Notice of Meeting

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

FRIDAY, 22ND FEBRUARY, 2008 at 10:30 HRS - COUNCIL CHAMBER, FIRST FLOOR, LONDON BOROUGH OF TOWER HAMLETS TOWN HALL, MULBERRY PLACE,5 CLOVE CRESCENT, E14 2BG.

Issue date: 14 February 2008
Contact: Louise Peek louise.peek@bexley.gov.uk, Telephone: 020 8294 6154

Committee Membership: attached.

Public Agenda

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES (PAGES 1 - 12)

To agree the minutes of the meeting held on 18 January 2008 (attached).

4. PROJECT PLAN (PAGES 13 - 16)

To receive a revised and updated version of the Project Plan (attached).

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE (PAGES 17 - 30)

To receive written submissions (attached)

6. WITNESS SESSION 1: HEALTHCARE FOR LONDON – THE IMPLICATIONS FOR PRIMARY CARE

Dr Clare Gerada - Vice-Chair, Royal College of GPs

Dr Tony Stanton - Joint Chief Executive, London-wide Local Medical Committees

7. WITNESS SESSION 2: HEALTHCARE FOR LONDON – THE IMPLICATIONS FOR MATERNITY CARE

Louise Silverton - Deputy General Secretary, Royal College of Midwives

A sandwich lunch will be served at the end of the morning session, at around 1.00 p.m. The afternoon session is scheduled to begin at 1.45 p.m.

Afternoon Session

8. WITNESS SESSION 3: HEALTHCARE FOR LONDON – THE IMPLICATIONS FOR PAEDIATRIC CARE AND CHILD HEALTH

Dr Simon Lenton - Vice-President for Health Services, Royal College of Paediatrics and Child Health

9. WITNESS SESSION 4: HEALTHCARE FOR LONDON – THE IMPLICATIONS FOR SPECIALIST CARE, COMPLEX EMERGENCY SURGERY AND PLANNED SURGERY.

Mr David Jones - Council Member – Royal College of Surgeons

10. ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

N.B. Business for the day's proceedings has been scheduled to allow the meeting to conclude by around 3.30 pm.

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

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

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

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

Exclusion of the Press and Public

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

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

11. PARTICIPATING AUTHORITIES

London Boroughs

Barking and Dagenham - Cllr Marie West
Barnet - Cllr Richard Cornelius
Bexley - Cllr David Hurt
Brent – Cllr Chris Leaman
Bromley - Cllr Carole Hubbard
Camden - Cllr David Abrahams
City of London - Cllr Ken Ayers
Croydon - Cllr Graham Bass
Ealing - Cllr Mark Reen
Enfield - Cllr Ann-Marie Pearce
Greenwich - Cllr Janet Gillman
Hackney - Cllr Jonathan McShane
Hammersmith and Fulham - Cllr Peter Tobias
Haringey - Cllr Gideon Bull
Harrow - Cllr Vina Mithani
Havering - Cllr Ted Eden
Hillingdon - Cllr Mary O'Connor
Hounslow - Cllr Jon Hardy
Islington - Cllr Meral Ece
Kensington and Chelsea - Cllr Christopher Buckmaster
Kingston upon Thames - Cllr Don Jordan
Lambeth - Cllr Helen O'Malley
Lewisham - Cllr Alan Hall
Merton - Cllr Gilli Lewis-Lavender
Newham - Cllr Megan Harris Mitchell
Redbridge - Cllr Allan Burgess
Richmond upon Thames - Cllr Nicola Urquhart
Southwark - Cllr Martin Seaton
Sutton - Cllr Stuart Gordon-Bullock
Tower Hamlets - Cllr Marc Francis
Waltham Forest - Cllr Richard Sweden
Wandsworth - Cllr Ian Hart
Westminster - Cllr Barrie Taylor

Health Scrutiny chairmen for social services authorities covering the areas of all the non-London PCTs to whom NHS London wrote in connection with 'Healthcare for London' were contacted (August 2007) concerning participation in the proposed JOSC. As of 30/11/07 (the first meeting of the JOSC) those authorities who have indicated a preference for participation are as follows:

Out-of-London Local Authorities

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

Agenda Item 3

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 18TH JANUARY 2008

The Guildhall, City of London, EC2

PRESENT:
Cllr Marie West - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard - London Borough of Bromley
Cllr David Abrahams - London Borough of Camden
Kenneth Ayres – City of London Corporation
Cllr Bass - London Borough of Croydon
Cllr Mark Reen - London Borough of Ealing
Cllr Ted Eden – London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Meral Ece - London Borough of Islington (Vice Chairman)
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Helen O'Malley - London Borough of Lambeth
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Megan Harris Mitchell - London Borough of Newham
Cllr Ralph Scott – London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Stuart Gordon Bullock - London Borough of Sutton
Cllr Mark Francis – London Borough of Tower Hamlets
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Barrie Taylor - London Borough of Westminster (Vice Chairman)
Cllr Chris Pond - Essex County Council
Cllr Mary Angell – Surrey County Council
Cllr Chris Pitt - Surrey County Council

ALSO PRESENT:

Officers:
Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Graham Walton – LB Bromley
Shama Smith – LB Camden
Sureka Perera – City of London Corporation
Helen Kearney – City of London Corporation
Neal Hounsell – City of London Corporation
Trevor Harness – LB Croydon

Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
Ben Vinter – LB Hackney
Tracey Anderson – LB Hackney
Sue Perrin – LB Hammersmith & Fulham
Nahreen Matlib – LB Harrow
Trevor Cripps – LB Haringey
Anthony Clements – LB Havering
Guy Fiegehen – LB Hillingdon
David Coombs – LB Hillingdon
Sunita Sharma – LB Hounslow
Deepa Patel – LB Hounslow
Peter Moore – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Elaine Carter – LB Lambeth
Nike Shadiya – LB Lewisham
Barbara Jarvis – LB Merton
Greg Leahy – LB Newham
Jonathan Shaw – LB Newham
Jilly Mushington LB Redbridge
Rachael Knight – LB Southwark
Afazul Hoque – LB Tower Hamlets
Phil Williams – LB Waltham Forest
Phillipa Stone – LB Westminster
Derek Cunningham – Surrey County Council

Speakers
Steve Pennant – Chief Executive, London Connects
David Walker – Editor, Guardian 'Public' Magazine
Niall Dickson – King's Fund
John Appleby – King's Fund
Cllr Merrick Cockell – Chairman, London Councils
Mark Brangwyn – Head of Health and Social Care, London Councils
Hannah Miller – Director of Social Services, London Borough of Croydon

CHAIR'S ANNOUNCEMENTS

I wish to also draw your attention to the fact that London Councils has arranged a Healthcare for London event on 14th February to be hosted at the Tower Hotel. We are advised to contact Valerie Solomon at London Councils if we wish to attend.

