

# *Keeping the NHS Local*

## **A New Direction of Travel**

Summary of consultation responses



# Summary of consultation responses

## 1. Introduction

Keeping the NHS Local – A New Direction of Travel was published on 14 February 2003. It had both guidance and consultation elements. The principles and approach to service change were, and continue to be, guidance for all health services planning change. The service models and modernisation strategies described were presented for consultation, to stimulate discussion and debate. This document presents a summary of the responses to the consultation.

Responses were invited by 14 May 2003. Some comments that were received after that deadline have also been taken into account in this summary.

A total of 66 organisations or individuals responded. Respondents are listed at Annex A.

## 2. Overview

Keeping the NHS Local – A New Direction of Travel proposed a number of ideas about the future shape of health services. The principles at the heart of the document, and in particular the new emphasis on patient and public involvement in health, were universally welcomed.

The vision of services built around the needs of the patient, with hospitals working together in networks, was also welcomed, but with some concerns about how that vision could be realised. For example, extensions and changes to typical roles of healthcare staff were supported in principle by many respondents, but in practice recruiting sufficient staff remains a key challenge. Similarly, information technology is a key component of the future vision, but respondents identified that there were some risks to implementation.

## 3. Summarising the responses and addressing the points raised

The document set out a number of specific questions, which were intended as prompts. Most responses did not address these directly. We sought information about other innovative approaches, and where possible these have been included in the Evidence File that accompanies this document. Some clear themes emerge from the responses, and the summary presented as an annex to this document is organised by theme as follows:

- Comments on the service models and modernisation strategies
- Specialty-specific issues
- Information technology
- Workforce

- Patient and public involvement
- Transport and accessibility
- Further information and support, at national or local level

The comments received have been helpful in defining the additional work that needs to be done to support the concepts described. There were also two specific questions about how the guidance fits with existing policy where some further explanation may be helpful:

## Does Keeping the NHS Local apply to mental health services?

Yes. Keeping the NHS Local contains both guidance and consultation elements. The guidance on service change, including the new legal framework for patient and public involvement, applies to all specialties. We also hope that the principles and concepts behind the proposed service models for the future will encourage similar innovation in mental health services, maximising local access to high quality services into the future.

## How does Keeping the NHS Local fit with specialty-specific guidance that recommends centralisation of services?

Keeping the NHS Local is clear that, where evidence shows that concentrating a particular service leads to better outcomes for patients, then it should be centralised. This means that, for example, some complex surgical procedures might need to be concentrated in one location. But that need not necessarily apply to the associated outpatient or follow-up care. A whole system approach, using networks of care, can help to ensure that patients are able to access appropriate elements of the services locally. The Evidence File which accompanies this document includes a more detailed discussion of the configuration issues in cancer and coronary heart disease services.

## 4. Moving Forward

We summarise here how the work has developed, including the tools and best practice information we have made available.

### Evidence File and examples of innovative services in practice

We have undertaken a major piece of work to develop an overview of the evidence underpinning the models and concepts discussed in Keeping the NHS Local. It is intended as a resource for organisations interested in implementing the approaches outlined in it.

Part One of the Evidence File is primarily a literature review drawn from national and international sources and ranges from clinical trials and overview studies to case reports and expert opinion. Part Two includes examples of good practice in service design from around the UK. All are examples that reflect the principles and objectives of Keeping the NHS Local.

## Keeping the NHS Local pilots

We described innovative plans at three sites – Central Middlesex Hospital in London, Bishop Auckland General Hospital in County Durham, and West Cornwall Hospital in Penzance. These pilots are now well underway, and a three-year evaluation programme, managed by the NHS Service Delivery and Organisational Research Programme, began in April 2004.

## Hospital at Night pilots

The ‘hospital at night’ concept we set out described a model of care for the out-of-hours period whereby a single, multidisciplinary team provides the care for patients during the out-of-hours period. This concept has now attracted support from a wide range of stakeholders as being a key strategy to meet the challenge of the European Working Time Directive.

