Notice of Meeting

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

FRIDAY, 25TH APRIL, 2008 at 10:30 HRS - COUNCIL CHAMBER, ROYAL BOROUGH OF KENSINGTON AND CHELSEA, KENSINGTON TOWN HALL, HORNTON STREET, LONDON W8 7NX.

Issue date: 18 April 2008
Contact: gavin.wilson@rbkc.gov.uk; tel: 020 7361 2264

Committee Membership: attached.

Public Agenda

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. CHAIRMANS WELCOME AND INTRODUCTION

4. MINUTES

To agree the minutes of the meetings held on 14th March 2008 and 28thMarch 2008.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE (PAGES 1 - 18)

To receive written submissions from LB Havering, LB Lambeth, LB Lewisham, LB Waltham Forest, and the Royal Pharmaceutical Society of Great Britain (attached).

6. FINAL REPORT OF THE JOINT OVERVIEW AND SCRUTINY COMMITTEE (PAGES 19 - 96)

To agree the final report. **(NB** The written submissions and minutes of JOSC meetings listed in Volume ll have been circulated previously, and are therefore not attached)

7. THE WAY FORWARD (TO FOLLOW)

To consider actions following agreement of the final report.

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

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.

PARTICIPATING AUTHORITIES

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

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

Out-of-London Local Authorities
Essex – Cllr Christopher Pond
Surrey County Council – Cllr Chris Pitt

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Agenda Item 4

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 14 MARCH 2008

London Borough of Ealing, Council Chamber,
New Broadway, W5 2BY

PRESENT:
Cllr Denyer - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr Pat Callaghan – London Borough of Camden
Cllr Graham Bass - London Borough of Croydon
Cllr Mark Reen – London Borough of Ealing
Cllr Ann-Marie Pearce – London Borough of Enfield
Cllr Gideon Bull - London Borough of Haringey
Cllr Jonathan McShane – London Borough of Hackney
Cllr Peter Tobias – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Fred Osbourne – London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Ralph Scott – London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Mark Francis – London Borough of Tower Hamlets
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Ian Hart – London Borough of Wandsworth
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)
Cllr Chris Pond - Essex County Council
Cllr Chris Pitt - Surrey County Council

ALSO PRESENT:

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Jacqueline Casson – LB Brent
Shama Smith – LB Camden
Neal Hounsell – Corporation of London
Trevor Harness – LB Croydon

Mike Davidson – LB Ealing
Keith Fraser – LB Ealing
Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
Ben Vinter – LB Hackney
Tracey Anderson – LB Hackney
Sue Perrin – LB Hammersmith & Fulham
Nahreen Matlib – LB Harrow
Rob Mack – LB Haringey
Anthony Clements – LB Havering
Guy Fiegehen – LB Hillingdon
David Coombs – LB Hillingdon
Sunita Sharma – LB Hounslow
Deepa Patel – LB Hounslow
Zoe Crane – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Nike Shadiya – LB Lewisham
Jonathan Shaw – LB Newham
Jilly Mushington - LB Redbridge

Speakers:

Professor Ian Gilmore – President, Royal College of Physicians
Martin Else – Chief Executive, Royal College of Physicians
Michelle Dix – Managing Director (Planning), Transport for London
Jason Killens – Assistant Director of Operations, London Ambulance Service
Tom Sandford – Director, Royal College of Nursing
Bernell Bussue – Director, Royal College of Nursing
Dr Bobbie Jacobson – Director, London Health Observatory
Dr. Sandra Husbands – Specialist Registrar, London Health Observatory

DATE AND VENUE FOR NEXT MEETING

28 March 2008, London Borough of Merton.

1. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:
Cllr Marie West – London Borough of Barking and Dagenham
Cllr Chris Leaman – London Borough of Brent
Cllr David Abrahams – London Borough of Camden
Cllr Viven Gillardi – London Borough of Enfield
Cllr Janet Gillman- London Borough of Greenwich
Cllr Mark Hayes – London Borough of Greenwich
Cllr Ted Eden – London Borough of Havering
Cllr Meral Ece - London Borough of Islington (Vice Chairman)
Cllr Alan Hall – London Borough of Lewisham
Cllr Megan Harris Mitchell – London Borough of Newham
Cllr Allan Burgess – London Borough of Redbridge

Apologies for Lateness were received from:
Cllr Carole Hubbard – London Borough of Bromley
Cllr Chris Pond – Essex County Council (early departure)

2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard, London Borough of Bromley, declared that she is an employee of Bromley PCT and a member of the Royal College of Nursing.

Cllr Vina Mithani, London Borough of Harrow, declared that she is an employee of the Health Protection Agency.

3. CHAIRMAN'S WELCOME AND INTRODUCTION

Councillor Mark Reen, Ealing's representative on the JOSC and the Chairman of their Health, Housing and Adult Social Services Standing Scrutiny Panel, welcomed everyone to the borough. An introduction to the borough was provided and the meeting noted the housekeeping arrangements.

The Chairman thanked Councillor Reen for his welcome. The Chairman went on to give the Committee an outline of the day's proceedings and explained that the minutes of the previous meeting would be taken after lunch as the first speaker, Professor Ian Gilmore, Royal College of Physicians, needed to leave promptly at 11:00am.

4. MINUTES

Prior to discussing the minutes, the Chairman thanked Ealing Council officers for accommodating the event and Cllr Hazel Ware (Mayor – LB Ealing) and Robert Creighton (Chief Executive – Ealing PCT) for attending lunch and meeting the members of the committee.

The minutes of the meeting held on 22 February 2008 were agreed subject to the following amendments:

That Cllr Peter Tobias of the London Borough Hammersmith and Fulham and Councillor McShane of the London Borough of Hackney, are stated as being present at the meeting.

That Councillor Viven Gillardi of the London Borough of Enfield is stated as being present not Councillor Ann-Marie Pearce.

That, referring to p7, paragraph 8, line 7, the second "not" should be deleted so that the sentence reads correctly.

That, referring to p10, paragraph 7, line 3, it should read RCM (Royal College of Midwives) not RCN.

That, referring to p11, paragraph 1, line 2, it should state M11 "gateway" area.

A number of members indicated that there were questions and answers missing from some of the witness sessions. The Chairman asked members to email the officer group with the details of any information not included.

The Chairman said that she would be taking one item under 'Any Other Oral or Written Items' which the Chairman considers urgent, a letter from the London Ambulance Service Patient and Public Involvement (PPI) Forum.

The Chairman ran through a number of key points from the meeting on 22 February 2008. Detailed below is a summary of the points made;

- GPs play a central role in the NHS and account for many people's main or sole contact with the NHS. GPs also help manage demand by acting as 'gate-keepers' for access to other NHS services. Numerous GP consultations can be provided for the same cost as a single night of hospital admission.
- The original proposal for 'polyclinics' in the Healthcare for London review did not acknowledge the many differences in local needs across London. Some areas and local populations may benefit from new large 'polyclinics' with extended hours, whereas others may prefer to keep a system that ensures a personalised GP-patient link. There must be a flexible approach that meets all of these needs.
- 'polyclinics' must not be 'mini-hospitals'. There are questions around the financial effectiveness of 'polyclinics': it is very costly to provide x-ray equipment and it may be more cost effective to invest resources instead to extend the opening hours of existing hospital-based diagnostic equipment and implementing solutions that improve primary care access to this equipment (e. g. certain times at which hospital diagnostic equipment is prioritised for primary care patients).
- GPs acknowledge that there are some problems with accessing existing provision however many oppose any attempt to impose a single blueprint on all areas of London.
- Midwifery is facing many challenges in relation to workforce: there is an ageing workforce with many retirements likely within the next 10 years. Midwifery services rely on funding for staffing and not equipment. However despite the ageing workforce, midwifery has seen a reduction in its share of the NHS budget. This is despite the fact that London has the fastest rising birth rate in England and greater challenges (e.g. diversity and poverty).

- The NHS must not simply be a sickness services and must seek to prevent illness occurring. Midwives can play a key role in establishing healthy lifestyles at a time when people are responsive to change (e.g. in encouraging breastfeeding or giving up smoking).

- It is important to manage children's long-term health needs. The hospital should only be one place where this care is provided. Schools (and in particular extended schools) can play a central role in providing this support.
- It is vital to reform services and not simply change the location where these are provided. Co-locating services on a single site (e.g. polyclinic) may help improved coordination but this will also require services to share more information and change the way they work.
- Centralisation of services may lead to improved outcomes in certain procedures by ensuring that surgeons have sufficient opportunity to refine and maintain their skills. Any centralisation will impact on the LAS who will need to be able to make the decision to take a patient with acute needs to a more distant specialist hospital and support the patient during this journey.
- London has specific needs and challenges: e.g. the mobile population can make it difficult to ensure high immunisation rates.
- It is important to strategically plan specialist services. However this can be difficult given the current NHS financial and commissioning process i.e. payment by results can lead to hospitals competing with each other rather than collaborating to agree that certain hospitals undertake particular services.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

The Chairman referred the committee to written submissions and replies to letters from;

NHS London
London Voluntary Service Council
BME Health Forum – Kensington and Chelsea and Westminster
London Travel Watch
LB Bexley
LB Croydon
LB Harrow
LB Hillingdon
LB Hackney
RB Kensington and Chelsea
London Network of Patients Forums

The Chairman said that all submissions should have been received by 29 February 2008, but if any London Boroughs have their own submissions they would like to feed into the JOSC, she, the vice

chairmen and the officer support group would be grateful to receive them as soon as possible.

6. Witness Session 1: Healthcare for London – The implications for Physicians
Professor Ian Gilmore, President, Royal College of Physicians
Martin Else, Chief Executive, Royal College of Physicians

The Chairman introduced Professor Ian Gilmore and Martin Else to the Committee. The following points were made during the presentation and ensuing discussion:

- The Royal College of Physicians' core business is setting standards in patient care and their work is carried out through the education and training of junior doctors and helping consultants keep up to date and competent.
- The Royal College represents 28 out of the 58 specialties (all non-operative) and identifies with many of the themes outlined in the Darzi report.
- The Royal College is involved in three strands directly and this work is detailed in 3 key documents, Acute Health Care Services (Academy of Medical Royal Sciences, Sept 07), Acute Medical Care – The right person in the right setting – first time (Royal College of Physicians, Oct 07) and Teams Without Walls (Royal College of Physicians).
- The Royal College does not get involved with discussions over which hospitals should stay open or closed but does get involved in providing advice as to how PCT's or NHS trusts best organise their services. The Royal College produces around 6 independent reports for trusts and PCTs each year but by and large, they tend to take a broad overview on issues.
- A common theme in the Darzi report and the Royal College's work is clinical leadership. It was noted that where things are going well (e.g. around diabetes), GPs are talking to doctors about what is best for the patient. Things go badly when PCT managers are talking to hospital managers (e.g. around Rheumatology) and the issue is driven managerially not clinically. Although managers want the same positive outcome they have to react to "top down pressures".
- Clinicians should get more involved in the development of services that take into account the needs of the wider population.
- The Royal College wants more clinicians to go into senior management roles.
- A shared agenda is needed between clinicians and managers to drive improvements in quality. Clinicians need information that is

meaningful and relevant to them (e.g. MRSA rates, the number of patients on the ward). This type of information will help bring length of stay down.

- There should not be a "one size fits all" approach as different solutions are needed for different areas.
- That referring to the themes in the document, and specifically how acute services should be configured, the Royal College believes that local hospitals still have a continued place in taking emergency medical admissions, but support services must be in place, such as intensive care facilities. It was explained that links with intensive care are crucial. The Royal College recognises, however, that such services need not be co-terminus with surgical services that are getting more specialised and will gravitate to larger hospitals.
- Referring to the document 'Acute Medical Care – The right person in the right setting – first time', acute medicine is the fastest growing specialty and it is vitally important that an acute medicine specialist sees admitted patients in the first 24 to 48 hours. The meeting noted that there is evidence, if a patient is seen by a fully trained physician at the start of the process, of the outcomes being much better with the patient getting on the right track and being discharged earlier. In summary, acute hubs are vitally important.
- The document 'Teams Without Walls' states that it's good for the money to follow the patient but some of the recent reforms don't help as much with unplanned care. The meeting noted that the document is about developing integrated care with joint commissioning at a primary and secondary level so that the NHS gets it right for patients early on. Ways of working need to be cost - and clinically-effective.

Questions

1. *The Chairman asked what physicians see as the biggest drawback to the Darzi's proposals?*

   Professor Gilmore replied that some practitioners aren't fully on board with the re-organisation and idea of 'polyclinics'. The meeting noted that the Royal College doesn't have a problem with working in primary care but it needs to be right for patients and make clinical sense for them to become involved. He said that specialist patients need specialist care and this doesn't mean GPs undertaking short courses in specific areas.

2. *Cllr Buckmaster (Kensington & Chelsea) noted that there is only a passing reference to social care in the Healthcare for London document and that Local Authorities (LAs) have a key role to play in the primary and secondary care interface, preventative measures and making sure that patients have good support when they move out of hospital.*

Professor Gilmore agreed that LAs are crucial because if you do not have an effective interface and discharge/transfer procedure, everything falls apart. In regards to preventative medicine, he said that the Royal College has a faculty of public health, has wanted a smoking ban since 1962 and seeks to tackle obesity and alcohol misuse.

3. *Cllr Cornelius (Barnet) imagined a scenario where 'polyclinics' have been introduced and district hospitals have gone with GPs and physicians based in the 'polyclinics' and acute hospitals. Noting the evidence from Professor Gilmore that medical and acute skills would still be needed in general hospitals, how will this work if the skills base has moved to the 'polyclinics'?*

   Professor Gilmore said that the information he provided was in regards to both urban and rural areas. He said that in London, 'polyclinics' would do some of the work of a district hospital but he does not envisage doctors being in 'polyclinics' 24/7. Using the example of cardiologists, he said that he could see them working in a hospital in the morning and holding a heart failure clinic in the afternoon at the polyclinic.

   Councillor Cornelius asked if the district hospital is being re-invented as the polyclinic. Professor Gilmore said that he could see 'polyclinics' accommodating services such as physiotherapy but not acute services.

4. *Councillor Hubbard (Bromley) asked if government targets have got in the way of best clinical access and care?*

   Professor Gilmore said that they have and they have not. He said that the positive aspects of targets include focussing on issues such as patients on trolleys and looking at what is right for the patient. Negatively, he said that there are perverse aspects to targets, such as the focus and extra resources into Coronary Heart Disease that has resulted in liver disease "falling down". He said that it is important for targets to have clinician "buy in". Martin Else highlighted the example of targets around stroke care that have had good clinician buy in. He said that clinicians look at and respond to information tables to build better care. In principle, he advocated collecting information that is designed by clinicians and not imposed managerially.

5. *Councillor Bass (Croydon) asked if transferring services from the centre to localities would lead to a reduction in the quality of care.*

   Professor Gilmore replied that there is a risk and for every condition there must be a patient pathway. He said that there needs to be a balance between clinical and patient need and vigilance would be needed in monitoring this.

6. *Cllr Urquhart (Richmond) asked if shared management would work under the Darzi model.*

   Professor Gilmore replied that people are suspicious of the next level up in the NHS, which is why the Royal College is developing initiatives on managers and clinicians working together. He reiterated that the Royal College wants clinicians in top posts and said that the NHS must "get smarter" about providing assistance and look at issues such as contracts.

7. *Councillor Reen (Ealing) asked if the polyclinic model was being set up in competition with district hospitals, if there was a danger of a "1 size fits all approach" because of different models in different areas and if a dis-investment in district hospitals would be required to make the model work.*

   Professor Gilmore replied that it depended on whether new services were being put in or not. He said that a one-size fits all approach won't work and the most important thing is for accessible services in the community.

8. *Councillor O'Malley (Lambeth) asked for an example of where it's beneficial to concentrate services.*

   Professor Gilmore provided the example of gastro and liver disease, where it is proven that early endoscopy improves outcome and survival. The meeting noted that to do this, specialist advice needs to be available 24/7. He said that specialist intervention in regards to urology also makes a difference to outcomes.

9. *Councillor Tobias (Hammersmith & Fulham) asked how the speakers thought the polyclinic model would evolve.*

   Professor Gilmore replied that the Royal College would not be looking to influence the details of the structure, but through the documents they have produced, wanted to help develop pathways from primary to secondary care that make sense for patients. He said that combined working is particularly important where the patient has chronic difficulties.

   Martin Else said that the Royal College has not opted for a particular model but were saying that clinical structure, network and what's right for the area needs to be looked at. He said that there should not be one model for one area and it may end up taking the form of a polyclinic or an enhanced district hospital. Professor Gilmore summarised by saying that certain principles should apply.

   The meeting broke from 10:55am to 11:05am for refreshments and a comfort break.

7. Witness Session 2: Healthcare for London – Transport Implications
Michele Dix, Managing Director of TfL Planning, Transport for London

The Chairman introduced Michele Dix to the Committee. The following points were made during the presentation and the ensuing discussion:

- TfL are aware of the impact of health policy decisions on transport, which is why they have responded to the Healthcare for London document.
- TfL should be involved at the start of the process, as the NHS should be thinking about transport when deciding where healthcare facilities are located.
- 5% (1 million) of all trips made in London each day are healthcare related, compared to 13% that are educational related. The majority of these healthcare trips are made by car, 59%, with 19% walking, 14% by bus and 10% by tube/rail.
- There are 1600 GP practices in London with an average travel time of 8 minutes to the nearest GP.
- TfL's concerns include changes impacting on the current balance resulting in increased demand and issues regarding general health, as they want to encourage healthy lifestyles through 'active travel' (walking and cycling). The proposed closure of the Chase Farm Hospital A&E unit was provided as an example, which, if it goes ahead, will result in 75,000 patients having to travel further. It was noted that the trust only looked at ambulance and not patient access as part of the proposals.
- TfL provides door-to-door transport through 3 schemes, Taxi Card, Capital Call and Dial-a-Ride. The meeting noted that the schemes provide access to the NHS for a significant number of people and there is a concern that the boroughs, NHS and TfL, should share this provision.
- TfL have been developing travel plans for 33 NHS trusts and each have been provided with £20k worth of advice and support. It was noted that travel plans have been successful in reducing car use.
- TfL, in their draft response to the document, have said that they support a move to enhanced choices but indicated that careful consideration needs to be given at the delivery stage to the demands that will be placed on transport (e.g. more people being treated at home = less demand; more specialisation and people travelling further by car = more demand). It was noted that if 70% of GPs moved to 'polyclinics', there would be an increased demand on the system but a reduced demand if 40% of hospital activity transfers to 'polyclinics'.
- TfL, in their draft response, have requested that the promotion of walking and cycling is a key consideration when locating facilities and supports the theme of prevention being better than care, which

TfL is promoting through active travel plans and reducing air pollution through the congestion charge.

- TfL believes that any re-configuration of healthcare services should reduce the need to travel by car, encourage a shift to more sustainable modes of transport and improve accessibility. The meeting noted that TfL would like to work with the NHS to develop criteria for the location of healthcare facilities and the feedback from the NHS has been positive on this proposal. Any future modelling should look at the effects on travel time and the numbers that will be advantaged and disadvantaged under any proposals.
- All 'polyclinics' and hospitals should have travel plans.
- Priority should be given to access by walking, cycling and public transport. An example was provided of a hospital with no pavements on its approach.

Questions

1. *Cllr Taylor (Westminster) said that there has been a discussion involving relevant boroughs about how the Academic Health Science Centre will impact on transport and an acceptance that NHS London and TfL need to look at physical access and accessibility in the future. He continued by highlighting a problem with the Taxi Card scheme, where patients are being told that they can't use the service for access to health care. He said that the terms under which the Taxi Card scheme operates needed to be altered and he would also like to see the terms of reference for the London Travel Group with a view to adding to them.*

   Michele Dix replied that the London Travel Group operates according to the accessibility model with planning and modellers in TfL's policy unit working with NHS London. She said that she would send out the terms of reference for the London Travel Group and said that people can attend and contribute to its meetings so that there is joined up working and effective lobbying of the NHS. This would help to ensure that the burden did not solely fall on transport providers. Cllr Taylor said that NHS London has a duty to consider its responsibilities to clients and service users and should provide taxis for hospital attendees, if needed.

2. *Cllr Bull (Haringey) asked what opportunity TfL has to "drill down locally" on issues such as the closure of GP practices.*

   Michele Dix replied that TfL get involved with travel plans and bus access but said that they tend to be more reactive than proactive and would like to influence the process much earlier on. Cllr Bull commented that this was wrong and TfL should be involved at a much earlier stage.

3. *Cllr Pond (Essex County Council) highlighted a cross border issue affecting Essex County Council where there is a problem accessing*

Whipps Cross Hospital by bus and stated that there should be a way of considering and improving such issues in the future.

Michele Dix said that she could ask John Barry (Bus Planner) to respond to Cllr Pond's specific issue but TfL should be proactive and responding in the first place rather than later on.

4. *Cllr Cornelius (Barnet) said that the Healthcare for London plans would fall down if the number of movements is doubled and asked for a direct message to be put forward that details need to be seen first.*

   Michele Dix said that TfL have concerns and think there will be wins and losses but it depends on which outweighs the other.

5. *Cllr Lewis-Lavender (Merton) agreed that strong lines of communication are needed between NHS London and TfL but acknowledged that there would be times where a journey needs to be longer (e.g.- to a specialist stroke treatment centre). In support of 'polyclinics', she said that having various services under one roof would reduce travel.*

   Michele Dix replied that TfL would need to see where the 'polyclinics' are located first. The meeting noted that all TfL can currently do is comment on the model and carry out theoretical testing.

6. *Cllr Hardy (Hounslow) asked if NHS London and other decision makers were reciprocating TfL's commitment to engagement.*

   Michele Dix replied that discussions have been positive to date and she is optimistic that TfL can have an influence. She said that if TfL lobby the NHS, they would listen, and TfL want to make sure that transport issues are high on the agenda.

7. *Cllr Mithani (Harrow) asked how TfL works with residents on travel to clinics.*

   Michele Dix replied that it is not TfL's role to directly engage with residents at this stage, but once the vision is clearer, they will work on the location criteria and hope that local people get involved at this stage.

8. *Cllr Scott (Redbridge) said that the travel instructions for all four bus routes to Queens Hospital, Romford, involve a change en route. He asked to what extent TfL is the provider and if unpopular routes could be put out to tender.*

   Michele Dix replied that TfL is the provider and if there were a demand, it would look at new routes. She said that TfL has to

ensure accessibility to facilities but the bus planning team faced difficulties finding a direct route when people are travelling from a wide area and the facility isn't in the right place. The meeting noted that patients could make use of Taxi card and Dial a Ride if they can't use public transport.

The Chairman thanked Michele Dix for her evidence and it was agreed that any further questions could be forwarded to TfL for a response.

8 Witness 3: Healthcare for London – the implications for the London Ambulance Service
Jason Killens, Assistant Director of Operations, London Ambulance Service

The Chairman introduced Jason Killens, Assistant Director of Operations, London Ambulance Service (LAS). The following points were made during the presentation and ensuing discussion.

- The LAS is the only pan-London NHS Trust.
- Although some non-urgent work is undertaken with trusts on a contract basis, the vast majority of work is taking patients to A&E (1 million requests). Of these 1 million requests, 75% are taken to A&E departments, 50% don't need to go to A&E and 5% need medical intervention at the scene.
- Each caller is asked questions at the first point of contact to determine clinical priority and what asset (vehicle) should be dispatched. The meeting noted that the LAS aspires to divert 200,000 patients per annum to primary care.
- The LAS supports Darzi's proposals in principle but with caveats.
- The LAS believes there is good evidence to support the centralisation of specialist care. The example of Cardiac Care hub and spoke model (Monday – Friday office hours) was provided, where seeing a specialist improves survival rates from 4% to 16%.
- Implications for the LAS could be: less ambulance availability because of extended journey times: extra training being needed as a result of ambulances having patients for longer; and paramedics and technicians requiring 'up-skilling' so that they are able to decide on the correct care pathway. The meeting noted that the LAS must receive additional funding to enable it to undertake the proposed enhanced role without weakening performance against national standards Jason Killens said the issue of whether the air ambulance should be centrally funded, rather than through charitable donations, would also need to be discussed if there was a move towards specialist trauma centres.
- The LAS need to get involved in service re-configurations at an early stage so that they can analyse what the ebb and flow of patients would be if there is widespread change.
- In conclusion, the LAS supports Darzi's vision but it is less clear what the implications will be. LAS would be looking for a consistent

level of service from 'polyclinics' and wanted to be engaged at the start on locations and service design.

