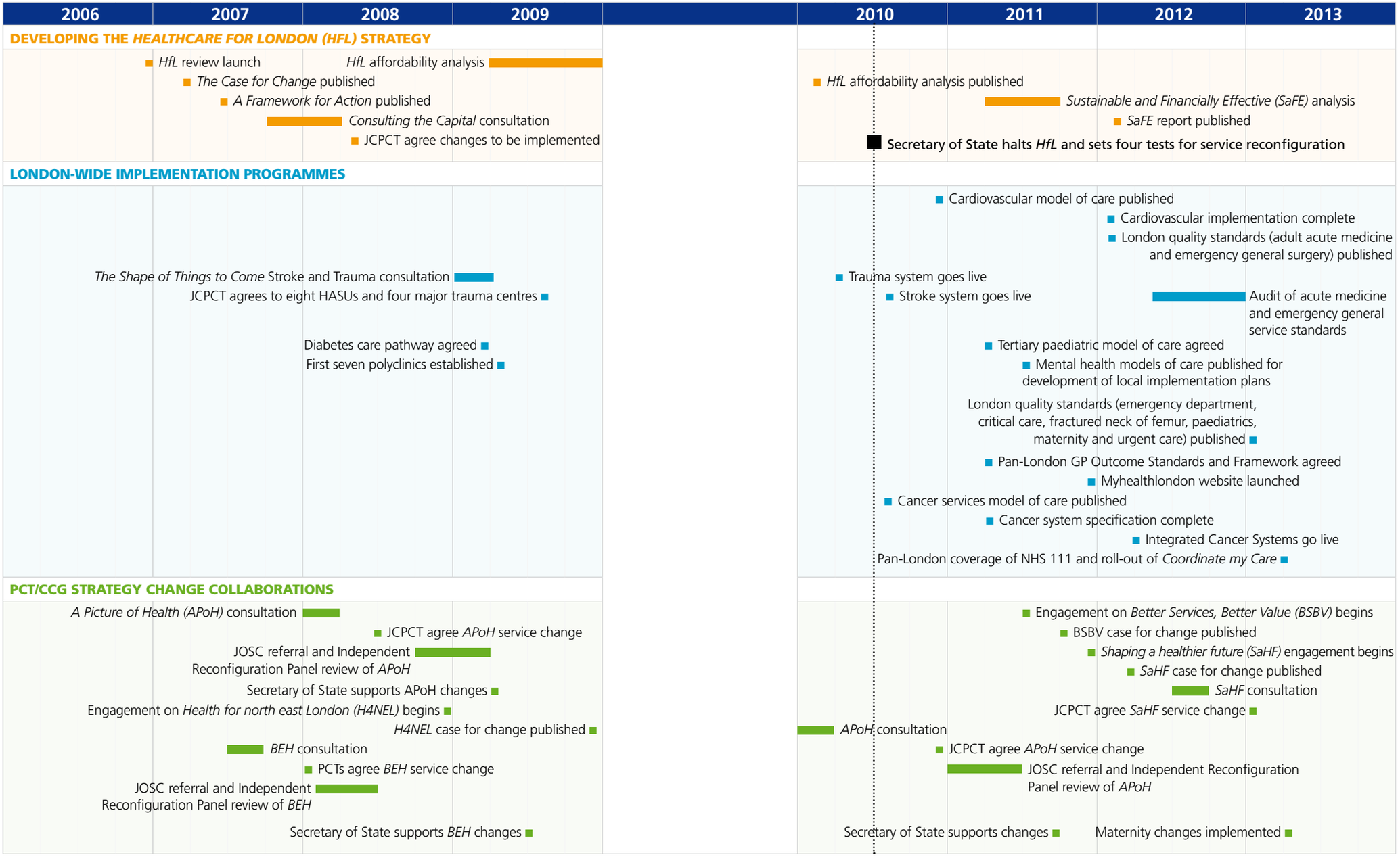
Health for North East London, Shaping a Healthier Future in north east London and *Better Services, Better Value* in south west London share the core principles of concentrating complex services on fewer sites and providing more services in the community. Each programme has included primary and community care services, urgent and emergency care, maternity services and specialist care.

Health for North East London has concentrated complex children's and vascular surgery at two hospitals in north east London and consultant-led obstetric services have been consolidated at five hospitals. Work will continue to deliver similar changes to emergency care and to develop King George Hospital in Ilford as a centre of excellence for planned care.

A joint board of commissioners in north west London has agreed changes proposed by *Shaping a Healthier Future* that will create one hospital providing highly specialised care, five hospitals providing emergency services and six hospitals providing maternity services. Proposals being developed by *Better Services, Better Value* in south west London are expected to deliver similar models.

These broad sets of changes across care pathways, hospitals and out-of-hospital care settings and the idea of integrating all these changes within a local area have all been inspired by *Case for Change*. They also have a common methodology, underpinned by careful review of the evidence by cross-cutting groups of clinicians to generate specific proposals on how care can be better delivered.

The relevant question today is how to continue to make large-scale change happen and address other issues in healthcare services against the backdrop of a more difficult and increasingly challenging context. This is discussed in more detail in chapters 4 and chapter 5.


2006
2007
2008
2009
2010
2011
2012
2013
DEVELOPING THE HEALTHCARE FOR LONDON (HFL) STRATEGY
HfL review launch
HfL affordability analysis
The Case for Change published
A Framework for Action published
Consulting the Capital consultation
JCPCT agree changes to be implemented
HfL affordability analysis published
Sustainable and Financially Effective (SaFE) analysis
SaFE report published
Secretary of State halts HfL and sets four tests for service reconfiguration
LONDON-WIDE IMPLEMENTATION PROGRAMMES
Cardiovascular model of care published
Cardiovascular implementation complete
London quality standards (adult acute medicine and emergency general surgery) published
The Shape of Things to Come Stroke and Trauma consultation
JCPCT agrees to eight HASUs and four major trauma centres
Trauma system goes live
Stroke system goes live
Audit of acute medicine and emergency general service standards
Diabetes care pathway agreed
First seven polyclinics established
Tertiary paediatric model of care agreed
Mental health models of care published for development of local implementation plans
London quality standards (emergency department, critical care, fractured neck of femur, paediatrics, maternity and urgent care) published
Pan-London GP Outcome Standards and Framework agreed
Myhealthlondon website launched
Cancer services model of care published
Cancer system specification complete
Integrated Cancer Systems go live
Pan-London coverage of NHS 111 and roll-out of Coordinate my Care
PCT/CCG STRATEGY CHANGE COLLABORATIONS
A Picture of Health (APoH) consultation
JCPCT agree APoH service change
JOSC referral and Independent Reconfiguration Panel review of APoH
Secretary of State supports APoH changes
Engagement on Health for north east London (H4NEL) begins
H4NEL case for change published
BEH consultation
PCTs agree BEH service change
JOSC referral and Independent Reconfiguration Panel review of BEH
Secretary of State supports BEH changes
Engagement on Better Services, Better Value (BSBV) begins
BSBV case for change published
Shaping a healthier future (SaHF) engagement begins
SaHF case for change published
SaHF consultation
JCPCT agree SaHF service change
APoH consultation
JCPCT agree APoH service change
JOSC referral and Independent Reconfiguration Panel review of APoH
Secretary of State supports changes
Maternity changes implemented

3

CASE STUDIES

IN THIS CHAPTER we case study three of the priority implementation programmes pursued as part of the delivery of *Healthcare for London*.

STROKE

PATIENT STORY

73-year old man from Harrow was one of the first patients to be taken to the Northwick Park Hospital hyper-acute stroke unit after suffering a stroke at home. He describes the experience as "miraculous".

He collapsed at home at 2.30am feeling sick and dizzy with weakness in his legs. His wife called an ambulance and paramedics took him to Northwick Park Hospital, where he was immediately given a CT scan and subsequently thrombolysis.

The patient recalls "It was very serious… My care at the hospital was superb. My speech was slurred before I had the injection but afterwards I was word perfect. It was incredible. After being given the treatment I came round straight away and the next day I woke up and was almost back to normal, had breakfast and went home. I am now completely back to normal and go to the gym twice a week."

The patient had also had a stroke three years previously following a triple heart bypass and was in hospital three and a half months following complications. This latest experience – in and out of hospital in less than two days – was a revelation to him.

The reconfiguration of stroke services across London has been widely praised nationally and internationally, winning the *Health Service Journal* award for clinical service redesign in 2010 and a *British Medical Journal* award for improvement in patient safety in 2012. Feedback from the interviews undertaken for this review was universally positive, with the reconfiguration the first accomplishment of *Healthcare for London* mentioned by most respondents, and has also been praised elsewhere, with the *Inside Your Hospital, Dr Foster Hospital Guide 2010-11* stating that: "The reorganisation [of stroke services] in London… is an exemplar of how services should be delivered within today's NHS."

Stroke care was one of the key targets identified in *A Framework for Action* and interviewees had clear views on the reasons for and the benefits of that choice:

> **The changes have been excellent as they have saved lives, significantly reduced disability and, hopefully, improved patient experience.**
>
> **– PCT CEO**

This case study looks at the experiences of those involved in the reconfiguration, the key enablers and challenges to change, and the outcomes so far.

The case for change

Approximately 8,000 patients have a stroke in London each year. It is the second biggest killer and can also cause long-term disability. *A Framework for Action* highlighted that changes to stroke care in London were both desirable and necessary[31].

Performance varied widely across London, with a few central London hospitals offering care similar to top international standards but few others able to match this:

> **There were no hospitals in the periphery of London that were offering a thrombolysis service 24 hours a day seven days a week and very few – I think only one – offering any sort of daytime thrombolysis service.**
>
> **– Senior clinician**

This table starkly illustrates the challenges faced:

	2004	2006
Number of hospitals treating >90% of patients in a dedicated stroke unit (total = 30)	4	3
Number of hospitals where >90% of patients receive a CT scan within 24 hours of admission (total = 30)	7	0
Percentage of patients treat on a dedicated stroke ward		53%
Percentage of patients offered thrombolysis		<1%

There was a small but compelling evidence base for centralising services. The national strategy was not being driven forward systematically for London as a whole. Only around half of patients were admitted directly to stroke units, there were low rates of thrombolysis, delays in scanning and insufficient use of early supported discharge.

Problems with individual components of inpatient rehabilitation and variable performance in secondary prevention, for example anticoagulation for patients in atrial fibrillation, were also identified.

Large-scale clinical trials show that thrombolysis in the acute phase of a stroke leads to significantly better clinical outcomes. On average, 3.1 patients need to be treated for one patient to have a better clinical outcome (this is the 'number needed to treat' or NNT – 3.1 is very low compared to many interventions) and eight patients needed to be treated for one patient to have a normal or near-normal outcome[32].

Experience in Canada has shown it is possible to achieve similar results across a whole health system to those achieved in drug studies (which often have greater resources and exclude certain patients)[33], whilst a 2009 Cochrane review of all the published literature on thrombolysis in acute stroke estimated the benefits of thrombolysis of the type used in London (rTPA) to be equivalent to 60 less dead or dependent patients per 1,000 treated[34].

Stroke was a high impact condition, a significant cause of mortality *and* morbidity, with many patients left dependent due to high levels of disability, and nationally recognised performance targets were not being met. This made for a powerful and engaging story for politicians, clinicians, managers and the public alike.

The process

Governance of the project was largely through a project board, supported by a clinical expert panel, reporting to the London Commissioning Group[35]. The senior responsible officer (SRO) for the project was Rachel Tyndall, an experienced PCT chief executive. The clinical lead was Dr Chris Streather, a renal physician and senior manager. Decisions also required sign-off from a joint committee of PCTs, formed prior to the consultation process, and were in turn scrutinised by a joint overview and scrutiny committee (JOSC).

Clinical standards and recommendations for the stroke pathway were the remit of the clinical expert panel, which synthesised international best practice and national guidance. Modelling of the current and future state of stroke services was performed by King's College London and the London School of Economics and was a key resource for designing the new system. Proposals were tested at engagement events, where the voices of patients and third sector groups were prominent.

A preliminary strategy was published that summarised the process described above, the case for change, the model of care and the next steps, including benefits realisation. The model included three levels of care: hyper-acute stroke units (HASUs), which would offer 24-hour access (part-time HASUs having been considered and rejected) to 72-hour admissions for high dependency care, stroke units, and transient ischaemic attack (TIA) services.

Acute trusts were invited to tender for these different levels of service. The number and distribution of HASUs were to be subject to committee decision, whereas any stroke unit meeting criteria would be accepted. The bids were ranked by experts in stroke care from outside London and the outcomes were used to generate and assess potential configurations for stroke services.

The key determinants in the designation process were:

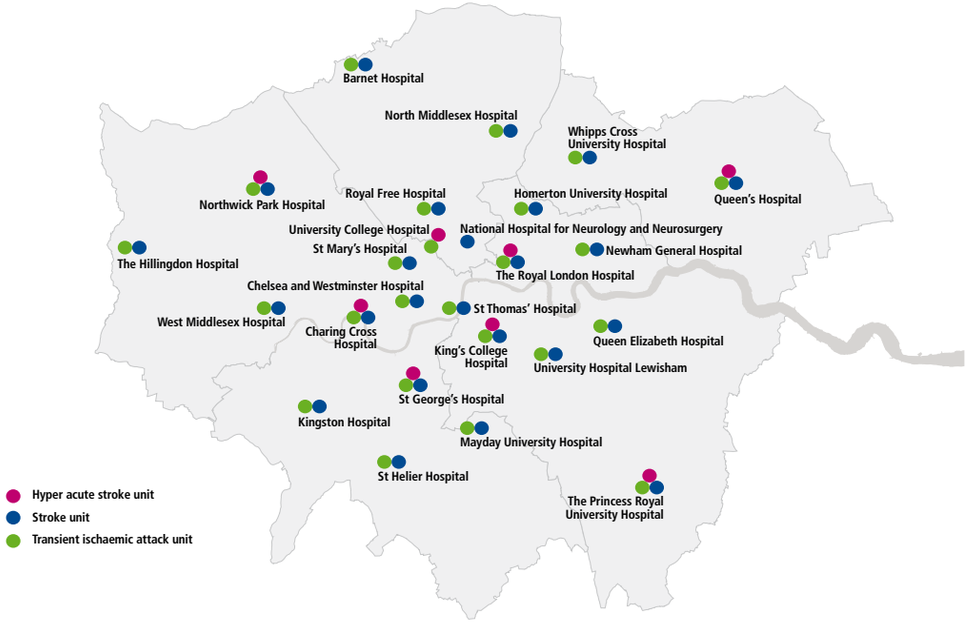
- **Quality of service** – did the bid meet the criteria? Would there be sufficient case volume? Did the trust have capacity to provide the service? Would implementation be timely?
- **Geography and access** – would the configuration of HASUs across London provide 30-minute access by blue light ambulance for all Londoners?[d] Which configuration would include the greatest number of high quality providers (accepting that some high quality bids would fail on grounds of their proximity to other providers)?
- **Strategic coherence** – bringing important acute services [in this case, HASUs and major trauma centres] together where there is benefit in doing so. The consultation document specifically referred to the development of HASUs and major trauma centres in major acute hospitals as being consistent with the *Healthcare for London* vision. Although the co-dependencies were not enormous, there were definite clinical reasons in favour and a National Clinical Advisory Team review highlighted the benefits of co-location, "to maximise the use of clinical expertise (particularly in the neurosciences) and investigative facilities"[36].

The establishment of HASUs and major trauma centres were also seen as a platform for further change and indeed vascular services have now also been consolidated.

The outcome of the modelling was that there were not enough credible HASU bids in certain areas to provide the necessary geographical coverage. This had not been anticipated by the project board and it was therefore necessary to provide support for failed bids to develop satisfactory services.

From 31 January 2009 to 8 May 2009, the proposals were the subject of a public consultation, *The Shape of Things to Come*[37] which also covered proposed changes to major trauma services. Whereas the consultation about major trauma gave several options for respondents to choose between, the stroke proposals gave only the preferred option, with the public asked to agree or disagree.

d *This reflects a balance between the need for treatment in the shortest possible time and the logistics of transporting patients within London.*



Once the joint committee of PCTs had signed off the proposed HASU designation, implementation could begin. Significant challenges existed, most notably a need for more skilled nurses and therapists. The five existing stroke networks were critically important enablers, supporting the trusts to get up to speed rapidly:

> The stroke and cardiac networks…were really quite well resourced and were an absolutely vital part of making sure that implementation happened. They had staff who could go out and work with the trusts, helping them to develop their plans, helping them to improve, helping the trust managers to reorganise their services, but at the same time putting the pressure on as well.
>
> **– Senior clinician**

In December 2009, Professor Tony Rudd became London's first Clinical Director for Stroke, providing even more high profile clinical leadership.

Another key factor was the funding for the new services, a total of £23 million, which was explicitly linked to capacity and performance. The majority of this funding was for acute stroke services, £13m for HASUs and £7m for stroke units[38], and mainly reflected the cost of increased staff numbers and skills. This was especially true for HASUs, which in the opinion of one clinician, "are equivalent to high dependency unit care". The funds would be received through new tariffs for stroke admissions. Other areas for investment included the London Ambulance Service and rehabilitation. Trusts were required to meet any infrastructure costs themselves.

Outcomes

The Royal College of Physician's (RCP's) Sentinel Stroke National Audit Programme (SSNAP) is a new programme of work that builds on the 2010 National Sentinel Stroke Audit. The scoring system now has more stringent criteria; however, both provide nationally comparative data with which to judge the performance of London's stroke services pre- and post-changes. The 2012 data demonstrates that the changes to the stroke pathway have improved the quality of care for patients. In the 2010 Audit, five of the eight top stroke services nationally were in London; in 2012 it was seven:

> This level of performance was a massive jump for the HASUs which were designated even though they didn't meet the criteria – I am more proud of this than the others that went from good to excellent.
>
> **NHS executive**

Corresponding to this, London scores above the national average for all eight acute organisational audit domains:

The rate of thrombolysis is higher than in the rest of the country and exceeds other major cities internationally, increasing from approximately 3% in 2009 to 19% today.

Domain	1	2	3	4	5	6	7	8
London average	92.6	77.0	81.9	62.2	88.1	86.0	95.3	88.2
National average	68.8	65	70	52.5	87.5	80.4	87.5	81.3

The 2011 Dr Foster report suggests that London has seen a particularly significant improvement for weekend care, stating that: "The result has been a significant fall in mortality between 2009/10 and 2010/11. Part of this has been achieved by improving the standards of care out of normal hours. Prior to the reorganisation (2009/10), ten per cent of stroke patients died within seven days of admission if they came into hospital at the weekend, compared with eight per cent admitted on weekdays. After the reorganisation, the weekday mortality rate dropped to 6.4 per cent. But the weekend mortality rate fell even faster to 7.3 per cent."[39,40]

The mortality rate from stroke is now 28% lower in London than the England average.

An independent academic evaluation was also carried out in 2011 and results suggest that London's stroke model has improved care and value for money, concluding that:

- At 30 days after stroke, costs were £3.3m higher with the new model of delivery. However, there were 214 fewer deaths and 51 more Quality Adjusted Life Years[e] (QALY) in the population
- At 3 months after stroke, costs were £5.4m lower with the new model of delivery thanks to reduced lengths of stay[f] (the lowest figures in England) and fewer patients being admitted to intensive care units. There were projected to be 238 fewer deaths and 112 more QALYs in the population
- In the period up to 10 years after stroke, ongoing patient costs should be £21.3 lower with the new model of delivery, because the number of patients admitted to institutional care will be lower and a smaller proportion of patients will be disabled. There will be 238 fewer deaths and 4492 QALYs gained in the population

These findings align with the modelling undertaken in the planning stages of the programme, which suggested there would be fewer patients dying or living with long-term disability if the model of stroke care were to change. It was expected there will be fewer stroke patients needing nursing home care or community support and increasing numbers able to get back to work. Efficiency gains are already being realised:

- The reduction in length of stay represents a potential provider saving of £3.5m over a six-month period
- It was estimated at the beginning of the project that 20% of patients would be discharged home from HASUs, but later figures showed this number to be approximately 40%

There remains work to be done, both to cement the improvements made to date and ensure the improvements extend into rehabilitation. In interview, a public health expert was keen to emphasise that more could be done to address health inequalities relating to stroke, thus reducing the overall incidence of stroke.

e *Quality Adjusted Life Years (QALY) is a measure of disease burden, including both the quality and the quantity of life lived. It is used in assessing the value for money of a medical intervention.*

f *Length of stay (LOS) across the pathway is approximately 11.5 days, a reduction of approximately 3.5 days. It was estimated at the beginning of the project that 20% of patients would be discharged home from HASUs. Latest figures show that in fact approximately 40% of patients are discharged home from HASUs.*

Reflections on the enablers of change

Data

There was widespread agreement that the case for change was extremely powerful. Sentinel Audit data, collected over many years, was a huge benefit and showed that London's performance in stroke care was not meeting expectations. Interviewees felt that data was an extremely potent motivator, bringing home the human cost of stroke and of sub-optimal services. In particular, focusing on data emphasised that changes were primarily about improving clinical quality rather than saving money:

> **Stroke [is] the second biggest killer in London, the biggest cause of adult disability… So the emphasis on stroke was a good one. The amount of duplication in London had delivered [poor quality] care, expensively.**
>
> **– Senior clinician**

Money and status

Opinion was clear that the extra money allocated to the stroke pathway was a major catalyst. The uplift for HASUs recognised the extra intensity of care, the structural reorganisation and the workforce development that was required from providers. It was a major facilitator, but as a lever for change it was the money being carefully linked to service quality that felt revolutionary:

> **It was hugely helpful to have a very large sum of money being thrown at stroke but thrown at stroke in a way that was really intelligent, linking the money to quality improvement… Standards were set that there should be a certain number of nurses and therapists per bed, for example, at much higher levels than anywhere else in the country – for the HASUs at almost high dependency unit type levels… The money would only be paid if you…could prove that you had those nurses in place. It wasn't good enough just to bring in people from agencies, they actually had to be permanent staff.**
>
> **– Senior clinician**

In light of this it was also critical to demonstrate the financial benefit of the change. Before this work was completed there was a perception that stroke care in London was excellent but costly. The evaluation debunked this myth.

Collaboration

Interviewees felt that unusual and impressive levels of collaboration existed between managers and clinicians:

> **I've never seen such close collaboration. It wasn't just at my own institution but everywhere else really, between managers and clinicians in putting these bids together and certainly the successful hospitals were the ones where you had that close collaboration. The whole process brought together managers and the clinicians on one hand and the commissioners on the other.**
>
> **Senior clinician**

Furthermore, clinicians from hospitals that were not awarded HASU status worked closely with their neighbours to help provide the best possible service for patients. This was not predicted, and the opposite might have been expected, but appears to have come from the desire to provide top quality care:

> The other thing that was really striking [was] the collaboration between the different units…Take St Mary's and Charing Cross, for example, never [close] really even though they were under a single trust. St Mary's [clinicians may have felt] aggrieved that they hadn't [been chosen by their trust to bid for] the HASU, that it was all going to be put onto the Charing Cross site, and yet the clinicians on two sites work incredibly closely together.
>
> **– Senior clinician**

> The Royal Free and UCLH, unsurprisingly, met the standard that we required; both were good units. We would have made a decision but actually we did not [have to]… In the context of the AHSC, they spoke to each other about it – the clinicians themselves within the two hospitals – [and] they agreed that the writing was [on the wall] for [only] one of them to be a hyper-acute unit. Between themselves, they agreed that it should be at UCH, which was actually very helpful and very mature behaviour.
>
> **– NHS manager**

Possible contributors to this collaboration included the existing London stroke networks, the demonstrable focus on quality, identification with the London stroke project as a binding mechanism, and a sense of being measured/viewed on collective, as opposed to individual, performance. Strong commissioning and concerns about income may also have played a part.

