Notice of Meeting

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

FRIDAY, 28TH MARCH, 2008 at 10:30 HRS - COUNCIL CHAMBER, LONDON BOROUGH OF MERTON, CIVIC CENTRE, LONDON ROAD, MORDEN, SM4 5DX.

Issue date: 22 November 2007
Contact: tracey.anderson@hackney.gov.uk, telephone: 020 8356 3312

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

Minutes of the meetings held on 14th March 2008 and 28th March 2008 will be attached to the agenda for 25th April 2008.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE (PAGES 1 - 50)

(Attached)

6. WITNESS SESSION 1: HEALTHCARE FOR LONDON (PAGES 51 - 66)

Health Impact Assessment – *London Health Commission*

7. WITNESS SESSION 2: HEALTHCARE FOR LONDON

Cyril Chantler – *End of Life Care*

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

Afternoon Session

8. WITNESS SESSION 3: HEALTHCARE FOR LONDON

Stephen Richards – *Director, Macmillian Cancer Support*

9. DRAFT CONCLUSIONS / RECOMMENDATIONS

JOSC – *Discussion item*

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

N.B. Business for the day's proceedings has been scheduled to allow the meeting to conclude by around 4.30 pm.

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

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

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

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

Exclusion of the Press and Public

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

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

11. PARTICIPATING AUTHORITIES

London Boroughs

Barking and Dagenham - Cllr Marie West
Barnet - Cllr Richard Cornelius
Bexley - Cllr David Hurt
Brent – Cllr Chris Leaman
Bromley - Cllr Carole Hubbard
Camden - Cllr David Abrahams
City of London - Cllr Ken Ayers
Croydon - Cllr Graham Bass
Ealing - Cllr Mark Reen
Enfield - Cllr Ann-Marie Pearce
Greenwich - Cllr Janet Gillman
Hackney - Cllr Jonathan McShane
Hammersmith and Fulham - Cllr Peter Tobias
Haringey - Cllr Gideon Bull
Harrow - Cllr Vina Mithani
Havering - Cllr Ted Eden
Hillingdon - Cllr Mary O'Connor
Hounslow - Cllr Jon Hardy
Islington - Cllr Meral Ece
Kensington and Chelsea - Cllr Christopher Buckmaster
Kingston upon Thames - Cllr Don Jordan
Lambeth - Cllr Helen O'Malley
Lewisham - Cllr 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

Agenda Item 5

Camden

Submission of Camden Health Scrutiny Committee to The Joint Overview and Scrutiny Committee on Healthcare for London

Camden Health Scrutiny Committee welcome this opportunity to contribute to the JOSC, and our comments are given below.

1. **Consultation document**

The consultation document is not clear to follow as it asks respondents to choose between items where the response may be both. Our understanding of Healthcare for London is that services provided locally will need to vary to meet local needs.

2. **Staying Healthy**

The Committee welcome the development of an NHS that promotes a 'health service' as well as a 'sickness service'. From our scrutiny of public health in Camden we recognise that promoting health requires joint work with all sectors of the community especially the local authority. The consultation document states that more money needs to be spent on preventing ill health. We are not clear how the NHS or central government will financially contribute to health activities they would like partners to deliver.

Our Committee have been working with Camden PCT to extend GP opening hours. We agree extended hours are important for working people and for the many adults and children who need relatives to help them to attend health services.

We also recognise the range of places in the community that people can learn about being healthy.

3. Maternity and newborn care

The committee welcomes that the proposals move towards women centred maternity services based in the community, and consistent midwife contact.

The consultation asks whether having a doctor led unit is more important than having a midwife led unit or being able to choose a home birth. A range of integrated provision across several boroughs, as we have in the north central region of London, could offer a choice to women and their families depending on the level of risk in their pregnancy and their housing conditions. While we recognise the improved outcomes community based midwife led services bring, there must also be hospital based services to support women through complex pregnancies. We would like to see a network of services that can respond to the differing needs of each pregnancy to allow women to make an informed choice. Having a good

transport strategy with trained staff linked to a doctor led unit is more important than having sites co-located.

We also value the important work midwives do in engaging vulnerable women and in assisting with child protection through home visits. Therefore we think midwives should continue to do at least one home visit for each woman, and have flexibility to do more as required. Midwives often operate in close partnership local authority services and might be co-located with family based services such as Sure-Start.

The Committee have concerns over the shortage of experienced midwives in London to deliver a quality service, and pathways to assist newly trained midwives to gain experience, employment and affordable housing.

4. **Children and young people**

We welcome the decision to form a separate working group to address children's health. Much of children's health and staying healthy is carried out in collaboration with local authority children, schools and families departments, and we would expect that the working group includes appropriate local authority partners.

5. **Mental health**

As London has significantly higher levels of mental ill health than other parts of the country we were concerned that mental health was not covered by the working groups. Mental health services have not seen the significant additional funds recently pumped into the NHS. We fear that the proposed budget for Healthcare for London will be insufficient to deliver the proposals yet to be indentified by the mental health working group.

Reducing inpatient admissions will require an increase in prevention services as well as support in the community. There has been insufficient detail on how much of this is expected to be met from Local Authority social care budgets and where additional resources will come from.

6. **Urgent Care**

We have some concerns about the ability of a centralised urgent care call centre to offer to book primary care appointments. GP's currently operate as private business partnerships, and we have found that they have incompatible telephone or appointment systems. It can be difficult for the public to book advance appointments with their GP of choice as GP's must meet their targets to offer appointments within 48 hours. Targets for Gp's must be compatible with the requirements of this call centre. Integrated IT systems and booking systems are also needed to make this proposal work.

The Committee think that joining GP surgeries to minor surgery or

‘polyclinics’ needs to be developed by each PCT in consultation with local residents, based on the effectiveness of existing services, opportunities and local priorities for partnerships and the distance to hospital care for local people. We would like to see new developments targeted strategically to improve the level of resources in wards of high deprivation and health inequality.

7. **Acute care**

The Committee agree with the arguments for more specialised services especially the improvements that can be delivered in areas such as stroke care. However we have concerns about the risk of transporting patients across London in the rush hour, and there needs to be a robust transport strategy to support this. During busy times transferring patients to local hospitals may be a safer in which case local hospital staff will need to be suitably trained and equipped.

8. **Planned care**

While we agree that local day surgery can be safer than a hospital admission for older people, providing aftercare increases the pressure on carers. Many people living alone who require surgery will not meet the eligibility criteria for social care services. Introducing charges might increase health inequalities. More detail needs to be developed in close consultation with social care commissioners about what aftercare services will be required and how these will be funded. One of the weaknesses of these proposals, as a whole, is a failure to give sufficient consideration to the impact they will have on social care services.

9. **Long term conditions**

We agree that people with long term conditions such as diabetes and asthma should be supported in the community to use new technologies to monitor their own health. There should be support in place for people who are vulnerable or have difficulty using technology.

10. **End of life care**

We welcome proposals to allow people to choose to end their life at home. In developing the end of life service providers, the NHS needs to work closely with commissioners in the local authority to complement rather than duplicate existing care packages.

11. **Where care is provided**

We think different polyclinic configurations need to be strategically negotiated by each PCT to target local health inequalities and use this opportunity to improve the quality or location of existing health services. The Committee is very concerned that the personal relationship between patients and GPs should not be undermined. Therefore we have not

selected our ‘top 5’ services to be included in a polyclinic.

A ‘hub and spoke’ model will be more suitable than a polyclinic in some areas to maintain existing GP patient relationships and location.

It could be too expensive to offer x-rays in polyclinics that are not co-located within a hospital due to the cost of building a leaded room.

12. Vision into reality

Costs

We have concerns that the costs do not specify the resources required from partners, especially local government. As children and mental health recommendations are still in progress, the estimated costs cannot be reliable.

Tackling inequality

We think the proposal could do more to improve access to health care for disadvantaged groups. Healthcare for London is an opportunity to address historical inequalities in health provision. It should work closely with the voluntary and community sector to engage hard to reach groups.

Mental health is an area where disadvantaged groups are over represented, yet this section is incomplete. The committee think proposals could include raising awareness and tackling stigma, and early intervention/prevention services targeted at disadvantaged groups.

Children are another group where proposals are incomplete and we hope that children will be consulted on changes affecting services for them.

IT systems

While we welcome the aim of improving service through integrated IT systems we urge caution in developing data sharing protocols given the recent failures to securely transport confidential personal data held electronically by public organisations.

Camden Health Scrutiny Committee
5th March 2008

London Borough of Hammersmith and Fulham
Response to Healthcare for London: Consulting the Capital

Healthcare for London Hammersmith and Fulham

	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?**
	Given the issues facing Hammersmith and Fulham, we would particularly focus on Improving diet; increasing exercise; giving up smoking and reducing alcohol intake. We see addressing these as creating the conditions for people to choose healthier options.
1b	**How could the NHS in London best help you make these changes**
	We would like to see a greater emphasis on the NHS as a health service, promoting good health through supporting positive lifestyle choices. This would involve working with local agencies, notably local government, to use their powers and responsibilities to improve health outcomes. We believe that there needs to be a clearer focus on the role that addressing the wider determinants of health can play in improving the health of London's residents.
1c	**What else could the NHS in London do to help you stay healthy?**
	We believe that NHS London should work more to prevent ill health and to ensure early interventions for people at risk of ill health. It is important that the NHS in London works in partnership because it alone cannot facilitate more people to live healthier lives.
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 staying healthy. However, we know that those most in need of healthcare are least likely to approach health services. We therefore believe that targeted health promotion activity which addresses the needs of those who are in reality least likely to approach a health care professional is fundamental and that advice on staying healthy should be available in other settings, not just those where a healthcare professional is present.

3	**Please give us any other comments in this section**
	We would like to see NHS London genuinely shifting its focus to working on public health issues and enabling partnerships between those agencies which are best placed to affect the health outcomes for individuals, specific communities and the whole population.
	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.**
	We believe that offering informed choice for mothers and families is the key consideration. This requires a range of interventions to be available at all stages of maternity and newborn care. We would therefore agree that being given a choice of home birth is important, but would also argue that being able to choose to give birth in other settings is equally important.
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?**
	As with most healthcare interventions, there needs to be a tailored approach which means that midwives spend most of their time with those who most need their support. A more targeted approach would mean that women who are able to support themselves with minimal support would be able to do so, whilst those in need of more midwife interventions would be able to gain access to these.
6	**Please give us any other comments on the proposals in this section**
	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.**
	As a framework proposal, we would agree that there should be specialist hospitals that are able to deal with

	conditions that are unusual, that affect relatively few children in any one area and need to be dealt with by specialists in their field. However, we would wish to see what the implications of such an approach would be for specified conditions (those which would be identified as specialist for example) and so for local residents before coming to a final view. Accessibility for parents and families is an important factor in the child's experience of their illness and should be taken into account in any reconfiguration of services.
8	**What, if anything, could we do to encourage more parents to immunise their children**
	We need to offer immunisation services in a range of settings, which mean that it is as easy as possible for parents to immunise their children. For example we could offer immunisations at schools where parents are regularly in attendance and where there is a regular demand. We need to ensure that we take immunisations to individuals rather than solely expecting them to come forward to services for example. We also need a fairly hard-hitting campaign on the risks of not immunising children to ensure that parents are seeking an informed choice.
9	**Please give us any other comments on this section below.**
	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.

