Notice of Meeting

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

FRIDAY, 14TH MARCH, 2008 at 10:00 HRS - LONDON BOROUGH OF EALING, EALING TOWN HALL, COUNCIL CHAMBER, NEW BROADWAY, W5 2BY.

Issue date: 6 March 2008
Contact: gavin.wilson@rbkc.gov.uk; tel: 020 7361 2264

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. CHAIRMANS WELCOME AND INTRODUCTION

4. MINUTES (PAGES 1 - 18)

To agree the minutes of the meeting held on 22 February 2008 (attached).

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE (PAGES 19 - 66)

(Attached)

6. WITNESS SESSION 1: HEALTHCARE FOR LONDON

Professor Ian Gilmore - *Royal College of Physicians*
Martin Else - *Chief Executive, Royal College of Physicians*

7. WITNESS SESSION 2: HEALTHCARE FOR LONDON

Michele Dix – *Managing Director TFL Planning, Transport for London*

8. WITNESS SESSION 3: HEALTHCARE FOR LONDON

Jason Killens – *Assistant Director of Operations, London Ambulance Service*

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

9. WITNESS SESSION 4: HEALTHCARE FOR LONDON

Tom Sandford – *Director, Royal College of Nursing*
Bernell Bussue – *Director, Royal College of Nursing*

10. WIITNESS SESSION 5: HEALTHCARE FOR LONDON

Bobbie Jacobson – *Director, London Health Observatory*

11. 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.

12. PARTICIPATING AUTHORITIES

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 Sylvia Scott
Merton - Cllr Gilli Lewis-Lavender
Newham - Cllr Megan Harris Mitchell
Redbridge - Cllr Allan Burgess
Richmond upon Thames - Cllr Nicola Urquhart
Southwark - Cllr Adedokun Lasaki
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

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Agenda Item 4

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 22nd February 2008

London Borough of Tower Hamlets, Council Chamber,
Mulberry Place, E14 2BG

PRESENT:
Cllr Marie West - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr Bass - London Borough of Croydon
Cllr Mark Reen – London borough of Ealing
Cllr Ann-Marie Pearce – London Borough of Enfield
Cllr Janet Gillman- London Borough of Greenwich
Cllr Gideon Bull - London Borough of Haringey
Cllr Ted Eden – London Borough of Havering
Cllr Vina Mithani – London Borough of Harrow
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 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 Mark Francis – London Borough of Tower Hamlets

Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Ian Hart – London Borough of Wandsworth
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)
Cllr Chris Pond - Essex County Council
Cllr Chris Pitt - Surrey County Council

ALSO PRESENT:

Cllr Ann Jackson – London Borough of Tower Hamlets (Mayor)

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Graham Walton – LB Bromley
Shama Smith – LB Camden
Sureka Perera – Corporation of London
Helen Kearney – Corporation of London

Neal Hounsell – Corporation of London
Trevor Harness – LB Croydon
Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
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
Shanara Matin – LB Tower Hamlets
Hannah Bailey – LB Tower Hamlets
Kwekue Quagraine – LB Tower Hamlets
Phil Williams – LB Waltham Forest
Phillipa Stone – LB Westminster
Derek Cunningham – Surrey County Council

Speakers:

Dr Clare Gerada -Vice Chair, Royal College of GPs
Dr Tony Stanton - Joint Chief Executive, London – wide Local Medical Committees
Louise Silverton - Deputy General Secretary, Royal College of Midwives
Dr Simon Lenton - Vice President for Health Services, Royal College of Paediatrics and Child Health.
Dr David Jones - Council Member- Royal College of Surgeons

DATE AND VENUE FOR NEXT MEETING

14TH March 2008, London Borough of Ealing.

1. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:
Cllr David Hurt – London Borough of Bexley
Cllr Kenneth Ayers- City of London
Cllr Helen O’Malley– London Borough of Lambeth

Cllr Mary Angell – Surrey County Council

Apologies for Lateness were received from:
Cllr Carole Hubbard – London Borough of Bromley

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 Mayor of Tower Hamlets Councillor Ann Jackson welcomed the Joint Committee to the borough. The Mayor gave members an overview of the history of the borough and famous landmarks. She further enlightened the Committee with a brief overview of the healthcare issues faced by residents of Tower Hamlets..

The Chairman thanked Mayor Councillor Ann Jackson for her address and thanked Tower Hamlets Council officers for accommodating the event. The Chairman went on to give the Committee an outline of the day's proceedings and noted that she had two items of other business , the final report and interim findings, which would be discussed at the appropriate agenda item.

The Committee were informed that the London Health Commission is holding a stakeholder workshop on the Health Inequalities and the Equalities Impact Assessments they are conducting for Healthcare for London on Wednesday 27th February 2008. Finally the Chairman explained to members that the scheduled JOSC meeting on the 14th March (due to take place in Ealing) would need to begin at 10am. She added that this was a result of the vast amount of evidence that is due to be considered at the meeting.

4. MINUTES

The minutes of the meeting held on 18th January 2008 were agreed subject to the following amendment:

That Cllr Gideon Bull of the London Borough of Haringey and Peter Tobias of the London Borough Hammersmith and Fulham, are stated as being present at the meeting.

That Cllr Peter Tobias' question to Hannah Miller on page 11 of the minutes be amended to reflect that the treatment of illness should be focused on prevention rather than cure.

5. PROJECT PLAN

The Project Plan was agreed.

6. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

The Committee received the submissions from the Outer North East London Joint Health Overview and Scrutiny Committee and the mental health organisation Mind in response to Lord Darzi's review of the NHS.

Mind welcomed the opportunity to submit policy ideas to the Darzi review. They responded to a number of other priority areas that impact on mental health: acute care, maternity services, planned care and staying healthy. Mind explained that they were advocates of a much more holistic approach to mental health, advising effective support for people with mental health problems would need to include health, social care and third sector support.

The Outer North East London Joint Health Overview and Scrutiny Committee in relation to the actual document felt that the document was too simplistic and failed to deal with funding issues regarding the reshaping of services. They explained it only talked about positive aspects which made it difficult to disagree with the overall principles given the way in which they are worded.

The Committee stated that they were 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. In regards to the role of Primary Care Trusts yet the Committee felt that PCT's had not been reflecting the views of their communities. They further questioned the assumptions used in the document with regard to future population growth explaining they were unconvinced that the proposed reforms would deliver sufficient capacity for London's health needs.

It was further highlighted that the document did not give enough emphasis to the role of carers. They additionally expressed concerned to the partnership proposals, as they believe it will effect little improvement in the Health Sector's partnership working with Local Authorities. They finally highlighted the lack of consideration attributed to transport issues within the document.

7. WITNESS SESSION 1: Healthcare for London – the implications for primary care

Dr Clare Gerada Vice-Chair, Royal College of GPs and Dr Tony Stanton Joint Chief Executive, London-wide Local Medical Committees

The Chairman introduced Dr Clare Gerada and Dr Tony Stanton to the Committee. The following points were made during the presentation and ensuing discussion:

- The Royal College of General Practitioners represent 30,000 GPs around the United Kingdom. The College feels that the NHS works because of General Practice. The cost per year per patient of one GP is equivalent to one day of acute care.
- The main point of contact for people who use the NHS are GPs.

- General practitioners work in small teams and provide personal care to a registered population. Their effectiveness is a result of the relationship formed with the population from 'cradle to the grave'.
- The Royal College of General Practitioners are not in favour of the one-size fits all Polyclinic model but are supportive of joint working through a federated model. The RCGPs felt that one fit solution across London will not serve the needs of the London population on a whole; each GP practice serves different communities with different problems.
- One of the main issues London residents have with GP services are accessibility.
- Each PCT has a body of GPs which serve on a Local Medical Committee. Each of these committees is banded together centrally under the umbrella of London-Wide LMCs.
- There is clinical evidence in the Healthcare for London document on which ideas about hospital services are based. But the polyclinic idea does not appear to be based on evidence from the primary care sector and it is questionable whether such an evidence base exists.
- London-wide LMCs will be making its own full response to the healthcare for London consultation.
- Many proposals in HfL are welcomed by London Medical Committees. However there are considerable concerns over the Polyclinic model, which have dominated consultation discussions.
- There are 1,300 GP practices in London and the average practice has 6,000 patients.
- The main point of contact with the NHS for many people is their GP. Only 10% end up in a secondary care hospital setting. GPs are patient carer advocates for frequent users (the elderly, long term sick and young children). GPs excel in demand management and keeping people out of hospital,.
- A key concern of London-wide LMCs are polyclinics. The original definition suggested the single site polyclinic, which would serve an average of 50,000 patients. The average population in each Borough is 250,000, which would indicate an average of 5 single site polyclinics in each borough.
- GPs are not opposed to change but are pushing for the highest possible standards, with a view to stronger relationships with boroughs and more visible support of continuity of care.
- A better approach of General Practices working together rather than as collective Polyclinics should be administered. Polyclinics could put GP practices under threat from mini Hospitals.
- Rather than installing new diagnostic equipment in polyclinics, it may be more cost effective to use this money to improve access to hospital based equipment (eg longer operating hours).
- There is a shortfall in provision. Some practices in deprived areas across London are operating out of terraced housing resulting in a lack of accessibility for vulnerable and deprived groups. The Polyclinic model would benefit some areas of London.
- The best place to manage a patient is within a primary care setting.

Questions

.Q The Chairman enquired what would be the impact of maintaining the Status Quo and not implementing the proposals?

It was responded that it would be wise to accept the arguments for hospital reconfiguration. If not supported Hospital patients would not get the necessary care for their specific needs. However the use of Polyclinics should not be adopted throughout London. Rather an approach of General Practices working together would be the desired method.

Q The Councillor for Croydon asked about possible issues that may arise with a resident receiving care across boroughs?

It was noted that London traditionally provides specialist hospitals. Under the Picture of Health proposals in South East London, Lewisham hospital for example may not retain accident and emergency services. Consideration would need to be given as to the spill over affect in that sector.

Q There was a supplementary question about the hub and spoke polyclinic model and whether the speakers saw any merit in moving some services currently only available in district general hospitals into communities and what could be recommended for out of hours surgeries ?

It was reiterated that the speakers were not against Polyclinics if it was the model which best suited a specific local population. They added that they were also not against moving services from out of hospitals and putting them into GP practices, but would advise caution as there were risks. In relation to out of hours operation, the speakers were in favour of extended hours but stated that co-operatives working together in larger populations would be their desired model.

Q The Councillor from Waltham Forest questioned the speakers' views of specialism within a practice.

It was suggested that specialists located in community settings may find their role scaled down, with general cases being seen that might not require a specialist. GPs may not also see specialist cases (diabetes for example) and so they then lose that part of their knowledge base, which is difficult to claw back.

Q The Councillor for Wandsworth asked how the speakers would propose to support flexibility within the GP Service.

The speakers explained that the profession recognised that access to GPs, particularly for working people, has been a problem for the general population. The national negotiating team had developed a workable solution in the Autumn but this had been stopped. They reiterated the point that services should be tailored to the needs of the particular population. There was often a fixation about bricks and mortar but it was the team delivering a service that influenced the efficacy and outcomes of that service.

Q The Councillor for Richmond Upon Thames queried if primary care was able to deliver equality of access for long term illness as particular diseases are perceived to be getting more attention than others?

The speakers responded arguing that they did not think particular conditions were receiving more attention adding that there was no truth in the concept of a unilaterally morbid condition as there were many different elements to long term conditions. Steps were being taken to improve case management.

Q The Councillor for Hackney asked the views of the Royal College of General Practitioners on the Darzi proposals regarding polyclinics and whether they are motivated by GPs' self interest?

It was responded that GPs have a big commitment to their local communities, as they have a stakes in their businesses. It was further stated that there was no underlying theme of self interest prevalent amongst the General Practicing community.

Q The Councillor for Enfield stated that Polyclinics would be highly beneficial for deprived residents of her borough. She enquired if the Polyclinic model would be opposed in her local borough?

The speakers explained that they were not opposed to a better service for her constituents, but suggested that a one size fits all Polyclinic model should not be introduced wholesale across London. They fully understood the current situation in Enfield and could see the Polyclinic model being a good solution to the issue of accessibility to GPs in the borough.

Q The Councillor for Tower Hamlets enquired what the differences were to the Polyclinic models and how much of the current proposals the speakers would endorse? He further asked if it was likely that polyclinics would see a proliferation of private companies taking over GP practices?

It was explained that in the initial proposal, it was suggested that a polyclinic would have all services located on one site. This would mean that there would be a polyclinic on every hospital site and then four more in each borough, but this model may work in some places and may not in others. Others may better suit a hub and spoke or federated model. It was added that the privatisation of general practice might seem attractive at first but it would not be a step the speakers would not endorse.

Q The Councillor for Islington asked what was being done in relation to an ageing GP population, in particular to address the situations where single-handed GPs are retiring and are not being replaced?

In response it was noted that single handed GPs are often unfairly targeted about the level of care that they provide. Often they come out top in customer satisfaction surveys. Some PCTs had a policy of not replacing single GP

practices on retirement which leads to the displacement of patients and the loss of GP patient liaison.

Q. The Councillor for Richmond upon Thames queried how the speakers would strengthen Primary Care and asked if they consider the proposals as an attack on community based medicine? How involved had GPs been in developing the proposals?