Commissioner power

Healthcare for London was viewed to have signalled a key change in the quality of commissioning of services in London. It was widely felt that until this point the balance of power between commissioners and providers strongly favoured the latter, mainly due to their much larger size but also, possibly, a relative lack of contract and performance management skills in the PCTs. The stroke reconfiguration, by its London-wide commissioner-led approach, altered this balance of power in an important way and paved the way for other reconfigurations:

> Actually for a lot of these hospitals, this was a pretty shocking process. [It felt like the first time that] commissioners had said to providers 'Here is the standard [and] if you do not meet it we are not going to let you do it'. Up until this point in time, all the power had sat with providers, not with commissioners, so this was quite a startling thing to say. It was a big wake-up call. The great majority of hospitals were shaken, and they [did not want] to be left out, so quite senior people got involved [and] quite a lot of energy went into putting things right.
>
> **– Senior NHS manager**

> I think we are only just starting to see the longer-term benefits [of this increased commissioning clout], for example in diabetes. The revolution is coming slowly and quietly.
>
> **– Communications expert**

London-wide planning

There was strong and consistent feedback that stroke pathway redesign was only possible because of the strategic approach to planning services for the whole of London. Despite the fact that some providers were inevitably unhappy at the HASU designation, interviewees were in no doubt as to the importance of such an overview in this sort of strategic work. Some have defined this as top-down planning, which they felt was the required model, but which may become more difficult with current changes to the structure of the NHS. Others, however, questioned whether the terms top-down and bottom-up were relevant to such a wide-ranging project and felt that changes were locally driven where appropriate:

> I think it's worth reflecting on what is top-down and what is bottom-up in the context of a strategic change being run across a whole city. Maybe we could have done more, but not much more, to engage. It really was clinically led. It really was supported by patients, carers, the third sector. It was not imposed. It was centrally facilitated.
>
> **– Senior NHS executive**

Third sector and patient involvement

Clinicians, managers and patient/third sector representatives all agreed the involvement of the latter, particularly the Stroke Association, was a key strength. One senior clinician referred to this as *"keeping the clinicians honest"* by continually bringing the debate back to the needs of patients. This involvement was extremely helpful for the project board and also at public and clinical engagement events:

"We tried to make it that every table in every meeting – not just every meeting, every table in every meeting – had a user or carer sat at the table. And I don't think we did a set-piece big meeting where we didn't have someone from the Stroke Association or a patient or a carer, speaking on the platform…I think there was a subtle benefit from that in that some of [those with] vested interests behave themselves a bit better if they've got a patient or a carer around." [Senior clinician]

> We had voluntary bodies like the Stroke Association and Connect and others involved. And that was really important…we needed the real stroke patients and real stroke carers, because they're the ones that understand what was good and what was bad about their own experiences.
>
> **– Senior management consultant**

Clinical engagement

The importance of clinical engagement was emphasised in the interviews. In particular, the presence in London of international leaders in stroke care and the multi-disciplinary clinical input was felt to be important, as was the clinical lead not being a stroke specialist, which removed vested interests from the debate at a central level and was felt to provide a level of objectivity. Clinicians, as well as commissioners, were used to deliver the key messages to varied audiences:

> I think one of the strengths we had when we were arguing the case is we could get commissioners, doctors, therapists, all kinds of people to stand up and say: 'The old way we organised stroke care was delivering [inadequate] care expensively and doing this – [never mind] what it does to institutions – will improve the quality of care'.
>
> **– Senior clinician**

A contributor to the stroke programme emphasised that the level of engagement achieved was not simply an automatic result of the strong case for change; it required detailed and focused work by the project and communications teams, for example in ensuring that senior clinical champions were well briefed and available to front events.

Reflections on the challenges to change

Interviewees were just about unanimous that the stroke pathway reconfiguration was tremendously successful. They did however report that a significant number of challenges had to be overcome; the lessons learnt from these were felt to be extremely valuable:

Limited evidence base for the model of care

Developing the model of care for stroke was challenging. Although there was a national strategy for stroke care, there was still a lot of work to be done to formulate a London-specific model. As with much service redesign, there was limited evidence on which to base change and in this case one or two papers served as the backbone for the decisions. Much of the drive for change came from evidence in other specialities about units with higher patient volumes achieving better outcomes. Whilst there was little disagreement on the key clinical targets, the question of which model would best provide this was somewhat contentious:

> There was basically one paper on [the volume/outcome ratio] in stroke and the numbers [were] relatively small so actually we had very little to go on. There is some evidence obviously from surgical specialties and from myocardial infarction to show that the busier the units are the better the quality of care they deliver but we didn't know about that particularly for stroke...so we came up with a range of models that was then put out to professional consultation.
>
> **– Senior clinician**

This demonstrates how important it is to be able to use assumptions and for these to be thoroughly discussed by clinicians and managers. The absence of directly transferrable evidence should not be a barrier to change.

The service model – How many HASUs?

As mentioned, the evidence base from which the best model of care was determined, particularly the key question of how many HASUs and stroke units would be required, was not crystal clear. Rather than the eight that were finally commissioned, the clinical expert panel favoured a larger number, perhaps as many as 14, to mitigate against temporary closures, recruitment difficulties and longer travel times for patients and staff.

Whilst London clinicians were heavily involved in working up the options for designation, to avoid conflicts of interest none were involved in the decision-making process. Although they understood the reasons for the eventual decision to have eight HASUs, it caused resentment amongst some of the clinical advisors. There were several powerful arguments for fewer HASUs, including the difficulty of resourcing larger numbers of small units, particularly in providing 24-hour consultant cover and keeping patient volumes high enough to maintain quality:

> There [was] a big workforce issue on stroke… we put in 500 new nurses [and other staff] to deliver on the stroke model…and you don't have a limitless amount of money, so you have to map what you need in workforce terms…[against] the amount of activity that you're going to have [and] the access that you need. Then [you need to ask] what is affordable, and how many specialists you have to man the 24/7 rotas.
>
> **– Senior NHS executive**

A senior manager told us that the centralised decision making process was one of the key factors that facilitated the redesign:

> If we had allowed a bottom-up approach to stroke, we would have a very large number of quasi-hyper-acute stroke units now, and they would not be distributed around London in a way that facilitates equal access.
>
> **– PCT CEO**

Designation

The designation process that ranked bids from all potential HASUs and stroke units was also controversial. The bids were assessed against a combination of the quality of the service proposed and access, specifically London-wide population coverage. After bids had been rated by external advisors it became clear it would not be possible to provide London-wide coverage with the specified maximum 30-minute 'blue light' ambulance journey:

> The problem we had was the mismatch between quality and strategic coherence.
> **– NHS manager**

This possibility had not been explicitly planned for by the project team, necessitating some difficult decisions.

> The mathematical modelling to work out the best combination of the bids that passed was terrifically complicated, and I think that probably sucked us in. We had not thought about what to do if they did not pass. We could have thought about it earlier.
> **– NHS manager**

The unexpected lack of geographical coverage left the project team with two choices – to run the bidding process again or to work with some units to help them reach required standards. The latter option was chosen as it was considered more likely to drive up standards. However, there was a feeling from some clinicians that this undermined the whole process:

> I can understand why the decisions were made about where you would put the hospitals because that's actually where the patients were and that's where you needed to have the services but, at the time, I felt very angry because I thought that the whole process had been a charade. I didn't know why we'd gone through the process of looking at quality if that was then going to be disregarded.
> **– Senior clinician**

As the clinical advisors to the programme worked in existing London stroke units that would be bidding for HASU status, this meant that they were inevitably affected. This is a reminder of the emotional and practical implications for individuals involved in a large-scale change process.

Ranking bids for quality did have some positive effects:

> [the invitation to bid] really galvanised action at almost every site. In fact, I think the assessments were more important and useful in the places that failed.
> **– Senior manager**

> A beneficial side effect was the way in which it made us work much more closely, perhaps than we would otherwise have done, with commissioners. We were already working with the networks, but not necessarily with PCTs and sector staff.
> **– NHS manager**

It was accepted by those close to the process that difficult decisions were required and some trusts and clinicians were going to be disappointed at the outcome:

> We were always going to have too many trusts able to deliver HASU services and too many of them in central London so we had to have a way of deciding which ones to choose. Getting them to bid to be designated and getting external people to mark their bids still seems a good way to me.
> **– PCT CEO**

Rehabilitation

Interviewees felt the decision to focus on acute stroke care was understandable, and probably correct, but that, as with major trauma, the issues of rehabilitation and long-term care were not as obviously addressed. A number of factors that may have influenced this were suggested:

- The project team spent more of their time on the acute pathway:

> At the outset our ambition was to divide the work into three: to look at the public health and prevention bits, at the hyper acute bit and the rehabilitation and long-term care. You could say we should have spent an equal amount of time on all three bits of the pathway and I think we spent probably three-fifths of our time on the middle bit of the pathway, instead of a third.
> **– Senior clinician**

- Existing services, infrastructures and payment models were extremely variable:

> [There was] a very diverse range of delivery models around London and real difficulty in understanding activity and costs. For example in-patient care was all paid for on [Healthcare Resource Groups] whereas there was no one currency for rehabilitation and no easy way of identifying stroke specific activity and costs.
> **– PCT CEO**

- The modelling was challenging because it depended on modelling HASU and stroke unit activity and the possible impact of increased thrombolysis rates on future disability levels. The variability in existing services also contributed to this difficulty
- There was limited evidence available on which to base new services. The best evidence, we were told, was for early supported discharge

- The introduction of new financial incentives was focused on the acute pathway:

> We've not made the step change in the sort of longer term care community rehab that we have done in the hospital sector. Why is that the case? Because all the financial incentive put into the process was being put into a hospital pathway. Early supported discharge is a proven treatment that produces better clinical outcomes at lower cost [but] if you're going to set up an early supported discharge team then the funding quite logically should be coming partly from the hospital and partly from the PCT [and] trying to persuade hospitals to part with some of their money hasn't worked.
>
> **– Senior clinician**

- There are fewer obvious outcome measures for rehabilitation and changes take longer to demonstrate benefit
- Rehabilitation is perceived as a less 'glamorous' area of care, which could affect recruitment, morale, retention etc

Those closest to the programme felt there had been improvements but they were hard to quantify:

> We did produce commissioning guides for both rehab and for long-term care. Progress on the ground has been steady rather than spectacular. I think that's more about the fact that you can't impose a single model on community services in the way you can hospitals because of the diversity in the way they are set up and run in each locality. The money is a secondary point.
>
> **– NHS manager**

NHS London also reviewed PCT action regularly and discussed with chief executives their plans for improving services. However, it seems that without the central facilitation successful change has been limited and slow.

Workforce

Setting up HASUs and, to a lesser extent, stroke units, and the exacting specifications that had to be met to ensure payment of the increased tariff, meant that serious attention had to be paid to workforce development:

> The hospitals had to spend a lot of money [because] there were huge numbers of staff to be recruited. Across the patch as a whole, 400 additional nurses and nearly 100 additional therapists [were] recruited into stroke and all that was done by the trusts on a promise of additional funding once the process went ahead.
>
> **– Senior clinician**

There were risk-sharing arrangements in place so that the PCTs absorbed some of this burden, but the need for workforce development is undeniable. This barrier was used by sceptics to cast doubt on the proposals during development yet, admittedly with considerable effort on behalf of the trusts and the stroke networks, the requirements were met.

Organisational futures and political considerations

Staff in some of the unsuccessful organisations were extremely upset and angry at the outcomes of the HASU designation and stroke unit approval process. The loss of status and potential negative implications of failed bids to provide HASU and/or stroke unit care were mentioned, an attitude some interviewees found frustrating:

> Ultimately there were some people who cared more about whether they were a designated HASU than about improving stroke care for Londoners, full stop.
>
> **– Senior clinician**

Those involved in the reconfiguration were adamant there was no agenda to undermine certain hospitals by closing stroke units:

> There was no predetermination to reduce the number of stroke units (as opposed to the firm view on the number of HASUs). If all the hospitals had passed the assessment they would all have been designated as stroke units.
>
> **– NHS manager**

The impact of politics on the changes, and vice versa, was also a common theme. It is, perhaps, unrealistic to expect local politicians to align themselves with typically unpopular decisions such as the perceived de-commissioning of local services. However, it becomes even more difficult if there is public disagreement. Although some difference of views was perhaps inevitable, overall there was less than might have been expected with politicians from only three councils expressing particular concerns. The JOSC, with its mix of local politicians, was a strong enabler here and the programme team and senior figures at NHS London invested a lot of time and energy in meeting MPs and peers from all parties to explain the plans.

Lack of pre-agreed evaluation

Several interviewees commented that evaluation of the changes to the stroke pathway should have been included in the planning process from the outset. However, there was no money set aside for this and it would have required a separate team with a specific set of skills.

Although this did not hinder implementation *per se*, it was felt that early arrangements for evaluation would have allowed data to be collected throughout the reconfiguration process, thus demonstrating more conclusively the effect of the changes and having consequent benefits for other pathways or future change programmes. It is also more difficult and possibly more expensive to evaluate change retrospectively, particularly if data collection methods have not been put in place, although the RCP's Sentinel Audit data did at least provide a baseline. However, an evaluation has been commissioned and the preliminary data is mentioned later in this chapter.

KEY LESSONS

- Changes work best when the evidence base is strong, messages (particularly about quality and safety) are communicated clearly and financial benefits are shared between commissioners and providers
- For large scale changes in relatively low-volume conditions, commissioners are best served by working together
- Putting in place dedicated resources to deliver the change programme supported by senior leadership (clinicians and managers) is advantageous
- Collaboration between clinicians from different providers is perfectly possible and should be facilitated
- Early and continuous engagement with patients, the public and their representatives is vital in securing broad support for the case for change and proposals for service improvement. In articulating the arguments, it is important to utilise the voices of service users, clinicians and the third sector
- Early identification and collection of data is necessary. In stroke, there was the advantage of Sentinel Audit data being available, going back for years, and providers were accustomed to it being collected
- Financial incentives and upfront investment can deliver changes and monitor financial benefits
- Planning for evaluation at the same time as planning proposals for change is advantageous
- Publicising 'good news' through NHS channels, networks and local and national media maintains a positive spotlight on the changes

Conclusions

> I think the work on stroke and major trauma, in particular, has shown that change can happen in a significant way.
>
> **PCT CEO**

The acute stroke service reconfiguration stands as testament to what can be achieved in a short space of time with strong leadership, including that of senior clinicians, and disciplined project management. The evidence base was small but robust, ambition was high and there was a firm cross-discipline agreement that change was essential.

It is interesting and important to note that, whilst the money provided to improve services was undoubtedly significant, professional pride, organisational status and the desire to provide top quality clinical services appear to have been the bigger motivators. The level of collaboration between clinicians from 'rival' departments following the HASU designations is inspirational and a source of great hope for the future.

The key part played by the Stroke Association shows the third sector almost certainly has more to give across a wide range of pathways, although clearly this will vary depending on the clinical and geographical areas concerned and the characteristics of the various third sector organisations. The same point can be made about the importance of patient engagement in service redesign, as the idea that patients 'keep clinicians honest' is a powerful one.

Not everyone agreed that the reconfiguration process delivered the best delivery model with respect to geographical coverage; participants in both the stroke and trauma reconfigurations felt the co-dependencies of the pathways and the potential benefits of co-location should have been considered earlier. The implication of this is that an overview of the whole system is required in order to determine priorities and ensure potential synergies are capitalised upon. Even those who did not agree with the eventual configuration tended to agree with this.

This case study emphasises that workforce issues, often seen as a serious obstacle to change, can be overcome. The speed with which a cohort of specialist stroke nurses was developed for the HASUs is nothing short of remarkable. Another commonly cited barrier, a lack of political support, was arguably less of an issue than might have been expected thanks to extensive, proactive engagement work.

The striking improvements in acute stroke care contrast with significantly slower and more varied progress on rehabilitation and post-stroke care. This reflects, among other things, the greater heterogeneity of community care currently in existence and the complexity of funding for rehabilitation.

While it is valuable, deserved and important for the system to reflect on success to date, interviewees were clear that London cannot rest on its laurels - stroke care can and must improve further.

TRAUMA

PATIENT STORY

Motorcyclist Robert Williamson was hit by a 17-tonne lorry in October 2010 and suffered a crushed pelvis and serious internal injuries. He was one of the first victims of major trauma to be treated in a fully operational major trauma centre. It was initially doubtful that he would survive the accident.

Mr Williamson was taken to the major trauma centre at St George's Hospital, where he received immediate treatment from a specialist team of physicians, trauma nurses and surgeons. He has since had over 20 operations and is able to walk again.

He said, "If I didn't have access to the major trauma centre I might not be walking at this point. It's incredibly important to me. I'm sure most people want to be like me and on the way back to their full health and ability after something like this, and I put this down to the trauma team."

The surgeon who operated on Mr Williamson said, "The concept of getting the right patient to the right hospital as quickly as possible has now become a reality for trauma patients across London. Through the tremendous team work of everybody from roadside to major trauma unit and beyond, Robert's life was saved and his long term disability reduced."

Approximately 50% of patients who undergo the type of surgical procedure given to Mr Williamson die. Without the new trauma system in place, with the right team available at all times, it is possible that Mr Williamson would not have survived.

A Framework for Action singled out the transformation of trauma services as an immediate priority. Trauma was an area in which London, in common with the rest of the UK, did not deliver patient care to the standard of other locations internationally. *A Framework for Action* proposed the development of a small number of major trauma centres, to allow 24-hour consultant-delivered care and better access to dedicated, highly specialised services. Each major trauma centre would be supported by a network of smaller trauma units.

There was much evidence and clinical support for the changes to trauma services. Interviewees agreed that implementation of the changes proposed by *A Framework for Action* had been necessary and have been, for the most part, successful. This chapter examines the case for change, and describes the enablers utilised and obstacles encountered. It also looks at outcomes and learning gained from the different experiences of those involved in the service redesign.

The design and process of the work programme, its governance and the public consultation are similar to that described in the case study on stroke, so are not replicated here. Only the elements specific to the trauma programme are described.

Case for change

There were a number of factors underpinning the case for change, the most important of which was strong clinical evidence. A report by the Royal College of Surgeons suggested that approximately one third of 1,000 trauma deaths could have been prevented had patients been managed better[41]. Further reports by the Royal College of Surgeons[42], the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Lord Turnberg[43] reinforced the view that trauma care in England was poor. The NCEPOD report, *Trauma, Who Cares?,* published in 2007, aligned closely with *A Framework for Action* in proposing regional planning for major trauma services and a 24-hour consultant presence on-site[44].

A working example of a major trauma centre was already in place at the Royal London Hospital, where mortality rates had dropped significantly since its establishment. In 2006 it had a 28% reduction in mortality in the most severely-injured patients when compared with the national average[45]. This was a model that could be rolled out elsewhere in the city, as several other London hospitals had the potential to develop major trauma centres with sufficient resources and appropriate specialities on-site.

Furthermore, a comparison of trauma services within London showed great variation between providers, with up to two-thirds of patients being transferred from local A&E departments to more specialist centres. Most hospitals in London treated very few trauma patients each year and access to specialists was limited[g]. Treatment varied according to location and factors such as time of admission, with fewer specialists available out-of-hours and at weekends.

There was clear evidence that London's trauma services compared poorly to the US, the Netherlands, Australia and Canada[46].

Possibly as a result of the factors described above, and key to the eventual success of the programme, there was a great deal of support among clinicians for reconfiguration. Interviewees referred to the proposed changes as 'pushing against an open door'. Specific reasons for this were:

- Although there were clear dependencies between trauma and areas such as neurosurgery, vascular surgery, anaesthetics and orthopaedics, compared to other specialties trauma was a relatively discrete area. The fall in patient numbers for most providers that would no longer treat serious injury would be as few as one patient per week, so changes might be implemented more easily than for other conditions

g *National Confidential Enquiry into Patient Outcome and Death, 2007. For example, 39.3% (72/183) of hospitals did not have a resident anaesthetist at Specialist Registrar level or above.*

- It was possible to bring about tangible improvements within a relatively short period, thus maintaining momentum and ensuring faith was not lost in the trauma programme and *Healthcare for London* as a whole
- Despite robust evidence that system change would improve patient outcomes, very little had been done to improve trauma services in recent years, leading to a pioneering spirit amongst clinicians involved in the programme

A leading trauma expert summed up the feelings of clinicians:

> **Establishing a case for change was very straightforward, and that had been gone over time and time again, but nobody had really had either the resources or the focus. Because major trauma affects a relatively small number of patients, and because they get spread all over London it's more difficult for the public to appreciate that there's a real need.**
>
> **– Senior clinician**

The process

Funding

The Joint Committee of PCTs agreed to pump-prime the new commissioning arrangements for trauma with £15 million (recurrent), which was top-sliced from PCT budgets. This comprised a quality annual premium of £2.6 million to each major trauma centre to deliver the service specification as well as a top-up tariff for the most seriously injured patients. Decreased length of stay thanks to a more effective clinical model and the reduction in lasting disability for patients would deliver a saving over time to commissioners.

Designation of sites

This process was similar to the stroke programme and interviewees agreed the process was robust and well run. However, the quality of some bids received was again low, with one external expert commenting:

> **There was no dodging the fact that certain centres did not come above the bar.**
>
> **– Clinician**

Three sites initially met required standard – King's College Hospital, the Royal London Hospital and St George's Hospital. However, this left much of the west and north west of London too far from a major trauma centre[h]. This was of particular concern due to a desire to ensure services were accessible for major incidents occurring at Heathrow airport.

h *'Too far' was taken to mean more than 45 minutes away by 'blue light' ambulance.*

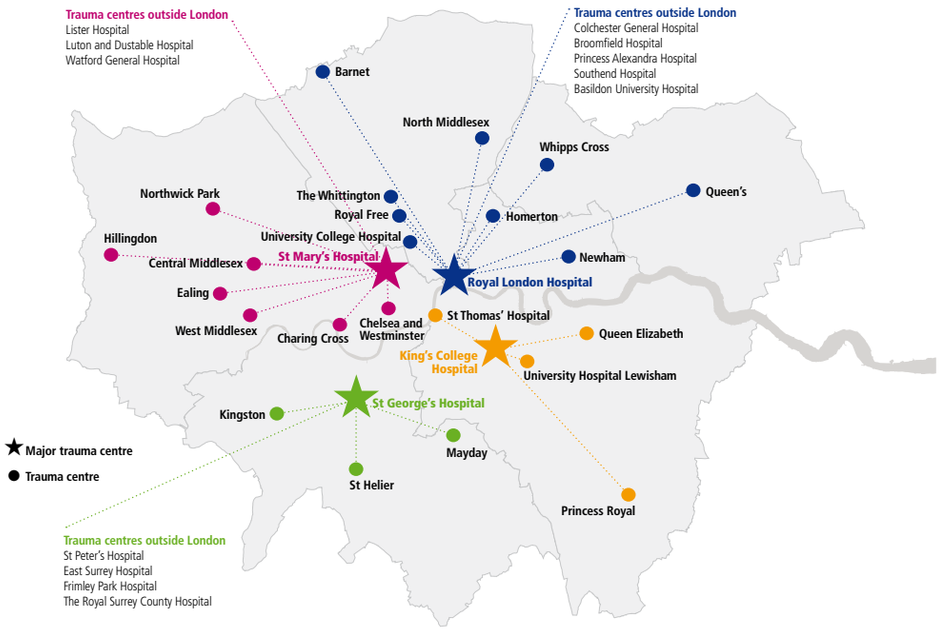
The process was re-run and Imperial Healthcare NHS Trust and the Royal Free Hampstead NHS Trust were supported to bid again, with Imperial choosing to focus its bid on St Mary's Hospital. Both St Mary's Hospital and the Royal Free Hospital were found to have the capacity to achieve the necessary standard by April 2012, achieving equal scoring on clinical ability, and were included in the options that went to public consultation.

Consultation

The Shape of Things to Come consultation included three options for public opinion. The joint committee of PCTs favoured the option of four major trauma centres as opposed to three. This would mean:

- Faster access to a major trauma centre from all areas of London
- Each major trauma centre would have fewer trauma centres with which to collaborate within the network
- The major trauma centres would be expected to admit sufficient numbers of patients to meet the volume requirements of safe practice, but not become overwhelmed and unable to cope
- They would provide greater capacity in the event of a major incident

St Mary's Hospital was the preferred fourth site because of the overall configuration of the resulting trauma networks. The Royal London Hospital (the best bidder and only existing major trauma centre) would manage a larger network than St Mary's Hospital, whereas the other four-site option would have put more of this burden on to the Royal Free Hospital. Emergency preparedness assessments had also shown St Mary's Hospital as offering a moderate advantage over the Royal Free Hospital in dealing with major incidents due to transport and road access issues and its proximity to high-risk areas such as central London and Heathrow. There was also better road access, which placed more people within 45 minutes of a major trauma centre.



The result of the consultation showed little disagreement with the principle of consolidating services, but travel times were an issue for many respondents. 51% agreed with the preferred option of the Joint Committee of PCTs. On 20 July 2009, the committee agreed to implement this option.

The stroke and trauma consultation was considered by some interviewees to be better than the *Consulting the Capital* process. It was argued that it was more engaging, but that this was easier to achieve because it concerned a more tangible issue:

> On trauma and stoke, because they were defined, and because one could identify specific interest groups, one could engage in much more depth, because the nature of the engagement, the people you were engaging with were much more focused.
>
> **– PCT CEO**

While the consultation was designed to elicit meaningful responses rather than just a high volume, many involved felt the time and resources put into the consultation was disproportionate to the reconfiguration involved and not matched by the number of responses received.

As *The Shape of Things to Come* concerned specific hospital sites, greater sensitivities were also evident. A disproportionate number of respondents (2,335 – 27%) were from Barnet, where the council led a campaign in favour of a major trauma centre at the Royal Free Hospital. Almost 90% of Barnet respondents supported this option and, consequently, support for St Mary's Hospital option fell from around 70% to 51% in a single week[47].

Implementation

Following the designation process and consultation, a dedicated team responsible for implementation was established and Dr Fionna Moore was appointed as the London Trauma Clinical Director. In addition, the London Ambulance Service established a clinical co-ordination desk and training for its entire frontline staff in the use of a pre-hospital triage protocol, developed specifically to support the change in service.