	We are particularly keen that mental health service users are not disadvantaged in terms of employment and accommodation which can have a long-lasting contribution to their ongoing mental wellbeing. We believe promoting positive mental health on a pan London basis may be one way to address this issue in the longer term. We would emphasise the critical importance of people with mental health needs being able to access high quality primary and mainstream care services, as well as the full range of other services deployed in the community. There has long been neglect of the physical health needs of mental health service users and the complex interaction of physical and mental health needs should be better understood.
	Acute Care
11	**If there was a telephone service to treat your urgent care needs, what facilities would you like it to have?**
	We believe that there could be room for confusion with NHS Direct and would urge caution in introducing another general telephone service for urgent care needs.
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?**

	As a Framework, we believe that the developments outlined do have some advantages for the future, particularly in terms of patient safety and wellbeing. However, we would still wish to consider any specific proposals affecting healthcare provision in Hammersmith and Fulham very carefully in order to come to a view as whether the impact locally is to be supported or not. Our belief that Charing Cross Hospital could provide an excellent setting for one of the trauma centres has already been noted in our previous submission and we would continue to support this option for the hospital.
	Please tell us why?
	The critical mass necessary to deliver excellence for those specialist conditions outlined above will only be achieved by limiting the number of locations where specialist services can be delivered. Failure to achieve targets in terms of treatment for stroke, for example, can mean life or death for individuals – and we need to find a way for people to access care this is what is important.
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?**
	Whilst this would need to be a decision for the individual ambulance crew in any particular instance, we do agree that the principle should be as outlined above. If local services continued to be used even for patients who would benefit from specialist centres, the role of such centres would become diminished and devalued, with an impact on patient treatment.
14	**Please give us any other comments on the proposals in this section**
	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 is often cited by as a major issue and extending opening hours would be welcomed by local people. We

	recognise that we would need to monitor take-up as the demand for extended opening hours is not always matched by usage.
16	**Please give us any other comments on the proposals in this section**
	We support the proposals to make more health services available in the community, particularly where access to health services is variable. We know that in more deprived services there is a reduced usage of secondary care services and would seek to ensure that health inequalities and inequity of access to service provision are not replicated through these proposals.
	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. Whilst we support Option A above the other options, we strongly believe that supporting self management/expert patient approaches is key to reducing the harm caused by long term conditions. This may mean investment in non healthcare professionals who can support individuals to take control of their own conditions or facilitate peer support and information exchange.
18	**Please give us any other comments on the proposals in this section**
	End of Life Care
19	**Do you think new end of life service providers responsible for co-coordinating end-of-life care will result in better or worse care for patients than the current arrangement?**
	The key to providing enhanced end-of-life care will lie in the ethos and approach adopted by the service providers. Ensuring choice, dignity, respect and legitimacy, for example, are fundamental to improving people's experience at the end of their life, regardless of age or condition.

20	**Please give us any other comments on the proposals in this section**
	Close working with local authorities and other partner agencies, including the voluntary sector, is essential in developing local services to deliver end of life care.
	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 believe that polyclinics should be planned and designed to meet the needs of their local population. The five factors which are most important are likely to differ for different communities, even within a borough as small as Hammersmith and Fulham. Local needs assessments should be carried out to ensure that polyclinics meet immediate local need and add value through the range of services they are able to offer. We would be disappointed to see a prescriptive approach to which services can be offered through polyclinics, but would encourage a localised approach which enables the selection of a wide range of services to meet local need.
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?**
	Whilst it may be important that all residents have access to the wider range of services offered by a polyclinic, this does not necessarily mean that all GPs should be part of a polyclinic. We would support a hub and spoke model where some GPs remain in and some outside the polyclinic, but where all patients have access to the wider range of facilities offered by the polyclinic.
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?**
	As noted above, we agree that the treatment of some conditions may be best carried out in specialist

	hospitals. We also note that some procedures currently available only in hospital could be offered in the community, which would be very welcomed.
24	**Please give us any other comments in this section**
	As we stated in our previous submission, the Council believes there is a compelling case for the enhancement of Charing Cross Hospital to become the specialist provider site for the major trauma centre for west London.
	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. However, we would note the requirement to consult in a meaningful manner in relation to any changes to services arising as a result of the application of the principles and notably principle 2, Localise where possible, regionalise where necessary. In our previous submission for example, we noted that "The Council recognises the need for change to maintain a world class healthcare system for London, but not at the expense of accessibility to services for the Borough's residents. The Council believes there is a compelling case for the enhancement of Charing Cross Hospital to become the specialist provider site for the major trauma centre for west London" and this remains our position.
26	**What, if any, other principles do you think there should be?**
	We would like to see a principle which reflects an emphasis on self-management and maximising the contribution individual patients can make to their own recovery and ongoing treatment and care. We believe this would support the provision of high quality information and an early intervention approach.
27	**To what extent do you agree with the following statements?**

	The Framework would appear to offer an excellent basis for improvements in both access to health services and to health outcomes. However, a recurring theme in this submission is the importance of effective implementation of the Framework and that this will require strong consultation and involvement of local residents and service providers. There will be a significant amount of detailed work required in order to take the Framework forward and without effective oversight and management there is a risk that the Framework's positive recommendations become diluted.
28	**What else could be done to improve access to health services and improve the health of deprived communities and disadvantaged groups?**
	It will be important that local services reflect the needs of local communities, based on sound needs assessment and the views of local residents. Ensuring effective involvement of individuals and patients – even those who are most hard to reach – in planning, managing and developing local health services will assist in both improving access to services and the health of deprived communities.
29	**Please give us any other comments on how health services in London could be improved over the next ten years**
	We believe that the long term vision of HealthCare for London offers a real opportunity to improve the health of Londoners over the next ten years. We urge that it be supported by adequate investment, high quality management and excellent clinical input at all stages of implementation. Equally important will be the involvement of local residents in the services which affect them so that long lasting changes meet local needs, even as these may evolve over time.

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Cllr Jon Hardy
Chair of Adults, Health and Social
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Dear NHS London

Healthcare for London Consultation

I am pleased to submit on behalf of my panel our response to Healthcare for London.

Introduction
The Adults Health and Social Care Scrutiny Panel was established in 2000 and has the remit to scrutinise local health services in Hounslow and to set up and take part in any joint health scrutiny reviews as set out in the Health and Social Care Act 2001. Our Panel is also represented on the pan London Joint Overview and Scrutiny Committee, which has you know has been set up to respond on a regional basis to NHS London's proposals.

Locally, we engage well with our PCT, West Middlesex Hospital and the West London Mental Health Trust.

This response compliments the response of the Council's submission.

General Comments
We note that HfL sets out a direction of travel for the future of healthcare across London. We look forward to receiving detail proposals for the Hounslow area so that we can consider implications for residents as well as the local health and social care economy.

Specific comments

Staying Healthy
1a - The changes listed are typical of the action, options, advice that people will consider when thinking about improvements in their health. We have no further comment to make on this list.

1b - Advice and support type services and activities need to be easily accessible. For example through more well-being type services run in partnership with the local authority and voluntary sector.

1c

- More emphasis on prevention type services
- More prescribing for health, e.g. fitness sessions etc
- Easy access to full range of health services e.g. longer opening GP surgery hours and at weekends
- More awareness and related services to address specific health needs of people with learning difficulties.

2. We strongly agree with the statement. All people should be able to get first level advice when coming into contact with health professionals. The experience of our residents is varied – from excellent advice being offered to none. We support any plans to enhance and develop training of healthcare staff so that they can provide this level of advice.

3. We feel strongly that realistic resource levels should be made available to Hounslow's local health economy so that localised services can be planned, developed and sustained in partnership with patients, public and key partners. Hounslow like other boroughs has many health issues in common with other areas. However it also has its own specific set of pressures. For example, high rate of sexually transmitted infections, teenage pregnancies and smoking cessation challenges. Therefore we would wish for resources targeted for prevention work is ring fenced and protected and that current and new models are allowed to develop and not subject to change. Constant change makes it hard for scrutiny members, patients and public to assess the effectiveness of impact and genuine outcomes.

Maternity and newborn

4. We feel strongly that women should have access to support and care during pregnancy, birth and post natal in settings of their choice. We consider that it is important that women can give birth

- in a midwife led unit in the community
- in a midwife led unit with a doctor led unit on the same site and
- at home.

However we also feel strongly that women must be able to access maternity services without having to travel significant distances and also incur travel costs. When reviewing Ashford and St Peters Hospital reconfiguration jointly with Surrey County Council's OSC, we heard from Hounslow GPs that some of their patients would not travel from Hounslow to St Peter's because of poor public transport and the costs of public transport outside of London. Furthermore this group of GPs pointed out that teenage girls who were pregnant were less likely to access antenatal care at St Peters because of travel distance and associated costs. As Hounslow is one of the areas were we have high teenage conception rates (in 2006:163 conceptions, 51% abortions and 83 live births.), we are understandably concerned that there should be good access to the full range of maternity services.

5. We feel strongly that women should have to option to choose either being visited at home or at a health clinic.

6. We are proud that our local hospital, West Middlesex, has excellent maternity services and is popular with local women from within Hounslow and neighbouring areas.

We support West Middlesex's plans to expand this service so that it can accommodate 1,000 more births through a new midwife led birth centre. We would also wish to see our hospital provide one to one midwives for vulnerable women along the lines of the Albany Midwife Group in Peckham.

Whilst we wish to see, and will support, West Middlesex Hospital in pursuing their plans to position themselves to one of larger units providing 7,000 births per year, we are worried about resources and infrastructure.

Resources - We are concerned about the shortage of midwives and the numbers that will retire over the next five years. Although we know that there is an increase in the number of midwives being trained, we are uncertain about the net gain and what this might mean for West Middlesex in the medium to long term.

Infrastructure – In order to expand we are aware that West Middlesex may need to rebuild the existing maternity unit. We would be disappointed if NHS London did not support the hospital in addressing the infrastructure issues.

Notwithstanding our support to see West Middlesex hospital expand into one of the larger units as set out in HfL we wonder if a larger units are the best way forward? We certainly understand the economic and professional reasons for larger units. However there may be a risk that expansion of highly successful maternity services will mean a loss of the unique features that made it both popular with local women and delivery of excellent performance from the healthcare professionals.

We look forward to seeing the detailed proposals for maternity and newborn care.

Children and Young People

7. Whilst we agree with the proposal that specialist care for children should be concentrated in specialist settings we feel strongly that there should be a balance between local provision and specialist. It would have helped if examples could have been provided as to what are deemed to be specialist conditions and the volume, capacity of these settings.

We would not wish to lose our inpatient children's' services at West Middlesex.

8. Information, choice and consistency of practice with regard to who is immunised. There should be no postcode lottery.

9. We believe that all agencies should work together to ensure children's health and well-being. This requires joint planning and commissioning and ensuring that services like speech and language therapy are provided for locally.