Four pilots are testing the model for adult acute services:

- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Wirral Hospital NHS Trust
- Morecambe Bay Hospitals NHS Trust
- Homerton Hospital NHS Trust

Further information, including the analysis tools needed to implement the approach, are available at: [www.modern.nhs.uk/hospitalatnight](http://www.modern.nhs.uk/hospitalatnight)

## Maternity and paediatrics

We have used the clinical audit tool developed for the hospital at night project to build a comprehensive picture of the requirements of these specialities. Details are available on the hospital at night website.

We have continued working with stakeholders to identify examples of EWTD compliant models of care and details can be found at: [www.modern.nhs.uk/workingtime](http://www.modern.nhs.uk/workingtime)

## Sharing good practice about service change

Since our original publication we have been working with a number of health systems planning change. These have been the first places to put the new approach to service in place, and have many useful lessons to pass on. We have provided summaries of their work, together with contact details, at [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/ConfiguringHospitals](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/ConfiguringHospitals)

## **5. What next?**

Keeping the NHS Local is now the core guidance to be followed by all health services planning change.

The work programme of the Configuring Hospitals Project has now come to an end. A new programme is being developed in the Modernisation Agency to support health organisations to take a whole systems approach to planning change, working with patients and the public. It will include up-to-date information on all the pilots and projects we have established up to now, and continue to develop tools and best practice information.

## **6. Conclusion**

Keeping the NHS Local unashamedly set a challenging vision of the future. It set out to give local health services and their users encouragement in developing imaginative, innovative approaches to providing the high quality, locally accessible health care that people have a right to expect. From the feedback we have received, it has, at the very least, stimulated discussion and debate at both local and national level.

Configuring Hospitals Team  
Department of Health  
July 2004

# Comments on the service models and modernisation strategies

## Key points

- **Those respondents who commented on the service models generally supported them, with some concerns on specific details. Some noted that they had been useful in stimulating local debate.**
- **The local emergency unit model and the model of emergency medicine supported by elective surgical care attracted the most comment. Specific concerns were often balanced by the same respondent being willing to engage in further discussion and development of the models.**
- **Many respondents welcomed the proposed full evaluation of the models and stressed its importance.**
- **A number of respondents noted that these models were rooted in hospital-based care, and it would be helpful to develop models with a broader, fully whole-systems perspective.**
- **The ‘hospital at night’ model was supported, with a number of respondents highlighting areas for further development, and some limitations.**
- **A number of respondents gave further examples of innovative service models.**

## Comments on the service models

Comments on the local emergency unit model (as piloted in West Cornwall) and the emergency medicine and elective surgery model (as piloted in Bishop Auckland) recognised their potential, but highlighted some areas of concern. Availability of appropriately skilled staff was a key issue. A few thought there was a risk that these models would not be able to deliver as high a quality of care as in larger hospitals. The models are all positioned as being part of a network of care, and to be successful they would rely on sophisticated IT links, and on very good transfer arrangements. There were some concerns that these issues had not been addressed sufficiently.

One respondent expressed the view that the local emergency unit could be developed into a centre providing an initial port of call for all care, treatment and support services including both physical and mental health and social care.

The planned evaluation of all the pilots was welcomed and seen as very important by all those who expressed a view on this subject. Early information from the evaluation and regular progress reports would also be helpful. The evidence underpinning some of the other redesign elements in the document was discussed by a number of respondents. Some highlighted specific areas where evidence was strong, such as proven efficacy of telemedicine links in some situations. Others noted gaps in the evidence where further work is needed. For example, one respondent noted that, at present, there is little evidence demonstrating that the quality of care in smaller hospitals is either better or worse than care in larger centres. (The Evidence File, which accompanies this document, includes a survey of the evidence underpinning the pilots and other key redesign approaches discussed.)

A number of respondents felt that the population size each model should serve should be defined.

Many respondents, including those who expressed concerns, indicated they would like to be involved in developing the models in more detail.

## Potential for further development

A number of respondents felt that the focus of the document was on hospital services, but that integration between primary and secondary care into a truly whole systems approach offered great potential to provide a wider range of high quality services for patients close to home.

One respondent saw community hospitals and other facilities like ‘ambulatory plus’ centres as resources that could be run principally by primary care practitioners – such facilities would not need residential medical cover. Services could be scaled down at night, at weekends and bank holidays so that scarce clinical resources could be relocated to acute hospitals.