It was noted that the Royal College of GPs is pushing for practice accreditation, which would set out standards on access and quality of care and would require practices to meet minimum standards. The speakers stated that they would recommend practitioner accreditation standards on quality and service. An investment in good buildings, Midwives, community nurses and more health visitors to support primary care was greatly needed as they were currently undervalued services. GPs had not been involved in developing the Darzi proposals.

Q The Councillor for Newham asked for the speakers' opinion on the idea of separating hospital diagnostics and General Practice diagnostics in a local setting. He further requested the links between Dentist and GPs as the current consensus amongst dentists was that they had been left out of the process.

It was explained that whilst it was feasible to move diagnostics such as ultrasound out of a hospital setting, this brought with it staffing, training and financial implications, and it was also important that polyclinics are not seen as a reinvention of local hospitals. The speakers welcomed a closer link with dentists in the reconfiguration process.

8. WITNESS SESSION 2: Healthcare for London - The implications for Maternity Care
Louise Silverton, Deputy General Secretary, Royal College of Midwives

The Chairman Cllr O'Connor introduced Mrs Louise Silverton to the Committee. The following points were made during her presentation and the ensuing discussion:

- Nearly 20% of all births were to women in London in 2006
- London has the fastest rising birth rate in England
- The number of women in London of childbearing age (15-44 years) is projected to increase by 11% by 2016, although these increases fluctuate across London
- A higher percentage of the population in London is young and significantly mobile. GP list turnover is between 20-40%
- Most maternity units in London do not have enough midwives to provide the level of one-to-one care that the Government has pledged to provide for women by 2009
- *Birthrate Plus* recommends a ratio of 1 midwife for every 28 deliveries for hospital births. This equates to approximately 36 midwives for every 1000

deliveries. Currently only Whittingham and Guy's and St Thomas' are the only hospitals to exceed the recommendation.

- London has the highest midwifery vacancy rates in England. The average vacancy rate in 2006/07 was 8.5%. Some hospitals have put a freeze on recruitment to address to some extent their deficits.
- During 2006/07 maternity services were suspended on 51 occasions and four related to medical/midwifery staffing.
- 18% of Midwives are working beyond the age of 55. 17.5% are in the position to retire now, 30% in 5 years and 53% in 10 years.
- 1.8% of births in London take place at home which is below the national average. Six units have home birth rates of less than 1%.
- London has a high rate of Caesarean section births – only eight NHS Trust achieved a rate below the national average of 23.5%.
- Midwives care for a woman during birth and sustain her past giving birth for a period of time. All women need a midwife, some need a doctor too. The number of visits a woman receives after going home varies across London. This is linked to the number of midwives per '000 of the population.
- The maternity sector is being starved of resources; with the current spend level reduced by 2% (equating to £55m).
- The size of maternity services in London and increases in child bearing ages of women are current challenges faced by the Royal College of Midwives.
- The rising number of complex births from women oversees has become an issue.
- Accessibility to housing is an issue for Midwives. Most Midwives who work in London do not actually live in London. They are also unable to qualify for the key worker housing scheme.

Questions

Q The Councillor for Wandsworth enquired if the speaker believed the Darzi report addressed midwifery issues and asked if she believed the NHS was up to the challenge of delivering a good service?

The speaker explained that the Darzi report did recognise some of the principles of maternity matters. However, free standing birth centres without obstetrics needed to be properly staffed and required clear protocols for transferring patients, and if these were in place then the Royal College could be more supportive of this proposal. She further remarked that the NHS was up to it, as resources are at their disposal and not everything is in need of being serviced. The NHS would need to be held accountable for the plans during the reconfiguration process.

Q The Councillor for Greenwich reported that at his Council's last Health Scrutiny Panel meeting a positive picture had been presented by his local PCT in relation to the recruitment process. As a result he queried the reason for the disparity between the speaker's views and those of health professionals in his borough.

It was responded that the Councillor's local PCT may have not carried out their full projections for staff required at the time of their presentation. Students on placement may not have been included in their calculations as well as a scrutiny of the age profile of midwives.

Q The Councillor for Newham queried whether there were concerns that the proposals would not meet the need of deprived areas?

The speaker responded that if we were starting again from scratch, tertiary centres in areas of deprivation could be built. The Darzi report did look at health issues for deprived areas to a lesser extent, but this needs to become a focus or we will just perpetuate what we have now. More midwives need to be in the communities, with signs saying that if you are pregnant, this is where you can find your midwife. Every woman needs to be able to have a choice. For a number of women with complications or social needs, they need to be able to access doctor led units. But things like post natal care could be delivered in communities.

Q The Councillor for Merton queried of the seven London trusts that had vacancy rates in double figures, did the trusts also have the highest hospital deficits?

It was explained that the speaker did not have the information present, but would be able to supply the relevant information in more detail.

Q The Councillor for Islington asked if the Royal College of Midwives viewed the proposals in the Darzi report in relation to maternity care as adequate?

It was noted that there is not really much in the report that could be disagreed with, although exception could be taken to the consultation questions. The RCN agreed with the proposal of a set group of midwives who care for a specific number of the pregnant population. However concern was aimed at how the PCT's across London would administer it. The speaker added that providing community based care is where problems would arise, further stating that the Royal College of Midwives would be looking for a bigger lead from commissioners in commissioning the right type of care.

Q The Chairman enquired in response to the earlier mentioning of choice in the presentation, how the Royal College of Midwives managed expectations?

It was explained that the main restriction to choice is a lack of capacity, but to balance that, you did not want to much choice that you are wasting capacity. The speaker added that money was drastically needed for all aspects of Midwifery as a lack of choice could become a problem. Movement across Boroughs is also an issue, a Trust might provide antenatal and post-natal care, but they do not get the money for it. A host borough commissions based on the number of births it expects..

Q The Councillor for Essex County Council asked what provisions were being made for the estimated population growth in the sub M11 area, Thames Gateway and Hertfordshire?

The speaker explained that she was unaware of any new plans for hospitals in the areas as it was an issue of planning. Despite this she understood that dialogue was occurring with local authorities and local PCT into what the projected plans for these areas will be.

Q The Councillor for Haringey queried how the Royal College of Midwives dealt with people who did not have English as their first language?

It was explained that this was a huge challenge midwives faced. She explained it was deemed unacceptable to expect the partners, or family members to translate. It is important Midwives are culturally sensitive. She added that the Royal College of Midwives provided professional and trade union services, and could not provide translation services.

9. 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

Councillor O'Connor introduced Dr Simon Lenton, Vice-President for Health Services, Royal College of Paediatrics and Child Health. During the presentation and ensuing discussion, the following key points were made:

- There are a number of factors signalling that reform of paediatric and child health services was needed, including the findings of UNICEF of children's health in the UK, rife inequalities in services and the view of the Healthcare Commission that acute services are poor;
- Current NHS reforms around elective and diagnostics fail to take into account that most children require care urgently or for long term conditions (LTC);
- Children are not mini-adults and have different needs and requirements in terms of their physiology, range of illnesses and the way in which we communicate with them;
- The need to take a holistic view of children's needs, from treatment itself to the environment this takes place in and the needs of the child's family, yet the fact that this did not always sit easily with a market-orientated approach to the provision of care;
- Whilst children are seen as the future, the Darzi report actually treats paediatrics and child services as something of an afterthought, with its piecemeal approach giving little focus to mental health services, disabled or disadvantaged children;
- The aspects of the Darzi report that the Royal College of Paediatrics and Child Health were in favour of was the proposed model of service delivery, with its focus on pathway thinking around a patient's journey, family friendly models of care and continuous improvement through feedback;

- The basic premise of the report that poor health with appropriate health care leads to better health was welcomed, but this needed to be broken down into the following steps – prevention – identification – assessment – short-term interventions – long-term support – palliation.
- Again, need for recognition of the differences in working with children was stressed. This was illustrated by the fact that targets set for adult care were not always suitable for children, in whom conditions developed in different ways;
- The Royal College weas of the opinion that children and their families should expect better care than that they currently receive, and this should be responsive to their needs and delivered in a range of appropriate settings, be this in the child's home, school, or local hospital;
- Clinical services needed to be delivered by teams working in integrated networks, with a focus on collaboration not competition. Whilst Dr Lenton expressed his view that there was not sufficient information about the vision for paediatrics and child health in the Darzi report, there was much scope to take these issues forward.

Questions

Q The Councillor from Hammersmith and Fulham enquired about the position of the models of excellence identified in the UNICEF report on child heath in the UK.

It was responded that foreign models were funded on a completely different basis. Whilst there were no simple solutions or single model proposed, there should be quality of care for children wherever it was delivered. Whilst there were current examples of patient-friendly care delivered according to the pathway model, but these needed to be expanded to be able to deliver on a larger scale.

Q The Councillor from Islington said that the importance of children growing up healthy should have been given far greater prominence in Darzi's vision. She asked how the model of holistic support could be developed over the next ten years and whether there was a role for local hospitals to provide care outside of centres of excellence.

It was responded that there were different ways of delivering treatment and these needed to be assessed on an individual basis. Broadly speaking however, there was a need to move away from traditional settings when caring for children and integrate services into their day-to-day lives, by providing care in homes and schools. Whilst it was inevitable that in some cases families would have to travel for specialist treatment at centres of excellence, this was often only one element of the process.

Q The Councillor from Westminster alluded to the report's views on the concentration of services on fewer sites and asked what Local Authorities could do to urge Darzi to take a more integrated approach to the provision of services.

It was responded that as there were not enough paediatricians to keep all units open at present, consideration needed to be given to the reconfiguration of services. There was a real need to proactively plan for the future and work realistically with the resources that were available. There was no single solution yet there was tacit acceptance that it was not efficient to continue in the same manner and the situation needed to change. However it was often small changes that could have the biggest impact – Dr Lenton drew Members' attention to the need for more paediatric nurses, which could be as important as the need for more paediatricians. In terms of the role of Local Authorities, Members were urged to consider a range of interventions, from looking at PSA targets and working more closely with the PCT, to reducing speed limits in residential areas to cut down on the numbers of children injured in road traffic accidents.

Q The Councillor from Harrow asked if Healthcare for London could lead to more immunisations amongst children

It was responded that there were often specific issues around immunisation in the capital due to the transient nature of the population. There was a definite need to upgrade computer systems in some boroughs to be able to keep an accurate track of children's records. Much work also needed to be done to educate parents around the benefits of immunisation.It was also important to ensure that health professionals provided consistent messages, particularly around MMR. Whilst there were always increases in the number of immunisations following an outbreak, it was not sufficient to rely on this' to meet the immunisation requirements of London's children

10. WITNESS SESSION 4: Healthcare for London – the implications for Specialist Care, Complex Emergency Surgery and Planned Surgery Mr David Jones, Council Member, The Royal College of Surgeons.

Councillor O'Connor introduced Mr David Jones, Council Member, The Royal College of Surgeons. During the presentation and ensuing discussion, the following key points were made:

- The Royal College of Surgeons (RCS) exist to enable surgeons to achieve and maintain the highest standards of surgical practice and patient care. In practice this meant training the surgeons of the future and handing on skills from one generation to the next;
- The College's Patient Liaison Group (PLG) are a part of the College Council and exists to keep the College's 'feet on the ground'. The PLG lobby for continuity of care and named doctors throughout a patient's care;
- The RCS felt that standards and indicators should be used to measure performance and underpin standards as opposed to targets;
- A service delivery model based around networks of care was advocated, with an agreement on provision of specialist and general care within a network which was funded appropriately;
- It was stressed that there were already good examples of networking in practice around children's surgical services and trauma care, but these needed to be further developed to cover all services;

- It was felt reasonable to create a handful of major trauma centres to deal with the most severe cases, and the RCS welcomed the recommendation in the Darzi report to create three such centres in London;
- However, alongside these major specialist centres there was still a role for local district hospitals in providing care for the majority of more minor injuries such as fractures;
- In terms of funding, the RCS felt that it was necessary to reward quality and safety rather than activity. Similarly, when commissioning, equal regard should be given for routine services alongside more specialist services;
- Any reconfiguration of services should have a sound clinical and evidence based and must not be based on a drive for financial, political or managerial expediency;
- In terms of the Darzi report, the RCS main concerns centred around access, safety, continuity of care, training and the need to consider specialties;
- Surgical care ideally needed to be delivered via defined networks, for those requiring specialised care this would be in a specialised centre, however for more routine procedures care could be delivered locally, where this was considered safe and possible;
- In conclusion, the RCS felt that the JOSC had a role to play in ensuring that the Darzi report had fully considered the most appropriate method of service delivery for trauma and children's care in the future.

Questions

Q The Councillor from Barnet enquired as to what was meant by the reference to 'dilution of care' amongst surgeons and asked whether the RCS felt that the Darzi report would improve surgical services or if it was a money-saving exercise?

It was explained that as surgery was a craft, practice was essential, particularly for newly-qualified surgeons. However, due to the European Working Time Directive (EWTD), surgeons' hours were reduced and they were not always able to gain sufficient levels of skill through practice. For this reason the RCS was opposed to the EWTD and often referred to the 'dilution' of skills due to this restriction. The view was expressed that Lord Darzi was a political appointment as well as a surgeon, and there was therefore a political angle to the report. The RCS felt that simple steps were needed to improve the UK healthcare system.

Q The Councillor from Richmond Upon Thames asked whether the London Ambulance Service would need any further training in order to be able to recognise major trauma and direct patients to the most appropriate centre for their needs.