We are pleased that Children's services are being considered separately as this will ensure that all agencies and partners who are responsible for children's services will be involved.
Young Carers and transport and access
We look forward to seeing the detailed proposals arising out of this work stream.

Mental Health
10. We support the recommendations set out in this section. You will be aware of our concerns with regard to CAMHS in Hounslow, which resulted in our referral to the Secretary of State. We are pleased that we have made good progress on tiers 1 and 2 locally and we will continue to monitor impact at tiers 3 and 4.

It is essential that more effort and practical steps are taken to ensure that black and ethnic minority communities can access support.

We agree that access to the full range of CBT and talking therapies services is problematic and we hope that additional work on this area will result in some clear proposals.

We look forward to the working groups findings.

Acute Health
11. We consider that a to f should be dealt with through a telephone based service for those that want, appropriate to their urgent circumstances. For others, and other situations to be able to easily access urgent care in any of the variety settings described – the emphasis here is easily accessible.

12. We agree with the proposals that there should be more specialised centres for trauma, stroke, and complex emergency surgery. We would hope that West Middlesex hospital would be one the specialised sites for strokes, especially when our local demographics are taken into account – high rates of diabetes, cardiac and vascular diseases combined with a large ethnic minority population. We look forward to receiving detailed proposals on the specialised centres before we can offer anything more than an in principal support. For example we would wish to see the London Stroke Strategy and how the patients could access CT scans within the 90-minute window.

13. We note that this is current practice already with stroke and heart patients. Therefore we agree that seriously ill and injured patients should be taken to specialist centres by ambulance staff.

14. No further comments.

Planned Care
15. Access to GPs in a 24/7 culture is important. Many people due to their working patterns or lifestyles can only make appointments in the evening or at weekends. The easier access to GPs the less that will turn up at A&E with less urgent, serious needs.

16. We agree that there should be more local and specialised care. However we would wish to see how the bottlenecks described for accessing diagnostic tests would be addressed before providing further comment. We note though that some diagnostics are likely to be situated in polyclinics.

Long-term conditions

17. We would support option A as this would enable patients to be in better control of their conditions and effective use of resources. In Hounslow we have some excellent community pharmacists and we would wish to see them also properly supported.

18. We are concerned that there will not be adequate resource allocation to support patients in managing their conditions and would wish to see the whole system adequately resourced.

End of life care

19. The joint working proposed will we believe result in better care. However we await the detailed plans.

20. No further comments at this stage.

Where we could provide care

21. We are aware that Hounslow PCT and the West Middlesex Hospital are in support of the model of polyclinics. Indeed we can see the potential for hub and spoke in the Heart of Hounslow. We also support the idea that health could be delivered in a range of settings, that is, where people naturally go. For example local midwives run a specialist antenatal clinic for teenage young women in Hounslow Youth Centre. However we feel agree that there should no one single model and would like to see the detailed plans and proposals for Hounslow which include start up costs before we can offer a more detailed view.

22. We believe that there should be a balance of same site and networked services. As already highlighted access and transport is key for patients. Again we would wish to see where the same sites and plans for networks before we can provide further comment.

Turning long term vision into reality

23. We mostly agree with option d.

24. No further comment at this stage.

25. We broadly agree with these principles but would want to see what local and regional meant for Hounslow patients and its community.

26. No comment

27. We would need to see the affect of these changes before providing comment.

I hope you find our response helpful and we look forward to receiving the local plans for Hounslow.

Kind regards

Cllr Jon Hardy
Chair of Adults, Health and Social Care Scrutiny Panel

Town Hall, Upper Street, Islington,
London N1 2UD
Website: www.islington.gov.uk

Reply to: Peter Murphy

Tel: 020 7527 3250
Fax: 020 7527 3256

Date: 7 March 2008

Ben Vinter
London Borough of Hackney
Town Hall
Mare Street
London E8 1EA

Dear Ben Vinter,

HEALTHCARE FOR LONDON : CONSULTING THE CAPITAL

I set out below the observations of the Council's Overview Committee for submission to the JOSC:

- The consultation document did not give any indication what the proposals would mean to the residents of Islington and how the introduction of polyclinics would lead to the closure of GP surgeries
- The proposals were a vision for healthcare in London and the Joint Committee of PCT's would be considering these at the beginning of June - it was anticipated that proposals for implementation across London and LBI would be considered in 2009
- Darzi was recommending that there should be a polyclinic on each hospital site - the polyclinic model may not be feasible in the short term given the lack of space available –the idea of a polyclinic was to bring GP's together to work more flexibly and provide more services but this proposal was less robustly based on evidence than the other proposals in the Darzi report and would need more debate
- The underlying weakness of the proposals appeared to be that the spacial dimension had not been considered – the 3/4 polyclinics proposed were likely to be on existing NHS sites and locating them in a hospital rather than the community did not seem to be fundamentally different – in addition would the culture of people and how they felt toward their GP's and their long term relationship change if there were large groupings of GPs in this way
- Concerns were expressed about how the public ethos of the NHS proposals would be affected and whether it would lead to privatisation of GP services
- There was also a debate that needed to take place as to where people would like to be registered – where they work or where they lived - Darzi had not addressed this

- There needed to be more thought given to the problems of access and the availability of transport for the young and the elderly
- The proposals seemed to be against the retention of single handed GP practices and whilst there may be savings from shared premises, IT etc. this may be at the expense of providing easy access to medical care
- It was difficult to express a view about the consultation document – most people wanted a patient led NHS whereas the proposals appeared to be mechanistic
- There needed to be assurances that the population growth in LBI had been taken into account – in addition how would polyclinics deal with mental health issues and would the creation of nationwide specialist hospitals affect the care and access for LBI patients
- Darzi had not really addressed mental health or children's services fully and more work was being done on this – there needed to be the development of an environment that promoted good mental health
- It was recognised that there appeared to be 3 core issues – access, quality of care and costing of the proposals – Darzi had identified a saving of £13.5 billion but there were huge implications on social care and costs being shifted to this as a result of the proposals and patients being treated in the community
- There were not really many examples of where polyclinics were in operation so this proposal was largely untested
- The view was expressed that bigger practices did not necessarily mean longer opening hours

Yours sincerely,

Peter Murphy
Scrutiny Manager

Chris Wood
Acting Chief Executive

Overview and Scrutiny Unit

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Healthcare for London
FREEPOST
Consulting the Capital

Ask for: Jonathan Shaw

Your ref:

Our ref:

Date: 6th March 2008

Dear sir/madam

Healthcare for London – consulting the capital: response of the London Borough of Newham

Thank you for the opportunity to respond to Lord Ara Darzi's report, 'Healthcare for London'. This is the joint response of Newham's Executive and the Health Scrutiny Commission. This is in addition to the formal response of the pan-London Joint Overview and Scrutiny Committee, which is currently gathering its evidence.

Our overarching comment is that clearly, one size doesn't fit all - London is a diverse place. The principles within the review are sound but we will want work through the implications for Newham and recognise that stage two of the consultation is key for us locally. We also see this as a good opportunity to consider the allocation of resources. East London has significant health inequalities and we need the resources to address them.

The Council is also keen to continue to develop effective partnerships with our local NHS and would point to the locally developed NeAT (Newham Assistive Technology). This is a remote system for monitoring people at risk of falling or with epilepsy and a good example of partnership working between health and social care. The Council will always invest in projects that benefit our residents even when the savings are likely to be shown in the NHS.

The following response covers each of the working group themes as well as the models of care:

Working Group themes

Maternity Care and care of the newborn Maternity Services in Newham are under significant pressure – we have a birthrate that is increasing sharply and many of our mothers have complex support needs. Indeed we recognise that maternity services are a London-wide issue with 19 of the 31 worst performing maternity units here in our capital.

The Council would welcome any initiatives that would drive service improvement in maternity provision across London.

Our view is that Newham needs a Doctor-led service because so many births are high risk, reflected in our high levels of infant mortality. However, we also want excellent community provision to support choice. Choice in maternity services is a key issue and even the poorest, most disadvantaged communities should be able to choose the type of service they want. Home births, for example are not currently available to our community.

Staying Healthy As has often been said, from Westminster to Stratford (here in Newham) on the Jubilee Line, one year of life expectancy is lost at each stop. Our health inequalities are significant and we need the resources to tackle them. Newham has made some progress with our public health messages and we recognise that this work is not just about NHS services. We have sought to tackle the wider determinants and have worked with the NHS in partnership. The Council would welcome a wider review of how to make public health messages more effective, and how organisations such as local authorities can contribute directly to health improvement.

We do recognise that there have been positive messages recently about prevention but there needs to be a genuine shift of resources to prevention and early intervention to ensure that we have a health service not just a sickness service. We also recognise that safer environments for walking and cycling, community-based exercise programmes and healthy eating promotion play an important role in helping our community stay healthy.

Mental Health *Healthcare for London* has not focused effectively on mental health and wellbeing. This is a key issue in London as we have high levels of mental health care needs in our capital. The mental health aspects of the report seem to focus on acute services and we would want to see more consideration of prevention, early intervention and evidence-based non-clinical interventions e.g. physical activity on prescription. We have a good experience locally of improving access to Cognitive Behavioural Therapy (CBT) and have seen the difference this has made to many of our residents.

In terms of acute care, choice is a key issue in mental health and though we have welcomed the steps our mental health trust has made in this area more needs to be done.

Polyclinics should encompass mental health provision. Mental health advice and treatment in primary care is currently inconsistent and the first point of call is key. We are keen to help de-stigmatise services wherever we can and along with our partners promote mental wellbeing.

Acute Care Newham values its local hospital. We are fairly unique in London in that the vast majority of acute cases are currently treated locally. With significant population growth predicted, the Council does not see a case for a down-grading of the current provision. Given our population size and with so many people with high level needs, a very young population with high levels of accidents (reflected in one of our Local Area Agreement (LAA) targets), and a high birth rate, the Council is of the view that we need a 24/7 A&E in Newham, with the appropriate support of specialist sub-regional hospitals.

The Council is not opposed to the development of specialist centres – our view is that it currently works well for heart disease patients, in particular many of whom are treated at the Barts and the London NHS Trust.

In terms of stroke care, we want our communities (some of whom at very high risk of stroke) to be able to access specialist care rapidly. Consideration needs to be given as to whether this should be provided in Newham, or whether there would be sufficient access from Newham to one or more sub-regional centres.

The London Ambulance Service has a key role in helping to deliver effective specialist care and needs to be organised and resourced to get people to specialist centres quickly and safely.

Demand management is also a key factor and this is not a simple issue of creating alternative telephone numbers. Our local experience is of people either not registered with primary care or they seek to access health services through urgent care provision because of guarantees of them being seen within a known timescale. We would like there to be effective information for both new and existing communities about what's available and how and when to access.

Planned Care The Council continues to be unconvinced about "payment by results", which actually appears to be "payment by activity", which has had some unwelcome consequences. We welcome the audit commission's recommendation regarding more flexibility in the tariff system so that particular local issues can be taken into account.

We would be looking to see more resources directed to prevention and in helping people with long-term conditions to self-manage in order to keep them out of hospital.

There is a need for more outpatient appointments outside of weekdays 9-5 and more outpatient appointments in the community.

