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.