It was responded that London Ambulance were already skilled in this area and also had to contend with traffic congestion in the capital as part of their decision making processes when referring cases to hospitals. There were very few hospitals in the UK that had the expertise and equipment to deal with all trauma cases at present, and only one of these was in the capital at

present, so more specialised centres of excellence were welcomed by the RCS.

Q The Councillor from Newham asked whether the RCS felt that payment by safety and quality would lead to a drop in those having surgery and possibly lead to longer waiting times

It was responded that surgeons were used to high volumes of work but this could often be affected by other issues, such as nurse shortages, infections and the 'target culture'. It was felt that the correct resources needed to be put into place to allow surgeons to deal with these issues; however the RCS resented being told what to do by the government.

Q The Councillor from Sutton asked whether there were sufficient resources in place to enable the training and accreditation of courses, trainers and professionals to take place

It was responded that at present young surgeons didn't have enough time to be trained to excellence; instead the RCS was settling for competence. Training was clearly a costly issue and there were no guidelines at present as to how it was proposed to revalidate senior professionals.

Q The Councillor from Waltham Forest asked for the opinion of the RCS on where the line should be drawn between general hospitals and specialist centres, particularly in terms of which services should be kept within district hospitals

It was responded that in broad terms, accident units, children's units, fragility fractures and limb injuries could remain within a district hospital setting, with some allowance for some specialist areas. Within present networks, there was recognition of the skills of certain specialists and the need to sometimes refer a patient to a particular doctor outside of their own local area.

Q The Chairman asked for the opinion of the RCS on the impact of not implementing the recommendations made by Darzi but keeping the status quo

It was responded that the RCS felt that many aspects of the report made practical sense, however much of the detail still needed to be expanded upon. Equity of care, irrespective of which part of London someone lived in, needed to be achieved

Q The Councillor from Croydon commented that in some scenarios (for example fracture surgery), the speaker seemed to be promoting networks of individual specialist surgeons across hospitals, rather than specialist hospital sites and asked what the RCS felt about the idea of publishing the performance statistics of individual consultants

It was responded that it was felt that performance statistics would come as part of the accreditation process, however it was often difficult to balance outcomes. For example, a skilled heart surgeon may have a much higher rate

of mortality amongst patients than a surgeon performing more routine operations.

Q The Councillor from Richmond Upon Thames asked what contact had been made with the Department of Health regarding last year's training issues?

It was responded that the situation regarding training was still in crisis, with a huge number of young people competing for a small number of places. There was an argument that training should be restructured to operate as it had done in the past to address this situation.

Q The Councillor from Harrow asked whether given current staff shortages, surgeons would be prepared to move to larger sites such as major trauma centres

It was responded that this was a major concern of the RCS and again came to down to the need to thrash out the detail of the Darzi report. Decisions such as this were for local negotiation and this was an instance when networks could come into play.

11. ANY OTHER BUSINESS

I. Interim Findings

Members were reminded that the deadline for submission of comments from individual boroughs was Friday 29th February. The Chairman indicated that a copy of the interim findings of the JOSC had been circulated to all Members and invited any initial comments. The following key points were raised:

- The need to address the issue of historic under-funding in some areas of East London in the final response;
- The adequacy of the entire consultation process;

There was discussion as to whether there would be any opportunity to follow-up on any of the responses received from NHS London? It was noted that the officer support group would follow this up should any Member indicate a specific issue. It was also agreed that the officer support group would forward to the witnesses any outstanding questions that Members had not had the opportunity to ask. .

Following discussions it was agreed by Members that the interim findings report could be shared with OSC at individual boroughs, but that the draft status of the report was to be stressed.

II. Format of the final response

The Chairman sought Members views on the format of the final response of the JOSC. It was proposed that an electronic copy be produced which boroughs could then decide to reproduce in hard copy if required. This was agreed by Members.

III. Further meetings

The Chairman notified Members of a number of forthcoming meetings once the JOSC's final report had been agreed:

- 6th May – MORI to respond to consultation outcomes (venue yet to be confirmed);
- 20th – 23rd May – PCTs to hold a series of public meetings;
- 12th June – Joint Committee of PCTs to agree consultation response.

12. CHAIRMAN'S CLOSING REMARKS

The Chairman thanked all those in attendance for their contribution to the meeting.

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Joint Overview and Scrutiny Commission

"Healthcare for London" scrutiny

Evidence of the effects on London's voluntary and community sector

Submitted by London Voluntary Service Council

February 2008

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1. London Voluntary Service Council

London Voluntary Service Council (LVSC) brings London's Voluntary and Community Sector (VCS) organisations together to learn and share best practice and to create a co-ordinated voice to influence policy makers. We provide up-to-date information on management and funding, advice and support for voluntary and community groups and an information service, practical publications and short courses for those working in the sector. LVSC also hosts and services networks including Third Sector Alliance, Voluntary Sector Forum, Second Tier Advisors Network and CASCADE. (www.lvsc.org.uk)

2. General comments

LVSC welcomes the opportunity to provide evidence to the joint overview and scrutiny committee on the proposals in the consultation document "Healthcare for London". We welcome the fact that London's VCS is seen as a key partner in improving healthcare in London and helping people to stay physically and mentally healthy.

There is an increasing drive from central government for the VCS (as part of the third sector) to be more involved in the delivery of public services, including health and social care services[1]. However, this response is not just based on the role of the sector in service delivery but also addresses:

- the beneficial social impact of the sector, which can play a major part in reducing health inequalities
- its role as a source of information and an advocate for individuals
- its role in lobbying and campaigning for service changes and improvements

3. Partnership working with social care

Many of the suggested changes in the consultation document will have a direct impact on the demand for social care services. For instance, the proposals that more surgery should be carried out as day cases and that more rehabilitation should take place at home will require more social care services, particularly for those who live on their own.

The fact that most people prefer not to stay in hospital and that this also reduces their risk of catching a hospital-acquired infection leads us to welcome this proposal. However, without an accompanying increase in the budget for social care services, there is huge concern that this proposal will have a negative effect on VCS groups and their users. Already we are seeing cuts in the number of people receiving social care services in London, and with the recent local government financial settlement for London being lower than expected[2], more and more London boroughs are likely to increase the eligibility criteria to receive social care services. The Commission for Social Care Inspection has recently estimated that 281 000 older people in England need help with washing, eating and other life-sustaining tasks but receive no

[1] "Partnership in Public Services: an action plan for third sector involvement", Office of the Third Sector, 2006

[2] "2008/09 to 2010/11 provisional local government finance settlements – a response by London Councils", London Councils, 2008

publicly funded services[3]. This report and reports from our members indicate that those who do not receive social care services are often "signposted" to and begin to use VCS groups. For example, the Age Activity Centre in Wandsworth, where the eligibility criteria for receiving social care was raised in June 2007, has noticed a significant increase in the number of people attending their centre, particularly members of the white community, although the centre was originally started to meet the needs of Black older people in Wandsworth.

This presents a problem to VCS organisations in two ways:

- although use of their services is increasing, there is usually no accompanying increase in funding;
- some of the users now accessing their services have needs that are much greater than, or are different from, those for whom the service was originally created, requiring more staff time and adaptations for their needs. If there is no additional funding, this can also compromise the standard of service.

It is vital that, if the proposals in "Healthcare for London" are implemented, the predicted financial savings made from a fall in hospital stays are invested in social care services to cope with the consequent increasing demand. This should include increases in funding for VCS groups if they have to provide more homecare services and for those providing preventative community services who find the number or needs of their service users are increasing.

4. Commissioning of services from the VCS

A lot of the changes proposed in "Healthcare for London" will depend on strong commissioning from Primary Care Trusts, to ensure an increase in preventative services provided in the community and a reduction of specialised services to particular centres of expertise. The importance of commissioning upon access and quality of services was demonstrated recently when the London Assembly scrutinised mental health services in London[4]. They found that "the lack of good quality commissioning data, resource pressures and variations in spending across London have all affected the availability of mental health services and the extent to which they meet local people's needs".

In the past Primary Care Trusts have commissioned relatively few services from the VCS and there have been problems when they have done so, because of the different governance arrangements and cultures of the two sectors. There needs to be more training for both the VCS and commissioners to improve commissioning of services from the VCS. The recent £2million programme delivered by the Improvement and Development Agency to train 2 000 local commissioners in involving third sector organisations in delivering services, provides a good example of how this issue can be addressed.

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[3] "The State of social care in England 2006 – 7", Commission for Social Care Inspection, 2008

[4] "Navigating the mental health maze", London Assembly Health & Public Services Committee, 2007

"There continues to be a wide variance in understanding of what the VCS can deliver in local authority areas and within specific services. Not all officers understand fully the ways in which the VCS operates, or how it might be best utilised in needs analysis, service specification work and ultimately delivery."[5]

4.1 Involvement of the VCS in needs assessment

A recent London Councils' report[5] has found that work on needs analysis does occur across London but evidence shows that the structures and processes to conduct this are not well developed. Examples of VCS engagement in the earliest stages of needs analysis work are currently very rare.

However, work for the London Health Inequalities Strategy[6] identified that the data on health needs of certain communities in London either does not exist or is difficult to access. This in turn limits the influence that these communities have on deciding the type of health services that are commissioned. It is often the VCS that works particularly closely with these communities and can represent their needs. It is therefore important that commissioners recognise the importance of involving the VCS in needs assessments, so that they can address the issue of health inequalities and access to mainstream healthcare.

It is important that Primary Care Trusts and local authorities note that the involvement of VCS organisations in needs assessment must be adequately resourced, if such involvement is to be accountable.

4.2 Quality of commissioners and their work with the VCS

In the past commissioners have not followed central government guidance[7] or the principles of the Compact[8] when commissioning services from the VCS. It is important that commissioners receive more training on how to work with the VCS, to ensure that they achieve the best service delivery from the sector.

Areas that have been problematic in the past include:

- the use of inappropriately short-term contracts
- contracting all risk on to the sector
- inappropriately complex levels of monitoring
- not paying for the full cost of the service[9]

In order to reduce health inequalities NHS commissioners should also begin to use social clauses more often in their contracts, as recommended by the Office for the Third Sector[10].

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[5] "Common themes on commissioning the VCS in selected local authorities in London", London Councils, 2007

[6] "Health Inequalities Community Outreach project", Greater London Authority, 2007

[7] "Improving financial relationships with the third sector: guidance for funders and purchasers", HM Treasury, 2006

[8] http://www.thecompact.org.uk/

[9] "No excuses. Embrace Partnership now. Step towards change!", Third Sector Commissioning Taskforce, Department of Health, 2006

[10] "Partnership in Public services: an action plan for third sector involvement ", Office of the Third Sector, 2006

4.3 Co-ordination of commissioning regionally and locally
There needs to be much greater co-ordination of regional, sub-regional and local commissioning. Currently London Councils funds many services, including many that affect health provided by the VCS regionally. However, our work with Voluntary Sector Forum members indicates that few local councillors and council officers realise that these particular VCS services are being funded to work in their borough. As a result this regional commissioning of services does not feed into local commissioning decisions.

There is also concern amongst London's VCS organisations about the transfer of service provision to polyclinics and the switch to practice-based commissioning. Organisations are concerned that this could result in a reduction in the commissioning of preventative community services. Our members' experiences suggest that knowledge of the VCS amongst GPs and other practice-based staff is "patchy" and preventative services are often a lower priority to them than clinical services. There is a danger that if the "Healthcare for London" proposals are adopted, there will be a reduction in the commissioning of preventative community services, particularly those provided by VCS organisations, in favour of clinical services. This would mean that these organisations would not be able to provide such services and their users needs would not be met. In the long term this would cost the NHS more as people would be more likely to engage in unhealthy behaviour and would present with illness at a later stage. This needs to be addressed by ensuring that spending on preventative community services is maintained or even increased and that appropriately trained commissioners work with the VCS to decide on how and where they should best be delivered.

4.4 Financial planning and sustainability
Another recent concern of VCS organisations has been around the various different ways in which their services can be funded. Some may be commissioned at a local or regional level, others may be commissioned by a particular GP or group of GP practices, while others may be paid for by individuals through direct payments and individual budgets. The financial uncertainty this produces makes it difficult for organisations to plan ahead and in many cases may threaten their continued existence.

Commissioners have two competing agendas in that they must provide the best value and most efficient service, which favours large contracts with mainstream organisations, whilst also developing the local market in order to offer patients choice in healthcare services and develop competition, which favours small specialist services. If the development of the market and choice for patients is ignored, it is feared that many VCS organisations will have to close and this could have a detrimental effect on "Healthcare for London"'s aspirations to increase access to healthcare services and reduce health inequalities. Commissioners will need to look carefully at how they can build up and resource small specialist VCS organisations to deliver the services that their users need. This may require some grant funding to provide financial sustainability.

If the changes we have suggested here are made to the way VCS organisations are commissioned to deliver services by the NHS and local authorities, we should begin to see the “better communication and co-operation needed between….the NHS, local government and voluntary organisations” mentioned in “Healthcare for London”.

5. Work with Local Involvement Networks

The new Local Involvement Networks offer an opportunity to improve patient and public involvement in health and social care in London. However, the distress of many at the closure of Community Health Councils and the problems that have been experienced by their replacements, the Patient & Public Involvement Forums, means that there is a danger that many Londoners will have become disillusioned with patient and public involvement activities.