Questions

1. *The Chairman asked how long the training or 'up skilling' would take and if the LAS has the required funding.*

   Jason Killens replied that the service level would determine the level of up skilling required. He said that, because of people working shifts, training could take up 24 dedicated months and they won't know how much funding is needed until needs are determined. The meeting noted that there would also be the issue of back filling whilst people are training.

2. *Cllr Pearce (Enfield) acknowledged it was good to have local stroke centres open Monday-Friday 9-5, but asked what happens in the evening or at the weekend.*

   Jason Killens replied that, as per the 'response to a heart attack model', the patient would be transported to a regional centre. He said that there could be 3, 4 or 5 Specialist Regional Stroke Centres in London open 24 hours a day, 7 days a week, supported by local centres open Monday-Friday, 9-5. He said that once a patient has been stabilised in the regional centre, they could be transported back to a local centre. It was also acknowledged, that there is a lack of stroke facilities in North London.

3. *Cllr Hardy (Hounslow) asked if the LAS average speed has gone up or down.*

   Jason Killens replied that he did not have that information to hand but following observations, the LAS have diversified their resource base. He said that the LAS have responded to the increase in congestion by doubling their number of motorbikes and bicycles. LAS noted that speed humps and other traffic calming measures slow ambulances down significantly.

4. *Councillor Urquhart (Richmond) asked if the LAS are responsible for calling the air ambulance.*

   Jason Killens replied that the LAS are responsible for calling the air ambulance and also transport the air ambulance doctors when the helicopter is not in use. He said that there is a criteria used to activate the helicopter, such as a road traffic accident. It was noted a paramedic at the scene could also call the air ambulance if the situation is more serious than initially thought.

5. *Cllr Scott (Lewisham) asked if any modelling work has been done on when patients are taken home but there's nobody there, as she is concerned about re-admittance.*

Jason Killens replied that re-admittance is an issue in some areas but it's too early in the vision for modelling, as the ebb and flow of the patients is not yet known.

6. *Cllr Sweden (Waltham Forest) asked what the impact of the proposals would be on the LAS if the diagnosis were not clear-cut, such as a stroke. Would it be better for them to go to a mixed district hospital to be triaged first?*

   Jason Killens replied that it is relatively easy to diagnose a stroke and although cardiac care is more complicated, the LAS have an Emergency Care Practitioner scheme, which has introduced a new level of diagnostic skill and equipment. The meeting noted that there is a number of Emergency Care Practitioners (ECPs) already operating in some boroughs that have a high level of diagnostic skill and can prescribe drugs. He said that LAS want to expand the ECP scheme, understand the level of care required and bridge any skill gap.

7. *Cllr Pond (Essex County Council) asked whether LAS has a good relationship with neighbouring ambulance trusts.*

   Jason Killens replied that the LAS relationship with neighbouring trusts is good and there's also a National Workforce Plan. In regards to a specific query relating to Essex, he said that the LAS would not influence where the East of England Trust take their patients as this is determined by where the patient lives.

8. *Councillor Tobias (Hammersmith & Fulham) asked if someone in the LAS is liaising with other ambulance services to provide a co-ordinated response.*

   Jason Killens replied that the LAS is the only provider of an urgent service but there were other providers contracted to provide non-urgent transportation. He said that it would be difficult to liaise with such providers as the LAS are all about care and provision and not tied into making money. The meeting noted that the Darzi proposals would impact on the 999 urgent service and not non-urgent work.
9. *Councillor Reen (Ealing) asked to what extent the proposals would impact on the LAS, if they were included in the process from an early stage and if the models are rolled out, were there people who get the 999 service now who would not get it in the future.*

   Jason Killens replied that, in regards to previous hospital closures, the LAS has been behind the curve, which has led to their contribution being "bolted on" at a later stage. He said that, in regards to Darzi, the LAS has been well involved from an early stage, had been able to influence the section on ambulance

provision prior to publication and was able to exert an influence now through their submission. In response to the issue of people receiving the service, he said that the LAS wanted to protect the national standard but if the service needed to do things in different numbers, additional funding would be needed to fund more ambulances.

10. *Cllr Bull (Haringey) asked if staff get feedback as to whether their initial triage assessment was accurate and if there are paramedics on every ambulance.*

    Jason Killens replied that there are two areas of triage for the LAS, reception of the 999 call and upon arrival at the patient. The meeting noted that in the control room an internationally used software package creates a red, amber or green category and the system is tightly controlled through quality assurance and consistently held up as an example of good quality. He said that on-street assessments are more difficult to quality-assure, but a system of peer reviews with clinical leaders is in place where time taken, treatment and the appropriateness of treatment is analysed. If issues are identified, action plans are implemented.

    In regards to the second part of the question, Jason Killens replied that technicians are not just drivers, but have 16 weeks of training and are re-assessed at the end of their probationary period. The meeting noted that technicians could diagnose heart attacks, give life saving drugs, treat conditions such as asthma and provide the bulk of care. He said that only 5% of patients would benefit from the care of a paramedic and the gap between technicians and paramedics is narrowing. Responding to the question, he confirmed that one third of staff on ambulances are trained paramedics and that if a technician is not able to administer a certain drug, a paramedic will be sent.

11. *Cllr Francis (Tower Hamlets) agreed that the case for getting centralised specialist care quickly is persuasive but asked if the LAS have any concerns that the shift might lead to a reduction in the quality of care. He also asked if the LAS wanted to see A&E units retained in District Hospitals.*

    Jason Killens replied that if there is a reduction in service it's a possibility that there might also be a reduction in the quality of care but it would depend on the design of services and how easy it is to access them. He said that there is potential for improvements through the vision but this needs to be done right. If it is planned, designed and resourced appropriately, services would be enhanced.

    In regards to the retention of A&E units in District Hospitals, he replied yes and no. He said that it would be "no" if primary health

pathways are resourced appropriately, as 50% of all urgent requests don't need to go to A&E and there isn't somewhere within primary care that the LAS can specifically refer people to at the moment. If the knowledge gap is bridged, A&E units do not need to be retained and this is at the heart of Darzi's proposals. The meeting noted that a recent Mori poll found that people primarily want an ambulance to arrive quickly and are less concerned about where they are taken or re-directed to. He recognised that the loss of a local A&E service is a real source of tension, as in some areas it does remain the only out of hours service.

12. *The Chairman asked what would happen if a paramedic picks up a patient, and decided the patient needs to go to a specialist centre but the patient unfortunately died on route.*

    Jason Killens replied that paramedics used to be disciplined 10 years ago for not taking patients to the local hospital. There has been a change in culture for staff, whom are now empowered to decide on the appropriate treatment option and signpost or deliver them to the site. If something did go wrong, LAS would always support a decision if it is reasonably justified. It was noted cases would be looked into if a paramedic stepped outside protocol.

The Chairman thanked Jason Killens for his evidence and it was agreed that any further questions could be forwarded to the LAS for a response.

The meeting broke from 1:04pm to 1:50pm for lunch.

9. Witness Session 4: Healthcare for London – the implications for Nursing and Mental Health Provision

The Chairman introduced Tom Sandford and Bernell Bussue, Directors of the Royal College of Nursing (RCN). The following points were made during the presentation and ensuing discussion. Bernell Bussue addressed general points whilst Tom Sandford focussed on mental health issues.

Bernell Bussue

- There are 50,000 RCN members in London and they have been consulted, using a variety of methods, on the Healthcare for London document.
- The RCN applauds NHS London and Healthcare for London for their efforts to engage on this matter.
- The RCN's concerns include a general feeling that the document doesn't promote the contribution that nurses and allied professionals make.
- The RCN sees benefits in London-wide services (e.g. diabetes, stroke) but feels that learning disabilities and other long-term

conditions, such as sickle cell anaemia, are not satisfactorily reflected in the report.
- Securing RCN members' "buy-in" for some of the proposals might be difficult.
- Trade unions and professionals should be engaged as soon as possible in the development, design and implementation of services.
- There are a variety of RCN views on 'polyclinics'. Some members are saying that the services provided by district hospitals should be improved rather than 'polyclinics' becoming 'mini hospitals', whilst others are saying that 'polyclinics' should develop services for local people.
- The consultation is predicated on an 'able sick' rather than a 'sick sick' and there is a sense that the services proposed may fail some of the people who are already having difficulty accessing service. Noting there should be a focus on improving services in the most deprived areas.
- From a workforce perspective, what is proposed over the next 10 years would require a shift in organisation, with a conservative estimate of 30% of staff being required to move from acute to primary care.
- In regards to transportation, TfL must engage with the NHS and local authorities to make sure systems are in place before any changes are made.

Tom Sandford (Mental Health Policy Advisor)
- Spend on mental health services in London is 21% higher than the national average.
- There are a number of health inequalities linked to mental health issues, such as a reduced life expectancy (10 years less than the average).
- The meeting noted that this is further compounded for people from Black and Minority Ethnic (BME) groups, who (it has been identified) are less likely to access the service.
- 63% of all BME referrals, it was noted, come from the police.
- In 2008, mental health trust providers had improved with 8 trusts classified as being in a 'strong position' - but work needs to be done on some fundamental issues.
- The meeting noted that not all trusts properly engage with local authorities; less than half of all mental health patients have a care plan; intelligence needs to be fed into joint commissioning; care pathways should be much clearer; early intervention is largely absent and access to psychological therapy is not quick enough.
- The RCN has carried out an impact assessment on the Healthcare for London plans and have warned that 'polyclinics' could deepen disadvantages if funding is not targeted.
- The meeting noted that if mental health is going to be one of the services provided at a 'polyclinic', appropriate staff and facilities need to be put in place, as people with problems referred by the

police can be intimidating. 'polyclinics' should be built considering patients with mental health needs.

- Under the proposals, psychiatrists would need to work with GPs in a different form of partnership.
- There is an issue with some targets, such as A&E departments being required to treat patients within four hours, as people with mental health problems may have been using drugs and alcohol and require time to settle.
- There are a number of local issues with: services provided at the Henderson and Cassel Hospitals at risk; the only emergency clinic at the Maudsley closing; Camden and Islington closing the St. Luke's site; and bed closures.
- The meeting noted that there are arguments for and against bed closures but families and relatives are concerned and in his opinion, the rationing of in-patient beds is linked to trusts applying for foundation trust status.
- The BME services in London are "underwhelming" and demand for the drug and alcohol service is huge but access is not keeping up with demand.

Questions

1. *Cllr Lasaki (Southwark) asked how young black boys could be encouraged to access mental health services where needed.*

   Tom Sandford replied that services needed to be made "culturally acceptable" as they are currently perceived as repressive. He said that services need to be available in different contexts to reach out to communities and a more systematic approach is needed around work in schools and accessing hard to reach communities.

2. *Cllr Buckmaster (K&C) commented on a couple of figures that he described as "stark", ie the 30% of nurses that will need to move from secondary to primary care and the 63% of all BME mental health referrals that come from the police. He asked if London had enough nurses and commented that, in Kensington and Chelsea, they have requested that all 'polyclinics' should have a mental health nurse.*

   Bernell Bussue replied that, in regards to staffing, it's mixed but overall London does not have enough nurses. He said that specialist areas have the biggest problems and it's a challenge to make sure that nurses in training have a place to go to. The meeting noted that it would be important getting workforce planning right and commissioners need to think about the number of trained nurses needed. He commented that there is also a move to bring in more healthcare assistants but nurses are still needed.

   Tom Sandford, in regards to the majority of BME referrals coming from the police, said that this is a complex issue. He said that the police are more skilled at recognising problems and using diversion

techniques and commented that friends and family generally, not just in BME communities, have a poor understanding of services available.

3. *Cllr Taylor (Westminster) said that NHS London should undertake a joint scrutiny project looking at access, as local authorities are looking for improvements in regards to access and care pathways, and asked if the RCN would help pursue this request.*

   Tom Sandford, said that the RCN would help pursue this request.

4. *Cllr Hart (Wandsworth) commented that there should be a full consultation exercise in regards to the Henderson and asked if the Darzi proposals will help address RCN's issues and whether NHS London are the right people to implement the changes.*

   Tom Sandford replied that providing mental health services is a challenging issue worldwide. He commended London PCTs for the level of funding that they provide to mental health services but said that the focus on inpatient services was an issue, making it difficult for patients to get ongoing meaningful support. The meeting noted that the Darzi proposals are more about physical health, which makes it difficult for 'polyclinics' to run mental health services unless they have really thought about it before hand. He said that there should be a safe place in 'polyclinics' for assessments and PCTs should look closely at the design and philosophy of 'polyclinics'.

   Bernell Bussue said the Darzi could represent a key element in how things will evolve and it's important that the RCN is able to influence the process.

5. *Cllr Sweden (Waltham Forest) asked whether Darzi is an opportunity to look at the high turnover of staff and the use of agencies and where the statistics provide are from and if they open to challenge.*

   Bernell Bussue said that he did not know if Darzi is a vehicle to look at the use of agency staff but it is widely recognised that a staff group predicated on agency staff does not help with continuity. He said the figure of 30% for nurses that will be needed to move from secondary to primary care was from the Strategic Health Authorities across the country and it could actually be a higher figure with bigger implications.

   Tom Sandford, said that Darzi is strong on centralisation and local community services, but making a polyclinic safe for mental health patients would be a big challenge. He said there had been a lot of focus into improving buildings so that they look better but not at how to accommodate an extremely distressed person with mental health issues. 'Polyclinics' would have to serious review this issue if they

intend to deal with mental health - with separate rooms for mental health assessments. Noting it would be “tragic” if this did not happen.

6. *Cllr Bass (Croydon) asked if Darzi would lead to the greater empowerment of nurses, break down the boundary between primary and secondary care and improve the level of care provided by nurses.*

   Bernell Bussue replied that one of the benefits of Darzi is that it will lessen the hold that GPs have on primary care and emphasise how nurses can help. In regards to diagnostics, he said this is currently only a service in acute care but its better provided in communities. In regards to the patient experience, the meeting noted that the intervention of qualified nurses helps reduce mortality rates. He said that stories of failure are at the more extreme end and these experiences are not the rule.

7. *Cllr Reen (Ealing) asked whether there would be workforce transfer implications if nurses are asked to move to areas of high deprivation and if they would be happy to do this.*

   Tom Sandford, replied that the merging of two trusts into one in Nottingham, resulting in over-provision and a subsequent analysis of how the nursing contribution could be changed, is evidence that it can be done.

   Bernell Bussue said the “jury’s out” as to whether nurses will move from primary to secondary care and vice versa and there is a nervousness amongst nurses. They would need to develop an entirely new set of skills and the key to how it happens would be in the re-education and training process.

8. *Cllr Callaghan (Camden) said that they have had to deal with a private sector provider, United Clinics, in Camden and asked how such companies should be dealt with in the future.*

   Bernell Bussue said that there is increased involvement of the private sector in health care provision, with around 30% of RCN’s members working in that sector. In regards to discussions about their continued involvement, he said that he doesn’t think there is evidence that the private sector do better than the public sector.

9. *Cllr O’Malley (Lambeth) noted that the closure of the emergency clinic at the Maudsley was broadly contested but still the NHS went ahead and the closure of beds has also been argued against. With this in mind, she asked how the situation should be moved forward.*

Tom Sandford, replied that the closure of the emergency clinic, despite the torrent of opposition to closure, is why he is sceptical about mental health services being located within 'polyclinics'.

10. *Cllr Urquhart (Richmond) asked why bed closures are linked to foundation trust applications and queried whether the Henderson Hospital is earmarked for closure.*

    Tom Sandford, replied that Monitor looks at financial management in foundation trusts and in his opinion this is why trusts become conservative at the time of a foundation trust application. Examples were provided where he thought this has happened and may happen in the future.

    He said that campaigns were currently underway to keep both the Cassel and Henderson Hospitals open and that he thinks that services at the Henderson are particularly at risk.

    Bernell Bussue commented that foundation trusts, such as the Academic Health Science Centre, have more freedom than other trusts and stressed that it is incumbent on all the people in attendance to analyse the plans that emerge at the next stage and to look at the "nuts and bolts" of changes.

11. *Cllr Francis (Tower Hamlets) asked what would be a reasonable time to wait before the impact of 'polyclinics' is assessed.*

    Bernell Bussue replied that there should be an element of caution with some sort of testing to establish whether 'polyclinics' deliver or not. He suggested there should be a couple of pilots and refined before the plans are fully rolled out. He said that 'polyclinics' would take some time to bed down (up to 5 years) but there may be a political urgency to move the process forward more quickly.

The Chairman thanked Tom Sandford and Bernell Bussue for their evidence and it was agreed that any further questions could be forwarded to RCN for a response.

10. Witness Session 5: Healthcare for London – the implications for Public Health

The Chairman introduced Dr Bobbie Jacobson, Director, London Health Observatory and Dr. Sandra Husbands, Specialist Registrar. The following points were made during the presentation and ensuing discussion.

- The London Health Observatory (LHO) has decided, because the framework is massive, to focus at this meeting, on one care pathway that Darzi proposes to address, and draw out some

common principles. The meeting noted that the LHO have chosen to examine the stroke care pathway, the third largest cause of mortality in London, because there is strong evidence about what works.

- It was explained that their example would link to two themes, “prevention is better than cure” and “focussing on reducing differences in health and healthcare across London”.
- Looking at the ‘Stroke care pathway: opportunities for preventing deaths and disability’, coronary heart disease (CHD) stroke’s poorer cousin and there is a need for the population to be more health-literate (green stage).
- At the yellow stage, primary care prevention, it’s important for risk factors to be identified.
- At the next stage (red), patients should have rapid access to TIA management.
- At the final stage, acute stroke management, (Darzi introduces proposals) but only 45% of people that have a stroke in London return to independent living.
- The cost of strokes to the NHS is large costing approximately £15k over five years - community care £1.7k per annum and individuals and their families £7k per annum.
- There is a spectrum of inequalities relating to stroke in London. Inequalities overlap with geography but this doesn’t explain the distribution alone.
- Less than 20% of Londoners with high blood pressure are adequately treated. The message from this is that we are doing a bad job managing risk factors.
- Looking at information presented at the meeting ‘Detecting Stroke and TIA – Actual to Expected in London’, not only are there geographical inequalities but there is also under-recording.
- Darzi’s proposals can help get the basics right by ensuring all Londoners are able to register with a GP. Insisting on seeing the best deployment of the GP and wider primary health and social care workforce in relation to need and by ensuring that the variations in the general quality of primary care are minimised.
- In conclusion, whilst the stroke unit proposals are welcome, there is a need to focus “further upstream” to get better value for money and recognise that prevention pays.
- Local reconfiguration plans will need to address two distinct sets of problems if health outcomes are to be improved for all:
    1. how local models can overcome the four basic challenges facing London (e.g. mobile and unregistered populations, culturally inappropriate and variable quality primary care, and an unequally distributed primary care workforce); and
    2. how local models can ensure that the missing parts of the stroke pathway are addressed (e.g. wider community and primary care prevention, fast access to TIA management in addition to the proposed stroke unit network).

- Some of the basic challenges may need more pan-London solutions that support the polyclinic model, but go beyond it in terms of population covered, (e.g. a pan-London approach to identifying, and offering un-registered populations the opportunity to register with a GP and helping practices develop proactive systems to ensure long term prevention and care).

Questions

1. *Cllr Urquhart asked if the vast majority of people with high blood pressure do know they have it.*

   Dr. Husbands confirmed that less than 20% of people diagnosed with high blood pressure are adequately treated. Dr. Jacobson said that she estimates around 160,000 people in London don't know that they have high blood pressure.

2. *Cllr Lewis-Lavender (Merton) suggested that the FAST (Facial, Arms, Speech Test) should be advertised in public places such as supermarkets.*

   Dr. Jacobson replied that, from the LHO's perspective, there are 2 key challenges, getting the basics right (see last bullet point) and looking at the specifics of the stroke care pathway to see what's missing.

   Dr Jacobson referred Councillors to look at where their own PCT on the 'Red List' showing all London PCTs highlighted what areas they had significant issues. Explaining not was a blaming exercise as the issues pertain to local populations as well as health services. It was noted that getting children out of poverty is one such issue that 22 PCTs have as a "significant issues" to address.

3. *The Chairman asked a question about the tracking of patients who receive treatment before moving on.*

   Dr. Jacobson replied that this information should be monitored and the meeting noted that, in regards to diabetes, when patients attend hospital their details should be captured and added to the appropriate register. It was recognised that it is a huge IT systems challenge to track moving communities.

4. *Cllr Hurt (Bexley) asked what impact stroke has on social care provision.*

   Dr. Jacobson said that although this issue is beyond her expertise, she thinks that "only the tip of" social care needs for stroke patients are addressed. She said that she thought 'polyclinics' could help with home care if there's a joint commitment and understanding amongst commissioners but these issues would need to be faced locally.

5. *Cllr Cornelius (Barnet) asked whether, given the government's bad record on ICT projects, it has the capability to introduce, back up and make the proposals work.*

   Dr. Jacobson replied that there are big expectations of NHS IT programmes and it may be advisable to test some examples first. Noting how IT had moved on in hospitals, so that you can easily see when patients were last tested or treated, but connecting primary and secondary care remains a key issue. She said that she did not know whether the process would be seamless but clinical involvement would be needed.

   Dr. Husbands said that there are 2 issues, access to notes and continuity of care. The meeting noted that patients might see different doctors in 'polyclinics', as it's not so important that you see the same person. But at a diabetes clinic you are likely to see the same doctor.

6. *Cllr Lewis-Lavender (Merton) asked if LHO information could be filtered down to borough health scrutiny panels.*

   Dr. Jacobson replied that if the LHO do pan-London work, information is provided to each borough and the LHO are also invited to comment on local scrutiny issues.

7. *Cllr Bass (Croydon) asked what percentage of the population is screened for hypertension. He provided an example of blood tests that he recently saw being carried out in a supermarket and stated that this information should be fed through to the appropriate contact so that it can be acted on.*

   Dr. Husbands replied that she doesn't have specific data on the percentage but it's a target to screen all adults that are registered with a GP. Dr. Jacobson said, in regards to blood tests in venues such as supermarkets, she agreed that staff needed to be trained to collect and pass through the information. She said that screening is unethical unless the whole system is set up.

The Chairman thanked Dr. Husbands and Dr. Jacobson for their evidence and it was agreed that any further questions could be forwarded to the LHO for a response.

11. Any other Oral or Written Items which the Chairman considers urgent.

The Chairman said that she has received a letter from the London Ambulance Service PPI Forum requesting that each local authority gives £2k to support its continuation. Members noted that overview and scrutiny committees are unable to make this decision and it may

be appropriate to forward the request onto the officers procuring Local Involvement Network (LINk) in each borough.

The meeting finished at 4.28pm.

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 28th March 2008

London Borough of Merton, Council Chamber
London Road, Morden, Surrey SM4 5DX

PRESENT:
Cllr Marie West – London Borough of Barking & Dagenham
Cllr Richard Cornelius – London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr David Abrahams – London Borough of Camden
Cllr Graham Bass – London Borough of Croydon
Cllr Mark Reen – London Borough of Ealing
Cllr Ann-Marie Pearce – London Borough of Enfield
Cllr Mick Hayes – London Borough of Greenwich (substituting)
Cllr Rory Vaughan – London Borough of Hammersmith & Fulham (substituting)
Cllr Gideon Bull – London Borough of Haringey
Cllr Margaret Davine – London Borough of Harrow (substituting)
Cllr Ted Eden – London Borough of Havering
Cllr Mary O'Connor – London Borough of Hillingdon (Chairman)
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender – London Borough of Merton
Cllr Allan Burgess – London Borough of Redbridge
Cllr Nicola Urquhart – London Borough of Richmond
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden – London Borough of Waltham Forest
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)

ALSO PRESENT:
Cllr John Bryant – London Borough of Camden
Cllr Margaret Brierly – London Borough of Merton
Cllr Maxi Martin - London Borough of Merton

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Shama Smith – LB Camden
Trevor Harness – LB Croydon
Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
Ben Vinter - LB Hackney

Tracey Anderson – LB Hackney
Sue Perrin – LB Hammersmith & Fulham
Nahreen Matlib – LB Harrow
Anthony Clements – LB Havering
David Coombs – LB Hillingdon
Guy Fiegehen – LB Hillingdon
Deepa Patel – LB Hounslow
Katie Cohen – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Nike Shadiya – LB Lewisham
Barbara Jarvis – LB Merton
Jonathan Shaw – LB Newham
Kris Hibbert – London Councils

Speakers:

Gail Findlay – London Health Commission
Sandra Husbands – London Health Observatory
Sir Cyril Chantler – Chair, Great Ormond Street Hospital NHS Trust, Chair, Clinical Advisory Group, End of Life Care
Stephen Richards – Director, Macmillan Cancer Support

Jessica Crowe, Executive Director, Centre for Public Scrutiny

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr Janet Gillman – London Borough of Greenwich
Cllr Peter Tobias – London Borough of Hammersmith & Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Jon Hardy – London Borough of Hounslow
Cllr Meral Ece – London Borough of Islington
Cllr Christopher Buckmaster – Royal Borough of Kensington & Chelsea
Cllr Megan Harris Mitchell – London Borough of Newham
Cllr Christopher Pond – Essex County Council

2. DECLARATIONS OF INTEREST

None received.