Long-term conditions We support all and any initiatives to support people with long-term conditions to self-manage. In Newham we are pioneering Newham Assistive Technology (NeAT) which has been an effective partnership between health and social care. The system is a remote monitoring programme that helps people at risk of falling or having epileptic fits. The Council will always invest in projects that benefit our residents even where the savings are likely to be shown in the NHS.

In terms of primary care, people with long-term conditions need good access to GPs and indeed to preventative services. Pharmacists have a key role and we have excellent local provision of community pharmacies and we would welcome support to continue to develop these services. The Council sees these as an effective community resource as many of our pharmacists speak a range of community languages and are very well located.

End of Life Care The Council supports the proposals for end of life service providers as a way of improving this care. Again, choice is a key issue for our residents as too few people actually choose where to die. However, it should be recognised that there are particular issues in a borough like ours – we have many houses in multiple occupation

and some poor quality housing and family support is of course different for different individuals and communities (for example, many of our older white British residents no longer have family living locally).

Where should care be provided?

Home As with our comments on end of life care above, there are particular issues in a borough like ours – we have many houses in multiple occupation and some poor quality housing which presents particular challenges to providing high quality and effective care at home.

Polyclinic The Council welcomes the concept of polyclinics. We believe that the "hub and spoke" approach is more easily deliverable given the likely resources available and our starting point, but we also recognise that same site polyclinics and hospital polyclinics are equally useful models. It should be recognised that communities are not homogenous – some people value one-to-one continuity provided by a small GP practice, other people want more convenient access and services that can only be provided by larger practices.

In terms of diagnostic equipment moving into polyclinics, we believe that this is a positive step but specialist staff are needed to operate equipment and analyse diagnostic results. This could have a significant resource implication.

In terms of the location of same site polyclinics, given the regeneration opportunities in our borough it will be easier in particular areas to develop new purpose built centres but we are keen to avoid growing inequalities within the borough as we want the best for all our residents. We are also concerned that the space requirements for same-site polyclinic with full range of services may be hard to deliver in densely populated urban areas.

The Council is of the view that there needs to be a proper review of the NHS estate to deliver the facilities we need. This is a good opportunity to work in partnership to develop multi-use and co-located facilities and we would hope that NHS London would support borough-wide estates reviews, involving key local public sector partners.

Local Hospital Newham values its local hospital and as stated above, we see no reason for a down-sizing of our provision. We agree with the proposals in *Healthcare for London* for what a local hospital should provide but recognise that this review is creating uncertainty over their future and making it hard for many hospitals to develop business plans for the medium term.

Elective Centres The Council values Newham's existing elective centre and welcomes the principles around the Elective Centre model in *Healthcare for London*.

Major acute hospital The principles of the major acute hospital and managing stroke care and having three trauma centres, for example are welcome. Again, the role of the

London Ambulance Service is key. Getting people to large, regional hospitals quickly puts significant pressure on the service.

Specialist Hospital Our experience is that access to cancer care in Newham is poor. Issues of late presentation need to be addressed in primary care but we do have poor outcomes once people access services. We welcome the specialist hospital model if it can deliver better clinical outcomes.

Additional comments Workforce development – the NHS needs to plan now for the kinds of staff and skills needed to operate an effective shift from provision of services in acute care to community settings. The NHS also needs to ensure that the best staff are not being drawn into specialist provision. This has been a problem in maternity services, for example.

Funding – We also see this as a good opportunity to consider the allocation of resources. East London has significant health inequalities and we need the resources to address them.

Again, the Council welcomes the opportunity to comment on *Healthcare for London*. Both the Executive and the Health Scrutiny Commission has worked closely with Newham PCT to support the local consultation. We do recognise, however that stage two of the consultation is key and we will continue to make sure that local voices are heard about how services are to be developed in Newham.

Yours sincerely,

Sir Robin Wales, Mayor of Newham
Councillor Megan Harris Mitchell (Chair, Health Scrutiny Commission)

London Borough of Sutton

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Date: 12 March 2008

Councillor Mary O'Connor
Chair of Darzi JOSC
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Dear Mary

Re: Response to Consultation on the Healthcare for London Proposals.

You asked for comments on the Darzi proposal by Friday 6 March. I regret that it was not possible to meet that deadline.

Our principal concern lies with the very short consultation period which has been allowed to help decide the future for this huge and vital service for London. It is likely to see the shape of health care in London for the foreseeable future. I also need to draw attention to developments which are already taking place that tend to suggest that Darzi is already being implemented and thus pre-empting what the consultation process may produce. I know that the various health trusts who are involved with this will argue that these are being done in the interests of clinical safety. Where changes are being made for the benefit of patients that must be applauded in spite of the timing. Nevertheless, it pre-empts the Darzi consultation. Some of the changes locally seem to be being made for business reasons e.g. the South West London and St George's Mental Health Trust's proposals to close the Henderson Hospital site for patients with personality disorders in Sutton.

This leads me to our next concern and that Darzi is completely silent about what is to be done about mental health care in London, although we understand that this is being dealt with separately. NHS expenditure on mental health care is the single biggest item of expenditure by that Service. This handling of mental health issues does not seem appropriate particularly as mental health care patients will disproportionately probably require greater access to other health care services. Thus there has not been a holistic approach to health.

In this vein, Darzi's treatment of paediatric services in the consultative document is very much an afterthought. We agree though that these services need to be specialized and from centres of excellence, though we would hope that these would be relatively small and within the local community to ensure easy contact for parents, etc. and to avoid creating an institutional approach.

Whilst generally we can see the sense in having centres of excellence for trauma, cardiac and stroke problems the Government's implementation plans must address how people are likely to be able to visit their friends and families when receiving this specialist care. It is a well-known fact that patients

recovery is both better and quicker where appropriately supported by families and loved ones.

A critical issue where we need assurances by Government now will be in the light of whatever the government decides to do with Darzi. Here we strongly believe there needs to be a separate consultation exercise on implementation. I have already noted that Darzi will lead to a major reshaping of health care services in London and we need to be satisfied that the infrastructure is there to take the new shape of NHS in London.

GPs will be taking on additional work from hospitals. We think this is highly appropriate where this can be done safely and where it is closer to people's homes and also achieves cost savings. Nevertheless, we need to be satisfied that GPs will have the necessary training and resources (by resources we mean building infrastructure, staffing, skill sets, competences, etc to take on this extra work. The Darzi vision in losing work from hospitals to GPs will clearly have an effect on staffing and on the financial viability of hospitals. In Sutton this is particularly complicated given the fact that services at the Epsom and St Helier hospital sites are commissioned both by the Sutton and Merton Primary Care Trust as well as the Surrey PCT. Surrey has already decided that it wishes to have different arrangements e.g. over kidney treatments. This poses a threat to the viability of the one and only, albeit outdated, hospital that we have serving a very large community, including one which by any test suffers from deprivation.

One underlying concern is that the test of deprivation may not fully address the physical deprivation, which for example the London Borough of Sutton experiences, with a disproportionate number of elderly people whose ability to travel to get medical treatment is severely limited. Their needs and the needs of an appropriate supporting transport infrastructure to service any changes must be taken into account and appropriate funding provided for it. This will be a new problem of this Government's own making and they must meet the full immediate and ongoing costs of addressing them.

With the need for government to consult on their implementation plans it might be helpful to explain in more detail our thinking here.

There will be a need for staff movement and changes in services and it is absolutely vital that the standard of care does not suffer. I regret that I need to disagree with your assessment that there needs to be equality of treatment across London. This is because that implies equality at the lowest common denominator. There must not be any reduction in the quality of service and services need to be brought up to the best standards.

The government's implementation plan also needs to address the training needs because there will need to be a major training and retraining initiative if services are to be maintained. We were particularly struck by the presentation by the Royal College of Surgeons and their proposals for accreditation of surgeons in order to address the problems identified by the report on the difficulties involving heart surgery at the Bristol hospitals. Accreditation of training courses, trainers and people will require quite a considerable lead in time, not least in the development of standards against which accreditation can be made. The government needs to work closely with the Royal College in funding this work in view of the societal cost of having surgeons who are not up to the job.

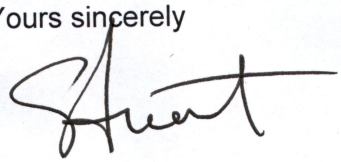
We would also expect to see an impact assessment which addresses adequately and particularly the environmental impact of more and longer journeys to reach centres of excellence and local community care centres.

Looking at particular services, we have concerns about maternity provision given the demands on the London health services from people whose ethnic background means that they are more prone to illness and complications in maternity. A balance needs to be struck between having centres of excellence for the difficult cases and having adequate local provision within the community for straightforward cases. Generally, capacity also needs to be built into the system so that it can manage the large migrant population that London has as typified for example by the increase in births to mothers here whose country of origin is other than the United Kingdom.

Our final point is that if Darzi results in work and/or responsibilities being shunted on to local authorities then that must be fully funded by government. We would expect to see this specifically addressed in the supporting impact assessment.

I am copying this response to members of my health scrutiny committee, local MPs, members of the Darzi JOSC and local borough /district councils

Yours sincerely



Cllr Stuart Gordon-Bullock
Chair
Health and Well Being Scrutiny Committee

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Healthcare for London: Consulting the Capital

Response to the consultation from the Health Scrutiny Task Group & Westminster City Council

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1. Firstly, we would like to thank you for the opportunity to respond to the Healthcare for London consultation. Westminster Health Scrutiny Task Group and Westminster City Council have been, and continue to be well engaged in the consultation process and have received a number of briefings on the proposals.

2. Westminster Health Scrutiny Task Group has also participated in the London Wide Scrutiny Commission to consider the proposals put forward by NHS London. In addition to the consultation with ourselves directly, we have also been impressed with the consultation process undertaken with members of the public.

3. We have carefully considered the implications of Healthcare for London for Westminster residents. Our response is as follows:

General comments

4. Overall, Westminster Health Scrutiny Task Group and City Council endorse the principles put forward in the consultation document and the direction of travel they signal. We also agree that this change is necessary to secure the health outcomes for Londoners in the future.

5. We would like to emphasise however that our endorsement of the principles for the models of care does not pre-empt our response to any proposals for specific changes to health services. Any proposals which may follow as part of the Healthcare for London consultations will be considered on a case by case basis before we form a view as to whether they will be in the best interests of Westminster residents and their health outcomes.

6. In general, Healthcare for London would benefit from a greater emphasis and more detail about delivery and development of preventative services. These services are central to securing the health and wellbeing of the wider population and are an essential element of demand management, ensuring resources are available to reinvest in service improvements.

7. The direction of travel outlined in Healthcare for London would be strengthened through more specific exploration of the role of Local Authorities in supporting the NHS to deliver this shift in healthcare, the delivery of preventative services in particular, through Local Strategic Partnership arrangements and through the new Local Area Agreement. An important element of this that will need to be taken into consideration is the Comprehensive Area Assessment (CAA). The CAA places an even stronger emphasis on partnership working and how delivering and driving improvements in a local area is achieved through these partnerships.

Specific comments:

a) Health inequalities

8. The report recognises and makes reference to the significance of health inequalities in London. The proposals however do not explore in depth how the suggested improvements in health services will address the stark inequalities currently experienced in the City and we would welcome more detail on this area.