As “Healthcare for London” suggests, there is huge concern that the NHS in London is not providing easily accessible high-quality care for most of the population nor the best quality specialist care for the few people who need it. Londoners also have the lowest satisfaction ratings for NHS services in the country. These issues can only be addressed if patients and the public are involved in making decisions about health and social care services. For example, a Race on the Agenda review[11] found that the experience of Black, Asian and Minority Ethnic (BAME) communities in accessing services improved when users were involved in service design. There is a danger that the health service, because of both policy and practice, have now so isolated many patients and members of the public they will find themselves working against a continuous opposition and a lack of public and patient engagement in working together to improve the quality and access of services.

In order to implement “Healthcare for London” this danger needs to be acknowledged and addressed. The successful development of Local Involvement Networks (LINks), and the involvement of local VCS infrastructure organisations as their hosts, should be given a priority as one way to address this issue.

6. Access to services

6.1 Information-giving, support and advocacy

The “Healthcare for London” consultation document draws attention to the fact that from 2008 patients will be able to choose any approved provider of healthcare for planned treatment and emphasises that there must be “better information” if people are to make informed choice. However, a 2007 survey by the King’s Fund[12] identified that 58% of Primary Care Trusts (PCTs) had not conducted any assessment to identify people who might need support making health care choices and two-thirds of PCTs had not commissioned any services to support choice.

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[11] “Mayor of London’s call for evidence on health inequalities”, Race on the Agenda, 2007

[12] “Choice and Equity survey”, King’s Fund, 2007

VCS organisations in London have already expressed concerns about the lack of funding for advocacy services for the most disadvantaged. VCS organisations that work with and advocate for the most disadvantaged communities are in an ideal position to provide the type of information to their clients that will help them to make an informed choice about the healthcare services they use. There needs to be an increased awareness amongst Primary Care Trusts that they need to commission such services, and that these are often best provided by VCS organisations that already have a relationship with a local community. If health inequalities are to be reduced, such services will need to be adequately planned for and resourced.

6.2 Language
London has a larger proportion of the population whose first language is not English than the rest of England. The need for language services in the health service is growing with increased levels of immigration. Race on the Agenda[9] have reported that the provision of language support through translation and interpretation services for non-English speakers, has been proven to prevent misdiagnosis.

However, recent Government policy has suggested that translation and interpretation should be more limited in the future[13]. Although the guidance mentions that “there will always be some circumstances in which translation is appropriate – for example, to enable particular individuals to access essential services like healthcare”, LVSC is receiving evidence that groups working with a “single community”, such as a particular ethnic group, who often provide such translation and interpretation services are having funding cut because funders suggest that they do not promote community cohesion.

Although we have not seen any examples of the translation of healthcare information being stopped because of misinterpretation of the translation guidelines, we are concerned that in an effort to save resources this could happen.

In a diverse region such as London, it is vital that those who need it continue to be provided with translated materials about health and social care, interpreters at face-to-face meetings with health and social care professionals and health–related advocacy support from VCS groups that understand their language and culture, if we are to increase access to services and reduce health inequalities as the proposals in “Healthcare for London” aspire to do.

6.3 Transport / accessibility
Some VCS groups, particularly some of those working with older people and disabled people have expressed concern about the proposals for polyclinics which would serve around 50 000 people. This could mean (depending upon the model adopted) that some patients would have to travel much further to see a GP. Similar concerns about access and transport are obviously raised if specialist services are to be concentrated in fewer centres of particular

[13] “Guidance for local authorities on translation of publications”, Communities and Local Government, 2007

expertise. There were also concerns that the GP-patient relationship and continuity of patient care would suffer. However, other VCS groups have praised the proposals for allowing greater flexibility in opening hours, more specialist services to be available in the community and the potential for VCS groups to offer particular services, such as counselling and advice, in the polyclinics themselves.

The “Healthcare for London” consultation document states that “we know that transport will be a key issue and we need to work with a range of organisations to ensure that places providing care are easily accessible.” LVSC suggests that this includes VCS groups with expertise in this area, such as Transport for All, groups working with older and disabled people (and other disadvantaged groups) and environmental groups, who are working to reduce congestion. The impact on journey times for patients should be assessed before any changes are made to the location of services.

Another concern raised by VCS equalities groups (those working with a community that has face discrimination) is the focus on geographical communities of the polyclinic model. Some people may experience discrimination in the area in which they live and would prefer to use specialist services for their community, even if they have to travel further. This will need to be considered by commissioners if people are to have a true choice of services.

6.4 GP registration
The consultation document highlights the fact that many people are using Accident & Emergency services inappropriately but does not specifically contain any proposals to increase registration with GPs. Many of those who do not routinely use GPs are from newly arrived communities, who do not understand the healthcare system in England and have language support needs. For example in 1997 in Camden & Islington 15% of communities from the Horn of Africa had not registered with a GP compared with 1% of the general population[14]. Similarly absence of a permanent address makes GP registration difficult. In London it is estimated that upwards of 40% of people who are sleeping rough can be unregistered[15]. It is usually those who already have the worst health outcomes who are not registered with GPs.

Many VCS organisations working with these types of users, provide help with issues such as GP registration and members of staff act as advocates and, sometimes interpreters, when people attend primary care appointments. Primary Care Trusts need to recognise the value of this work and contribute to the costs of providing such holistic services for particularly vulnerable people.

7. Relationship with Mayor’s Health Inequalities Strategy and community development
LVSC welcomes the proposals in the “Healthcare for London” consultation document to work with the Mayor of London to address the priorities he sets

[14] Health Matters 30, 1997
[15] “Health and Homelessness in London: a review”, King’s Fund, 1996

out in “Reducing health inequalities – issues for London and priorities for action”. This document emphasised the view that poor community engagement leads to widening inequalities and many of those who contributed to its preparation agreed that the VCS was a key vehicle for community development approaches[16].

LVSC, and the VCS groups that it works with, have expressed concerns in many recent consultation responses[17] that community development skills have been undervalued and there are a lack of opportunities for training and qualifications in community development and participation in London. LVSC is lobbying for more investment in community participation skills, through Learning and Skills Councils funding or other specific funding sources. Such an approach is also supported by the National Community Forum’s report[18] that recommends that local and central government should “invest in training in community participation skills for community members”.

LVSC is currently the accountable body for the London Regional Consortium of ChangeUp, which means it is responsible for the funds that the government has invested in developing VCS infrastructure in London. This Consortium wanted to establish whether there was sufficient community development training in London to meet demand, so commissioned a mapping project.

The key findings of the project were:

- There was a poor understanding of what community development work was. Although many respondents said they were undertaking community development, they were only increasing individual skills or improving a group’s organisation. There were only a few organisations in London that were working with communities to determine their agendas and to take action to meet those needs.
- At the sub-regional level only the East London sub-region has a good range of programmes at different levels and with different kinds of learning.
- There were very few community development taster type sessions being offered to people in the community.
- The National Open College Network Community Development award is only available through Tower Hamlets, Greenwich and Newham Community Colleges.
- There are no NVQ assessment centres for community development within London.
- There is little work-based learning, although in East London there are mentoring schemes for residents and tenants and a number of support groups.
- Very few organisations had heard of, or knew about, occupational standards or the Community Development Work National Occupational

[16] “Commentary on written submissions to a Greater London Authority ‘Call for Evidence’ on health inequalities” Greater London Authority, 2007.
[17] “Third Sector Review: A London Perspective”, LVSC and MiNet, 2006
[18] “Removing the barriers to community participation”, National Community Forum, 2006

Standards, but most were interested to find out more about them and their applications.

If there is to be a reduction in health inequalities, this evidence suggests that those involved in implementing “Healthcare for London”’s proposals should work closely with those implementing the Mayor’s Health Inequalities Strategy and London’s VCS to use community development techniques to reduce inequalities and to ensure there is better access to community development training across London.

LVSC is currently beginning to work more closely with the regional teaching public health network, which has recently set up a third sector sub-group. This group could provide a hub for the various different sectors involved to come together to address community development training issues.

LVSC welcomes the recommendation that training is improved so that “NHS staff stay up to date in their understanding of inequalities and the needs of vulnerable groups” and suggest that some of this training could be provided by VCS groups that work with disadvantaged communities.

LVSC also welcomes the proposal that “Healthcare for London” is to undergo an equalities and health impact assessment, which we know is to involve VCS groups in London – although we suggest that this should have been a central feature of the consultation.

9. Mental health

LVSC welcomes the inclusion of mental health as a priority issue in the “Healthcare for London” consultation document, and the aspiration for more patients to have access to psychological therapies. However, LVSC supports Mind’s response to Lord Darzi’s review of the NHS[19] in stating that mental health is not entirely a medical issue and that when looking at how health services should be provided and funded there should be a more holistic approach, including health, social care and third sector support.
Mental health is a particular priority for London as a region, where 130 200 Londoners, or 44% of incapacity benefit claimants, are claiming the benefit for a mental or behavioural problem[20].

A Social Exclusion Unit report[21] identified that being in employment and maintaining social contacts improves mental health outcomes, prevents suicide and reduces reliance on health services. The Sainsbury Centre for Mental Health[22] states that research and practice has shown that the vast majority of people with a mental health problem can take up and sustain employment. However, support needs to be given to employers to address their fears, reduce stigma and skill up line mangers to identify and manage mental problems as they arise within the workplace.

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[19] “Mind’s response to Lord Darzi’s review of the NHS”, Mind, 2008
[20] “London Mental Health and Employment Strategy”, London Development Centre, 2008
[21] “Mental health and social exclusion”, Social Exclusion Unit, 2004
[22] “’In Work, better off’ – consultation response”, The Sainsbury Centre for Mental Health, 2007

LVSC has been working closely with the London Skills & Employment Board on their draft Strategy for Employment and Skills in London and with the London Mental Health & Employment Partnership looking at some of these issues. It is important that those implementing “Healthcare for London” also work closely with these partnerships to address the issue of increasing the employment of people with a mental health problem. In addition as a major public sector employer in London, it is important that the NHS addresses its own policies, procedures and actions to better manage the health of its staff who have a mental health issue and to encourage the recruitment of former mental health service users.

11. The politics of closures

The “Healthcare for London” consultation document provides some evidence of the benefits in terms of quality and safety of concentrating specialist services in a few expert centres in the capital. However, the closure of local services is always an emotive issue and will often be opposed by local people. It is for this reason that other suggested re-structurings of the health system in London have not taken place and have often developed in to party political issues.

It is vital that there is sufficient patient, public and VCS engagement in this debate to ensure that communities have been presented with the relevant facts rather than waiting for views to be formed by party politics and emotive campaigning. LVSC would be happy to work with the NHS and other public sector organisations to ensure the VCS in London could help to engage people in this process.

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LONDON BOROUGH OF BEXLEY

Healthcare for London
Consultation Response from the London Borough of Bexley

	Staying Healthy
1a	**Looking at the list below, which of the following changes, if any, would you like to make in the future to improve your health?**
	The list included here is fairly inclusive of the types of general advice people would be looking for when thinking about improving their health.
1b	**How could the NHS in London best help you make these changes**
	To help people make changes to their life style and to encourage people to stay healthy, access to advice on these issues needs to be easily accessible. Access to GP services can be difficult for some people, going to a GP for general advice rather than when you are ill may not be something that people often consider. If wider advisory services are available from a surgery or clinic locally patients should be notified of these services and provided with the details as a matter of course. There is some confusion around the level of services offered at different surgeries or other healthcare providers. Services should be tailored to the needs of a specific area and the services offered across the area should be clearly advertised. If your own GP surgery does not provide the advisory service you are looking for then patients should be told where they could access the service. With so many changes on the horizon to the way services are delivered, clarity around what will be available and where, whether at a clinic or at home, and for whom, will be essential.
1c	**What else could the NHS in London do to help you stay healthy?**
	Accessibility to services is key and feeling as though you have inconvenienced your local surgery by asking for an appointment will not encourage people to seek help on what they feel are not essentially serious medical issues such as help with weight loss. The service should be more approachable and customer focused if preventative services and general advisory services are to be effective and uptake encouraged. Joint working with partner organisations and developing strategies jointly to deal with public health issues. Availability at times convenient to the client group is also essential. The nine to five approach does not work for everyone.