Last week you will have received an email requesting for you to make me aware who you would like the JOSC to write to in order to capture their views. Request forms were available at the meeting. Following the meeting the Chairman proposes to write to all such organizations in order to make them aware of the work of the JOSC.

You will also note on page 31 (published for the first time) the previously (electronically) circulated NHS Statement regarding the timings and receipt of the JOSC report.

Please note we do not yet have central and accessible venues for our two meetings in March it was noted support was needed in securing venues and providing the support.

DATE AND VENUE FOR NEXT MEETING

22nd February. London Borough of Tower Hamlets

1. APOLOGIES FOR ABSENCE

Apologies of Absence were received from;
Cllr Janet Gillman – London Borough of Greenwich
Cllr Mick Hayes – London Borough of Greenwich
Cllr Vina Mithani - London Borough of Harrow
Cllr Alan Burgess - London Borough of Redbridge

2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard - London Borough of Bromley, declared that she is an employee of Bromley PCT

3. CHAIRMAN'S WELCOME AND INTRODUCTION

The Chairman welcomed the Committee to Guildhall.

4. MINUTES

The minutes of the meeting held on 30 November were agreed subject to the following amendment:

The meeting was adjourned at 11.30am not pm.

The minutes of the meeting held on 7 December were agreed subject to the following amendment:

Cllr Scott of Lewisham was present, not Cllr Hall.

It was noted Officer Rob Mack (L.B. Haringey) was in attendance at both meetings.

It was noted Officer Nike Shadiya (Lewisham) was in attendance at the meeting on 7th December 2007.

5. PROJECT PLAN

The Project Plan was agreed.

6. WITNESS SESSION 1

Steve Pennant, Chief Executive, London Connects

Cllr O'Connor introduced Steve Pennant, Chief Executive, London Connects. During the presentation and ensuing discussion, the following points were made:

- Network security was a sensitive issue. Would Boroughs be happy that that the NHS had access to their data? Protocols and codes of data connection should be shared but would take time.
- Stakeholder management – the people who develop the systems should understand what the professionals, who would use the system, wanted. Small scale projects were easier to manage as there was less of a gap between developers and users. When managing projects, it was important to recognise the management of risks from development to operation.
- Single emergency number – worked well in New York but there are only five boroughs and less services so this was easier to develop.
- Secure e-mail – with this system, people can be sure that the name at the bottom of the e-mail is the person sending the e-mail.
- How can Boroughs add value to NHS? One stop shops, face to face, call-centre services, access to NHS Direct etc.
- Websites – there is much greater scope for making these complementary to other websites.
- Joint and partnership working - The incentive is not there for managers to work in partnership as their performance is measured in terms of the performance of their own organisation or department.
- The NHS does have the capacity to deliver increased connections between organisations but this also depends on altering the incentives to NHS staff (i.e. to incentivise them to work in partnership).
- Some GP surgeries were still not communicating electronically with hospitals
- Selling these concepts to the NHS was an issue as was the cost and the need for the correct software to mesh in with the NHS
- Political will would be required to implement a new IT system; however this carried potentially greater risks, including impacts from possible service loss. Incremental development, based on a review of existing systems, might prove to be a better approach.

Questions

Q The Chairman asked if the NHS had the capacity to deliver increased connections between organisations.

It was responded that a great deal of work had been done and that the technical competence was available; however incentives for NHS managers needed to be changed.

Q The Councillor for Newham commented that GP surgeries in her borough were not communicating electronically with hospitals.

It was responded that this should not be the case.

Q The Councillor from Croydon asked if this was too complex a move at this time.

It was responded that there was good practice out there which should be emulated.

Q The Councillor from Hammersmith and Fulham asked whether the micro was being looked at rather that the macro and whether there was the political will to implement the same IT system within the NHS and the Boroughs. He inquired also as to whether a zero-based examination of the system was required rather than endless 'patch-up jobs' which would enable the system to weather political change.

It was responded that a lot of political will was required to get the system implemented, however he refuted the claim that it was a patch-up job. There was incremental development.

Q The Councillor from Hounslow asked if it there was widespread recognition of the need for training.

It was responded that this was not generally recognised amongst Boroughs.

Q The Councillor from Essex County Council commented that there should be some regard for those authorities outside the GLA boundary.

It was responded that London Connects' remit was confined to the Greater London local authority area.

Q The Councillor from Redbridge asked if there was a date for a connected working system to go live.

It was responded that a date could not be given at this stage, however the project would be implemented in incremental steps rather than on a specific 'go live' date

7. WITNESS SESSION 2

David Walker, Editor, Guardian "Public" Magazine

Cllr O'Connor introduced David Walker, Editor, Guardian "Public" Magazine. During the presentation and ensuing discussion, the following points were made:

- London was pioneering scrutiny and overview of health; the problem lay with the institutional coverage of health issues in the media.
- Follow-up to scrutiny process was lacking and how this linked in with political reform. This needed to be couched in terms of 'leverage'. There was a need to consider the wider politics of health policy.
- There must be accountability for health – through Councillors or direct election to PCT.