A further external assurance process was run in January 2010 to obtain an objective view of progress prior to the new services going live. Three major trauma centres were assessed as ready to go live in April 2010. St Mary's Hospital went live as a fully-operational major trauma centre on 11 January 2011, considerably earlier than the date of 2012 suggested in the original bid.

The London Trauma Office, hosted by the London Specialised Commissioning Group on behalf of London's PCTs, has overseen the management of the trauma system.

Outcomes

The changes represent the development of the first trauma system in the UK and interviewees were universally positive about the outcome of the programme. All major trauma centres have a consultant leading the team 24 hours a day, seven days a week.

Four associated trauma networks have also been developed that extend beyond London. For example, the St George's network formally includes Surrey. As adjacent areas establish their own trauma networks, there may be changes in network boundaries and patient pathways may alter.

Interviewees reported a high degree of collaboration within the trauma networks, with combined research on patient pathways and the ongoing development of protocols to support them. However, collecting Trauma Audit and Research Network (TARN) data continues to be challenging in trauma units, although major trauma centres have good levels of data input. Nevertheless, the data is sufficient to demonstrate that London now has patient outcomes comparable to other major international cities. Data from TARN using expected versus actual survivors from different severity of injury demonstrated an additional 58 survivors over 12 months compared to the number expected.

Several improvements to the process surrounding the treatment of major trauma patients were reported:

- **Time to scan** – Most patients admitted to the Royal London Hospital who require imaging are scanned within half an hour. At St George's Hospital, King's College Hospital and St Mary's Hospital, the time from admission to scan has dropped from two hours to a maximum of one hour
- **Performance standards** – A new performance standards framework was implemented when the trauma system went live that involved quarterly visits to each network to examine specific and core aspects of trauma care. Formal feedback on performance is provided, with timeframes for addressing improvement requirements. Release of the quality premium is dependent on successful completion of these visits and any arising actions. The quality premium was withheld on occasion whilst issues in performance in a specific area were addressed. It therefore acts as a lever for performance improvement
- **Triage Decision Tool** – A new tool is used by the London Ambulance Service to determine where trauma patients should be taken. It is extremely difficult to determine severity of injury at the scene, so a triage protocol has been developed to help ensure patients at highest risk of serious injury are taken to a major trauma centre. Evaluation of data from the first six months of operation (April to September 2010) showed that 11 patients a day (4,000 per year) triggered the tool. 32% of these had major trauma (injury severity score >15) and an additional 12% had significant injury. Around 25% were discharged from A&E without significant injuries[48]. This represents some degree of over-admission to major trauma centres, which is expected in a trauma system:

> **Some patients trigger the tool and will have serious life-threatening injuries. Others will trigger the tool and go home from A&E. This is in line with data from elsewhere across the world. If someone has a knife wound to the chest, it could have gone into their heart and lungs or it could just be under the skin and you can't see that at the scene.**
>
> **– NHS manager**

Other areas in England have now followed London's lead in developing regional trauma networks. The service specification, performance framework, triage tool and other protocols developed as part of the *Healthcare for London* trauma programme have been widely shared.

Reflections on the enablers of change

The leadership and engagement of clinicians was felt by all interviewees to be key to the success of the trauma programme. Clarity of message and availability of strong supporting evidence were also vital.

Clinical leadership

Several aspects of clinical leadership were mentioned by interviewees. Both the trauma and stroke programmes stemmed from work done by the clinical working group on acute care. This group, initially chaired by Lord Darzi, was widely felt to have been cohesive and productive and many praised the chair's leadership skills. The consensus reached made it hard to backtrack when site-specific recommendations were developed in the implementation programme.

Key players were engaged early to ensure an agreed case for change and underlying principles for the subsequent work programme. All those questioned about trauma as part of this report specifically referred to the value of the clinical advisory group (chaired by Professor Sir Cyril Chantler) and expert panel (chaired by Professor Matt Thompson). Defining the type of service required and the performance standards that should underpin it was a key contribution by these groups.

Previous reviews of trauma services had engaged clinicians. However, in this case they also fronted the campaign and articulated the case for change to the public and colleagues. This was thought to be a significant difference, particularly in keeping the clinical community on side and minimising the number of dissenting voices:

> **The real advantage this time was… securing the leadership [of clinicians], using them to articulate the reason why change was both desirable, and necessary, and using them to help define the system. So Matt [Thompson]'s leadership, Fionna [Moore]'s leadership and others, meant that [although] I knew all of that stuff, they were far better placed than I was to articulate that to their peers and, when necessary, to the public.**
>
> **– PCT CEO**

The enthusiasm and sense of pioneering spirit amongst clinicians, combined with a sense of inevitability about the plans, due to the weight of supporting evidence, drove the changes forward.

National and international evidence

The use of evidence was thought to be helpful in communicating the case for change and particularly for engaging healthcare professionals.

> When we took the big arguments that were pan-London, trauma particularly, they were very focused, we could martial the evidence, and we could construct a dialogue that enabled us to articulate why change was necessary, and how change was going to happen.
>
> **– PCT CEO**

Evidence also underpinned the development of the model of care, through understanding and applying best practice, evidence-based approaches and how best to apply them to the whole of London.

Central oversight

Having a central, decision-making body was felt by many interviewees to be critical in the implementation of changes to trauma services:

> The sort of stuff that can't be achieved, except London-wide, is things like the stroke and trauma changes, where you've really got to come to an agreement to disinvest from certain sites and to reinvest into other sites.
>
> **– NHS Manager with the London Ambulance Service**

Others stated that the presence of a single responsible administrative body providing leadership and strategic direction represented a new opportunity to implement large-scale change.

Overall, however, the most powerful driver was the belief in the need for change and the will amongst all concerned to implement it:

> Reputation, money – not enough but some – and I think, a really genuine desire to get this sorted.
>
> **– Senior clinician**

Reflections on the challenges to change

There were three main challenges in the establishment of major trauma centres in London – the availability of information on patient volumes, the politics associated with the changes and the omission of rehabilitation services in the programme.

Understanding patient volumes

There was a lack of clarity surrounding potential numbers of major trauma patients. Prior to *A Framework for Action*, data on trauma patients had not been collected adequately and only the Royal London Hospital was routinely returning data. The trauma programme team simply could not accurately determine how many individuals required treatment for major trauma each year in London.

A team of consultants were employed to analyse the available data and estimate likely patient numbers. The results contained a large margin for error, indicating that the number of seriously injured patients was between 1,200 and 2,000 per year. This correlated with data produced by the London Severe Injuries Working Party in 1999, but did not provide enough information to determine how many major trauma centres should be developed.

Three or four centres?

The lack of supporting data on patient numbers in London meant the benefit of four as opposed to three centres was unclear. Existing evidence from the US on volume to outcome ratios suggested at least 650 patients a year were needed to ensure sufficient critical mass to maintain skills and justify resources in a single major trauma centre[49]. However, this was based on US hospitals and few exist of comparable size in the UK. Even the estimated maximum of 2,000 patients would not support the presence of four trauma centres under this criterion.

Due to the ambiguity of the evidence, judgements were made by the programme team and clinical expert panel on the best way to proceed, taking into account the need to ensure adequate coverage for the whole city. After much debate it was agreed that three or four centres could cope with the estimated number of patients and volume would be sufficient to give the critical mass needed to provide high quality care and improved outcomes. However, it was felt that four centres would allow swifter access for patients, afford greater resilience, and provide a sensible network size for each.

Data collected since the system went live has shown that around 1,300 patients are treated for major trauma each year. Some interviewees felt that three centres would have been sufficient on this basis. However, many agreed that the additional benefits of three compared to four centres would be minimal and that any further change would not only be inappropriate but would undermine the network development that has taken place:

> Now the evidence is clearer, the data is clearer, we probably do not need four, but we are in a system, certainly short to medium term, that requires four trauma systems to work together because unless you get the system working, the trauma centre on its own will not deliver the benefits.
>
> **– PCT CEO**

In the future, more patients from outside London could be treated in the four major trauma centres to make better use of available resources. This would require buy-in from commissioners, acute providers from outside London and the London Ambulance Service.

Air ambulances already make use of the helipad at the Royal London Hospital and construction of a helipad at St George's Hospital has commenced and is expected to be operational later this year, which could allow the admission of patients from deep into the Home Counties.

Strategic alignment

This was an issue for Imperial College Healthcare NHS Trust, which has its hyper-acute stroke unit (HASU) at the Charing Cross site and its major trauma centre at the St Mary's site, although the Joint Committee of PCTs acknowledged the need to address this imperfect outcome at the time of consultation and decision-making. This was partly due to the benefits of strategic alignment of the various decisions on the future configuration of specialist acute services being recognised relatively late in the process, even though *A Framework for Action* had signalled the importance of new delivery models, including a limited number of major acute hospitals for London. In practice, greater communication and joint planning between the stroke and trauma workstreams might have avoided this problem:

> The two were not stitched together, and actually Charing Cross and St Mary's were allowed to come to a conclusion that stroke would be one, and trauma was another one. Absolutely everybody knew that was complete cobblers… So, I think that does not help credibility and the unforeseen consequences could actually be clinically bad.
>
> **– Acute Trust Chair**

Politics

Almost all interviewees alluded to the impact of politics – national, local, institutional or professional – on the work they were involved in or observed. In relation to trauma, the actions of Barnet Council in encouraging residents to back the option that would see the Royal Free Hospital developed as a major trauma centre had a disproportionate impact on the consultation outcome.

Commenting on *Healthcare for London* more widely, a senior clinician and a management consultant suggested it would have been preferable to plan the whole of elective and emergency care at once, but that this would have been highly complex, as well as politically impossible due to likely levels of opposition.

Professional and organisational politics were cited as a challenge in the trauma work programme, as in many other *Healthcare for London* workstreams. One clinician referred to the "*complacency of the medical profession*" in reference to a reluctance to address calls for change to services or organisations. However, the consensus was that, in the case of trauma, those involved supported the changes and vested interests did not interfere with the process.

Rehabilitation

Interviewees felt that rehabilitation services became 'lost' during the development of the trauma workstream. Rehabilitation was included in the original pathway development work and there was a therapist on the trauma programme team and project board. The complexity of rehabilitation and the lack of robust data on need were cited as reasons why rehabilitation presented challenges that could not be met in the timeframe of the project. Also, the consultation focused on the acute aspects of major trauma and stroke.

Trauma networks were asked to submit plans as to how they would improve rehabilitation, and it was hoped that rehabilitation would be dealt with at this level. However, this approach was not as successful in delivering change.

Some participants considered the inclusion of rehabilitation in the programme as too difficult. The lack of focus on rehabilitation was considered a mistake by several interviewees and that more detailed planning might have allowed its full inclusion within the work programme:

> We should have put in a bid for an equivalent to Headley Court for London because London has no dedicated rehabilitation centre for complex rehabilitation problems. Now, if you have a single system problem, like you have a traumatic brain injury, or you have a single pelvic fracture, there is probably a pathway that you can follow. If you have a selection of problems… then nobody's going to want you… so we don't have the rehabilitation facilities that we need for the capital.
>
> **– Senior clinician**

KEY LESSONS

- A high level of clinical leadership and engagement was critical to success
- Requiring providers to bid to become major trauma centres showed the power of commissioners and encouraged a healthy sense of competition
- The system of performance management from the London Trauma Office, with regular updates required, worked well in ensuring milestones were met and change took place. The quality premium was withheld on more than one occasion when progress was not judged to be sufficient
- The ambulance service was key to the delivery of significant changes to acute services, none more so than for major trauma. In future, it needs to be engaged early so that its views and role in making change happen are included in the planning process
- Specific patient groups for trauma do not exist in the same way as for many other conditions. Nonetheless, patients' views should be considered on the longer-term implications of trauma, such as rehabilitation. Joint working between clinical and patient groups enables recommendations to be more focused
- There should be transparency regarding the current state of services. The evidence showed that London trauma services were poor in comparison to other international cities
- The resources used to estimate the numbers of trauma cases could have been better spent putting long-term data collection systems in place, such as those used by TARN

Conclusions

Lord Darzi was clear that *A Framework for Action* should not be a report that 'sat on the shelf' as previous reviews had done. Interviewees were clear that, for major trauma, this had not been the case. It is generally accepted that the strategy and implementation of changes to services was broadly successful and brought significant benefits to patients and the NHS. The transformation programme has been recognised nationally and was shortlisted for a *Health Service Journal* award in 2011.

Subsequent analysis has provided additional proof of the rationale behind many of the changes, as well as the quality of services delivered by many London hospitals. 2011's *Inside Your Hospital* report showed improved mortality rates among hospitals with high throughput for complex surgery and demonstrated the benefits of clinical networks, both of which were integral elements of the new major trauma service. This research also showed increased risk associated with admission during evenings and weekends, demonstrating the benefits of having a specialist team on-site 24 hours a day, seven days a week, as in major trauma centres[50].

Lessons can clearly be learnt from the trauma work, which should be considered in any future redesign of acute services. There is also more to do:

> **The results that we've got so far are very encouraging. But in terms of is our work done? No, it's not. Because I think that these fledgling trauma networks and major trauma centres do need support and ongoing scrutiny to ensure that their standards remain high and continue to improve.**
>
> **– Senior clinician**

This sets the agenda for further developing the monitoring and performance management of the changes that have taken place and systematically evaluating them.

POLYCLINICS

One of the key changes signalled in *A Framework for Action* was the development of polyclinics, which was an attempt to introduce a new delivery model that could improve access (with a wider range of services and longer opening hours), quality (through more proactive and integrated services) and productivity.

The term 'polyclinic' arose following a series of public events that tested a proposed new model of primary care – 'to deliver a new model of community-based care at a level that falls between the current GP practice and the traditional District General Hospital'. It was inspired by models of care in the UK and internationally that succeeded in delivering a broader range of services in a way convenient to patients (through longer opening hours and more integration of services) and that supported cost-effective delivery through the impact on managing disease better and delivering hospital services less expensively. Specific examples include the Kaiser Permanente clinics in Colorado, Polikum clinics in Berlin and community hospitals in England such as in Tiverton, Devon.

The polyclinic concept was the single most contentious proposal in *A Framework for Action*, generating both positive and negative professional, media and public responses at the time. The polyclinics set up before the halting of *Healthcare for London* have had mixed success and there has been no large scale implementation of the model across London. However, the work undertaken on the polyclinic implementation programme informed the development of subsequent work programmes, including the *Pan London General Practice Outcome Standards and Framework* and the integrated care pilots.

This case study looks at the experiences of those involved in the programme, the case for change, the goals of polyclinics, the context for change, the outcomes so far and reflections on the key enablers and challenges to change. It ends with how the work on polyclinics has influenced the development of integrated care pilots and a new programme focusing on primary care transformation.

Case for Change

The development of the polyclinic model outlined in *A Framework for Action* sought to address an urgent need to improve primary care in London and recognised that many services being provided in local district hospitals could be delivered more conveniently in the community. The delivery models in *Healthcare for London*, including the polyclinic concept, were intended to facilitate the delivery of the care pathway recommendations. The case for changing services to better support people with long-term conditions, along with the need for better delivery of planned care services, provided a significant motivation for the polyclinic concept. High level modelling during the development of *A Framework for Action* suggested that polyclinics serving 50,000 patients would be within 1-2km of the majority of Londoners' homes, giving 12 hours a day, week-long access to high quality primary and community-based services.

Key factors behind the recommended development of polyclinics were:

- There were large numbers of small (1 doctor or 2 doctors) practices in London – a higher proportion than the rest of the country (54% v 40% when *A Framework for Action* was published). Our interviews demonstrated a strong feeling that this, particularly the generally less comprehensive infrastructure of smaller practices, is one factor behind the variable quality of general practice in London, which clearly follows the inverse care law[i]
- GPs reported high levels of dissatisfaction with their own premises, many reporting that they were limited in their ability to access simple diagnostic equipment or provide a broader range of service from their practice due to space constraints
- There was net dissatisfaction from GPs with access to care, particularly urgent care, and A&E attendance rates were higher in London than the rest of the country
- Hospitals are an expensive setting for care. International experience showed that it was possible for more hospital outpatient work to be safely delivered in the community, closer to patients' homes and reducing the need for multiple visits to different locations in order to determine a diagnosis or to receive care
- GPs reported difficulties in the co-ordination of care across different care settings. Interviewees reported this as being a particular barrier to the development of integrated care

A Framework for Action also outlined a number of potential benefits of polyclinics, including:

- More integrated management of patient care, especially for long-term conditions, through better communication and coordination between specialties made possible by providing multiple services under one roof
- Providing an alternative to A&E by providing access during extended hours. It was also envisaged that every hospital would have a polyclinic urgent care centre. It was also felt that having a critical mass of clinicians together in a single location would make it easier to access clinicians by telephone
- A shift of services out of acute hospitals would result in care (including access to a specialist opinion, diagnostics and minor surgery) being delivered closer to patients' homes
- Offering a wide range of services together, including diagnostics, community and social care services, healthy living services, pharmacy and dentistry, in a highly convenient 'one-stop-shop'
- Improved access for disadvantaged groups
- Improving patient experience through improved coordination of care and ease of access
- Financial savings

i *The Inverse Care Law states that: 'The availability of good medical care tends to vary inversely with the need for it in the population served.' Tudor Hart J, 1971. "The Inverse Care Law".*

The potential of polyclinics to improve productivity was outlined in the *Healthcare for London Technical Paper* and expanded on in 2009 by the *London Affordability Analysis*. These analyses concluded that if nothing was done to change the trend the total cost of care in London would outstrip expected funding allocations. By fully implementing the polyclinic model, the NHS in London could make a saving of about 10% of total system cost. This analysis was based on four main drivers:

- Inspired by Kaiser Permanente, long-term conditions could be better managed through proactive management of care including disease registers, care planning and the work of a multidisciplinary team
- Some hospital services could be provided in polyclinics, including about 50% of outpatient services and minor surgery. Given that polyclinics were envisaged to make lean use of estate and would not carry the expensive corporate staff of hospitals, the overhead rate of polyclinics was assumed to be very small. As a result, hospital services shifted to polyclinics were assumed to be deliverable at 70% of hospital costs
- A&E attendances, which were charged on the national tariff per attendance, could be avoided by improved primary care access and extended hours that were paid for on a capitated model
- Productivity savings could be made in primary care and community services through more efficient working practice

The context for change

The polyclinic concept in *A Framework for Action* was the most contentious proposal at the time of the report's publication. It became the subject of a number of the newspaper headlines. Within days, negative quotes focused on the polyclinic proposal were appearing in the media that demonstrated a strong aversion among doctor leaders[j].

There were also a number of negative public and professional attitudes at the time, including:

- Concerns about the future viability and threats to existing general practices to which both patients and staff were very attached
- Worries about access due to a loss of continuity of care and/or increasing travel time for patients
- Anxiety about the cost of building new infrastructure, an issue that was exacerbated by the financial crisis. Experience with Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) schemes and GPs' concerns for their premises, which they often owned themselves, all contributed to this
- Fear that polyclinics were actually part of a privatisation agenda for the NHS, given that *A Framework for Action* was silent on who should provide them. There was, however, during implementation, a simultaneous national policy (under then health minister Lord Darzi) to develop one 'GP-led health centre' for each PCT in England. These were designed to address under-provision in some areas of the country and were to be procured under Alternative Provider Medical Services (APMS) contracts, which allowed non-NHS organisations to bid to run them. These centres were nicknamed 'Darzi centres' and were confused by many as being the same as polyclinics

The process

Despite the controversy, and following *Consulting the Capital*, commissioners and NHS London decided that polyclinics needed to be a priority for implementation, given issues with the variable quality of primary care and the importance of better care for those with long-term conditions. The aim was to establish five early implementer polyclinics during the first year of the implementation programme. By the end of that first year, seven had been delivered and each PCT in London had plans to implement more.

A polyclinic programme board was established to support the implementation of polyclinics across London. The board was chaired by Heather O'Meara (then Chief Executive of Redbridge PCT) but with clinical leadership from three GPs, a senior nurse and a pharmacist. The programme, by its very nature, had multiple links to other projects, for example unscheduled care, diabetes and end-of-life care. It was not responsible for implementing polyclinics, but rather facilitating PCTs in delivery.

However, the effectiveness of these early implementers was extremely variable, in part due to the approach taken. The project began by inviting applications from PCTs to develop early implementers. Those chosen were, in most cases, well along the path towards implementing a new health centre and chose to adapt their plans and develop a polyclinic. There was a clear recognition of the risks of this approach, but these were felt to be outweighed by the potential benefits of 'getting the ball rolling'.

To support implementation, a London-wide 'core offer' was developed that defined what patients could expect from each polyclinic:

> **The idea of a 'core offer' was very important feature from the very first discussions of polyclinics. Just as Tesco's had a Super Store, Metro and Express format and consumers knew what to expect in terms of range of products, size and opening hours, so too, the health service needed to have a clearly understood brand for the different delivery models it offered.**
>
> **– Senior management consultant**

j *Headlines from 12 July 2007 included: 'GPs slam super surgeries' (Daily Express); 'Super GP Surgeries will lead to gridlock' (Daily Telegraph), and; 'GPs to be herded into polyclinics' (Pulse)*

This was particularly important in relation to the provision of unscheduled care. The central polyclinic programme team therefore pushed hard to keep certain prerequisites, such as 8am-8pm opening for urgent appointments, with varying levels of success.

The principles behind polyclinics were felt to be already at the heart of some PCTs' plans, meaning they could 'tweak' their plans to the new agenda. Although this approach required time, effort and paperwork to demonstrate new alignment, it was felt to be significantly less effort than starting from scratch. This approach to building on existing programmes and principles successfully generated pace in some areas, but created variation in progress across London.

The term 'polyclinic' became increasingly controversial because the policy was widely interpreted as simply a reconfiguration of primary care into new large buildings; there was little understanding of the wider aims of the project and its desire to achieve integrated services that improved access and saved money:

> **I was shocked when a member of the polyclinic team said to me, two years into implementation, that 'it's not like polyclinics were designed to save money. They're about improving quality and the patient experience.' But the financial strategy that made *Healthcare for London* affordable depended to a large extent on the promise of polyclinics and we seemed to merrily heading for a set of over-scoped centres that would add cost and deliver no savings because it had been lost in translation that we should be saving money through polyclinics.**
>
> **– Senior management consultant**

For this reason, two major changes were made to the programme. First, to stress that it was not merely about new buildings or necessarily moving GPs out of their practices – which had been the focus of much of the public attention – a hub-and-spoke format began to be emphasised, with existing GP surgeries feeding into a central facility that was smaller than originally envisaged[k]. This was also similar to the 'federated' model of primary care being advanced at the time by Professor Steve Field, Chairman of the Royal College of General Practitioners. This hub-and-spoke model was later renamed a 'polysystem', a term coined in Redbridge to reflect the idea of a system working across multiple clinical areas:

> **As a clinician, I care about improved care pathways [not buildings] so wouldn't it be better to call this a polysystem rather than a polyclinic?**
>
> **– Senior clinician**

k *The possibility of this had been anticipated in* A Framework for Action, *which set out three models for polyclinics—one version that was a large centre, another that was a hub-and-spoke model, and a third model on the 'front door' of a hospital.*

The second major change to the programme was to highlight the economic implications underpinning the concept, which had been played down previously. With the deteriorating financial position of the economy, the concern was that *Healthcare for London* was unaffordable. This led to the *London Affordability Analysis*, which was designed to test whether *Healthcare for London* was indeed affordable and concluded that it was, based on a set of assumptions where polyclinics delivered system savings. It made these economic assumptions explicit, to inform implementation by PCTs and so that NHS London could test whether the commissioning plans of PCTs made economic sense.

Over the two years it existed, the polyclinic implementation programme's central team developed a number of tools to facilitate local implementation. This included the development of a common service specification (the core offer), an economic modelling tool to analyse the cost and opportunity to save money through polyclinics, and a planning framework that outlined the steps needed to commission a polyclinic. The team also delivered masterclasses, established a clinical network and offered advice and support to encourage the sharing of learning.

However, progress on local delivery was variable and entirely dependent on the effectiveness of individual PCTs. NHS London sought to mitigate this through its strategic planning assurance process, looking to make clear that PCTs were addressing the quality of primary care services and making more local care available. By January 2010, PCTs had established 10 polysystems across London and developed plans for 102 more[51]. The halting of *Healthcare for London* after the May 2010 general election had a profound impact on the polyclinics programme. The existing depth of opposition, coupled with the impact of the coalition government's NHS reforms, meant the central component of the programme came to an end. However, the lessons learnt and the continued relevance of the case for change led to new programmes of work in primary care and integrated care.

Outcomes

It was always going to be extremely difficult to categorically link improved outcomes to polysystem development and demonstrate financial savings. There is scepticism from within the system as to the benefits of the programme – one interviewee for the King's Fund report on London[52] described progress as having been "close to zero". Whether this is fair or not, significant issues undoubtedly remain. For example, in the 2010/11 GP Patient Survey, London ranked worst of all the ten SHA regions in England for 26 out of 31 categories.