Several respondents recognised that care could become more home-based with developments in telemedicine and diagnostics, a development likely to be particularly important in management of chronic disease. This would need to be supported by increased numbers of peripatetic ‘outreach’ staff, who could visit patients at home. These views were balanced by the argument that home-based care can bring additional costs and inefficiencies, with medical staff having to spend significant time travelling to make home visits.

## Hospital at night

Many professional bodies found the ‘hospital at night’ concept interesting, and made a range of comments about its possibilities and limitations.

The Faculty of A&E Medicine welcomed the recognition of the role of a generalist in provision of care, especially in assessment and management of acute unselected cases. They identified a proposed Basic Specialty Training Programme in Emergency Care which would equip doctors for a choice of careers in anaesthesia, intensive care, general medicine or A&E medicine. This would provide the basis to build the knowledge, skills and attitude of a generalist workforce able to work in the style needed for models such as ‘hospital at night’.

The Royal College of Obstetricians and Gynaecologists highlighted that, while gynaecology services could potentially be part of a ‘hospital at night’ cover arrangement as suggested in the document, the same medical staff also provide cover for obstetrics, which would need to be considered separately. The Royal College of Paediatrics and Child Health noted that neo-natal intensive care also needed to be considered separately.

The Royal College of General Practitioners thought it likely that capacity would need to be increased during the day to enable night cover to be reduced. Attention would also need to be given to the interface with primary care and ambulance services, so that when a GP makes a decision to admit a patient during the day they are transferred to the hospital at an appropriate time and do not contribute to the out-of-hours workload unless absolutely necessary.

## Other examples of innovative service models

A number of respondents described innovative service developments in line with the principles of Keeping the NHS Local. These demonstrated how many of the modernisation strategies described are already an integral part of local NHS services. Specific examples fell into three broad categories of workforce (particularly extended roles), information technology (such as telemedicine links), and systems (examples here include a jointly provided NHS and social service intermediate care service and jointly developed rapid response service designed to avoid or supplement hospital admissions).

A few respondents gave detailed descriptions of current or planned service models. Where appropriate these examples have been included in the Evidence File that accompanies this document.

# Specialty specific issues

## Key Points

- **Proposal that maternity, paediatrics and anaesthetics should be looked at in more detail was supported.**
- **Concerns were expressed that the document did not address mental health services specifically.**
- **Some specialties were seen as having potential for being more available in local settings, with appropriate quality assurance arrangements (pathology; radiology; dermatology)**
- **Comments relating to some other specialties highlighted an apparent tension between the Keeping the NHS Local approach and the need to centralise some very specialised services to assure high quality outcomes.**
- **The complexity of consultation on service change for a service covering a very large population was highlighted.**

## Maternity and Paediatrics

Maternity and paediatrics services were recognised as areas where some dedicated work is required. The Royal College of Obstetricians and Gynaecologists expressed a concern that obstetric-led units are being replaced already with midwife-led units without sufficiently detailed consideration of the consequences. The College drew attention to its recent submission to the Maternity Services Sub-Committee of the Health Select Committee, which proposed that a national strategy for provision of maternity services should be developed. The College's submission also highlighted the need for improved data about maternity services in England; the need for managed networks for maternity and neonatal care; and training programmes for obstetricians and midwives.

The Royal College of Midwives supported the need for women to be able to access care locally and that future configuration change needs to be developed in partnership with local communities and local staff. Developing new and extended roles for midwives has great potential, but these developments should be based on the needs of the patient or service user rather than the convenience of the care provider. It is important not to see the relationship between obstetricians, midwives and care assistants as a linear one, assuming tasks can be delegated down. Extending roles for midwives should only be considered where it will improve the quality of, and access to, midwifery expertise. For example, perineal suturing, examination of the newborn and undertaking the six-week postnatal examination all enable women to benefit from greater continuity of care. In contrast, routinely assisting at caesarean sections is a task that can be undertaken by an appropriately trained support worker.