- There was a deficit in primary care between what people wanted and what GPs supplied (their contracts). How should primary care be shaped? Direct employment of GPs by entities such as councils? The BMA is a very powerful body and will refuse to discuss this but councils must counter this.
- Doctors present major issues concerning the management of sophisticated professionals – need to draw on experience of handling other similar professionals such as teachers, academics and social workers

Niall Dickson, Chief Executive, 'Kings Fund and John Appleby, Chief Economist, King's Fund

Cllr O'Connor introduced Niall Dickson, Chief Executive, 'Kings Fund and John Appleby, Chief Economist, King's Fund. During the presentation and ensuing discussion, the following points were made:

- Healthcare for London proposals - overall impression of health in London is upbeat but London needs to change. There are forces on the healthcare system such as access, quality and health inequalities which need addressing.
- Principle of Darzi – centralisation where necessary, localisation where possible.
- Darzi is not a blueprint or plan – it sets i) a direction of travel, ii) the need to be flexible and iii) take account of local circumstances and current configuration of services and how they have developed (heritage).
- Access and travel times to services
- Evidence for polyclinics less clear; there is some evidence for the need to get consultants out of hospitals
- Access and speed of diagnostics
- Must get clinicians on board otherwise the public will be convinced less likely to support reform.
- Single-handed GP surgeries will become a thing of the past
- Possibility of federating smaller practices – specialist and generalist care together but the mechanics of this have not been figured out yet.
- Ease of access to GPs depends on where the practice locates which leads to a disparity in the basic model of provision
- NHS is starting to measure quality of health care
- Achievements of Darzi – NHS must conduct evaluation; much will change over next 10-20 years including medicine and public expectations
- Direct employment of GPs not a sound idea. However it should be easier for people to change GPs.
- Recognition that there are inequalities in social care with intense care going to a small number of people, and people just above the benefits level suffering the most
- Need to look at international healthcare systems for examples of best practice, polyclinics etc.
- NHS is now underspending – not necessarily a good thing

Questions

Q The Councillor from Bromley commented that her experience of single-handed GPs was very good.

It was responded that whilst single-handed GPs did provide a good service, it was more a question of access. Federating small practices was an option but there was no clear model of how this could be taken forward.

Q The Councillor for Newham referred to funding gaps and the deprivation found in her borough which lead to stark health inequalities.

It was responded that there would be a revision to the funding formula in the next few years but it was not known how this would impact on individual areas.

Q The Councillor for Lewisham commented that there was no mention of the 'Picture of Health'.

It was responded that the King's Fund was not undertaking work on the 'Picture of Health'.

Q The Councillor from Westminster referred to the need to address 'access' issues.

It was responded that a variety of models of access to GPs is likely to prove best-suited to local needs. Greater competition would allow people greater freedom to move from one GP to another.

Q The Councillor from Kensington and Chelsea referred to the issues raised by the NHS being a free universal service, but social care being means-tested, providing specialised care to smaller numbers of people.

It was responded that the Government appeared to have accepted arguments put forward (in 2006) for greater funding for local authority social care. It had committed to a Green paper which would explore issues, and the movement seemed to be towards the possibility of the two funding systems being made more compatible.

Q The Councillor for Ealing asked about ways in which local authorities could capture local politics and take the lead in areas such as social care etc.

It was responded that local authorities needed to fight for forms of accountability.

Q The Councillor for Waltham Forest asked how older people's care could be delivered at the same time as the Darzi recommendations, particularly as councils were trying to reduce the costs of residential care and home care.

It was responded that the King's Fund were still looking at these issues within the Darzi framework.

Q The Councillor for Hounslow queried whether Darzi's framework, which was written from a clinician's viewpoint, had been 'hijacked' by bureaucrats to justify what they needed to do to balance the books and without any regard for healthcare.

It was responded that whilst Lord Darzi was a surgeon, he was now also a politician. There were tensions within the clinical community about the right answers. In defence of 'bureaucrats', they faced severe financial pressure as managers.-

Q The Councillor for Hammersmith and Fulham commented that not enough attention was being paid to what was happening abroad and what could be learned from the experience in other countries.

It was responded that overseas examples of polyclinics such as those found in Germany and the US had been identified and looked at.

Q The Councillor for Camden commented that that there was a lack of evidence on the efficacy of polyclinics which was a cause for concern given that a central plank of Darzi's report was polyclinics.

It was responded that it was a mistake to think Healthcare for London is simply about polyclinics.

Q The Councillor for Lambeth asked what implications there were for mental health from the Darzi report.

It was responded that mental health represented 12% of the NHS budget which was a large proportion and serious consideration was required as to how this could be represented in the Darzi discourse.

Q The Councillor for Havering drew attention to the need for adequate numbers to provide increased care in the home.

It was responded that the likely diminishing pool of carers in the future represented an issue for serious consideration.

8. WITNESS SESSION 3
Councillor Merrick Cockell, Chairman, London Councils and Mark Brangwyn, Head of Health and Social Care, London Councils
Councillor O'Connor introduced Councillor Merrick Cockell and Mark Brangwyn.

Councillor Cockell made the following points in his presentation:

- NHS is essential for London, although it currently does not offer equity of service
- Education is key, with an emphasis on prevention rather than cure. Healthy lifestyles need to be taught, especially in terms of diet, sporting activity, smoking and alcohol.

- Service needs to be local; if 'polyclinics' were to be established, they would need to cater to local need. Further, transport links would need to be considered.
- Choice should be a strong part of new policy, as should treatment at home.
- Funding of social services need to be reassessed, especially those concerning Mental health, that do not benefit from the funding floor.
- In moving forward, all changes need to be monitored in order to assess their effectiveness, and certain issues, such as social care funding, need to be brought to the top of the agenda.

Hannah Miller, Director of Social Services, London Borough of Croydon
Councillor O'Connor introduced Hannah Miller.