3. CHAIRMAN'S WELCOME AND INTRODUCTION

Councillor Gilli Lewis-Lavender, Merton's Chair of the Health & Community Care Scrutiny Panel, welcomed the Joint Committee members, officers and the public to Merton's council chamber and the meeting. Cllr Lewis-Lavender mentioned some of Merton's famous former residents and advised that Merton has a considerable east/west divide in terms of health inequalities.

The Chairman thanked Cllr Lewis-Lavender for her welcome and thanked Merton for hosting the meeting. The Chairman outlined the programme for the day's proceedings, advising that this meeting was the 6th evidence gathering meeting of the Joint Committee.

4. MINUTES

The members were informed that the minutes of the meeting held on 14th March in Ealing and of this meeting will be presented for approval at the next meeting on 25th April 2008. However, the Chairman verbally summarised the key points which had emerged from the meeting on 14h March by way of a reminder to members.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

Written submissions contained within the agenda were received.

6. WITNESS SESSION 1: Healthcare for London – Health Impact Assessment
Speakers: Gail Findlay, London Health Commission and
Dr Sandra Husbands, London Health Observatory.

The Chairman introduced the speakers to the Committee. The following points were made during the presentation and ensuing discussion:-

- The London Health Commission leads work on health inequalities and the wider determinants of health and was established in 2000. Health Impact Assessments are the particular approach identified as a key public health tool to inform policies related to health and to take into consideration the maximum and minimum impacts.
- The London Health Observatory established a steering group to look at the Healthcare for London consultation document. The timeframe for this health impact assessment was very short and the key areas for maximum impact on health inequalities were identified as:-
    - primary care
    - maternity care
    - stroke pathway in terms of prevention and rehabilitation
- The London Health Observatory has produced a Health Equality Profile for London. Ben Cave Associates also undertook a review of the evidence for Healthcare for London and a policy appraisal.
- A stakeholder workshop with 50 delegates was held and other consultation information was gathered from Healthcare for London, NHS London, Healthlink, IPSOS Mori and PCTs.
- The overall recommendations within Healthcare for London are ambitious and exciting, with the opportunity to improve most elements of healthcare and health outcomes as a whole. However, success will depend on how the proposals are implemented and the

impact on health inequalities. It was considered there is a danger that that there will be overall improvement to health but that specific groups may continue to suffer.

- A firm recommendation from the work undertaken is that both health impact assessment and equality impact assessment must be ongoing and that the proposals in Healthcare for London must be implemented in full because partial implementation would increase risk in terms of health inequalities. For example, the stroke pathways and discharge would lead to additional pressure on carers, who are already a vulnerable group.
- On prioritising and meeting unmet needs, there is a need to identify mainstream mechanisms to seek out and address this.
- Data collection issues are key in relation to equalities groups in terms of monitoring impact on health improvement. It is difficult to evaluate the needs of disadvantaged groups because data collation for this was incomplete. Health inequalities need to be measurable before they can be addressed.
- It is vital that priority is given to disadvantaged groups and services targeted to overcome inequalities; language support is key.
- The final report from the above work will be produced shortly.

Questions

Q The Chairman asked whether the proposals represent a suitable balance in expenditure between health service provision and health promotion/prevention, or will the NHS remain a sickness treatment service?

It was responded that the proposals represent a very high level framework and the principle of prevention is included in the document. However, the NHS has difficulties in diverting mainstream resources towards prevention and so it will need a fundamental change with tangible shifts in resources towards prevention, and not just for the short term.

Q The Councillor for Haringey asked about mortality rates and health inequalities and whether it should be for PCTs to address this or whether it should be central government-led.

It was responded that the London Health Commission is working towards raising awareness of health inequalities across all sectors. But it is important not to 'let the NHS off the hook' because a person with a life expectancy of eight years less than others still needs help in the present.

Q A supplementary issue was raised about tackling obesity in schools, with reference to the lack of strategic vision - through developments built on open land and playing fields, which reduced the opportunities for sport.

It was agreed that there is the need for a more strategic approach, but that strategies such as the one for tackling obesity in schools is a real step forward, but there is still a long way to go.

Q The Councillor for Merton firstly questioned whether the recommendations from the health impact assessment work would be implemented, and secondly whether the help with benefits for stroke patients would be available when a patient was sent home (as this is not a voluntary sector role).

It was responded that in this huge change process, the issue of health inequalities could get lost, but Government had asked for the health impact assessment and so should take note of the recommendations and there could be some monitoring of key actions twelve months on. The whole process of health impact assessments must be ongoing as the proposals represent a real opportunity to make a difference.

On the issue of stroke pathways, it was important that the wider context was highlighted and it was considered that polyclinics should be able to offer all the necessary advice. It was accepted that there may need to be a more specific recommendation in relation to outreach services to make this stronger. Local PCTs should be held to account to make sure that the work is ongoing at local level.

Q The Councillor for Havering questioned where the additional carers would come from to provide help for the 20% of disadvantaged people identified.

It was responded that the overall aim of Healthcare for London is to have the most effective models of care and that hopefully the 80% of people who are satisfactorily treated will increase. In terms of who the disadvantaged people are, carers are recognised as an inequalities group but are at risk particularly if the proposed stroke pathway is not properly implemented. There are also workforce issues with a shortage of primary care staff and Healthcare for London will provide an opportunity to acquire a more skilled workforce to help disadvantaged groups. There is also a need to identify other groups, including those relating to specific illnesses.

Q The Councillor for Croydon asked which issues needed to be resolved first?

The response was that, if schemes can be piloted first, then there is an opportunity to get things right. It would be beneficial to monitor and evaluate any pilots in terms of their impact on health and on health inequalities.

Q The Councillor for Camden asked who was responsible for the problems relating to the lack of data and what recommendations the

Joint Committee could make on this? Also, how can data be collected for those people who are not attending a GP surgery?

It was responded that there is a cultural issue with data collection and that more mandatory collection was required, with sanctions for non-collection. But this is difficult to achieve without government intervention. However, where PCTs are performance managed they will collect data to demonstrate good performance, so it can be achieved. GPs also have a lot of patient information but are not required to report all of it. So a cultural change is needed with information collated into large data sets for wider use. Even if people do not visit a GP, they interface in other ways, through benefits, schools etc and very few people are entirely 'off the radar'.

Q The Councillor for Hammersmith and Fulham asked firstly when assessments should happen, and secondly how unmet need is measured if there is lack of data, and what data would be most useful to address this, as health impact assessments are not statutory requirements.

The response was that the ongoing process of health impact assessments is recommended and the overall framework for this needs to be examined. The lead is with the PCTs and they need to ensure overall plans include health impact assessments. On identification of unmet need, it could be reasonable to assume that people with unmet need would express this to patients forums. The difficulty is establishing the level of need. There are no specific recommendations on the type of data needed and local needs vary including in terms of age, ethnic mix etc, which is already locally known. There is a lot of in-depth work on unmet need, e.g. on the homeless and on immunisation and screening, where people present very late.

Q The Councillor for Richmond raised the issue of the growing need for mental health care and the fact that there is no model included in the proposals for this.

The response was that mental health is an area requiring stronger focus and this has not been fully worked up yet, but work is ongoing.

Q The Councillor for Ealing asked what limits there are to influence lifestyle choices e.g. on smoking and, if health is a finite system, how far can the NHS spread resources before its core function is affected.

It was responded that the issue is not just about lifestyle but about unhealthy choices which may be made by people living in difficult circumstances, e.g. smoking to relieve stress. By mainstream investment and tailoring resources, an impact can be made e.g. through smoking cessation. But there must be targeting and increased investment. On the spread of resources, the Wanless report stated that if we prevent illness, it would save the NHS money and allow for

more investment on highly technical equipment etc. So there is a good economic case for tackling health inequalities and reducing illness to allow for resources to be used elsewhere. It is not about forcing people to change but enabling them to make healthy choices with access to the right services.

7. WITNESS SESSION 2: Healthcare for London – End of Life Care
Speaker: Sir Cyril Chantler, Chairman, Great Ormond Street Hospital NHS Trust; Chair of Clinical Advisory Group, End of Life Care

The Chairman introduced the speakers to the Committee. The following points were made during the presentation and ensuing discussion:-

- There are three main pillars to the Darzi report: managing chronic illness; access to healthcare; and staying healthy. 80% of health services focus on chronic illness and this is where most of the resources are allocated. End of Life care is management of another chronic illness.
- Polyclinics, or community care hospitals, are not a new idea and they are mentioned in the 1962 Building Plan and in the Lancet in 1967.
- There must be more focus on health promotion and improving health or we will not be able to afford a health service.
- On health inequalities, the less advantaged people do worse in all areas, with the worst access to health services. Polyclinics/community care hospitals will be a means to address that inequality and healthy living centres/well-being centres are ambitious proposals underpinning the document.
- The majority or the population want to die at home or in a hospice, but 70% of Londoners die in hospital. Some people would prefer to die in the care home in which they live, but are moved to hospital on the basis that the home cannot or will not deal with the issue.
- The full End of Life report from the End of Life Clinical Working Group is on the King's Fund website and the NHS London website.
- End of Life care is fragmented and 54% of complaints to the Healthcare Commission relate to the death of a relative. So there is a need for integrated and co-ordinated care.
- The report recommends and there should be End of Life care in the locality, but on a larger than borough or individual PCT basis, with five zones for London adults (children's care would be on a London wide basis). These zones will provide an adequate population base with which to be able to deliver appropriate end of life services. It is recommended that two End of Life service providers are sought in each area to co-ordinate the service – these might include voluntary sector organisations or charities.
- The Marie Curie Trust has operated a pilot service in South London – if people are supported to die at home, the costs are likely to be roughly neutral.

- The service requirements/entitlements for mortal illness should be:-
  1. to be on a register
  2. to have a conversation with a qualified professional
  3. to have a service plan
  4. to have the service co-ordinated by an End of Life service provider
  5. to have 24 hour access to the service

- The individual's plan would continue after the death for benefit of the relatives, and it is important for PCTs to audit the performance of the End of Life care service provider.
- This is an ambitious proposal within HfL and one which requires a methodical approach, with lessons learnt from pilots before the plan is rolled out.

Questions

Q The Councillor for Southwark asked when the service should 'kick in' for terminally ill people

The response was that some countries certify a length of remaining life but clinicians are generally not very good at this and so there is no clear definition.

Q The Councillor for Lewisham asked what the impact on social services departments would be.

The response was that the service specification should cover both health and social services and an End of Life provider might be a social services provider. Social care would remain a very important aspect of the care provided.

Q The Councillor for Ealing queried the PCT/local authority boundary and how a larger zone would work. He also raised the issue of the eligibility criteria for social services and the need for movement of resources.

The response was that it was recommended that PCTs consider working together with boroughs to provide this care, but it was not a directive. However, to provide the service on a borough basis would result in resources being spread too thinly. A population level of 100,000 is generally needed to get all the people needed together to provide an effective and responsive service. The PCTs need to want to work together though. On the issue of resources, the health budget represents 9% of the GDP. But it is not just about levels of resource, as countries such as Japan, Singapore and Denmark spend less on health care but achieve better health outcomes. It is not clear where health ends and social care begins, but some transfer of resources to social care would not be unreasonable.

Q The Councillor for Westminster stated that he could see the rationale for a register to be established, but for the poorest people with issues such as poor housing conditions, he queried what protection there would be on the level of standards and on advocacy, and how registered social landlords would be convinced to invest in the process?

The response was that the living environment matters greatly and poor housing affects health. But End of Life care can only play a part in that. There must be improved care in the community, localised where possible. We need integrated care with improved quality and safety in healthcare. Healthcare for London will be providing health service direction for the next decade.

Q The Councillor for Camden queried how people could be sent home to die when the home is not to a decent standard, and added that five zones would not really provide local care. Also, there could be resistance to having a conversation about dying.

It was responded that there are both practical and political issues and a lot of homes might not be suitable for end of life care. The service might be delivered in different ways depending on where a person lives, but the fundamental problem is scale, which needs a large enough population base and therefore coordination across borough boundaries. On the issue of having a conversation, the majority of people want to know the truth about dying, but in a sympathetic way. Information can be used to improve the remaining lifespan and time matters. People need knowledge and advice to be able to take a view on their situation. It is really about supporting people and hearing their views.

Q The Councillor for Barnet asked about whether a poor person having to take a longer journey would really be better off.

The response was that the service should not interfere with local GP services but there should be a network with better availability, or areas where the GP services are sparse and remote could be targeted.

Q A supplementary question on the proposal to move GPs into polyclinics was posed.

The response was that this notion is not what is intended and that interpretation of the document was incorrect.

Q The Councillor for Waltham Forest raised the issue of what happens if people are too ill to move, if there needs to be negotiations with district nurses and health visitors, highlighting that it could lead to conflict over resources for continuing care. He also queried whether there are sufficient hospices and whether money for End of Life care would be ring fenced.

The response was that there may not be enough hospice places overall, although this is not clear, but also worrying is the number of residential care beds. So we need to ensure that there is the best provision possible. It was agreed that there should be a defined budget spend for End of Life care.

Q The Councillor for Bexley asked about palliative care nurses, who were the first to be made redundant in his local NHS trust. End of Life coordinators were also made redundant and so there was little evidence of support for this service area.

It was responded that the service needs to be recognised as an important one, and lack of support is not good enough.

Q The Councillor for Lambeth asked about the 54% complaints level and the added family guilt on End of Life care. There can be a slow decline in health, but if End of Life care is institutionalised, people lose the personal contact and they need an advocate.

The response was that the proposals are not institutionalism but everyone should get the sort of support they need and deserve and the service enables providers to find out what they actually want. Nurse led beds are also for respite purposes as well as for health needs.

Q The Councillor for Ealing asked about the huge workforce implications behind the Darzi proposals and the challenges of this and whether there is too much emphasis on the responsibilities for commissioning in terms of whether there is sufficient expertise.

It was responded that the workforce implications are a challenge and NHS London is looking at this for the next 10 years. The historic dispute between hospital based consultants and community based GPs in the UK persists and there needs to be a move towards the sharing of expertise – but this will not happen overnight. On commissioning, the problem is how you think about the service that you believe customers need and then how to deliver it. Health agencies must work together to commission and deliver services to avoid the process being done 31 times across London.

Q The Councillor for Southwark raised the issue of voluntary euthanasia.

The response was that this is outside the remit of the proposals and outside the current legal framework. Essentially the law must be adhered to.

8. WITNESS SESSION 3: Healthcare for London
Speaker: Stephen Richards, Director, Macmillan Cancer Support

The Chairman introduced the speakers to the Committee. The following points were made during the presentation and ensuing discussion:-

- The Joint Committee was informed that Macmillan is supportive of the main thrust of the proposals in Healthcare for London. With regard to specialist treatment centres, it was important to have good quality specialist care and better coordinated care. The patient and carer are at the centre of care.
- With regard to End of Life care, the End of Life Care Strategy by the Department of Health includes the 'surprise question' for clinicians to ask themselves: *"Would I be surprised if death occurred in 6-12 months?"* This increases the number of patients referred to End of Life programmes.
- There is generally a lack of opportunity for people to ask what is wrong with them – leading to acute crisis at home and movement to hospital. It is easier for families if there is early discussion.
- The impact of cancer on people's financial situation is major – expenses are incurred through being off work, travelling to treatment, childcare, extra heating etc. Healthcare for London does not address this.
- Doctors are very cautious about giving a prognosis of six months or less to live and it is difficult to broach the subject, which gets in the way of people claiming benefits.
- With regard to out of hours care, the recommendation is to have 24 hours access to care and allow patients to die where they want to die, but there are training issues around nursing home staff. Nevertheless, out of hours care is crucial.
- There needs to be certain standards on factors like access to medication; communication between agencies; clarity on resuscitation criteria; sufficient education and training.
- The equivalent value of there being six million carers is £67billion annually, which needs to be borne in mind.
- The DH Cancer Reform Strategy advocates shared decision making, tailored information and involving users in decisions.
- The End of Life proposals should have a strengthening of the user voice in service design, commissioning, identifying and assessing carers early on, improved availability for bereavement and counselling provision.
- On palliative care in the community, it is important that symptom management is a key factor requiring effort, with greater importance attached to training. Doctors do not spend enough time developing communication skills and use of pain relieving drugs. So this is a very important area.

Questions

Q The Chairman asked how much funding there is for hospices and whether this will increase under the Healthcare for London proposals.

The response given was that there is no money or grant for Macmillan, but Marie Curie hospices receive 30% funding of their total revenue costs. (children's hospices are only funded to 10%) The role of the voluntary sector is underplayed in the Healthcare for London report and more money from Government would be very welcome. Hospices often have to work hard to raise adequate funds to support their continued existence.

Q The Councillor for Richmond asked how an agency like Macmillan would manage if asked to provide End of Life care along the lines set out by Sir Cyril Chantler?

It was responded that Macmillan is a charity, adding value to the NHS and therefore not directly providing services. The End of Life care providers mentioned in relation to the five zones would be keen to know more detail – the zones are likely to mirror the current five cancer networks. Clarity is needed on operating boundaries for them to be effective.

The Councillor for Havering suggested that there was not enough support for carers, which really needs to be there early on. If someone is dying at home, a range of changes is needed. It will be several years before Darzi proposals come to fruition and they will require changed attitudes and training. Fewer people are entering the caring professions and so it is not clear whether a sufficient number of people will be available. The role of volunteers may need to be explored in future but the demand on carers will continue.

Q The Councillor for Merton raised the issue of stigma attached to claiming carers allowance and disparity in terms of the allowance ceasing at age 65 years. The whole issue of benefits is a worry and queried if this might impact on the proposals.

The response was that benefits are a right and there should not be a stigma, as they can help people to stay at home.

Q The Chairman asked how the NHS can improve cancer patient care; how the Darzi proposals would improve patient care; and how the proposals could be improved.

The response was that the proposals will promote good quality care at or near home, with better coordination and linking of specialist and general services. If Darzi accomplishes this, it will achieve a great deal. In terms of how to improve the proposals, the training and upskilling of GPs is key; this is also the case with district nurses. Also the relationship between health and social care in terms of communication, and clarity on who provides what, is important.

The Councillor for Lewisham stated that some carers are children, who lose out over education and claiming of benefits. Sometimes there is a young carers support group nearby, but not always. Another omission is good quality information.

9. DRAFT CONCLUSIONS/RECOMMENDATIONS

Jessica Crowe from the Centre for Public Scrutiny joined the meeting for this item.

Councillors considered the draft recommendations put forward and commented on each one in turn. The suggested changes were noted and the amendments will be made to the proposed recommendations prior to the next Joint Committee meeting.

The point was made that the detail on mental health and on children's services is not available in the Healthcare for London document and it should be stated that this is not acceptable and these areas will require full consultation in their own right.

It was suggested that the language should be more robust in the Joint Committee's response and that there should be an introductory set of recommendations with general concerns, followed by recommendations on specific services.

It would be worth mentioning that the Joint Committee has operated without a budget and within a tight timeframe and the findings might be presented to the Leaders Committee of London Councils. Press coverage might be useful. There should also be the opportunity to reflect on the joint scrutiny process and learn from it, possibly through a questionnaire.

10. ANY OTHER BUSINESS

It was agreed that the issue of future meetings of the Joint Committee would be considered at the next meeting on 25th April, which would be a half day meeting at Kensington & Chelsea Town Hall.

11. CHAIRMAN'S CLOSING REMARKS

The Chairman closed the meeting by thanking all those members who had attended and contributed to the Joint Committee's work so far and to the officer support group who had ensured that the meetings had operated smoothly and efficiently.

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Agenda Item 5

Ian Buckmaster
Manager of Committee a
Overview & Scrutiny Support

OVERVIEW AND SCRUTINY TEAM
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Please contact: Anthony Clements
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Date: 05 March 2008

TO:

Healthcare for London
Freepost Consulting the Capital

Your Reference:
Our Reference: **AC**

Dear Sir/Madam

Response of Havering Health Overview and Scrutiny Committee to Healthcare for London – Consulting the Capital Consultation

I am writing on behalf of the Havering Health Overview and Scrutiny Committee in order to give the Committee's formal response to the above consultation. This response has also been copied to the Chairman and Clerk of the Pan-London Joint Health Overview and Scrutiny Committee as it is that Committee which is the statutory consultee in this instance. Copies have also been sent to the Chief Executive and Head of Communications at Havering Primary Care Trust (PCT).

The response of the Havering Health Overview and Scrutiny Committee to the Healthcare for London – Consulting the Capital consultation is as follows:

1. **Staff Recruitment and Retention** - It is the view of the Committee that many of the proposals out forward in the consultation document will require a considerable increase in the numbers of medical staff of all kinds and levels. Health organisations in North East London are already experiencing difficulties in both recruiting and retaining suitable staff. Whilst current human resources difficulties are being addressed by individual Trusts, the Committee is concerned that the Healthcare for London proposals, even if they may have merit in themselves, are likely to fail due to a lack of suitably qualified staff to implement them.

2. **Agency Staff –** It is the view of the Committee that the higher numbers of staff required under many of the proposals will inevitably result, at least in the short term, in a greater reliance by the NHS on the use of agency staff. The Committee feels that the use of agency staff has exacerbated the financial

problems encountered by certain local Health Trusts and that any such expenditure as a result of the Healthcare for London proposals must be carefully monitored and controlled.

3. **Health Inequalities** – The Committee supports the aim of Healthcare for London to reduce Health Inequalities but is not convinced that the proposals will actually achieve this. There are pockets of considerable deprivation within Havering and the Committee feels it is vital that health services for these poorest members of society are improved. The Committee wishes to see more detailed proposals for the how the Healthcare for London plans will address this area.

4. **Role of Carers –** The Committee is disappointed that there is little focus on the role of carers within the consultation document. Within Havering alone, according to the census of 2000, there are in excess of 28,000 unpaid carers. The Committee is concerned that the emphasis on having more services available in the community and/or at home will simply increase the workload on carers and wishes to see a specific carers' strategy incorporated within any Healthcare for London proposals.

5. **Future Role of PCTs –** The consultation document does not appear to consider the structure of London PCTs. The Committee has formed a view during its work that there are far too many PCTs in London, creating an excess of bureaucracy, and feels that any proposed restructuring of health services in London should also consider the issue of what is the appropriate number of PCTs for the London area.

6. **Effect of Demographic Changes** – Havering, in common with the rest of the North East London and Thames Gateway areas, is experiencing an increase in population that is likely to continue in the coming years. The Committee is concerned that these changes have not been fully taken into account in Healthcare for London and would like further reassurance that changes to health services have in fact been planned using correct assumptions about future population growth.

Yours sincerely

Anthony Clements
Principal Overview and Scrutiny Officer

CC: Gabrielle Teague, Head of Communications, Healthcare for London
Councillor Mary O'Connor, Chairman, Pan-London Joint Health Overview and Scrutiny Committee
Louise Peek, Officer Clerking Team, Pan-London Joint Health Overview and Scrutiny Committee
Ben Vinter, Officer Clerking Team, Pan-London Joint Health Overview and Scrutiny Committee

All Members and Supporting Officers, Outer North East London Joint Health Overview and Scrutiny Committee
Ralph McCormack, Chief Executive, Havering PCT
Paul Kennard, Head of Communications & Scrutiny Lead, Havering PCT

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Response to Healthcare for London; Consulting the Capital
Health and Adult Services Scrutiny Sub Committee
Committee Meeting of March 6th 2008
Chair Cllr Helen O'Malley

The following commentary is submitted by the Health and Adult Services Scrutiny Sub Committee of Lambeth Council in response to the ' Healthcare for London: Consulting the Capital.' The response is structured to give an overview of the key strategic considerations which the committee deem need to be addressed if the PCT Board is to progress the consultation proposals, followed by responses to the specific issues raised within the HfL consultation document and questionnaire.

1. Changes to health services in London should work to the existing strengths of each locality and represent an evolutionary process, rather than the NHS embarking on radical change. There are many areas of outstanding medical achievement and exsisting facilities.. London is not a homogenous entity but a global city with great divergence between wealth and poverty and inherent health inequalities. Whilst it is positive that the modelling proposals contained in HfL have been led by clinicians with a specific focus on the patient pathway and ensuring the safer delivery of healthcare, we do not believe that a 'one size fits all' approach is workable across our city. Patient needs and health priorities vary enormously across the capital and the expectation must be that there will be a high level of local determination on how and where health services are delivered in the future.