2	**I would welcome advice on staying healthy when I come into contact with a healthcare professional**
	We would strongly agree that when a patient comes into contact with a healthcare professional that person should be able to provide a general level of advice and support and direct patients to where further information can be accessed on their specific question around staying healthy. We think health promotion work such as road shows that educate people further on issues such as healthy eating and stop smoking are very good in getting key messages across to people and would like to see more of this in Bexley.
3	**Please give us any other comments in this section**
	We agree that advisory services and services designed to tackle and prevent public health issues such as obesity and sexual health present a major challenge in the coming years. Bexley faces different issues to other London Boroughs and there should be flexibility and funding available for local Primary Care Trusts to develop solutions that work for their local population. These services need to be developed and monitored for longer term effectiveness as often new services do not have time to take effect before another round of service reconfigurations presents itself. A longer term plan and vision is essential with local Healthcare Commissioners driving the services they need and working with partners to address issues and design the services that work for the community – in the long term.
	Maternity and newborn care
4	**We are trying to balance various factors when developing proposals for maternity care in London. We would like to know what three factors are most important to you.**
	The most important factor for the London Borough of Bexley is to have a consultant led unit for our residents. The local unit at Queen Mary's Hospital (which incidentally is rated the safest in London S.E) is threatened with closure under the Picture of Health Consultation. In response to the list provided all of the issues are of importance when thinking about maternity care. We are encouraged to see the work taking place in Bexley - Delivering Choice in Maternity Services. It is essential that expectant mothers have full information about the services available to them and the associated risks to enable them to make an informed choice about how and where they give birth. There has been much negative press around the time mothers are left alone when giving birth in hospitals, the lack of midwives and how this could affect services in the future and whether home births are safe. We would like to see some of

	these issues addressed as part of the choices communicated in order to build public confidence in the variety of maternity services that will be offered in the future. Also the inter-relationships between these choices should be explored - if your choice is for a home birth, where is the nearest consultant-led unit, what is a safe distance and what is the process of transfer to that unit if there is an emergency? Offering the services only presents real choice if expectant mothers are fully informed. Presentations from Professor Sir George Alberti in relation to 'A Picture of Health for Outer South East London' recently suggested that midwifery-led units should be attached to a doctor-led unit – which is reassuring in terms of clinical safety. This consultation document however sets out the prospect of stand alone midwife-led units in the community. We would like to see some further information about stand alone midwifery led units and how these would work; who they benefit and what are the positive outcomes for patients when compared to a Consultant led unit.
5	**To be able to give high-quality care, we need to balance the time that midwives can spend with mothers after the birth of their baby with the time taken to travel to women's homes. Which option would you prefer?**
	There are two options set out as responses to this question. In answering this question we would like to reflect on the issue of choice; if mothers would prefer to be visited at home then this should continue to be an option – not only when necessary but when it is their preferred option. Attending appointments at a health clinic should not in itself equate automatically to more time with the midwife as this should depend on the individual needs of each mother.
6	**Please give us any other comments on the proposals in this section**
	The document states that currently 97% of births in London take place in obstetric (doctor-led) units. This may be due to the lack of alternative services and lack of consistent choice of alternatives but it could also reflect people's choice, based on the service they want or feel most comfortable with. Much more information is needed here about what each level of service entails, including the risks and benefits of each option before an informed opinion or choice can be made.
	Children and Young People

7	**The majority of care for children, including urgent care, will continue to be provided locally. We are proposing that specialist care for children will be concentrated in hospitals with specialist childcare. This may mean that they are further away from your home. To what extent do you agree or disagree with this proposal.**
	We would strongly agree that there should be specialist hospitals that are able to deal with conditions that are unusual, that effect relatively few children in any one area and need to be dealt with by specialists in their field. What is missing from the information here are the conditions that are regarded as specialist and the numbers of patients per year that would be treated in these units. There needs to be a balance between good local services that are accessible to parents and families for a majority of their needs, and specialist centres that deal with more complex cases. Also if patients, especially younger patients, have to travel to specialist units for treatment there needs to be adequate support locally for on-going or follow up treatments to be dealt with locally where possible. The residents of Bexley require a local inpatient service for children. Our local hospital, Queen Mary's Sidcup children's wards are under threat of closure under the Picture of Health Consultation. Not all child illnesses require 'specialist care' and often being closer to friends and family so they can be visited will have a very positive impact on a child's recovery. Families can struggle if they have other children at home and added travel will make the pressure harder. We feel strongly that preventative measures and striving to achieve early intervention through agencies working together is important to children's health and well-being. How services for children and families are planned and commissioned needs to be developed jointly to meet the needs of the community. The availability of local services such as speech and language therapy and occupational therapy and identifying the need for these services early are essential.
8	**What, if anything, could we do to encourage more parents to** 5 **immunise their children**
	This question would be better phrased as "what are the barriers that prevent you getting your child immunised?" There is a lack of public confidence regarding some combined vaccinations and the consultation should give people the opportunity to express their concerns. Is there any scope to offer more choice in the vaccinations available? Choice is a key theme in many other service areas. If a barrier to immunisation is the types of vaccination offered, would the choice be widened and individual vaccinations

	offered for example. We are also aware of an element of "postcode lottery" when it comes to vaccinations such as BCG across Bexley and Greenwich. In Greenwich the vaccination is available to everyone, in Bexley it is only recommended if the patient or their family come from a country considered to be a risk. Immunisation services should be equitable not different from Borough to Borough.
9	**Please give us any other comments on this section below.**
	We are pleased to see Children's issues are being managed separately through this process. It is essential that parents have access to 24 hour emergency care for children locally. Evidence suggests that parents often take their children to A&E as a precautionary measure because their GP is not accessible, even if the condition would not necessarily be considered an emergency. An additional facility for parents to access urgent healthcare locally, at any time of day or night is essential.
	Mental Health
10	**We established a new mental health working group including more clinical representatives. The results of this work will be published in Summer 2008. In the meantime, please give us your views on the recommendations shown in this section, to help us with the more detailed work.**
	The recommendations included in the consultation document are inline with what we would like to see and we hope that the mental health working group will translate these into plans for local services that better meet the needs of this vulnerable group. Accessing the right services when they are needed has proved difficult with long waits for therapies and other treatments. Close working with partner organisations is needed to improve the long-term prospects for people with mental health needs. We would like to see more information regarding a strategy for the enhancement of the delivery of mental health services; this is clearly an area in need of greater investment and is an area that has been a victim of cost cutting in the past. The situation that 93% of GPs have prescribed anti-depressants because of a lack of suitable alternative is clearly alarming as is the fact that Londoners do not receive the same level of service as other parts of Britain. There is not an easy solution to these problems but without more investment, a higher priority for mental health services and a lot of work to map out a sustainable service that will work on the ground, these issues will not be adequately addressed, we look forward to reading the working groups findings.

	Acute Care
11	**If there was a telephone service to treat your urgent care needs, what facilities would you like it to have?**
	The section discussing telephone access to urgent care states that callers are often confused as to the number to ring. The solution put forward is to bring in another number for urgent healthcare queries. However, it is unclear how this would differ to NHS Direct and why it would be more effective than the current service? Question 11 outlines the facilities that could be available – most of which are available already and have been considered in some cases to be ineffective. We are concerned that the IT infrastructure may not be in place to deliver the "Hear and Treat" service. Are there plans for sufficient investment to make this work?
12	**We propose developing some hospitals to provide more specialist care to treat the urgent care needs of the following conditions. These would probably be further away from your home than your local hospital. If these proposals are adopted, the number and locations will be subject to later consultation:** • **Trauma – about three hospitals in London** • **Stroke – about seven hospitals in London providing 24/7 urgent care with other hospitals providing urgent care during the day and rehabilitation** • **Complex emergency surgery needs – we need further work to assess the number of hospitals required.** **To what extent do you disagree with the proposals to create more specialised centres for the treatment of severe injury, stroke and complex surgery needs?** **Trauma –** Tend to agree in principle **Stroke –** Tend to agree in principle **Complex emergency surgery needs –** Tend to agree in principle
	Please tell us why?
	We would tend to agree in the principle that specialist centres in some cases could deal with patients with

	more severe needs more effectively to ensure that they are seen by specialists in their field and treated as quickly as possible to achieve the optimum outcomes. However we are agreeing with this statement as a broad principle without any information to a specific condition or information regarding the location and configuration of a specialist centre. For example, with regard to Stroke services, we would like to see the detail of a London Stroke Strategy before we could agree or disagree with this statement with regard to this condition. We would need to understand more about the number of people involved, the accessibility of the proposed seven units to ensure patients from across London would be able to access the essential CT scan within the 90 minutes timeframe and that the staffing arrangements would meet demand. A further issue that stems from this is having services locally that patients can be transferred to after their initial life saving treatment to deal with their continuing care needs. If bed blocking occurs at the regional centre because the local care isn't in place to transfer patients, this poses a risk to the effectiveness of the whole system. If the day care / local care arrangements are insufficient this will happen. We are aware of the lack of therapists locally and often bed blocking occurs on stroke wards because of insufficient rehab services. Community services must be in place first and accessible 24 hours a day. Once people are discharged from hospital their healthcare needs should be managed seamlessly as they return home, whether this is through continued healthcare treatment at home or at local hospitals through outpatient appointments. Care pathways must be in place to ensure that care continues locally from treatment in a specialist hospital and that the care pathways for patients are communicated and discussed with them. Intermediate care needs need careful considered locally for patients who cannot be cared for at home but have continuing healthcare needs. IT infrastructure is important here so that all healthcare providers have access to patients' information to be able to understand their history and deal with issues effectively. There is much anecdotal evidence of patients suffering through lack of communication between healthcare institutions and, as more patients are treated by a number of different institutions, this problem could worsen if there are not adequate systems in place.
13	**If you agree that there should be specialist centres for the treatment of trauma, stroke and complex surgery, to what extent do you agree or disagree that ambulance staff should take seriously ill and injured patients directly to these specialist centres, even if there is another hospital nearby?**
	We are assured that this is already the case in Bexley as some stroke patients and certain heart attack

	patients are taken to directly to inner London hospitals that are better equipped to deal with these issues. The consultation material states that in 2006 no hospital trust in London gave at least 90 per cent of stroke patients a scan within the less-than-ideal benchmark of 24 hours. This implies that patients who are currently being taken directly to other hospitals in London are still not receiving 'best practice' treatment. Will the performance of specialist hospitals in delivering specialist care be monitored against the 'best practice' benchmarks rather than against the current 'less-than-ideal' benchmarks?
14	**Please give us any other comments on the proposals in this section**
	Access to 24 hour urgent care is an essential local service that should be factored into any local plans for reconfiguration of services. More clarity is required around what Urgent Care Centres are and how they operate as there are Centres that offer services for minor injuries operating under different names and at different times depending on where they are located. It would be useful to introduce some consistency that enables the public to understand what is offered and when it can be accessed.
	Planned Care
15	**How useful, if at all, would you find it for GP surgeries to open for appointments in the evenings and at the weekend?**
	This would be very useful. In boroughs where major healthcare reconfigurations are taking place (i.e. changes to the structure and location of A&E, out of hours Urgent Care and services moving closer to the community), extended availability of local GP services will be essential in minimising the numbers of patients attending A&E with minor issues, particularly if there may be less A&E departments to deal with the demand.
16	**Please give us any other comments on the proposals in this section**
	There is mention of access to MRI and CT scans and bottlenecks in accessing these diagnostic tests. However, it does not elaborate any further on how it is proposed to deal with these bottlenecks. Diagnostic services are on the list of services to be available in local hospitals and polyclinics as part of the original Healthcare for London report so it would be helpful to know if there will be investment in more equipment for community facilities as well as those already provided in our local hospitals?
	Long Term Conditions

17	**Thinking about how the NHS in London is balancing the resources it spends on long-term conditions (e.g. asthma, diabetes), do you think :**
	Options: A – a greater proportion of future spending should go to help people with long-term conditions stay healthy by investing in more GPs, specialist nurses and other health professionals and the services they provide.
	Please tell us why?
	Patients should be supported in managing their conditions. More funding for community healthcare is needed if people are to be supported in this way.
18	**Please give us any other comments on the proposals in this section**
	It is important that patients are supported by healthcare professionals in the community to enable them to have more control over their conditions and how they live and to manage their conditions independently. Better education and access to services and advice is essential for patients to feel comfortable and supported in managing their own care. Adequate investment is needed to make this work to ensure the pressure and financial burden is not shifted from one organisation to another.
	End of Life Care
19	**Do you think new end of life service providers responsible for co-ordinating end-of-life care will result in better or worse care for patients than the current arrangement?**
	The model presented for End of Life Service Providers sets out a joint approach to end of life care that has been lacking in the past. It should result in better care.
20	**Please give us any other comments on the proposals in this section**
	Close working with local authorities is essential in developing local service plans for end of life care pathways.
	Where we could provide care
21	**The proposed polyclinics would have a number of features. We would like to know what five factors are most important to you.**
	We feel that the questions regarding the services included in a polyclinic are ill-considered. The question

	presents a number of options for services that could be included and some of these would not necessarily be achievable in Bexley. For example: the prospects for co-locating leisure facilities with healthcare services would need to be discussed in detail and the practicalities explored before it is presented as a possible option for the future. Otherwise, people's expectations may be raised unnecessarily. For this reason, we feel that the list of options should contain known deliverable options for a specific area.
22	**To what extent do you agree or disagree that almost all GP practices in London should be part of a polyclinic, either networked or same-site?**
	The document sets out the different ways in which a polyclinic should work and asks a question about same-site or networked services. The document states that if all GPs in an area wished to relocate to the same building, the vast majority of Londoners would be within 1.5 miles of a polyclinic. As a Borough with an aging population, many elderly people choose a GP surgery that is convenient and easy to reach as they access these services regularly within the standard opening hours. Therefore across the borough, co-located services could work in one area and cause difficulties in another. The needs of each community should be considered before this question can be answered and local solutions should be freely developed to meet the needs of the community.
23	**We are proposing moving the treatment of some conditions (e.g. trauma, stroke and complex surgery) to specialist hospitals and providing more outpatient care, minor procedures and tests in the community. Local hospitals would continue to provide other types of care as they do now. Which of these statements closely fits your view?**
	Option number four we would mostly agree with: The treatment of some conditions (e.g. trauma, stroke and complex emergency surgery) should be moved to specialist hospitals; and more outpatient care, minor procedures and tests should be provided in the community. Local hospitals would continue to provide other types of care as they do now.
24	**Please give us any other comments in this section**
	Community facilities need substantial planning and investment to enable services to be provided in line with the vision set out in this document. Joint working with partners is essential in making this work and adequate funding to provide the enhanced working practices that are set out as part of out of the vision of hospital care.

