**MEETING OF THE**
**JOINT OVERVIEW AND SCRUTINY COMMITTEE**
**TO REVIEW HEALTHCARE FOR LONDON**
**FRIDAY 14 MARCH 2008**

**London Borough of Ealing, Council Chamber,**
**New Broadway, W5 2BY**

**PRESENT:**
Cllr Denyer - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr Pat Callaghan – London Borough of Camden
Cllr Graham Bass - London Borough of Croydon
Cllr Mark Reen – London Borough of Ealing
Cllr Ann-Marie Pearce – London Borough of Enfield
Cllr Gideon Bull - London Borough of Haringey
Cllr Jonathan McShane – London Borough of Hackney
Cllr Peter Tobias – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Fred Osbourne – London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Ralph Scott – London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Mark Francis – 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 – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Jacqueline Casson – LB Brent
Shama Smith – LB Camden
Neal Hounsell – Corporation of London
Trevor Harness – LB Croydon

Mike Davidson – LB Ealing
Keith Fraser – LB Ealing
Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
Ben Vinter – LB Hackney
Tracey Anderson – LB Hackney
Sue Perrin – LB Hammersmith & Fulham
Nahreen Matlib – LB Harrow
Rob Mack – LB Haringey
Anthony Clements – LB Havering
Guy Fiegehen – LB Hillingdon
David Coombs – LB Hillingdon
Sunita Sharma – LB Hounslow
Deepa Patel – LB Hounslow
Zoe Crane – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Nike Shadiya – LB Lewisham
Jonathan Shaw – LB Newham
Jilly Mushington - LB Redbridge

**Speakers:**

Professor Ian Gilmore – President, Royal College of Physicians
Martin Else – Chief Executive, Royal College of Physicians
Michelle 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

## DATE AND VENUE FOR NEXT MEETING

28 March 2008, London Borough of Merton.

## 1. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:
Cllr Marie West – London Borough of Barking and Dagenham
Cllr Chris Leaman – London Borough of Brent
Cllr David Abrahams – London Borough of Camden
Cllr Viven Gillardi – London Borough of Enfield
Cllr Janet Gillman- London Borough of Greenwich
Cllr Mark Hayes – London Borough of Greenwich
Cllr Ted Eden – London Borough of Havering
Cllr Meral Ece - London Borough of Islington (Vice Chairman)
Cllr Alan Hall – London Borough of Lewisham
Cllr Megan Harris Mitchell – London Borough of Newham
Cllr Allan Burgess – London Borough of Redbridge

Apologies for Lateness were received from:
Cllr Carole Hubbard – London Borough of Bromley
Cllr Chris Pond – Essex County Council (early departure)

## 2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard, London Borough of Bromley, declared that she is an employee of Bromley PCT and a member of the Royal College of Nursing.

Cllr Vina Mithani, London Borough of Harrow, declared that she is an employee of the Health Protection Agency.

## 3. CHAIRMAN'S WELCOME AND INTRODUCTION

Councillor Mark Reen, Ealing's representative on the JOSC and the Chairman of their Health, Housing and Adult Social Services Standing Scrutiny Panel, welcomed everyone to the borough. An introduction to the borough was provided and the meeting noted the housekeeping arrangements.

The Chairman thanked Councillor Reen for his welcome. The Chairman went on to give the Committee an outline of the day's proceedings and explained that the minutes of the previous meeting would be taken after lunch as the first speaker, Professor Ian Gilmore, Royal College of Physicians, needed to leave promptly at 11:00am.

## 4. MINUTES

Prior to discussing the minutes, the Chairman thanked Ealing Council officers for accommodating the event and Cllr Hazel Ware (Mayor – LB Ealing) and Robert Creighton (Chief Executive – Ealing PCT) for attending lunch and meeting the members of the committee.

The minutes of the meeting held on 22 February 2008 were agreed subject to the following amendments:

That Cllr Peter Tobias of the London Borough Hammersmith and Fulham and Councillor McShane of the London Borough of Hackney, are stated as being present at the meeting.

That Councillor Viven Gillardi of the London Borough of Enfield is stated as being present not Councillor Ann-Marie Pearce.

That, referring to p7, paragraph 8, line 7, the second "not" should be deleted so that the sentence reads correctly.

That, referring to p10, paragraph 7, line 3, it should read RCM (Royal College of Midwives) not RCN.

That, referring to p11, paragraph 1, line 2, it should state M11 "gateway" area.

A number of members indicated that there were questions and answers missing from some of the witness sessions. The Chairman asked members to email the officer group with the details of any information not included.