2. There needs to be a clear evidence base to support changes. Whilst the proposals provide a sound basis for centralisation of some services (stroke services, severe trauma care, complex emergency surgery) there is less compelling evidence available in respect of other proposals. In addition to the need for robust clinical evidence to support change, we also note that work on equalities impact assessments is outstanding and will not be available until the conclusion of the public consultation period. For a borough such as Lambeth, which has pockets of acute deprivation, an ethnically diverse population and an on average worse health than the rest of London or the UK (life expectancy is lower and the infant mortality is higher) an understanding of how these changes might positively or negatively effect our residents is imperative if health inequalities are to be addressed. It is not yet clear that impact assessments have been undertaken on some proposals.

3 Our evidence is that the General Practitioners are central to the working of the Health Service, are usually the first 'port of call' for established communities and are very widely trusted. We would want to see this role enhanced not diminished, as the 'king pin' in relating community to medical specialists and health advice.

4. In particular we would highlight the significant impact which will fall on partners -across local authorities, community sectors - and on carers. Whilst the working in partnership role is acknowledged within the Staying Healthy Agenda, there is very little within the document as a whole to indicate that the proposals have been developed in conjunction with partners. Indeed the document acknowledges that the NHS will need to improve how it works with social services, voluntary sector, higher education and other organisations. Of major concern is that the proposals have not been considered from the

interface of health and social care either with respect to costs or responsibilities.

5. A great deal of work needs to go into finance modelling. For example, the long term consequences of debt arising from PFI Contracts must be transparently factored in with detailed debate around future LIFT Projects.

6. IT systems; given the extra-ordinary costs accumulating around IT systems, we would want to see major scrutiny into the effectiveness of existing and proposed systems.

7. Travel implications need to be fully mapped. There is clear potential that those with the least capacity to travel but who are the biggest users of health services – older people, pregnant women, families with young children, carers and those who are cared for – may in some circumstances need to go further for some elements of their health provision. Important therefore to evidence in advance whether there is more benefit in providing a greater range of services in locations potentially at distance from the client and balancing against very providing very local services which may be less comprehensive but are more immediately accessible to, and utilised by, local communities. (*This has been picked up by 'Travel Watch')*

8. We met with a number of observations about the issues surrounding the development of effective partnership working. These included references to the need for 'culture changes' within different professional groups in order for dialogue to progress.

9. Workforce; an ongoing concern centres on the wellbeing and stability of the work force. Change that comes with hasty planning and unexpected redundancies not only wastes existing expertise, demoralises and destabilises the work place but also cause great community stress, with unemployment and danger of family debt.

10. The 'Picture of Health' consultation for the South-East boroughs is felt to be premature because the 'Healthcare for London' consultation has not yet run its course. This impacts particularly on Maternity and A+E provision.

Questionaire (we have responded as a committee to these questions'.)
Staying Healthy
1, 2, 3 aoc We support the investment in public health and greater focus given to preventing ill health but see little explicit detail on how outcomes might be achieved. Along with the focus on sexual health, smoking and health protection we would add as a priority alcohol and binge drinking. On a visit by the committee to St Thomas Hospital it was reported that overnight alcohol related attendance to the Emergency Department had increased significantly over a 12 month period.

We would note that the Director of Public Health has good borough data and that there are projects in Lambeth that do pursue an active 'Healthy living' Agenda, such as 'Healthy Schools'. GPs remain central to this agenda.

Maternity and New Born Care
4 giving birth, 5 mid-wives, 6 aoc Lambeth has both the best maternity care in London and the most challenging statistics. (St Thomas is cited as the one of the best in country and now has some 6,000 birth pa.) Lambeth is a borough of high resident mobility; a high proportion of new mothers are from ethnic minority

backgrounds; teenage pregnancy rates are the highest in the country. All these are factors whereby expectant mothers are less likely to make informed early choice about where they give birth. Proposals for 'A Picture of Health in South East London' will see the cessation of maternity and new born services at QMS and potentially Lewisham Hospital which will put high pressure on existing ante natal places and beds, particularly at Kings. The proposals to increase home births, and greater 1:1 care in labour, present additional pressures. Excellent existing provision in Lambeth could be at risk without detailed planning.

Whilst proposals to offer greater choice are to be welcomed, in view of the crisis and difficulty of recruitment and retention of midwives in London, the high proportion of midwives due to retire in the next 15 years (53%) and the highest birthrate in the country (1 in 5 births being in London), the committee has concerns whether the aspirations for maternity and new born care are achievable in London even within a ten year plan.
Support to parents through Health Visitors in the first years of life is seen as of great value.

Children and young people
7 Hospitals with specialised Child Care. Good in principle for London. Do we not already have this locally, as good practise? Are we not including surgery in the services offered at Children's Hospitals?

8 Immunisation Local public education programme.

9 aoc Local teenage representatives have strong views on the most effective ways of providing accessible services for them, including sexual health support. There are in addition, key issues for the support of looked after children in the borough plus a need for better dental back-up. There is local interest in the Lambeth Early Onset services achievements. Care for adolescents is an issue in its own right.

10 Mental Health
We note that this is only just being worked through and welcome the initiative. We are conscious of the need for very detailed scoping of a very complex area. We are concerned for the role played by many community groupings and User Groups which may be in danger of being sidelined, despite the commitment to patient choice. This is another partnership issue, involving amongst others, Education and Housing. This is a massive agenda for the whole community.

Acute Care
11 We are cautious about the practicalities of a different number to call for urgent care advice which is separate from the Emergency Services, and running along side GP number and NHS Direct. Many people may already be confused about where to ring – would not bringing in another number duplicate this?. If so, would this be an easily remembered number (variation on 999) rather than an NHS direct style figure which would need to be actively sought.
12 Welcome the broad principle of specialist centres where there is clear evidence that will improve patient outcomes. But this is without knowing specifics on locations and levels of provision and staffing. The centralisation of some acute services located care at significant distance from an individuals home presents potentially a trade off between personal linkages and family connections. We would speculate that there are other specialist care conditions that could come into this category, such as liver/kidney failure - is this so? What about Appendicitis? Is not specialist care for Burns already so organised? We know developments in the treatment of Stroke have greatly improved outcomes. We would speculate that these developments need to

familiar to all medical personnel and the ability to respond very quickly may need to be accessible at more centres than the document proposes.

13 Specialist Centre and ambulance service : Do not ambulance services already make decisions about where to take patients?. Is this question more about the potential for upgrading the training ambulance/paramedics do get?

14 aoc We have noted that locally A+E departments are adapting. There are GPs and minor injuries units already in place at hospitals. Although only about 20% of those presenting are admitted, very many more are correctly signposted to other help or are given appropriate and needed professional reassurance.

We want to be assured that all planning will include modelling for major public crises, such as fires and terrorist attacks. As a major capital city, we have to sustain some flexibility and adequate resourcing to accommodate unexpected demands.

Planned Care A

15 GP surgeries open at weekends: This seems to us to be a practical issue to be resolved within the local professional community.

16 aoc This Chapter does not seem to relate well to the question. The proposal here seems to be to offer GPs greater support in giving care, this is excellent. We note offering care closer to home could involve health professionals spending much more time travelling. More planning needed again.

Long Term Conditions

17 Where long term conditions such as Diabetes and Sickle Cell Disease (A Lambeth problem) are brought out of hospital, there has to be a corresponding investment in training and access to expert advice. How far this does, or will happen seems problematic. We cannot answer this question without detailed discussions with professionals.

18 aoc Carers have raised with the committee their concerns that a further burden of care will fall on to them, and it is often carers who themselves are vulnerable and in poor health. No modelling appears to have been done on the implications of needs through early discharge and need to ensure that advocacy is in place for vulnerable adults.
Casework is already coming through to councillors where 'care in the Community' poses great problems, which can be life-threatening. Where hospital care is moving into a community setting then have to ensure that there is investment in the infrastructure to support. The consultation highlights enabling hospital based clinicians to work in community services and GPs to offer more to their patients; this also needs to be supported by investment in school nurses, health visitors, community nurses. But it also needs to ensure that appropriate seniority and experienced levels of nursing staff are employed - the Royal College of Nursing has recently discussed with the committee its concerns that assistant practitioners are being brought in to replace higher graded primary care practitioners

End of Life Care

19 We think this will result in worse care.

20 aoc End of life care – We note that GPs already provide this together with district nurses; therefore we want to be reassured that this is an effective and improving service rather than see a whole new, separate tier created remote from the patient. We advocate investment in local groups that already provide support to vulnerable

individuals, thus expanding home and local support systems to include quality of life issues which will be different for each person. We want to explore further the role of Day Centres with good access and advocacy and therapists within reach.

Where we could provide care

* Transition and implementation – ensuring services are not lost/reduced in interim arrangements. Transitional funding not address - finances don't take up parallel running costs

Home

* Greater use of day care surgery/early discharge etc will be challenging for vulnerable people who will require after care at home (social care not just medical care). Darzi model implies more people will need to receive broader range of personal care but there is little detailed focus on how this will be funded. Financial impact on council social services of providing support at home does not appear to have been integrated into the broad NHS financial appraisal of the end costs.

* Social care is means tested with eligibility criteria and there is a danger that people who are judged to have the ability to pay will decide not to. Following an increase in home care charges Lambeth has recently seen some service users cancelling their care. If early discharge leads to more home care and cost falls on the individual people may want to stay in hospital longer – this situation will clearly need to be carefully managed or has potential to undermine much of the good work that has been undertaken jointly by our local trusts, the PCT and the council.

* Greater mapping of social care forward planning will be needed. Casework is already being generated for vulnerable residents on serious issues which could become life-threatening.

* We have noted that new planning regulations are being introduced to help ensure that homes can be stay useable right up to the end of life.

Polyclinic

21 Polyclinic features The proposal for Polyclinics has dominated much of the debate and there are clearly going to be different land and infrastructure issues which need to be addressed across the capital. Consequently we do not believe that a 'one size fits all' approach can work but needs to be based on local need and circumstances. Therefore we welcome that proposals have moved from a single site serving a large population to a more flexible federated or networked model. We think that Lambeth is well covered with GP services and is well into the process of upgrading facilities within a compact, densely populated borough which enjoys good hospital and specialist provision. We do not want to see the central role of the committed GP and the direct relationship with residents weakened.

* However within itself the polyclinic model potentially proposes a contradiction: whilst the document is arguing for more localised care and care close to home, the potential for polyclinics is in fact a greater centralisation of services more remote from people's home. There will be resultant travel and depersonalisation problems

* Where a polyclinic is now figured to comprise around 25 GP's working out of one or several sites it may need to be determined how the patient/GP relationship is maintained. Similarly whilst the extended opening hours will be welcomed by many patients, there will be an impact on other working arrangements since GPs cannot be on call all the time. As the consultation document recognises, continuity of care is key for many patients. What is the evidence base that polyclinic model provides better

quality of care than individual practises, albeit with greater variety?

* GPs do need to create viable teams of individuals who co-ordinate care based on knowledge of their patients. (Locally, the optimum size seems to go from 2 to about 6 GPs in a shared practise.

* Access to 24 hour urgent care will continue to be a need. (Changes in management of A+E, is this already happening? See Q 14 and Q16.)The proposals lack some clarity on what Urgent Care Centres are, how they operate and openings.

* We welcome that blood testing and heart checks should be standard community provision and regret that patients are often required to attend at hospital for what should be available at GP. However, we highlight that other testing equipment is expensive – eg. x-ray and ultra sound – and require not just initial capital investment but continuing revenue support for maintenance etc as well as trained staff. We welcome the aspiration to make these more accessible in a community setting but we need this to go alongside assurances of continuous funding to ensure equipment is not under utilized or redundant.

22 Practices based in polyclinics? No, we do not agree that this should be a basic model or principle. We note the extent of the planning needed to improve much medical practise, as outlined in the document. We note the lack of financial analysis for change. We note a local example suggesting that there is already an issue of unaffordability in polyclinic-style arrangements.

23 Specialist hospitals: We do not think it helpful to theorise, as the reality is that if the variety of hospital locally accessible is thought in need of change, then this must be done with very detailed and transparent partnership planning. The situation is much more complex than is suggested here.

Local Hospital and Major Acute Hospital
*** Planned care B:- Elective centre** These need to be closely aligned with hospital specialisms. Where these have operated outside hospital management, privately, they have proved expensive where the flow of work is not even. There are reports of loss of expertise and a problem of balance to ensure junior doctors can build up necessary experience to move into the specialism. The main hospital still must be able to cope with complications. These could well be part of Hospital provision. We currently know of hip and cataract work.

24 aoc We are maybe just stating the obvious; that all change must be planned with detailed partnership care for the needs of local communities and the wider regional/national networks.

Vision into reality
25 5 principles yes

26 aoc Reservations are listed in the response given above.

27 Improve access to disadvantaged: No, these changes will not, in themselves improve the outcomes for minority groups.

28 aoc Changes in the ways services are promoted and explained are needed. Ensure for everything that good inclusion policies are followed, including for literature and communications; user friendly strategies, etc

29 what else? be very careful and honest in following 'demand-management' policies and be willing to monitor outcomes of all such policies.

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Lewisham

Tracey Anderson
LB Hackney
JHOSC officer support group

Dear Tracey

Re Submission of Healthier Communities Select Committee to the Joint Health Overview & Scrutiny Committee on Healthcare for London

Lewisham Healthier Communities Select Committee welcomes this opportunity to contribute to the work of the Health Overview and Scrutiny Committee (JHOSC) established to scrutinise the proposals contained in Healthcare for London: A Framework for Action.

The Select Committee considered the draft report of the JHOSC on 20th March 2008 and made a number of comments on the consultation document issued by NHS London – these have been relayed to the Healthcare for London team.

In relation to the draft JHOSC report, the Select Committee endorsed the content and the recommendations contained within the report.

Yours sincerely,

Nike Shadiya

nike.shadiya@lewisham.gov.uk

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Cllr. Mary O'Connor
Chairman
Joint Overview & Scrutiny Committee
London Borough of Hillingdon
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4 April, 2008

Dear Ms O'Connor

'Healthcare for London' review: an invitation to submit evidence - Joint Overview and Scrutiny Committee (JOSC)

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation.

The primary objectives of the RPSGB are to lead, regulate, develop and represent the profession of pharmacy.

The RPSGB leads and supports the development of the profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

The RPSGB has responsibility for a wide range of functions that combine to assure competence and fitness to practise. These include controlled entry into the profession, education, registration, setting and enforcing professional standards, promoting good practice, providing support for improvement, dealing with poor performance, dealing with misconduct and removal from the register.

The RPSGB welcomes this consultation and our response is set out as outlined below.

This consultation is wide ranging: we have focussed on the issues around improving access to primary care services and more specifically our views on the establishment of polyclinics, and described the essential contribution of community pharmacy to primary care access.

1. Establishment of polyclinics and access to primary care services

The Society supports the aim of Lord Darzi's review to deliver healthcare that is better, safer and more accessible and helps people stay healthier; however, we are unsure whether polyclinics will achieve that. The Society is not opposed to service redesign, particularly where it brings aspects of hospital care closer to the community. The Society is, however, concerned that the network of community pharmacies and the public's access to them could be put at risk if the model of polyclinics proposed in the review is introduced across the whole of London. 78% of people travel less than one mile to their usual pharmacy, and convenient location of pharmacies is a key concern for the public (rated ahead of being close to the doctor's surgery).[i] Will polyclinics undermine that accessibility?

Where a polyclinic is under consideration the Society feels that there should be an impact assessment as part of the consultative process so that local communities are able to assess the likely effects of any change. These consultations should always involve representatives of community pharmacy. There are also social and economic impacts to consider too. What will be the impact on the sustainability of local communities[ii] and will the transport links to polyclinics for patients (particularly those from vulnerable sections of the community), their family members and carers, be adequate?[iii] This review has described a number of different models for polyclinics and our concerns will vary depending on the model chosen for a particular location.

In regards to access to primary care services it should be noted that the vast majority of community pharmacies are open on Saturdays and some are also open on Sundays. On a rota basis, community pharmacies can provide evening and night time services. In 2006, 1,432 pharmacies in England contracted with PCTs to provide out-of-hours cover (e.g. to match GP surgery extended evening hours).[iv]

2. Long term conditions and healthy lives – the role of the new community pharmacy contract

Your review has posed the question about the potential role of pharmacists in helping people to manage long term conditions (LTCs) and lead healthy lives. This role is already a reality brought about in part by the implementation of the new pharmacy contractual framework in 2005[v]. The framework is comprised of three levels of service; essential, advanced and enhanced.

- Essential; services are provided by all community pharmacies in contract with their local PCT and are centrally funded.
- Advanced services are also centrally funded but only provided by pharmacies that are accredited. Accredited pharmacies require to have a consultation area approved by the PCT. It is estimated that 75% of all pharmacies across England now provide this service.
- Enhanced services are commissioned and funded by PCTs based on their local needs.

a) Essential Services

These include a number of services that support LTCs and staying healthy as well as improving access as outlined below: -

- Repeat Dispensing – Patients receiving repeat prescriptions whose treatment is stabilised may have their repeats managed by their community pharmacy for up to 12 months without going back to the surgery. This is a time saving for surgeries and a convenience to patients and their carers.
- Public Health – all community pharmacies now provide advice on healthy lifestyles to a consistent format. In addition they can participate in up to six health promotion campaigns each year dependant on the local PCT's priorities.

- Signposting – all community pharmacies are now provided with a directory by their local PC T that provides information on local health an d social care services and related organisations.
- Self Care – all community pharmacies now provide advice on self care with supportive information. They have traditionally provided a wide range of medicines for minor ailments which has widened in recent years as more prescription only medicines have been de-regulated and can now be purchased from registered pharmacies.

b) Advanced Services

There is only one at present, which is the medicines use review and prescription intervention service. This provides patients with the opportunity to have their medicines use reviewed in a one to one consultation with the pharmacist in a consultation area in the pharmacy. The aim is to maximise the benefits that the patient receives from their medicines and make recommendations to the patient and their GP where appropriate.

The Society endorses the recommendations of the All-Party Parliamentary Group on Pharmacy about increasing the scope of advanced services to cover several key public health priorities.[vi]

c) Enhanced Services

Availability of these services in each PCT will vary dependent on local priorities and available funding. Examples of these services are outlined below: -

- Minor Ailments – here patients are referred to community pharmacies for management of minor ailments and receive appropriate treatment on the NHS selected from a designated list of medicines. This saves time for GPs and improves access for patients.
- Sexual Health – a variety of services are provided here including provision of emergency hormonal contraception, Chlamydia testing and treatment and general advice and support on sexual health matters.
- Drug Misuse – this includes syringe needle exchange services, supervised consumption and general advice and support in harm reduction.
- Diagnostic testing – this covers the main LTCs such as diabetes, asthma, COPD and heart disease. Tests provided might include measurement of blood pressure, spirometry and certain blood tests such as blood sugar levels, total cholesterol.
- Weight Management – here pharmacists provide regular life style advice and support including measurement and monitoring of body mass index.
- Smoking Cessation – patients receive regular counselling and support from pharmacists as part of the PCT's smoking cessation service. The service may also include provision of nicotine replacement therapy and related products.

In addition to all of the above, certain pharmacists are now qualified to prescribe medicines in certain LTCs. The appointment of Pharmacists with special interests will provide further support to LTCs and the development of enhanced services in PCTs.

There is a need for the accreditation of enhanced services to be harmonised across PCTs: at present pharmacists may have to be accredited separately by each PCT commissioning a similar service from them. This wastes time and resources; it is holding back the wider involvement of pharmacists and hence constraining capacity. Our English Pharmacy Board is promoting the national roll-out of the North West Harmonisation of Accreditation scheme with PCT commissioners of enhanced pharmacy services.

The services provided in the new pharmacy contract are supported by a clinical governance framework and monitoring by the local PCTs. The provision of enhanced services in PCTs will vary according to the results of the local pharmaceutical needs assessment, involvement of

pharmacy in local commissioning arrangements and availability of local funding. Recent evidence suggests that PCTs have not fully addressed these issues resulting in the potential for community pharmacies to support LTCs and healthy lifestyles not being fully realised.[vii] [viii] Furthermore there has not been the degree of collaborative working between other healthcare professions, practice based commissioning groups and community pharmacy that we would like to see. Issues such as IT support also require considerable development.

Pharmacists play a key role in advising carers on newly-prescribed medicines and potential adverse effects.

We would like to see pharmacists getting involved in the new mechanism for patient and public involvement in health and social care – LINks.[ix]

A new White Paper for pharmacy was published today which sets out plans for pharmacists to extend their clinical roles in several important ways, including helping people with long-term conditions to get the best from their medicines.

We hope these views are of use to your joint overview and scrutiny committee and look forward to hearing the outcome.

Yours sincerely

Jeremy Holmes
Chief Executive & Registrar

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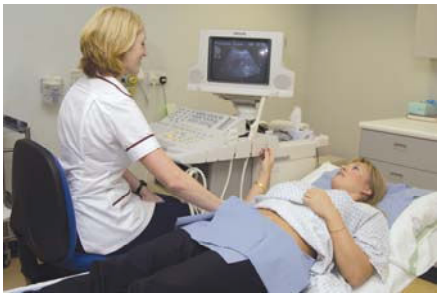
[i] Office of Fair Trading (2003). *Consumers' use of prescription pharmacies in the UK*, paras. D17-D18, page 85. http://www.oft.gov.uk/shared_oft/reports/comp_policy/oft609annexed.pdf (accessed 3 April 2008).
[ii] New Economics Foundation. Ghost Town Britain 11. NEF, London, March 2003
[iii] Ben Cave Associates/London Health Commission . *Update for Healthcare for London on the rapid evidence review and appraisal as part of the health inequality impact assessment and equalities impact assessment.* February 2008.
[iv] http://www.ic.nhs.uk/webfiles/publications/pharmservs/GeneralPharmaceuticalServices270706_PDF.pdf [accessed 20th March 2008] – see Table 5, p. 10
[v] Department of Health Contractual Framework for Community Pharmacy NHS Regulations 2005
[vi] All-Party Pharmacy Group (2007). *The future of pharmacy: report of the APPG inquiry.* http://www.appg.org.uk/documents/ThefutureofPharmacy_006.pdf (accessed 3 April 2008)
[vii] The Future of Pharmacy Report of the All-Party Pharmacy Group Inquiry June 2007
[viii] Blenkinsopp A. *Progress achieved with new pharmacy contract but room for improvement* Pharmaceutical Journal; 279: Supplement October 2007
[ix] http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/index.htm (accessed 3 April 2008)

Joint Overview & Scrutiny Committee (JOSC) to review 'Healthcare for London'



A joint authority health scrutiny committee comprising all of the London Boroughs and the City of London, Essex and Surrey County Councils

Final report of the Committee

April 2008

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Joint Overview & Scrutiny Committee (JOSC) to review Healthcare for London

Final report of the Committee

Contents

Appendices

Written submissions to the JOSC and minutes of the meetings are available in a separate volume

Joint Foreword from the Chairman and Vice-Chairmen

We are delighted to present the findings of our ground breaking scrutiny review. This is the first time a joint authority overview & scrutiny committee (JOSC) has operated on such a scale, representing a population of over seven million Londoners and residents of parts of Essex and Surrey, who together speak hundreds of languages and live in 33 Primary Care Trust areas. We believe it demonstrates the role elected Councillors can play in tackling the democratic deficit in the NHS.

In this report we present our findings, concerns and recommendations unanimously agreed by the JOSC. These are based on a substantial body of evidence.

We transcend geographical, political and social divides, and this unanimity sends a powerful message. Our report must stimulate action and we expect the NHS to do more than politely 'note' our findings. We will meet again in the autumn to hear how the NHS is incorporating our recommendations into its proposals for developing London's health services.

Lord Darzi presents a compelling case why London's health services must change. Many of these reasons are not new, and past attempts to reform London's health services have failed. The doubling of resources for London's NHS since 2000 means reform cannot stall this time: the NHS must deliver a lasting return on this historic investment.

Lasting change will require the NHS to commit expenditure to areas recently squeezed in times of financial pressure, e.g. workforce development and public health. Failure to fund new services properly will lead to another round of mere tinkering.

Sustainable reform will require effective partnerships - particularly with local authorities - as the distinction between 'health' and 'social' care becomes increasingly blurred. Thankfully the NHS has realised the gaping omission in the original HfL review and is now working closely with London Councils to quantify the impact on social care. 'Money follows the patient' in the modern NHS, and we are sure London Councils will press hard to ensure that local authorities

are funded for increased demands for social care services following the proposed reductions in hospital treatment.