A formal evaluation by the London School of Hygiene and Tropical Medicine was commissioned by the polysystems programme board, which examined four of the key goals of the polysystems programme – access, quality, patient experience and value for money. There were problems with the quality and availability of data and the complexity of the changes made it difficult to show clear improvements in outcomes. However, a polysystem that included an urgent care centre at the 'front end' of A&E did show evidence of a reduction in emergency admissions to hospital.

Patient satisfaction with services was high, with 75-90% of patients rating their care as excellent or very good, although there was less satisfaction at the level of engagement in the planning process and physical access to the polysystem hub was a concern for some. There was no conclusive evidence of any cost savings, although the report was not a full-scale evaluation and concerns were expressed by interviewees that existing services were not decommissioned as new services were introduced. Double running costs of urgent care were also a potential issue, when the majority of urgent care centre users were already registered with local GPs.

Although the pace of change was thought to have caused problems, leading to a lack of joined up thinking in places, the polysystems programme was reported to have laid the groundwork for clinical commissioning development in some parts of London, with GPs heavily involved in the commissioning process.

Aside from the formal evaluation, local experience of several early implementer polysystems was positive. For example, the Loxford Polyclinic in Ilford, now a polysystem hub, showed positive trends in a range of areas, including patient satisfaction, A&E attendances, independent sector treatment centre (ISTC) block contract utilisation, chlamydia screening and breastfeeding uptake.

Some of those working within primary care have taken a positive view. One senior GP, speaking in 2011, summarised the benefits of the polysystems programme as follows:

> We've had a change in a way of working [for] GPs. They're much more collaborative, designing services [and improving] access together… Second, we've had a massive improvement in the estate that the GPs are seeing their patients in. When I visit the polyclinics, you know, they're usually either new or semi renovated buildings. Third, we've got a primary care infrastructure, which can now legitimately do lots of out of hospital care. Before, we always had a wish to do it, but [couldn't] deliver it. Fourth, we have got much better GP access. All the polyclinic hubs have access in the evenings and at weekends, and we've got increasing satisfaction of patients with GP access in London. Fifth, I would say that we are getting an increasingly strong focus on long term conditions, with more and more clinical nurse specialists, focusing on long term conditions to reduce emergency attendances. We're getting gradual outpatient shifts into the community, [as well as] different models. Some people are doing outpatient triage systems; some are moving nurse led services out; some are moving consultant led services out. That's the ripple effect.
>
> **– Senior clinician**

Reflections on the enablers of change

Despite the variable success of implementing polysystems across London, there are a number of factors that tended to be in place in areas where there was discernible progress.

Clinical leadership

The clinical champions on the programme board (three GPs, a senior nurse and a pharmacist) were used to address hostility to the polyclinics concept and to engage with their peers through a clinical network and a programme of masterclasses for each area of London.

Despite the complex and sometimes difficult relationships between groups of clinicians, the polysystems programme saw, in many areas, dialogue increasing between neighbouring GPs and between primary and secondary care clinicians. It is not possible to state categorically that clinical leadership has been causal in these improvements but, for one PCT, where all primary care is now delivered in polysystems, there is a strong feeling that it was a key enabler:

> [What we got was] groups of GPs coming together, working out how to look after communities of patients better, working out how they best used their buildings, how they could use them to [have] greater impact for the community that they served.
>
> **– PCT CEO**

The development of clinical commissioning groups has acted as a catalyst for forging relationships across primary and secondary care. Many of their ambitions align to the principles that *Healthcare for London* was seeking to deliver.

Executive leadership

The polysystems programme gained most traction in the areas where senior PCT managers, particularly chief executives, were most committed to the model of care. For those leaders, rather than taking a confrontational approach and attempting to enforce change, it was suggested that identifying mutually beneficial business models (for commissioners and all providers) was a key lever:

> It's about being person-driven... It's the dialogue in generating win-wins [that matters].
>
> **– PCT CEO**

Polysystems required implementing complex change – behavioural, organisational, relational, and across systems, processes and infrastructure. Capable management teams with vision and influence were pivotal in supporting clinicians to do this.

Clinical engagement

Clinical engagement is central to any change programme in the NHS. However, it was of particular importance (and a particular challenge) for the polysystems programme because of the need for local development and implementation of the model of care. Many more clinicians had to be engaged in order to deliver the vision of polysystems for London than to change the acute care part of the stroke pathway in London:

> I think probably we had a gap of about a year where we didn't do sufficient GP engagement and then we realised that that was the thing which was holding us up; that without [it] we were going to just get continual opposition and a lack of understanding of our message… so then we started a big GP engagement process, both with the LMC for informal meetings, but also by setting up a polyclinics clinical network which still runs today.
>
> **– Senior clinician**

Several difficulties in gaining clinical engagement with the polysystems programme were brought up during the interviews. The need for local leaders was greater than for high profile central figures, engagement tended to be least effective where it was needed most – in the poorest performing GP practices and clinicians, whilst organisational loyalties were a barrier to engagement.

Professional loyalties mean that clinicians are more likely to accept messages from 'one of their own' and Lord Darzi's surgical background was sometimes felt to be a hindrance because those opposing the proposals, such GPs and pharmacists, questioned the validity of a surgeon with little understanding of primary care drawing them up. One PCT manager reflected this was perceived much more strongly amongst those who had most anxiety about the effects of competition on their business and those who felt least able to influence local debate.

The evidence base for the shifting care into the community

International evidence was at the heart of the case for polyclinics. Two particular concepts drove the development of the model. First, experience in Germany and in the US showed that the vast majority of ambulatory care can be safely provided outside a hospital setting. Second, services in the US had shown that diagnostics can be provided through the 'local doctor's office'.

Also cited was a German study of treating migraine where, with early specialist input, it was possible to show simultaneous quality improvements and cost savings. This is at odds with England's model of general practice where GPs act as gatekeepers, limiting access to specialist colleagues.

> If you create a system which prevents patients from accessing secondary care, you'll kill them… [In Germany] they've created this national migraine integrated care pathway. The usual stuff: all the neurologists disagreed; all the primary care physicians disagreed. They just set it up. It was not until the eighth month that the cost went below what it was before. [There were] massive improvements in the quality of management of migraine in its entirety [but] first, you do have to do more imaging and investigations. Once you've done that, [the cost] goes down.
>
> **– Acute trust CEO**

This evidence enabled the debate to shift and provided increased confidence that more care could be implemented in the community. The polyclinic economic model augmented this work, providing a framework for delivering clinical and financial benefits. However, the applicability to the NHS of wholesale models of care from abroad, was strongly questioned by some – as discussed in the challenges section below.

The core offer

As discussed, developing a core offer of what needed to be provided in a polysystem was thought important to aid patient understanding of the service. Interviewees discussed the A&E 'brand' – a 'safe haven', with 24-hour access to all forms of care. They felt that for polyclinics to absorb demand for unscheduled care, there needed to be a clear set of core services across the whole of London that patients, and indeed ambulance crews, would understand:

> We were clear…that a polyclinic needed to have a core offer…How do we get the public to understand what these polyclinics are about, what are the range of services that are within them and how would they use them?
>
> **– PCT CEO**

> If you are a patient [and have] broken your arm, you walk into a polyclinic and they say 'Sorry we have not got x-ray', you would never go back to either that polyclinic or any other polyclinic because you assume that none of them have got x-ray. [There were] two walk-in clinics in Wandsworth. One had x-ray, one did not, and the difference was about 150 patients a day in one, and about 60 a day in the other. So we always said that we wanted to get a consistent offering… but… I am not sure that we ever got that.
>
> **– Senior NHS manager**

The point is clear – if patients are not sure what they can expect from a given care setting, it will inhibit them from using it.

Reflections on the challenges to change

Unlike the more discrete stroke and trauma projects, which focused on particular clinical pathways, polysystems were a delivery model that was intended to facilitate the implementation of a broad range of the pathway recommendations in *A Framework for Action*. This made planning more complex and meant there was often little hard evidence on which to base macro-level recommendations. This is reflected in the large number of challenges reported. It also allowed for too much focus on the organisational arrangement or facility and insufficient focus, in some cases, on clinical outcomes, service experience and financial savings.

Rejection of the case for change

There was widespread hostility from the GP community to the initial proposals for polyclinics. There were multiple reasons for this, but one significant theme was a defence of the traditional model of general practice:

> General practice is the bottom feeder of the NHS. We're responsible for everything that goes wrong. But the problem is: good general practice is invisible; bad general practice is notorious. All of the opinion leaders are only too familiar with bad general practice because it sticks out like a sore thumb. But the vast majority of general practice that attracts nobody's attention is what the public see and that's why you have this apparently anachronistic relationship between the public and general practice, because they know who's there to hold their hand when it goes well. And the consultants only know when it goes badly but they have the ear of the politicians. So we are the pariahs of the NHS.
>
> **– Senior GP leader**

This may overstate the case, but many GPs certainly felt anxious about the implications of the proposals and continue to feel their traditional service model is undervalued. Even in the new era of clinical commissioning, the benefits of close GP relationships with their patients and their community are felt to be under-appreciated by some. While the polysystems programme was running, one engaged GP leader declared that what was needed was not a wholesale restructuring, but simply money for GPs to spend on healthcare targeted to their local population's needs.

Complexity

The polysystems programme was highly complex, affecting many care pathways. In contrast, stroke and trauma, which focused on the hospital end of the pathway rather than rehabilitation, were two of a small number of pathways with fewer co-dependencies and relatively easy planning requirements.

Joined up working between pathway teams was a particular challenge, both in how respective project teams went about their tasks and communicated and in how their eventual recommendations fitted together. It was suggested, for example, that the polyclinics project evolved along a largely medical model and did not fully grasp the opportunity to look at the wider determinants of health:

> "The real opportunity for polysystems was to put [them] together with housing advice and benefits and the things that some really good PCTs and GPs had done in their practices…You put it in the centre of the community, with libraries and access to the internet, things like…social services and benefits advice. You could make such a difference in people's lives, particularly in deprived areas, by putting those in place and, to be honest, I'm really disappointed that most of the polysystems have gone down a really medical model, which just misses that opportunity.
>
> **– Senior public health clinician**

Scepticism about international evidence

The idea for polyclinics came largely from international models of care and concerns were expressed as to their applicability to a system as complex as the NHS.

> It's not quite clear that what was envisaged as a polyclinic in London was the same as the polyclinic concept in Germany, or eastern Europe, or some of the places where that sort of term is being used… the German polyclinics are largely staffed by secondary care clinicians who haven't got jobs in secondary care organisations…So it's like an in-patients service and an out-patient service, whereas the model in this country is we've combined in-patients and out-patients because we don't produce [an excess of] doctors.
>
> **– Acute trust medical director**

This opposition to the application of international evidence represented an apparent paradox – clinicians regularly demand an evidence base for any changes to practice and yet these evidence-based models of care were rejected.

It is far harder to demonstrate clear evidence for an entire system of care such as a polysystem than for a discrete pathway, such as stroke. The complexity of such a multi-disciplinary model, comprising numerous different pathways and interacting with many different parts of public services, the third sector and society generally, makes measurement extremely challenging, not least in deciding what to measure. It also makes counter-arguments easier to develop. For example, in the case of international evidence it is simple to highlight differences in context (eg. funding, provider structures and demographics) and use these to cast doubt on the applicability of the model.

Language and communications

It was widely felt that the name polyclinic, which became polysystem, was unhelpful. Shortly after the publication of *A Framework for Action*, the Department of Health announced that every PCT in the country would have to procure one GP-led health centre under an APMS contract; these were designed to improve access to GP services by opening for longer and open to unregistered patients. Many PCTs had also introduced urgent care centres, which were similarly about access to unscheduled rather than routine primary care.

Polyclinics, which were intended to offer a far wider range of services, became synonymous with both these centres, with all three distinct concepts being labelled 'Darzi centres', and there was much misunderstanding of the London strategy. This mislabelling was widespread: even the British Medical Association referred to GP-led health centres as 'polyclinics'.

The situation was complicated further by confusion over whether London's PCTs would have to implement GP-led health centres, given some overlap with the polyclinics programme. NHS London and London's PCTs initially thought they would be exempted from the requirements, but this was not the case. Consequently, several PCTs who were developing early implementer polyclinics took the pragmatic decision to put GP-led health centres in their polyclinic, which deepened the confusion.

There was furious opposition to GP-led health centres nationally, including the raising of a 1.2million signature petition against the policy[53]. Part of the reason for this negativity was concern they were part of a privatisation agenda for the NHS, as they were to be procured on APMS contracts, which encourage non-NHS providers to enter the market. There was also opposition to the way the policy was applied, with each PCT compelled to open one within a short space of time. The confusion over nomenclature caused serious collateral damage to the polysystems programme:

> **The difference in the policy is that we were trying then to do polyclinics by engagement, whereas GP-led health centres were meant to be additional capacity, top-down, external procurement, which was not part of polyclinics.**
>
> **– Senior NHS manager**

The misunderstanding was largely out of the control of the programme team. However, changing the name to polysystems may have increased confusion rather than improving the situation. Although its aim was to clarify the move to a hub-and-spoke model, the name did not become widely understood for some time, if at all.

As discussed previously, mitigation of these difficulties included high profile executive sponsorship, the use of clinical champions and a clinical network, and a clear clinical case for change. Local interpretations of the polysystems model are now widely accepted. However, it took a long time to build this momentum and progress has been patchy. Indeed, there are still high profile leaders in primary care who remain opposed to the concept of polysystems and see them as a threat to general practice.

Politics

The polyclinics programme was affected by politics in several ways. As for *Healthcare for London* as a whole, some commentators felt the appointment of Lord Darzi as a health minister politicised polyclinics and led to them being seen as party policy rather than an independent recommendation.

The changes suggested would impact on local people and this affected local politicians and London MPs, particularly when there were concerns about the effects of the proposed service transfers on local hospitals.

Professional and organisational politics

Just as politicians' opinions are influenced by the perceived implications for their local services and the opinions of their constituents, clinicians have personal interests that influence their responses to proposed service developments. GPs run their own business and thus have a very strong loyalty to their practices, not just financially but in terms of emotional investment in the service, meaning loyalty to the wider NHS system is affected.

> **One of the biggest weaknesses of the health service is the independent contractor status of GPs… Unless we get GPs into the system in a more cohesive way we'll never develop integrated care systems along the lines of those that are successful in many places around the world.**
>
> **– Acute trust CEO**

Furthermore, relationships between neighbouring practices are not always harmonious, which meant the network-style solution of polysystems was likely to be hard to implement.

Secondary care clinicians also have strong allegiances to their specialties and the organisations that employ them, so expecting them to work in a totally new setting such as polyclinics was going to need a lot of persuasion. There were concerns about destabilising acute trusts and the potential job insecurity that might engender. This was not just about the building in which the work would be done, but also about challenging existing habits, customs and procedures.

> You can take the consultant out of the hospital but you can't take the hospital out of the consultant.
>
> **– Senior clinician**

Non-medical clinicians have similarly strong connections to their workplaces and working practices and equally strong concerns about career security. All of this needed to be factored in to the planning, engagement and implementation processes.

Financial, contracting and estate issues

The financial modelling for polysystems was questioned, both because of the complexity of the system making it impossible to predict unintended effects from pathway changes and because of the hidden costs of reconfiguration. Those involved in the programme emphasised that polysystems were intended to be cheaper than existing services and maintain that this is still possible, whilst admitting that the modelling and/or analysis required to demonstrate the financial benefits is complex and can be difficult to understand. As the financial analysis was not included in the main *A Framework for Action* report it did not receive as much prominence or attention.

Some interviewees felt the case for polyclinics was weakened by the financial arguments and that real costs would be higher than suggested. They reflected that GPs are not generally 'cheaper' than specialists and that many new buildings have been built under expensive LIFT and, occasionally, PFI arrangements.

> Polyclinics felt like 'an article of faith' unrelated to what was going on at ground level. They may have increased access but there were also increased costs.
>
> **– PCT CEO**

Also, some questioned whether the 'experts' doing the underpinning financial analysis had fully understood the contracting arrangements in primary care and the resistance to change that would result from these:

> We were assisted by a management consultancy, which did not necessarily have a great understanding of the British health service, and therefore they often suggested writing the report in a way which didn't reflect how service level agreements, or GMS and PMS contracts work. There was a strong feeling that you could just move contracts around and bring in new providers [which] would, by itself, raise standards. [This] caused a concern in the general population and in the medical profession that it was about privatisation.
>
> **– Senior clinician**

As stated earlier, the affordability analysis undertaken in 2009 aimed to strengthen the financial underpinning of *Healthcare for London*. It made a clearer case for the financial benefits of the overall vision and of polysystems in particular. Much greater effort went into communicating this work and engaging commissioners. However, it exposed that while savings should flow to commissioners, it could leave hospitals in particular with considerable financial pressures. Given that polysystems were supposed to support integrating services and required collaboration with secondary care, this did little to help organisational tensions.

There was also recognition that a considerable amount of the primary care estate in London was not fit for purpose. The polyclinics model was, in part, a response to this problem but perhaps underestimated the challenges involved in reconfiguration. We were also told the business model did not deal sufficiently with GPs' concerns regarding their pensions and properties (for those who owned their premises):

> The estates issue in the community was an unanswered question.
>
> **– Senior clinical advisor**

Top-down instruction versus bottom-up development

The polyclinics programme trod a fine line between these two extremes. Senior managers were anxious about just giving outcome targets, because they feared it would be difficult to monitor progress due to inadequate data capture. However, as a primary care service model, implementation was inevitably going to be in the realm of the PCTs and, unlike stroke or trauma, the spread of services to multiple small providers across the whole of London meant that implementation would crucially depend on local leadership and engagement:

> In order for people to believe a vision and to make change at their level, they have to have [a say] in the change agenda, they have to co-produce it with you. No matter how good an idea is, it becomes more likely to be implemented at the point people feel they've influenced it. And, you know, it wasn't possible to do that at a London level.
>
> **– PCT CEO**

Those involved in the programme reported mixed messages from PCTs who tended to resist top-down directions, arguing for the flexibility to develop local solutions, but also wanted clear guidance about certain issues, particularly concerning specifications:

> Often, the same people who will heavily criticise top-down management are the same people who say they do not know what they want.
>
> **– PCT CEO**

A specific example of this was whether or not to have radiography services in polysystem hubs, an expensive addition that some PCTs felt was not appropriate due to local circumstances (for example, one PCT had three A&E departments close by, all of which saw significant numbers of the PCT's patients and all of which had X-ray facilities). Some within London wanted to mandate this as a requirement, whereas others, especially the clinicians within the programme, felt it should be left to individual PCTs to decide as appropriate:

> We drew a diagram of what a polyclinic might look like, and then that almost became the agreed list of what must be in a polyclinic, no matter how many times you said to people, 'No, this is what it could be', it's amazing [how hard] the performance management role of the NHS is to get away from.
>
> **– Senior clinician**

This can be seen as a tension between the need to have a core service so that staff and the public would know exactly what they could expect, and the need to adapt to local circumstances.

> How do we get the public to understand what these polyclinics are about, what are the range of services that are within them and how would they use them?
>
> **– PCT CEO**

Several clinicians mentioned that managerial colleagues tended to want to mandate a rigid service specification. This was echoed by one PCT manager who felt that those closely involved in the central programme generally found it difficult to 'let go' and allow the PCTs to get on with implementation which, by definition, required local ownership, leadership and engagement:

> There has to be a point in time when the baton is passed on to someone else to take the vision and localise it. Some of the people at that London level felt the loss of that… What I'd say is that people really enjoy being part of a change agenda and it's hard for them... it was hard for us in polysystems as well, to hand over to [those at] the next level who need to take this phase of the strategy and deliver the next phase.
>
> **– PCT CEO**

On the other hand, there were concerns about a lack of capacity, understanding or commitment within some PCTs that would mean the required engagement was always going to be difficult to achieve:

> We were also clear that what we wanted to do was to get each PCT to take responsibility to take that vision, understand the messages and cascade it down... it absolutely depended then on the level of leadership and buy-in and their own PCT, and I don't think every PCT was as committed to make it a priority.
>
> **– PCT CEO**

It is understandable, therefore, that senior managers have concerns about what will happen when a strategy agreed collaboratively (ie. London-wide) needs to be implemented locally, given that local engagement is necessary for change to be enacted. It is possible that intuition is more important than standard procedures and the evidence of our interviews suggests that some highly experienced and effective leaders get this balance right and reap the rewards.

Insights also suggested a differentiated approach would be necessary if polysystems were to be implemented effectively London-wide as there were PCTs capable of delivery and others that would have needed additional support in many forms.

Key lessons for commissioners

Having commissioners leading the implementation of the polyclinic model was entirely logical. However, not all the markers of success were present to deliver large-scale change. The key lessons are:

- Create a compelling case for change. For polyclinics, this was a problem with access, patient experience and the lack of integrated services. However, this case did not sufficiently mobilise clinical leaders in the same way as, for example, the case for change for stroke
- Consider the needs of the patient population, including a deep understanding of patient segments and their demand for services. With polyclinics, *Healthcare for London* was trying to address two quite different segments – people with chronic conditions who needed more integrated services and people with a need for a more convenient response to care. It may have been better to considered these needs separately and more explicitly
- Be very clear about the vision of what needs to be delivered, so those delivering it are committed to the changes
- Identify specific changes in pathways and how they are underpinned by clinical evidence and local data. This was a pivotal force in *Healthcare for London* and one that remains critically important
- Make sure the economic underpinning of any changes are fully understood and clearly linked to how change will be delivered. With polyclinics, the economic thread was lost
- Consider what changes need to be delivered from both commissioner and provider angle

- Focus on enablers – contractual levers, incentives and the flow of information should all be linked tightly to the economic case. Changes in estates and workforce should be clearly motivated by requirements of the delivery model. When all of these are aligned, significant change can be achieved effectively and efficiently
- Never settle for the things that are easy and make sure the right resources are matched to the task. Whereas stroke had a high-powered team driving central procurement that transformed care, polyclinics relied on a distributed approach to implementation with varying levels of capacity and capability
- Assess the capabilities of individuals identified as critical to delivering change. Be clear about what needs to be achieved by when and adjust the delivery plan accordingly

Independent of this review, the polysystems team produced a 'lessons learnt' document that summarises the experiences of the early implementer polysystems. There is considerable overlap with the findings from this report, particularly around communications and engagement[54].

Learning from polyclinics in developing integrated care in London

Many of the lessons learned from the polyclinics implementation programme informed the development of integrated care in London and in 2010, London's three AHSCs were invited to develop integrated care pilots:

> To be honest with you, the only structures which have a definite future are the AHSCs. They will become the de facto organisational unit around which London probably will [be organised]…at the moment, they're the only ones that have the breadth in research, service, education, and – increasingly – links with primary care and secondary care providers to actually be the effective healthcare unit.
>
> **– Acute trust CEO**

> I think *Healthcare for London* was trying to push the polyclinic thing because it was trying to push the concept of integrated care and, to start that up, you need some facility.
>
> **– Acute trust CEO**

The development of Academic Health Science Networks (AHSNs) in London, with a clearer link to primary care than the AHSCs, may further strengthen this role.

There was powerful feedback that the policy to establish clinical commissioning groups has great potential to drive the development of polysystems and integrated community-based care. The importance of collaboration in developing new pathways was emphasised:

> [What] my experience in polysystems taught me was that the best way to do that is to co-produce…[to take] a movement from the vision to the strategy to the delivery, the people who are actually going to make it happen have to be fully involved and it takes a lot of time.
>
> **– PCT CEO**

The integrated care pilots bring together primary and secondary providers as well as local government and voluntary organisations. This inclusion of acute provision, social care and other local government services was an important, but variably delivered, part of the original polysystems vision. Establishing three pilots was an attempt to facilitate improvements in care delivery by focusing primarily on the enablers of change. Done well, these integrated care systems identify a cohort of the patient population, consider the specific changes in how care should be delivered and then focus on the enablers. By identifying and overcoming obstacles that have prevented change elsewhere, the North West London Integrated Care Pilot in particular has been widely recognised as a leading system for developing integrated care, winning a *Health Service Journal* award in 2011 in the category of managing long-term conditions.

The London pilots have begun demonstrating the potential of integrated care as well as facilitating learning across all three, in particular about the core components and critical enablers required to deliver an effective integrated care system. Recent analysis suggests that such systems have great potential to improve patient care and patient experience and to contribute to cost savings and productivity improvements. In the North West London pilot, there has been a focus on older people and people with diabetes populations and a decrease of 6.6% in emergency admissions has already been demonstrated during a period when other areas of London have seen a rise of 0.3%[55].