The Royal College of Paediatrics and Child Health welcomed the publication but expressed a concern that discussion of the European Working Time Directive did not sufficiently acknowledge the scale of change in clinical practice and service configuration if compliance is to be achieved. The workforce and redesign principles outlined in the document had limited relevance to paediatrics, and different

approaches would be needed. Another respondent noted that it is not just children's health needs that are changing – there are increasing demands for psychological preparation as well as the clinical and technical issues; and the increasing need to consult children and young people. Another felt it was important to recognise the integration between community paediatrics and education, services for 'Looked After Children' and child and adolescent mental health services.

## Mental Health

Three respondents felt that insufficient attention had been paid to mental health services, or it was unclear as to whether the guidance applied to mental health.

## Opportunities for increasing services in local hospitals

The Royal College of Pathologists felt that Keeping the NHS Local fitted well with the pathology modernisation agenda, although substantial investment in IT would be essential to their success. It supported the availability of diagnostic pathology in all healthcare settings. Quality assurance, for example through laboratory accreditation, would continue to be essential for patient safety. Some aspects of near-patient testing also needed to be subject to the same quality control procedures as would take place in a laboratory, and the need for expert interpretation of results should not be overlooked. Telepathology does have potential, although the research evidence needs to be developed.

The Royal College of Radiologists supported greater provision of plain x-ray and ultrasound to smaller units, but this needs to be backed by appropriate training and skills to ensure accurate interpretation of the results. Imaging protocols are required to ensure that patients are not exposed to unnecessary radiation.

## Tensions between Keeping the NHS Local and the needs of some specialties

A number of respondents felt that there was a tension between the approach set out in Keeping the NHS Local, and the needs of some particular specialties. The Society of British Neurological Surgeons noted that neurological surgery addresses a number of relatively rare conditions and case numbers need to be sufficiently high for specialist skills to be maintained. The very specialist expertise required meant that the workforce redesign approaches outlined in the document – such as a single multi-disciplinary team at night – would not be appropriate.

A few respondents noted that some of the recommendations in the *Improving Outcomes* series of guidance about cancer services recommend centralisation of surgery, for example for upper gastrointestinal tract cancer, some gynaecological and other rare cancer services. Similar examples were given from a few other specialties including transplantation and cleft lip and palate services.

## Consultation for reconfiguration of specialist services

A few respondents commented on the complexity of managing a consultation process across a wide area, as is the case when reconfiguration of specialist services is being considered. One Regional Specialist Commissioning Group indicated they were considering how best to deliver effective consultation, working with Overview and Scrutiny Committees.

# Information Technology

## Key points

- **Widespread recognition of the potential of IT to enable development of more locally-based services**
- **Lack of confidence about the timescales for planned implementation of new IT systems in the NHS**
- **A number of examples were given of innovative current practice or future aspirations**

On the positive side there was acceptance that new technologies offered opportunities to empower patients, maximise convenience to them, relieve pressure to centralise services, and rethink the type of healthcare professionals needed in the same location as the patient by, for example, having telemedicine links with specialist centres.

There were a number of doubts expressed about the ability to deliver improved IT at the rate envisaged. Apart from the availability of finance and the complexity of implementation, some pointed up the need for a cultural shift, with specific training for the new generation of health professionals. A small number of respondents referred to concerns about patient confidentiality. Some respondents thought IT developments should be prioritised. Some of these suggested that health communities facing the most acute pressures should be targeted first; others that particular IT developments should come first across the whole NHS.

Telemedicine attracted a number of comments. Some respondents gave examples of where systems are already in place and working well, particularly in A&E. It was also clear that respondents felt the evidence base for using telemedicine is not uniform – while there are good examples in some specialties, in others there is no evidence. It was suggested that conditions for which it is and is not an appropriate tool should be defined.

Some practical issues were also highlighted, including the need for appropriately skilled staff to be available at the receiving end, and the need for robust contingency plans to be in place should the technology fail. A few respondents considered that electronically transmitted scans or test results are no substitute for listening to and physically examining a patient.

A number of respondents mentioned current or proposed uses for new technologies. These included the use of Picture Archiving and Communications Systems (PACS) to create effective links between peripheral and central units, and travelling technology such as Lithotripter vans and mobile operating theatres which have the potential to deliver traditionally complex secondary care near to the patient.