Reform must also overcome the inequalities in London's health; we cannot continue with such variations in the health of our residents. London has some world class health services: the challenge we set to the NHS is to ensure that these become the norm across the capital.

Furthermore, all care must be designed around the needs of the patient and not those of NHS institutions. To deliver a truly 'patient centred' NHS, all reforms must improve access to, and the accessibility of, health services.

Finally, the NHS must be bold and make difficult decisions about much loved institutions. However it must also be honest and open. Early and meaningful dialogue with local people and their elected representatives will improve proposals to reform London's health services and smooth their implementation.

Those running London's health services are privileged to oversee an exceptional range of services accounting for a budget larger than the economy of many countries. With this power comes a massive responsibility to those living in London and the thousands of dedicated professionals working in these services.

Our final message to you: *Please do not let Londoners and those dedicated to our NHS down; working together we can deliver an NHS of which everyone in this great city can be proud.*

Cllr Mary O'Connor
Chairman

Cllr Barrie Taylor
Vice-Chairman

Cllr Meral Ece
Vice-Chairman

Introduction

This report presents the formal response of the Joint Overview & Scrutiny Committee (JOSC) established to respond to the 'Healthcare for London: Consulting the Capital' consultation undertaken by the Joint Committee of Primary Care Trusts (JCPCTs) between November 2007 and March 2008.

The JOSC was established under the regulations governing joint authority health scrutiny and comprised of representatives from all of the London local authorities as shown below:[1]

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

[1] Further information on the legal basis of the JOSC is contained in appendix 3.

The Social Services authorities in the Strategic Health Authorities neighbouring London were also invited to participate in the JOSC. This reflected an invitation from the NHS for the PCTs in these areas to participate in the Joint Committee of PCTs. Essex and Surrey County Councils appointed the following Members to the JOSC:

- Essex County Council: Cllr Chris Pond
- Surrey County Council: Cllr Chris Pitt

The JOSC held its first formal meeting on 30th November 2007 at the London Borough of Hammersmith & Fulham. This meeting appointed the Chairman and the two Vice-Chairmen of the JOSC (drawn from each of the three major political groups represented in London) and agreed the following terms of reference:

ii) To consider and respond to the proposals set out in the PCT consultation document 'Healthcare for London: A Framework for Action';

iii) To consider whether the 'Healthcare for London' proposals are in the interests of the health of local people and will deliver better healthcare for the people of London;

iiii) To consider the PCT consultation arrangements, including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive.

Our review focused on examining the proposals outlined in the consultation document. We note the variation in the local consultation process across London but do not comment further. We will reconvene in the autumn to consider the NHS' formal response to our recommendations and the latest work to develop options for change.

We are aware of the varied audience for this report and present our recommendations at the start for ease of reference. For those seeking more detailed information on our work we then present our main findings from each meeting, followed by details of the witness sessions and evidence gathered. All of the written submissions to the Committee are available in volume II.

Acknowledgements

The JOSC would like to thank all of the witnesses who gave up their time to attend our meetings; the stakeholders who submitted written evidence to us; the officers in the 'officer support group' who balanced high quality advice and support with their day-jobs in Bexley, Hackney and Kensington & Chelsea; and to the Boroughs that hosted, clerked and provided hospitality for our meetings.

This unprecedented scrutiny review has operated without a dedicated budget, and this has only been possible by the shared desire of everyone involved in the JOSC to ensure London has top-quality health services. Future work of the JOSC may depend on a more formalised solution for resourcing the Committee.

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Conclusions and recommendations

The JOSC welcome the opportunity to comment at this early stage on the models of care outlined in 'Healthcare for London' (HfL). We share Lord Darzi's diagnosis that there is a clear need for London's health services to change in order to meet the demands of the next ten years and beyond.

However, HfL is a vision, not a detailed strategy or plan, and we are deeply concerned about significant gaps in the review. It is not acceptable that mental health and children's services were added as an afterthought. The JOSC expect the same opportunity to analyse proposals for these services as with the services originally included in HfL.

Similarly, we heard that further work is underway on key areas to develop the vision outlined in HfL, including the impact on social care and the implications for NHS estates and finances. As this important information is not yet available, we – the scrutiny Members of London's local authorities and surrounding areas participating in the JOSC – reserve our position to comment on specific proposals when this detail becomes available.

The varying response to the HfL consultation across London demonstrates the NHS must work harder to develop the public's understanding that turning the HfL vision into reality will fundamentally change the way their health services are provided. The NHS must rise to this challenge and deliver meaningful engagement in future discussions on specific changes.

We now present our recommendations in response to the HfL consultation which highlight issues that cause us concern, areas in which further work is required and aspects of the review that we believe are positive. A recurring theme is the need to ensure reforms improve the accessibility of healthcare services and the physical access to facilities where these are provided. We are pleased that NHS London has already accepted the key role that local authorities play in this process, and we look forward to authorities being invited to take part in further detailed considerations.

The JOSC has unanimously agreed these recommendations, demonstrating the strength of shared feeling across all London's local authorities. In line with health scrutiny legislation we look forward to receiving an appropriate response from the NHS and will reconvene in the autumn to discuss this response and examine NHS London's next steps.

****

1. Financing the reforms

We have not heard any evidence that the appropriate resources exist (or have even been identified) to establish and then support the major changes proposed in HfL. Selling under-used estates may help pay for new facilities, but such sales can only take place once the new services are operational. We have not heard whether additional 'pump-priming' resources will be available to solve this dilemma.

(a) *We recommend* that NHS London states in specific terms where the money will come from to develop new services in order to address concerns about whether the NHS has the resources available to deliver major reform.

Resources for providing health care are finite. The proposals are likely to lead to primary and social care providing treatment currently undertaken in hospitals.

(b) *We recommend* that the NHS ensures that 'the money follows the patient' and resources are reallocated from acute trusts to primary and social care to reflect changes in the way that patients are treated.

2. Health and social care for London not 'Healthcare for London'

It is unacceptable that local authorities were not part of the original review. The NHS and local authorities must work together in partnership, and steps must be taken to prevent partners working to different (and potentially conflicting) priorities.

(a) *We recommend* that London Councils is involved in developing further detailed proposals for London's health services, including fully quantifying the impact on community care services. Partners must have a shared understanding of their required contribution.

Providing world-class health services for London will require ever-closer working between health and social care providers, including increased joint commissioning between these organisations. The NHS budget for London has more than doubled in the last eight years; however funding for social care services has seen nothing like this rise.

(b) *We recommend* that NHS London outlines how seamless care will be provided in the context of the hugely differing budget increases for health and social care that have sharpened the distinction between universal health services and means-tested social care services.

3. Health inequalities

Lord Darzi correctly highlights that there are significant inequalities in the health of London's residents.

(a) *We recommend* that the NHS focuses resources on communities with greatest health and social care need.

Health inequality assessments are key to ensuring this happens, and we therefore welcome the impact assessment the NHS made on the broad proposals in HfL. This must not be a one-off piece of work.

(b) *We recommend* that the NHS carries out further health inequalities impact assessments (i) once detailed proposals have been developed and (ii) a year after implementation of each new care pathway to demonstrate that reforms have reduced not worsened inequalities.

4. A staged approach to reform

'Big bang' reform can be risky, and 'teething problems' with new health services could have fatal consequences.

(a) *We recommend* that a staged approach is undertaken to implementing new care pathways with, for example, 'polyclinics' piloted in a selected number of sites. Any lessons learnt must be fed into any subsequent roll-out across London.

The NHS must be clear and accountable so that it cannot be accused of implementing the HfL vision in a piecemeal fashion.

(b) *We recommend* that the NHS publish a transparent timetable for implementing the HfL vision which will enable Overview & Scrutiny Committees to hold the NHS to account.

5. Helping people stay healthy and out of hospital

Admission to hospital is not always in the best interest of patients or their families. Staff working in the community (e.g. community matrons) along with pharmacists can help people manage their long-term conditions and prevent the need for emergency hospital admission.

Sufficient resources will be required to fund key professionals such as physiotherapists and occupational therapists who will provide rehabilitation and treatment in the community following the proposed earlier discharge from hospital.

Much of HfL focuses on ensuring patients receive high quality care once they become sick. However intervention 'upstream', e.g. helping people quit smoking, can prevent the need for hospital treatment later.

***We recommend* that NHS London sets a minimum level of expenditure that PCTs must commit to (a) helping people lead healthy lives and (b) helping patients manage their long term conditions. This approach will involve close working with partners such as local authorities.**

6. Carers

In addition to impacting on social care, greater care in the community will place additional demands on unpaid carers.

***We recommend* that NHS London ensures reforms do not increase the burden on the often 'hidden army' of carers in London and the NHS outlines how any proposals arising from this consultation will not increase this burden.**

7. Maternity services

We are concerned that HfL is likely to require further midwives at a time when the profession is already under severe strain.

(a) *We recommend* that the NHS re-examines the allocation of funding for midwifery and commits expenditure to expand the number of midwives in London (i.e. through improved recruitment and retention).

We support the principle of maternal choice where this is affordable, but we have doubts about the benefits of stand-alone midwife-led units given that examples of these in London have not proved popular.

(b) *We recommend* that the NHS reconsiders the proposals for stand-alone midwife-led units.

8. Children's health

We are unable to give a substantive view on how children's health services should develop given the omission of children's services from the original HfL review. We again express our dissatisfaction with this situation.

(a) *We recommend* that if specialist care is further centralised then the NHS examines how it will manage the impact on children's families during this treatment at more distant specialist hospitals.

As with adults, hospital treatment should be a last resort for children and non-NHS community facilities should be used to promote good health.

(b) *We recommend* that the NHS works with local authorities to ensure that Children's Centres and Extended Schools are equipped and resourced to provide community health services for our young residents.

9. Centralising specialist care

We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes. However, we will not give blanket approval to all proposals for centralising specialist care at this stage, and expect future consultations to set out prominently the clinical benefits of each particular proposal.

(a) We *recommend* that clinicians are prominently involved in developing proposals, and expect them to be involved in explaining to the public that proposals seek to improve patient care rather than save money.

London is a congested city for much of the day. At peak times it may take a long time to travel short distances.

(b) *We recommend* that the London Ambulance Service (LAS) and Transport for London (TfL) are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS London must work with these organisations to agree a travel plan to underpin any expansion of a hospital's services.

(c) *We recommend* that the NHS adopts a 'hub and spoke' model that involves local hospitals treating less complicated cases of specialist care in the daytime with specialist centres providing treatment out of hours when travel times are shorter.

Centralisation of specialist care may involve critically ill or injured patients spending longer in ambulances.

(d) *We recommend* that any centralisation of specialist care can only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require.

10. The future of the local hospital

The proposals could lead to local hospitals (often referred to as District General Hospitals or 'DGHs') losing services either to specialist centres or to polyclinics providing more general care. However, sufficient beds will be required in local hospitals to enable discharge from specialist centres once the initial treatment has been provided, as well as continuing to deliver the majority of hospital treatment that does not need to be undertaken at a specialist centre.

(a) *We recommend* that NHS London provides a firm commitment that reforms arising from HfL will not threaten the viability of DGHs, and that these hospitals will not suffer a 'salami slicing' of services that create diseconomies of scale.

Patients, particularly the elderly, often have several health problems.

(b) *We recommend* that NHS London outlines how increased specialisation of hospital care will improve the care for people with multiple health needs (often referred to as 'co-morbidities').

11. GP services and 'polyclinics'

We agree that Londoners could benefit from the provision of a broader range of services in the community. It is unacceptable to expect people to travel to a hospital to have a routine blood test, for example. However, it is expensive to provide certain diagnostic services and resources must not be duplicated with polyclinics becoming 'mini-hospitals'.

(a) *We recommend* that the NHS demonstrates that providing complex diagnostic services in new community facilities offers better value than using this funding to expand access to existing services (e.g. greater or improved access to hospital x-ray equipment for primary care patients).

There has been much debate in our meetings about the proposal for polyclinics. We do not believe 'one size fits all'. Partners such as local authorities must be fully involved in providing services in pilot polyclinics in order to realise the potential of these as holistic 'well-being' centres.

(b) *We recommend* that PCTs, local authorities and other partners are able to decide the appropriate models for providing access to GP and primary care services taking into account specific local circumstances.

It will be vital to balance benefits of a greater range of services with the importance of ensuring GP services are accessible.

(c) *We recommend* that the NHS provides a commitment that reforms will improve access to, and the accessibility of, GPs and reforms will not undermine the patient/GP relationship that for many is at the heart of the NHS.

The NHS must ensure reforms take account of the fact that many GP patients do not have access to a car.

(d) *We recommend* that new primary care facilities (i.e. the model referred to as 'polyclinics') can only proceed if the NHS has agreed a travel plan with TfL and the relevant local authority.

12. Mental health

Mental health services must not be the forgotten or neglected aspect of the NHS in London. Again, we express our deep dissatisfaction that mental health (one of the largest services in the NHS) was excluded from the original HfL review, and we wish to hear how the NHS will develop services for the majority of mental health service users that do not require in-patient treatment.

***We recommend* that NHS London outlines how it will ensure sufficient resources will be allocated to meet the challenges facing London's mental health services, including the establishment of talking therapies and other non-drug based treatments.**

13. End of life care

Again, 'one size does not fit all' and end of life services must be tailored to individual need, circumstances and preferences. Improvements to end of life care will require joint working across health and social care organisations in the public, private and voluntary sectors.

(a) *We recommend* that NHS London provides a commitment that any reforms to end of life care will not lead to people dying in poor quality housing and/or alone.

Nursing/care homes are people's homes and proposals for improved end of life care must reflect the needs of residents of these.

(b) W*e recommend* that NHS London clarifies how it will ensure residents of nursing/care homes are not transferred to a hospital to die when this is driven by the needs and wishes of the care home rather than the individual.

14. Understanding the cross-border implications

London is not a self-contained entity, and patients travel in either direction across the London boundary to receive NHS care.

We recommend **that NHS London works closely with colleagues from the surrounding Strategic Health Authorities to explore the implications of any reforms on patients crossing the Greater London Authority (GLA) boundary.**

15. Workforce

The major changes proposed in HfL may require professionals to acquire new skills and work differently. Reforms cannot proceed if the workforce is not in place. However HfL is silent on whether staff will be willing to move from secondary to primary care. Also, different teams of professionals must work together if the aim of seamless care is to be achieved.

We recommend **that NHS London publish a workforce strategy that will enable the delivery of any changes to London's health services: resources for workforce development must not be diverted in times of financial difficulty.**

16. ICT: providing the electronic connections

Providing seamless health and social care services will also require the ability for different parts of the health and social care economy to be able to communicate electronically.

We recommend **that further work is undertaken to ensure that the appropriate ICT infrastructure is in place to deliver the care pathways arising from this and subsequent consultations. The NHS must state what it has learnt from the recent attempts to implement major ICT projects.**

17. Compatibility with recent reforms to the NHS

The NHS has undergone significant reform in recent years including the introduction of Payment by Results and the creation of Foundation Trusts. We are concerned that Payment by Results may encourage competition between acute trusts rather than the cooperation required to establish specialist centres, while the freedoms for Foundation Trusts may complicate the proposed shift to greater care in the community.

***We recommend* that the NHS provides further reassurance on how the ability of Foundation Trusts to retain resources from the disposal of their estates affects NHS London's proposal to use the sale of underused assets to pay for polyclinics and new community facilities.**

18. Moving forward

This Committee demonstrates the value of the unelected NHS talking to local Councillors who are elected to represent and speak up on behalf of local communities. This does not happen enough and engagement of local Councillors must not be limited to formal participation in Overview & Scrutiny Committees to respond to consultations.

(a) *We recommend* that the NHS is proactive in approaching local Councillors when changes to services are still in development: the NHS must have an ongoing dialogue with Overview & Scrutiny Committees (OSCs) to discuss the appropriate level of consultation required.

We do not believe that Londoners, including those working in the NHS, appreciate the impact that the reforms proposed in HfL could have on existing services.

(b) *We recommend* that the NHS in London overcomes this limited awareness and ensures widespread engagement in future consultations.

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We will meet again in the autumn to examine NHS London's response to these recommendations and the consultation more generally. At that meeting we will look forward to hearing more on the strategy for implementing the reforms that HfL states are essential to ensure the NHS meets London's needs.

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Findings

In this section we present the main findings from our evidence gathering. We summarise the discussions with our witnesses and then highlight what we believe are the key points. These findings underpin our recommendations outlined in the previous section.

The findings are presented on a meeting-by-meeting basis.

- **30th November 2007: LB Hammersmith & Fulham**
- **7th December 2007: LB Camden**
- **18th January 2008: City of London**
- **22nd February 2008: LB Tower Hamlets**
- **14th March: LB Ealing**
- **28th March 2008: LB Merton**

Minutes of each meeting are available in volume II of the report along with the written submissions considered by the JOSC.

30th November 2007: LB Hammersmith & Fulham

Witness session: Context of the Healthcare for London review, consultation process and next steps

Richard Sumray: ***Chair of the Joint Committee of Primary Care Trusts (JCPCT)***

In his opening comments Richard Sumray stated that PCTs will be responsible for implementing reforms arising from the consultation given that they are the NHS Trusts responsible for commissioning services for their local area. He said that the decision making process will be flexible with PCTs taking as many decisions as possible locally. Decisions will only be taken at a higher level if absolutely necessary.

PCTs are therefore undertaking this initial consultation which is about the vision and direction of travel in Healthcare for London (HfL), not specific NHS facilities. At the end of the consultation all of the information will be gathered and analysed. There are likely to be subsequent consultations on specific proposals for implementing the vision.

The JCPCT, which has been set up specifically for the purpose of the first stage consultation, will meet monthly. Meetings will be in public when decisions were being made i.e. at the start and end of the consultation. The JCPCT will seek to ensure that all PCTs give the same message and undertake a similar level of consultation, but there will be some local variations to meet the needs of boroughs.

Questions to Richard Sumray

In the ensuing 'Question and Answer' session, the following main points were made:

- There needed to be clarity about the funding allocated both for the consultation and the subsequent implementation of any proposals. Richard Sumray said that funding had been allocated for the consultation. There has been a broad financial appraisal of the end costs, and he believed the proposals are affordable given the continued increases in funding for healthcare in London (significantly above inflation). NHS finances have turned around in the last 18 months, although a few Trusts still have deficits.

- Local authorities must be included in developing proposals for health services in London. Richard Sumray acknowledged that the original HfL review had not fully considered the implications on social services and there will be further consultation with local authorities to address this.

- In response to concerns that the reorganisation of PCTs could distract from the implementation of HfL, Richard Sumray said that he was not aware of any move to reorganise PCTs in the short to medium term. However there is likely to be increased joint commissioning with local authorities, and a reduction in PCTs' role as a service provider.

- Consultations on the future of health services are already underway in parts of London and it is essential to ensure that these are compatible with the Healthcare for London consultation.

Ruth Carnall: ***Chief Executive, NHS London***

Before answering questions from the JOSC Ruth Carnall gave a brief presentation on the background to Healthcare for London. She said that the review sought to identify models of future healthcare based around care pathways and not existing institutions/providers.

Changes to health services will require sufficient attention to be given to the 'enablers' of reform. For example, it will be essential to use the training and education budgets to develop the skills required to deliver new care pathways, and there are also opportunities to use the NHS estate more effectively.

HfL presents a case for why London's health services need to change and it will be important to balance the need for consultation with maintaining the momentum of reform.

Questions to Ruth Carnall

In the ensuing 'Question and Answer' session, the following main points were made:

- An incremental implementation of reforms could lead to a gradual loss of services for certain health service providers, particularly local hospitals. However, a 'big bang approach is not possible given that further work is required on certain aspects of the proposals.

- It is important to ensure there are financial incentives in place to deliver the reforms. NHS London believes that many of the levers for reform are already in place, but these need to be used properly. Foundation Trusts are accountable to PCTs through their contracts, and have been supportive and engaged with HfL so far.

- With respect to pathology services, the development of a larger facility will deliver cost efficiencies, but local x-ray facilities, for example, could be provided and improve access times.

- Members highlighted local concerns about NHS London 'top-slicing' PCT budgets. Ruth Carnall said that NHS London does not plan to top-slice

PCT budgets again and some £135 million has already been returned. Additionally, PCTs will be allowed to retain surpluses, and through the commissioning process will be able to direct resources to services that best meet local need.

- NHS London will challenge PCTs on their use of resources without interfering, and will provide greater freedom to good performing PCTs.

- In relation to the JOSC's involvement with the work to develop proposals for London's health services, Ruth Carnall said that NHS London would welcome any advice from the JOSC as to the success or otherwise of the work so far.

- Mental health providers have so far been enthusiastic about 'polyclinics' and integration with primary care services. There has been significant progress in the provision of care outside of hospitals. Furthermore, there will be a further review of mental health and children's services as these were not covered in adequate depth by the original HfL review.

- NHS London is currently developing an estates plan that will include requirements for Trusts wishing to gain foundation status. Members stressed that it is important to ensure Trusts are not forced to sell off land in order to balance their books. Ruth Carnall responded that NHS London does not want this to happen and added that it is expensive to own and maintain underused assets.

Key points:

- Decisions on the future of health services must be taken as locally as possible: i.e. by individual PCTs or small groups of PCTs rather than a pan-London JCPCT.

- Healthcare for London presents an opportunity to ensure health services meet the future needs of London. Successful implementation of reform will require sufficient attention to be given to key issues such as workforce development, ICT and estates.

- The autonomy of Foundation Trusts may complicate the implementation of the reforms outlined in HfL.

- There are concerns and uncertainty about how the proposals could be implemented and in what order. There is a danger of a 'salami slicing' of services away from some district hospitals and this could lead to uncertainty in Trusts in their financial and service planning.

- There are still some uncertainties about the future of PCTs: another round of organisational restructuring of PCTs could undermine or distract from the implementation of proposals arising from HfL.

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7th December 2007: LB Camden

Witness session 1: Background to and rationale behind 'Healthcare for London'

Dr Chris Streather: ***Medical Director, St George's Healthcare NHS Trust and Member of HfL Acute Care Working Group***

In some initial remarks, Dr Streather recognised that the Darzi review has certain features which distinguish it from previous reviews of healthcare services in London. In particular:

- it was not based predominantly on suggesting new configurations of institutions, but on a 'pathways for patients' approach which aims to deliver a high quality of care;

- there had been a high level of involvement from clinicians, leading to a greater likelihood of 'buy-in' and effective implementation of the final proposals. All five Clinical Pathways working groups had been clinician-led;

- it was far more evidence-based than previous reviews: a good deal of diagnostic work had been carried out in the course of the Darzi review, and MORI had been commissioned to seek people's views;

- it is accepted the existence of health inequalities across London, and recognised the need to address the improvement of the quality of care for *all* patients, wherever they live.

In terms of accessing acute care, it is often very complicated for patients to decide what to do if they have a pressing condition (e.g. abdominal pain). A number of options currently existed (including NHS Direct where over 70% of calls received are re-directed). This helps to explain increased attendances at Accident and Emergency (A&E) departments in London since some form of treatment is guaranteed.

Darzi's solution is to make patient choice simpler by introducing, for example, a single telephone number for health emergencies. A need also exists to provide more accessible 'emergency' care in a community setting closer to where people live.

Whilst Darzi's principle is to provide care in a community-based setting where possible, it was recognised that some elements would have to be centralised (e.g. treatment of complex trauma and specialised stroke care). It is likely that, in time, further centralisation of other specialist treatments will follow.

Evidence shows that mortality rates are lower at centralised, specialist stroke centres, and presently a large number of centres handling strokes are not

meeting standards. Dr Streather considered therefore that the principle of centralising specialist stroke care for all Londoners is to be welcomed. However, the vast majority of stroke treatments (75-85%) are undertaken in local stroke units, and there was no reason why, if Darzi's proposals were implemented, this should not remain the case.

Darzi proposes these principles be applied in a similar fashion to trauma cases with the small number of highly complex cases being carried out in (perhaps three) specialist settings across the capital, but the vast majority of other cases still being handled at district general hospitals (DGHs).

Dr Streather took the view that setting up a small number of specialist treatment centres should not be allowed to destabilise 'local' hospitals (DGHs) across London. It wis important to maintain skills and an appropriate quality of care in DGHs. He therefore cautioned against a highly centralised model, whereby DGHs' existing functions are leached away. He highlighted work that could continue to be done in a local hospital setting.

In general, he believed that Darzi's report conveyed poorly the continuing role for local hospitals under his proposals – in particular, where it stated: 'The days of the DGH seeking to provide all services to a high enough standard are over...'.