	Turning the vision into reality
25	**In the front of this booklet we described five principles. Now that you have seen how these principles will be applied throughout the proposals, please tell us whether you agree or disagree with each of these principles?**
	We would broadly agree with all of the principles. We would not agree that regional services should replace local facilities that people in the community want and need.
26	**What, if any, other principles do you think there should be?**
	Accessible local services that meet the needs of the community, specialist regional services to provide cutting edge specialist care.
27	**To what extent do you agree with the following statements?**
	If local services are commissioned locally through joint working and are given the necessary investment required and time and management to make them work effectively then we would agree with both of these statements.
28	**What else could be done to improve access to health services and improve the health of deprived communities and disadvantaged groups?**
	Planning should be undertaken at a local level to ensure that the services commissioned and the way services are delivered meet the needs of each community. Work should be undertaken with partner organisations to ensure each service provider understands in detail the issues that face their local community and joint strategies can be identified to deal with them.
29	**Please give us any other comments on how health services in London could be improved over the next ten years**
	Over the last 10 years there has been a substantial amount of investment in the NHS which has resulted in improvements – but these improvements do not match the significant investment received. This is coupled with huge financial deficits across London resulting in some Trusts being considered financially unviable. Some of this is a result of having commissioned new facilities that present unsustainable long term financial

	burdens for the local health economy and this, in turn, means that some facilities are at risk. Some of these burdens have then been worsened by the changes to the way that Trusts receive payments for the work they do that has been implemented by the Department centrally. There is often a lack of cohesion between Primary and Secondary care which we have witnessed when visiting primary care led services in secondary care facilities. These issues need to be addressed if the reality of a world class healthcare service for London is to be achieved. A long term vision needs to be just that – long term, not overtaken by a further review in two years time. The vision set out by Lord Darzi needs investment, not only in Healthcare but in other related services to ensure the services work seamlessly as they are set out in this document and the financial burden is not simply passed on elsewhere e.g. to local authorities. The services should be developed locally with all partners involved in the discussions and joined up care should be provide (as outlined in principle number two) with a commitment to investing long term to make this work.

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Health Care for London Consultation

The BME Health Forum, which works in Kensington, Chelsea and Westminster (KCW), held a 'Health Care for London' consultation event on 14th February 2008. The event was organised in partnership with Kensington & Chelsea (K&C) PCT and Westminster PCT and, was attended by 30 people including representatives of BME community groups from KCW.

The event involved three discussion groups on:

1. Maternity and Children & Young People
2. Access to GP practices and health centres
3. Mental Health

General comments:

1. We have been informed that NHS London will only consider or give priority to feedback which submitted through the questionnaires, i.e. direct comments and feedback will not be reviewed. We are very concerned about this as we believe this will exclude many people from all groups and communities but especially from BME communities. Newly arrived asylum seekers, particularly those who cannot write or read English and those who do not have the confidence to express their views in writing, will be excluded as a result. In addition, many of our members and clients find discussion groups as the best way to put their views and ideas forward and would find filling out questionnaires off-putting. This is why we decided to organise an event and conduct the discussion groups.

   A simple **Equality Impact Assessment** would have identified that considering questionnaires alone as feedback is a discriminatory practice, which will exclude the views and input of many vulnerable people.

2. Most of the BME community representatives who attended the event felt that the consultation document failed to address equality and diversity issues adequately. These include issues such as access to services for BME groups, including asylum seekers and refugees; needs of older people from BME communities; and the need to promote and provide opportunities for BME professionals to be represented at all levels of NHS to provide a better understanding of the needs of all BME communities in London in general and KCW specifically.

3. We would like a response from NHS London to the two points above as they represent general concerns about the process of consultation rather than specific comments on the proposals of the consultation itself.

The following is a summary of the Main Discussion Points from this meeting:

Maternity and Children & Young People:

- While a lot of women prefer midwifery care, care by consultation and doctors in situ is also essential
- Different choices should be available for different people in differing circumstances.
- There should be a choice of midwife-led services and, a consultant made available if needed. Not a trade-off.
- People do not opt for home births because they do not have the confidence that they will get the support they need
- In practice, even when they opt for home births, they usually end up in hospital
- Prefer home visits from midwives after birth
- It would be good to have the additional option of dropping in to a midwifery service
- In practice, some women do not get visits by midwives
- Issue about the capacity of specialist centres
- Specialist centres in KCW work well, but only have a local remit
- People feel very pressurised by GPs to agree to vaccinations

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GP Practices and Polyclinics:

- Perceived shortage of GPs resulting in low take-up of appointments
- Who determines the ratio of GPs per practice?
- Would be very useful to have access to GPs in the morning (7 – 8am), evening (5 – 8pm) and on weekends (9am – 2pm); maybe preference for set appointments rather than drop-in, but need a good booking system in place. This will require flexible working for GPs and their staff.
- Enable on-line booking of appointments
- Ongoing issue of the behaviour of some receptionists, particularly if the patient’s first language is not English. Perhaps provide training for them?
- Would be very useful to have the option of having some tests done at GP surgeries – will reduce travelling time, need for multiple appointments, and ideally, be more personal due to familiarity with staff
- Issues raised about continuity of care, eg. Seeing same GP, forging GP/patient relationships

- Regarding Polyclinics → will polyclinics replace GP surgeries? This raised concerns about access, long distances to travel etc. Should be thoroughly assessed before implementation
- Patients would like to see the following services in the proposed polyclinics:
    - Dental services
    - Specialist consultant clinics
    - Link Workers (to assist people to access services)
    - Advice services
    - The Homeless population needs to be catered for – specific services required
    - Create space for community groups to use i.e. generic facility and promote it.

- Regarding A&E/minor ailments unit:
    - The diversity of London's population must be given careful consideration as a 'generic polyclinic' to suit all areas would not be suitable
    - Ongoing issues need to be looked at when exploring how services are to be delivered in future eg. Low use of interpreters, other barriers to registering with and accessing services
    - Improve dissemination of information about services
- More is required within the consultation on why health inequalities arise
- All new proposals for service changes need to be equality and equity assessed
- The current proposals do not explore diversity issues enough
- As they stand, the frameworks will not address existing health inequalities
- Training for GP and primary care staff on diversity, health inequalities and the needs of specific groups

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Mental Health:

- Reducing fear and stigma
- Interpreting/language needs
- Culturally sensitive services
- People's background/ethnicity etc should be acknowledged and incorporated from the top-down
- Training members about BME communities,; access to training for BME individuals
- Fear of strong medication prevents many patients seeking treatment
- Provide post-diagnosis support to individuals
- Involve carers /family more
- Involve/educate community leaders
- Enable patients to access the different types of services on offer
- Prevent quick/overzealous diagnosis
- Educate about what actually happens in various treatments and what different medications do
- Encourage recruitment of female health professionals

- Promote talking therapy from within BME communities (increase in value)
- Explore partnership working
- Training community individuals/groups who provide services
- Commission the voluntary sector as an information resource
- Increase recognition of the voluntary sector as a link to the community
- Increase the capacity of voluntary sector through funding
- The Commissioning process should be more accessible to voluntary sector organisations who may not have full capacity

Regarding Assertive Outreach:

- Good in theory but practice is questionable; Other issues need to be tackled before carrying out Assertive outreach
- Engage and highlight various avenues/treatments
- Joint visits with community groups
- Community groups should be trained to provide outreach
- Increase education of services (tackle language barriers)
- Alternative therapies should be highlighted
- Independent service/advocacy is essential
- The OREMI Centre (in K&C) could provide outreach model
- Generally→ recognise that BME communities have different needs, learn from community models which are in place (i.e. Jewish community)

Amjad Taha
BME Health Forum Manager
25th February 2008

Response of the London Borough of Croydon
Health and Adult Social Care Scrutiny Sub-Committee
to the consultation on Healthcare for London

The Sub-Committee welcomes many of the proposals contained within the Healthcare for London consultation document and recognises that they seek to build on much best practise that already exists across the capital in the provision of healthcare. The aspiration to develop a service that meets the needs and expectations of all who live and work in London is obviously to be welcomed. Our residents can take comfort from the active participation of acknowledged clinicians in the drafting of the models contained in *A Framework for Action*, ensuring that the proposals for the delivery of that service are genuinely patient centred, rather than being bureaucratic solutions to their needs.

The Sub-Committee recognises the extensive consultation process that has been undertaken and commends Croydon Primary Care Trust for its Local Implementation Plan underpinning that consultation locally. Presentations to community groups, Neighbourhood Partnerships, as well as to elected Members have enabled residents' voices to be heard; although the difficulty of engaging hard to reach groups remains a particular problem for all such exercises. Recent experience with consultation on a Primary Care Strategy for Croydon demonstrates the eagerness of residents to engage with healthcare issues; as well as the need for their views to be taken on board.

The Sub-Committee particularly welcomes the recognition that there has to be local flexibility in any future implementation of the models contained within the consultation document; one size will not fit all. The NHS is not starting with a blank canvass and future plans and proposals will need to recognise existing provision, local identities and the large variations in population densities and localised need across the capital. It needs to recognise issues of patient choice and accessibility.

The emphasis on prevention and staying healthy is to be welcomed and builds on the strong partnership working that already exists between Primary Care Trusts, voluntary and community sector organisations, local authorities and others in providing services to encourage and enable people to stay mentally and physically healthy. The introduction of extended services in schools and the development of children centres as part of the Every Child Matters agenda offer excellent opportunities to promote preventative work at an early age. The Building Schools for the Future programme will enable this partnership working literally to be built in the heart of local communities, and bring healthy living services closer to residents, including often disadvantaged groups. Recent controversy over proposed changes to HIV prevention funding illustrates the need for such preventative work not to be seen as the poor relative in healthcare services where funding gaps can be closed.

Members welcome the development of Academic Health Science Centres and recognise their role in the global healthcare science and research community; the Sub-Committee recognises that the pre-eminent position already enjoyed by its mental healthcare provider the South London and Maudsley NHS Foundation Trust and would support its involvement in a South London grouping of such centres.

The Sub-Committee welcomes the proposals to create more specialised centres for the treatment of severe injury, stroke and complex emergency surgery; the supporting evidence around assuring quality through critical mass and the resultant skills base is compelling. The South West London Collaborative Commissioning Initiative on Acute Stroke Services which is currently being piloted reflects the weight of this evidence and is intended to deliver scans and thrombolysis within the recommended three hour window, if clinically necessary.

The South West London Elective Orthopaedic Centre (SWLEOC), with its attendant very low rates of healthcare acquired infections, offers a local example of successful specialisation with which residents can identify. Members are very mindful of equality issues, both financial and physical, of a move to provide more services in specialised units in locations further from residents' home; these concerns must, however, be counterbalanced by the increased equality of outcome such units provide.

The Sub-Committee welcomes the greater emphasis on local service delivery contained in the consultation document. As the Primary Care Strategy consultation conducted by Croydon Primary Trust in 2007 demonstrated, however, any suggested changes to the structures of primary care delivery can be controversial and the case for change needs to be well made. A universal model cannot be imposed; local flexibility is fundamental to popular acceptance. The importance, however, of polyclinics being able to open outside of traditional working hours is not to be underestimated, especially if they are truly to become healthy living centres attractive to those who infrequently visit GP surgeries. The proposals for polyclinics contain much that could be attractive to a local authority as they offer the potential for social care services to be further integrated with health care provision, but they do highlight the major weakness in the Healthcare for London proposals: the gaps in detail on social care, especially, but not solely, the unanswered funding issues raised.

The consultation document rightly acknowledges the role of partnership working in the future delivery of a healthier London, but fails to address in detail the cost to local authorities of the increased emphasis on home care and social care explicit in the proposals. There is no escaping the fact that the division between health care free at the point of need and means tested social care remains a source of concern not only to financially pressured local authorities, but also a source of bewilderment and despair to residents and their families.

The Sub-Committee finds it hard to conceive how any local authority can support proposals that address health care issues whilst remaining largely silent on the future provision and funding of social care; to sign such a blank cheque would not be in the interests of the population we are elected to serve. The lack of any predictive modelling or triangulation of the proposals to gauge the financial impact on social care services and budgets is the most obvious gap in the proposals being considered.

The presentation of our Director of Adult Social Services to the Joint Committee on 18th January reiterated many of the concerns earlier raised by Members of the Joint Committee in relation to the need for transparency in social care funding and the potential for increased cost shunting in the future. The suggestion for an extension to the tariff approach to include explicitly the additional, and potentially differential, social care cost elements is to be supported.

Any move to increased treatment and rehabilitation in peoples' homes will impact on social care provision and this needs to be reflected in refocused funding allocations channels as monies are released from acute hospital care; best practice in such joint commissioning funding needs to be shared across London and more formally embedded in the proposals. Transitional or capacity building funding would need to be identified for any further developments in both this area and others contained in the consultation document.

The Sub-Committee also recognises that the proposals will carry capital funding implications and the review of the NHS estate in London is to be welcomed in terms of ensuring value for money. Locally elected Members, however, are aware of the concerns of residents were redevelopments involving the building of large blocks of flats to be the outcome. Any reduction in the NHS estate needs to be seen as the inevitable result of the review rather than its driver.

The Sub-Committee notes the potential impact on district general hospitals of top-slicing of specialist provision to designated units and the transfer of additional services to primary care settings: district general hospitals could face reduced revenue streams and still face the same capital expenses associated with their estate and Members need to be reassured that this is being addressed.