Hannah Miller covered the following issues as part of her presentation;

- There was much to admire in the Darzi report, not least the emphasis on prevention
- However, there were major flaws, including the lack of modelling of the impact of the proposals on social care
- The lack of consultation with social services departments, social service professionals and experts in the field was disappointing, and potentially harmful for the health care system
- Health care cannot be separated from social care; they form part of the same package and involve the same issues.
- Care can be provided at home; Croydon's 'virtual ward' would be an example, as would 'tele-care': these could be cost effective options for providing immediate care without the need to visit a clinic.
- Aspects of the 'polyclinic' idea are useful, such as the co-location of services, which would certainly save funds, but whilst the service would be attractive to service providers it would not necessarily be attractive to service users, many of whom expect a local and personal service.
- All issues surrounding health care of the elderly need to be reviewed
- More clarity is required over funding; at present the proposals are unclear over this, and the potential is for Local Authorities to foot the bill. Detailed costing needs to be provided, including details of who would pay for each stage of care and recovery
- The lack of detailed evidence could mean there is potential for hidden costs and generating overspend without realising.
- Darzi presents certain opportunities, such as the possibility of Local Authorities to work more closely with the NHS, or with local businesses, to promote healthy lifestyles.

During the discussion that followed these two presentations, the following questions were asked and responded to:

Q. The Chairman asked if there had been discussion with Local Councils or social services regarding the costs of discharges.

Those present were advised that from her experience at a local level (Croydon) discussions had taken place dealing with discharges from hospitals; working groups had been set up. On a national or London level it is understood that working groups established to review models of care had been created, though none involving social care. Local Councils should be in a strong position to push for such involvement and discussion.

Q. The Councillor for Barnet asked whether the speakers felt that the scrutiny of the committee would be listened to.

It was responded that the proposal of 'polyclinics' was a good example of government listening to suggestions of Local Authorities. The key would be to stress the importance of identifying the needs of local communities.

Q. The Councillor for Ealing asked whether the current size of PCT's would be enough to cope with the potential changes, what role they would have and what challenges would be presented for them by Darzi.

It was responded that the changes would need bigger PCTs, possibly with sub groups. There would be potential from problems to arise with such a set up, as currently relationships between local authorities and PCTs are strong and there was a risk of losing this. The fact that Darzi was now working for the government could possibly indicate that his report and the implications of it would be considered seriously.

Q. The Councillor for Islington expressed surprise that the government may reform PCTs, and expressed the opinion that Local Authorities would have an opportunity to influence any such changes

It was responded that circumstances were changing, and that there was a hope that the NHS could work London-wide in the same effective way as Local Authorities. An important, logical step would be the involvement of PCTs with social services.

Q. The Councillor from Newham expressed the opinion that as all Boroughs are different, local knowledge would need to be kept. As well as this, if social care and discharges were to change, proper support would be needed for vulnerable adults.

It was responded that early discharges would be monitored. There was currently a good record for this, and it would need to be maintained. The principles of correct management would need to be adhered to in order to ensure that the implications of the Darzi report need not be harmful.

Q. The Councillor from Hounslow expressed concern over the potential for cost shunting, especially if budgets were pooled.

It was agreed that this could cause potential problems. However, there is also scope for improving current situations, and as such this should be something that is addressed in the response of the committee.

Q. The Councillor for Camden asked what could be done to address the problems of Darzi, such as the lack of an holistic approach, the lack of inclusion of social care, and the lack of financial modelling.

It was responded that the report was purely a clinician's report, and that the response from this committee would be the opportunity to give evidence from Local Authorities about such issues.

Q. The Councillor from Bromley stated that there would be an impact on nurses as well as social care if people were to be leaving hospitals sooner, and sicker.

It was responded that stronger hospital care systems would be needed to deal with this.

Q. The Councillor from Waltham Forest asked whether teams of care workers should be increased, and funds for these be ring-fenced.

It was responded that without predictive modelling, the impact of measures and therefore the actions needed to reduce problems cannot be properly known. Complete recommendations would therefore be difficult to make. It was said that good management would be crucial in arranging joined-up services.

Q. A question was asked regarding whether the views of the London Councils would be reported to this committee.

In response the Leader of London Councils said that the deadlines of the consultations would not allow this, but he hoped that the two responses would be similar, and recommended that officers and Councillors work towards this.

Q. The Councillor for Hammersmith and Fulham commented that reductions in illness should be a focus, rather than just prevention.

It was responded that prevention was a good way of creating reduction in illnesses.

Q. The Councillor for Harrow emphasised the need for localism, as Darzi assumes a 'one size fits all' model.

It was responded that Boroughs would need to be worked with to develop local targets and strategic partnerships. Boroughs potentially could have a large impact on NHS London. The local knowledge of Local Authorities would be extremely useful given that the NHS had little success of responding to local needs.

Q. The Councillor for Surrey asked if it would be possible to look at the 'polyclinic' in Tower Hamlets as a site visit.

It was responded that this was a possibility and would be looked into.

Q. The Councillor for Kensington and Chelsea commented that the Darzi report had grown from merely being a medical report, and asked how it could be implemented with current structure.

It was responded that funding would need to be better and an agreed part of the strategy. The future of PCTs would need to be addressed, although there was hesitation over reform of PCTs whilst the impact of Darzi was still unknown.

Councillor O'Connor thanked Councillor Merrick Cockell, Mark Brangwyn and Hannah Miller for their contributions.

9. ANY OTHER BUSINESS

There was no other business

Revised Draft Project Plan

Activity	Intended Outcome	Timescale 1
Meeting 1 <u>10 - 12.30pm</u> To agree Chairman/terms of reference/rules of procedure/project plan. <u>1.30 – 3.30pm</u> Presentations from: Ruth Carnall, Chief Executive, NHS London Richard Sumray, Joint Committee of London PCTs	To agree 'house-keeping' issues and way forward for JOSC. To receive further clarification on the context of the Healthcare for London Review, broadly how it is intended the proposals would be financed, how the consultation documents were developed, next steps, and plans for consultation and engagement with stakeholders.	30 Nov 2007
Meeting 2 <u>10-12.30pm</u> Presentation from representative[s] of Darzi Review Team <u>1.30-4pm</u> Dr. Fiona Campbell to present the findings of report to London Councils for London Boroughs Health Overview and Scrutiny Committees and to critique morning presentations.	To receive information on the background to and rationale behind the *Healthcare for London* review and how and why the models of care and delivery proposed in the report were developed To offer an independent view of the Healthcare for London report and to advise on way forward for the JOSC.	7 Dec 2007

