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

Final report of the Committee

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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.

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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.

<u>Questions to Ruth Carnall</u>

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.

<u>Questions to the London Health Observatory</u>

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