# Workforce

## Key points

- **New and extended roles were generally welcomed, with many examples of extended roles already in place. Staff shortages in some areas mean recruitment or development of different ways of working can be difficult. Team working is established and works well in some specialties.**
- **Training for all staff groups needs to ensure that staff are equipped with the skills and competencies they need to work in different ways.**
- **Implementation of the European Working Time Directive (EWTd) for junior doctors in 2004 represents a major challenge.**

## New and extended roles

This issue prompted the most responses. Proposals for new and extended roles for staff were seen to offer potential for many and were generally welcomed. It was made clear that developments in this area were already happening in many parts of the country. Other examples highlighted included the role of paramedics and community paramedics who are able to offer services in the home or workplace in partnership with local practitioner colleagues, neo-natal nurse practitioners, nurse consultants, GPs with special interests, and integrated care management teams. It was also pointed out that the role mentioned for medical assistants to provide administrative support in hospitals could equally apply to primary care.

One key issue raised by a number of respondents was that, while extended roles for nurses have clear potential, current recruitment difficulties in some areas mean that it is unlikely that nurses in traditional roles can be released to take on new roles. The need for consistent interpretation of extended roles was highlighted, with one respondent suggesting that national standards were needed.

Potential problems with new working practices were envisaged because of staff shortages and low morale in some areas, which made it difficult to introduce new ideas. Some suggested that both clinical and managerial leaders or champions would be needed to create the right environment for change. Some health authorities envisaged difficulties in persuading professional bodies of the need for change, and the professional bodies themselves recommended caution – changes needed careful evaluation, scope for further cross-cover was limited, and the impact on working lives had not been sufficiently considered with potential implications for the doctor/patient relationship, and well-being and job satisfaction for staff.

Team working attracted a number of comments. Some stressed that team working already exists, others felt it important in the new order, but that there was a potential conflict with the need for continuity of care. One respondent, referring specifically to surgery, suggested that there may be delays to care if the unified team does not include someone with the appropriate sub-specialty expertise. The British Association of A&E Medicine said that there were many teamworking models that can provide sustainable high quality care.

## Training implications

Many respondents saw the changing workforce as having significant implications for training – both in terms of the impact on current training programmes and the training required for new types of healthcare professionals required in the future.

Three respondents raised the needs of junior doctors in training, including how they will acquire skills in the future. Other medical training issues included the role of small units in teaching holistic medicine in the foundation years. The need for a workforce fit to operate mostly at primary and secondary levels was highlighted in contrast to traditional training of both undergraduates and specialist postgraduates, which has been dominated by tertiary care.

Some specific examples were given of approaches that could be developed. These included a ‘dual certificate’ in General Practice and emergency medicine to give a young consultant or GP the skills to practise ‘front door medicine’. The needs of an ageing population may also demand new types of specialty to be developed. For example, combining general practice, gynaecology and urology with some elderly care medicine.

One respondent noted that the proposed changes to medical training set out in Modernising Medical Careers fit very well with Keeping the NHS Local.

Training issues for other professional groups were also raised. In particular, extended roles for nurses and other staff need to be supported by training, information systems and clear lines of accountability.

## European Working Time Directive (EWTd)

A number of respondents highlighted the EWTd, which comes into force in August 2004 for doctors in training. This was seen as a major challenge, and there was a concern that the timescale meant that there was insufficient time for the types of changes to working practices outlined in the consultation document to be implemented. Furthermore, respondents felt that reconfiguration with concentration of services into larger centres could not be excluded as one response to the EWTd, something which acts against the principles of Keeping the NHS Local.

# Patient and Public Involvement

## Key Points

- **The vision of greater patient and public involvement in the development of health services was universally welcomed.**
- **The new process would require more time, skills and resources to be invested, but ultimately should result in better decision-making.**
- **Patients and the public need to understand the service delivery options and have adequate information on which to base their views.**
- **Strategic health authorities have a key role to play in providing leadership in planning service change.**

The need for greater patient and public involvement was universally welcomed, but this also presented a number of challenges. There were calls for a wide debate about change in the NHS, with patient and public education on service delivery options. Concerns that patients and the public may not be able to understand the complexity of the issues were balanced by other respondents cautioning against being patronising to patients.

