MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 7TH DECEMBER 2007

PRESENT:
Cllr Mrs. Marie West - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr Graham D'Amiral - London Borough of Bexley
Cllr Chris Leaman - London Borough of Brent
Cllr Carole Hubbard - London Borough of Bromley
Cllr David Abrahams - London Borough of Camden
Cllr Bass - London Borough of Croydon
Cllr Mark Reen - London Borough of Ealing
Cllr Jonathan McShane - London Borough of Hackney
Cllr Martin Newton - London Borough of Haringey
Cllr Vina Mithani - London Borough of Harrow
Cllr Mary O Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Merel Ece - London Borough of Islington (Vice Chairman)
Cllr Helen O'Malley - London Borough of Lambeth
Cllr Alan Hall - London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Megan Harris Mitchell - London Borough of Newham
Cllr Alan Burgess - London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Stuart Gordon Bullock - London Borough of Sutton
Cllr Stephanie Eaton - London Borough of Tower Hamlets
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Ian Hart - London Borough of Wandsworth
Cllr Barrie Taylor - London Borough of Westminster (Vice Chairman)
Cllr Chris Pond - Essex County Council
Cllr. Chris Pitt - Surrey County Council

ALSO PRESENT:

Officers:
Tim Pearce – L.B.Barking & Dagenham
Bathsheeba Mali – LB Barnet
Louise Peek – L.B.Bexley
Jacqueline Casson – L.B.Brent
Graham Walton – L.B.Bromley
Michael Carr – L.B. Camden
Shama Smith – L.B.Camden
Neal Hounsell – City of London Corporation
Trevor Harness – L.B. Croydon
Alain Lodge – L.B.Greenwich
Ben Vinter – L.B.Hackney
Tracey Anderson – L.B.Hackney

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Sue Perrin – L.B. Hammersmith & Fulham
Nahreen Matlib – L.B.Harrow
Guy Fiegehen – L.B.Hillingdon
David Coombs – L.B.Hillingdon
Sunita Sharma – L.B.Hounslow
Deepa Patel – L.B.Hounslow
Peter Moore – L.B.Islington
Gavin Wilson – R.B. Kensington & Chelsea
Elaine Carter – L.B. Lambeth
Barbara Jarvis – L.B.Merton
Greg Leahy – L.B. Newham
Jilly Mushington L.B. Redbridge
Jeanette Phillips – L.B.Richmond Upon Thames
Shanara Matin – L.B. Tower Hamlets
Phil Williams – L.B.Waltham Forest
Tasneem Mueen – L.B.Westminster
Phillipa Stone – L.B. Westminster
Derek Cunningham – Surrey County Council

Speakers

Dr Martin Wake – Joint Medical Director of Sutton and Merton Primary Care Trust
Dr Chris Streather – Medical Director of St Georges Healthcare NHS Trust
Dr Fiona Campbell – healthcare consultant

CHAIR'S ANNOUNCMENTS

Future meetings

All future meetings will start at 10:30 and conclude at 4:30pm, with the option of a 30 minute extension.

The Joint Overview and Scrutiny Committee (JOSC) and Officer Support Group will be available for ½ hour before each meeting to discuss the approach to questioning in advance of receiving evidence.

The Officer Support Group will circulate suggested lines of questioning in advance of each meeting.

The minutes from last week's meeting and today will be circulated with the agenda of our next full meeting.

Dates

The following timescale for meetings was proposed;

1. 18th January
2. 22nd February
3. 14th March

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4. 28th March
5. 25th April – Final meeting and consideration of the scrutiny report.

The deadline for the final scrutiny report is 2nd May 2008.

Venue for next meeting

Venues and speakers will be confirmed with the agenda pack for our next meeting.

It is proposed that the next meeting will take place at the Corporation of London (Guildhall) on 18th January 2008.

The JOSC Scrutiny Report

It is presently envisaged that the Officer Support Group will assist the committee in preparing the report. However requests may, in due course, be made for additional support, if this is required.

Submissions

All submissions proposed for consideration in the formal papers for this committee need to be submitted to the Officer Support Group no later than 2 weeks in advance of any of the declared meeting dates.