The Chairman said that she would be taking one item under 'Any Other Oral or Written Items' which the Chairman considers urgent, a letter from the London Ambulance Service Patient and Public Involvement (PPI) Forum.

The Chairman ran through a number of key points from the meeting on 22 February 2008. Detailed below is a summary of the points made;

- GPs play a central role in the NHS and account for many people's main or sole contact with the NHS. GPs also help manage demand by acting as 'gate-keepers' for access to other NHS services. Numerous GP consultations can be provided for the same cost as a single night of hospital admission.
- The original proposal for 'polyclinics' in the Healthcare for London review did not acknowledge the many differences in local needs across London. 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. There must be a flexible approach that meets all of these needs.
- 'polyclinics' must not be 'mini-hospitals'. There are questions around the financial effectiveness of 'polyclinics': it is very costly to provide x-ray equipment and it may be more cost effective to invest resources instead to extend the opening hours of existing hospital-based diagnostic equipment and implementing solutions that improve primary care access to this equipment (e. g. certain times at which hospital diagnostic equipment is prioritised for primary care patients).
- GPs acknowledge that there are some problems with accessing existing provision however many oppose any attempt to impose a single blueprint on all areas of London.
- Midwifery is facing many challenges in relation to workforce: there is an ageing workforce with many retirements likely within the next 10 years. Midwifery services rely on funding for staffing and not equipment. However despite the ageing workforce, midwifery has seen a reduction in its share of the NHS budget. This is despite the fact that London has the fastest rising birth rate in England and greater challenges (e.g. diversity and poverty).

- The NHS must not simply be a sickness services and must seek to prevent illness occurring. Midwives can play a key role in establishing healthy lifestyles at a time when people are responsive to change (e.g. in encouraging breastfeeding or giving up smoking).

- It is important to manage children's long-term health needs. The hospital should only be one place where this care is provided. Schools (and in particular extended schools) can play a central role in providing this support.
- It is vital to reform services and not simply change the location where these are provided. Co-locating services on a single site (e.g. polyclinic) may help improved coordination but this will also require services to share more information and change the way they work.
- 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 LAS 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.
- London has specific needs and challenges: e.g. the mobile population can make it difficult to ensure high immunisation rates.
- It is important to strategically plan specialist services. However this can be difficult given the current NHS financial and commissioning process i.e. payment by results can lead to hospitals competing with each other rather than collaborating to agree that certain hospitals undertake particular services.

## 5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

The Chairman referred the committee to written submissions and replies to letters from;

NHS London
London Voluntary Service Council
BME Health Forum – Kensington and Chelsea and Westminster
London Travel Watch
LB Bexley
LB Croydon
LB Harrow
LB Hillingdon
LB Hackney
RB Kensington and Chelsea
London Network of Patients Forums

The Chairman said that all submissions should have been received by 29 February 2008, but if any London Boroughs have their own submissions they would like to feed into the JOSC, she, the vice

chairmen and the officer support group would be grateful to receive them as soon as possible.

## 6. Witness Session 1: Healthcare for London – The implications for Physicians

**Professor Ian Gilmore, President, Royal College of Physicians**
**Martin Else, Chief Executive, Royal College of Physicians**

The Chairman introduced Professor Ian Gilmore and Martin Else to the Committee. The following points were made during the presentation and ensuing discussion:

- The Royal College of Physicians' core business is setting standards in patient care and their work is carried out through the education and training of junior doctors and helping consultants keep up to date and competent.
- The Royal College represents 28 out of the 58 specialties (all non-operative) and identifies with many of the themes outlined in the Darzi report.
- The Royal College is involved in three strands directly and this work is detailed in 3 key documents, Acute Health Care Services (Academy of Medical Royal Sciences, Sept 07), Acute Medical Care – The right person in the right setting – first time (Royal College of Physicians, Oct 07) and Teams Without Walls (Royal College of Physicians).
- The Royal College does not get involved with discussions over which hospitals should stay open or closed but does get involved in providing advice as to how PCT's or NHS trusts best organise their services. The Royal College produces around 6 independent reports for trusts and PCTs each year but by and large, they tend to take a broad overview on issues.
- A common theme in the Darzi report and the Royal College's work is clinical leadership. It was noted that where things are going well (e.g. around diabetes), GPs are talking to doctors about what is best for the patient. Things go badly when PCT managers are talking to hospital managers (e.g. around Rheumatology) and the issue is driven managerially not clinically. Although managers want the same positive outcome they have to react to "top down pressures".
- Clinicians should get more involved in the development of services that take into account the needs of the wider population.
- The Royal College wants more clinicians to go into senior management roles.
- A shared agenda is needed between clinicians and managers to drive improvements in quality. Clinicians need information that is

meaningful and relevant to them (e.g. MRSA rates, the number of patients on the ward). This type of information will help bring length of stay down.