Dr Martyn Wake: ***GP and Joint Medical Director, Sutton and Merton PCT and Chair of HfL Planned Care Working Group***

Dr Wake believed that although the standard of health services generally in London is not poor, overall there was a considerable variation in standards, and in some areas provision *is* poor. He considered that the provision of specialist care can be improved by a degree of centralisation. However, much care could be moved out of a traditional hospital setting (i.e. DGH), for example, minor surgery and routine diagnostics into a more local setting. Travelling significant distances to a hospital (e.g. for a routine blood test) did not make sense.

Centralising elective (i.e. planned) care can be achieved in several ways. Some care (e.g. hip replacements and cataract surgery) could be located in an area physically separate from emergency care. He also considered that there is much potential for *routine* specialist treatment currently carried out in large hospitals to be undertaken in a community setting.

Darzi's vision recognises that it is important to provide better community health services in a number of areas (e.g. end-of-life care). Community support and enhanced rehabilitation have tended to be overlooked as a component of effective health provision, and have suffered from under-investment. Greater investment would help promote independence and support early discharge from hospital, and help avoid admission for conditions where hospital-based treatment is inappropriate.

A greater emphasis on community health provision should also improve 'end of life' support, allowing more people the choice of dying at home. Currently, around 20% of Londoners die at home, but research consistently showed that over 50% of people had this as their preferred option.

Dr Wake emphasised the need for better integration of pre- and post-operation 'pathways' (i.e. treatments): e.g. integration of nursing care, intermediate care and social/end of life care. The present situation can be confusing for patients and GPs alike. A shared commitment from all agencies involved is required, with the focus on the patient as an individual.

Darzi offers a commitment to providing a 'polyclinic' at every hospital site – recognising the large number of patients who attend A&E with mainly 'GP-treatable' symptoms: medical staff at these sites (GPs and specialist nurses) are likely to require some up-skilling.

Polyclinics are likely to require longer travel times (1-2 Km) in many cases. Discussion involving Local Authorities would be crucial.

Loss of continuity of care is likely to be an issue for some, principally patients who wanted to be seen quickly and those who wanted to see 'their' GP.

'Heart of Hounslow' experience demonstrates the key importance of polyclinics being fully accessible for people with mobility difficulties. Close working with Local Authorities will be needed regarding: a) individual premises b) suitable parking c) infrastructure, supported by adequate transport links.

Regarding the cross-London border question, there is the possibility that London might have many polyclinics but, for example, the three Essex PCTs might (initially) have none – thus causing possible tensions, including travel implications into London, and the need to ensure that greater health inequalities were not unwittingly created.

<u>Questions to Dr Chris Streather and Dr Martyn Wake</u>

In the ensuing 'Question and Answer' session, the following main points were made:

- PCTs will have the freedom to negotiate contracts for extended GPs' hours – 'polyclinics' will allow PCTs to look in detail at GP contracts to achieve desired provision to best meet public need. Effective monitoring of GP contracts will be important.

- There is a need to ask NHS London what consideration has been given to the implications – particularly financial – of a shift from existing healthcare models to greater community-based health service provision. This covers the likely impact on Local Authorities,

community/voluntary sectors, and carers. The support of Local Authorities in this area is crucial if Darzi's vision is to be translated effectively into practice.

- A realistic cost assessment (both for health service providers and Local Authorities, principally as social care providers) is needed. The cost of this significant change has to be managed realistically – under-investment would be a false short-term economy, with negative long-term implications.

- There is a legitimate argument for additional Government funding for the 'transitional' period (i.e. from the existing situation to the Darzi model of healthcare provision).

- Mental health care and children's care services had not been sufficiently addressed in Darzi's report, but it is welcome that further work is being carried out in these areas.

- There is a need to guard against an over-prescriptive centralised model of healthcare provision, with the viability of DGHs threatened by the piecemeal removal of functions. The implications of redistribution of existing provision (e.g. adequate transport links) needed to be considered carefully, in close consultation with Local Authorities and local people.

- NHS London must recognise the need to explain clearly to ordinary people how they can access care for different health needs.

Key points:

- Changes to arrangements for accessing healthcare need to be explained clearly to Londoners.

- Darzi's proposals must not lead to any greater centralisation of care than is absolutely necessary. GP surgeries are the primary source of contact for most people with the NHS; moving all existing GP surgeries into 'polyclinics' would be a source of concern.

- Developing 'polyclinics' must be carried out flexibly – not on a ‘one size fits all’ basis.

- Implementation must be strategically planned to ensure that services are not ‘salami-sliced’ from District General Hospitals (DGHs) as a result of the creation of 'polyclinics' and the centralisation of some specialist services in a small number of hospitals.

Witness session 2: An independent view of 'Healthcare for London' and the way forward for the JOSC

Fiona Campbell: ***Independent consultant on health and social care policy and Board Member of the Centre for Public Scrutiny***

Dr Campbell provided a factual commentary upon the context, consultation, underlying principles, main findings and conclusions of the Darzi report. She also highlighted a number of key questions which the JOSC might wish to consider. These detailed points are contained in the Minutes of the meeting appended to this report and are therefore not repeated here.

Some supplementary issues raised are set out below:

Turning the NHS into a 'health' rather than a 'sickness' service is an aspect of Darzi's report which Dr Campbell considered had not received a great deal of emphasis so far, but the 'preventative' healthcare agenda ISs a key part of the overall equation.

Darzi referred to 'incentives in the system' to allow a shift towards greater investment in health improvement. Dr Campbell cautioned that it Is important to be clear as to whether such incentives are capable of achieving what they are intended to.

There had been no clinical working group set up under the Darzi review to specifically address the needs of older people who represent a significant, and growing part of the population. The JOSC might want to take account of this in seeking views from this sector.

Similarly, the JOSC might wish to consider the impact of the proposals on carers (who were often elderly) when people are discharged early from hospital.

One significant issue is that Darzi's proposals assumed an extension of healthcare service provision whilst local authority patterns of social care provision (driven by restricted finance) had for a number of years been focusing resources on fewer individual cases (those with the greatest needs).

Questions to Fiona Campbell

In the ensuing 'Question and Answer' session, the following main points were made:

- Further evidence from NHS London is needed in order to demonstrate its capacity to deliver Darzi's vision. However, the involvement of clinicians bodes well for its successful implementation.

- Investing in an approach which gives suitable emphasis to 'prevention' of health difficulties represents sound long-term financial sense.

- The overarching focus in the Darzi report had been on clinicians' issues, and 'lifestyle' factors had been largely sidelined. However, it is important to stress the full integration of Darzi's vision into the Health agenda of recent years (as set out in 'Our health, our care, our say') and the importance of joined-up Health and Social Care.

- It is important to achieve clarity between urgent care and emergency care in terms of contact points and healthcare access, so that members of the public know where to go for different health conditions.

- The accountability of Foundation Trusts (FTs) and how their role might change under Darzi's proposals are issues that might usefully be raised with the FTs' regulating body 'Monitor'.

- Account should be taken of the difficulties experienced nationally by the NHS in introducing a large new computer system, in terms of the potential implications for implementing Darzi's proposals for London.

- Darzi's report indicated that savings from reconfiguring acute services could be reinvested in preventative healthcare, or alternatively the NHS should be prepared to subsidise Local Authorities' social care costs.

Key points:

- The involvement of clinicians in developing the ‘Healthcare for London’ review is welcome. Equally, it is vital that NHS London commit to include those involved in delivering social care in developing proposals, since models of care in the review will clearly have a significant impact on social care.

- The NHS must not simply be a ‘sickness service’. Resources should be used to prevent health problems, including through health promotion.

- A shift to greater use of day-case surgery and reduced length of stay for other surgery will impact on Local Authorities, and require extra investment – this must be recognised and addressed by NHS London.

- Closer working between the NHS and local authorities (e.g. through 'polyclinics') could present problems in that NHS services are universal, whereas financial pressures have led to many social services being restricted to those with the highest need.

- Money will be required for implementing the proposals in the review. Releasing under-used estates might help pay for new services, but existing services will still need to operate until these new services became operational.

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18th January 2008: City of London

Witness session 1: Partnerships, infrastructure and economics

Steve Pennant, Chief Executive, *London Connects*

Mr Pennant referred to the fact that there are no processes in place in the NHS to deal with a partnership of boroughs, and consequently partnership accountabilities between the NHS and London Boroughs need developing.

He drew attention to the critical role that programme and project management have in the successful operation of complex, large-scale ICT programmes. Equally important is the incorporation of users' views and requirements into ICT systems by those developing these systems.

ICT security raises important questions (in view of certain high-profile national cases in the recent past) and management procedures for managing data need to be sound.

Effective operation of a single non-emergency telephone number for booking GP appointments would be complex across thirty-two London Boroughs. However, this should not hinder 'common access' being taken forward in discussions with the NHS.

Well-developed electronic connections between health and social care bodies is important if seamless care is to be achieved. Difficulties could exist when different networks are used (e.g. when Local Authority social workers needed to access NHS information): 'codes of connection' are needed, to avoid verification problems. Staff training and security are crucial elements.

Costs of hardware and network costs are reducing as technology advanced – therefore costs of 'joining up' health/social care ICT infrastructure were capable of being broadly contained within existing budgets. Bigger issues in this context are: political will; proper management of change; and secure management of sensitive data.

Boroughs can add value to the NHS through providing more and easier-to-navigate links from Council call centres and websites to health service information. Also, it is important to aim to provide easy access to NHS information through Council 'one-stop shops'.

A good framework for closer joint PCTs/Boroughs working is needed. This is likely to involve suitable motivation/incentives being built into the system, to encourage managers to work in partnership with an 'outside' body. Good training is also an essential ingredient.

Questions to Steve Pennant

In the ensuing 'Question and Answer' session, the following main points were made:

- The NHS does have appropriate capacity to deliver increased NHS/Local Authority connections; however, further consideration to incentives for NHS management may be needed as a catalyst for change.

- A key issue is whether the political will existed to implement a new NHS/Local Authority e-interface system. A top-down national approach is unlikely to prove the best way forward, based on experience to date (big risk; potential loss of customer service etc). Instead, incremental development might be better building on, and developing, existing systems.

- Training is a vital element. Local Authorities needed to recognise the need for adequate ICT and training budgets for social care staff who work with health professionals, and similarly for Boroughs' customer care staff.

- A big 'software cost shunt' (as Boroughs purchase necessary software to connect to NHS systems) should not happen, though councils may have to buy 'smart card' readers for their PCs. However, Boroughs need to be speaking to the NHS about such issues.

Key points:

- Increased Health/Local Authority partnership working (requiring political and senior managerial support, and adequate budgetary and staff resources) is needed if seamless services are to be achieved. Care must be taken to ensure that joint agreements on developing and implementing services are robust, and are adhered to.

- Ensuring that those actually delivering an ICT service are involved in designing new models of care, and also how these reforms are implemented, are essential. Stakeholder management is a key ingredient in successful programme management.

- Health and social care organisations will only be able to provide a viable joined-up service if they are able to communicate effectively electronically. This might involve costs around ICT software, but also presents challenges around data security.

David Walker: ***Editor, The Guardian's 'PUBLIC' magazine***

During the presentation and the ensuing 'Question and Answer' session, the following main points were made:-

- In formulating its recommendations, the JOSC should consider the broader political canvas and developments in healthcare policy.

- Options for the future provision of primary care need to be considered carefully – to what extent, and how, might primary care services be reshaped?

- How best might the 'primary care deficit' (between the public's wishes and what GPs provid) be addressed? Is direct employment of GPs by Local Authorities (or bodies directly accountable to them) a realistic possibility?

- Local Government might wish to reflect on its experience of sophisticated professional management (e.g. teachers) before advancing a serious case for extending its sphere of operations into the provision of primary care services Would Local Government be prepared to 'take on' the power-base of the British Medical Association (BMA) for example?

- If Local Government does wish to extend its role into primary care, an incremental approach, based on trialling by individual councils would be sensible.

Niall Dickson: ***Chief Executive, King's Fund***
John Appleby: ***Chief Economist, King's Fund***

The King's Fund's recognised that, in an international market of improving healthcare, the means of delivering London's healthcare has to change. Key issues raised by the Darzi report include: access to the healthcare system; quality and safety; health inequalities; and cost.

Darzi's commitment to tap into clinicians' expertise was very sensible. His vision should not be regarded as an inflexible blueprint to be implemented, rather as providing a first step(s) in a desired direction of travel which should take account of local circumstances, and how local services are currently delivered.

Evidence for centralising certain services (e.g. stroke) is considered pretty sound.

However, evidence for moving GPs into bigger centres (i.e. 'polyclinics') is less clear. Whilst there might be some benefits for patients (e.g. quicker

access to diagnostics), the case for this model of health provision had not yet been convincingly made.

Evidence for GPs carrying out more specialised work is mixed – this could sometimes be more costly than if carried out by hospital consultants.

Darzi's report has not demonstrated that the public are supportive of his proposals, and whether clinicians broadly support his proposals is likely to prove critical to securing broad public acceptance.

Reconfiguration of services alone (a 'bricks and mortar' approach) will not be enough to achieve what 'Healthcare for London' intends – changes in skills and culture within the NHS will also be important.

The King's Fund had looked at a possible future budget for the provision of healthcare services in London up to 2016. This investigation showed that the existing model could be as affordable as Darzi's proposals. Financial figures supporting this scenario would be included in a critique currently under preparation, which would be presented to NHS London.

Attention was drawn to question-marks over Darzi's cost estimate of implementation (over 50% of savings being derived from implementation of polyclinics) which, at £13.1 billion for 2016/17, is exactly the same as the projected NHS cost based on current models of provision.

Polyclinics had been costed on an average size of approximately 2,000 sq. metres – however, the 'Heart of Hounslow' model (one of the few currently in existence) was around 8,500 sq. metres.

Transitional costs are likely to represent a critical issue, though these were not identified by Darzi. However, he had the expectation that some of the NHS estate would need to be sold, and the sale of hospital buildings was likely to be very unpopular with local people.

There are important issues around access. Darzi estimated that around 70% of GPs would be located in polyclinics, and this has implications for travel distances for many people – particularly for the elderly.

<u>Questions to the King's Fund speakers</u>

In the ensuing 'Question and Answer' session, the following main points were made:

- There is no clear model of how primary care services might best evolve, although they expected single-GP practices to become virtually extinct over the next twenty years. Federating smaller GP practices might be one model which developed. A variety of models is required, best-suited to local needs. Incorporating a greater element of

competition into provision will allow patients to move more easily from one GP to another.

- The NHS is moving towards capturing more effectively patients' perceptions of whether NHS treatment has benefited them. In this context, evaluation of the effect Darzi's proposals had after 'x' years of implementation will be important.

- It was recognised that a tension existed between the NHS's free service to all, and the means-tested social care provided by Local Authorities. However, arguments put to the Government by the King's Fund in 2006 for greater funding of social care appear to have been accepted. The Government have committed to a Green paper to investigate issues, and to try and achieve a cross-party consensus on the way forward. This points to the possibility of NHS funding and local authority funding systems being made more compatible.

- It would be a mistake to focus too much on 'polyclinics' and their role, at the relative exclusion of other elements in Darzi's report, such as the future role of District General Hospitals. 'Polyclinics' might not be a panacea – but equally they were unlikely to prove a disaster.

- In preparing its critique to be presented to the NHS (referred to above), the King's Fund are looking abroad and assessing international evidence (including the USA and Germany).

- It is important for the broader clinical community (i.e. including nurses, auxiliary staff etc) to be engaged effectively in the consultation process on Darzi's proposals.

- It was noted that Darzi's report had little to say about how his proposals fitted in with evolving models within the NHS (e.g. Foundation Trusts) and mechanisms and incentives to achieve change which had already been introduced (e.g. 'payment by results') but these are important factors to consider.

- Darzi's model appears to rely quite heavily on removing certain functions from DGHs (e.g. to specialist centres and 'polyclinics'), and the proportionate reduction in hospitals' funding is a factor which required consideration.

- With the increasing reliance on care in the home under Darzi's proposals, there is likely to be a serious challenge posed by a likely diminishing pool of carers in the future. Whilst greater use of telecare might help, this will not be enough on its own.

Witness session 2: Local authorities and social care

Cllr Merrick Cockell: ***Chairman, London Councils***
Mark Brangwyn: ***Head of Health and Social Care, London Councils***

The NHS in London is currently not operating in a number of respects as well as Londoners have the right to expect, for example, in providing equity of service and access to its services across all areas of the capital.

A greater role for health education, emphasising the role of 'prevention rather than cure', is needed as well as suitable emphasis on the benefits of leading a healthy lifestyle.

The proposals will bring extra costs for Local Authorities, and the strategy which emerges to implement Darzi's proposals must take account of this, with an appropriate transfer of resources from the NHS to the Boroughs. London Councils want to see a strong commitment to investment in home care through joint commissioning and NHS investment in costs.

Local solutions (e.g. 'polyclinics' and good transport links) should be developed in a way which take full account of local people's views.

The implementation of proposals should allow for a greater range of care and support to be provided for people with mental ill-health.

London Councils expect to see more effective use of the NHS estate, with the full engagement of London Boroughs (and the Greater London Assembly) in the development of options for the future use of land and buildings.

Key points:

- There must be flexibility in how models of care are implemented: 'one size does *not* fit all'. Decisions around the provision of services need to be taken as locally as possible. However, this must not be at the expense of achieving differing levels of quality in healthcare provision across London.

- It is important to examine how the reforms relate to the new financial regime in the NHS. (e.g. 'Payment by Results' will mean that shifting care out of hospitals will impact on the finances of hospital trusts – while Foundation Trusts have a larger degree of autonomy over their service provision and may be less willing to reduce the amount of activity they undertake).

- It is important to ensure that the public are kept informed about any proposed changes in health services; clinicians will have a key role in explaining the rationale behind changes (i.e. that reforms are not cost-saving cuts).

- When considering whether to establish 'polyclinics', it is important to balance the benefit of grouping together a larger range of services with the disadvantage of reduced accessibility in terms of greater travel distance.

Hannah Miller: ***Director of Adult Social Services, London Borough of Croydon***

Sadly, the preparation of the Darzi report lacked serious engagement with social care professionals. Further, a key weakness in the proposals was the lack of predictive modelling to gauge likely additional burdens on social care. It was essential that joint research was commissioned to scope the demand for social care and associated costs.

There are a number of issues around home care and its potential impact on social care which need to be considered, including changing people's expectations about how they receive quality care. Also, caution needs to be exercised about potential cost savings, since a properly resourced multi-agency team will be required to provide 'home' support.

Various aspects of the 'polyclinic' model (such as co-location of health and local authority services and the development of genuine 'healthy living centres') appears attractive. However, based on experience in Croydon, 'polyclinics' might not be so popular with the public, which often placed considerable importance on personalised and truly local services that a 'polyclinic' serving a large population (e.g. 50,000) could struggle to provide.

Whilst Darzi addresses world-class practice for stroke treatment, a similar approach is needed for conditions such as respiratory problems, and diabetes. Similarly high standards in terms of discharge, support and rehabilitation should be aimed for.

The lack of capital costings in Darzi's report is a flaw, and greater clarity over funding issues generally is required since the potential existed for greater care costs to fall upon Local Authorities. The present differential approach to charging for health and social care is unlikely to be finally resolved by the forthcoming Green Paper.

If funding released from acute hospital care is streamed to social care and community health, specific longer-term funding for social care ought not to be required. However, in the short-term, Government specific-grant funding will

be essential if Local Authorities are to develop the levels of care needed to support the models of healthcare proposed in Darzi's report.

Moving care out of hospitals through the prevention of admissions and/or early discharge is likely to increase the pressure on social care services, as could high-throughput, early discharge elective centres.

Local Authorities have a role to play jointly with the NHS in assisting individuals and their families to take care of themselves; again, however, adequate funding (e.g. for individualised budgets) will be a consideration. They also have a potentially significant role (working with the NHS, the 'Third Sector' and business) to promote a 'preventative' approach, as part of a move away from the NHS being primarily a 'sickness service'.

Questions to Hannah Miller

In the ensuing 'Question and Answer' session, the following main points were made:

- Without predictive financial modelling of social care costs, it is impossible properly to take into consideration the cost implications of increased early discharge in an overall cost assessment of Darzi's proposals.

- Good management covering joint working arrangements between health and social care staff – as well as proper funding mechanisms – is important. Pilot projects to explore joint health/social care working (e.g. in delivering intermediate care) can play a valuable role.

- A move towards fewer and larger PCT areas (favoured by some within the NHS) is likely to have a detrimental impact on achieving better healthcare in various respects; existing coterminous Local Authority/PCT boundaries represented a significant advantage (e.g. in achieving effective local commissioning).

- If there was to be increased early discharge, sufficient consideration needs to be given to additional social care support to the individuals concerned. Government monitoring of early discharge has to continue. Adequate funding to meet the needs of all individuals/families must be provided; joint local protocols can serve a useful purpose.

- LB Croydon is an example of a Local Authority that is developing many of the elements of an integrated health/social care model of provision (e.g. jointly managed intermediate care service). There is a good strategic agreement; joint badging; and multi-agency partnerships groups through which all matters are channelled. However, there

remains a need for greater investment. Darzi's agenda is likely to provide further impetus to develop closer joint working.

- Differences in health (e.g. obesity) in different parts of London (the 'health inequalities' agenda) serves to underline the very local nature of population needs. Part 2 of NHS London's consultation on implementing Darzi's proposals (which is expected to make specific proposals affecting individual areas, e.g. new healthcare centres; possible hospital closures) will be a crucial exercise in seeking to achieve a balance between local circumstances and needs, and effective pan-London provision.

Key point:

- Further work is required on the financial implications of the models of care. Similarly, it is essential to undertake work to model the impact of the Darzi reforms on social care. This modelling could suggest that funding will need to be reallocated from the NHS to social care.

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22nd February 2008: LB Tower Hamlets

Witness session 1: Primary care

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

Dr Gerada began the evidence session by giving a brief introduction noting that the Royal College of GPs represents around 30,000 GPs. It is the view of the Royal College that the NHS works because of GPs, who work in small teams in community settings, often over a long period of time. GPs are successful as they are often able to form relationships with patients from the cradle to grave.

The Royal College is not in favour of the single-site 'polyclinic' model, but it is supportive of joint working through a federated model. Individual practices serve different communities and patient groups, each with their own differing needs and thus the College believes that a 'one size fits all' approach will not work.

Dr Tony Stanton: ***Joint Chief Executive, London-wide Local Medical Committees (LMCs)***

Dr Stanton began by offering a brief explanation as to the role of London-Wide LMCs. Each Primary Care Trust area in London nominates a body of GPs which serve on a local medical committee. Each local committee is banded together centrally under the umbrella of London-wide LMCs.

Dr Stanton shared Dr Gerada's observation that general practice is most people's main point of contact with the NHS. Only 10% of patients end up in a secondary care setting. The elderly, chronically sick and parents with young children are the most frequent users. GPs are generalists, tasked with managing demand and keeping people out of hospital.

In relation to Healthcare for London (HfL), Dr Stanton noted that changes to acute services as proposed by Lord Darzi are based on clinical evidence. There was concern that changes to the provision of primary care appear to have little evidence base from within the primary care arena; rather the changes could perhaps be seen as a clinician's preferred view of primary care.

Dr Stanton welcomed many of the proposals in HfL, although he also had concerns about the single-site 'polyclinic' model that has dominated local consultation discussions. Based on the original assumptions in the HfL report, a polyclinic would be based on a single site and each polyclinic would serve around 50,000 patients with the average Borough therefore having five polyclinics. Currently, GP practices are often regarded as the heart of local

communities and Dr Stanton would not want to see the loss of buildings and services in the heart of communities.

Questions to Dr Claire Gerada and Dr Tony Stanton

In the ensuing 'Question and Answer' session, the following main points were made:

- There appears to be a very strong clinical evidence base for changes to the delivery of acute care across London. However, the evidence appears to be less strong for the introduction of 'polyclinics' – and there would appear to be no adverse effect on patient safety should they not go ahead.

- GPs are not opposed to change but are pushing for the highest possible standards, with a view to stronger relationships with boroughs and more visible support of continuity of care.

- In relation to strengthening primary care, the Royal College of GPs is pushing for practice accreditation, which would set out standards on access and quality of care and would require practices to meet minimum standards. An investment in good buildings, midwives, community nurses and more health visitors to support primary care is greatly needed as they are currently undervalued services.

- The profession recognises that access to GPs, particularly for working people, is a problem for the general population. Services should be tailored to the needs of the particular population.