The Chairman and Vice Chairs will exercise the final decision about what papers will be included in an agenda dispatch.

Written submissions are invited from any affected local authority, local Overview and Scrutiny Committee or interested organisation. Any such documents should be submitted to the Officer Support Group no later than 29th February 2008.

Legal Advice

Legal advice has been sought from legal officers in relation to the operation of the JOSC. The London Borough of Hackney's legal representatives were at the last meeting of the committee and are happy to continue to contribute.

The Chairman summarised the key points from the witness session JOSC: 30th November 2007:

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

- The Darzi report presents an opportunity to ensure health services meet future needs of London. However there are concerns about whether the NHS will be able to implement reforms due to the financial systems in place, and the lack of incentives for NHS Trusts to reform.

In particular there is concern about the autonomy of Foundation Trusts. Note that previous attempts at reform have failed.

- It is vital to future-proof reforms to health services: i.e. the NHS must plan for future demographic changes including the population growth in the Thames Gateway.

- There are concerns and uncertainty about how the proposals could be implemented and in which order. There is a danger of a ‘salami slicing’ of services away from some district hospitals and this could lead to uncertainty in NHS 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 any of the Darzi proposals.

- This JOSC is only the start of the involvement of scrutiny councillors: the NHS must continue to informally discuss proposals for health services with local health scrutiny councillors outside of the formal scrutiny committees. This will enable local councillors to feed in views from the local community and help manage future formal consultations.

1. APOLOGIES FOR ABSENCE

Cllr Ken Ayers - City of London
Cllr Marie Pearce - London Borough of Enfield
Cllr Janet Gilman – London Borough of Greenwich
Cllr Peter Tobias - London Borough of Hammersmith and Fulham
Councillor Ted Eden - London Borough of Havering
Cllr Christopher Buckmaster - London Borough of Kensington and Chelsea
Cllr Ken Smith - London Borough of Kingston upon Thames
Cllr Micheal Seaton - London Borough of Southwark
Cllr Gideon Bull – London Borough of Haringey

2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard - London Borough of Bromley, declared that she is an employee of Bromley PCT

Cllr Vina Mithani - London Borough of Harrow, declared that she is employed by the Health Protection Agency

3. PRESENTATION: ‘HEALTHCARE FOR LONDON’: A FRAMEWORK FOR ACTION

Dr Martin Wake – Joint Medical Director of Sutton and Merton Primary Care Trust and Chairman of the “Planned Care” Pathway Clinical Working Group in the Darzi Report Review Team and Dr Chris Streather – Medical Director of St Georges Healthcare NHS Trust and member of the “Acute Care” Pathway Clinical Working Group in the Darzi Report Review Team, addressed the

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committee to give a presentation and answer questions on the background and rationale behind the Darzi review, including how and why the proposed models of care and delivery were developed.

Dr Streather explained that the Darzi report went back to the experience of patients and considered the quality of care, unlike previous health reviews that have focused more upon health institutions. A great deal of diagnostic work has been carried out, as well as the research agency MORI providing consultation information, asking patients what they perceive as problems in the health service and health inequalities.

The acute care pathway is very complicated for patients. 70% of calls that go to NHS Direct have to be redirected. A lot of people therefore choose Accident and Emergency as the simplest option. One of the Lord Darzi's objectives is to make patients' choice simpler and easier to discern. There is a need to provide accessible community care in community based settings near to where people live and urgent primary care located where patients are; to localise where possible and centralise where necessary; the "hub and spoke" model.

There are some services that may be better centralised, e.g. complex trauma, stroke care. At the moment there is a mortality cost in providing stroke care in local settings; this is a cost of not centralising. There is a need to take active measures to improve stroke care in London. 70 – 80% of patients would still be treated in local stroke units, but with high tech care to the smaller number of people who need it.

The vast majority of care should still be delivered in local hospitals, so there is a need to maintain skills and quality of care in district hospital units. Big institutions would be overwhelmed if large amount of care currently provided by district hospitals moved to large specialist centres; centralising should only take place where this improves the quality of care for the minority of patients that need specialist care.