Meeting 3 – Local Authorities, social care and reality checking 10:30 -1.00pm Interviewing of 2 panels of witnesses in connection with JOSC identified key themes 1.45 – 4:30pm Interviewing of 2 panels of witnesses in connection with JOSC identified key themes	*Covering, context, partnerships, infrastructure, economics* Evidence gathering and testing of proposals set out in *Healthcare for London* report. Evidence gathering and testing of proposals set out in *Healthcare for London* report.	**18 January 2008** *Location* **Corporation of London**
Meeting 4 – Clinicians 10:30 -1.00pm Interviewing of 2 panels of witnesses in connection with JOSC identified key themes 1.45 – 4:00pm Interviewing of 2 panels of witnesses in connection with JOSC identified key themes	*Covering, Primary, Secondary and Specialist Care, Maternity and Mental health* Evidence gathering and testing of proposals set out in *Healthcare for London* report. Evidence gathering and testing of proposals set out in *Healthcare for London* report	**22 Feb 2008** *Location* **Tower Hamlets**

Meeting 5 – Access and Public Health <u>10:30 -1.00pm</u> Interviewing of 2 panels of witnesses in connection with JOSC identified key themes <u>1.45 – 4:00pm</u> Interviewing of 2 panels of witnesses in connection with JOSC identified key themes	*Covering; Access, Accessibility, Equalities, Social Care, public health and participation* Evidence gathering and testing of proposals set out in *Healthcare for London* report. Evidence gathering and testing of proposals set out in *Healthcare for London* report.	**14 March 2008** *Location* **Ealing**
Meeting 6 – <u>10:30 -1.00pm</u> Consideration of Equalities Impact Assessment and any early feedback on consultation outcomes (if available) <u>1.45 – 4:00pm</u> Agreement of conclusions and recommendations (paper to be circulated in advance based on previous evidence gathering).	*Covering; consultation activities, independent review and conclusions* Evidence gathering and testing of proposals set out in *Healthcare for London* report. Allow for preparation of final report	**28th March 2008** *Location* **Merton**
Drafting of report		28th March – 16 April 2008

Draft final report to JOSC Members with agenda		17th April 2008
Final Meeting JOSC approves final report	*Covering; findings, recommendations and report approval*	**25 April 2008** *Location* **Royal Borough of Kensington and Chelsea**
Any final amendments made plus final endorsement by Chair and Vice Chairs		29th April to 1st May 2008
Deadline for Response		2 May 2008

Mind's response to Lord Darzi's review of the NHS

January 2008

Mind's vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.

The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change.

Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.

We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.

We do all this to make it possible for people who experience mental distress to livefull lives, and play their full part in society.

Being informed, diversity, partnership, integrity and determination are the values underpinning Mind's work.

Mind welcomes the opportunity to submit policy ideas to the Darzi review. We are delighted that mental health is one of the priority areas. Although our response covers the mental health priority area specifically, we are also responding to a number of other priority areas that impact on mental health: acute care, maternity services, planned care and staying healthy. Mental health is not a purely medical issue and when looking at how health services should be provided and funded, Mind advocates a much more holistic approach to mental health. The pathway to effective support for people with mental health problems will need to include health, social care and third sector support.

Mental Health

Primary Care

Many people who use mental health services find it difficult to access support when they need it. Approximately nine out of ten adults with mental health problems receive all their support in primary care and around 30% of GP consultations concern mental distress.(1) However people's experiences of primary care services are often poor; there is very little training in mental health for primary care workers; a lack of access to psychological services; and mental health diagnosis and treatment is often led by an overly 'medicalised' approach.

There is an urgent need to improve the response of primary care to people who are experiencing early signs of a mental health problem. Clinicians need the support of a range of treatment options which offer a personalised service.

Diagnosis and treatment

Many of the measurement scales currently used to assess people's mood or mental state before and after treatment are neither developed by service users nor completed by the person concerned. The clinician's assessment and their proposals for treatment may not reflect in any way what matters to the person experiencing mental distress.

As part of a major consultation, Mind has been collecting views of what mental well-being actually means for service users, in order to develop a service user designed distress scale. Through a consultation and an on-line questionnaire, we have asked service users about what mental distress means for them. We hope that the service user designed distress scale will be used by clinicians and researchers to assess whether treatment is actually delivering the things that matter most to service users.

To achieve NHS mental health care which is patient centred, assessment, diagnosis and treatment needs to take more account of patient needs. This is particularly true in mental health where individual responses to particular treatments vary.

Training for professionals

People with mental distress often experience levels of ignorance and discrimination by health professionals in primary care services. A report by Shift (2007) found that positive attitudes towards people with mental distress has actually decreased since their survey started in 1994. Many studies have found that 'catching young people' when training to be medical students results in positive and optimistic attitudes towards mental health.(2)

[1] See ODPM (2004) Mental Health and Social Exclusion 2004:35
[2] See Thornicraft, G (2006) Actions speak louder… Tackling discrimination against people with mental illness. Mental Health Foundation

Given the numbers of people approaching their GP with a mental health complaint, it is essential that medical training incorporates mental health awareness training from a more social model approach. Primary care services should also ensure that they are meeting their obligations under the Disability Discrimination Act. Disability access is about much more than 'ramps and lifts'. For example, for people who experience mental distress, 'a reasonable adjustment' might mean letting an anxious person wait outside a GP's waiting room, or the front-line staff being more flexible about appointment times such as allowing people to book in advance to see the doctor of their choice.

Understanding of mental health by health professionals needs to be a major priority for the next generation of NHS staff. The outcome of this investment should be a fairer NHS which recognises mental health as an essential component to the wellbeing of every patient.

Health inequalities in primary care

People with mental health problems have higher rates of physical ill-health and premature death from non-mental health related problems, in comparison with the general population. In 2006 the DRC's formal investigation into health inequalities found that people with mental health problems (and learning difficulties) are more likely to have significant health problems such as heart disease, high blood pressure, respiratory disease, diabetes and stroke(3). The DRC found that people with mental health problems experience 'diagnostic overshadowing', that is reports of physical ill health being viewed as part of the mental health problem and not being investigated properly.