- There should not be a "one size fits all" approach as different solutions are needed for different areas.
- That referring to the themes in the document, and specifically how acute services should be configured, the Royal College believes that local hospitals still have a continued place in taking emergency medical admissions, but support services must be in place, such as intensive care facilities. It was explained that links with intensive care are crucial. The Royal College recognises, however, that such services need not be co-terminus with surgical services that are getting more specialised and will gravitate to larger hospitals.
- Referring to the document 'Acute Medical Care – The right person in the right setting – first time', acute medicine is the fastest growing specialty and it is vitally important that an acute medicine specialist sees admitted patients in the first 24 to 48 hours. The meeting noted that there is evidence, if a patient is seen by a fully trained physician at the start of the process, of the outcomes being much better with the patient getting on the right track and being discharged earlier. In summary, acute hubs are vitally important.
- The document 'Teams Without Walls' states that it's good for the money to follow the patient but some of the recent reforms don't help as much with unplanned care. The meeting noted that the document is about developing integrated care with joint commissioning at a primary and secondary level so that the NHS gets it right for patients early on. Ways of working need to be cost - and clinically-effective.

**Questions**

1. *The Chairman asked what physicians see as the biggest drawback to the Darzi's proposals?*

   Professor Gilmore replied that some practitioners aren't fully on board with the re-organisation and idea of 'polyclinics'. The meeting noted that the Royal College doesn't have a problem with working in primary care but it needs to be right for patients and make clinical sense for them to become involved. He said that specialist patients need specialist care and this doesn't mean GPs undertaking short courses in specific areas.

2. *Cllr Buckmaster (Kensington & Chelsea) noted that there is only a passing reference to social care in the Healthcare for London document and that Local Authorities (LAs) have a key role to play in the primary and secondary care interface, preventative measures and making sure that patients have good support when they move out of hospital.*

Professor Gilmore agreed that LAs are crucial because if you do not have an effective interface and discharge/transfer procedure, everything falls apart. In regards to preventative medicine, he said that the Royal College has a faculty of public health, has wanted a smoking ban since 1962 and seeks to tackle obesity and alcohol misuse.

3. *Cllr Cornelius (Barnet) imagined a scenario where 'polyclinics' have been introduced and district hospitals have gone with GPs and physicians based in the 'polyclinics' and acute hospitals. Noting the evidence from Professor Gilmore that medical and acute skills would still be needed in general hospitals, how will this work if the skills base has moved to the 'polyclinics'?*

   Professor Gilmore said that the information he provided was in regards to both urban and rural areas. He said that in London, 'polyclinics' would do some of the work of a district hospital but he does not envisage doctors being in 'polyclinics' 24/7. Using the example of cardiologists, he said that he could see them working in a hospital in the morning and holding a heart failure clinic in the afternoon at the polyclinic.

   Councillor Cornelius asked if the district hospital is being re-invented as the polyclinic. Professor Gilmore said that he could see 'polyclinics' accommodating services such as physiotherapy but not acute services.

4. *Councillor Hubbard (Bromley) asked if government targets have got in the way of best clinical access and care?*

   Professor Gilmore said that they have and they have not. He said that the positive aspects of targets include focussing on issues such as patients on trolleys and looking at what is right for the patient. Negatively, he said that there are perverse aspects to targets, such as the focus and extra resources into Coronary Heart Disease that has resulted in liver disease "falling down". He said that it is important for targets to have clinician "buy in". Martin Else highlighted the example of targets around stroke care that have had good clinician buy in. He said that clinicians look at and respond to information tables to build better care. In principle, he advocated collecting information that is designed by clinicians and not imposed managerially.

5. *Councillor Bass (Croydon) asked if transferring services from the centre to localities would lead to a reduction in the quality of care.*

   Professor Gilmore replied that there is a risk and for every condition there must be a patient pathway. He said that there needs to be a balance between clinical and patient need and vigilance would be needed in monitoring this.

6. *Cllr Urquhart (Richmond) asked if shared management would work under the Darzi model.*

   Professor Gilmore replied that people are suspicious of the next level up in the NHS, which is why the Royal College is developing initiatives on managers and clinicians working together. He reiterated that the Royal College wants clinicians in top posts and said that the NHS must "get smarter" about providing assistance and look at issues such as contracts.

7. *Councillor Reen (Ealing) asked if the polyclinic model was being set up in competition with district hospitals, if there was a danger of a "1 size fits all approach" because of different models in different areas and if a dis-investment in district hospitals would be required to make the model work.*

   Professor Gilmore replied that it depended on whether new services were being put in or not. He said that a one-size fits all approach won't work and the most important thing is for accessible services in the community.