- There appears to be support for a federated or 'hub and spoke' polyclinic model, which would allow highly skilled teams to work together to deliver the best service to local populations. This could help to increase accessibility and the range of services available. A 'one-size fits all' polyclinic model should not be introduced wholesale across London, but only where this would secure the best outcomes for local people.

- Care is needed to avoid polyclinics merely re-inventing local district general hospitals. Rather than installing new diagnostic equipment in polyclinics, it may be more cost-effective to use this money to improve access to hospital-based equipment (e.g. longer operating hours).

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

- There is evidence in London of care successfully being delivered across Borough boundaries, for example the existing specialist hospitals.

- Consideration also needs to be given to dentistry and how this could fit in with the delivery of primary care in London.

Key points:

- GPs play a central role in the NHS and account for many people's main or sole contact with the NHS.

- Polyclinics are not a 'one-size fits all' model. GP practices serve communities with differing needs and problems. They are accessible and are often based at the heart of their community. Some areas and local populations may benefit from new large polyclinics with extended hours , whereas others may prefer to keep a system that ensures a personalised GP/patient link. Polyclinics should only be introduced where there is local need and where this would result in the best outcomes for local people.

- The federated polyclinic model may offer greater flexibility, allowing for a range of services and specialisms to be provided across a number of sites, with extended opening to reflect local need.

- A practice accreditation scheme could strengthen primary care and overcome concern about differences in quality of care.

- Polyclinics must not be 'mini-hospitals'. The financial effectiveness of polyclinics needs careful examination. For example, X-ray equipment is costly to provide, and it may be more economic instead to extend the opening hours for such existing, hospital-based diagnostic services.

- There is a fine balance between specialism and general practice in primary care. GPs need to maintain their wide-ranging skill base. Moves to expand the number of GPs with special interests (so called 'GPSIs) must not dilute the strengths of general practice.

Witness session 2: Maternity services

Louise Silverton: ***Deputy General Secretary, Royal College of Midwives***

Ms. Silverton noted that HfL builds on the key issues as set out in *'Maternity Matters'*, namely birthing choice, one-to-one care and choice in post-natal care. Ms Silverton's presentation then focused on providing contextual

statistical information on maternity services and birthing rates and on the challenges facing midwives in London.

In 2006 nearly 20% of all births were to women in London. London has the fastest rising birth rate in England and the number of women in London of childbearing age (15-44 years) is projected to increase by 11% by 2016, although these increases fluctuate across the capital.

Midwives care for a woman during birth and sustain her beyond giving birth for a period of time. All women need a midwife, some need a doctor too. The number of visits a woman receives after going home varies across London. This is linked to the number of midwives per thousand of the population.

The Royal College of Midwives faces many challenges, most of which are generic, although some are more acute in London. Ms Silverton said the maternity sector is being starved of resources with the current spend level reduced by 2% (equating to £55m).

Most maternity units in London do not have enough midwives to provide the level of one-to-one care that the Government has pledged to provide for women by 2009. *Birthrate Plus* recommends a ratio of 1 midwife for every 28 deliveries for hospital births. This equates to approximately 36 midwives for every 1000 deliveries. Currently Whittington and Guy's & St Thomas' are the only hospitals to exceed the recommendation.

London has the highest midwifery vacancy rates in England. The average vacancy rate in 2006/7 was 8.5%. Some hospitals have put a freeze on recruitment to address to some extent their deficits. During 2006/7 maternity services were suspended on 51 occasions, four times being related to medical/midwifery staffing. 18% of Midwives are working beyond the age of 55. 17.5% are in the position to retire now, 30% in 5 years and 53% in 10 years.

London also has Caesarean rates above the national average, and home birth rates below the national average. There are a rising number of complex births amongst women from overseas.

<u>Questions to Louise Silverton</u>

In the ensuing 'Question and Answer' session, the following main points were made:

- Every woman should have a choice about where to give birth. Some women with complications or social needs will need to access obstetric support. However, most women do not need medical intervention. Midwife-led services or home births might be the best option for them.

- Free-standing birth centres without obstetrics need to be properly staffed and require clear protocols for transferring patients.

- More midwives need to be based within the communities that they serve, with information clearly available as to where a person can find their local midwife. Post-natal care could effectively be delivered in local settings. This would have a particular impact in deprived communities where maternity services may be least accessible.

- The future health of a child is determined in the foetus. With sufficient resource, midwives could play a major role in offering preventative care and healthy living advice to expectant mothers.

- The theory that all mothers should receive care from the same team from early pregnancy until after the birth, and one-to-one midwifery care during established labour, is a good one. But there are not the midwifery resources in London for this to be the reality for all expectant mothers.

- In order to give women choice, PCTs will have to consider the way that they commission maternity and newborn care, which is currently hospital-focused. The Royal College of Midwives will be looking for commissioners to take a lead in commissioning the right type of care.

- If choice is to be properly funded, care should be paid for where a woman receives it. Host PCTs currently commission (and funding is allocated) based on the number of *births* it expects in a given year.

- Cultural considerations have a huge influence in maternity care, and it is important that midwives are culturally sensitive.

- In areas identified for significant future population growth (e.g. the Thames Gateway) it is important that dialogue occurs between local authorities and local PCTs on the projected plans for these areas.

Key points:

- Services need to respect the importance of cultural background in the impact it can have on women's preferences for maternity care.

- Midwifery faces many challenges in relation to the workforce, for example the large proportion of older midwives who will retire soon. But midwifery has seen a reduction in its share of the NHS budget despite its ageing workforce and the challenges it faces in London from the fastest rising birth rate in England.

- Every woman should have a choice about where to give birth.

- The commissioning of maternity services needs to move away from the current focus on hospital-based services .Some women with complications or social needs will need to access obstetric support, but most women do not need medical intervention. Midwife-led services, either in hospital or stand-alone units, or home births are possible for women with no complications.

- Midwives need to be accessible, based in local communities and be able to draw on professional translation services so they do not have to rely on interpretation by other family members.

Witness session 3: Paediatric care and child health

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

Dr Lenton noted that there are a number of factors signalling that reform of paediatric and child health services was needed, including the findings of UNICEF on children's health in the UK, rife inequalities in services and the view of the Healthcare Commission that acute services are poor. It is important that this reform is undertaken in the right way to allow the right decision to be taken at the right time with the right outcomes. Children are not mini-adults and have different needs and requirements.

The basic premise of the report that poor health with appropriate health care leads to better health was welcomed, but this needed to be broken down into the following steps: prevention – identification – assessment – short-term interventions – long-term support – palliation. Parents need to know where they can go to access the right level of care.

In current service configurations for inpatient and acute children's services, there are insufficient numbers of children passing through to retain the expertise of clinicians. Consideration needs to be given to the services that need to be co-located with specialist centres to deliver the best outcomes for children. Clinical services needed to be delivered by teams working in integrated networks, with a focus on collaboration not competition.

There are not currently enough trained staff to deliver children's health services across the primary sector. Only 40% of GPs are specifically trained in paediatrics, and the Royal College would want to see more GPs competent in dealing with childhood diseases.

There is a need to take a holistic view of children's needs, from treatment itself to the environment this takes place in, and the needs of the child's family; yet this does not always sit easily with a market-orientated approach to

the provision of care. Paediatricians would prefer to treat children in environments which they are exposed to during their daily lives. This could include children's centres and extended schools.

The HfL report seems to consider paediatrics and child health as an after thought and takes a piecemeal approach, which gives little focus to mental health services, disabled or disadvantaged children. There needs to be a clear vision so that decisions taken along the way can be aligned with that vision. The Royal College would want to see world-class commissioning, regulation and improvement and national innovation centres (which seem to have been lost from the original report).

Questions to Dr Simon Lenton

In the ensuing 'Question and Answer' session, the following main points were made:

- There had not been much dialogue with the Royal College of Paediatrics and Child Health before the HfL report was produced, though it is hoped that a meeting will take place in the near future.

- There are no simple solutions, and it would not be appropriate to introduce a single model across the board. A set of core values had been presented that the Royal College would like to see delivered.

- There are different ways of delivering treatment and these need to be assessed on an individual basis. Broadly speaking, there is a need to move away from traditional settings when caring for children and integrate services into their day-to-day lives, by providing care in homes and schools. In some cases families would have to travel for specialist treatment at centres of excellence.

- There is a need for more paediatric nurses.

- Local Authorities could consider a range of interventions, from looking at local targets and working more closely with the PCT, to reducing speed limits in residential areas to cut down on the numbers of children injured in road traffic accidents.

- In relation to increasing immunisation of children, it is noted that there are specific issues in the capital due to the transient nature of the population. There is a definite need to upgrade computer systems in some boroughs to be able to keep an accurate track of children's records. Much work is also needed to educate parents around the benefits of immunisation. It is also important to ensure that health professionals provide consistent messages, particularly around MMR.

Key points:

- Children's health is determined by a wide range of social, economic and environmental factors.
- It is vital to reform services and not simply the location where they are provided. Co-locating on a single site (e.g. a polyclinic) may help improved coordination but this will also require services to share more information and change the way they work.
- Moving children's services away from traditional settings and integrating them into children's day-to-day lives may also help. This could include children's centres and extended schools.
- In a minority of cases, specialist treatment at centres of excellence could lead to improved care.
- The HfL report seems to consider paediatrics and child health as an afterthought and takes a piecemeal approach, which gives little focus to mental health services, disabled or disadvantaged children. Further consideration needs to be given to these aspects.

Witness session 4: Surgery

Mr David Jones: ***Council Member, Royal College of Surgeons***

Mr Jones explained that Royal College of Surgeons (RCS) exists to enable surgeons to achieve and maintain the highest standards of surgical practice and patient care. In practice this meant training the surgeons of the future and handing on skills from one generation to the next. He noted that his comments related to surgery generally and that individual specialities would have their own ways of working.

The College's Patient Liaison Group (PLG) are a part of the College Council and exists to keep the College's 'feet on the ground'. The PLG lobbies for continuity of care and named doctors throughout a patient's care.

Surgery is best provided through integrated networks of teams which can decide on the provision of general and specialised surgery within that network. Specialised care would ideally be provided in a specialised centre. Routine surgery could be provided closer to home where this is safe and possible. There are already good examples of such networks within trauma and paediatric surgery.

In relation to trauma care, it is reasonable to identify a small number of specialised centres. But this is important only for the minority of patients who are seriously injured; minor injuries and fractures could be treated locally. The Royal College of Surgeons welcomes the recommendation for three such trauma centres in London.

Surgeons need a level of throughput to achieve and maintain their skill levels. Within networks, surgeons have particular skills and the best outcome for the patient may be achieved by referring a patient to a particular doctor outside of their own local area.

Questions to Mr David Jones

In the ensuing 'Question and Answer' session, the following main points were made:

- Surgery is a craft and practice is essential, particularly for newly-qualified surgeons. The European Working Time Directive reduced surgeons' hours. Thus it is not always possible able to gain sufficient levels of skill through practice and young surgeons are trained to a level of competence rather than excellence. The training of young doctors is in crisis, with a large number of young people competing for a small number of places. There were no guidelines at present as to the revalidation of senior professionals.

- The London Ambulance Service are already good at taking patients to the place where they will receive the most appropriate care. They are used to contending with traffic congestion in the capital as part of their decision-making processes when referring cases to hospitals. Consideration will need to be given to the transfer of non-emergencies between sites.

- In terms of funding, quality and safety – rather than activity – should be rewarded. Surgeons are used to high-volume surgery, but resources needed to be put in place to allow surgeons to deal with issues such as nurse shortages, infections and the 'target' culture.

- It was suggested that London-wide networks of surgeons could ensure that patients are sent to the right place to receive surgery.

- Further detail needed to be added to the Darzi report, and this would need to be discussed locally.

- Equity of care, irrespective of which part of London someone lives in, needed to be achieved.

Key points:

- Surgery is a craft that needs practice.
- It is best provided through integrated networks of teams which can decide on the provision of general and specialised surgery within that network. Specialised care should ideally be provided in a specialised centre. Routine surgery can be provided closer to home where this is safe and possible.
- Within networks, surgeons have particular skills and the best outcome for the patient may be achieved by referring a patient to a particular doctor outside of their own local area.
- Centralisation of services may lead to improved outcomes in certain procedures by ensuring that surgeons have sufficient opportunity to refine and maintain their skills.
- Any centralisation will impact on the London Ambulance Service who will need to be able to make the decision to take a patient with acute needs to a more distant specialist hospital and support the patient during this journey.
- It is reasonable to identify a small number of specialised centres for severe trauma.

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14th March: LB Ealing

Witness session 1: Further evidence on secondary and specialist care

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

Professor Gilmore opened by stating that the Royal College of Physicians (RCP) is an organisation supporting physicians throughout their career by championing the values of the medical profession, developing standards of patient care, education and training for junior doctors and by helping consultants keep up to date with developments in their field. He said that physicians are usually closely involved in cases involving surgery as well as the surgeons themselves. The RCP has produced research looking at acute services and at integrating staff from primary and acute care.

A key driver for quality and improvement is clinical leadership. If clinicians take a leadership role and are set meaningful development targets, service improvements will follow. Clinicians acknowledge the positive influence they can have over service changes e.g. where GPs talk to hospital doctors about best service for patients. Service improvements do not work well when driven by managerial/budget pressures alone.

It is important for healthcare reforms to avoid a 'one size fits all' approach. Success will depend upon different solutions for different areas and circumstances.

Acute Care
RCP recognise merits in less routine surgery gravitating toward larger, more centralised hospitals. The vast majority of patients will continue to be treated by physicians, not surgeons. There is a difference between A&E and Surgery (trauma), and non-elective surgery can be located in specialist centres.

Local hospitals have a place within the community and in dealing locally with emergency care. These must be supported by intensive care facilities which are distinct from acute care. Local hospitals must be able to treat and stabilise patients and refer them elsewhere when more specialised care is needed.

RCP referred to evidence that showed a patient experiences better outcomes when seeing a trained specialist earlier in the duration of their care.

Integrating Primary and Acute Care Staff - Teams without walls
Clear potential for patient benefit exists from the integration of primary and acute care staff, enabling improved treatment nearer to a patient's home.

Making a success of such integration rests on developing effective reforms for unplanned care, supported through centralised trauma provision but with

localised ‘core hours’ emergency care and on delivering integrated care including social care in community-based settings appropriate for the patient. Getting treatment for the patient right early in their treatment is usually more cost effective.

Questions to the Royal College of Physicians

In the ensuing 'Question and Answer' session, the following main points were made:

- ‘Buy in’ from primary care is essential; physicians see few challenges with working in the community if this is evidenced as best for the patient, cost-effective and specialist care is provided when needed. The RCP is sceptical about training GPs as specialists.

- It is essential to have an effective interface with social care for successful integration of 'teams without walls'.

- The vision for polyclinics means they will not be relevant for acute medically ill in-patients.

- It is essential to keep targets relevant and not static, and they need clinical buy-in.

- Proposals to move services from central towards local provision will need to maintain a critical mass of patients to maintain expertise. If not supported by an agreed and managed process, patient care may suffer through diluted expertise.

- There can be tension sometimes between clinicians and management about service changes, but this can be overcome by improving working relationships and encouraging clinicians to take up management positions.

- Considering how the facility is developed (whether via a polyclinic or health centre model) means looking at the clinical structure and what is needed in a particular area.

- Specialist acute expertise and intensive care services are needed with good diagnosis to stabilise patients so they are ready for specialist care wherever it is located.

Key points:

- Surgery is only a small part of hospital activity: centralisation of specialist surgery does not necessarily require the centralisation of non-surgical activity. A&E and surgery are different and can be located at different sites.

- Centralisation of specialist care will only work if specialist trusts are able to discharge patients to local hospitals once the initial treatment is provided. A lack of beds at local hospitals (and the staff to support them) will lead to 'bed blocking' and undermine the care pathway.

- Providing care closer to home can improve the patient experience by reducing travel times. However, there may be instances where asking patients to travel further will improve care.

- Local hospitals may be able to provide specialist care at peak times, with patients travelling to specialist times at evenings and weekends when travel times are less.

- Moving patients between different care settings will also lead to greater transport needs.

- Full operation of 'teams without walls' will require integration of primary and secondary care including social care.

Witness session 2: Access and accessibility: transport implications of Healthcare for London

Michéle Dix: ***Managing Director (Planning), Transport for London***

TfL is the main provider of transport services in London and plays a key role in ensuring appropriate access to healthcare services. Where and how health services are provided impact on London's travel patterns.

TfL is responsible for ensuring safe accessible public transport, working with Boroughs to deliver door-to-door transport by public transport or other means and providing services such as Dial a Ride, Taxi Card and Capital Call.

TfL and Boroughs fund Taxi Card, and its most significant use is for NHS appointments. Given this, TfL believe the NHS should consider shared funding for this service.

TfL argue that transport consequences need to be considered during the planning and scoping stage of every health infrastructure decision. Ms Dix highlighted the closure of Chase Farm A&E as an example where TfL should have been consulted earlier to ensure the impact on the highway network, bus services, patient access and active travel were considered in addition to London Ambulance Service (LAS) mapping. Any decisions by health trusts to place health facilities away from transport hubs can pose big problems for patients and also be very costly to TfL.

Analysis shows health-related journeys represent less than 5% of the total trips made in London. Of these 51% are by car, 19% by walking, 14% by bus and 10% by tube/rail. There are currently 1600 GP practices in London, and the average travel time to the nearest GP is 8 minutes. At present more than 80% of people access their GP by walking. Changes to the location of healthcare facilities can therefore also affect people's health of people if there is resulting a shift in emphasis away from walking. TfL believe work on developing active travel will assist in the development of Darzi's vision that 'prevention is better than cure'.

TfL and Boroughs have no powers to request that more detailed impact assessments are carried out. TfL, NHS London, Boroughs and PCTs should work together to develop criteria for optimising access to polyclinics, hospitals and other large facilities.

Ms Dix gave two examples of the ways the proposals could impact on transport:

- travel to 33 London hospitals could reduce if 40% of out patient activity is moved to the predicted 150 polyclinics
- in contrast, if 70% of GP services – there are currently 1600 GPs in London – moved to the predicted 150 polyclinics this could increase the travel needs of London.

TfL are developing a new health facilities travel model with NHS London to allow different health service configurations to be tested for their transport impacts. This will provide more information about the accessibility implications of changing health services and help TfL plan the bus network to cope with the expected additional trips and population groups affected.

TfL believe feel the Darzi proposals must:

- reduce the need to travel, especially by car
- help to influence a shift towards more sustainable modes of transport for able-bodied patients
- encourage access to services on foot or cycle through the design of healthcare sites
- reduce inequalities in access to healthcare.

TfL support the principle of enhancing patient choice in NHS services but want NHS London to consider as an integral part of the decision-making process how people will access health services. Providing more centralised specialist services could lead to more patients travelling longer, presumably by car thus impacting on highways.

Questions to Transport for London

In the ensuing 'Question and Answer' session, the following main points were made:

- Engagement with TfL has been more reactive than proactive, and TfL want to be involved earlier. TfL are developing a travel model to inform decisions about locations of sites. If it appears costs will be borne by TfL and the Boroughs, this should be identified and NHS London lobbied to meet those costs.

- Without detailed proposals it is hard to say how Darzi's proposals will impact on Londoners' travel needs.

- TfL's role is to look at the accessibility of the proposed polyclinics and try to influence their location.

Key points:

- Proposals should encourage access to healthcare facilities by foot or sustainable public transport options.

- All health changes must be required to have travel plans beyond the current NHS transport assessment.

- The past lack of TfL involvement at an early enough stage to influence planning is improving. The NHS must enforce Trusts involve TfL and local authorities to avoid the risk of shunting transport and infrastructure costs to these partners.

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

Jason Killens highlighted that the London Ambulance Service (LAS) is the only pan-London NHS trust, providing services to approximately one million emergency requests for assistance per year. Their principal service focus is accident and emergency, although they also provide non-emergency services via contracts with the individual health trusts.

Demand for ambulances is managed by an operator telephony system supported by a diagnostic assessment system which determines the type of service dispatched to an incident.

Major trauma represents approximately 10% of cases. LAS do not oppose proposals to have major trauma centres. If these go ahead, London's helicopter emergency medical service (HEM) will need to be reviewed as it is currently based in only one location.

Jason Killens stated that the LAS support the Darzi principles. Implementation of specific proposals needs to consider availability and extended journey times for ambulances to ensure changes in care services do not reduce ambulance availability levels. National standards (as delivered by LAS) should be protected.

Historically, LAS staff have usually taken patients to the nearest hospital. Now LAS staff can decide which hospital the patient goes to based upon their need assessment. The importance of those decisions to saving lives is likely to increase under Darzi. LAS believe there is strong evidence to support specialist centres for stoke treatment.

Mapping and understanding of patient flows must take place but can only happen when specific proposals are developed. A comparable assessment of training and development requirements for staff is also required to ensure LAS can meet care expectations.

Questions to London Ambulance Service

In the ensuing 'Question and Answer' session, the following main points were made:

- Assessments of ambulance cover needs will depend on the envisaged service level required. LAS can then identify the extent of up-skilling staff may require. If the training required is significant, it could mean a 12-24 month dedicated programme for LAS staff which would need to be funded.

- LAS have no definitive figures in relation to projected ambulance response times and London's traffic, but it was noted speed humps and traffic calming measures present problems to LAS as they slow vehicles down with an adverse impact on response times.

- Some LAS staff have become more skilled, carry more equipment and can therefore diagnose more conditions in the field than previously. The potential exists for further improvement in the service but depends upon design and good practice.

- If primary healthcare resources were sufficient to receive patients for rehabilitation, over half the patients LAS presently taken to A&E could be redirected.

Key points

- The NHS must ensure that any additional costs for LAS arising from re-modelling of care pathways or additional transport burden is properly funded so that national standards continue to be applied. Mapping the full consequences for LAS can only be done after detailed proposals are made. NHS London must ensure resources are available for modelling ambulance requirements.

- Centralisation of major trauma services will require the NHS to examine funding for LAS.

- Training and re-skilling may be required for LAS staff as a result of any proposals emerging from HfL. Such training could be costly and require a significant period of time. This time lag must be built into the planning of new care services.

Witness session 3: Further evidence on the proposals including mental health

Bernell Bussue and Tom Sandford: *Directors, Royal College of Nursing*

Bernell Busse opened by highlighting that the Royal College of Nursing (RCN) have approximately 50,000 members in London and the largest Black and Minority Ethnic (BME) membership for a professional organisation. RCN believe NHS London have made good efforts to engage the public and professionals in the development of the HfL proposals but feel that engagement in the consultation has not been as high as expected.

RCN believe HfL proposals do not adequately capture all the areas of healthcare need. More attention needs to be given to areas such as learning difficulties or long term conditions.

Access

NHS London should seek to improve hospital services and avoid creating polyclinics as mini-hospitals. HfL seems to entail a vision of health services for the able sick as opposed to the sick/sick. Health inequalities could widen if access for people already able to access health services were to improve but not for people who experience difficulties in doing so.

Workforce

Realising the HfL vision requires a shift in how the workforce is organised. RCN estimate 30% of staff may need to move from acute to primary care setting. This will present major challenges. Many nurses feel ill equipped to move into the community without re-training and a clear communications plan and rationale.

RCN support an NHS London review of workforce planning capability and capacity. Overview and Scrutiny needs to engage with TfL and local authorities with transport changes at the forefront.

Tom Sandford opened by highlighting that the physical health of mental health patients is very poor. Life expectancy is 10 years less for a person with mental health conditions and high levels of mental health are associated with poverty, housing issues and drugs.

Access to mental health support and specific services are still not adequate, though improving. Whilst PCTs have made recent improvements and spend approximately 12% of their budget on mental health services more assessment is needed for mental health, including the development of shared protocols for GPs.

Black and Minority Ethnic groups (BME) are less likely to use mental health services, with an estimated 60% of BME patients accessing mental health care through the police – suggesting access to mental health services is not adequate.

Polyclinics could be a means of de-stigmatising mental health. They should be designed to accommodate mental health needs, providing services that meet the range of mental health needs and include appropriate identification and fast-track referral. It is equally imperative for distress and disturbances to be avoided for other polyclinic users.

It was noted the provisions for appropriately accessible mental health services are decreasing with a number of facilities having been closed or closing. HfL needs to establish a means of effective provision for mental health.

It had been suggested that some mental health bed closures (resulting in further reduction of accessible facilities) were linked to trusts applying for foundation trust status.

RCN queried how appropriate and timely access to psychiatrists will be guaranteed and fit with the two models HfL envisages – community and more specialised care.

Early mental health intervention saves costs elsewhere e.g. Children and Young People Mental Health, and Child and Adolescent Mental Health Services (CAMHS). Early interventions may save large costs arising later when such children become young people not in education, employment or training.