9. Care needs to be taken to ensure that the proposals do not in fact present a risk of increasing the levels of inequalities experienced. For example, the increase provision of care at home across a number of the themed areas including maternity and end of life care is sound in principle, but does not take into account the existence of overcrowded housing in London, the conditions within some of these homes and the high proportion of single-person households in Central London. It cannot be assumed that care at home is always an option for our populations and travelling further for services will have the greatest impact and pose the most significant challenges in terms of access for the most vulnerable people.

10. Healthcare for London would also benefit from a greater and more explicit recognition of a partnership approach to tackling health inequalities and improving public health. Westminster City Council and other City partners play a key role in improving the health and wellbeing of the population in Westminster, and this strong basis could be built upon through shared resources to tackle obesity, alcohol misuse and physical activity, for example, and in particular amongst Westminster's most deprived communities. The Council also plays a key role in tackling the wider determinants of ill health through education, housing and economic development and this role should be more strongly reflected in this work programme.

b) Acute care

11. Westminster Health Scrutiny Committee and Westminster City Council endorse the proposals to offer a broader range of pathways into urgent care. In delivery of this shift however, the complexities of why patients choose particular care pathways need to be addressed in their cultural context.

12. As the consultation document recognises, London is a diverse and multi-cultural city, with a shifting and mobile population. Inappropriate use of A&E services can often be because people are not registered or do not know how to register with a GP, or culturally are more accustomed to using acute health services, rather than primary health care. Whilst a polyclinic attached to A&E may address some of these barriers, it will need to be coupled with other strategies to raise awareness of health service choice, such as including information in welcome packs for new migrant communities as proposed by the Mayor of London.

c) Planned care and end of life care

13. Supporting greater choice and control for service users, and enabling people to receive care in their own home is welcomed as a principle and aligns well with the strategic development of services in Westminster.

14. However, the expansion of rehabilitation at home and end of life care at home will have an impact on social care services and carers (sometimes referred to as informal carers). There will need to be close work with carers in the implementation phase of these proposals to carefully work through the implications for them. Successful implementation will also require strong partnerships and joint working with social care providers and commissioners.

d) Primary health care and polyclinics

15. The development of polyclinics is welcomed locally but requires a rigorous assessment of cost, opportunities and the need to develop local solutions. In Westminster, there are a range of models for primary care within General Practice and the proposals within Healthcare for London need to build on these existing arrangements rather than replace them.

16. Integration of health care delivery from these clinics with a range of local authority services would be a positive move forward for seamless service delivery for our shared community. We would welcome further exploration of the opportunities within this.

e) Estates and investment

17. Local authorities will play a key role in supporting the NHS estate developments associated with this strategy in the development of polyclinics. There will need to be early engagement on this issue, in particular to build in requirements to the Local Development Framework Core Strategy.

18. Thank you again for the opportunity to comment on this strategy which has significant potential to support healthy communities and individuals across London.

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Healthcare for London: consulting the capital

Response by London Councils

1. London Councils is committed to fighting for more resources for London and getting the best possible deal for London's 33 councils. We develop policy, lobby government and others, and run a range of services designed to make life better for Londoners.

2. This response by London Councils reflects the responsibility of Leaders of London boroughs and lead members for service delivery and developing partnerships and communities in London. It is separate from the views of those members charged with a broader scrutiny responsibility which will be captured in the work of the London-wide Joint Overview and Scrutiny Committees established to consider the Healthcare for London proposals.

3. London Councils welcomes the opportunity to contribute to the development of London's healthcare strategy and the broad aims and objectives of the consultation paper.

4. London Councils is however concerned that some of the local consultation has raised issues of change in service in advance of the completion of the London healthcare strategy. London NHS is asked to ensure that there is effective consultation on all proposals for change to ensure that local interests may contribute to planning future services.

5. London Councils will continue to monitor local proposals and borough councils will require close involvement and opportunities for scrutiny of specific proposals as the Healthcare for London programme develops.

6. The drive for improvement in health care should be a top priority. More should be done to ensure every resident of London gets equal access to world class health care appropriate for the people who contribute so much to making London a world class city. It is essential for all patients and their carers, to receive quality services and to be assured that the right links to further care and support is available when returning home from hospital.

7. It is also necessary to build confidence in London's NHS and, where appropriate, the case for change in local services. Working closely with London local government, the thriving community and voluntary sector, carers, parents and the people of London themselves is needed to build services and achieve a major improvement in the health and well being of all who live and work in the city..

8. There are major challenges. Inequalities in health across London and inequalities in access to effective treatment need to be tackled urgently. Too many Londoners struggle to register with a GP or dentist; it remains difficult for people to make an appointment at a convenient time. .

9. The NHS does not yet deliver the value for money that is needed to obtain the best from the resources given to it.

10. London Councils will continue to make the case to Government for fair funding of both local government and health services. Substantial investment is needed to achieve high standards for all Londoners. It will be necessary to invest in community and primary care services and to invest in social care where that is needed to deliver high standards of continuity of care and home care.

11. London NHS will need to deliver a greater level of management skill and control to deliver quality services. While progress has been made in addressing the recent financial issues in the NHS in London, London's NHS must meet the challenge of poor services in critical areas as well as the challenges of high mobility, tourism and migration, poverty and deprivation across the capital.

12. Poor delivery of health care in parts of London will require a coherent financial and estates management plan to achieve the improvement that is essential.

13. London's NHS must be better engaged with local government and local communities. Once again, positive progress has been made recently. It is worth re-affirming, however, that London's councils offer accountability to their communities as well as providing services that enhance the health and well being of the population and deliver the home care and residential care needed to enable the NHS to achieve its objectives. Future consultation on services should be delivered jointly by PCTs working with London's councils.

14. Local strategic partnerships, local area agreements and comprehensive area assessments should be a key part of the engagement of the NHS with its local partners. Strong local partnerships are necessary to identify priorities, focus investment to deliver better services and offer the essential continuity between NHS and London local government.

15. London Councils and NHS London should work with the boroughs and PCTs to secure robust support of people with continuing care needs and achieve the transition to new arrangements now proposed by Government. The promotion of choice and personalisation of services is a shared objective for both councils and NHS alongside the development of direct payments and individual budgets that require close working and understanding of objectives.

16. The Healthcare Strategy for London should include greater emphasis on local delivery. The PCTs and NHS trusts must develop stronger partnerships with the London boroughs and their communities to ensure that service developments are geared to meeting local concerns and opportunities. Commissioning services jointly with local government, and building services around communities requires further development as the next stages of transforming London's NHS get underway. London Councils is keen to pursue the issue of local accountability in commissioning of healthcare with NHS London.

17. The general direction of the Healthcare for London strategy related to hospitals is right – all hospitals should offer treatment quickly and in partnership with patients who are confident that the treatment will be safe and effective. Additional investment in new technologies and specialist treatments that are both proven to work will be needed. However, it would not be right to close valued local services unless communities are satisfied that alternatives offer a clear improvement in access and quality of care.

18. The emphasis on achieving a new balance between the investment in hospital care and investment in community health is right. The reduction of costs of hospital and acute care could be achieved provided that primary and social care services are also in place and receiving the financial support necessary. London boroughs face severe restraints on spending and new resources will be needed to achieve the investment in social care envisaged by the report. A joint programme between NHS London and London Councils

to address the social care and other costs associated with the changes is required. This can build on the work that we are already jointly engaged in.

19. It will also be necessary to invest further in local health care and prevention services to reduce the call on acute and specialist health care.

20. The prescription for the health service in London can be improved. The next stage of development will require development of coherent local services, publication of investment priorities and strong partnerships with local government and communities. Robust local strategic partnerships between NHS and boroughs are key for investment. A clear strategy for the use of estates, new transport and employment/training strategies are needed as well as building strong partnerships for continuity of health and social care.

21. The proposals can be improved through specific schemes for::

22. **Greater investment in public health solutions –** London's record in tackling the public health issues that can prevent illness and premature death is mixed. Stronger partnerships with local government and a renewed drive to support people to reduce smoking, alcohol consumption and obesity while encouraging people to immunise their children, promote contraception amongst young people, increase physical fitness, promote mental health and improve diet can each show results by reducing calls on health care. A renewed approach to public health, involving shared resources with the London boroughs working with schools and voluntary agencies, can create a focus for work with communities in London and take action to tackle local issues.

23. **Local solutions to improving primary health care –** the aim of providing a range of services – including local government services – in health centres is important. A range of options including a networked polyclinic, same-site polyclinics or hospital polyclinics should be considered if the polyclinic model can provide combined services that are accessible and offer improvements on current provisions. Given the importance attached to the development of polyclinics in these proposals, London Councils is concerned that more has not been done to define more closely the spectrum of facilities they might include. There is a relationship here to the level of general public understanding about polyclinics and the proposals overall. Building a clearer level of public understanding is

vital to the task of building support among community for any proposed changes being proposed.

24. There has been insufficient assessment of the cost and opportunities for local solutions involving GPs to meet local circumstances. The focus on better access to GPs, improved access to therapies diagnostics and treatments is vital. The NHS should ensure that GPs, communities and London boroughs are fully engaged in the development of primary and community health care in each area involving integration of services and extended access based on a range of approaches is appropriate. Particular care needs to be given in developing and explaining potential changes with those people, particularly older people, who place a high degree of importance upon their relationship with their individual GP.

25. **The modernisation of hospitals and creation of specialist units –** the case for a coherent framework for acute care is made. The development of local hospitals, major acute hospitals, specialist hospitals and elective centres offer a basis for continued investment in equipment, staff and buildings to achieve world class standards in London. Once again promoting an understanding among the public more generally about the future role of hospital facilities and the relationship of these proposals to what polyclinics are likely to offer is vital. The NHS should ensure that new services are accessible, understood by the communities that they aim to serve and are in place before current services are closed. All services must meet high standards of care, hygiene and efficiency throughout the consultation. While the consultation focuses on stroke and heart disease, there are also wide variations in treatment for cancers and inequalities in the care of children and young people that must be tackled. Robust arrangements for admission and investment in aftercare and social care must be developed with new centres prior to their introduction. The development of initiatives such as “virtual wards” that build confidence and administration in the continuity of care and social care should be evaluated and extended as appropriate.

26. **Improved mental health services –** London NHS should aim to generate a full spectrum of care and support for people with mental health concerns including secure beds for patients in crisis and safe release into the community, emergency admission through specialist units, outpatient support through drug and counselling treatments and talking therapies. Mental health trusts should seek to build partnerships with communities and social care and include, as part of treatment, work with agencies that can deliver

opportunities for people to work and maintain inclusion. There should be greater consistency in the role of child and adolescent mental health teams across London and equal access to "talking therapies" across London. Mental health services will need to develop a preventive approach to mental health and well being. The mental health services should be working closely with schools, colleges and youth centres. London NHS should achieve integration of drugs, alcohol and mental health services in the interests of effective patient care as well as generate opportunities for patients. Mental health services will need to work with employers and deliver services in prisons to reduce re-offending.

