Interim findings of the Joint Overview & Scrutiny Committee (JOSC) to review ‘Healthcare for London’

These are the interim findings of the JOSC following the first three evidence sessions held between November 2007 and January 2008. The JOSC’s final conclusions may differ to these as a result of evidence taken at the remaining witness sessions and consideration of written submissions from interested parties. The findings are not presented in any order of importance. Summary information on the JOSC’s work programme is attached as an appendix.

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Overview and Scrutiny came into being through the 2000 Local Government Act as has powers distinct from those of the Executive function of Local Authorities.

Overview and Scrutiny may hold the Executive (and other local providers as detailed in legislation including Health Trusts) to account on behalf of local residents for decisions taken. Scrutiny does this in a number of ways but may conduct policy reviews, where independent analysis of proposals takes place and community views are considered.

Overview and Scrutiny derived such powers, specific to health, from the Health and Social Care Act 2001, Section 7 and Section 11.

> Section 7
> Overview and scrutiny Committee or Committees of an authority to which section 7 of the Health and Social Care Act 2001 applies, may review and scrutinise, in accordance with regulations under that section, matters relating to the health service (planning, provision and operation of health services) in the authority’s area, and to make reports and recommendations on such matters in accordance with the regulations to NHS bodies and to it’s local authority on any matter reviewed or scrutinised.
>
> The above applies to:
> - any county council,
> - any county borough council,
> - the council of any district comprised in an area for which there is no county council,
> - any London borough council.
>
> Section 11 - Public involvement and consultation (Formal)
> Where a local NHS body has under consideration any proposal for a substantial development of the health service in the area of an authority, or for a substantial variation in the provision of such service, it shall consult the overview and scrutiny committee of that authority.

As re-affirmed in;
The National Health Service Act 2006
The Local Government and Public Involvement in Health Act 2007.

The involvement of clinicians

1. The involvement of clinicians in the 'Healthcare for London' review is welcome for it is these experts who have the knowledge of providing care to Londoners each day. The Connecting for Health (CFH) programme presents a warning: those who deliver a service must be involved in designing reform and any implementation plan. Improving health services is not simply about the buildings in which care is provided; it is essential to reform care pathways and ways of working. Opening new buildings known as polyclinics will not in itself improve health services.

   The JOSC was also pleased to hear the additional work is planned relating to Mental health Services and Children's Services

Impact on Social Services: the missing element of Healthcare for London

2. The proposals in the review will impact on social care and not just the NHS. Given the above comments on clinician involvement it is unfortunate that local authorities were not significantly involved in Healthcare for London.

3. Greater use of day-case surgery and a reduction in the length of stay in hospital after non day-case surgery will require investment in community services (i.e. services not provided in a hospital. For example, an elderly person discharged after a hip replacement will need physiotherapy and homecare support. Under current practice the NHS is unlikely to meet all of these costs. It is therefore essential to undertake work to model the impact of the Healthcare for London proposals on the whole health and social care economy. This could suggest funding will need to be reallocated from the NHS to social care in response to new care pathways.

4. Closer working between the NHS and local authorities (e.g. through polyclinics) could benefit service users through providing a more integrated service at a 'one stop shop'. However, co-location without the above financial modelling (and potential resource reallocation) could exacerbate the tension whereby NHS services are universal and free at the point of use while social services are increasingly restricted to those with the highest need and means tested. This difference may be hard for the public to understand.

5. Successful joint working will require health and social care organisations to share an agreement on how services should be developed: steps must be taken to prevent partners working to different, and potentially conflicting, priorities. This may not be straightforward given the different accountability mechanisms for health and social care organisations. Seamless services can only be provided when all of the organisations involved have committed sufficient budgetary and staff resources. The respective contributions of each organisation and their staff must be agreed at the start of any

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partnership working so that disputes do not derail the implementation and delivery of the joint working.

Centralisation and localisation: new locations for providing specialist and primary care

6. Centralisation must only occur when there is clear evidence that this will improve patient care. Centralisation of specialist services must consider both travel times and distance: many roads in London are heavily congested and the London Ambulance Service will need to be involved in developing such proposals.

7. GP surgeries are many people's only or main point of contact with the NHS and it is essential to ensure that these services remain accessible. It is welcome that polyclinics could enable some services to be delivered outside of hospitals and nearer to people's homes e.g. blood tests, physiotherapy and diagnostic tests. However it is vital to balance the benefit of a larger range of services with the disadvantage of reduced accessibility in terms of distance. Early modelling undertaken as part of the review suggests that polyclinics will be up to 2km away from people's homes: however this is further away than most existing GP practices in London and mean that elderly or vulnerable people are no longer able to walk to where they receive GP care.

8. There must therefore be a flexible approach to developing polyclinics. London's health needs differ and it must not be 'one size fits all'. A PCT, Local Authority and other partners within a locality must be allowed to determine that area's appropriate balance for models of GP provision to ensure that those who want to see a specific GP are able to do so, while opening hours are extended where required. Diagnostic equipment is expensive to purchase and run: it will not be possible to have this equipment at every polyclinic and a 'federated' model that 'links' up existing GP practices could help address many of these concerns.