Dr Wake explained he is also a GP with 25 years experience had has seen health care change hugely during that time noting he had been chairman of the Planned Care group; one of the sub committee groups contributing to the background to the Darzi investigation and report. He said that although health services are not poor in London overall, they are patently poor in some areas. He said that specialist care would be improved by a degree of centralisation in specialist centres e.g. the Marsden Hospital and that some services would be better decentralised. He said that surgery in London is way behind the best in the country.

Centralising care can be achieved in a variety of ways. Elective care, e.g. hip and knee replacements, eye surgery etc can be located in stand alone areas separate from emergency care. On the other hand, other services such as cancer surgery could be delivered through worldwide centres where a large number of specialist surgeries can be performed. This type of surgery is

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better provided in a small number of centres, providing more economic and better quality outcomes.

The Darzi report envisages a shift towards community-based care, where routine diagnostic tests can be carried out locally.

Community support and rehabilitation services have suffered from a lack of investment up until now, which means that people are being cared for in a hospital setting when it would be better to receive care at home. More investment here would promote independence and support early discharge from hospital and also prevent admission for people where hospital based care is inappropriate.

This would also improve choice for end of life support services; the choice to die at home. At the moment approximately 20% of deaths take place at home, but more than 50% of people would choose to die at home as a first choice.

He said there was a need to integrate some pre and post care pathways, e.g. integration of nursing care, intermediate care and end of life care. Overall there is a need to keep the strategic focus on the patient as an individual.

The Darzi report envisages the emergence of "polyclinics"; which can be a building or a network of buildings that have services appropriate for a locality, e.g. a network of GPs. The proposal is to have a polyclinic attached to each hospital site which includes an urgent care centre run by primary care. Polyclinics will have to be sensitive to local needs and no polyclinic will look exactly like another. This could provide a great opportunity for social care to bring together services for older people.

Questions

Q It was asked why these reforms will be implemented when other attempts to improve hospitals have not.

It was responded that an important strength of the Darzi review is that it has considered the perspective of pathways to care by patients rather than a purely institutional perspective. It is also more clinically driven and the clinician's perceptive is important in making proposals feasible and credible in the NHS.

Q It was asked how the review will attempt to change people's perception of pathways to care and the new approach.

It was responded that we need to start by changing the reality of care provision, e.g. choice about the use of GP services and GP surgery opening hours, e.g. evenings and weekends. Some patients want to be seen quickly, some want continuity and we need to ensure that both of these objectives can be met within polyclinics.

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Q It was stated that the past few years has seen pressures to close local hospitals and health services and that some of the Darzi proposals seem to suggest a reversal of this.

It was responded that we need to consider the costs and benefits of the localisation of care, but that there needs to be a presumption in favour of local provision, e.g. blood testing can be carried out in GP clinics. Hospice care should continue, although at the moment a lack of capacity means that more patients cannot be provided for. End of life care at home is not cheaper than hospitals and services can be difficult to co-ordinate. A significant problem is the overuse of Accident and Emergency in hospitals. This is caused by reduced opening hours and under capacity at GP surgeries, but it is also the result of a more mobile population in London, where many people are not registered with a GP. A&E services are also a victim of their own success, as people know that they will be seen.

Q It was asked if NHS London was ready and able to introduce the big changes implied from the Darzi report.

It was responded that there is a real change in the tone about strategy and strategic planning in the NHS. A lot of emphasis has been focused upon meeting performance indicators and budgets and this review is an attempt to change this towards a more strategic approach. In addition, there are a lot of people who have profound influence within the NHS involved in this review.

Q It was asked if it will be possible to provide more flexible GP opening hours and if the GP contract can be re-negotiated to accommodate this.

Dr Martin responded that he was not aware of any national negotiations to extend GP contracts but that GP contracts are now subject to local negotiation. The introduction of polyclinics could be a mechanism by which to review GP contracts.

Q It was asked about the sites for possible infrastructure developments, and given the shortage of land in London, if this was already being considered.

Dr Martin responded that the NHS is aware of how long it can take to bring about change of this level and the NHS is reviewing the estates it already has, some of which are not currently being put to full use.