Access to Psychological Therapies

Access to psychological therapies has historically been very poor on the NHS with people waiting months (or in some cases years) for an assessment or treatment. There is currently very little choice of therapy or therapist. This choice can be important for people experiencing mental distress because talking therapies work in different ways. For example some people may wish to discuss their difficulties with a counsellor who plays a supportive role and may offer practical advice, others might want to use cognitive behavioural therapy to identify negative emotions and thoughts, in order to develop coping skills. Likewise, for some people, seeing a therapist with whom they identify, perhaps because of their sexuality or culture, may be important to building up the therapeutic alliance.

The official guidelines from the National Institute for Clinical Excellence (NICE) states that psychological treatments should be available to all people with depression, anxiety and schizophrenia, unless the problem is very mild or recent. Despite this, in March 2006, a national survey found that 93% of GPs said they

[3] DRC (2006) Closing the Gap: formal investigation into health inequalities DRC

had been forced to prescribe anti-depressants instead of talking therapies due to a lack of availability of therapy. The research commissioned by 'Pulse' magazine found patchy provision of services across the country. Cognitive behavioural therapy, the therapy with the strongest evidence base, was not offered at all by a fifth of primary care organisations. Where it was, average waiting times were five months.(4)

Mind, in collaboration with four other mental health organisations, have campaigned for improved access to psychological therapies on the NHS.5 On the 10th of October last year, the Department of Health announced £170 million for their improved access to psychological therapies programme and PSA targets for delivering therapy. We are delighted with this announcement but would like this to be accompanied with a waiting time measure for psychological therapy. Whilst other parts of the health service are led by targets and waiting time measures, there is an absence of these in mental health and arguably this is one of the reasons why provision has been so poor.

The next phase of the NHS needs to deliver on this significant commitment to extend access to psychological therapies, and ensure that beyond 2010/11 there is a clear plan to extend this access to 100% of the population. For clinicians, prescribing psychological therapies should become as straightforward as prescribing anti-depressants.

Access to Ecotherapy

Last year, Mind commissioned the University of Essex to undertake two new studies investigating the benefits of ecotherapy for mental distress.(6) Ecotherapy is a natural, inexpensive (or maybe cost-effective?) and accessible treatment that boosts our mental wellbeing. Whether it's a horticultural development programme supervised by a therapist or a simple walk in the park, being outdoors and being active is proven to benefit our mental health.

Mind is calling for ecotherapy to be recognised as a clinically valid treatment for mental distress and for GPs to consider referral for green exercise as a treatment option for every patient experiencing mental distress. Access to green space should be considered as a key issue in all care planning and care assessments across health and social care.

Mind's wants to see a broadening of the range of treatment options and more research on non-drug based treatments for mental health.

Acute Care

---

[4] Pulse News (March 2nd 2006) Depression Investigation
[5] We Need to Talk (2006) Mental Health Foundation, Mind, Rethink, Sainsbury Centre for Mental Health and YoungMinds
[6] Mind (2007) Ecotherapy

Crises Care

Mind welcomes the great deal of emphasis that has been placed on the development of community based services. In particular, assertive outreach and crisis resolution/home treatment teams have been responsive to service users' needs and has led to greater social inclusion.

Crisis Resolution Home Treatment (CRHT) teams help people through short-term mental health crises by providing intensive treatment and support, ideally in people's own homes. Crisis resolution home treatment teams are having a positive impact on local acute mental health services, providing an alternative to hospital admission. However, a report by the National Audit Office (2007) has found that services are being limited by a lack of input from specialist health and social care professionals and variations in staffing levels across the country. Department guidelines specify that teams should be multi-disciplinary with input from a variety of health and social care professionals.7

Access to crises care is also a problem. The Healthcare Commission has found that 77% of local implementation teams provides people in their area with specialist mental health services at all times. However when HCC asked service users whether they had a phone number or contact out of hours, only 49% said that they did. So even if the service is available, many people can not use it.(8)

Mind welcomes more emphasis on crises care in the community but it needs to be available at all times, to all those who need them.

With more emphasis on crises care in the community, a major debate about the purpose and focus of inpatient care is now needed.

In-patient Conditions

Mind survey of current and recent inpatients[9] found a mixed picture of in-patient conditions. For some it offered space to recover and get well but for many, poor accommodation and security, safety concerns, insufficient staffing levels and intense boredom exacerbated existing mental health conditions and even created new ones.

A staggering 51 per cent of respondents reported being verbally or physically threatened with 20 per cent reporting physical assault. Just one in five (20 per cent) of respondents felt that they were treated with respect and dignity by staff

[7] NAO (2007) Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services
[8] Healthcare Commission (2007) No Choice, No Voice.
[9] Mind (2004) Wardwatch: Mind's campaign to improve hospital conditions for mental health patients

These findings have been supported by other reports[10].

However we still do not know the full extent of the problems in in-patient units as reporting mechanisms vary so much and the information given to the NPSA is voluntary. A further report by Mind[11] has found that incidents in hospitals are often not identified as crimes and victims do not expect justice to be done. A more robust system of identifying, reporting and monitoring is needed.

The Healthcare Commission (2007) have also found the true state of mixed-sex wards: a disturbing 68 per cent of mental health patients were accommodated on these wards this year[12], despite the Government insisting that 99% of trusts are

[10] For example, the National Patient Safety Agency revealed an alarming number of incidences of violence and self harm in mental health services

[11] Mind (2007) Another Assault: Mind's campaign for equal access to justice for people with mental health problems

[12] Healthcare Commission (2007) Count Me In: Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales

now single sex. The census of in-patients also found no improvement in racial discrimination in the NHS, with black men 79 per cent more likely than average to be secluded (locked away in a room by themselves).

The Government must meet its commitment to single sex wards

Hospitals should be a place of recovery. Action must be taken to reduce levels of violence and abuse.