8. *Councillor O'Malley (Lambeth) asked for an example of where it's beneficial to concentrate services.*

   Professor Gilmore provided the example of gastro and liver disease, where it is proven that early endoscopy improves outcome and survival. The meeting noted that to do this, specialist advice needs to be available 24/7. He said that specialist intervention in regards to urology also makes a difference to outcomes.

9. *Councillor Tobias (Hammersmith & Fulham) asked how the speakers thought the polyclinic model would evolve.*

   Professor Gilmore replied that the Royal College would not be looking to influence the details of the structure, but through the documents they have produced, wanted to help develop pathways from primary to secondary care that make sense for patients. He said that combined working is particularly important where the patient has chronic difficulties.

   Martin Else said that the Royal College has not opted for a particular model but were saying that clinical structure, network and what's right for the area needs to be looked at. He said that there should not be one model for one area and it may end up taking the form of a polyclinic or an enhanced district hospital. Professor Gilmore summarised by saying that certain principles should apply.

   *The meeting broke from 10:55am to 11:05am for refreshments and a comfort break.*

## 7. Witness Session 2: Healthcare for London – Transport Implications
## Michele Dix, Managing Director of TfL Planning, Transport for London

The Chairman introduced Michele Dix to the Committee. The following points were made during the presentation and the ensuing discussion:

- TfL are aware of the impact of health policy decisions on transport, which is why they have responded to the Healthcare for London document.
- TfL should be involved at the start of the process, as the NHS should be thinking about transport when deciding where healthcare facilities are located.
- 5% (1 million) of all trips made in London each day are healthcare related, compared to 13% that are educational related. The majority of these healthcare trips are made by car, 59%, with 19% walking, 14% by bus and 10% by tube/rail.
- There are 1600 GP practices in London with an average travel time of 8 minutes to the nearest GP.
- TfL's concerns include changes impacting on the current balance resulting in increased demand and issues regarding general health, as they want to encourage healthy lifestyles through 'active travel' (walking and cycling). The proposed closure of the Chase Farm Hospital A&E unit was provided as an example, which, if it goes ahead, will result in 75,000 patients having to travel further. It was noted that the trust only looked at ambulance and not patient access as part of the proposals.
- TfL provides door-to-door transport through 3 schemes, Taxi Card, Capital Call and Dial-a-Ride. The meeting noted that the schemes provide access to the NHS for a significant number of people and there is a concern that the boroughs, NHS and TfL, should share this provision.
- TfL have been developing travel plans for 33 NHS trusts and each have been provided with £20k worth of advice and support. It was noted that travel plans have been successful in reducing car use.
- TfL, in their draft response to the document, have said that they support a move to enhanced choices but indicated that careful consideration needs to be given at the delivery stage to the demands that will be placed on transport (e.g. more people being treated at home = less demand; more specialisation and people travelling further by car = more demand). It was noted that if 70% of GPs moved to 'polyclinics', there would be an increased demand on the system but a reduced demand if 40% of hospital activity transfers to 'polyclinics'.
- TfL, in their draft response, have requested that the promotion of walking and cycling is a key consideration when locating facilities and supports the theme of prevention being better than care, which

TfL is promoting through active travel plans and reducing air pollution through the congestion charge.

- TfL believes that any re-configuration of healthcare services should reduce the need to travel by car, encourage a shift to more sustainable modes of transport and improve accessibility. The meeting noted that TfL would like to work with the NHS to develop criteria for the location of healthcare facilities and the feedback from the NHS has been positive on this proposal. Any future modelling should look at the effects on travel time and the numbers that will be advantaged and disadvantaged under any proposals.
- All 'polyclinics' and hospitals should have travel plans.
- Priority should be given to access by walking, cycling and public transport. An example was provided of a hospital with no pavements on its approach.

**Questions**

1. *Cllr Taylor (Westminster) said that there has been a discussion involving relevant boroughs about how the Academic Health Science Centre will impact on transport and an acceptance that NHS London and TfL need to look at physical access and accessibility in the future. He continued by highlighting a problem with the Taxi Card scheme, where patients are being told that they can't use the service for access to health care. He said that the terms under which the Taxi Card scheme operates needed to be altered and he would also like to see the terms of reference for the London Travel Group with a view to adding to them.*

   Michele Dix replied that the London Travel Group operates according to the accessibility model with planning and modellers in TfL's policy unit working with NHS London. She said that she would send out the terms of reference for the London Travel Group and said that people can attend and contribute to its meetings so that there is joined up working and effective lobbying of the NHS. This would help to ensure that the burden did not solely fall on transport providers. Cllr Taylor said that NHS London has a duty to consider its responsibilities to clients and service users and should provide taxis for hospital attendees, if needed.