Members also recognise that our partners in the Primary Care Trusts need confidence in the sustainability of their long-term budgets; assurance is sought, through external or independent validation, that realistic levels of future costs and demand have been fully factored into the predictive financial models contained in the consultation document.

Information Technology also provides a cause for concern, especially the reliability, confidentiality and security of systems. The potential for more patients to receive treatment outside of their immediate locality, for example in specialist hospitals, would necessitate enhanced communication pan-London and the consultation document offers no assurance that adequate systems are in place across the 32 London boroughs and 31 Primary Care Trusts. Funding to address any deficiencies in this integral area is not discussed in the consultation document.

As Overview and Scrutiny Members, we recognise that Croydon Council enjoys a constructive and progressive relationship with our local Primary Care Trust and many of the proposals contained in the consultation document outline best practice already being implemented locally for the people of Croydon. To move forward, however, requires certainty and transparency around the governance arrangements for the provision of health and social care services: will the local authority and PCT remain coterminous? How can greater accountability be assured moving forward? Should the local authority increasingly be the commissioner of health services for its residents?

The Sub-Committee acknowledges, however, that *Healthcare for London* is primarily a consultation document. Members would expect to engage on a significantly greater scale when service changes are formally brought forward as opposed to the policy process with which the Joint Overview and Scrutiny Committee is currently engaged. Some of these implementation proposals may have pan-London implications and would need to be scrutinised by a new Joint Overview and Scrutiny Committee with

amended terms of reference; others would require scrutiny on a borough, or where appropriate cross borough basis with full public engagement.

In summary, the Sub-Committee finds much to praise in both the consultation process and consultation document, but as locally elected Members we find it hard to support a document that leaves unanswered so many questions that will impact on the lives, and potentially pockets, of our residents.

Scrutiny

Councillor STANLEY SHEINWALD
Chairman, Overview and Scrutiny Committee

NHS London
Freepost
Consulting the Capital

21 February 2008

Harrow Overview and Scrutiny Committee's response to the local *Healthcare for London* consultation by Harrow Primary Care Trust

We write in response to the local consultation conducted by Harrow Primary Care Trust (on behalf of NHS London) on *Healthcare for London: A Framework for Action*. We are sharing this response with the Chairman of the pan-London Joint Overview and Scrutiny Committee (JOSC) on *Healthcare for London.* The JOSC Chairman may feel it appropriate to share with scrutiny colleagues on the JOSC our local scrutiny enquiries around *Healthcare for London* and that this be considered as evidence to inform deliberations at a wider pan-London level.

By way of background to our processes, to facilitate our contributions to the JOSC, in Harrow we established a cross-party working group of scrutiny councillors to lead on the *Healthcare for London* scrutiny work. This working group (consisting of Councillors Vina Mithani, Margaret Davine, Barry Macleod-Cullinane, Rekha Shah and Dinesh Solanki) has pulled together this response on behalf of scrutiny in Harrow. We are clear that this response represents a Harrow scrutiny perspective and as such does not preclude any other groups/organisations/individuals from our organisation or the wider health and health and social care economy from submitting their own views. We acknowledge that as a JOSC has been established to consider *Healthcare for London*, NHS bodies are not obliged to respond to our individual Overview and Scrutiny Committee's comments.

Our comments are based on evidence from previous scrutiny work in Harrow, as well as conversations we have had with key players in the local health and social care arena. This culminated in discussions at our recent Overview and Scrutiny Committee on 28 January on the implications of *Healthcare for London* for Harrow which involved Harrow Primary Care Trust, Harrow Council's Corporate Director of Adults and Housing and the Adults Services Portfolio Holder. Our response is contained in the attached paper and is presented with reference to the appropriate sections of the consultation document and our specific areas of focus/evidence.

We recognise that it is not scrutiny's role to carry out the consultation on *Healthcare for London* with stakeholders as the responsibility rests with the local NHS, however we would like to

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Councillor STANLEY SHEINWALD
Chairman, Overview and Scrutiny Committee

facilitate the consultation and develop local understanding to ensure that our residents are aware of the impact of these proposals on their health and social care services.

We thank our colleagues from across the Council and health organisations for their contributions to our discussions around *Healthcare for London* and sharing their perspectives on the implications for Harrow. We have welcomed the openness of this dialogue and will strive to ensure that this dialogue is an ongoing one. Should you need any elaboration on the evidence used in our comments, please do not hesitate to contact us through the Scrutiny Unit (details as given at the bottom of this letter), and further, more details can be found on our website www.harrow.gov.uk/scrutiny.

Yours faithfully

S. Sheinwald	Mitzi Green
Councillor Stanley Sheinwald, Chairman of Harrow Overview & Scrutiny Committee	Councillor Mitzi Green, Vice- Chairman of Harrow Overview & Scrutiny Committee

Cc:
Ruth Carnall - Chief Executive NHS London
Paul Clark – Corporate Director Children's Services, Harrow Council
Sarah Crowther - Chief Executive, Harrow Primary Care Trust
Michael Lockwood - Chief Executive, Harrow Council
Councillor Chris Mote - Leader of Harrow Council
Councillor Janet Mote – Children's Services Portfolio Holder, Harrow Council
Paul Najsarek - Corporate Director Adults & Housing, Harrow Council
Councillor Mary O'Connor - Chairman of Joint Overview and Scrutiny Committee to review Healthcare for London
Councillor Eric Silver - Adults Services Portfolio Holder, Harrow Council

Enc:

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Consultation questionnaire section:	'Healthcare for London – Consulting the Capital'
Our focus:	Local consultation process

Our response:

Local consultation activities

Harrow PCT held a public consultation event on Saturday 26 January at Harrow Civic Centre as part of its ongoing consultation activities, which have also involved a wraparound on local newspapers and events at health venues and supermarkets across the borough. As pointed out to us by the PCT, there are limited venues within the borough that can adequately facilitate the space, time and technology needed to support people in watching a video on healthcare and filling in the lengthy consultation questionnaire. The PCT recognises that it is taking time for people to complete the questionnaire but stresses the need to balance considerations around the quality as well as the quantity of the responses.

It is estimated that about 50 people attended this public consultation event with the key message coming from local people that highlighted the importance of joint working across agencies in providing care - patients welcome an improved flow of information and ask that health services better link up with social care and the voluntary sector. We would concur with this view.

Improving consultation processes

Previous scrutiny work around the Alexandra Avenue Health and Social Care Centre consultation by Harrow PCT uncovered some concerns around the consultation process, namely that people may not have been clear about the purpose/content of the proposals (i.e. the closure of two local clinics and moving services to Alexandra Avenue). Furthermore, there were low numbers of respondents to the PCT consultation (150), especially when set against the number of people signing a petition opposing the proposals (300) that was subsequently presented to scrutiny. We are adamant that consultation activities must learn from previous attempts to engage with local residents around their healthcare needs to inform the current local consultation strategy.

It is important that the local NHS is not seen to be merely paying lipservice to this consultation and is doing enough to publicise it. It is imperative that the PCT ensures that it gleans the views of all residents and not just the 'usual suspects', including capturing the views of children and young people, and other hard-to-reach groups. Particular note should also be given to current patient and public involvement forums which are winding down as the Local Involvement Networks are being established, so as to ensure that these views are still being captured during the transitional period.

Our scrutiny members have questioned whether this local consultation process on *Healthcare for London* represents much effort for very little return, but accepts that it is perhaps too early to judge although the PCT is doing as much as it can to engage with residents. The PCT will need to solidly progress the *Healthcare for London* plans and build on the momentum once it knows the implications locally. Our PCT is comfortable that it can implement the direction of travel laid out in *Healthcare for London* as it is already moving forward with some of this work. Work needs to begin now on gearing up the local health economy for the changes and we feel that there needs to be a sufficient focus on the transitional movements.

In determining how Harrow Council could further help in the PCT's consultation efforts, the Overview and Scrutiny Committee has recommended that the consultation be highlighted on the council's own website.

Consultation questionnaire section:	'Maternity and newborn care'
Our focus:	Maternity at Northwick Park Hospital and Brent Birthing Centre (both part of North West London Hospitals Trust)

Our response:
In providing women more choice about how and where they give birth, the *Healthcare for London* working group for maternity and newborn care proposes a model with fewer obstetric units but with a greater ratio of consultants, more midwifery units (one for each obstetrics unit) and more home births. There is the assumption that many women will choose home delivery or a midwifery unit rather than hospital. Also proposed is more use of one-stop community facilities for the provision of antenatal and postnatal care, almost certainly meaning fewer home visits.

Questioning maternity assumptions
The case of Brent Birthing Centre has questioned the assumption that women want home deliveries or midwifery-led units rather than hospital experiences. This assumption has not been borne out locally as there is not the demand for the model of care as proposed by *Healthcare for London*. Brent Birthing Centre, despite being actively promoted by local healthcare professionals, only delivers 300 births a year with a 16% occupancy rate. Given the size of the Brent/Harrow catchment area, the trust would expect to see 1200-1500 women choosing to deliver their baby at the Brent Birthing Centre. Furthermore, 25% of the women choosing Brent Birthing Centre have to be transferred to Northwick Park Hospital, as they need the care of obstetricians due to complications. In the past when Northwick Park Hospital's maternity unit was placed under special measures following an investigation by the Healthcare Commission, local women still did not opt for births at Brent Birthing Centre, suggesting that perhaps what women want is the assurance of medical back-up.

This situation does not seem peculiar only to Harrow/Brent. As a comparison, it is understood that Barnet Birth Centre delivers about 360-420 births per year. The transfer rate to hospital is around 23% antenatally but much lower during labour (about 12-14%). Barnet Birth Centre takes bookings for about 60-70 women a month, although it targets for around 100, suggesting that the occupancy rate there too could be improved.

Allied with our concerns regarding the demand for some elements of the model of maternity care outlined in *Healthcare for London*, there are also the real pressures of adequate staffing levels given the current low numbers of midwives in London to consider. Will London have sufficient numbers of midwives to staff the maternity models outlined in *Healthcare for London*?

Please note that the North West London Hospitals Trust has recently consulted on its proposals for changes at Brent Birthing Centre and Harrow's scrutiny lead members for children and young people and adult health and social care have responded to this consultation separately.

Consultation questionnaire section:	'Acute care'
Our focus:	Local stroke services

Our response:
Better clinical outcomes
Our health partners recognise the need to do more around acute care especially stroke care and cardiology and that *Healthcare for London* provides the lever for this. There is strong evidence that, given the changes in technology and staffing arrangements (for example the recent workforce directive around hours worked by NHS staff) in the NHS, that concentrating specialist services for example for stroke care, in fewer places where there is enough volume for staff to develop their clinical skills, has better clinical outcomes.

For those suffering from a stroke episode to get the best clinical outcomes, they need to receive a CT scan within 90 minutes and thrombolytic drugs within 3 hours. Specialist care can provide this as well as access to better rehabilitation services. Opening hours to access these levels of care is an issue not only in Harrow but also across London. In North West London, there are very few hospitals that can offer 24 hour care for stroke patients although other hospitals do offer intensive care. It is felt that London underdelivers for stroke patients and this must be addressed.

Infrastructure issues: transport, equipment and staff
There remains much concern about the transport infrastructure required to deliver more centralised services like specialist stroke centres, especially given high levels of congestion in some parts of London including Harrow. Consideration of access times remains an important issue to align with clinical arguments for specialist centres. Further work in this area will be vital in informing local decisions around the location of specialist centres. The traffic and travel analysis part of the work around specialist centres will be vital in informing local decisions. We would urge our NHS colleagues to open dialogue with the London Ambulance Services and Transport for London about access issues and also give consideration to how decisions will be fully explained to the public. The public will need to be reassured that ambulances by-passing local hospitals in order to get patients to specialist centres is in the interest of better clinical outcomes, and perhaps the model of cardiac care can be used to educate public opinion in this respect.

It has been suggested to us that the biggest concern around specialist centres will not be the locations, but rather the staffing models to fit providing a sufficient workforce to man 24-hour care. At a national level, more MRI scanners are needed within the health service, especially when compared to figures abroad e.g. USA. This has implications for purchasing equipment and also training staff to use them. The model of stroke care in Ontario, Canada shows that outcomes are 20% better where care is centralised rather than using local facilities. However we ask whether the levels of technology (and training of staff) both locally and across London can match that of Canada? We are of the mind that *Healthcare for London* appears to underplay the importance of technology in achieving some of its proposed models of care.

Centralising specialist services
We acknowledge that should the *Healthcare for London* vision be adopted by NHS colleagues in London that in the months to come there will be difficult conversations and decisions to be made around services such as stroke care, as local areas will lose services that have been centralised. This makes it all the more necessary to start early messages that local access to better specialist services will deliver better clinical

outcomes. We have heard from NHS colleagues that Northwick Park Hospital could be considered as an appropriate site to develop into a specialist centre for stroke care and we would ask for continued dialogue on this.

Consultation questionnaire section:	'Where we could provide care'
Our focus:	Polyclinics and the future of the district general hospital

Our response:
Polyclinics
Much of the attention around *Healthcare for London* has fallen on the idea of developing polyclinics in London. Described as at "a level that falls between the current GP practice and the traditional district general hospital", based on population needs it is suggested that there should be a polyclinic to serve a population of 50,000 people. Therefore it follows that for a borough the size of Harrow this would mean about 4-5 polyclinics.