One of the fears is that the Darzi review could lead to an over-centralised model, and this needs to be avoided, as it could impact upon the capacity of local hospitals to carry out elective work. There is the possibility of elective centres in district hospitals.

Q It was asked what guarantee there is that Londoners would have improved access to GP services.

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Dr Wake agreed that patients should not have to wait for GP appointments and that the onus will have to be on PCTs to commission effective GP services. PCTs are variable in their effectiveness in monitoring GP contracts and they are increasingly their role is one of commissioning hospital and GP services. He said that there needs to be pressure to provide better services and that there is a need to work closely with local authorities.

Q It was asked if the Darzi review will bring in a centralised model of care under the guise of polyclinics. Can it be assured that the model will not be too prescriptive?

Dr Streather responded that local proposals will be drawn up in consultation borough by borough and that there was no appetite for a prescriptive model for the whole of London. It is part of the role of overview and scrutiny to hold the NHS to account for the scale of localisation. Type 2 diabetes care, for example, should be provided close to the patient's home as far as possible.

Q It was asked if the Darzi review will actually increase the scope for patient choice.

There should be flexibility and the non prescriptive nature of the new polyclinics should provide for patient choice. PCTs should seek to commission services that are appropriate and affordable in consultation with local people.

Q A concern was raised that despite the benefits of centralising trauma services and stroke services, access may be impaired because of London transport congestion. Have journey times been factored into the strategy?

Dr Streather said that the London Ambulance Service is very good at estimating journey times in London. Some periods, e.g., in the middle of the night journey times are relatively short. In the middle of the day there is a need to make sure that there are enough accessible rapid response centres e.g., (stroke centres etc.). Otherwise, centralised care can provide further health inequalities. It should be quite straight forward to define access as part of the quality description for those services.

Q If there is to be greater use of day surgery, this will provide real challenges especially to older people, as many people require after care support.

Hip replacements in hospitals are down to just a few days, but there is a need for very good home visiting therapists.

It was commented that mental care and children's care services are not given enough emphasis in the report but there is further work being carried out in these areas.

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Q It was asked if a weakness of the Darzi report was that it focussed too much on the NHS rather than looking at a spectrum of care including social care.

Dr Streather responded that there is a great deal of talk about improving linkages and breaking down some of the barriers between professionals in health, primary care/secondary care, and social care.

Q It was asked how the local consultation and process can be meaningful and clear since the principles in the Darzi report provide very little details for local areas.

It was responded that there is a consultation document available from NHS London, which will be delivered to every council. Dr Wake responded that details about local area consultation are deliberately absent from this document. PCTs are expected to consult locally on the principles of the document, consultation on a framework which may result in service changes.

Q It was asked which population statistics will be used given the high migration figures for London?

Dr Wake responded that there is a need to work with local authorities to get accurate population estimates but conceded that this is difficult in London with high rates of migration.

Q It was asked that, since there are difficulties recruiting GPs, how GPs will be retained and new GPs recruited into London.

Dr Wake responded that PCTs are very aware of the number of GPs coming up to retirement. It is easier for GPs to get employed status rather than to become practice partners, but this fits very well with the concept of polyclinics. There are large numbers of new GPs currently being trained.

Q It was asked what consideration has been given to cross-border issues e.g., people who commute into London.

Dr Streather responded that there was a tension between not imposing a single model and avoiding local arrangements which increase health inequalities. The approach should encourage high clinical standards and yet allowed local determination of how to deliver these. If we import people into our boundaries there is a need to ensure quality but also be open about the resource implication.

Q It was asked if GPs will sign up to employee status.

Dr Wake said that a significant number of GPs want to be NHS employees, a younger generation often seem to prefer a salaried situation and that this is an increasing trend.

Q It was asked if extra money will be made available by the government to introduce proposals from this review.

Dr Wake said that the NHS will be expected to make the best use of the resources it has as it has had a high level of funding in recent years, although it is possible to envisage extra government help with transitional arrangements.

Q A question was asked about public perceptions about how to access to services, in view of the range of access points available.

It was responded that it is important to consider access to care as it has been much too complex for patients.

Q It was asked what the role of the General Hospital will be in the context of the proposals for polyclinics. Is leaving this to PCTs to determine not putting too much strain on local commissioning services?