2. *Cllr Bull (Haringey) asked what opportunity TfL has to "drill down locally" on issues such as the closure of GP practices.*

   Michele Dix replied that TfL get involved with travel plans and bus access but said that they tend to be more reactive than proactive and would like to influence the process much earlier on. Cllr Bull commented that this was wrong and TfL should be involved at a much earlier stage.

3. *Cllr Pond (Essex County Council) highlighted a cross border issue affecting Essex County Council where there is a problem accessing*

*Whipps Cross Hospital by bus and stated that there should be a way of considering and improving such issues in the future.*

Michele Dix said that she could ask John Barry (Bus Planner) to respond to Cllr Pond's specific issue but TfL should be proactive and responding in the first place rather than later on.

4. *Cllr Cornelius (Barnet) said that the Healthcare for London plans would fall down if the number of movements is doubled and asked for a direct message to be put forward that details need to be seen first.*

   Michele Dix said that TfL have concerns and think there will be wins and losses but it depends on which outweighs the other.

5. *Cllr Lewis-Lavender (Merton) agreed that strong lines of communication are needed between NHS London and TfL but acknowledged that there would be times where a journey needs to be longer (e.g.- to a specialist stroke treatment centre). In support of 'polyclinics', she said that having various services under one roof would reduce travel.*

   Michele Dix replied that TfL would need to see where the 'polyclinics' are located first. The meeting noted that all TfL can currently do is comment on the model and carry out theoretical testing.

6. *Cllr Hardy (Hounslow) asked if NHS London and other decision makers were reciprocating TfL's commitment to engagement.*

   Michele Dix replied that discussions have been positive to date and she is optimistic that TfL can have an influence. She said that if TfL lobby the NHS, they would listen, and TfL want to make sure that transport issues are high on the agenda.

7. *Cllr Mithani (Harrow) asked how TfL works with residents on travel to clinics.*

   Michele Dix replied that it is not TfL's role to directly engage with residents at this stage, but once the vision is clearer, they will work on the location criteria and hope that local people get involved at this stage.

8. *Cllr Scott (Redbridge) said that the travel instructions for all four bus routes to Queens Hospital, Romford, involve a change en route. He asked to what extent TfL is the provider and if unpopular routes could be put out to tender.*

   Michele Dix replied that TfL is the provider and if there were a demand, it would look at new routes. She said that TfL has to

ensure accessibility to facilities but the bus planning team faced difficulties finding a direct route when people are travelling from a wide area and the facility isn't in the right place. The meeting noted that patients could make use of Taxi card and Dial a Ride if they can't use public transport.

*The Chairman thanked Michele Dix for her evidence and it was agreed that any further questions could be forwarded to TfL for a response.*

**8 Witness 3: Healthcare for London – the implications for the London Ambulance Service**
**Jason Killens, Assistant Director of Operations, London Ambulance Service**

The Chairman introduced Jason Killens, Assistant Director of Operations, London Ambulance Service (LAS). The following points were made during the presentation and ensuing discussion.

- The LAS is the only pan-London NHS Trust.
- Although some non-urgent work is undertaken with trusts on a contract basis, the vast majority of work is taking patients to A&E (1 million requests). Of these 1 million requests, 75% are taken to A&E departments, 50% don't need to go to A&E and 5% need medical intervention at the scene.
- Each caller is asked questions at the first point of contact to determine clinical priority and what asset (vehicle) should be dispatched. The meeting noted that the LAS aspires to divert 200,000 patients per annum to primary care.
- The LAS supports Darzi's proposals in principle but with caveats.
- The LAS believes there is good evidence to support the centralisation of specialist care. The example of Cardiac Care hub and spoke model (Monday – Friday office hours) was provided, where seeing a specialist improves survival rates from 4% to 16%.
- Implications for the LAS could be: less ambulance availability because of extended journey times: extra training being needed as a result of ambulances having patients for longer; and paramedics and technicians requiring 'up-skilling' so that they are able to decide on the correct care pathway. The meeting noted that the LAS must receive additional funding to enable it to undertake the proposed enhanced role without weakening performance against national standards Jason Killens said the issue of whether the air ambulance should be centrally funded, rather than through charitable donations, would also need to be discussed if there was a move towards specialist trauma centres.
- The LAS need to get involved in service re-configurations at an early stage so that they can analyse what the ebb and flow of patients would be if there is widespread change.
- In conclusion, the LAS supports Darzi's vision but it is less clear what the implications will be. LAS would be looking for a consistent

level of service from ‘polyclinics’ and wanted to be engaged at the start on locations and service design.