Maternity Services

Mental distress during or shortly after pregnancy is not unusual- in fact it affects 1 in 6 women. Despite this prevalence, the issue hasn't commanded the attention it deserves - evident in the drastic shortfall in services and support for new mothers experiencing mental distress. Mind's report in 2006 showed that mental health care during this period is falling short of expected standards in a number of ways- lack of provision, a failure to identify risks, inadequate treatment of severe mental health problems and a lack of co-ordination between services.

Over two thirds of our respondents had to wait a month or more for treatment, and worryingly, over 1 in 10 had to wait over a year. ¾ of the women had medication and just over 1/3 were offered counselling. This is worrying, given the potential risks of taking medication during pregnancy and whilst breastfeeding. Of those who were admitted, 63% were placed on a general psychiatric ward, usually without their baby. Mental health services are generally not organised around the needs of mothers and their children and some trusts are still admitting mothers and babies into non-specialist wards, contrary to national recommendations[13].

Effective management of women with maternal mental health problems depends on good co-ordination between the different services and specialists. The Confidential Enquiry into Maternal and Child Health (2004) found that professionals can fail to communicate important information and that GPs and psychiatrists often fail to provide information to maternity services about previous mental health problems[14].

Women who responded to the Mind survey felt strongly about the need for health professionals to have a good working knowledge of the nature of maternal mental health problems. Health professionals (including midwives, health visitors and general practitioners) should be aware of the importance of mental wellbeing in pregnancy and the postnatal period. Mind would like to see mental health and

---

[13] Mind (2006) Out of the Blue

[14] The Confidential Enquiry into Maternal and Child Health (2004) Why mothers die- Deaths from psychiatric causes. London RCOG Press.

social care services being more responsive and flexible to the needs of mothers and children. This might involve providing childcare so women can attend appointments on their own or providing opportunities for women to meet other mothers.

Planned Care

For those who experience mental distress, planned care is important as many different people might be involved in the care package. This is usually carried out through the Care Programme Approach (or CPA). There has been much research documenting the problems with the CPA, dating back to when it was first used in 1991. These concerns have included: 1. Problems with the delivery of the care plan (for example, professionals not consulting each other, services not being able to address needs and care plans not being reviewed adequately); 2. Issues with the role of the care co-ordinator (staff training issues, high volumes of cases, resources issues); and 3. Service users not being sufficiently involved and supported (review meetings taking place without service users being there, not being listened to and service users not knowing who their care co-ordinator is).[15]

Problems with implementing the CPA were highlighted by many of our service users and local Mind associations in our own consultation last year. Local Mind associations highlighted operational problems such as the care co-ordinator's large case loads, current budget difficulties and a breakdown in partnership working in some areas.

However the CPA 'tool' itself is not the problem, rather it is the contextual problems within which the CPA operates- such as lack of resources and services. Mind believes that mental health service users, regardless of the severity of their mental distress, are entitled to have their needs identified and met through co-ordinated support and that service uses should be supported to identify their needs and wishes. We are concerned about the current proposals to only offer CPA to those with the most severe mental health problems as the CPA is often used to decide whether people are eligible for services in some areas, this might result in a disturbing pattern of higher thresholds for access.

Mind's expects co-ordinated support and planning for all those who experience mental distress.

Mind supports the independent living agenda, which is about enabling people to live independent lives with the support and services they need. This incorporates individual budgets and direct payments (IB/DP) to the extent that IB/DP allow people to take control of their needs and buy services that suit their lifestyle. Yet

[15] See North and Richie, 1993, Newton et al, 1996 and Wolfe, 1997 in Warner, L (2005) Review of the literature on the Care Programme Approach Sainsbury Centre for Mental Health

Mind is keen to emphasise that IB/DP are not the most important mechanism for promoting independent living in mental health. Independent living should be about supporting recovery, having equal access to and a right to quality health and/or social care services when you need them, promoting advocacy, and eradicating discrimination.

The Government has made a commitment to reform social care with the injection of £520million including a commitment to create "first stop shops", to allow easy access to social care, with advocacy, advice and info all provided in the same place locally (and accessible through online and phone services too). Mind supports the need for "first stop shops" and believes that it is essential that where people with mental distress are given greater control of their care through personal budgets and choice initiatives, strong and accessible support networks must be available to promote empowerment and manage risks to the service user.

Mind believes that the initial gateway to services should be co-ordinated and streamlined across health and social care, so that people with mental distress do not have to undergo different assessments for health services and social care services.

Streamlining across health and social care might provide the opportunity for preventive health and care services to be provided to people experiencing mental distress, to reduce the burden on acute-end health services. Through personal budgets for preventive care, service users could better manage their own wellbeing, through psychological therapies, exercise prescriptions or ecotherapy, day services and a range of other interventions.

Mental health is not just about 'health,' it is a rights and equalities issue.

People with direct experience must have a central role in their treatment and support.

The health service must recognise the role and importance of non-health based services.

Staying Healthy

Mental Health Promotion

The National Service Framework for Mental Health (1999) went some way to acknowledge the importance of providing appropriate mental health promotion. However, mental health promotion often falls off the agenda when more pressing calls on funding are made. Despite its inclusion in the NSF, mental health promotion is not currently part of quality incentive schemes in primary care. In addition community-based approaches to mental health promotion often fall

outside what is traditionally understood as “health” – for example, housing and employment and social exclusion. A social, rather than medical model of health promotion needs to be used in planning and funding decisions.

In recognising the importance of mental health promotion, Mind is one of the organisations (with Mental Health Media, Rethink, the Institute of Psychiatry, King's College London) leading the ‘Moving People’ programme of national and local activity. Modelled on similar programmes that have worked elsewhere in the world, ‘Moving People’ aims to create a measurable shift in public attitudes, and a genuine reduction in discrimination. It’s based on two years of consultation with people who experience mental health problems and will include a national campaign and community activity, to reduce stigma and discrimination.