27. **Children and young people –** a stronger role for the NHS in schools and working with councils to support young people on contraception advice, reducing teenage pregnancy and tackling the allure of drugs and alcohol. The NHS will need to work with schools and families to improve access to mental health services and tackle obesity. The NHS will need to develop new ways of working with children and young people in hospital and through aftercare. New ways of working between health, schools and family centres are needed to build interest in and understanding of health and well being. While major improvements have been made in the care of children and young people with acute and long-term medical conditions, a clear strategy is needed to extend engagement and prevention work in the next stage. While specialist hospitals are needed, opportunities for local treatment of children and young people is also necessary to build knowledge and awareness of child health issues and reassure parents and carers.

28. **Maternity and newborn care –** the proposals include ambitious targets for the expansion of maternity care and offering choice to expectant mothers. Mothers should have access to continuity of support from a midwife throughout pregnancy and post natal support. However, the persistence of child poverty and single parent households illustrate that the NHS has a continuing role and a commitment to maintain (with other agencies) contact with mothers and children throughout early years to ensure access to day care, schools, training and return to employment is needed. A programme for the training and retention of midwives and specialist staff able to meet the needs of children and young people is required.

29. **Phones and ambulances –** the report sets out options for new phone contacts and non emergency contacts which may be confusing when patients generally prefer access to their local GP/polyclinic and support from the ambulance service in emergencies. London

Ambulance Service is seen as effective. A further drive to reduce non emergency calls through public information and registration with a GP is required. Local services should include improved phone access to polyclinics and GPs. The review is an opportunity to introduce simplified funding arrangements for the ambulance service (and air ambulance) and develop new support arrangements for people with major mental health concerns or dementia where transfer to accident and emergency is not always appropriate. The training of paramedics should be extended to ensure early interventions and support for non emergency cases is needed.

30. **Estates and investment –** The Healthcare for London Strategy should comply with the London Plan and borough planning objectives. The strategy and individual schemes should ensure the NHS estate is used effectively and that opportunities are taken for shared use of premises and mixed use of development land. Effective working with London boroughs and the Greater London Authority is needed to deliver early options for the use of land and buildings including new uses such as recreational activities and sport to help people gain fitness. .

31. **Transport –** The Healthcare for London Strategy should include opportunities to reduce the need to travel and repeat visits to hospital and other health care services. The strategy should ensure that additional costs are not generated for patients or for local government in supporting vulnerable people gain access to health care. London Councils will continue to assist the development of a new travel strategy that will increase public transport access to health care.

32. **Cost to social care –** The Healthcare for London strategy can bring additional costs to social care due to reduced hospital stays, recovery at home, home care and maternity services at home and enabling people to choose to die at home. London Councils and NHS London will review costs and investment strategies with the boroughs and PCTs. New Joint Strategic Needs Assessment, Local Strategic Partnerships and Local Area Agreements will require additional resources from the NHS. There are opportunities for joint commissioning of community care and social care, pooling of budgets and better support to people with continuing care needs, people with long-term conditions and people at the end of their lives. A strong commitment to partnership working with London's councils and voluntary agencies is needed to meet costs, develop new markets and introduce greater choice in services across London. Advocacy and support of carers and volunteers are joint concerns for boroughs and local NHS services. London Councils

is working with NHS London to assess current community care costs and set a framework for assessment of future costs and the outcome of this work should be used to inform both the London Healthcare Strategy and local proposals for service development.

33. London Councils will continue to work with the boroughs and NHS in London to assist the development of quality health care services, fair funding for boroughs and NHS service and the investment in quality health and social care accessible to all.

4 March 2008

The Faculty of Clinical Radiology of The Royal College of Radiologists Response to:

Healthcare for London: *A Framework for Action*

The Royal College of Radiologists (RCR) is very pleased to see this publication come to fruition on such a relatively short time frame and was pleased to be able to contribute.

Radiology is in the unique position of delivering imaging services at all levels of care and is therefore involved in provision for primary care, acute care, planned care and long term conditions.

General Comments
While agreeing that some extension of Health services out of hours will be essential the demographic changes to an increasingly elderly population is unlikely to put further strain on the out of hours services as these individuals usually wish to access healthcare during daylight hours and when not at work, are able to do so. The overall move to hub and spoke provision of services is very much in line with the RCR model of delivering imaging services (1).

Challenges to the implementation of the plan will be to convince healthcare professionals, and in particular doctors, that, after previous reports have seen little change, this will be different and the move to establish well functioning prototype units will be essential to counteract the understanding scepticisms.

The motivation of the majority of consultants and general practitioners is to provide a good service and many ideas in recent years have been stifled by short term financial pressures. There will need to be evidence that this will change with improved commissioning.

'Hear and Treat'
Proposals in this section are welcome but a robust, accurate and efficient service will be essential if patient safety is not to be compromised. Lessons must be learned from problems encountered with NHS direct and other telephone advice arrangements. There may be an element of over optimistic estimation of [in particular] the older population's use of electronic and telephone communication, and of non English or non first language English speaking populations.

Urgent Care Centres
It appears these are proposed in two scenarios, one as a front of A&E triage and the other as a stand alone centre. The A&E triage model may be more viable as there will already be full X-ray, ultrasound, CT and possible interventional radiology service available as backup to A&E, particularly if associated with specialist care hospital.

However providing imaging for 'Stand Alone' urgent care centres is more problematic. The RCR was very disappointed to see ultrasound again equated with 'simple blood test', as it was in the preliminary report. This unfortunate and inaccurate reference has been included despite assurances that this was a mistake and would be corrected in the final report.

Paragraph 1.3.1, suggests that stand alone urgent care centres will have diagnostic equipment on site including x-ray and ultrasound. As these care centres are to be based

in primary care environments with extended opening hours, in some cases for 24 hours, ultrasound provision would be undeliverable in these circumstances. Little recognition has been given to the establishment of x-rays with expensive equipment and ionising radiation regulations which will need to be complied with and could be very costly if duplicated across all urgent care centres.

Ultrasound provision remains one of the challenges for delivery of the 18 week targets as it is demanding of expert staffing. Extending this service further into primary urgent care centres will be undeliverable even if it were necessary.

Emergency Surgery
The RCR would fully support the suggestions for arrangements for emergency surgery. This very much gels with the *hub and spoke* model we have been advocating and would enable full CT and interventional radiological procedures to be available and fully staffed in the fewer centres where emergency surgery was to be performed.

Paragraph 1.5.8, states *'tariff unbundling will support centralisation specialist care'*. For radiology this will be essential to fund expensive and high quality interventional services which are increasingly an integral part of trauma and emergency treatment and which has been the province of surgery in the past.

Planned Care
The stated key proposals *'to move routine diagnostics out of large hospitals'* are misleading. Some diagnostic services may be provided in urgent care centres outside large hospitals. However, the routine imaging aspects of diagnostics will still be an essential part of a comprehensive imaging service and will need to exist in large hospitals in parallel to those in the community.

Paragraph 1.6.1, suggests that good practice should be developed across the country. The challenge here is to translate good practice developed by enthusiasts into other settings.

Paragraph 1.6.5, suggests that access to imaging by GPs and in the community should be more available. The Royal College of Radiologists has already addressed this issue in the joint publication with the Royal College of General Practitioners '*The Framework for Primary Care Assess to Imaging – Right Test, Right Time, Right Place'* (2).

Paragraph 1.8.1, again the RCR would strongly support the hub and spoke model. With the increasing provision of electronic transfer of imaging this would be feasible but the success of this would only be possible when good robust and efficient transfer of images between Trusts is established. Despite good progress on PACS rollout, this is not yet available but hopefully will be over the period of time this document addresses.

References
1. Academy of Medical Royal Colleges. *Acute health care services. Report of a Working Party*. September 2007. Pages A67 – A70.
2. The Royal College of Radiologists and The Royal College of General Practitioners. *Framework for Primary Care Access to Imaging*. The Royal College of Radiologists, September 2006.

August 2007

Cllr Mary O'Connor
Chairman
London Borough of Hillingdon
Civic Centre
High Street
Uxbridge
UB8 1UW

13 March 2008

Dear Cllr. O'Connor

Re: Joint Overview and Scrutiny Committee – 'Healthcare for London' review: invitation to submit evidence

Thank you for providing this opportunity to submit evidence on the future of London's health services and the potential impact on occupational therapists working within Local Authorities.

You asked for our views on proposals to reduce hospital length of stays and the provision of greater care out of the hospital setting.

General Points

If more hospital consultants are to work in the community they will need to have a greater understanding of the difference between medical and social models of care and have a greater awareness of local community support services, their availability, the services they offer and their limits.

1. Reduce hospital length of stays

The consultation document suggests that more surgery is to be carried out as day care. The provision of vital rehabilitation, and timely community based support services will be key to successful outcomes for patients. In addition reducing lengths of stay will mean that patients will be discharged with a higher level of dependency and conquently a greater need for rehabilitation.

Day surgery for frail, older people who do not have family support or carers, is likely to increase the need for community based support services.

Impact on occupational therapists and social care services

- Given the expected increase in dependency of patients discharged to the community due to reduced stay, day care treatments, there will be a potentially greater demand for equipment / assistive technology and minor works such as grab rails etc, which will impact on Occupational Therapy services

- If people live in surrounding areas but have had their treatment in London (Choice agenda), this may have an impact on the delivery of a seamless health and social care service, as co-ordinated discharge arrangements may be more complex. In addition the increase in demand i.e. fast-track systems for provision of equipment/adaptations, or the need for an assessment by an occupational therapist due to complexity, may impact on the throughput of case work.

- Many occupational therapists in social care are involved in enablement / re-ablement services and the potential demand for these could increase (this may be dependent on local joint arrangements with PCTs) in order that those discharged reach their full potential and recovery maximized.

- Planned care (elective) centers must offer therapist led rehabilitation and pre- surgical screening in order to promote a swift and full recovery

- Polyclinics are intended to increase the throughput of treatments for patients, which may require additional workforce capacity in community services.

2. Greater care outside hospital

More services could be provided via GP premises/polyclinics, including occupational therapy. As the only profession trained to work in both health and social care, occupational therapists are well suited to this environment and can easily liaise/negotiate/signpost to a wide range of other services, plus co-ordinate complex care packages. Within primary care, occupational therapists can lead on health promotion and lifestyle improvement schemes

Occupational therapists are one of the largest professions already providing rehabilitation in the home although at present they have a very limited time to do so. However, if more expert care is to be provided to people at home, interventions may need to last longer (i.e. more treatment sessions), and the workforce will therefore need to grow in number to keep up with demand.

Impact on social care and occupational therapists

- Some detailed work will be required to look at potential local population needs in relation to the occupational therapy resource required to support these initiatives that will include projecting future need and also informing workforce planning.

- Continuity of service may need to be enhanced by the integration of occupational therapy services. The College launched a strategy 'Interface to Integration' to support an integrated approach across health and social care for occupational therapy services (this is available on our website www.cot.org.uk).

3.Additional Points

Occupational therapists are key in managing long-term conditions; the impact of this on the workforce needs for occupational therapy is yet undetermined.

In the report there is recognition of the incidence of mental health problems within London. There have been a number of reports, which highlight the vacancies for occupational therapists in the London area within mental health services.