**Questions**

1. *The Chairman asked how long the training or ‘up skilling’ would take and if the LAS has the required funding.*

   Jason Killens replied that the service level would determine the level of up skilling required. He said that, because of people working shifts, training could take up 24 dedicated months and they won’t know how much funding is needed until needs are determined. The meeting noted that there would also be the issue of back filling whilst people are training.

2. *Cllr Pearce (Enfield) acknowledged it was good to have local stroke centres open Monday-Friday 9-5, but asked what happens in the evening or at the weekend.*

   Jason Killens replied that, as per the ‘response to a heart attack model’, the patient would be transported to a regional centre. He said that there could be 3, 4 or 5 Specialist Regional Stroke Centres in London open 24 hours a day, 7 days a week, supported by local centres open Monday-Friday, 9-5. He said that once a patient has been stabilised in the regional centre, they could be transported back to a local centre. It was also acknowledged, that there is a lack of stroke facilities in North London.

3. *Cllr Hardy (Hounslow) asked if the LAS average speed has gone up or down.*

   Jason Killens replied that he did not have that information to hand but following observations, the LAS have diversified their resource base. He said that the LAS have responded to the increase in congestion by doubling their number of motorbikes and bicycles. LAS noted that speed humps and other traffic calming measures slow ambulances down significantly.

4. *Councillor Urquhart (Richmond) asked if the LAS are responsible for calling the air ambulance.*

   Jason Killens replied that the LAS are responsible for calling the air ambulance and also transport the air ambulance doctors when the helicopter is not in use. He said that there is a criteria used to activate the helicopter, such as a road traffic accident. It was noted a paramedic at the scene could also call the air ambulance if the situation is more serious than initially thought.

5. *Cllr Scott (Lewisham) asked if any modelling work has been done on when patients are taken home but there’s nobody there, as she is concerned about re-admittance.*

Jason Killens replied that re-admittance is an issue in some areas but it's too early in the vision for modelling, as the ebb and flow of the patients is not yet known.

6. *Cllr Sweden (Waltham Forest) asked what the impact of the proposals would be on the LAS if the diagnosis were not clear-cut, such as a stroke. Would it be better for them to go to a mixed district hospital to be triaged first?*

   Jason Killens replied that it is relatively easy to diagnose a stroke and although cardiac care is more complicated, the LAS have an Emergency Care Practitioner scheme, which has introduced a new level of diagnostic skill and equipment. The meeting noted that there is a number of Emergency Care Practitioners (ECPs) already operating in some boroughs that have a high level of diagnostic skill and can prescribe drugs. He said that LAS want to expand the ECP scheme, understand the level of care required and bridge any skill gap.

7. *Cllr Pond (Essex County Council) asked whether LAS has a good relationship with neighbouring ambulance trusts.*

   Jason Killens replied that the LAS relationship with neighbouring trusts is good and there's also a National Workforce Plan. In regards to a specific query relating to Essex, he said that the LAS would not influence where the East of England Trust take their patients as this is determined by where the patient lives.

8. *Councillor Tobias (Hammersmith & Fulham) asked if someone in the LAS is liaising with other ambulance services to provide a co-ordinated response.*

   Jason Killens replied that the LAS is the only provider of an urgent service but there were other providers contracted to provide non-urgent transportation. He said that it would be difficult to liaise with such providers as the LAS are all about care and provision and not tied into making money. The meeting noted that the Darzi proposals would impact on the 999 urgent service and not non-urgent work.
9. *Councillor Reen (Ealing) asked to what extent the proposals would impact on the LAS, if they were included in the process from an early stage and if the models are rolled out, were there people who get the 999 service now who would not get it in the future.*

   Jason Killens replied that, in regards to previous hospital closures, the LAS has been behind the curve, which has led to their contribution being "bolted on" at a later stage. He said that, in regards to Darzi, the LAS has been well involved from an early stage, had been able to influence the section on ambulance

provision prior to publication and was able to exert an influence now through their submission. In response to the issue of people receiving the service, he said that the LAS wanted to protect the national standard but if the service needed to do things in different numbers, additional funding would be needed to fund more ambulances.

10. *Cllr Bull (Haringey) asked if staff get feedback as to whether their initial triage assessment was accurate and if there are paramedics on every ambulance.*

    Jason Killens replied that there are two areas of triage for the LAS, reception of the 999 call and upon arrival at the patient. The meeting noted that in the control room an internationally used software package creates a red, amber or green category and the system is tightly controlled through quality assurance and consistently held up as an example of good quality. He said that on-street assessments are more difficult to quality-assure, but a system of peer reviews with clinical leaders is in place where time taken, treatment and the appropriateness of treatment is analysed. If issues are identified, action plans are implemented.