9. The role, and likely benefits, of the proposed urgent care phone number is unclear. Many callers to NHS Direct subsequently attend A&E or their GP and the new service may struggle to be more successful. In addition, the ability for this phone service to book GP appointments is very challenging. This would require GP practices releasing control over the booking of appointments and some form of harmonisation of differing booking systems and procedures across GP practices.

The future of the local hospital

10. There is uncertainty, and therefore concern, about how the proposals will be implemented and in what order. There is a danger of a 'salami slicing' of services away from District General Hospitals (DGHs) and this could lead to difficulty in these trusts developing business plans. Any implementation of the proposals must be strategically planned to ensure that local hospitals do not become financially unsustainable (and therefore potentially close) in unforeseen circumstances or simply through neglect due to a loss of services downwards to polyclinics and the centralisation of specialist services to a small number of hospitals. Likewise, it will be essential to ensure that local

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hospitals are not seen as ‘second best’ and therefore struggle to attract staff and patients.

Financial questions remain

11. Funding will be required to implement the proposals. A more efficient use of estates and subsequent release of underutilised property may help pay for new facilities (e.g. polyclinics). However existing services will still need to operate until these new facilities are operational, and it is unclear whether additional ‘pump-priming’ or transitional resources are available. (see also Impact on Social Care; sections 2-5)

12. It is important to examine how the reforms relate to the new financial regime in the NHS. Payment by Results (PbR) will mean that shifting care out of hospitals will impact on the finances of hospital trusts (as outlined above), 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. Similarly, Foundation Trusts are able to retain capital receipts from releasing property and this money will not available to the wider NHS in London for developing new facilities.

13. Healthcare for London presents a vision rather than a detailed plan or strategy. Experts not involved in the review have questioned the financial assumptions in Healthcare for London. Further work is therefore required to model the financial implications of both reforming services and maintaining the status quo: as highlighted above this work must include the impact on social care.

14. There is currently a lot of debate about the NHS coming under increasing financial pressure: it is essential to ensure that any reforms take account of future demographic changes including the population growth in the Thames Gateway and increasing diversity. The NHS must not simply be a ‘sickness service’. Resources should be used to prevent health problems for this is highly likely to save money in the long-term and enable the NHS to meet growing demand.

Decisions over the future of health services: the role of PCTs

15. Decisions on the future of health services should be taken as locally as possible: i.e. by individual PCTs rather than a pan-London Joint Committee of PCTs. Any joint commissioning by several PCTs must be clear and transparent and discussed at individual PCT Board level.

16. The Strategic Health Authority expects PCTs to lead on the implementation of the proposals through their commissioning role. However, another round of organisational restructuring of PCTs could undermine or distract from the implementation of the Healthcare for London proposals. It would also undermine the increasingly closer relationships that are developing between PCTs and local authorities, something that is central to implementing Healthcare for London.

Public engagement

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17. The NHS, both locally and nationally, will need to be proactive in explaining the rationale for proposed reforms and changes in how care is accessed. For example, failure to undertake publicity to advise patients of any revised arrangements for accessing healthcare out of GP practice hours (e.g. through the new urgent care telephone number) will undermine the success of attempts to reduce A&E attendances. Clinicians will have a key role in explaining the rationale behind any changes to health services (i.e. that reforms are about improving patient care rather than saving money). The development of a national campaign may prove to be most appropriate.

The role of overview & scrutiny committees (OSCs)

18. This JOSC is only part of the involvement of overview & scrutiny Councillors. The NHS must continue to informally discuss proposals for health services with local overview & scrutiny Councillors outside of formal committees (i.e. what was previously known as 'section 11' under the Health & Social Care Act). This will enable Councillors to feed in views from the local community and help manage future formal consultations (what was 'section 7'). The NHS must be proactive in approaching local Councillors when changes to services are still in development. In this way, health scrutiny Councillors will look forward to having the opportunity to discuss the proposed reforms with the NHS over the coming months.

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Appendix: JOSC work programme and witness sessions

1. The JOSC has held three meetings (30th November, 7th December and 18th January) and taken evidence from the following witnesses:
   - Richard Sumray: Chair, Joint Committee of PCTs (JCPCT)
   - Ruth Carnall: Chief Executive, NHS London
   - Dr Martyn Wake: Chair of ‘Planned Care’ Working Group on Healthcare for London Review
   - Dr Chris Streather: Member of ‘Acute Care’ Working Group on Healthcare for London Review
   - Fiona Campbell: healthcare consultant commissioned by the London Scrutiny Network to review Healthcare for London
   - 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
   - Cllr Merrick Cockell: Chairman, London Councils
   - Mark Brangwyn: Head of Policy and Grants (Health & Social Care Team)
   - Hannah Miller: Director of Social Services, London Borough of Croydon

2. Further evidence sessions are planned for **22nd February, 14th March** and **28th March** with witnesses drawn from the following organisations:
   - The Royal Colleges of GPs, Nursing, Midwives, Surgeons, Physicians, Paediatrics and Child Health
   - London wide Local Medical Committees
   - Transport for London (TfL)
   - London Ambulance Service (LAS)
   - London Health Observatory
   - Healthlink

3. The JOSC is due to meet on **25th April** to agree its final report. This will be formally presented to the NHS at a meeting of the JCPCT on **6th May**.

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