It was responded it is envisaged that most people who go to a General Hospital now will go there in the future.

Q It was asked what the government's view was as to how GPs would work under the proposals.

Dr Wake responded that this depends on the model of GP care that is commissioned by the PCT and that there is scope for a variety of different models and different roles for GPs.

Q It was asked what is required and what the best process is for upgrading skills in line with the proposals.

Dr Streather responded that in the past there has been insufficient surgery in local hospitals to train local surgeons and that there is a need to manage this more proactively.

4. PRESENTATION: 'HEALTHCARE FOR LONDON': REPORT TO LONDON COUNCILS FOR LONDON BOROUGHS' OVERVIEW & SCRUTINY COMMITTEES

Dr Fiona Campbell, healthcare consultant, delivered a presentation on the main findings and conclusions of the report.

Dr Campbell said that although it may be in the nature of scrutiny to focus upon the negative aspects of proposals, it is important not to loose sight of the very positive aspects of the Darzi review, as she believes that it is a genuine attempt to improve health services in London. One of the key strengths of the review is that it has tended to take a patient's pathway perspective through healthcare.

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Dr Campbell set out the context for the review:
- It provides a ten-year vision
- Many of the issues are a focus of national attention
- Little detailed reference to social care
- Further work still being done

She set out the key consultations being undertaken:
- Six clinical working groups and one on mental health with chief executives
- Opinion Leader consultation events (voluntary sector and public)
- Written consultation – 67 submissions
- Ipsos Mori telephone survey (7,000)
- Healthlink supporting consultation with traditionally excluded groups
- Other meetings and events

The consultation document on the models of care was published on 30 November. Consultation ends 7th March 2008, with further work on mental health and children's services after that. There is a parallel health inequalities impact assessment carried out by London Health Commission, but there are concerns that it may not be available until the end of the scrutiny process.

The NHS is currently carrying out a review of its estates, but this review has not yet reported.

Dr Campbell set out the proposals for the second stage consultation.
- Second stage consultation will be focused on practical application of the proposals
- Second stage consultation will be subject to outcome of first stage consultation

The second stage consultation will be likely to be at different levels depending on the scale of the proposal being consulted upon:
- pan London
- regional/cluster (e.g. NE London/SW London)
- individual PCT/LA area
- surrounding counties

This may need further joint overview and scrutiny committees; which may imply further work for this established committee.

Dr Campbell outlined Lord Darzi's case for change:
- Healthcare in London is not good enough
- Specific London challenges
- Low levels of satisfaction
- Inequalities
- Moving out of hospital
- Centralising emergency care
- London's historical role
- Effective use of workforce and buildings

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- Funding issues – e.g. reducing hospital stays to England average "would save £200m".

Dr Campbell outlined the principles of the review:
- Focus on individual needs and choices
- Localise where possible, centralise where necessary
- Truly integrated care and partnership working
- Prevention is better than cure
- Focus on health inequalities and diversity

Dr Campbell outlined the focus of the report:
- Maternity and newborn care
- Staying healthy (i.e. prevention of ill health and health improvement)
- Mental health
- Acute care (i.e. "accident and emergency")
- Planned care (i.e. elective treatment which can be planned in advance, e.g. hip replacements)
- Long-term conditions (e.g. diabetes, asthma)
- End-of-life care (issues such as giving people a choice about where they die)

Dr Campbell outlined some key questions for scrutiny committee – listed in Appendix One.

Questions

Q It was asked if the NHS would be able to deliver the proposals.

Dr Campbell responded that the approach has been to involve clinicians and that this may prove more successful than in the past.

Q A question was asked about preventative healthcare.

Dr Campbell responded that prevention may not always be more expensive than treatment but that upfront investment is needed and an 'invest to save' approach.

Q Concerns were raised as to the relocation of healthcare services where distance from home is too great, for example, issues of removing personal links with family and friends, culture and knowledge of the area.

It was responded that distances for treatment are a trade off between individual's own priorities and the best health outcomes.

Q It was stated that there is a lack of clarity about how urgent healthcare centres are envisaged as opposed to A&E.