    In regards to the second part of the question, Jason Killens replied that technicians are not just drivers, but have 16 weeks of training and are re-assessed at the end of their probationary period. The meeting noted that technicians could diagnose heart attacks, give life saving drugs, treat conditions such as asthma and provide the bulk of care. He said that only 5% of patients would benefit from the care of a paramedic and the gap between technicians and paramedics is narrowing. Responding to the question, he confirmed that one third of staff on ambulances are trained paramedics and that if a technician is not able to administer a certain drug, a paramedic will be sent.

11. *Cllr Francis (Tower Hamlets) agreed that the case for getting centralised specialist care quickly is persuasive but asked if the LAS have any concerns that the shift might lead to a reduction in the quality of care. He also asked if the LAS wanted to see A&E units retained in District Hospitals.*

    Jason Killens replied that if there is a reduction in service it's a possibility that there might also be a reduction in the quality of care but it would depend on the design of services and how easy it is to access them. He said that there is potential for improvements through the vision but this needs to be done right. If it is planned, designed and resourced appropriately, services would be enhanced.

    In regards to the retention of A&E units in District Hospitals, he replied yes and no. He said that it would be "no" if primary health

pathways are resourced appropriately, as 50% of all urgent requests don't need to go to A&E and there isn't somewhere within primary care that the LAS can specifically refer people to at the moment. If the knowledge gap is bridged, A&E units do not need to be retained and this is at the heart of Darzi's proposals. The meeting noted that a recent Mori poll found that people primarily want an ambulance to arrive quickly and are less concerned about where they are taken or re-directed to. He recognised that the loss of a local A&E service is a real source of tension, as in some areas it does remain the only out of hours service.

12. *The Chairman asked what would happen if a paramedic picks up a patient, and decided the patient needs to go to a specialist centre but the patient unfortunately died on route.*

    Jason Killens replied that paramedics used to be disciplined 10 years ago for not taking patients to the local hospital. There has been a change in culture for staff, whom are now empowered to decide on the appropriate treatment option and signpost or deliver them to the site. If something did go wrong, LAS would always support a decision if it is reasonably justified. It was noted cases would be looked into if a paramedic stepped outside protocol.

*The Chairman thanked Jason Killens for his evidence and it was agreed that any further questions could be forwarded to the LAS for a response.*

*The meeting broke from 1:04pm to 1:50pm for lunch.*

## 9. Witness Session 4: Healthcare for London – the implications for Nursing and Mental Health Provision

The Chairman introduced Tom Sandford and Bernell Bussue, Directors of the Royal College of Nursing (RCN). The following points were made during the presentation and ensuing discussion. Bernell Bussue addressed general points whilst Tom Sandford focussed on mental health issues.

*Bernell Bussue*

- There are 50,000 RCN members in London and they have been consulted, using a variety of methods, on the Healthcare for London document.
- The RCN applauds NHS London and Healthcare for London for their efforts to engage on this matter.
- The RCN's concerns include a general feeling that the document doesn't promote the contribution that nurses and allied professionals make.
- The RCN sees benefits in London-wide services (e.g. diabetes, stroke) but feels that learning disabilities and other long-term

conditions, such as sickle cell anaemia, are not satisfactorily reflected in the report.

- Securing RCN members' "buy-in" for some of the proposals might be difficult.
- Trade unions and professionals should be engaged as soon as possible in the development, design and implementation of services.
- There are a variety of RCN views on 'polyclinics'. Some members are saying that the services provided by district hospitals should be improved rather than 'polyclinics' becoming 'mini hospitals', whilst others are saying that 'polyclinics' should develop services for local people.
- The consultation is predicated on an 'able sick' rather than a 'sick sick' and there is a sense that the services proposed may fail some of the people who are already having difficulty accessing service. Noting there should be a focus on improving services in the most deprived areas.
- From a workforce perspective, what is proposed over the next 10 years would require a shift in organisation, with a conservative estimate of 30% of staff being required to move from acute to primary care.
- In regards to transportation, TfL must engage with the NHS and local authorities to make sure systems are in place before any changes are made.