The review also promotes health promotion and consideration will need to be given to the management of OT health promotion activities such as: prevention of falls exercise programmes, hazard checking in homes and, other seated exercise programmes for older people, all of which can be delivered by occupational therapists based in a variety of settings.

In summary, occupational therapists are used to working across traditional health/social care boundaries but occupational therapists working within social care services are struggling to meet existing demands. In consequence further investment in growing the numbers of the community based Occupational Therapy workforce and developing their areas of expertise, is required.

If you require any further information, please do not hesitate to get in touch.

Yours sincerely

Julia Scott
Chief Executive
College of Occupational Therapists

Cc David Coombs, Scrutiny Advisor

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Update for Healthcare for London on the
Rapid Evidence Review and Appraisal
as part of the
Health Inequality Impact Assessment and Equalities Impact Assessment

Prepared by Ben Cave Associates
on behalf of the London Health Commission

February 2008

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Date
29th February 2008

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Approved by	Ben Cave
For	London Health Commission

1. Purpose and background of this report

1.1 The purpose of this report is to update Healthcare for London on the progress of the health inequalities and equalities impact assessment (HIIA/EqIA) on the proposals contained in *Healthcare for London: consulting the capital*. The HIIA/EqIA is being undertaken by the London Health Commission (LHC).

1.2 Specifically, this report provides details of progress with the rapid evidence review and appraisal of the health inequalities and equalities impacts that the LHC commissioned Ben Cave Associates (BCA) to undertake on 19th December 2007 and the emerging findings from that work.

1.3 In addition to the rapid evidence review and appraisal, the HIIA/EqIA process also includes a baseline profile of health inequalities in London prepared by the London Health Observatory and findings from a stakeholder workshop held on 27th February.

1.4 On 17th March the LHC will present a final report of the HIIA/EqIA to Healthcare for London. This report will include findings and recommendations based on the rapid evidence review, the stakeholder workshop and the baseline profile.

1.5 The HIIA/EqIA process has been overseen by a Steering Group, which includes representatives of the LHC and London Equalities Commission and other key stakeholders including the GLA, LHO, NHS London, Local Authorities, London Development Centre/CSIP. The Steering Group have met regularly to design the HIIA/EqIA process, define the scope of the HIIA/EqIA and review emerging findings. The Steering Group will sign off the final report of the HIIA/EqIA.

Aim of the HIIA/EqIA

1.6 The aim of the integrated HIIA/EqIA as defined by the Steering Group is "to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities".

Scope, structure and methodology of the rapid evidence review and appraisal

1.7 It is essential the scope, structure and methodology of the rapid evidence review and appraisal are transparent, coherent and robust enough to withstand external scrutiny. They must also meet the requirements of the Steering Group and be realistic given the time available. Therefore, the full report of the rapid evidence review and appraisal describes the proposed approach in some detail.

1.8 An initial assessment was carried out by the Steering Group on *Healthcare for London: consulting the capital* (1) to identify which of the proposals were most relevant for equality equalities groups and health inequalities. The following policies were identified as being of most relevance and this report focuses on these policies:

- Primary care;
- Maternity care; and
- Stroke pathway.

1.9 Therefore, the rapid evidence review and appraisal has examined the proposals relating to these areas.

1.10 The scope of this work was to identify and review evidence that builds understanding of how the proposals contained in *Healthcare for London: Consulting the Capital* (1) may impact on health inequalities and equalities groups in London. It was not within the scope of this work to critique the clinical evidence base used to inform the proposals or to critically re-evaluate the analytical framework that describes current and future health care activity and costings.

1.11 The rapid evidence review and appraisal has drawn on systematic reviews, but has not been conducted using the methodology of a systematic review. Because there is very little routine data on the health and healthcare experiences of the equalities groups, many non-routine sources of data and evidence have been used, including grey literature, systematic reviews, community intelligence and primary research. The full report of rapid evidence review and appraisal explains in some detail how evidence has been identified, the benefits and limitations of each type of evidence and how this evidence has been used.

1.12 As the proposals concern healthcare, discussion on health inequalities has focussed on health status and outcomes, including life-expectancy and morbidity, and health services, including access and patient experience.

1.13 The rapid evidence review and appraisal has used the definition of equalities used by the Greater London Authority (GLA), as directed by the Steering Group. This definition is based on six equality themes - age, disability, faith, gender, race and sexual orientation. Each of these themes contains one or more equality groups. The full report also highlights particular vulnerable groups where these are not covered by these equalities groups.

1.14 The methodology of the rapid evidence review and appraisal has six key stages: project start-up; scoping; identifying and reviewing of key documents and evidence; undertaking the initial appraisal and preparing the interim report; participating in the stakeholder workshop; and undertaking the final appraisal and preparing the final report.

1.15 Public organizations have statutory responsibilities to assess and consult on the likely impact of proposed policies on equalities groups. These responsibilities arise from section 71 of the Race Relations (Amendment) Act 2000 (2), Section 3 of the Disability Discrimination Act 2005 (3) and Part 4 of the Equality Act 2006 (4).

1.16 The rapid evidence review and appraisal has been undertaken in line with GLA (5;6) and Commission for Race Equality (7) best practice. This will assist NHS London and the London Commissioning Group to fulfill their statutory duties and it will contribute to the examination of whether NHS London and the London Commissioning Group have given proper consideration to the likely impact on equalities groups.

1.17 Equalities groups have been considered consistently throughout the rapid evidence review and appraisal. In addition to the likely impacts of the proposals on race, disability and gender equality, as statutorily required, the rapid evidence review and appraisal also assesses the likely impact on age, faith and sexual orientation equality. The approach has been ratified by the London Equalities Commission.

Findings and emerging issues

Overall findings

1.18 A recurring theme is that the proposals could either increase or reduce health inequalities depending on *how* they are implemented. The changes to models of care proposed are likely to improve health outcomes. However, if these improvements primarily benefit those who already have adequate levels of access to quality healthcare and healthy lifestyles at the expense with those who currently have poorer access, health inequalities will increase.

1.19 In addition, while the implementation of the proposals *in full* is likely to improve health outcomes, their *partial* implementation could further exacerbate health inequalities. For example, a move to earlier discharge after stroke without an improvement in home support could lead to an additional burden on carers, who are themselves a vulnerable group whose health needs are often unmet.

1.20 In order for the proposals to reduce health inequalities the improved models of care need to benefit those who have the worst health now. Broadly speaking this will involve several major changes to current healthcare models.

1.21 *The inverse care law must be reversed*. More deprived areas must receive resources, including funding, staffing and infrastructure, in line with the higher levels of health need in those areas.

1.22 Models for *assessing and meeting unmet health* need should be developed and incorporated into PCT planning and performance management. There is a danger that vulnerable groups who currently cannot access healthcare will be left out of the improvements promised by the proposals, further increasing health inequalities between the most marginalized groups and the population as a whole.

1.23 New models of healthcare must take account of the needs of equalities groups, vulnerable groups and those with the worst health by *addressing the barriers that have historically prevented equalities groups and deprived communities accessing health care* and benefiting from health improvement initiatives. These barriers for different equalities groups include physically inaccessible services, a lack of language support and the cultural insensitivity of services. For deprived communities barriers also include poor access to healthy lifestyle choices, stress, social isolation, low aspirations and the affects of multiple deprivation such as poor housing, crime and fear of crime, unemployment, and poor access to services.

1.24 New initiatives and improved models of healthcare must be *targeted* at equalities groups, vulnerable groups and those with the worst health and provided at sufficient levels to meet their needs. This will necessitate developing ways of incentivising healthcare providers to work with traditionally-under-represented groups.

Emerging issues relating to primary care

- Clarification is needed from NHS London on the modelling on the location and average distance to polyclinics used in *Healthcare for London: consulting the capital*. Ensure physical proximity and ease of travel by public transport is prioritised in the development of polyclinics. This means avoiding an ad-hoc development based solely on the location of existing healthcare infrastructure and ensuring that polyclinics are situated where there are good public transport facilities.
- Healthcare for London and Transport for London should jointly issue guidance to primary care trusts outlining the transport planning issues to be considered in developing polyclinics. Transport accessibility indicators should be developed. Each polyclinic should develop of a travel plan. Patients should be made aware of how to get to the polyclinic, for example through leaflets.
- Ensure that in implementing the proposals, investment patterns are shifted to reverse the inverse care law. Areas with the highest levels of need must receive adequate levels of funding to meet these needs.
- Ensure ways continuity of care can be protected, for example by including this as an explicit feature of polyclinics.
- Polyclinics should include co-located non-healthcare services such as advice and support on employment, housing and welfare, exercise facilities, adult education and community organisations.
- Put in place mainstream services to ensure the recruitment and retention of sufficient staff in the most deprived areas of London.
- Explore models of primary care that specifically target those who have very poor existing access such as homeless people, refugees and asylum seeks or those living in deprived areas that are underserved by existing services.
- Include a commitment that the polyclinic model will include the development of premises to replace existing physically inaccessible and unsuitable GP surgeries.
- Build measures to improve the accessibility of all primary care services into the proposals. These should include adequate and consistently available language support and support for those with sensory impairment, learning disabilities and mental health problems. They should also include measures to ensure the sensitivity of services to lesbians and gay men. As a first step Healthcare for London should obtain and make public up to date information on the accessibility and suitablity of GP premises and how they are dispersed across London.
- Build in language support and accessibility for people with disabilities as a core part of any new telephone service.

- Ensure that new health improvement initiatives take into account the stress, isolation and disempowerment and lack of access that prevent many vulnerable groups from benefiting from existing initiatives.
- Ensure that preventative services are targeted at deprived and vulnerable groups and provided at a level which reflects their need.
- Ensure that PCTs commission immunisation services to cover services that were provided by GPs who have since opted out.
- Obtain further data on which equalities groups and vulnerable groups are most affected by being unable to register with a GP.
- Ensure primary care offers adequate and appropriate support to women experiencing domestic violence. This will require working in partnership with other agencies. It will also require proper training and support for staff.
- Primary care services need to ensure they take active steps to support carers in their caring roles but also to ensure that carers own health needs are meet.

Emerging issues relating to maternity care

- In view of the poor performance of London trusts in the Healthcare Commission's recent review of maternity services, urgent attention should be given to improving maternity care across the capital.
- Pre-conception advice and support should be built into the proposals.
- Women from disadvantaged groups and deprived communities should be targeted to ensure early ante-natal booking. Health equity audits of women booked for ante-natal care by 12 weeks and >22 weeks should be undertaken across London as recommended by the DH.
- The development of maternity services should include direct access to community midwives.
- Interpretation services should be available to support the whole range of maternity services from pre-pregnancy care to post-natal care. Women should not be expected to use children, partners of other family members as interpreters.
- Maternity services need to take account of the particular needs of women experiencing domestic violence.
- Culturally sensitive and appropriate care should be available to women living with Female Genital Cutting/Mutilation (FGC/M). Women from counties where this is likely to be practiced should be sensitively asked about this during pregnancy and management plans agreed during the antenatal period. Adequate training and support should be available for midwives, obstetricians and other healthcare staff to ensure they can provide this support.