One respondent highlighted that, although the services smaller hospitals may provide may be excellent, should anything untoward happen the patient will need to be transferred to a larger centre. The view was put forward that larger centres therefore provide a better overall quality of care as they are better equipped to cope with the unexpected. This was echoed by a number of other respondents, who characterised this as the need for patients and the public to understand the 'quality vs local access' argument.

The practicalities of how to develop greater public involvement attracted a number of comments. At national level one respondent suggested that a future patient working group be set up to consider what future patients and the public will want from the NHS and what technology will be able to deliver in the next ten years or more. A cultural shift, both for users and professionals – was needed. Professionals need to work more openly with patients and the public, while users need to balance their own personal health needs with more general quality concerns.

Although the greater involvement of patients and the public was widely supported, a number of respondents also highlighted that the views of local people in developing more local facilities may be very different from those of health professionals or NHS managers. More information on how those differing views could be balanced both locally and by the Independent Reconfiguration Panel was called for.

Front line staff are also part of the local population and can be key advocates for change. One respondent felt that being more explicit with the public about problems faced in order to offer clearer explanations for considering change would take great courage and require excellent leadership. Local managers will need to bear in mind the pace of working, and timing of significant events will need to be built around the way in which public functions rather than to predetermined timetables.

A number of respondents highlighted the role of the strategic health authorities (SHAs). Some respondents felt that SHAs are best placed to develop a whole system approach which crosses institutional and professional boundaries, and noted their role in guiding investments in strategic capital, IM&T and workforce. Clear and consistent leadership from SHAs could be essential to ensure that the different political, professional and institutional vested interests do not work against progress in redesigning local NHS services.

# Transport Issues

## Key points

- **More local services provides opportunities to minimise dependence on motor transport, and encourage people to access services earlier**
- **Definitions are important – "local" can mean different things to different groups of people.**
- **'Treat and transfer' arrangements highlights issues around transfer of patients between hospitals.**

Many respondents recognised the benefits of more locally accessible services, particularly in areas where the transport systems are relatively poor. It was also suggested that, when reconfiguring services, transport planning needed to be an integral part of the process. There were opportunities to take advantage of support from local authorities and others, such as the Department of Transport programme Transport Energy Best Practice.

One respondent noted that 'local' can mean different things to different people. A car owner may consider anywhere within a 10-mile radius to be local, but an elderly person reliant on local buses may feel rather differently.

The likely increased role of 'treat and transfer' type arrangements, with a local hospital able to assess and treat most patients, but needing to transfer some who require more specialised care, attracted a few comments about how these arrangements would need to be developed. For example, staff would be needed to accompany the patients, which may be a particular issue in small units with limited staffing at night and protocols would be needed for provision and monitoring of medication while travelling. The consequences of delays to transfer – for example if an appropriate specialist bed cannot be found immediately – need to be considered as well. One respondent suggested that ambulance service response times have to be quality assured and guaranteed if they are to be given added responsibility of transferring increasing numbers of critically ill patients from Trusts with no on-site surgical and anaesthetic cover.

# Further Information and Support

## Key points

- **Strong support for early feedback and evaluation of the models identified in Keeping the NHS Local, and any other models developed.**
- **Other means of sharing information and good practice would be helpful**
- **Additional information and tools would be helpful both to help local service providers, and to support the new approach to consultation and patient and public involvement.**

About a third of respondents wanted early feedback and evaluation of the models discussed in the document, and of any other models that were developed. One specific suggestion was that it would be helpful to share information on whole system models associated with chronic disease management, given growth in demand in this area.

About a third of respondents also wanted to be able to access means of sharing good practice and information. A number of helpful suggestions were made, including learning sets, and electronic means including the existing website and further developments such as a discussion board mediated by the Department of Health. A number of respondents highlighted how helpful it can be to have access to clinical experts from outside the local area who can come and talk to groups locally about the potential for change and facilitate the dialogue between the NHS, its staff and the local community about options for service change.