A summary of integrated care experience globally[56] lists three sets of factors that help support integrated care:

- Addressing patient needs in a pathway (eg. diabetes, chronic obstructive pulmonary disease (COPD), dementia) and stratifying patients according to their risk of hospitalisation
- Working in a multi-disciplinary system, using patient registries, risk stratification tools, protocols, care plans and case conferences to back up multi-disciplinary care
- Establishing key enablers for support, such as accountability, clinical leadership, information sharing, aligned incentives and patient engagement

All of these principles were at the heart of the *Healthcare for London* vision, although it is true that they were variably achieved through the focus on implementing polysystems.

Learning from polyclinics for the transformation of primary care in London

A key premise of the polyclinic and, especially, the polysystem was the need for high quality general practice at the heart of the model. This is equally true for integrated care. At the outset, it was recognised that the quality of general practice varied drastically both across London and within localities. This was an acknowledged risk and yet it was envisaged that the formation of GP networks within polysystems would drive up performance through, effectively, peer pressure. The same argument has been made, of course, for clinical consulting groups, which have the potential to make considerable progress in addressing the unwarranted variation that has been a feature of London's primary care landscape for decades.

The development of the *Pan London General Practice Outcome Standards and Framework* was intended to facilitate this peer process, as well as creating a greater level of transparency about the variation that exists. This work, summarised in chapter 2, led to the development of www.myhealth.london.nhs.uk, a website where the public can compare the quality of their local general practices. The design stages of this work took longer and involved many more GPs than the design of the polyclinic delivery model. The project has been recognised nationally and won a *Health Service Award* in 2012 in the category of enhancing care with data and information.

Overall, the polysystems programme taught London a huge amount about the difficulty of moving people towards a new working environment such as a polyclinic. Working around this led to the idea of the hub-and-spoke model. This seems to be a more palatable idea for healthcare professionals and there are many examples of GP practices forming networks and federations in order to benefit from economies of scale and shared learning. Examples include the formation of GP networks delivering multiple care packages in Tower Hamlets and the development of multi-site providers such as AT Medics and the Hurley Group.

Effective utilisation of London's primary care estate remains a major issue, with large numbers of GP providers in London working out of premises that are likely to fail a CQC inspection. This may be a key driver towards co-located services, which is even more likely in the context of increasing GP workloads, an ageing GP workforce heading towards retirement, increasing financial pressures for GP surgeries and younger GPs less wedded to the concept of partnership. However, the financial climate may make the *Healthcare for London* vision of a wide range of services located in polyclinics hard to realise.

Conclusions

There was wide variation in views on the success or otherwise of the polyclinic programme:

> **I think polyclinics were almost destined to fail from the outset, unless there was going to be pressure on primary care to reform…How can [you have] integrated care while the key frontline workers, the GPs, an absolutely vital, extremely highly regarded part of the healthcare system, retain their independence outside of the integrated care system? It's a misnomer.**
>
> **– Acute trust CEO**

> **Polysystems, whatever they may end up being called, seem to be the way forward. In discussions with architects, designers and planners there is no doubt that they are trying to commission or win commissions for 'integrated care' centres with multiple services in one building. It feels as if a tipping point has been reached.**
>
> **– Senior political advisor**

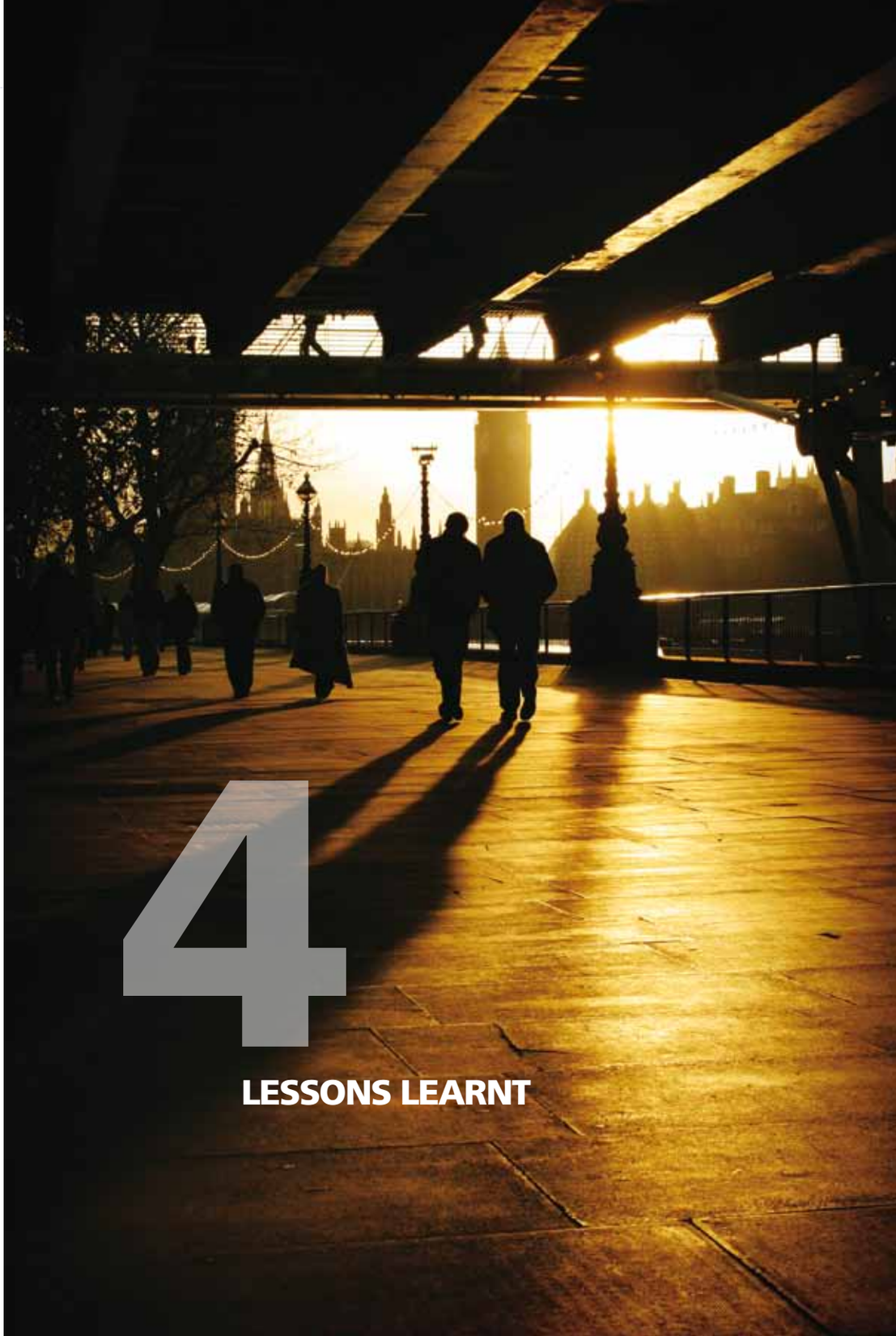
Despite the challenges faced, in particular the difficulty of developing a consistent vision and achieving large-scale implementation through 31 PCTs, some of the key principles of polysystems appear to have taken hold in many parts of London, but are being delivered through other routes. These include improved access, coordinated care, integration with social services, care closer to home, improved communications, a wider range of services, and a pathway approach.

The name 'polysystem' did eventually generate reasonable 'brand recognition' among clinicians and, despite Andrew Lansley's moratorium on service change in 2010, was still being used by many commissioners to drive improvements in primary care in 2011. Other areas immediately rejected the term polysystem, but were working to strikingly similar principles in developing integrated care systems. Today, it is clear that the term has become outmoded and it is unlikely to be resurrected.

The issue of recognition for the term polysystem, the difficulty in articulating a consistent model, and the delicate balance between top-down and bottom-up development, reflect the difficulty of communicating ideas for large-scale change. By definition, such ideas come from 'the centre' and diffusion to 'the periphery' is hard to achieve. Local clinicians and politicians were more easily able to influence public opinion against the plans, partly due to their location and availability, but also their local credibility. Changes to NHS services often tend to be contentious and, in this case, the future of general practice and local hospitals both exerted a strong emotional pull.

Many of the barriers to polysystem development, such as estates, information technology and contracts, hinder all attempts to change primary care. There are no clear and universal solutions to these problems, but awareness of them during the planning phase is critically important. The need to integrate healthcare with the wider determinants of health, to avoid a purely medical model, through collaboration with other sectors is another key principle that should be achieved.

In conclusion, implementing polyclinics and polysystems in London has been, at best, variable. However, it is clear that the work has laid a firm foundation for rolling out integrated care in a way that needs to be fully exploited if the care and treatment of people with long-term conditions is to be transformed. The establishment of clinical commissioning groups and health and wellbeing boards has created clinically-led organisations and local partnerships that present the ideal opportunity to engage local leaders in the improvement of community-based services in a way that best meets local needs.



4

LESSONS LEARNT

THIS SECTION examines lessons learnt from *Healthcare for London*, drawing on the 80 or so interviews undertaken in the preparation of this report and focusing on the six core themes that emerged. Each of these themes need attention in order to implement large-scale change and trade-offs might be necessary in order to make change a practical reality. The six themes are:

- Leadership
- Engagement and communication
- Investment and resource
- Organisational capability
- Data, evidence and analysis
- 'Once-for-London' or 'local'

LEADERSHIP

> "Involves multiple actors who take up leadership roles both formally and informally and importantly share leadership by working collaboratively. This takes place across organisational or professional boundaries. Thus shared and collaborative leadership is more than numerically having 'more leaders'."
>
> **– The Future of Leadership and Management in the NHS, The King's Fund, 2011**

Clear, focused and dedicated leadership is fundamental to gaining commitment and achieving the necessary impetus to bring about large-scale change. It was mentioned frequently as essential to the delivery of change programmes. The development of groups of individuals to provide leadership from both clinical and executive backgrounds, was at an advanced stage in London several years before the King's Fund published its recommendations on leadership in 2011.

In the simplest terms, clinical leadership met two primary needs – a direct contribution to planning and then delivering service improvements, and as a means of articulating the case for change to the public, politicians, managers and other clinicians. Executive leaders were required to facilitate this clinical leadership and to align their organisations (eg. NHS London, commissioners, AHSCs and acute provider trusts) behind the guiding principles of *Healthcare for London*.

Clinical leadership

Although the clinical working groups were multi-disciplinary in their make-up, interviewees were clear that *Healthcare for London* prioritised doctor leadership. Non-doctors may have felt marginalised and individuals with proven leadership abilities within the wider clinical workforce may have not have been fully utilised:

> "There are paramedics, both within this organisation and the country as a whole, who are incredibly strong clinical leaders and innovators… So [leaders] don't necessarily need to be doctors.
>
> **– London Ambulance Service manager**

On the other hand, many of the respondents felt the focus on doctors as leaders was appropriate, even inevitable, given the task at hand:

> "I suppose it's about what you're looking to achieve. If it is a new community-based nursing strategy, then you're insane if you don't involve the community based nurses. But, if what you're trying to do is shut vascular surgical units, you can't send a nurse in to visit Northwick Park, with three vascular consultants, to tell them they're shutting. You need to send the Professor of Vascular Surgery from the south west, who you've asked to do a review, to go in and tell them that that's what's going to happen.
>
> **– Senior clinician**

A variety of themes were identified through our interviews. The term 'clinical leadership', in theory, refers to all clinicians working in healthcare. However, there was quite a clear bias towards doctors, reflecting their professional status, financial impact on the system and powerful professional bodies. They were seen to be capable of being obstructive if they felt change was being imposed on them or if they disagreed with the aims or methods of the process. Some doctors were unapologetic about this approach:

> "I'm challenged quite often on whether or not, when we talk about clinical engagement or clinical leadership, what we're really talking about is medical engagement and medical leadership, but we use the words clinical to make it sound more palatable.
>
> **– Senior (medical) clinician**

A senior management consultant with a medical background commented that one of NHS London's key success factors was the doctor-centric engagement in strategy development and the decision by other SHAs not to follow this approach was a major barrier to change around the country:

> For me the absolutely critical thing that made *Healthcare for London* a success in terms of [developing] clear conclusions and proposals was that it was unashamedly doctor-driven with unashamedly high calibre peer group facilitation.
>
> **– Senior management consultant**

However, it was also recognised that hearing opinions from a range of professions was a good thing:

> There was certainly a value in cross-cutting. So, having someone from the London Ambulance Service there [at Clinical Working Group meetings], having someone from the Royal College of Midwives, having someone who was a community pharmacist, was really good.
>
> **– Senior clinician**

The strength of clinical leaders in articulating messages to politicians and the public was flagged as a mixed blessing, particularly when difficult decisions regarding organisational futures were concerned:

> … you've got 50 consultants who people don't know, who are drawn from all over London, saying it's a good thing to remove service X, but the two or three consultants who are delivering service X, and who are known to that community, stand up and say 'This is absolute nonsense'. Because the message is unpalatable, people will immediately think 'These guys are right: everybody else is talking about some idealised nonsense that we don't need to deliver'.
>
> **– Acute trust CEO**

As well as the strong theme that clinical leadership was critical, *how* they were asked to contribute was felt to be particularly important. One management consultant referred to this as agreeing "*the terms of engagement*" – using clinicians as experts in their fields, not as mouthpieces for their institutions or project managers. The contributions of clinicians were certainly focused in this way, through how the various working groups and project boards were set up and by the provision of excellent administrative support. This was one reason for the sense of enjoyment and satisfaction reflected by clinicians involved.

An additional risk highlighted during the interviews was that the clinical leadership pool could be relatively shallow, unless attempts were made not only to engage with a spectrum of professions, but also across different professional levels:

> It's very hard not to just get the usual suspects. [We have] paid people, if I'm honest, because that enables people to engage who otherwise would be restricted. Then [they can] make networks themselves – that's part of their role.
>
> **– Senior NHS executive**

Having a clinical figurehead

The process of delivering *Healthcare for London* utilised a wide range of clinical leaders. The six – later eight – clinical working groups that helped to draw up *A Framework for Action* were populated by around 150 high-profile and highly-qualified clinical leaders and those who contributed to this report as interviewees mostly remembered the process fondly, partly because of the way in which their time was valued and used in an efficient manner. Inevitably perhaps, some of the groups were more coherent than others, which may have reflected inter-disciplinary tensions, a lack of engagement with the process amongst certain groups, or variable leadership of the groups themselves.

The single leader approach, which saw Lord Darzi being chosen as the figurehead for *Healthcare for London*, the author of *A Framework for Action* and, until he became a government minister, a key driver of implementation, was felt to have had pros and cons:

Positives	Negatives
• The highest calibre individual can be chosen	• Territorial issues: – Some specialities may question the validity of the leadership and thus disengage – Institutional favouritism may be alleged
• Identification of the project as a whole with that individual (although this also has its downsides)	• More than one communication style may be needed for different groups
• Clarity and consistency of communication – both style and message	• Smaller overall network of contacts (compared with a group of leaders)
• Provides a role model for future leaders	• Lack of constructive criticism

Those close to the decision-making process were confident that the use of a single, independent clinical leader as the figurehead for *Healthcare for London* was appropriate and took account of the potential risks, which were mitigated by support from a cadre of clinical working group chairs. The choice of a secondary care clinician reflected the institutional power of secondary care and the need for a clinical leader of standing in this sector.

> We needed someone independent from the SHA, someone who had a reputation in secondary care but would think wider.
>
> **– Senior NHS executive**

> [Lord Darzi] brought a good balance of independence, and yet knowledge and ownership by being in London. In my view, one of the weaknesses of previous reforms was [that] they had the benefit of independence but no ownership therefore no follow through.
>
> **– Senior NHS executive**

Many felt the personal qualities of Lord Darzi made him particularly well suited to this role. He had credibility with politicians, whilst his passionate advocacy of quality and the patient experience was sustained by his role as a leading surgeon renowned for academic and technical expertise.

> I wouldn't have traded Ara for anything. He was determined… in the amount of commitment he gave to the review. He combined a track record in the field with a level of charisma. He was fantastic in mixed groups, on a platform…
>
> **– Senior NHS executive**

Lord Darzi was also well connected throughout London and across sectors and was able to involve and motivate a diverse group of senior clinicians, as well as being open to involving those from all clinical backgrounds:

> He came across as a health professional who embraced multidisciplinary working and did not put doctors on a pedestal.
>
> **– Senior NHS executive**

However, there was some negative feedback about the use of Lord Darzi as a figurehead leader. In particular, there were comments about the appropriateness of a surgeon advising on changes to primary care. Although Lord Darzi's networks have been mentioned as a positive, it is possible these were skewed towards secondary care:

> I definitely think there was inadequate general practice representation [in the development of *A Framework for Action*] and I think that caused a number of the problems we had with implementation.
>
> **– London GP**

This may have contributed to the relatively negative reaction to *Healthcare for London* from the primary care community and press; one GP stated at the time that: "Surgeon Lord Darzi seems unaware of the principles of primary care."[57]

Given that primary care was a priority area for service improvement in London, this can be seen either as an error of planning or as poor communication, given there were GPs on each of the clinical working groups, two of whom were chairs.

This raises the question of whether errors or misinterpretation have contributed to the lack of progress in the delivery of primary care improvements in London, which has seen less progress than other areas. However, there might not be a straightforward leadership model for primary care, which complicates the challenge of securing a consensus for strategic change in this area. General practice is largely made up of relatively small independent practices, in which leadership hierarchies are limited, whilst hospitals have far bigger organisational structures with clear hierarchies and leadership figures. This suggests a far broader level of engagement is needed to secure a shared vision and commitment from primary care professionals, as a lead representative or opinion former is much harder to find.

Executive leadership

There was a strong feeling that leadership from chief executives and boards was critical to the success of *Healthcare for London*. Many positive comments were recorded as to the clarity of the leadership from NHS London, in particular that provided by Dame Ruth Carnall:

> At the end of the day, energised leadership from NHS London was very important.
>
> **– Senior management consultant**

There was more varied feedback about the leadership of *Healthcare for London* from the wider London healthcare system, with praise for many executives, especially those who took on the leadership of the work programmes for developing pathways. However, there were clear concerns expressed about the variation in the quality and passion of London's healthcare leadership, with several themes emerging. The pressures of day-to-day work were found to be critical, leading some organisations to dedicate too little time to planning for and executing the *Healthcare for London* changes:

> You can't expect people to make a major change happen on top of their day job. It needs focused resource and dedicated leadership and then it needs support from the most senior leaders in the system; they need to be championing it.
>
> **– Senior NHS executive**

Not all commissioning leaders bought into the change programme and consequently some did not align their organisations behind it; this may have related to other priorities these organisations were dealing with, or alternatively they did not believe change was possible. There were also concerns that the failure of previous attempts at strategic change in London had led the system to doubt NHS London's capacity and capability to implement its own strategy:

> There was this whole attitude at the time that London was good at strategies, but no good at implementation; it couldn't possibly deliver on them. So, the system didn't have confidence that it was actually going to get done.
>
> **– Senior NHS executive**

These doubts may have undermined the buy-in from senior executive leaders at London's NHS organisations, particularly the acute trusts:

> Most trust chief executives, at the time, were quite agnostic about [*Healthcare for London*'s] implementation, because I don't think they thought it was genuinely going to happen.
>
> **– Senior NHS executive**

Overall, there was more positive than negative feedback on the 'system leadership'[l] of the NHS in London. However, there is now a question as to whether there is sufficient capability to deliver large-scale change after April 2013, when the implementation of the coalition government's reforms is completed.

The King's Fund's report on London[58] highlights this issue and quotes Lord Darzi, speaking at a debate in the House of Lords: "The lesson from experience of implementing the Darzi review is the need to engage clinicians in the process of making improvements through effective system leadership. The question that this raises is 'who will provide system leadership in the reformed NHS?"

Lord Darzi also made his reservations clear:

> ...nothing in the Bill explains how strategic change will be made to the NHS. With perhaps 300 consortia [now clinical commissioning groups], how will the necessary changes be made on a regional level? The programme that I led, *Healthcare for London*, built an alliance of hundreds of clinicians and managers across the capital to improve care. It led to London becoming the world leader in stroke and cardiac care... How will similar improvements happen in future?
>
> **– Lord Darzi**

What most commentators appeared to agree on is that the scale of change outlined in *A Framework for Action* could only be developed and delivered through unified leadership across the whole health system. Given the forces of opposition that can, if unchecked, prevent change, the importance of having leadership aligned behind the case for change and subsequent proposals cannot be underestimated. *Healthcare for London* demonstrated that working in partnership across organisations can deliver the necessary level of alignment. The challenge for the new system from April 2013 is whether, in the absence of an SHA for London, there is the vision, appetite and determination to align multiple organisation leadership behind a common purpose.

l *As defined by: Dixon A, Ham C; 2010.* Liberating the NHS: The right prescription in a cold climate? *The King's Fund*

Leadership development

The importance of leadership development was mentioned frequently as something that was critically important to strategic change programmes such as *Healthcare for London*, in particular the nurturing of a new generation of clinical leaders:

> [It is critically important to] select your clinical leader(s) carefully and coach them to provide constructive challenge [to others].
>
> **– Management consultant**

> One of the positive things was the networking involved in the Clinical Advisory Group that Cyril Chantler ran. One met with clinicians of all specialities from all over London, and it was almost as if we were in an action learning set. Cyril made sure that we had specific sort of educational things in the regular meetings, as well as our own work, so I think it developed a large group of us to a greater degree than we would otherwise have been developed.
>
> **– Clinician**

NHS London has invested heavily in this area, as part of its work on the *Healthcare for London* enablers. It established the Leading for Health initiative, including such programmes as Prepare to Lead, Fellowships in Clinical Leadership (previously known as Darzi Fellowships), Aspiring Nurse Leaders and Next Generation Directors. This investment is anticipated to bear fruit over the next decade, so there were few direct references to these schemes in the interviews. However, it is clear that success is reliant on clinical and managerial capability and, arguably, change to date has been limited by the available talent pool.

KEY LESSONS

- Effective leadership is essential for the success of any change programme
- Clinical leadership is key when making clinical change and needs to balance engaging a range of clinical leaders with focused leadership from relevant service experts
- Executive leadership and support for the change is also vital in making progress, although there is often a risk of being distracted by the 'day job'
- It should be clear to leaders what role they are being asked to play and their input should be recognised and valued
- There are both benefits and risks to having a single figure leading a major change programme
- There has been a limited talent pool from which to draw NHS leaders; those that have been developed through recent leadership programmes should now be utilised
- Leaders of the NHS in London now face the challenge of working out how they will align multiple organisations to deliver on common goals

ENGAGEMENT AND COMMUNICATION

> "If you read the Turnberg Report, it goes on about beds [and other] technical jargon which did not really add up [for] the local community… I could not even see any engagement. So what I wanted to do was… engage the tide of Londoners, patients and clinicians, in really driving and creating a framework in which we can improve London's health care."
> **– Lord Darzi**

The relationship between leadership and engagement is unarguable, particularly when it comes to clinicians. Even key leaders may require input to engender engagement early in the process and more of this sort of input will be required for leaders in the wider health system. However, there is also a particular need to engage with clinicians, managers, patients and the public, which is best considered separately.

The importance of a clear engagement strategy was emphasised frequently in the interviews. There was widespread agreement that engagement needs to start early in the process and continue throughout and that different methods and messages should be developed for specific groups. Other themes highlighted included the use of clinical champions, patient representative groups and third sector organisations as advocates for and influencers of the programme, leadership development and the diffusion of messages across the system.

Good engagement is critical at every step of the change process:

Change process – steps	Purpose of engagement
Pre-planning Identifying what needs to change	To develop a broad consensus of understanding about the need to change and to begin development of a shared vision
Planning Defining what the future should look like	To ensure services are developed with input from service users and all relevant experts that responds to the case for change and meet health needs and expectations
Pre-implementation Designing how change will be implemented	Engaging all relevant parties in coordinating activity, ensuring change is delivered in the most efficient and least disruptive manner, without compromising the safety and quality of services
Implementation Making the changes	highest calibre individual can be chosen
Evaluation Measuring the effects	To understand the impact of the change process on those affected. Being sure the original aims are achieved, to identify any further action necessary and inform future change programmes

When planning, the purpose of engagement must be clear. For example, engagement with staff about a change programme such as *Healthcare for London* is different to engaging with staff about day-to-day responsibilities. Equally, the different stages of change require specific approaches. The team who worked on delivering *Healthcare for London* changes put considerable time and effort into this engagement process.

Key areas for engagement are discussed below:

Clinical engagement

Whilst public engagement is hugely important when developing and embedding new services and board-level engagement is critical in order for organisations to align themselves with new strategies, it is clinicians that actually deliver the service to patients and are therefore vital to success.

Clinicians have an important perspective on proposals for change, as they understand the clinical decision-making that occurs on the frontline. Unless those involved are engaged and enthused by the plans, there is a risk that implementation of those changes will fail.

Another factor is the day-to-day contact that clinicians have with patients, which provides de facto public engagement, whilst support from the clinical community can be critical in negating public or political objections.

There remains a significant question as to whether involving a range, however wide, of clinicians in working groups constitutes 'clinical engagement'. It is helpful to think about engagement levels – the majority of clinicians should be engaged in the sense of knowing about and understanding the reasons for change, but only a small proportion of the clinical community can ever be actively involved in inputting directly into committees and working groups.