Emerging issues relating to stroke pathways

- Participte in further research to better understand the increased susceptibility of minority ethnic groups to stroke, including which communities have an increased susceptibility and why, so as to better design prevention, treatment and rehabilitation to meet the needs of these communities.
- Ensure that stroke prevention initiatives are culturally sensitive to the needs Black and Minority Ethnic groups and targeted to them in view of the higher incidence of stroke amongst these communities.
- Ensure that stroke prevention initiatives address the factors that have historically prevented vulnerable groups and deprived communities from benefiting from health improvement measures.
- Ensure that stroke prevention initiatives actively target vulnerable groups and deprived communities, as well as groups at a higher risk of stroke and that funds are made available to support this targeting.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerabily in the local population and which groups are currently not accessing services. This will require local health equity audits and health inequality impact assessments.

- Ensure that measures are in place to identify and support carers.
- Ensure that home based rehabilitation is adequately resourced, and that there is adequate funding for local authorities' socal care services. This will require close joint working.

Emerging issues outside the scope of the rapid evidence review and appraisal

- Because the economic and employment impacts of the proposals are potentially significant, more detailed modelling needs to be done to explore the net job loss or gains, which areas they are likely to occur in, which equalities groups may be affected and how these could impact on health and health inequalities.
- The environmental and economic impacts of redeveloping NHS sites on health and health inequalities, including how the affect the equalities groups, need to be considered as part of local impact assessments on proposals to dispose of and redevelop individual sites.

Key groups at risk of experiencing continued health inequalities

- Carers
- People not currently registered with a GP
- Refugees, asylum seekers and newly arrived people who may have existing unmet health needs
- People with physical and sensory disabilities, reflecting the high numbers of inaccessible primary care premises based on most recent information

Summary of emerging recommendations

- The implementation of Healthcare for London needs to reverse the inverse care law. Deprived areas need high quality health services and a level of provision that reflects the higher level of health need their popuations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits and health inequality impact assessments.
- More information is needed about groups that are not currently accessing healthcare and the extent of this unmet need.
- Monitoring and addressing unmet need should be included in the performance management of healthcare commissioners and providers.
- Mainstream services must be designed to meet the needs of traditionally-under-represented groups by taking account of the low income, stress, social isolation, cultural sensitivities, lack of transport, poor access to exercise facilities.
- Mainstream services must be targeted at traditionally-under-represented, deprived and vulnerable groups.
- Extra funding and incentives must be made available to ensure healthcare commissioners and providers do target these groups.
- Reducing health inequalities should be included as an explicit objective in local plans for implementation. Healthcare for London needs to agree indicators for this objective.
- Service infrastructure developments and reconfigurations must re-provide existing inadequate and inaccessible premises, rather than incorporating them.
- Planning for accessibility by public transport must be included in an early stage of the development of polyclinics. Transport plans should be developed for each polyclinic and other major healthcare facilities. Transport for London and Healthcare for London should work together to provide PCTs with guidance on how to do this.
- When planning the reconfiguration of services Primary Care Trusts must be aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000, Section 3 of the Disability Discrimination Act 2005 and Part 4 of the Equality Act 2006.

- Healthcare for London should ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

2. Reference list

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LONDON
HEALTH COMMISSION

Health Equity Profile for London - Summary

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1. Summary

This report provides an overview of health inequalities in London. In doing so, it aims to help provide some understanding of the likely impact of the *Healthcare for London* proposed changes on those groups most at risk of being disadvantaged. The report aims to describe inequalities in health and in access to health services in London, using specific indicators of determinants of health and access to health care.

This profile describes both inequalities, such as variations in uptake of childhood immunisations and health inequities, such as poorer access to GP services by people in deprived areas. . Health inequalities describe differences of fact, which are not necessarily inequitable, as long as they are based on need, while health inequities are about lack of fairness.

The report focuses on those groups of people, who are most at risk of being disadvantaged, namely the equalities target groups: black, Asian and other minority ethnic groups (BAME); children and young people; people living with disabilities; people from faith groups; lesbian, gay and bisexual people; older people; women; and other vulnerable groups. It has not been possible to present information about each of these groups, since for some there is no routine data collection that would allow this. E.g. there are no data on mortality rates of different ethnic groups, faith groups or lesbian, gay and bisexual people.

London is populous and diverse, which presents a challenge when trying to develop a strategy for providing healthcare at the London level.

Inequalities in health are prevalent and widespread. Life expectancy in the capital ranges from over 80 years for men and women in Kensington and Chelsea, to around 78 years for women in Newham and only about 74 years for Islington men.

Wide variations exist between boroughs in terms of mortality, primary care provision and birth outcomes, with the most deprived boroughs usually featuring among those areas with the worst indicators. Variations also exist in uptake of preventive services, but these display a more complex pattern, not readily linked to area deprivation.

Overall, the distribution of inequalities is complex – it is not always the same geographical area that fares the worst, nor is it always the most deprived. Spearhead areas tend to fare worst in terms of health outcome, but they are not always the worst for each indicator.

In taking forward the *Healthcare for London* strategy it will be important to look at local community equity profiles, taking account of local intelligence, to ensure that health inequalities will be reduced and not increased.

Interpreting the indicators is not simple: it requires insight into the local culture and other local factors.

The key points and implications from this profile are summarised below and at the end of each section.

2. Background

- Inequalities in health exist between geographical areas and between socioeconomic groups.
- Health inequalities also exist between different age groups, gender groups and ethnic groups.
- The NHS has a significant role to play in reducing health inequalities, through understanding differing needs and equitable resource allocation.

3. London's Geography and Population

- London is a very populous and diverse city.
- London is a predominantly young city, with two thirds of residents being 40 years old or younger.
- London is also ethnically and religious diverse: one third of Londoners is of ethnic minority origin and a significant majority of residents of each borough belongs to a faith group.
- The capital is not uniform and individual boroughs are ethnically diverse to different degrees.

- Migration makes an important contribution to population change in London, but net migration cannot be measured.

Implications

- Targeted interventions will probably be required to ensure that the proposed changes result in services that provide services to meet the diverse needs of the diverse population of London.

4. Inequalities

- Inequalities in health mirror inequalities in general.
- There are both very affluent and very deprived areas and people in London.
- Levels of income deprivation and unemployment vary between boroughs, with unemployment ranging from 7% in Richmond, the most affluent area of London, to 24% in Hackney, one of the most deprived.
- London has 11 of the 70 areas in England that are in the most deprived fifth of areas and that are in the worst fifth of areas for life expectancy and mortality from cardiovascular disease and cancer.
- The equalities target groups, which have historically been disadvantaged or subject to discrimination, tend to have poorer access to health services and worse health outcomes than the general population.
- Life expectancy is highest and all-age, all cause mortality is lowest in affluent Kensington and Chelsea, while highest all-age, all cause mortality occurs in more deprived areas, such as Barking and Dagenham, Islington and Newham.

Implications

- Local factors, both area factors and individual factors, must be considered when implementing the *Healthcare for London* proposals in any given area.

5. Primary care and polyclinics

- There is marked variation in several aspects of access to primary care services across London boroughs.

- Some boroughs are currently under-doctored, i.e. there are fewer GPs per weighted population than the England average.
- There is variation in PCT performance on providing GP access within 48hours of requesting an appointment, ranging from less than 70% in Tower Hamlets to over 90% in Kingston.
- 7 PCTs appear to have a significant resident population (more than 10,000), who are not registered with a GP. This could represent a significant problem with access to primary care, but needs to be looked into further for full understanding.
- Primary care quality is even more variable than access, as measured by potentially avoidable emergency hospital admissions. These vary from just over 100 per 100,000population in Kensington and Chelsea to around 300 per 100,000 population in Ealing.

Implications

- Reorganisation of primary care services needs to take into account the potential difficulty of recruiting GPs into certain areas.
- Making it easier to register with a practice or making provision for unregistered populations to receive adequate services will also be important.

6. Preventive Health Care

- There is variation in access to and uptake of preventive services, which could be explained in part by different health seeking behaviours of different groups, but also in part by inability of services to reach certain groups.
- London shows variation in access to and effectiveness of smoking cessation services.
- Variation in access occurs by age and by borough. The worst access/poorest uptake of smoking cessation services is among those under 18 years, while 18 to 34 years old have the highest uptake.
- In Ealing nearly 80% of those smokers, who set a quit date with smoking cessation services remained quit at four weeks. Whereas, in Croydon only 40% were converted to four week quitters.

- There are variations in uptake of childhood immunisations at all ages and across boroughs. The picture is complex, with coverage differing between individual vaccines and no clear relationship to deprivation or affluence.
- Variations in uptake of flu vaccine by older people are less than for childhood immunisations.

Implications

- Understanding local factors and more precisely targeting preventive interventions could help improve their uptake and effectiveness.

7. Maternity

- High proportions of sole registered births, teen pregnancies and low birth weight occur in some of the most deprived London boroughs.
- Low birth weight shows marked variation across London with rates almost doubling from the lowest, in Richmond, to the highest, in Southwark.
- The infant mortality rate is 3-4 times higher in the areas with the highest rates than in the areas with the least infant deaths.
- Early booking is essential for good antenatal care. The proportion of women booking before 12 weeks of pregnancy varies markedly between boroughs. Late booking does not appear to be associated with deprivation – being far commoner in Tower Hamlets (over 60%0 than in Kingston upon Thames (less than 10%).

Implications

- To ensure the best outcomes, there might be more need for specialised obstetric units – or at least ready access to them – in the most deprived areas, with higher rates of risk factors for poor neonatal outcomes.

8. Stroke

- Stroke is a major cause of death and disability, contributing to the gap in CVD mortality between the spearhead areas and the country as a whole.
- There are ethnic variations in prevalence of hypertension and occurrence of strokes. The incidence of stroke is 60% higher in black people than in white.

- Stroke is primarily a disease of older people – 75% of strokes occur in those over 65 years.
- Despite its importance as a risk factor for CVD, hypertension is poorly managed, with only 15-18% of people being adequately treated.
- There is probably some under-recording of stroke in GP registers, meaning that opportunities for secondary prevention are being missed.
- Rates of both stroke and hypertension are lower across London than the England average, probably as a result of London's relatively young population.
- No routine dataset exists to enable us to determine what proportion of people who have had strokes were treated in specialist stroke units.

Implications

- Stroke prevention requires increased case finding for hypertension and better treatment.
- Recording of stroke in disease registers needs to improve, to enable more targeted secondary prevention.
- A single, national definition of a stroke unit and routine data collection are necessary to allow proper comparisons of treatment outcomes.

9. Conclusion

This report provides an overview of health inequalities in London. In doing so, it helps provide some understanding of the likely impact of the *Healthcare for London* proposed changes on those groups most at risk of being disadvantaged. The report describes inequalities in health and in access to health services in London, using specific indicators of determinants of health and access to health care.

Health inequalities exist across all the areas of health and health care considered here: primary care and preventive services, maternity care and stroke care. The pattern of inequalities is complex. To understand it fully we would need to take a more detailed look at inequalities in local areas and make use of local intelligence about the culture of the people and the services. In taking forward the *Healthcare for London* strategy, it will, therefore, also be important to use local community equity profiles to ensure the best outcome for equalities groups in local areas.

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