Non-health based services

A method which focuses only on health services will not be sufficient or effective in achieving good mental health for the whole population. People’s mental health is affected and can be improved as much, if not more, by social factors such as housing, employment and social engagement as by medical interventions. A joined-up approach needs to be taken to address the breadth of factors which affect the mental health of the population.

The needs of diverse groups

Mental health services must be responsive to the needs of diverse groups. It is often the people who are most marginalised in society who both experience greater mental health difficulties and also find it difficult to access services appropriate to their needs. People from black and minority ethnic groups, older people, people living in rural areas, refugees and asylum seekers, disabled people and people with learning difficulties, war veterans, people in prison. people who are gay, lesbian or bisexual are all known to have a greater incidence of mental health problems, but their particular needs are often not met by mainstream services.

There needs to be more emphasis, for example, on ensuring the delivering race equality programme is applied to local communities. Professional’s training must include alternative representations of mental illness and well-being which characterise a diversity of cultural understandings and providers who fall short of their statutory requirements must be called to account.

Summary

Mind believes that the health service should be holistic in it’s approach to mental health. When looking at how health services should be provided and funded, Mind advocates a much more holistic approach to mental health. The pathway to effective support for people with mental health problems will need to include

health, social care and third sector support, as well as a number of other agencies.

Key points:

- **NHS mental health care should be person centred.**
- **Understanding of mental health by health professionals needs to be a major priority for the next generation of NHS staff.**
- **Mind's wants to see a broadening of the range of treatment options, including psychological therapies and ecotherapy**
- **Mind wants crisis services and more community based services to be available to all those who need them.**
- **Mind's expects co-ordinated support and planning for all those who experience mental distress.**
- **Mental health is not just about 'health,' it is a rights and equalities issue.**

Emily Wooster
Policy Officer
January 2007

This page is intentionally left blank

Ian Buckmaster
Manager of Committee and Overview & Scrutiny Support

OVERVIEW AND SCRUTINY TEAM
London Borough of Havering
Town Hall Main Road
Romford RM1 3BD

Please contact: Anthony Clements
Telephone: 01708 433065
Fax: 01708 432424
email: anthony.clements@havering.gov.uk

Date: 11 February 2008

TO:

Healthcare for London
Freepost Consulting the Capital

Your Reference:
Our Reference: **AC**

Dear Sir/Madam

Response of Outer North East London Joint Health Overview and Scrutiny Committee to Healthcare for London – Consulting the Capital Consultation

I am writing on behalf of the Outer North East London Joint Health Overview and Scrutiny Committee in order to give the Committee's formal response to the above Consultation. The Committee is made up of Councillors from the London Boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest as well as observer Members from Epping Forest District Council and Essex County Council. Several co-opted Members of the Committee have also input into the Committee's formal response which is shown below. Please would you note that, as previously discussed with your Head of Communications, this response does not preclude in any way individual constituent Borough Overview and Scrutiny Committees from making their own responses to the Consultation and indeed, you are likely to receive several of these during the Consultation period. This response has also been copied to the Chairman and Clerk of the Pan-London Joint Health Overview and Scrutiny Committee as it is that Committee which is the statutory consultee in this instance.

The response of the Outer North East London Joint Health Overview and Scrutiny Committee to the Healthcare for London – Consulting the Capital Consultation is as follows:

1. **The Consultation Document itself** – The Committee feels that the document is too simplistic and fails to deal with funding issues regarding the reshaping of services. The consultation document only talks about positive aspects and it is difficult to disagree with the overall principles, given the way in which they are worded. This also makes it difficult to give negative responses to the questionnaire. Indeed, Members feel that the questions asked in the document have been loaded in order to produce the responses desired by the Health Trusts.

2. **GP Services –** The Committee is unconvinced by the prospect of GPs being open longer hours as several GP practices in London Borough of Redbridge have in fact been closed down by the relevant Primary Care Trust (PCT) in the last 18 months. Healthcare for London places more emphasis on community facilities. Members have however received numerous reports of local GPs not spotting underlying conditions such as asthma and are not therefore convinced that the proposed community facilities will have sufficient expertise. The Committee is also

concerned that the proposed community facilities may lead to a doubling up of services already offered by hospitals.

3. **Role of Primary Care Trusts –** The consultation is being led by the Joint Committee of Primary Care Trusts yet the Committee feels that PCTs have not been reflecting the views of their communities. The Committee feels that it and hence local people were not listened to during the Fit for the Future pre-consultation and the Committee is therefore concerned that the PCTs will once again fail to listen to these views during any consultation on the phase 2 proposals.

4. **Growth Rate Statistics –** The Committee questions the assumptions used in the document with regard to future population growth etc. and is unconvinced that the proposed reforms will deliver sufficient capacity for London's health needs.

5. **Burden on Carers –** The document does not give enough emphasis to the role of carers. The Committee is also concerned that proposals such as allowing people to die at home, although possibly having merit in themselves, will inevitably result in an increase in the burden on carers.

6. **Increase in Specialist Centres –** There is concern by the Committee that the increase in prevalence of specialist centres of the type referred to in the consultation document will lead to the downgrading by stealth of local hospitals.

7. **Financial Issues –** The Committee feels that the severe financial difficulties currently experienced by some local Health Trusts will make the Healthcare for London plans unworkable.

8. **Partnership Working –** The Committee is concerned that the proposals will effect little improvement in the Health Sector's partnership working with Local Authorities. Should this prove to be the case, the Committee is also concerned that the proposals will have little impact on health inequalities in London.

9. **Transport Issues –** It is the view of the Committee that transport issues have not been sufficiently considered during the consultation process. Services located closer to people's homes still need to be easily accessible and this issue has not been addressed in the consultation document.

Yours sincerely

Anthony Clements
Principal Overview and Scrutiny Officer

CC: Gabrielle Teague, Head of Communications, Healthcare for London
Councillor Mary O'Connor, Chairman, Pan-London Joint Health Overview and Scrutiny Committee
Ben Vinter, Officer Clerking Team, Pan-London Joint Health Overview and Scrutiny Committee
All Members and Supporting Officers, Outer North East London Joint Health Overview and Scrutiny Committee