Suggested additional tools and information that might help service providers implementing the new approach to service change included:

- Support to build the skills and capacity needed within local health services to put this new way of working into practice;
- Further guidance and information about IT and knowledge management, including well-defined clinical protocols and well-managed patient pathways.
- Further information and examples exploring the interdependency of different specialities;
- An assessment of how the changes in service provision suggested in Keeping the NHS Local will impact on demand for care (for example, the impact on primary care of the way chronic diseases will be managed in the future).
- Tools to support the evaluation of innovative approaches at local level;

Suggested additional tools and information that would support local discussion about service change included:

- A resource pack containing ideas for how best to engage stakeholders in debates about service change. This might include sample information such as publicity material aimed at attracting a wide range of stakeholders, together with practical advice about what sorts of information can be found from other sources (for example, local councils have access to population and census

data and analysis, and tools for transport planning as well as a range of other information and skills).

- Clinical evidence supporting the models and new ways of working could be helpful in informing local debate with clinicians and help to encourage innovation;
- A user-friendly general guide explaining how health services are organised and provided, defining roles and responsibilities of the different stakeholders in discussion about service change, and including a brief overview of the drivers for change.

# Annex A

## Respondents

Airedale General Hospital  
Academy of Medical Royal Colleges  
Ashfield Primary Care Trust  
Association of Anaesthetists of Great Britain & Northern Ireland  
British Association for A&E Medicine  
British Association of Urological Surgeons  
British Dental Association  
British Medical Association  
Canterbury & Thanet Community Health Council  
City Hospitals Sunderland NHS Trust  
Community Hospitals Association  
Community Voice  
Cornwall County Council  
Dean of Faculty of Dental Surgery, Royal College of Surgeons  
Doncaster & Bassetlaw Health & Social Care Community  
Dorset & Somerset Health Community  
Dr Michael Crawford, Consultant Medical Oncologist, Airedale General Hospital  
Dr Richard Taylor MP  
Dr Sue Roberts, National Clinical Director for Diabetes  
Faculty of A&E Medicine  
Faculty of Public Health Medicine  
Forum for Associate Specialists & Staff Grades in Emergency Medicine  
Gateshead Health NHS Trust  
Grampian Association of Community Hospitals  
Hampshire & Isle of Wight SHA  
Independent Healthcare Association  
Intensive Care Society  
Joint Consultants Committee  
London Health Link (Regional Ass. of London CHCs)  
Mayors Parlour Campaign Team of Penwith & Kerrier  
NHS in South East London

Norfolk, Suffolk & Cambridgeshire SHA  
North West Neuroscience Partnership  
North Western Deanery  
Northumberland Care Trust  
Northumberland, Tyne & Wear SHA  
Orthotic Research & Locomotor Assessment Unit  
Oxfordshire Community Health Council  
Rethink  
Royal College of Anaesthetists Patient Liaison Group  
Royal College of General Practitioners  
Royal College of Midwives  
Royal College of Obstetricians & Gynaecologists  
Royal College of Paediatrics and Child Health  
Royal College of Pathologists  
Royal College of Physicians  
Royal College of Physicians, Edinburgh  
Royal College of Radiologists  
Royal College of Surgeons of England  
Royal Liverpool Children's NHS Trust (Alder Hey)  
Royal National Orthopaedic Hospital  
Rural Health Forum  
Salford NHS Trust  
Society & College of Radiographers  
Society of British Neurological Surgeons  
South Regional Specialist Commissioning Group  
South Staffordshire Healthcare NHS Trust  
South Tyneside Health Care NHS Trust  
Sunderland City Council  
Sunderland Community Health Council  
Sustrans  
The Pain Society  
Vale of Aylesbury Primary Care Trust  
West Midlands Gait Laboratory Consortium  
West Sussex County Council Health Scrutiny Committee  
West Yorkshire Primary Care Organisations  
Western Health and Social Service Board







© Crown Copyright  
Produced by the Department of Health  
00000 Op 0k Jul 04 (MWL)  
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission or charge for personal in-house use.

First published: March 2004

If you require further copies of this publication quote *00000/Keeping the NHS Local – A New Direction of Travel* and contact:

Department of Health Publications  
PO Box 777  
London SE1 6XH  
Tel: 08701 555 455  
Fax: 01623 724524  
Email [doh@prolog.uk.com](mailto:doh@prolog.uk.com)



08700 102870 – Textphone (for minicom users) for the hard of hearing  
8am-6pm Monday to Friday

*00000/Keeping the NHS Local – A New Direction of Travel* can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.