Achieving the right balance of individuals providing input can be difficult, due to other demands, but attracting individuals other than the 'usual suspects' is particularly important if leadership is to be used as a surrogate for widespread engagement. However, a pragmatic approach that makes the best possible use of available resources is inevitable:

> We had 150 clinicians engaged, which is a small fraction of the quarter million employees in London, but the entire [structure of the clinical working groups] was put together within about two or three months so I thought that was a pretty good balance.
>
> **– Management consultant**

There is no doubt that clinicians were engaged in strategy development, planning and implementation for all *Healthcare for London* projects, which was one of the key messages of *A Framework for Action*. Clinical champions were used extensively to provide expert backing for proposed changes and there was an expectation that information and messages would filter through to clinicians everywhere:

> Do not miss the chance to create a 'cascade' of communication – clinicians telling clinicians, telling other clinicians about the rationale and benefits of change.
>
> **– Management consultant**

In reality, these information cascades were not always successful:

> Nobody has addresses for everybody so, for example, for stakeholder events… an invitation goes out to the chief executive of my hospital, it then sits there for, I don't know, a week or so, he then has to pass it down to another director. Eventually, it gets to the person who might want to go to the meeting, usually about a day before the meeting.
>
> **– Clinician**

This lack of reach undoubtedly had multiple causes, including the hiatus between the dissolution of the clinical working groups (on publication of *A Framework for Action*) and the formation of the clinical advisory group, which became the organ of clinical engagement and leadership for the implementation of *Healthcare for London*.

The difficulty of diffusing information from the working groups and project teams may help explain why some people perceived the clinical advisory group as elitist. It was replaced in 2010 by a much larger and broader group – the London Clinical Senate that, in line with the coalition government's reforms, now works alongside the London-wide Clinical Commissioning Council. Clinical senates themselves are also now part of the NHS architecture and it is hoped that these groups will secure much broader clinical engagement. However, it is unclear what resources will be available to these groups and it may be too early to comment on their likely effectiveness in analysing problems and proposing solutions. What is clear is that facilitating and investing in these groups will be critical if London is to achieve large-scale improvements in care.

Clinical engagement is both an enabler and an outcome of change programmes. However, whilst clinical engagement is hard to define and challenging to achieve, its value is even harder to measure[m]. As we have seen, *Healthcare for London* had mixed success – engagement was mentioned as one of its key strengths and yet it may have been limited to a group of senior doctors with variable, sometimes limited, reach to local level. For future commissioners this is an area requiring close attention.

Organisational engagement

A clear engagement strategy is needed for organisations within a system such as the NHS in London. Organisational alignment is critical and the whole trust board needs to be given attention, although the approach of engaging executive and non-executive directors should be considered separately.

Executive teams

There was a strong feeling that PCT executive buy-in to *Healthcare for London* was variable across London and that the success of some programmes was highly dependent on this. This was not helped by the 'ambiguous hierarchy' between PCT independence and accountability to the SHA:

> Most PCTs [were not] willing or able to confront that reality [that change was necessary and, as] they were free standing and independent bodies, the battle was really difficult to win.
>
> **– PCT CEO**

> Where were the PCTs in this game? Because there was a sense in which the PCTs could have been saying 'This is our review, this is our responsibility, and we want to take this forward'
>
> **– Senior NHS executive**

m *The best known example of a measurement is the Medical Engagement Scale – see the NHS Institute website for more details*

There were few comments about the attitude of acute trusts and their boards to the broader aims of *Healthcare for London*, which may imply a lack of engagement outside pathway-specific work such as stroke reconfiguration. At chief executive level, aspects of *Healthcare for London*, specifically polyclinics, were felt to be unworkable and therefore not credible.

There were opposing views about the engagement levels of the NHS London executive team. On one hand, some felt that certain directors were not fully behind the strategy; on the other, several interviewees from within NHS London felt that, although understanding and commitment may have varied, this was recognised early and adjustments were made.

One factor mentioned was the need to integrate new members of an executive team into an ongoing programme. Given the high turnover of senior NHS leadership, this is something that would be best considered early:

> There was a time when we assumed that everyone understood a lot more about *Healthcare for London* than they did. There were colleagues who joined after *Healthcare for London* had been launched [and] we assumed that, despite the fact that [they] hadn't been part of it, [they] would understand it. But [they] hadn't ever been through the journey of producing [it]. We assumed more understanding of the agenda and why things were the way they were; how it all fitted together, how the clinical strategy fitted with the economic aspects of it than, in practice, we had any reason to expect.
>
> **– Senior NHS executive**

The most successful implementation programmes had input both from NHS London directors and a high profile PCT chief executive, with significant levels of engagement from other directors across the NHS in London.

Non-executive directors

Several interviewees commented on the importance of the non-executive directors of NHS organisations in supporting and facilitating service improvement and that this group was not fully utilised as a resource. Several reasons were mentioned for this, including institutional loyalties amongst acute sector non-executives and a lack of targeted communication and information for this group:

> [Boards and their governors] should be better connected into their communities… [and] need to be thinking more about the quality of the service, and how patients [can] best [be] helped. Actually what we condition them to do is to love the institution, the bricks and mortar, the fabric, the history.
>
> **– Senior political advisor**

The 2010 resignation of NHS London Chair Sir Richard Sykes, and some other non-executives, was felt to be a significant blow.

> The resignation of [some of] the NHS London board was a massive issue. They were really getting behind it, really getting going. That has probably put the whole thing back a good one to two years.
>
> **– Management consultant**

The resignation occurred at a time when many felt the board was becoming increasingly, and helpfully, influential. Sir Richard Sykes was widely admired and it was suggested that, had he stayed, he could have used his standing to communicate directly with the public to emphasise the benefits of *Healthcare for London* and build broader support:

> I think the non-executives we had, under Richard Sykes, absolutely had bought into [*Healthcare for London*], had brought critical rigour to it, had been quite challenging of us in developing it; but were becoming major assets in securing it, and being ready to support and drive it.
>
> **– Senior NHS executive**

This should not be interpreted as criticism of the current NHS London board, which has continued to show commitment to service transformation. Rather, it reflects the importance of stable leadership in a transitional period.

Public engagement

Public engagement in the pre-planning phase of *Healthcare for London* involved focus groups, roadshows and workshops. Many of those involved felt this achieved a reasonable level of engagement:

> The whole process was consulting, we had one hundred people with us, we went to every jamboree you can think of, I went everywhere, including places I had never been in London.
>
> **– Lord Darzi**

Many interviewees felt it was important this stage of the process should progress quickly:

> Momentum is really important [for] this kind of change programme. Getting on and doing stuff and accepting that by making changes you fundamentally believe are grounded in best clinical practice and are feasible for London: that has to be the priority.
>
> **– Management consultant**

> Things like this only really work at reasonable speed if you're prepared to be autocratic about it.
>
> **– Senior clinician**

Although there was strong agreement that a faster pace was preferable and helpful, one PCT chief executive argued that the pace of change was too rapid and that NHS London missed the opportunity to prepare the ground for *Healthcare for London* and show the public why change was necessary and involve them in shaping the agenda:

> With hindsight, we did far too little on pre-consultation engagement. If we did this again, I would say we need to spend a good year, maybe longer, actually setting the ground out about the nature of the debate we wish to have, and the reason why this debate is important.
>
> **– PCT CEO**

Public consultation: *Consulting the Capital*

Unlike most public consultations, which usually ask patients, their representatives and members of the public for their opinions on relatively detailed proposals, PCTs consulted the public on the actual strategy for change. There were no site-specific suggestions for change, as these had not yet been developed, and a lot of effort was taken to keep the arguments clear and focused. However, it was suggested that consulting on ideas is much more difficult than for detailed plans, and that true engagement was correspondingly difficult to achieve:

> I think doing a formal NHS consultation on a conceptual design, as opposed to a specific service change was unusual and difficult.
>
> **– Senior management consultant**

> It is very difficult to consult with the public on grand strategy. When we started to break it down into bite size chunks we had a much more satisfactory level of engagement and, indeed, far less opposition.
>
> **– PCT CEO**

Feedback was mixed, with some managers and clinicians feeling the process delayed the change programme unnecessarily. By contrast, those closely involved in the consultation itself and several PCT managers felt that *Consulting the Capital* mobilised the health community, addressed public opinion and specific concerns, and localised the *Healthcare for London* strategy:

> We ran a lot of events in outer northeast London [and] got a huge amount of buy-in. I personally attended a number of road shows; there were particular groups for people with learning disabilities and other special interest groups. What it did was generate a huge amount of enthusiasm, energy and local people feeling really involved.
>
> **– PCT CEO**

> What we did in [our PCT was use] it as a way of communicating [more effectively] with our public, so we tagged all sorts of things on and actually got a really good engagement. I started out being a huge sceptic – I couldn't see the point – and by the end I thought, yes, that was actually really worth it, and it was really well done.
>
> **– PCT CEO**

A huge effort went into gaining widespread engagement:

> There was a completely separate firm used for consulting the hard-to-get groups. And I think they were more consulted than they'd ever been before. [It] meant quite a lot of money was spent on very small populations but it was necessary, because they were sufferers in silence otherwise.
>
> **– Patient representative**

Some respondents commented that *Consulting the Capital* should have been clearer, particularly for groups for whom English was not a first language. Partly, this perhaps reflects the fact it was directed at clinicians, organisations and the public. Giving enough detail for the former groups and still making it intelligible for the latter was a challenge:

> It is not enough to just put it out there and say well that is the facts get on with it, especially [when] most of the stuff is written in language that normal people do not understand.
>
> **– Senior political advisor**

Overall, there was more positive than negative feedback about *Consulting the Capital*, although reservations were expressed about cost and the difficulty in determining whether it provided value for money.

Public engagement in implementation

Public engagement approaches were gradually modified as *Healthcare for London* moved from a London-wide strategy development to implementing specific changes. Public engagement began to vary across workstreams and between localities. The polyclinics programme, for example, was implemented in localities by PCTs thus involved relatively little central engagement. In implementing polysystems, some PCTs embraced public engagement, with patient panels or representatives at the heart of the implementation process; other PCTs did not.

The London-wide programmes adopted a more systematic approach. The diabetes workstream had a patient reference group and at least one patient on every board and at every meeting. The stroke programme extensively utilised patients in the pathway redesign process and used the Stroke Association as a surrogate for patient opinion and an advocate for change. All other programmes acted similarly:

> The fact that they engaged stakeholders very early on, particularly patients, I think was very strong. It's not just 'put something together and then we'll pay lip service to stakeholder engagement by showing it to them before we publish it', we've actually had them in from the start.
>
> **– Senior clinician**

The public consultation on the stroke and trauma pathways[59] learned much from *Consulting the Capital*. However, there was still a great deal of difficulty in gaining an adequate level of feedback and results were potentially skewed by local politics with some local councils expressing concern about access to the new services, an attitude best exemplified by Barnet Council campaigning for one of the four major trauma centres to be located at the Royal Free Hospital.

One useful point, that may not be widely appreciated, is that different arguments may be required for the general public, who do not use services often, and regular patients:

> The former group [the general public i.e. taxpayers] have a very particular view that I would paraphrase as 'I pay my taxes, why can't you sustain my local hospital?'. Patients are much more in tune with the quality and experience of care and prepared to engage in debate about the trade-off between accessibility, quality and outcomes.
>
> **– PCT CEO**

Whilst it is not possible in this report to formally assess the level of public engagement achieved by the overall and individual work programmes, those involved in *Healthcare for London* were clear that the programme benefited hugely from the input of patients and patient groups and this is something that should be repeated and built upon in the future.

Indeed, patients should be seen as a valuable resource in the redesign of services and engaged from the start in order to better understand the case for change and defining what the work programme will attempt to do.

Politicians

Any significant changes to health services are bound to generate the interest of politicians. Consistently, we heard about the challenge of securing support from national and local politicians across the political spectrum. A particular factor in London is the variation in support for the different political parties:

> If you think of most other parts of the country, there is quite substantial uniformity in the political parties [with a Labour constituency in the middle of most cities and greater Tory support in outlying and more rural areas] … there is a political ease because there is not [the need to look for] party political advantage. When you come to London it is basically 50/50, the coalition is 50% and the Labour party is 50%.
>
> **– Acute trust CEO**

Several interviewees commented on the need to brief politicians from different political parties separately and the complexity this added to the engagement process. The politicisation of *Healthcare for London*, which arguably occurred when Lord Darzi was appointed as a junior health minister, made attracting cross-party support and other interactions with politicians even more challenging. Conversely, some interviewees believed that Lord Darzi's appointment as a minister brought an enhanced focus to *Healthcare for London*, which was helpful.

The reluctance of politicians to be seen supporting proposals perceived by the wider population as reductions in the availability and accessibility of healthcare[n], was accepted by many interviewees:

> The MPs and councillors tended to operate in a slightly different sphere and I don't know what we could have done more to get the politicians to understand what it was all about. Basically no politician is going to vote for closing their own hospital.
>
> **– Acute trust medical director**

> I have spoken to politicians who say that it would be [career] suicide for them to support any configuration that resulted in a loss of a service from their local hospital. If they believe the proposal will save lives the best they will do is not say anything.
>
> **– Communications expert**

n *Media coverage from the time included, in July 2007, the former Secretary of State for Health, Alan Johnson, telling the Evening Standard "No London Hospitals of A&Es to close'" (Evening Standard 25 July 2007) and the then Leader of the Opposition, David Cameron, pledging to "save" the UK and London's district hospitals (Evening Standard, Daily Telegraph 20 August 2007).*

Most London MPs take a keen interest in health matters due to being on the doorstep of Westminster and thus in the spotlight of local and national media, meaning that London's healthcare issues perhaps attract a disproportionate amount of parliamentary and media attention. London also has local councils with varying approaches to interaction with the NHS and a Mayor for London with specific responsibilities for Londoners' health. It was questioned whether *Healthcare for London* fully exploited the opportunity to connect with the Mayor's office:

> *Healthcare for London* felt like a very medical model – it was 'medically driven' – and although we should listen to clinicians, this also risks missing many of the wider determinants of health.
>
> **– London policy expert**

One City Hall insider recollected having to 'rattle sabres' during the development of *A Framework for Action*, because the data being used did not tally with that of the Greater London Authority's demographers (who provide much of the data for the London Health Observatory). Once this was appreciated by the *Healthcare for London* team and its management consultancy support, the data discrepancies were dealt with and communications between the two sides improved.

Although there is no question that those working on *Healthcare for London* linked frequently with the Mayor's Office, we heard several comments about how the links could have been used more effectively and this may be a useful learning point for any future attempts to redesign services in London:

> The SHA could have linked across [to the Mayor's office] much more... Giving the Mayor [new] powers in the [2006 GLA] review was potentially hugely [important] and I think…they missed a trick.
>
> **– Senior public health expert**

The crossover between the health service and wider public services was highlighted as an area where efforts had been made as part of *Healthcare for London* but more would have been desirable:

> The health service… thinks that it is solely responsible for people's health and well being... [and] expects to solve the problems of the world itself. It is pretty poor at thinking anyone else would be able to help it.
>
> **– Senior political advisor**

Areas where respondents felt these links were not sufficiently exploited included stroke and trauma, where rehabilitation and long-term care needs are highly relevant to local authority services, and polyclinics/polysystems/integrated care, which, by definition, cross boundaries between primary and secondary care and health and social care

Some felt there was, and remains, an over-reliance on engagement with overview and scrutiny committees by the NHS as a whole and this was replicated by *Healthcare for London* programme in engaging with the JOSC, instead of working directly with local politicians at all levels. Whilst there was little doubt of the positive influence of the JOSC on endorsing change, it is possible that more could have been done to engage with local government leaders:

> I think the NHS has missed a trick in being very nervous of dealing with elected politicians, and confusing chairs of scrutiny and scrutiny committees generally with cabinets and leaders of council…If they had spent more time going to [council] leaders and explaining how the mechanics of the NHS, finance and quality work, they would have had a better dividend.
>
> **– Senior political advisor**

As with public engagement, the most effective way to engage politicians was felt to be the use of clinical champions to articulate the case for change:

> The more GPs or clinicians saying, yes this is really good, the easier it is for the politicians to think 'I would love to help you [fight this change] but actually this expert says people will die'…they do not want to be in the position of arguing against an expert.
>
> **– Senior political advisor**

Despite reflections about the difficulty of engaging with politicians, there was a feeling that *Healthcare for London* achieved a lot in this respect:

> I think they did pretty well at depoliticising it. They used [Lord Darzi] with his clinical charisma. There was a huge commitment to evidence based change. It was extensively clinically led.
>
> **– Senior political advisor**

However, despite the cost and time-consuming nature of clinical, public, organisational and political engagement, there is little doubt that investing in it has been a critical force in delivering changes.

KEY LESSONS

- Engagement should start early in any change programme, and continue to the end of implementation
- Programmes should have a clear engagement strategy, with a variety of engagement mechanisms to suit different audiences
- Communicating to clinicians on the frontline is key as they will help patients understand and manage the change. To achieve this, clinical engagement should have a breadth of input so as not to be seen as elitist
- Executive and non-executive leaders can be helpful in effectively communicating key messages to different groups
- When new leaders join they should be supported to understand the whole programme
- The benefits of patient involvement in change programmes should not be underestimated, although the difference in the opinions of the general public and patients that regularly use services should be recognised
- Change programmes should not underestimate the importance and challenges of engaging with politicians, especially in London

INVESTMENT AND RESOURCES

> "The resource to support the development of proposals and then to secure their implementation [was key]… Each of the projects has cost at least several hundred thousand, normally a couple of million, and that's not money lightly freed up. So that was an issue, although I think we've increasingly come to an understanding of the scale of investment you need in order to secure large-scale strategic change."
>
> **– PCT CEO**

Significant resources were invested in the development of *A Framework for Action*, *Consulting the Capital* and implementation programmes. This was justified on clinical and financial grounds by NHS London. Without the dedicated teams to support Lord Darzi and subsequent work, funded jointly by London PCTs and NHS London, it would have been impossible to make progress at the pace and to the scale that took place. Trying to embed the work in organisations' usual functions simply would not have succeeded. Capacity issues in PCTs around delivery were exposed when implementation was focused more locally.

Dedicated staff and resources were cited as key reasons behind the success of *Healthcare for London*:

> **I think good programme management and governance worked well. The fact we put money into it, to fund people to do the work rather than everybody trying to do it part-time, worked well.**
>
> **– PCT CEO**

Others commented that sufficient resources were not always identified for central teams and in PCTs when the programme moved towards implementation. A management consultant suggested that *Healthcare for London "fell down [the PCTs'] agenda"* and that a planning phase beyond the start-up was needed to ensure changes were properly implemented. A reason given for this perceived lack of commitment was a lack of engagement from the senior leaders of many organisations that may not have seen *Healthcare for London* as their highest priority.

The use of management consultants by PCTs and NHS London has attracted criticism. However, it is clear that the contribution of consultants has been an important factor in success, as they bring important modelling and analytical skills that are not prevalent enough in the NHS, whilst the assumptions they use and the approach they take must be agreed and refined with clinicians, otherwise the basis of their work would be flawed. In the development of proposals in *A Framework for Action*, management consultants also

succeeded in facilitating the discussions of some of the clinical working groups, helping them to achieve the right conclusions. Adopting this approach is useful when vested interests might make it difficult to have candid and constructive discussions.

Management consultancies can also bring knowledge of best practice implementation techniques from other parts of the world; international evidence was core to the *Healthcare for London* ambition.

When engaging consultants, it is critical to use them efficiently and, where appropriate, ensure there is transfer of learning and knowledge to the NHS teams with whom they are working, to avoid repeated dependence on them in the future. Managed properly, they can inject additional energy and pace, but if this is not required it is a poor use of resources and can be frustrating for those involved.

Looking to the future, a very senior manager who led one of the implementation programmes voiced fears about the ability of the new NHS structures to implement large-scale change:

> **Both sides [commissioners and clinicians/providers] need to recognise the strengths of the other. But the biggest problem is because they're taking so much out of the middle tier… how do you make the system work?... There will not be the capacity to do that, neither the capacity, nor the jobs.**
>
> **– Senior NHS executive**

However, as well as ensuring there is sufficient management capacity to deliver a programme of work, there needs to be a level of investment in the change itself. This was significant in contributing to the success of both the major trauma and stroke change programmes, for example by delivering around 400 additional stroke care nurses and up to 100 new stroke therapists. Also, providers of HASUs and major trauma centres attract additional tariff payments and, through contracting arrangements with commissioners, there are financial incentives to improve the quality of care. Investments were cited as being important to the success of the programmes and in delivering savings for commissioners in the long-term.

Understanding the financial and economic impact of proposed changes is critical to associated investment decisions. Financial modelling and business case development are important in this, as are measuring and evaluating financial outcomes.

KEY LESSONS

- Investment – both one-off and recurrent – is critical to creating new models of delivery
- A clearly defined business case outlining benefits expected from any investment is needed to mobilise resources
- Dedicated resources are critical to major change programmes and need to be in place right through to implementation, not just at the planning stage
- Management consultants can make a valuable contribution by plugging gaps in skills and knowledge but must be used wisely and integrated into the overall change effort to have maximum benefit
- It is important to agree on how providers will be reimbursed to cover any increased cost incurred as a result of service changes
- Deep analysis of financial benefits can be compelling in showing the advantages of change, especially where changes in cost affect multiple organisations

ORGANISATIONAL CAPABILITY

> "The single biggest impediment to taking the vision [for the NHS in London] forward is the absence of quality leadership in all geographies."
> **– PCT CEO**

Limited capability in some areas meant that delivering the changes associated with *Healthcare for London* was challenging, which may explain varying levels of success across different programmes of work. The relatively small size of London PCTs meant limited in-house staff, resources and capability; this supported the need for dedicated central resources:

> **The financial underpinning could only be done whole-city-wide because some places just couldn't do it for themselves.**
> **– Senior NHS executive**

The establishment of the *Healthcare for London* implementation team, with its dedicated focus on supporting PCTs and NHS London to deliver the priority programmes, concentrated strategic and change management capability in one place. It created an environment where teams could learn from one another, allowing the refinement of the approaches being used to deliver change across a complex system. This created a transformational capability that did not exist at the beginning. Having one team dedicated to this task was seen as positive by many:

> **One of the advantages of *Healthcare for London* was that…a lot of the people that we worked with didn't have other responsibilities, so weren't trying to juggle things… The central team was set up specifically for that.**
> **– Senior NHS executive**

However, there is also a risk in this approach that those responsible for day-to-day operations can neglect the need for change, believing it is 'someone else's job'. Without aligned and engaged leadership it is difficult for transformational change to occur in the NHS, particularly as the dominant culture appears to be that what the 'centre' says is important.

Many of the interviewees reflected that, for a period, *Healthcare for London* became something outside of NHS London and the PCTs. Although NHS London purposefully 'stepped away' to diffuse ownership of the strategy, the result was not entirely as intended as priorities proliferated and focus was lost. More changes were being proposed than the system could cope with, which had a frustrating impact on clinicians engaged in the work programmes. The leadership recognised this and it prompted a change of governance, with reinvigorated leadership arrangements from commissioners and NHS London. Through all this, however, the concept of dedicated resources remained.

The prevailing approach on centrally delivered work programmes has been largely effective and continues to be adopted via the London Health Programmes team. Many of those involved will continue managing London-wide work programmes as part of the Transformation Directorate in the NHS Commissioning Board's London regional team.

However, the problem of capability was never fully resolved for those work programmes delivered locally but supported or facilitated centrally, such as the polyclinics programme. These were much more variable in their impact, with organisational capability at the local level being a significant factor.

The capability challenge was acknowledged in *A Framework for Action* through the articulation of the enablers of change, in particular the need to strengthen commissioning. PCTs and NHS London were seeking to deliver change through commissioners, even though there were question marks against the capacity and capability of local commissioners. The work programme set up in response to this sought to develop the case for changing commissioning arrangements, following which it was decided to develop sectors to pool talent and capability and increase the influence of commissioners.

Following the publication of the coalition government's white paper *Equity and Excellence: Liberating the NHS* in July 2010, sectors became the platform for PCT clusters in London. However, the purpose of PCT clusters was different – they were temporary organisational structures that sought to stabilise the commissioning system at a time of great change and to create the space for emerging clinical commissioning groups (CCGs) to lead. Sectors might be better likened to commissioning support units, operating at a larger scale than CCGs and able to attract and utilise scarce talent across broader geographies. What was, and still could be, the potential stumbling block was the quality of leadership.

Beyond commissioning, there was a view that leaders in the NHS were developed to provide day-to-day delivery, but then asked to lead complex change without extra preparation. NHS London established Leading for Health as a means of fostering talent for the future and creating a new cadre of leaders more skilled at effecting change and able to work across organisational barriers. The ongoing development of people able to lead change is vital for the future.

