Joint Overview and Scrutiny Commission

"Healthcare for London" scrutiny

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

Submitted by London Voluntary Service Council

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1. London Voluntary Service Council

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

2. General comments

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

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

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

3. Partnership working with social care

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

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

[1] "Partnership in Public Services: an action plan for third sector involvement", Office of the Third Sector, 2006
[2] "2008/09 to 2010/11 provisional local government finance settlements – a response by London Councils", London Councils, 2008

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

This presents a problem to VCS organisations in two ways:

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

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

4. Commissioning of services from the VCS

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

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

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

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

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

4.1 Involvement of the VCS in needs assessment

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

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

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

4.2 Quality of commissioners and their work with the VCS

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

Areas that have been problematic in the past include:

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Work with Local Involvement Networks

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

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

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

6. Access to services

6.1 Information-giving, support and advocacy

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

[11] "Mayor of London's call for evidence on health inequalities", Race on the Agenda, 2007
[12] "Choice and Equity survey", King's Fund, 2007

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

6.2 Language

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

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

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

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

6.3 Transport / accessibility

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

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

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

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

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

6.4 GP registration

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

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

7. Relationship with Mayor's Health Inequalities Strategy and community development

LVSC welcomes the proposals in the "Healthcare for London" consultation document to work with the Mayor of London to address the priorities he sets

[14] Health Matters 30, 1997

[15] "Health and Homelessness in London: a review", King's Fund, 1996

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

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

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

The key findings of the project were:

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

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

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

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

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

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

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

9. Mental health

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

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

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

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

11. The politics of closures

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

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