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It was responded that both urgent care and A&E will be attached to polyclinics but that it is envisaged to have separate centres for 'urgent care' from A&E.

Dr Campbell suggested that comparisons can be drawn with New York, which has already gone down the road of centralisation. Expert witnesses from New York may be useful to talk about this experience.

Q Given less dense population, it was asked if the notion that polyclinics should serve an area of 50,000 people and yet be local is not a contradiction in terms for outer London.

It was responded that this population area figure is an average and that each borough will have to consider the implications for populations served for their own area. Planning and infrastructure issues will be considered in phase 2 of the consultation.

Q It was asked what the implications might be for information technology, e.g., costs, use of IT and service delivery, implications for privacy and security.

It was responded that there is a proposal for a common database for NHS patients, although this may run into problems. It was suggested to ask the NHS 'Connecting for Health' programme that is considering this.

Q It was asked what the impact on local authorities might be and what investment there might be for local authorities.

Dr Campbell said that it was assumed that any resultant savings would either invested in prevention or subsidise social care.

Q The provisions for local accountability of polyclinics was raised; if polyclinics are to deliver 60% of healthcare, what kind of accountability and input from patient and user groups will we have.

It was responded that the new government commission may be able to give a view to the Scrutiny Committee as part of this Scrutiny review.

The chairman thanked Dr Campbell for her presentation.

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

None.

MINUTES END

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Appendix One - key questions for scrutiny committee

General

■How interdependent are the models e.g. does centralisation depend on further devolution?
■How dependent are the models on improved information technology?

Patient and public involvement

■What involvement is there in further development of the proposals?
■What involvement will there be in proposed clinical networks?
■What are the views of older people?

Health Equalities

■Under doctored areas
■Inequalities in funding
■Proposal to site polyclinics on existing hospital sites “to support financial viability of local hospitals” – how will this address location of healthcare by need?
■The relationship with the Mayor’s health inequalities strategy?
■The representative nature of the NHS workforce esp. language and translation issues.

Impact on social service and local govt

■Involvement of Directors of adult and children’s services – is there any work on a model of social care to mirror and integrate with Darzi models?
■How far do the proposed models of healthcare and the pathways extend to social care – are they medical or social models?
■Is there any analysis of the potential impact on social care e.g. from early discharge?
Questions for scrutiny – impact on social service and local govt
■Social care moving to greater care for fewer people.
■Darzi models imply more people need to receive a broader range of personal care.
■NHS is universal free service, social care is means tested with eligibility criteria. How are these contradictions to be resolved?

Impact on “local” hospitals

■Given reduction in core functions, will local hospitals have sufficient volume and throughput to be sustainable?
■Are they in danger of becoming “sinks”?
■How will they retain expertise to cope with non-routine procedures?
■Wouldn’t there be enormous duplication?
■How would night-time cover work?

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Polyclinics

■How flexible is the model?
■What will be the status of GPs?
■Flexibility for practice-base commissioning?
■Extent of new providers?
■Governance model?
■Will the model make efficient and effective use of consultant and specialist time?

Further workforce issues

■Is there capacity in numbers and skills?
■Current vacancy levels?
■Model appears to suggest fewer consultants and more GPs – is there capacity for this?
■Models suggest training needs – budgets?

Commissioning

■How will commissioning cover local, sectoral and London-wide strategic planning? A bigger role for NHS London?
■Balance between PBC and PCT commissioning?
■How will commissioning shift balance from acute to prevention? Is it realistic to expect it to do so?
■Will commissioning be powerful enough to align budgets with needs?

Funding and investment

■How is it possible to estimate affordability without estimate of capital costs?
■Will there be a double running/transition fund? Where will it come from?
■How will additional social care be funded?
■Where will capital funding come from?
–How confident is NHS London that funding can be released from NHS estates?
–What is the position of NHS Foundation Trusts?
–How will current LIFT projects be affected?

Transport and travel

■Has any modelling been done to show impact of models on number and length of journeys for LAS?
■Has any modelling been done to show impact on number and length of journeys for patients e.g.
–Pregnant women
–Older people
–People with long term conditions?
■Is there any information on the net effect on staff time and demand for parking?

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