KEY LESSONS

- A lack of organisational capability is a significantly limiting obstacle to making change happen. Having the right talent, skills and experience within a work programme's resources is critical
- Financial and analytical skills are both critical to change programmes and particularly scarce in the NHS; routes to accessing such capabilities are essential
- Having dedicated teams in place avoids unhelpful distractions from the 'day job' and allows people to learn from each other
- Dedicated transformation resources need to be governed through clear leadership arrangements to ensure change is aligned with the organisations other activities
- Local capability is desirable when change needs to be delivered locally

USE OF DATA, EVIDENCE AND ANALYSIS

> "There's nothing like really holding a mirror on the metrics. It's not performance management, but actually if you're sitting in that meeting and you look and you say, well, why is Lambeth or Lewisham doing much better on X and Y than [another area]? It's peer review and peer pressure, which works really well with clinicians [using] transparent, real, proper data, that they agree with. Being reviewed and then a bit of competition can test ability."
>
> **– PCT CEO**

Making the most of research and other evidence was a powerful tool used effectively by the NHS in London. It created an argument for change and provided the evidence base for making improvements. Lord Darzi was clear from the start that evidence should be at the heart of the *Healthcare for London* effort, providing a means of galvanising support within the NHS and beyond, and this approach continues to be relevant. Many interviewees praised the way in which *A Framework for Action* and the individual implementation programmes made use of data and information. Some commented that the stroke and trauma service changes in particular had a strong evidence base and stressed that future service changes should follow this example.

Interviewees exhorted the benefits of using evidence in the engagement process:

> **The use of local data and, more important than that, the engagement of the health care professionals seeing that data…was really very valuable.**
>
> **– Senior clinician**

The nature of clinical training, with its emphasis on interpreting evidence in clinical literature, was mentioned as being important when designing and implementing new pathways:

> **The advantage of [involving] clinicians is [that] they are data literate, and their whole training leads them to want to be reflective of the data, and reflective of their practice… Once you bring that to bear on the bigger problem it is very influential.**
>
> **– PCT CEO**

Others encouraged the use of clinical evidence when engaging with the public and politicians.

The medical director of an acute trust also urged the NHS not to shy away from using economic evidence when putting forward the case for changing services, stating that both the public and clinicians understand and accept resources are limited. This argument may have greater resonance today than when *Healthcare for London* was introduced.

Interviewees stressed that data must be used in a way the public understands and that interests them and also, perhaps influenced by contemporary debate on data transparency, commented on the need for more open discussion of the rationale for change:

> Transparency, the publishing of information, creates an environment where it is much easier to [say that some departments are unsafe]. The publication of evidence for patients [on] primary care, the publication of outcomes around cancer and all the rest of it, is the environment you need to create for the population and for politicians… Getting the evidence out there will create a better context for it to go forward.
>
> **– Senior NHS executive**

Although there was general agreement on the importance of data for engagement, context was also flagged as important. An understanding of the emotional nature of debate is necessary, as well as clarity regarding the proposed alternatives and a subtlety of communication:

> My reality in [my locality] was standing up in front of hundreds of people who were very angry about the propositions, and when one attempted to engage in logical, rational argument it missed completely what was in essence an emotional response to people's anxieties and fears about losing well regarded local infrastructure.
>
> **– PCT CEO**

The logical extension to the discussions around a need for clarity and openness with professionals and the public is that there needs to be a medium for information to be shared. There were suggestions that the NHS was, and is, too risk-averse in handling information and in its relationships with the press and politicians. Arguments about safety being withheld to avoid damaging public confidence were challenged. One comment was "*we deal in half truths and proxies*", whilst making information public in a piecemeal way could adversely the system's credibility:

> Everything is perfect until it is not perfect, in which case it is catastrophic. The public cannot believe that is a rational position, and so it builds distrust.
>
> **– Senior political advisor**

> I think the NHS senior management – the NHS management, period – is way too risk averse in terms of tackling the press and fearing the ministers. The politicians have a stranglehold on the senior management, [who] go a long way out of their way to avoid saying what they really think.
>
> **– Senior clinician**

The process of developing of *A Framework for London* highlighted the importance of presenting data in gaining commitment for change. However, as noted in chapter 2, it was a challenging task. In the years that followed, NHS London and London PCTs sought to improve the availability and comparability of data and put it in the public domain. All London-wide programmes generated new monitoring requirements to understand better the effectiveness of services (see the stroke and major trauma case studies in chapter 3). The work to develop and operationalise the *Pan London General Practice Outcome Standards and Framework* enabled, for the first time, a comparison of outcomes achieved by general practices in London and, by acting as a portal for presenting this data to the public, has taken things one step further. This is wholly aligned with the coalition government's vision of an information revolution in the planning and delivery of healthcare. Whilst this has been a significant step forward, there is much more to do.

Several issues emerged in relation to data, however, which demonstrated both the importance of accurate and accessible data and the problems associated with incomplete or unavailable information.

Data quality and availability

Good quality information provided a powerful case for change and suggested solutions to problems with London's health services. A lengthy trawl of existing evidence was carried out at the start of the *Healthcare for London* work programme by NHS London and Lord Darzi's team at Imperial, as well as an external consultancy. There was some overlap, but this was actively encouraged to confirm and quality assure the resultant data.

Workstream-specific information was collected for each of the clinical working groups. The groups assessed the robustness of the evidence and used it as the basis for recommendations on future pathway redesign. Following the publication of *A Framework for Action*, and as work began to focus on specific pathways, the clinical advisory panels for each of the implementation programmes used a similar process of data collection and assessment to generate individual and more specific cases for change.

Localised information was used to great effect. For example, Sentinel Audit data regarding stroke services showed the performance of many London hospitals did not meet expectations over an extended period of time, and fell well below international standards[60]. PCT-specific quality and outcomes framework data on diabetes showed that, overall, London scored poorly. Modelling the future cost of poor diabetic control combined with the comparative data secured buy-in from PCTs, at least initially. A member of the programme team confirmed, "*We shocked them into taking an interest*".

In the mental health pathway, borough by borough examination of dementia prevalence and use of services resulted in localised data for use by GPs and introduction of a model that has now been rolled out nationally:

> Every [emerging clinical commissioning group] and PCT in London has got a map of the numbers, the levels of severity… what's the prevalence, what's the early identification as partly identified through GP QOF registers? What, then, is the available resource in the healthcare system, in the social care system? What's the pattern of current service provision, borough by borough?
>
> **– Senior mental health advisor**

Demonstrating the extent of local data available was valuable, but begged the question of why it had not been more widely publicised or utilised before:

> One thing that staggered me was how much data existed… in my area that I had never seen, and this was being held somewhere, and somebody was looking at it. As a local person on the ground, I had no idea what was going on locally.
>
> **– Senior clinician**

On the other hand, data was sometimes not available or was highly variable in quality:

> The evidence base is not very robust. It's rather low quality, anecdotal, not academically rigorous, and that's partly because the data sources are not reliable. 50% of A&E attendances at this time were not coded at all and the other 50% were coded by largely admin and clerical staff, who'd put down a diagnosis.
>
> **– Senior clinician**

While some acute activity data is robust, particularly when linked to payment, direct comparison of, for example, patient outcomes between individual organisations was not possible as the relevant data was not collected. Primary care data was found to be fairly limited and community data was non-existent. Data on inequalities was felt to be inadequate.

Lack of detail may also present a problem:

> It was easy to get a broad brush view of how things should look but the details eluded us because there was not a great evidence base.
>
> **– Senior clinician**

For example, in psychiatric services, only one bed type is recorded by London providers, which includes all categories of bed – acute, intensive care, open and closed rehabilitation beds etc. The scope for detailed analysis of bed occupancy is therefore limited.

A lack of detailed data in primary care was suggested as a reason for the limited success of *Healthcare for London* in this area and is also the rationale behind the London-wide programme on an outcomes framework for primary care[61]. Lack of detail was also cited as an issue for workforce planning and maternity services.

A number of organisations alleged that some of the data used in the *Healthcare for London* programmes was not accurate. However, in many cases, the information was provided by the organisations themselves. The belief behind using it was that it would incentivise organisations to improve their data capture and would eventually lead to an improvement in quality. The risk, however, is that work programmes may be undermined in the short-term.

Interpretation and analysis

Where data was available, its use was often very powerful. However, it may be difficult to interpret. One example, highlighted in the case study on major trauma, saw an external consultancy estimate the likely annual numbers of major trauma patients in London. Available data was limited and the resultant estimate gave an extremely high margin for error – arguably too large to use effectively as the basis of pathway design. It was suggested that resources could have been better used by establishing a pilot scheme to report true major trauma cases over a set period and extrapolate the data to the whole city. The programme team would then have been able to work from real data and the data collection systems would have been set up and trialled for ongoing use.

A second example demonstrated the risks associated with using contested data where the analytical approach was not broadly accepted by relevant clinicians. An external consultancy carried out a review of A&E attendances to establish the proportion of patients who would be more suitably treated by GPs in either a practice or an urgent care centre. Examining the diagnostic data, they concluded that 60% of A&E attendances could potentially be treated by GPs. This formed the basis for wide-ranging recommendations. However, a senior A&E physician suggested that looking at cases retrospectively was misleading and that viewing at the same cases prospectively, with no prior knowledge of the investigations or eventual diagnosis, would provide a figure of 20-30%[o]:

> They looked at their attendances and asked, I think, a GP subsequently whether [the patient] could have been seen by a GP or not – and that's where the 60% came from. So, it was done as a retrospective, where we think if someone comes in with chest pain, for example, or headaches or whatever it is, you should be asking them at the point of the entry whether the GP would be able to manage it rather than knowing the full results, the outcome and then say, yes I could have managed it.
>
> **– Senior clinician**

o *This reflects work by the Primary Care Foundation, which found that 10-30% of patients presenting to A&E could be treated by primary care physicians. Carson D, Clay H, Stern R, 2010.* Primary Care and Emergency Departments: Report from the Primary Care Foundation

The impact of such potentially different interpretations may be profound. As there was insufficient support to the analytical approach, the change process got absorbed in the dispute about data, distracting everyone from making improvements in care.

It is debatable whether making more extensive use of staff from within the NHS might have mitigated these problems. Some interviewees held this view, questioning the use of external consultancies to analyse NHS data and suggesting that internal resources should have been used. However, the capacity and availability of skilled analysts within the NHS is limited. What is most critical is taking the time to agree the analytical approach and involve relevant clinicians and managers in the process; this can be important when people do not like the outcomes of analysis.

Future data collection and publication

Data collection, interpretation, analysis and publication should be integral to future health service planning. It was a central plank of the successes in both the development of *A Framework for Action* and the subsequent programmes of implementation. One of the reasons for programmes failing to deliver large-scale change is that the data and evidence base is either absent or of poor quality, or the programme itself moves away from having those principles at its heart and becomes caught up in the broader behavioural complexity of change.

Data and evidence provide the rationale for change and the focus of what is being attempted, as well as enabling the measurement of its effectiveness. Poor or unavailable data may cause delays or errors in the planning stages and the debate it provokes can become a distraction to improving service.

Mechanisms for collecting, analysing, storing and refreshing data and evidence should therefore be built in from the start. Some mentioned the robust information now available on patient flows stemming from the stroke and trauma changes as evidence of the importance of this. However, data collection requires ongoing resources to evaluate and update it, with real-time data collection being the most useful but most costly, which must be borne in mind during service redesign.

KEY LESSONS

- A good evidence base is essential – decisions should be based on data from the start
- Effective data can support good engagement but must be presented appropriately for different audiences
- The NHS should not shy away from sharing challenging data, such as quality and economic data – there should be transparency in the data being used
- There are risks around variability in data availability and quality, as well as the ability to effectively analyse it; the earlier this can be addressed the greater the benefit in decision making
- The benefits of investing in effective data collection and analysis from the start should be considered alongside cost

'ONCE-FOR-LONDON' OR 'LOCAL'

> "We cannot run a health service with just bottom-up, it is an absurdity… Getting creative clinical involvement is absolutely essential into the decision-making process but, with the best will in the world, how many GPs are there in London? The idea that six thousand people will all agree is nonsense; and the idea, incidentally, that the number of consultants would all agree is even further nonsense."
>
> **– Senior clinician**

The level at which service change should be designed, commissioned, developed and implemented was discussed by many interviewees and there were two distinct schools of thought. Those working in primary care, either in management or service delivery, tended to favour local, community-based development, although most accepted the rationale for a city-wide approach for certain changes such as the stroke and trauma projects. In contrast, senior managers and clinicians working in the acute sector and in cross-city roles strongly favoured development planned and led for London as a whole. However, it was widely recognised that the approaches are not mutually exclusive

Advantages of a once-for-London approach

For many interviewees, *Healthcare for London* would not have been possible without the presence of what a senior clinician called a "*unified decision-making body*" with responsibility for the whole city and a bird's eye view of the system as a whole. Many felt it was helpful to look at things managerially and to provide London-wide direction:

> [In the previous SHA arrangement] however well those regional general managers got on with each other, administrative boundaries got in the way of taking a holistic view of the capital.
>
> **– Senior NHS executive**

The presence of a single body with responsibility for healthcare across the city was considered one reason for the success of *Healthcare for London* compared to previous reviews. Several interviewees commented that London had not had a single administrative body for many years and that this provided an opportunity that did not exist before, allowing the necessary degree of planning:

> One of the criticisms of *Healthcare for London* was [that it was] too top-down… the sinister, Stalinist SHA planning everything. I think that's a stupid criticism because health systems need some degree of planning. I don't think there's any evidence of success from a totally unplanned system unless you're willing to spend twice as much of GDP on health as we do.
>
> **– Senior management consultant**

Some cited the natural coherence of London, alongside the factors that set it apart from other places, such as a denser, younger and more transient population and stark inequalities within small areas, as reasons for a specific approach potentially different to elsewhere in the country:

> You need to think about the organisation of London in the context of what needs to happen.
>
> **– Senior NHS executive**

A strategic overview ensures an even spread of services and adequate coverage across a geographical area. Limited consideration of, and coordination with, neighbouring areas during planning, risks the development of services that are too close together (for example, two similar facilities on either side of a PCT boundary) or too far apart.

The majority of interviewees agreed a London-wide approach was appropriate for the reconfiguration of acute services to ensure adequate coverage and access to services across a large area of the city:

> I think working at a whole London level was entirely appropriate. All the evidence says you have to get big [health care] systems to work together.
>
> **– PCT CEO**

Doing work once for London allows economies of scale and limits duplication of work. Where appropriate, it will always be more efficient to plan services once rather than five times (the previous PCT cluster arrangement) or 31/32 times (at PCT / borough and now CCG level). Data can be collected and analysed once, by a single group. This may be particularly important when a specific skill set, unlikely to be present throughout the system, is required.

While many people felt it had proved possible for the 31 London PCTs to work together, the inherent logistical difficulties were also stressed. For instance, PCT representatives involved in the Diabetes Commissioning Reference Group, established early to contribute to the strategic direction of this workstream, often failed to attend meetings. They did not, as a group, peer-review the model of care and only a handful were felt to be fully engaged with the project by the time of implementation. As implementation was reliant on PCTs across

London, it is perhaps understandable why much of London is still not delivering care in line with this best practice pathway. Requiring PCT staff to handle this additional work on top of their existing jobs was cited as one reason for the difficulties. It is impossible to identify any examples of real large-scale change in London from a devolved approach.

London-level direction and planning may improve the likelihood of achieving a defined outcome, such as the development of a set number of centres providing a specific service, or the delivery of a performance standard:

> I don't think [*Healthcare for London*] was too top-down. Delivering safe and sustainable services … was absolutely essential. A drive [was] the bottom line: a drive for quality and a drive for an integrated system whereby primary care links to community care, links to hospital care… secondary care links to tertiary care… [with] networks there as a central driver. That was absolutely right.
>
> **– Acute sector CEO**

A central mechanism to performance manage change may limit variation in provision and outcome (although others argue that performance management stifles innovation). A sense of ownership is necessary to plan and deliver change but, according to interviewees, this was sometimes not evident in the individual PCTs. For instance, it proved challenging to implement the new diabetes model of care and interviewees described great difficulty in engaging PCTs on the subject, despite the fact that it was already identified as a clinical priority for many of them.

Pace

Maintaining momentum was seen as a key factor in ensuring that *A Framework for Action* was not 'left on the shelf':

> For me there was something about the pace [of the changes]. Things happening at pace is depressingly unusual in the NHS, so actually, the fact that this was rolling quickly was quite energising in itself.
>
> **– Senior NHS executive**

> I thought [the pace] was ambitious, and we probably set out to do too much, but if [we] were doing it again, that's what I would do, because if you set your ambitions high and you achieve 70% of it, then you will have achieved more than if you set up some kind of realistic plan and then plod towards it. … I'm not sure people would unanimously agree with me on that, but without that pace behind it, I don't think we would have done some of the things that we did do. I think we'd still be talking about it.
>
> **– Senior NHS executive**

Pace brings its own risks, however. We were told that the links between the stroke and major trauma workstreams were not as strong as they should have been as a result of the desire to make progress speedily. One interviewee stated this had also been a problem for the different clinical working groups taking part in the initial review stage:

> We were essentially doing the bulk of the work in a three-month period. So, that did make it harder to get the linkages. But that's a trade-off you need to maintain momentum and show that you're pushing on to an end-product.
>
> **– Programme manager**

Whilst maintaining momentum within the programme was vital, it was also important in the political context. A change in government may result in a tendency to re-examine and alter work in progress. The politics of service change, as in the case of *Healthcare for London*, may threaten its implementation so ensuring implementation is not only swift but fits with the political cycle is key.

Some interviewees discussed the idea of a 'tipping point' – enacting enough change with enough pace to make the benefits so apparent that the rest of the programme is bound to continue, regardless of who is running the various parts of the system or the political make-up of government:

> If we had got past the tipping point, then it would have been seen as something that had been done, rather than something that still needed to be done.
>
> **– Senior NHS executive**

The pace of change was seen as one of the key factors behind the success of *Healthcare for London* and many interviewees cited the presence of a central focus as key to establishing and maintaining this pace.

Communications

A single communications function ensures consistency of message and availability of evidence. A central mechanism may be more economical and may have more resources to dedicate to the task. In particular, the communications function of NHS London and, later, the PCT-funded *Healthcare for London* implementation team, had the skills and contacts to engage with politicians and the media.

While smaller organisations may be in a better position to communicate with their local population, considerable resources are needed to do this effectively and assessing progress may be a challenge. Interviewees praised some PCTs for effective communication but stated that others did not have the time or staff necessary to take on this work.

Advantages of a local approach

Some interviewees, notably those from outside the NHS, were strongly in favour of London strategic development and leadership, while others argued that to succeed in the long term, a single approach needed to be tempered by significant local involvement:

> I think had there been a top-down directive to implement diabetes we would have got nowhere.
>
> **– PCT CEO**

However, examination of the evidence shows the proposed improvements in diabetes care in *Healthcare for London* have not been fully implemented and, even now, only a small number of boroughs in London have improved services. Clinical commissioning may address this issue in the future, but the local approach to implementation did not work. It is important to state that this might not be due to the scale at which the planning is taking place, as in some areas (eg. Tower Hamlets) improvements in diabetes care have occurred because of the focus of local leadership and local organisational capability. So, 'local' could be right but the approach to injecting capability might need to be different. This is something that requires significant consideration if the pace of improving local services is to be accelerated.

Sensitivity to local variation

Disease prevalence varies across London, whilst socio-economic and cultural differences also lead to differences in the way people use the NHS. A local approach allows closer tailoring of services to those that need and use them:

> It's not access to health care. It's recognition that 'I need to go and see a doctor' that is the problem. We have whole swathes of population in the East End that just shrug their shoulders and get on with it and say, 'Well, you know, a bit of belly ache. I'm sure it will get better,' and then six years later they're nearly dead. Then they come to hospital. A lot of it is [also] people not knowing how to access healthcare systems in this country.
>
> **– Acute trust medical director**

A PCT cluster chief executive agreed that London's diversity meant there should be greater openness to different solutions for different areas, whilst a senior clinician suggested that services for long-term conditions should be planned locally.

Many interviewees stressed the need for GP involvement in both London-level and local planning. GPs are likely to have a better understanding of local variation, key needs and how best to respond to them. However, it was reportedly difficult to identify and attract GPs to work centrally to develop the *Healthcare for London* vision and those who were involved reported feeling isolated:

> There were a lot of clinicians involved in [the development of *Healthcare for London*: *A Framework for Action*] – at the first meeting we had there were probably about 15 clinicians. I was the only GP, and I was often the only GP for the first few months of the project, so I definitely think there was inadequate general practice representation.
>
> **– Senior clinician**

Improved planning

The direct involvement of those who will go on to commission or provide a service may result in more pragmatically designed services. The greater flexibility allowed by planning at a local level avoids shoe-horning a local service into a centrally dictated model.

The chief executive of a foundation trust in London stated that centrally defined *Healthcare for London* pathways were sometimes too dogmatic, with a focus on process and unrealistic expectations that all services would fit neatly into a prescribed pathway. In some cases, "*the best became the enemy of the good*", with "*decent services*" put at risk as a result.

However, many local commissioners and providers adapted their existing plans to fit new guidance and were able to mobilise themselves rapidly.

Better local buy-in

Greater local buy-in may lead to improved implementation and some suggested that there was too little involvement of frontline staff in the planning of some *Healthcare for London* programmes and that this affected results. A lack of GP involvement in planning the model of care and overall engagement overall was cited as one of the main reasons for difficulty in achieving GP buy-in to the polyclinics model:

> I would have engaged people more in the development of the delivery models, as we did with the pathway groups. We should also have engaged GPs much more than we did at the time.
>
> **– Senior NHS London executive**

> I think we still haven't cracked the 'how do you do large-scale change of a more diverse dispersed nature' [question. It's] probably more heavily dependent by definition on local leadership, local resources, local commitment and local delivery mechanisms.
>
> **– PCT CEO**

Some interviewees argued that the polyclinics workstream did include local development and, whilst general principles were developed centrally for the service model, there was an opportunity to develop the model on the basis of local needs. However, it was widely agreed that the work did not deliver the outcomes anticipated. A lack of local input, and consequent lack of engagement, in many areas of London may have contributed to the limited success of the programme.

A summary of the benefits of London and local approaches to large-scale change is below:

Benefits of London approach	Benefits of local approach
Economy of scale	Flexibility and sensitivity to local needs and cultural issues; local interest groups can have their say
Allows planning once only	Avoids central imposition of a process that does not fit locally
Reduces boundary issues	Provides what is realistic with the given workforce, estate, etc
May reduce risk of variation in provision and outcome	Variation in provision may be appropriate and may produce better outcomes

Striking the balance

Strategic thinking may often result in the same answer to the same problem, whether it takes place centrally or locally. However, assigning responsibility for delivery and implementation planning to the correct part of the system is key to achieving a successful outcome. Although our interview sample was skewed towards senior and central management figures, there was still an overall sense that a balance must be struck between central and local service development and implementation:

> If you can get the best of both worlds, then you're away because you get… the combination of that good quality [strategic thinking] with the practical experience around delivering health care services on the ground.
>
> **– PCT CEO**

> We have been more collectively successful on the big-picture, small-volume stuff, like major trauma, like hyper-acute stroke; I think it is harder to take a London-wide approach to stuff that is very local.
>
> **– PCT CEO**

It was felt too much central direction risks a lack of local buy-in and possible resentment on the ground, whilst entirely local control risks a limited strategic overview:

> Whilst it's very important you get it right for the local community, I have never really seen major change happening without a strong hold from the centre. For example the teenage pregnancy strategy being held at DH level has helped to focus people's energies on the agenda.
>
> **– Senior clinician**

The stroke and major trauma processes were led once for London, supported by local bodies, whilst the polyclinics programme was delivered locally, supported by a London-wide team. Given the relative success of the stroke and trauma programmes it could easily be interpreted that central direction is better. However, it is not as straightforward as that as, leaving aside the huge variability in existing primary care provision, the very large number of providers and the various other obstacles, key issues include local capacity, capability and commitment to complex change. Where local organisations had this capability, for example, implementing the polyclinic model proved more successful.

Interviewees felt the balance between a central and local approach should vary depending on the service being addressed and that clarity about the work to be done at each level would be beneficial from the outset. For example, the polyclinic model could not be delivered once for London because the services in question needed a predominantly local focus. Similarly, the treatment of long-term conditions, which may include certain key evidence-based steps, is likely to require an approach that is more sensitive to local needs and existing services and infrastructure, as well as the inherent complexity of managing conditions for individuals with very different co-morbidities, priorities and health beliefs. The core personal relationships of the clinicians delivering these services are local. In contrast, pancreatic surgery has very clear and specific requirements, including the need for sufficient volume of cases, so services must be distributed equitably in order to ensure universally high quality outcomes, which requires a level of central planning.