We have heard the view of Harrow PCT that polyclinics will offer a wider range of high quality services over a number of extended hours and that it is advantageous that there is not one definition or model of polyclinics as this will allow for local polyclinics to tailor themselves to the needs the communities that they serve within the borough. Inevitably there will some overlap with some services of the local hospitals.

We note that *Healthcare for London*'s financial modelling and funding calculations for the polyclinic model do not take account of start up capital costs for polyclinics and we have questioned how Harrow PCT is going to pay for its new polyclinics. We would suggest that this would require the use of monies from existing local NHS estate, whilst acknowledging that the assets of partner agencies (e.g. the Council's Neighbourhood Resource Centres and Children's Centres) may well also be considered when determining which locations best meet the needs of residents. Locally, the new Alexandra Avenue Health and Social Care Centre could be developed into a polyclinic as could the front of Northwick Park Hospital, as *Healthcare for London* envisages that all hospitals with A&E departments would be co-located with a polyclinic which alongside its other functions would include an urgent care centre as a "front door". Therefore polyclinics should not all require rebuilds. We note the advice from health colleagues that there is a need to appreciate the phasing and strategic approach of the 10-year vision provided by *Healthcare for London.* However as yet, without further financial modelling on a local level at least, we remain unconvinced that the development of polyclinics will not require investment in capital buildings to deliver this vision.

Previously Harrow councillors have expressed concerns around the location of the Health and Social Care Centre in Alexandra Avenue, for the reason that travel access to the facilities is poor. Should this be developed into a polyclinic, thought should be given to eradicating access problems through work with Transport for London. The PCT has highlighted to us the importance of phasing in the implementation of the *Healthcare for London* proposals. Assumptions, for example around transport links, staff transfers and equipment needs, must be tested through the phased approach and the learning carried forward to future phases.

The role of GPs
There appears to be a reliance on practice based commissioning as a lever for the visions contained within *Healthcare for London*, requiring GP buy in and innovative commissioning to fund some of the Darzi vision and services at polyclinics. The Government has made it clear that it expects a significant proportion of funding to be channelled through Practice Based Commissioning. It must be a local priority that local GPs are brought on board with the *Healthcare for London* visions and the implications of these for their own practices and

services. There has been a reluctance from local GPs to provide services at Alexandra Avenue Health and Social Care Centre and we would urge the PCT to understand why this is the case, especially if Alexandra Avenue is to become a polyclinic and serve as a forerunner for such a model locally. Furthermore, we are clear that in locating future polyclinics and GP services that they are in locations accessible to residents. If, as *Healthcare for London* promotes, over time polyclinics are to become the site for most GP care, this suggests that people will have to travel further to see their GP. We question whether all of Harrow's communities are mobile enough to do this. This should not serve to accentuate inequalities e.g. for the elderly, those with mental health problems, those without cars or those with young children – polyclinics must be attractive to service users as well as service providers.

Consultation questionnaire section:	'Turning the vision into reality'
Our focus:	Implications on social care and wider partnership working in Harrow

Our response:

Partnership working

Most of the principles contained in *Healthcare for London* have already been reflected in recent Department of Health and NHS policy including Local Area Agreements and section 31 of Health Act 1999 where partnership working and collaboration between health and local government encourages flexibilities. As the PCT is moving away from a provider role toward that of a commissioner, there is a greater emphasis on joint commissioning with the local authority. We are hopeful that our local bodies are adequately configured for this and that Harrow Council and Harrow PCT can work together to provide a 'single patient pathway'. We welcome the PCT's assurances of continued dialogue with local authority colleagues. We wholeheartedly endorse the view of Harrow PCT's Chief Executive that as this is only the start of the process it is important to get the principles right and that it is highly important that we start to think locally across organisations about how to take *Healthcare for London* forward. This includes in large parts consideration of the impact upon other partners.

We believe that the *Healthcare for London* proposals on integrated care, prevention and tackling inequalities are the least well worked out, partly because their success will lie outside of the sole remit of the NHS and depend upon collaboration with other agencies. It concerns us that *Healthcare for London* makes very little reference to the impact on local authorities, especially social care. This raises questions about the capacity of other practitioners to take on added responsibilities. Shifting expenditure from acute hospital care into prevention is extremely difficult to achieve. This will undoubtedly increase the demand for social care. Transitional arrangements during the shift from treatment to prevention apply as much to social care as to health services.

Modelling impacts

There has been a lack of predictive modelling to gauge the implications on social care, especially in assessing the impact (in service provision, financial and on workforce) of the demands of these changes. The Adults Services Portfolio Holder has impressed the need for health agencies to work with social care partners, especially as much of the financial information on impact on social care is lacking from *Healthcare for London*. The PCT's Chief Executive agrees that there remains much work to be done on the finances and locally there needs to be solutions that suit all. It is noted that *Healthcare for London's* financial modelling forecasts are for the end point in 10 years time and there remains the need to consider the year-on-year impact in between. We have been reassured that Harrow PCT is working on this technical information to ascertain what it will mean for Harrow's annual budgets and that service planning decisions will involve the Council. Throughout this we reinforce the point that the focus should very much remain on the users and what they want, and this should not be secondary to the needs of providers.

One of the key planks of the planned care proposals centres on early discharge from hospital to home – this will require greater use of social care. The planned care working group in *Healthcare for London* suggested "resources freed up from more day cases may need to be re-invested into social care support" and further "the need for increasing support from social care and the associated costs of this should be considered as part of

NHS commissioning, with NHS resources being used, where appropriate, to commission social care." How this will work in practice is essential for the local authority to gauge.

Shared resources
We should not assume that only NHS estates can deliver the *Healthcare for London* models and suggest that consideration should be given to Harrow's new Neighbourhood Resource Centres (due to open in 2009) and children's centres as futures homes for such integrated health and social care. We would advise that the PCT discusses with local authority colleagues the feasibility of these options and that both organisations think jointly about their assets. We reiterate that the local authority and PCT should do early work together to consider the local implications of *Healthcare for London* on Harrow's communities, for example the location of polyclinics and better use of community transport - this could be used to dovetail with providing a better patient transport service if fleets were shared e.g. use the fleets for SEN transport around school times and for patient transport at other times. This could reduce patient transport waiting times, the cost of SEN transport, as well as bring together health and social care.

We take this opportunity to raise our concerns relating to the development of the NHS estates plan. It has been suggested to us that there is a real fear that services currently provided at Royal National Orthopaedic Hospital's Stanmore site may be moved elsewhere so that the estate can be sold. We would question how this can be reconciled with the need for specialist centres, of which RNOH is currently an internationally renowned exemplar.

Local priorities
We support our Corporate Director of Adults and Housing's recognition that there are a number of risks and opportunities attached to the *Healthcare for London* vision and that the Council should warm to projected progress of public health emphases in healthcare messages. The second stage of the consultation will yield the most interest as it becomes clearer the impact of the proposals – what, where and for whom. Wherever possible, the local authority and PCT should aim to conduct joint consultations to help people gain a better understanding of the health and social care interface. The aim of public consultation should be to lead public opinion as well as to follow public opinion, and this is especially true when giving messages around people taking more responsibility for their own health.

It will be key to tie in the *Healthcare for London* implications to the priorities of the local authority, for example through the Local Area Agreement so that work is complementary, makes best use of resources and builds on local partnership working. There is a clear direction of travel within *Healthcare for London* and we are assured that locally there will be more time and resources given to preventative and health promotion work. This fosters the need for greater partnership working and we feel that locally across organisations there is the genuine will to build upon partnerships and to enable them to flourish.

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Our Ref:
Your Ref:

25 February 2008

Cllr. Mary O'Connor
Chairman of the Joint Overview and Scrutiny Committee
London Borough of Hillingdon
Civic Centre
High Street
Uxbridge UB8 1UW

Dear Cllr O'Connor

Healthcare for London' review

Thank you for your letter of 25 January 2008 inviting a submission from London TraveWatch to the joint overview and scrutiny committee (JOSC) of 'Healthcare for London'. We are grateful to be able to comment.

London TravelWatch is the statutory watchdog set up by Parliament and sponsored by, but independent of, the London Assembly to represent transport users in London.

In March last year we convened an Access to Hospitals Task Force to consider the issues of access to hospitals because for many years we have received representations regarding the difficulties patients, staff and visitors have in getting to hospitals, particularly by public transport. In the light of the publication of the Darzi report and the subsequent PCT 'Consulting the Capital' programme we have made our response to these documents our first priority.

As an organisation concerned with travel and transport, we will not express views on the reorganisation of healthcare facilities in London except to say that world class healthcare will remain an aspiration for many Londoners if they cannot reasonably get to the sites from which those services are provided. We therefore believe it is paramount that the accessibility of any new, or reconfigured facility should be considered at the earliest possible planning stage, giving particular regard to travelling by public transport, bicycle and on foot.

London TravelWatch and its predecessor bodies have accumulated much anecdotal evidence that access to hospitals has not been taken account of early enough in the planning process. Too many hospitals have been relocated to places remote from public transport on the assumption that the transport provider, often Transport for London (TfL) buses, will be able to introduce new routes or divert others. Often this is not the case.

We know of nine particular hospitals with existing access problems, the most recent being the relocated Princess Royal University Hospital (PRUH), Orpington, which has ongoing access deficiencies.

Other issues include the non-validity of Freedom Passes for reaching out-of-London facilities (Darrent Valley Hospital, Dartford); access issues from local streets (Ealing Hospital); reluctance of hospital authorities to provide the bus stands and stops required (PRUH), and site management issues where hospital grounds have become parked up to such an extent that the bus route has narrowed to barely wide enough for the vehicle to pass and the bus stopping area at the hospital entrance is often congested (St Georges Hospital, Tooting).

Public policy on this topic is best summarised in an NHS publication by the National Institute for Health and Clinical Excellence (NIHCE) : 'Accessibility Planning and the NHS, improving patient access to health services'. It defines the aim of accessibility planning as being to promote social inclusion by helping people from disadvantaged groups or areas to access jobs and essential services (a definition derived from a report by the Government's Social Exclusion Unit in 2003).

NIHCE regards accessibility as being whether people – particularly those from disadvantaged groups and areas - are able to reach the jobs and key services they need, particularly health care, education and food shops, either by travelling to those services or by having the services brought to them (a concept derived from a Department of Health publication in 2004).

It is worth noting that outside London accessibility planning is a key principle of the Local Transport Plan process.

NIHCE proposes a specific health sector accessibility indicator, viz :

> "Access to hospitals : percentage of households without access to a car, within 30 and 60 minutes from a hospital by public transport."

From our investigations we found no evidence that the concept of accessibility planning is recognised in the health service in London.

It is clear that joint working is needed between the NHS in London, TfL and the London boroughs, at the earliest planning stage of new facilities and where changes to the siting of existing services are planned, in order to enable joined up planning for improved access to hospitals and major healthcare centres in London.

Our first recommendation is made to encourage and promote greater joint working between the health service and TfL and get the concept of accessibility planning adopted. We recommend that :

> the London Strategic Health Authority and TfL should adopt accessibility planning when considering access to London's existing and planned healthcare facilities. Accessibility indicators should be developed. The London Strategic Health Authority and TfL should jointly issue guidance to primary care trusts outlining the transport planning issues to be considered to assure accessible hospitals and major healthcare centres in London and outside of London where they serve London residents.

To plan for access to hospitals and major healthcare centres, it is essential that the facility managers understand their catchment areas and have travel data for staff, patients and visitors.

Hospital travel planning is a well established process for doing this. There are examples of best practice, and committed practitioners at some hospitals. However, we believe that hospital travel planning does not get the senior management support it requires across all of London's hospitals. It is imperative that the senior management team at hospitals and major healthcare centres accept their responsibility in managing how staff, patients and visitors access their facility.

Our second recommendation therefore seeks to raise the priority that hospitals and major health care centres give to travel planning. We recommend that:

> every hospital and major health care facility in London, or which serves London residents, existing or planned, should develop a travel plan which is independently audited for quality. Every hospital trust and healthcare management board should appoint a member to be the hospital travel planning champion.

Hospitals and primary care trusts are not routinely planning for travel to newly located hospitals as part of the process of developing their plans for new hospital sites.

Our third recommendation seeks to ensure best practice travel plans are a planning condition for new hospital and major healthcare centre development. We recommend that :

> local Planning Authorities must make permission for any new hospital and major healthcare centre development conditional upon on the production of a travel plan demonstrating how it will serve its catchment area for patients, staff and visitors. Applicants should have to demonstrate that they have modelled their travel plan on Transport for London's: 'Best practice for workplace travel planning for New Development' and that TfL is supportive of the travel plan.

Presently TfL takes the view that all passengers' journey needs are of equal value. This view however, may conflict with the concept of accessibility planning which treats journeys to hospitals and major healthcare centres as essential and therefore as having greater priority. TfL suggested to us that one mechanism to prioritise trips to hospitals and major healthcare centres may be to increase the 'value of time' for such trips in their planning models.

Our final recommendation therefore seeks a review of how TfL models passenger trips to hospitals and major healthcare centres in its planning. We recommend :

> that TfL should review its stance of treating all passengers' journey needs as being equal. It should adopt the principle of accessibility planning, and take account of the essential journey requirements of patients, visitors and staff travelling to and from hospitals and major healthcare centres.

I hope this is helpful to your scrutiny. If you require further information from us or have any questions please contact, Vincent Stops at London TravelWatch, on 020 7726 9956.

Yours sincerely

Sarah Pond
Chair of the Access to Hospitals Task Force