<u>Questions to the RCN</u>

In the ensuing 'Question and Answer' session, the following main points were made:

- Mental health services are not always attractive to patients and need to be culturally sensitive. Specific challenges exist with young males and high suicide rates.

- It is believed there are not enough nurses in London to move to care being fully delivered in the community setting, even more so for care in specialist areas.

- At present there is a poor understanding of how to access services. A disproportionately high number of patients access services for the first time when coming into contact with the police rather than the preferred route via health professionals.

- Given the issues of social isolation and poverty it can often be difficult to ensure that patients access mental health services unless they are an in-patient. Early treatment can prevent escalation of less pronounced conditions. The Darzi proposals did not focus on this issue, nor the physical health of mentally ill patients.

- Although A&E services have changed they have not changed sufficiently to accommodate a mentally-ill patient in distress.

- Caution was expressed about adopting a 'big bang' approach to HfL reforms which need to be seen as a 10-year framework. There will be benefits from establishing a number of trials.

- The Darzi proposals should be helpful for diagnostics and could create new opportunities for nurses. It is well established that the intervention of qualified nurses improves mortality rates.

Key points:

- Funding should be focused upon the most deprived areas.

- The Darzi proposals will mean significant reorganisation and relocation of nursing staff with up to 30% of staff moving from acute to primary care.

- There are concerns about the closure and uncertain status of some mental health facilities in London. HfL pays insignificant attention to mental health needs. The NHS needs to establish appropriate and integrated provision for mental health patients.

- Access for those requiring mental health services is inadequate. Over 60% of people from BME communities accessing mental health services do so through the police.

- Polyclinics must provide suitable facilities for mental health patients e.g. suitable waiting and treatment areas for people who may be suffering from severe dementia or drug/alcohol problems.

Witness session 4: Equalities and public health

Dr Bobbie Jacobson: ***Director, London Health Observatory (LHO)***
Dr Sandra Husbands: ***Specialist Registrar, LHO***

The LHO was set up by NHS London to monitor health and healthcare in London from a public health perspective. Prevention, improving general health levels and the impact on health inequalities are key concerns. Assessments of any healthcare proposals need to consider the whole population evidence base.

As a starting point to understanding the possible impact of the Darzi proposals, LHO analysed the proposed stroke care pathway in terms of two main principles in the HfL framework:

- prevention is better than cure
- there must be a focus on reducing differences in health and healthcare across London.

Whilst LHO welcome the proposed care pathway for stroke, LHO believe greater focus is needed 'upstream' i.e. on more and better preventative work. Research suggests, that reducing population risk factors such as smoking is effective and achieves value for money. The Darzi proposals will only affect patient health once a stroke has occurred.

LHO identified five stages relevant to the stroke pathway, of which three occur before HfL kicks in and where improved prevention methods could help reduce the number of strokes:

- Healthy community – population prevention through health education and lifestyle modifications.
- Management of risk factors in individuals – high blood pressure affects 1.7 million people in London with approximately 63% of cases untreated.
- Rapid Access Transient Ischaemic Attack (TIA) management - there are approximately 1000 per year in London.
- New Stroke Centres (*Darzi proposals commence*) - acute stroke management including CT scans and thrombolysis.
- Return to independent living / long term disability – Rehabilitation hospital and community.

Missed opportunities for preventing strokes include untreated high blood pressure, which is a major risk factor. Less than 20% of the affected population receive adequate treatment.

LHO advised each stroke costs the NHS an average of £15,000 over 5 years. The average cost of the community care involved is £1,700 p.a. The costs to patients, their families and carers come to £7,000p.a.

LHO has identified a broad spectrum of factors associated with inequalities for stroke and highlighted the following examples of ethnic inequalities:

- 60% higher incidence of strokes in black people than white and also higher for Pakistani and Bangladeshi communities than the general population
- higher prevalence of high blood pressure among black people – more likely to be diagnosed, but less likely to be adequately treated
- TIA more important risk factor for white people than for other groups.

LHO believe health services need to think about how they can make their services more culturally appropriate.

Statistics on stoke treatment at borough level show 22 PCTs have a significant issue to address. Variations in general quality of primary care need to be minimised, as well as a more even distribution of the primary care workforce.

If polyclinics are to be developed to fit local circumstances, a pan London approach to prevention and initiatives prior to the commencement of existing care pathways needs to be developed.

Questions to the London Health Observatory

In the ensuing 'Question and Answer' session, the following main points were made:

- Of those diagnosed with high blood pressure less than 20% are being treated correctly. This did not include people who have a problem but had not been diagnosed.

- Only the tip of social care need is addressed by social care services. The polyclinic model could facilitate some of the homecare needs of a patient if agreed between providers.

- The cross-over to primary care will be challenging along with delivery of full integrated care. It is likely there will be continuity of care for clinics whether care in the future is through polyclinics or another model.

Key points:

- Many of the proposals may well deliver improved outcomes, but they concentrate too far down the care pathway to be optimally effective e.g. stroke. The NHS needs to give greater focus to prevention and general health improvement.

- Innovative ways of encouraging greater public awareness of health (e.g. blood pressure tests in large supermarkets) need to be evaluated.

- London faces specific challenges as a result of its highly mobile population. This can make it difficult to ensure high rates of childhood immunisation, for example. The NHS and its partners need to address this.

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28th March 2008: LB Merton

Witness session 1: Health Inequalities Impact Assessment for 'Healthcare for London'

Gail Findlay: ***Coordinator, London Health Commission***
Dr Sandra Husbands: Specialist Registrar, ***London Health Observatory***

In their opening remarks to the JOSC, Gail Findlay and Sandra Husbands outlined the background to the London Health Commission (LHC) and its work on Healthcare for London (HfL).

The LHC is a multi-agency partnership established in 2000 to examine health in London, and includes the London Health Observatory (the organisation that gave evidence to the previous JOSC meeting).

Health Inequality Impact Assessments (HIIAs) seek to ensure that policies and strategies do not increase health inequalities, and are applied to major policies and plans across the Greater London Authority (GLA) Group (e.g. the Mayor's transport strategy).

Given the short timescale for undertaking the HIIA for HfL, the LHC focused on aspects that could have the biggest impact on health inequalities: primary care, maternity care, and the proposed new stroke pathway.

Gail Findlay and Sandra Husbands said that HfL is an ambitious project and presents an exciting opportunity for change. On the whole, the proposals in HfL are likely to improve health outcomes in London and reduce inequalities. However, much will depend on how HfL is implemented. They added that the care pathways must be implemented in full otherwise inequalities could worsen e.g. if patients are discharged into the community after a shorter hospital stay without the necessary additional investment in community services to support rehabilitation. There is currently a shortage of primary care staff in certain parts of London and HfL also provides an opportunity to develop a skilled workforce that helps disadvantaged groups.

They advised that it is important to focus resources on areas/communities with the greatest unmet need: reform must recognise that there are pockets of deprivation in areas that are perceived as affluent. Priority must be given to helping disadvantaged groups overcome barriers to accessing health services. However, the witnesses highlighted that the lack of high quality data can make it hard to understand the needs of priority groups. Much better data collection and evaluation will be required if the impact of the reforms in tackling health inequalities is to be monitored.

Finally they said that it is essential to undertake future impact assessments when further detail is available on the proposals, and to also evaluate the

impact of new care pathways once these have been implemented. This information must be used to inform the roll-out of similar pathways across London.

Questions to Gail Findlay and Sandra Husbands

In the ensuing 'Question and Answer' session, the following main points were made:

- It is vital to move beyond a 'sickness service' and ensure sufficient resources are allocated to promoting healthy lifestyles and preventing hospital admission. Although prevention and tackling inequalities are two of the seven principles underpinning HfL, it was noted that the NHS has diverted resources from these services in order to address past financial problems. Resources for this work must become part of PCTs' core expenditure to avoid the need for projects having to bid for new resources every few years.

- PCTs alone cannot overcome the health inequalities in London. Central and local government will have a key role to play in relation to providing suitable housing and amenities. It was noted that the recent cross-government obesity strategy demonstrates the growing acceptance that the NHS cannot deliver public health by itself.

- Carers are already facing huge challenges, and there is a danger that the proposals could lead to them facing further disadvantage.

- It is appropriate for the NHS to seek to influence people's decisions about their lifestyle, e.g. help to stop smoking, for this can prevent illness and the need for expensive medical care.

- Whether the NHS should wait until further work is undertaken to address gaps in the proposals before implementing any reform. However, it was noted that the extent of need in some areas means that it is not possible to wait several years for new services, and that pilots could help refine the proposals. Any evaluation of pilots will require good quality data (i.e. to demonstrate the impact of the reforms). However, data collection varies across organisations and professions.

- Overview & Scrutiny Committees will have a key role in ensuring that the NHS undertakes impact assessments once further detail is available on the proposed care pathways.

Key points:

- HfL could reduce health inequalities if fully implemented. However, poor or partial implementation of the proposals could increase inequalities.

- Resources must be focused on communities with greatest need. However, further work is required to improve the collection of the data that will help identify these priorities.

- Health Inequality Impact Assessments must be undertaken once further information on the care pathways is available and after the reforms have been piloted.

- Resources for health promotion and preventing hospital admission must be part of mainstream NHS expenditure and not diverted in times of financial difficulty.

- The NHS alone cannot ensure London is healthy.

Witness session 2: End of life care

Sir Cyril Chantler: ***Chair of Great Ormond Street Hospital, Chair of the Health for London Clinical Advisory Group and the End of Life Working Group***

In his opening remarks Sir Cyril highlighted that the demands currently facing the NHS are very different to those when it was established 60 years ago. Advances in medicine mean that 80% of the NHS' workload relates to supporting people with chronic conditions whereas in the past people would survive for far less time once they became ill. In addition, people now tend to develop multiple conditions which further increases the challenge to the NHS. The NHS cannot afford to maintain the status quo: existing models of service will become unaffordable.

The poor and unemployed have more difficulties accessing health services than the population as a whole, and polyclinics could provide an opportunity to improve well-being for these groups and the wider population. This will involve extending polyclinics beyond simply health services. He added that the idea of a polyclinic is not new and similar services were previously proposed.

In relation to end of life care, he stated that the majority of people want to die at home or in a hospice. However, 70% of Londoners die in hospital, which is much higher than the rest of the country.

Sir Cyril said that the Healthcare for London End of Life Working Group found end of life care is fragmented in London. Their proposed reforms seek to ensure greater coordination. Under the proposed models, there would be five zones for commissioning end of life care for adults, while end of life care for children would be organised on a pan-London basis (due to the lower number of patients). The PCTs within these zones would produce a specification of the required services to meet the needs of their population and commission two providers for that zone. These service providers would arrange for

discussions to take place with individuals to find out their wishes for end of life care and then arrange for these services to be delivered (as far as possible). The Working Group believe it is unlikely that the service provider will directly provide all of the care and instead commission many of the required services from other organisations.

The service providers could be drawn from the NHS, or may be from the independent or voluntary sectors. Marie Curie deliver a similar service in Lincolnshire and this demonstrates the plans should roughly be cost neutral given the anticipated reduction in the number of people dying in hospital.

Questions to Sir Cyril Chantler

In the ensuing 'Question and Answer' session, the following main points were made:

- The proposals will require people to overcome the taboo of talking about death. It will also require decisions to be taken to identify when someone is approaching the end of their life. It is not always straightforward to accurately predict life expectancy, although one option would be for people to be referred to end of life services when diagnosed with terminal illnesses.

- The proposals could impact on social care services, and like other aspects of chronic disease management it would be vital to ensure that the service specification for the end of life service providers included both health and social care.

- There was concern that the five zones could undermine local authority/PCT relationships, and that this could conflict with the HfL principle of localising care. Sir Cyril highlighted that it would be for the PCTs to decide whether to work together to commission end of life care. It is proposed to group PCTs into zones because it is unlikely individual PCTs will have enough patients to commission services on their own.

- It was highlighted that these proposals (like other aspects of HfL) could again raise problems in that social care services are increasingly means-tested while health services are universal.

- Some London residents live in very poor quality accommodation and it is essential to ensure that these people are not forced to die at home. It was agreed that protections would need to be built into the system so that people who want to die at home are able to do so, while those wishing to die in hospital are able to also. In this respect, the proposals will seek to provide services that meet individual need and circumstance.

- It can be very difficult to find terminally ill patients a place in hospices, and individuals may be too poorly to be transferred by the time a space is available. Care homes may often refuse to take a very ill resident back after hospital treatment despite this being the person's home. This may be because the care homes do not feel they have the expertise to support a very sick resident or because they feel the death of a resident will affect their reputation. It was agreed that any proposals must address this situation.

Key points:

- It is essential to tailor services to individual circumstance and preference. 'One size does not fit all' and it may not be appropriate for everyone to die at home.

- Individuals and NHS services may be reluctant to talk about death but these conversations will be essential if services are to meet individual need.

- Care/nursing homes are people's homes and therefore reforms must ensure that people are able to die there if that is their wish.

Stephen Richards: *Director, Macmillan Cancer Support*

In his opening comments to the JOSC, Stephen Richards outlined the range of services provided by Macmillan. The organisation spends approximately £6 million on cancer and palliative care in London each year and employs 600 staff. Macmillan offers a range of support to people starting from when they suspect they may have cancer right through to the end of life.

Clinicians should change their approach to giving a life expectancy and should instead ask themselves whether they would be surprised if a patient dies within a set time. In addition, patients need to be given more information about their life expectancy to enable discussions on end of life care. It would not be appropriate to routinely tell people how long they have to live, but doctors should be prepared to give more information than is sometimes the case. He highlighted that bereavement is less stressful for relatives when end of life care is discussed prior to death.

Cancer can have a huge impact on a person's life, particularly their finances. Patients will have to pay for parking during frequent hospital visits and may struggle to pay bills and other living costs while unable to work. Significantly, over half the number of people who die from cancer did not claim the Disability Living Allowance and Attendance Allowance to which they were entitled. The Healthcare for London review does not outline how it will address these issues.

In relation to the proposals, Stephen Richards said that any reform must ensure appropriate out of hours care services are in place. He highlighted that when faced with severe pains or complications many cancer patients currently attend Accident & Emergency (A&E) when other health services are closed.

He said that further work is required to develop the palliative care skills of those working in general practice, and doctors may require additional training on how to offer emotional support to patients diagnosed or living with cancer. He highlighted that carers must be identified and their views incorporated into end of life plans.

Questions to Stephen Richards

In the ensuing 'Question and Answer' session, the following main points were made:

- Hospices do not receive guaranteed funding from PCTs and fund raising activities account for much of their income.

- The end of life proposals could impact on carers. It is vital to identify the needs of carers early on and ensure they have the support to cope in their role. Government policy can mean that carers receive less state financial support once they reach pensionable age. Macmillan employ support workers to help people claim benefits and this has been very effective at increasing benefit take-up.

- The proposals in HfL will require a significant transfer of nurses from hospitals to community care. It may take several years to ensure that nurses have the different skills required to work in the community. In addition, current experience highlights that it is difficult to recruit nursing staff in certain areas and roles. Nursing jobs often need to be advertised up to four times before an appointment is made.

- Disagreements between organisations as to what is 'health' and what is 'social' care can undermine the quality of care provided to individuals. Very sick people may not have time to wait for lengthy discussions to be resolved.

Key points:

- Clinicians must be encouraged and become willing to start discussions with their patients about their life expectancy when diagnosed with terminal illness.

- The proposals for end of life care will require additional community nursing staff. This will not happen overnight. However, a failure to ensure these staff are in place will increase the burden on carers.

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Appendices

Appendix 1: Witnesses attending the JOSC

Friday 30 November 2007:
London Borough of Hammersmith and Fulham

Context of the Healthcare for London Review, next steps and plans for consultation and engagement with stakeholders

- Richard Sumray: Chair, Joint Committee of PCTs (JCPCT)
- Ruth Carnall: Chief Executive, NHS London

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Friday 7 December 2007: London Borough of Camden

Background to and rationale behind 'Healthcare for London'

- Dr Martyn Wake: GP and Joint Medical Director, Sutton and Merton PCT and Chair of Healthcare for London Planned Care Working Group
- Dr Chris Streather: Medical Director, St George's Healthcare NHS Trust and Member of Healthcare for London Acute Care Working Group

An independent view of 'Healthcare for London' and the way forward for the JOSC

- Fiona Campbell: Independent consultant on health and social care policy and Board Member of the Centre for Public Scrutiny

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Friday 18 January 2008: City of London

Partnerships, infrastructure and economics

- Steve Pennant: Chief Executive, London Connects
- Niall Dickson: Chief Executive, King's Fund
- John Appleby: Chief Economist, Health Policy, King's Fund
- David Walker: Editor, Guardian *Public* Magazine

Local authorities and social care.

- Cllr Merrick Cockell: Chairman, London Councils
- Mark Brangwyn: Head of Health & Social Care
- Hannah Miller: Director of Social Services, London Borough of Croydon

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Friday 22 February 2008: London Borough of Tower Hamlets

Primary, secondary and specialist care

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

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Friday 14th March: London Borough of Ealing

Access, accessibility, equalities, public health and further evidence on primary, secondary and specialist care

- Professor Ian Gilmore: President, Royal College of Physicians
- Martin Else: Chief Executive, Royal College of Physicians
- Michele Dix: Managing Director (Planning), Transport for London
- Jason Killens: Assistant Director of Operations, London Ambulance Service
- Tom Sandford: Director, Royal College of Nursing
- Bernell Bussue: Director, Royal College of Nursing
- Dr Bobbie Jacobson: Director, London Health Observatory
- Dr Sandra Husbands: Specialist Registrar, London Health Observatory

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Friday 28th March: London Borough of Merton

Health Inequalities Impact Assessment for 'Healthcare for London'

- Gail Findlay: Coordinator, London Health Commission
- Dr Sandra Husbands – Specialist Registrar, London Health Observatory

End of life care

- Sir Cyril Chantler: Chair, Great Ormond Street Hospital, Chair of the HfL Clinical Advisory Group and End of Life Working Group
- Stephen Richards: Director, Macmillan Cancer Support

Appendix 2: List of written submissions to the JOSC

1. Submissions from London Boroughs

- LB Bexley
- LB Camden: Health Scrutiny Committee
- LB Croydon: Health & Adult Social Care Scrutiny Sub-Committee
- LB Hackney: Health in Hackney Scrutiny Commission
- LB Hammersmith and Fulham
- LB Harrow: Overview & Scrutiny Committee
- LB Havering: Health Overview & Scrutiny Committee
- LB Hillingdon: External Services Scrutiny Committee
- LB Hounslow: Adults, Health and Social Care Scrutiny Panel
- LB Islington: Overview Committee
- LB Lambeth: Health and Adult Services Scrutiny Sub Committee
- LB Lewisham: Healthier Communities Select Committee
- LB Newham
- Royal Borough of Kensington and Chelsea
- LB Sutton: Health & Well Being Scrutiny Committee
- LB Waltham Forest: Health, Adults and Older Persons Services Overview & Scrutiny Sub-Committee
- Westminster City Council
- Outer North East London Joint Health Overview & Scrutiny Committee
- London Councils

2. Submissions from key stakeholders and professional organisations requested by the JOSC

- Age Concern London
- College of Occupational Therapists
- London Travel Watch
- London Voluntary Service Council
- Mind
- Royal College of Pharmacists
- Royal College of Radiologists
- Royal Pharmaceutical Society of Great Britain

3. Submissions presented to the JOSC by Chairman and Vice-Chairmen

- Black and Minority Ethnic Forum in Kensington & Chelsea and Westminster Response
- London Forum of Pharmaceutical Committees
- London Network of Patients' Forums
- National Pensioners Convention, Greater London Region

These submissions are available in volume II of the JOSC report along with minutes of each meeting.

Appendix 3: Legal basis to the JOSC

Under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, the Secretary of State for Health issued a Direction about joint health OSCs in July 2003 relating to consultations by NHS bodies under the Health and Social Care Act 2001 where people from more than one local authority area may be affected by proposed variations or developments to NHS services. In these circumstances, all health OSCs consulted must decide whether they consider the proposals to be "substantial". Those health OSCs that do consider them to be substantial must form a joint health OSC to deal with the consultation and to respond on behalf of their communities.

With this in mind the proposals arising from the Darzi report were considered substantial changes to the NHS services in London. Therefore a joint overview and scrutiny committee (JOSC) comprising of 1 Member representative from each London Borough's health overview and scrutiny committees (OSCs) was constituted.

Upon formation of a JOSC the scrutiny powers held by each London Borough Health OSC relating to requiring information and the attendance of NHS witnesses at meetings is given to the JOSC. Individual Health OSCs may choose not to participate in the JOSC. If so, they are not prevented from considering the issues which is the subject of JOSC review, but they lose their statutory powers of calling for information and witnesses in respect of the particular topic being considered by the JOSC. They do not, however, lose the power to refer the issue to the Secretary of State. As specific practical proposals emerging from the Darzi report are not yet known, it is not clear at what level future consultations would need to be held. However, Health OSCs should be prepared for the possibility that further joint committees may be necessary – either at a pan-London (and possibly beyond) level, or at a sub regional level similar to the old SHA regions, or among a smaller regional group of Health OSCs whose boroughs are particularly affected by certain proposals.

Appendix 4: Glossary

A&E	Accident & Emergency
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
DGH	District General Hospital
FT	Foundation Trust
GLA	Greater London Authority
GPSIs	General Practitioners with Special Interests
HEMS	Helicopter Emergency Medical Service
HfL	Healthcare for London
HIIAs	Health Inequality Impact Assessments
ICT	Information Communications Technology
JCPCT	Joint Committee of Primary Care Trusts
JOSC	Joint Overview and Scrutiny Committee
LAS	London Ambulance Service
LHC	London Health Commission
LMCs	Local Medical Committees
OSCs	Overview & Scrutiny Committees
PCT	Primary Care Trusts
PLG	Patient Liaison Group
RCP	Royal College of Physicians
RCN	Royal College of Nursing
RCS	Royal College of Surgeons
SHA	Strategic Health Authority
TfL	Transport for London

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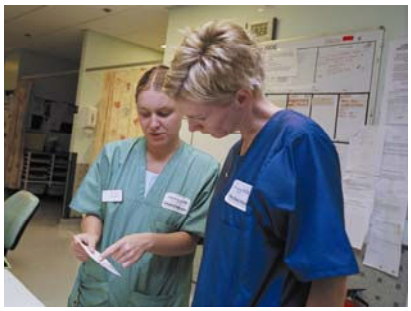
Joint Overview & Scrutiny Committee (JOSC) to review 'Healthcare for London'


Final report of the Committee

April 2008

Volume II

Written submissions & minutes of the JOSC meetings

Joint Overview & Scrutiny Committee (JOSC) to review Healthcare for London

FINAL REPORT: VOLUME II

Part A: Written submissions

Submissions from London Boroughs

1. LB Bexley
2. LB Camden: Health Scrutiny Committee
3. LB Croydon: Health & Adult Social Care Scrutiny Sub-Committee
4. LB Hackney: Health in Hackney Scrutiny Commission
5. LB Hammersmith and Fulham
6. LB Harrow: Overview & Scrutiny Committee
7. LB Havering: Health Overview & Scrutiny Committee
8. LB Hillingdon: External Services Scrutiny Committee
9. LB Hounslow: Adults, Health and Social Care Scrutiny Panel
10. LB Islington: Overview Committee
11. LB Lambeth
12. LB Lewisham: Healthier Communities Select Committee
13. LB Newham
14. Royal Borough of Kensington and Chelsea
15. LB Sutton: Health & Well Being Scrutiny Committee
16. Westminster City Council
17. Outer North East London Joint Health Overview & Scrutiny Committee
18. London Councils

Submissions from key stakeholders and professional organisations requested by the JOSC

19. Age Concern London
20. College of Occupational Therapists
21. London Travel Watch
22. London Voluntary Service Council
23. Mind
24. Royal College of Radiologists
25. Royal Pharmaceutical Society of Great Britain

Submissions presented to the JOSC by Chairman and Vice-Chairmen

26. Black and Minority Ethnic Forum in Kensington & Chelsea and Westminster
27. London Network of Patients' Forums

Part B: Formal Minutes

	Date of Meeting	Meeting venue
28.	Friday 30th November 2007	LB Hammersmith and Fulham
29.	Friday 7th December 2007	LB Camden
30.	Friday 18th January 2008	City of London
31.	Friday 22nd February 2008	LB Tower Hamlets
32.	Friday 14th March 2008	LB Ealing
33.	Friday 28th March 2008	LB Merton
34.	Friday 25th April 2008	RB Kensington & Chelsea

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