Many interviewees felt that *Healthcare for London* had not always achieved the necessary balance – some felt it had been too centrally driven, whilst others argued that some programmes would have benefited from more central direction. The chief executive of a large acute trust counselled, however:

> You're bound to tread on people's toes, because this is about changing medical practice.
>
> **– Acute trust CEO**

A collaborative approach to service redesign between central and local bodies was recommended but it is clear that to improve services fully, London needs to establish how to improve local services.

Factors to consider

As discussed above, successful change programmes need both local and central approaches. It may be more helpful to think of this as a kind of Likert scale, where at different points of the process the management responsibility may tend towards either local or central:

Consideration of certain aspects of the service in question may help define where this line of focus should be drawn.

Some conditions and services require high volumes of patients to ensure acceptable outcomes. The evidence base for this is particularly strong in surgery, which requires high levels of technical ability and high quality support services. The archetype of this is abdominal aortic aneurysm surgery[62,63]. Recent research by Dr Foster has clearly shown higher mortality levels in hospitals that treat fewer than 35 patients for abdominal aortic aneurysm per year[64]. As discussed earlier in the report, the implication of this is that only a limited number of centres will be able to deliver such services to keep the numbers high enough to maintain quality. Interviewees felt that the redesign of such acute services – requiring high levels of skill and a critical mass of patients – should be carried out centrally to ensure even coverage and quality of service. Clearly, however, local engagement would also be needed to explain to staff, patients and the public why services are changing.

Another factor is that changes to treatment of a discrete condition will affect fewer care pathways. It will therefore be easier to move services without significantly impacting on other departments or the provider as a whole, so a central focus may be appropriate in such cases.

The number of patients affected by a service is also a key consideration. Many patients will be affected if a service treats either a common condition or a number of different conditions (eg. general practice). Fewer patients are affected if prevalence of the condition is low or, in some cases, if the service concerns several conditions of low prevalence, such as major trauma. Given that high quality care close to home is a clear preference for most patients, it could be argued that those conditions affecting large numbers should have a greater local engagement and planning component to ensure consideration of local needs and circumstances.

Services treating large numbers of patients will also normally involve multiple provider sites and there will almost certainly be greater variation in how existing services are delivered. The transactional costs of changing services at multiple sites are potentially significant, particularly because more staff will be involved, requiring extensive engagement resources.

London needs to replicate the impact it has had on improving some acute services and make significant improvements to out-of-hospital services. The successful mechanism for doing this in a systematic fashion is, arguably, yet to be found. Where individual PCTs have made an impact, this has not often been diffused further and so progress on some of the *Healthcare for London* recommendations has been highly variable.

It may be a point of learning for future NHS commissioners that a careful, nuanced and, possibly, varying balance between central direction and local engagement and decision-making may represent a means of ensuring levels of success in non-acute change programmes similar to those achieved in London's stroke and trauma services.

What is universally true both of the local- and the central-led programmes that have made a positive impact on outcomes is that the other five themes in this chapter have been present. For each of them it is possible to demonstrate that they were well led, had broad engagement, had sufficient resources invested in them, were managed by capable and dedicated teams, and were driven from an evidence base of what works with a clear understanding of what is happening. This could explain why some locally-led programmes – which did not have the same characteristics running through them – have failed, despite it being entirely appropriate that they were planned locally. Therefore, a key question to ask is – what is the right level to plan for change and how can a team be established capable of achieving the change?

KEY LESSONS

- London-wide programmes can benefit from an ability to plan strategically, collaborate on enablers such as communication, reduce duplication and have often benefited from a greater pace of implementation
- Local variation must be recognised and can be informed by GPs and local government
- Local planning and buy-in can support more effective implementation
- Individual programmes should consider what the most appropriate level of implementation is, with consideration for the volume of patients that might be involved, the pathways that will be affected and the leadership required

5

CONCLUSION

HEALTHCARE FOR LONDON has achieved widely recognised success in some important areas. Other parts of the implementation programme have been less effective, although many of those interviewed in the preparation of this report expressed the hope that attempts to change might prove to be the seed for future improvements across the board.

Where *Healthcare for London* was successful, the leadership of the healthcare system aligned resources and levers for change behind the delivery of the programmes. A lack of alignment in other areas proved a major barrier to success, as existing organisations and their systems and processes exerted a powerful pull towards maintaining the status quo.

We found that participants in the *Healthcare for London* process had been energised by the work, seeing it as a new and different approach to service change and, unlike previous reviews, one that would actually lead to improved service and patient care. They were, overall, highly committed to the vision and the improvements it entailed. A senior political advisor, working outside the NHS, summed things up:

> **"It was a nice surprise for me to move into a large scale planning exercise in the health sector (having previously been largely involved in local government) and to see how committed everyone was to the NHS.**
>
> **– Senior political advisor**

This commitment was evident from everyone, so perhaps the key question in London is how to harness the workforce's passion for the NHS to provide improving services in financially challenged times. The hundreds of clinical leaders who stepped up to the challenges of *Healthcare for London* are still ready and willing to take this on.

What are the challenges facing London today?

Based on our experience, and in light of ongoing reforms, we would suggest the following key challenges face the NHS in London:

- Delivering integrated services in community settings, in particular for people with chronic long-term conditions and for frail older people, so that their enforced reliance on services in acute hospital settings is dramatically reduced
- Improving the quality and accessibility of primary care for all the population but especially for deprived communities
- Implementing agreed service reconfigurations and, where necessary, supporting clinicians to propose further changes, but with far greater pace than has been possible to date
- Improving the care of people with mental ill health, including integration between mental health and physical health
- Improving overall patient experience of health services
- Adopting a more innovative approach to the delivery of healthcare, maximising the opportunities provided by the technological revolution and the potential that three academic health science centres and networks offers to London in making the most of the research and development community as part of the Strategy for UK Life Sciences
- Recognising the potential of the reforms to fragment the health and social care systems. A London-wide partnership drawing in the Mayor, AHSCs, the NHS Commissioning Board, clinical commissioning groups and local government should be forged

The first of these challenges reflects that of a population that is not only living longer but is increasingly living with one long-term condition or more. In short, we are faced with caring for an increasing number of frail older people with chronic illness and although the challenges and complexities of planning and delivering integrated health and social care services for this group have been recognised, there is little evidence so far of this translating into high quality care.

Whilst there are things that can be done at different levels of the system to address all these challenges, responsibility for the quality of care and health outcomes for patients must be rooted at local level. The actions taken at other levels of the system should be to challenge out-of-date practice and identify system-wide levers for change in a way that ultimately empowers local clinical teams to transform healthcare.

The quality and accessibility of primary care is variable across London and indeed within individual boroughs. The case for change in primary care set out in *A Framework for Action* remains as relevant today as it did when Lord Darzi's vision was published. London is a national outlier for single and double-handed practices, which poses a challenge to the delivery of an extended range of services that would ideally be offered in the community. The NHS should aim to raise standards across the board, addressing quality gaps and improving patients' experience of primary care services. Investing in a programme of transformational change, underpinned by clear implementation plans, will reap the benefits of an improvement in clinical and service quality and in a reduction in hospital usage and costs. This was a constant refrain in the 80 or so interviews undertaken in preparing this report – that addressing the variation in general practice and improving access should be a priority:

> **So, you're an 80-year old and you had a trip and you bumped your head; the only way you could be seen in a timely fashion is your local A&E department – there's no other way. GPs don't see those patients as a matter of priority.**
>
> **– Clinician**

This is linked to the issue of the NHS estate in London, which is hugely variable in both quantity by area and quality. Improving access to primary care depends on this; in the current financial climate, there may be a temptation to ignore this issue, but that will stifle change.

The reconfiguration of acute hospitals, as proposed in all previous reviews dating back to 1892 and a clear implication of *Healthcare for London*, is more relevant today than ever. Chapter 2 set out the good progress that has been made in most parts of London, in particular in consulting patients and the public on proposals for change underpinned by powerful clinical evidence. However, at the time of writing, few reconfigurations have been fully implemented and there needs to be an increased focus on implementing changes already agreed. At the same time, NHS London's assessment of the challenges facing the acute hospital sector paints a clear picture of the need for further service change to allow for the provision of emergency and maternity care 24 hours a day, seven days a week, together with a rebalance of resources to support people at home and in the community and prevent excessive financial losses in acute trusts. Better articulation of the need for change and the benefits that could arise is required, with clinicians best placed to provide this argument.

In chapter 2 we argued that the failure to integrate the work of the Mental Health Clinical Working Group properly with the vision of care pathways and delivery models set out in *A Framework for Action* was a missed opportunity. Since 2009, there has been London-wide work to develop models of care for people experiencing crisis and for people with long-term mental health conditions. However, implementation of the models of care was left to local commissioners, which means there has been mixed success in transforming care. London continues to experience high levels of mental illness and the diversity of its population means that people experience its impact and related health services in different ways. This requires attention and acknowledgement of the need for better integration between mental health and physical health services.

Patient satisfaction surveys continue to suggest that improvements in patients' experience of the NHS across a range of different services have not kept pace with improvements in care. This issue was flagged up in *A Framework for Action*, which suggests that even where quality of care has been transformed as a result of *Healthcare for London*, further work is required to understand what the public expects from a modern health service and how to transform their experiences of the NHS.

London has three Academic Health Science Networks, which means the NHS in London is uniquely positioned to benefit from the system leadership that can be provided by all three working together. London is already recognised as a major centre for health research as it is home to three of the UK's five biomedical research centres, responsible for around half the UK's biomedical research funding, and plays a huge role in the education and training of the NHS workforce by playing host to around 40% of England's postgraduate medical and dental students.

We need to ensure what is learnt within the three networks can be shared across London and this means all three elements of an Academic Health Science Network – research, clinical practice and education – coming together to improve patient outcomes and population health. We need to build on the work already started in this area, including the diffusion of innovation and best practice across all care settings and providers.

London plays a unique role in healthcare, which is important for both the population of the capital and the whole country, but the city's extremely diverse population places significant demands on the health system. However, current reforms have the potential to fragment the leadership for research, training and specialised service provision. The Mayor, through chairing the London Health Board, is in a position to champion these issues and protect against fragmentation by working closely with the Academic Health Science Networks, the regional office of the NHS Commissioning Board and clinical commissioning groups.

What can we learn from *Healthcare for London* and apply to the future?

Healthcare for London was different from previous reviews; it set out principles and care pathways and avoided jumping to organisational conclusions. Some of those involved saw it as a 'social movement' and were genuinely inspired by the programme and its aims:

> Overall my feeling is *Healthcare for London* was the boldest and most successful attempt to align an entire region behind a set of changes [ever] achieved...It succeeded in building real consensus behind the need for change and the broad outlines of the change required.

> What the report did, in the short period of time, I think certainly from a policy fit, was the best piece of work I had done. There is no question about that...

> It is not one hundred percent [implemented], I do not think it is even eighty percent, but if you change ten percent of London you have achieved huge amounts.

So, what are the lessons and what do they mean for the future?

Clearly, there are the benefits of strong leadership. The combination of clinical leadership headed by Lord Darzi and managerial leadership headed by Dame Ruth Carnall was key to the development of the vision in *A Framework for Action* and in building the momentum necessary to implement strategic change.

Any major programme of work that proposes significant service change in a way perceived to threaten local services attracts the interest of politicians. On the face of it, *Healthcare for London* was no different to other service reconfiguration proposals, which see politicians leading local campaigns opposing change, irrespective of the evidence in favour. The NHS is often paralysed by politicians' opposition to change, with a lack of 'political permission' being a significant obstacle to improvement.

The halting of *Healthcare for London* highlights this, but also shows the importance of political timing. Launching *Healthcare for London* in July 2007 was ideal timing to the extent that it was midway between two general elections, arguably the point when politicians demonstrate the courage to make the most difficult decisions or endorse the most contentious strategies, liberated from the electorate's disapproval. In terms of the NHS, there was recognition at this time that significantly increased resources for it had not resulted in a corresponding increase in productivity. Therefore, the NHS in London had the opportunity to adopt a different approach. However, it would seem that achieving London-wide change at pace requires ongoing political consensus to back up clinical evidence and high-quality leadership. There is possibly a role for the Mayor in facilitating this.

It is also important to emphasise the advantages of broad and deep clinical engagement, which in connection to *Healthcare for London* was widely praised:

> I think the scale of clinical engagement that we got through *Healthcare for London*, both through the clinical working groups but also the broader roadshows that Ara went on, were just streets ahead of anything else I had seen before or heard about before.
>
> **– Management consultant**

The importance of broader stakeholder engagement should also be acknowledged. It is common for those closely involved in illustrating the need and developing proposals for change to become intolerant of those who struggle to take up the same position. What was needed with *A Framework for Action*, even with such a compelling case for change, was a deep strategy of engagement, adopting different methods for reaching the different audiences of clinical and other staff, patients, the public, local authorities, the Mayor and national politicians.

It is important to stress the benefits of the clinical pathway approach to service redesign adopted in the development of *A Framework for Action* and the focus on quality. Measuring and publishing outcomes represented a significant shift in approach. An emphasis on the use of clinical evidence was a key element in this, with clinical working groups searching for the best national and international clinical evidence. This approach stressed the importance of identifying what was best practice care, in order to drive change from a quality standpoint rather than merely a financial one.

However, the financial standpoint was not forgotten and the economic analysis that underpins *Healthcare for London* strengthened over time. This analysis has been essential to facilitating the delivery of change, with its importance more pertinent today than ever given the challenged finances of the public sector. Having the capability to understand the financial implications of changing services and how payment innovation can facilitate this are core enablers to change.

These factors, combined with the holistic view that was taken of health services in London, were widely felt to be extremely helpful and to set *Healthcare for London* apart from previous reviews:

> **[One] thing that made a big difference in *Healthcare for London* was it told an end-to-end story, so it did not look at just one part of the system, it looked at the whole system and it did not just look at clinical pathways and/or hospitals and primary care and/or what is required but it looked at everything.**
>
> **– Management consultant**

There may be a temptation to try to implement too much too soon, especially with something as big as *Healthcare for London*. However, a feature of the review's success was the early identification of implementation priorities, tested out through the engagement strategy and agreed by commissioners, clinical leaders and NHS London. Once consultation was complete, the team dedicated to driving implementation was in place and focused on a handful of priority programmes. Importantly, consensus around the priority list had been secured, backed by the financial commitment of London's commissioners.

The common threads of success throughout the six-year period of developing the vision of change and delivering the transformation of services are that they were grounded in clinical evidence and clinical engagement. Mistakes were made and lessons have been learnt, but nothing would have been delivered without the relentless determination and leadership exhibited by Lord Darzi and, since the publication of *A Framework for Action*, by talented clinical leaders across the NHS in London.

The case for change is as relevant today as it was in 2007 and the task facing the NHS in London is to harness the leadership of clinical commissioning groups, which have unique and long-standing insights into their communities and fantastic ambitions for transforming local services.

APPENDIX 1 – QUESTIONS

(Not all questions were appropriate for all interviewees.)

Overview interviews

1 How / why did you get involved?

2a What were your initial views of the ambition and direction of the *Healthcare for London* programme?

2b How did these change as the programme developed?

3 What was the main objective of *Healthcare for London*, as far as you were concerned?

4 Were the main areas of focus determined appropriately/with sufficient research, evidence, engagement, etc.?

5 What were the main strengths of the consultation process? And the weaknesses?

5b Did you feel all relevant groups were able to contribute? [only relevant for those close to the consultation or who were involved with *Healthcare for London* when it took place]

6 What were the biggest obstacles that had to be overcome in developing a case for change/understanding and applying the clinical evidence/writing the *Healthcare for London* material/ planning for implementation/making change happen? [use as appropriate]

6b How have these been addressed?

7 What do you see as the main achievements/outcomes of *Healthcare for London*?

7b Has it had any unexpected effects?

8 Is there a gap between what could have been achieved and what has been achieved? If so, why do you think this is?

9 What were the lessons learned? What would you do differently if the opportunity arose?

10 What should GP commissioners take from *Healthcare for London*? [note: 9 and 10 may be answered together]

Questions for pathway experts

1 What was the initial process for strategy development within your specific area?

2 Would you make any changes to this, in retrospect?

3 How do you see your workstream developing in the future?

4 What were the main barriers to the programme in your area? Were these reasonable?

5 Is there a gap between what could have been achieved and what has been achieved?

6 What were the lessons learned? What would you do differently/recommended be done differently if the opportunity arose?

7 What should GP commissioners take from your experience in reconfiguring stroke / trauma / primary care / diabetes services?

HANNAH FARRAR
Director of Strategy, Commissioning and Provider Development, NHS London

Hannah joined NHS London in June 2006, a month before its establishment. As Deputy Director of Strategy and Commissioning she supported Lord Darzi in producing *Healthcare for London: A Framework for Action*. On its completion she led the set up of the implementation programme. In 2008, Hannah became an executive member of the Board of NHS London responsible for strategy, commissioning and, latterly, provider development. Working with leading clinicians, strategists and delivery partners, Hannah has provided strategic leadership to London's health community, with a particular focus on service transformation.

Between July 2012 and March 2013, she was chief strategic adviser to the Trust Special Administrator appointed to South London Healthcare NHS Trust under the Unsustainable Provider Regime.

ALASTAIR FINNEY
Deputy Director of Strategy and Provider Development, NHS London

Alastair joined NHS London in June 2007 as Head of Service Reconfiguration, having previously been Deputy Head of the National Reconfiguration Team in the Department of Health. In September 2008, he was promoted to the post of Deputy Director for Service Transformation.

During his time at NHS London, Alastair has programme managed NHS London's oversight of the implementation of *Healthcare for London*. He has led the quality assurance of PCTs' delivery of significant service reconfiguration proposals, including the development of major trauma and stroke services, the early implementer polyclinics, *A Picture of Health* in south east London, the *Barnet, Enfield and Haringey Clinical Strategy, Health for North East London* and *Shaping a Healthier Future* in north west London. Since 2012, he has led NHS London's oversight of the development of proposals for securing the clinical and financial sustainability of a number of NHS trusts unable to become Foundation Trusts as standalone organisations.

DR DAVID GRIFFITHS
General Practitioner and clinical adviser for strategic change, NHS London

David Griffiths works half his week as a GP in a 13,000 patient practice in Oxford. He has recently been leading a project promoting innovation as a way to drive primary care transformation in London. He previously worked on issues of clinical engagement and clinical leadership for Commissioning Support for London and was a member of the polyclinics programme team. David is a member of the primary care teaching faculty at the NHS Institute for Innovation and Improvement and facilitates workshops on many aspects of quality improvement and patient safety.

Passionate about inspiring the next generation of clinicians to become involved in improving the system, he is also a Programme Director for the Oxford District GP Training Scheme and in 2010 he organised what was then the first formal quality improvement training programme for GP specialty trainees. David was a member of the first cohort of 'Prepare to Lead', NHS London's leadership mentoring scheme which he credits with radically changing the course of his career within a year.

CHRISTINE KIRKPATRICK

Christine joined NHS London in 2008 and during her time there has led on a variety of projects, mainly in relation to strategy, commissioning development and service reconfiguration, including aspects of *A Picture of Health* in south east London and the Barnet, Enfield and Haringey Clinical Strategy.

Before joining NHS London, she was a Committee Specialist at the House of Commons Health Select Committee, leading on inquiries including the Influence of the Pharmaceutical Industry and NHS Deficits. Before that, she was a medical writer for a specialist communications company and an editor of scientific and medical journals. She has also spent some time in Australia, designing and carrying out research studies on healthcare access for patients living in remote and rural areas.

She works part time and has two small children.

1 Department of Health, 2005

2 House of Commons, Health Select Committee, 2008. *Public Expenditure on Health and Personal Social Services 2008*

3 House of Commons, Health Select Committee, 2006. *NHS Deficits*

4 HMSO, 1992: ISBN:0113215487

5 Department of Health, 1997

6 NHS London, 2007. *Healthcare for London: A Framework for Action*

7 NHS London, 2007. *Healthcare for London: A Framework for Action*

8 Gomes B, Higginson IJ, 2008. *Where people die (1974–2030): Past trends, future projections and implications for care*. Palliative Medicine; 22: 33–41, cited in Department of Health, 2008 *End of Life Care Strategy*

9 NHS London, 2007. *Healthcare for London: A Framework for Action*

10 London Health Observatory, 2006. *London Health Inequalities Forecast*

11 London Child Poverty Commission, 2010. *Legacy Report*

12 NHS London, 2007. *Healthcare for London: A Framework for Action*

13 NHS London, 2007. *Healthcare for London: A Framework for Action*

14 Royal College of Physicians, 2004. National Sentinel Stroke Audit

15 NHS London, 2007. *Healthcare for London: A Framework for Action*

16 NHS London, 2008. *Workforce for London*

17 Ipsos MORI, 2007. *London Residents' Attitudes to Local Health Services and Patient Choice*

18 http://secondlife.com/whatis/

19 Evening Standard, 9 March 2007

20 BBC Politics Show, 28 January 2007

21 The Guardian, 11 July 2007

22 Evening Standard, 11 July 2007

23 Evening Standard, 13 July 2007

24 NHS London, 2007. *Healthcare for London: A Framework for Action, Technical Paper*

25 NHS London, 2009. *Healthcare for London Affordability Analysis*

26 NHS London, 2012. *Acute Hospitals in London: Sustainable and Financially Effective*

27 NHS London, 2008. *Consulting the Capital*

28 Joint Overview & Scrutiny Committee (JOSC), 2008. Final report of the Committee

29 GP Online, 19 May 2010

30 The Telegraph, 21 May 2010

31 NHS London, 2007. *Healthcare for London: A Framework for Action*

32 The National Institute of Neurological Disorders and Stroke rt-PA Study Group, 1995. *Tissue Plasminogen activator for acute ischemic stroke*. New England Journal of Medicine, 333, 1581–7

33 Hill MD, Buchan AM, 2005. *Canadian Alteplase for Stroke Effectiveness Study (CASES) Investigators. Thrombolysis for acute ischemic stroke: results of the Canadian Alteplase for Stroke Effectiveness Study. Canadian Medical Association Journal*.172:1307–12.

34 Wardlaw JM, Murray V, Berge E, del Zoppo GJ, 2009. *Thrombolysis for acute ischaemic stroke*. Cochrane Database of Systematic Reviews, Issue 4

35 NHS London, 2008. *Healthcare for London*. Appendix A: Stroke Project Governance Arrangements

36 NHS London, 2009. *The Shape of things to come*

37 Ibid

38 Healthcare for London, stroke strategy. http://www.londonprogrammes.nhs.uk/wp-content/uploads/2011/03/London-Stroke-Strategy.pdf

39 WL Palmer, 2011. Unpublished analysis on weekend stroke care produced for NHS London.

40 Dr Foster Hospital Guide, 2011. *Inside Your Hospital*

41 Royal College of Surgeons of England, 1988. Report of the working party on the management of patients with major injuries

42 Royal College of Surgeons, 2000. *Better care for the severely injured*

43 Turnberg 1997

44 National Confidential Enquiry into Patient Outcome and Death, 2007. *Trauma, Who Cares?*

45 UK Trauma Audit & Research Network, 2006

46 NHS London, 2007. *Healthcare for London: A Framework for Action*

47 Ipsos MORI, 2009. *The shape of things to come. Consultation analysis conducted for Healthcare for London*

48 London Trauma Office Annual Report, April 2010 – March 2011

49 Nathens AB, Jurkovich GJ, Maier RV, Grossman DC, MacKenzie EJ, Moore M, Rivara FP, 2001. *Relationship Between Trauma Center Volume and Outcomes*, Journal of the American Medical Association; 285:1164-1171

50 Dr Foster Hospital Guide, 2011. *Inside your hospital*

51 NHS London, 2010. *Delivering Healthcare for London: An integrated strategic plan 2010-2015*

52 King's Fund, 2011. *Improving health and health care in London. Who will take the lead?*

53 O'Dowd A, 2008. BMJ 2008;336:1399.2

54 Commissioning Support for London, 2009. *Review of lessons learned from early implementer polyclinic sites*

55 Vize R, 2012. *Integrated care: a story of hard won success*, BMJ 2012;344:e3529

56 Carter K, Chalouhi E, McKenna S, Richardson B, 2011. *What it takes to make integrated care work*, Health International, Issue 11

57 Pulse Newspaper, 26 March 2008

58 The King's Fund, 2011. *Improving Health and Healthcare in London: Who will take the lead?*

59 NHS London, 2009. *The shape of things to come*

60 Royal College of Physicians, 2004. National Sentinel Stroke Audit

61 NHS London, 2011. *Pan-London General Practice Outcome Standards and Framework*

62 Holt PJ, Poloniecki JD, Gerrard D, Loftus IM, Thompson MM, 2007. *Meta-analysis and systematic review of the relationship between volume and outcome in abdominal aortic aneurysm surgery*. British Journal of Surgery, 94: 1-9

63 Birkmeyer JD, Stukel TA, Siewers AE, Goodney PP, Wennberg DE, Lucas FL, 2003. *Surgeon volume and operative mortality in the United States*. New England Journal of Medicine, 349: 2117-2127

64 Dr Foster, 2011. *Good Hospital Guide 2011*

Report produced by Raffertys

NHS
London