*Tom Sandford (Mental Health Policy Advisor)*

- Spend on mental health services in London is 21% higher than the national average.
- There are a number of health inequalities linked to mental health issues, such as a reduced life expectancy (10 years less than the average).
- The meeting noted that this is further compounded for people from Black and Minority Ethnic (BME) groups, who (it has been identified) are less likely to access the service.
- 63% of all BME referrals, it was noted, come from the police.
- In 2008, mental health trust providers had improved with 8 trusts classified as being in a 'strong position' - but work needs to be done on some fundamental issues.
- The meeting noted that not all trusts properly engage with local authorities; less than half of all mental health patients have a care plan; intelligence needs to be fed into joint commissioning; care pathways should be much clearer; early intervention is largely absent and access to psychological therapy is not quick enough.
- The RCN has carried out an impact assessment on the Healthcare for London plans and have warned that 'polyclinics' could deepen disadvantages if funding is not targeted.
- The meeting noted that if mental health is going to be one of the services provided at a 'polyclinic', appropriate staff and facilities need to be put in place, as people with problems referred by the

police can be intimidating. 'polyclinics' should be built considering patients with mental health needs.

- Under the proposals, psychiatrists would need to work with GPs in a different form of partnership.
- There is an issue with some targets, such as A&E departments being required to treat patients within four hours, as people with mental health problems may have been using drugs and alcohol and require time to settle.
- There are a number of local issues with: services provided at the Henderson and Cassel Hospitals at risk; the only emergency clinic at the Maudsley closing; Camden and Islington closing the St. Luke's site; and bed closures.
- The meeting noted that there are arguments for and against bed closures but families and relatives are concerned and in his opinion, the rationing of in-patient beds is linked to trusts applying for foundation trust status.
- The BME services in London are "underwhelming" and demand for the drug and alcohol service is huge but access is not keeping up with demand.

**Questions**

1. *Cllr Lasaki (Southwark) asked how young black boys could be encouraged to access mental health services where needed.*

   Tom Sandford replied that services needed to be made "culturally acceptable" as they are currently perceived as repressive. He said that services need to be available in different contexts to reach out to communities and a more systematic approach is needed around work in schools and accessing hard to reach communities.

2. *Cllr Buckmaster (K&C) commented on a couple of figures that he described as "stark", ie the 30% of nurses that will need to move from secondary to primary care and the 63% of all BME mental health referrals that come from the police. He asked if London had enough nurses and commented that, in Kensington and Chelsea, they have requested that all 'polyclinics' should have a mental health nurse.*

   Bernell Bussue replied that, in regards to staffing, it's mixed but overall London does not have enough nurses. He said that specialist areas have the biggest problems and it's a challenge to make sure that nurses in training have a place to go to. The meeting noted that it would be important getting workforce planning right and commissioners need to think about the number of trained nurses needed. He commented that there is also a move to bring in more healthcare assistants but nurses are still needed.

   Tom Sandford, in regards to the majority of BME referrals coming from the police, said that this is a complex issue. He said that the police are more skilled at recognising problems and using diversion

techniques and commented that friends and family generally, not just in BME communities, have a poor understanding of services available.

3. *Cllr Taylor (Westminster) said that NHS London should undertake a joint scrutiny project looking at access, as local authorities are looking for improvements in regards to access and care pathways, and asked if the RCN would help pursue this request.*

   Tom Sandford, said that the RCN would help pursue this request.

4. *Cllr Hart (Wandsworth) commented that there should be a full consultation exercise in regards to the Henderson and asked if the Darzi proposals will help address RCN's issues and whether NHS London are the right people to implement the changes.*

   Tom Sandford replied that providing mental health services is a challenging issue worldwide. He commended London PCTs for the level of funding that they provide to mental health services but said that the focus on inpatient services was an issue, making it difficult for patients to get ongoing meaningful support. The meeting noted that the Darzi proposals are more about physical health, which makes it difficult for 'polyclinics' to run mental health services unless they have really thought about it before hand. He said that there should be a safe place in 'polyclinics' for assessments and PCTs should look closely at the design and philosophy of 'polyclinics'.

   Bernell Bussue said the Darzi could represent a key element in how things will evolve and it's important that the RCN is able to influence the process.

5. *Cllr Sweden (Waltham Forest) asked whether Darzi is an opportunity to look at the high turnover of staff and the use of agencies and where the statistics provide are from and if they open to challenge.*

   Bernell Bussue said that he did not know if Darzi is a vehicle to look at the use of agency staff but it is widely recognised that a staff group predicated on agency staff does not help with continuity. He said the figure of 30% for nurses that will be needed to move from secondary to primary care was from the Strategic Health Authorities across the country and it could actually be a higher figure with bigger implications.

   Tom Sandford, said that Darzi is strong on centralisation and local community services, but making a polyclinic safe for mental health patients would be a big challenge. He said there had been a lot of focus into improving buildings so that they look better but not at how to accommodate an extremely distressed person with mental health issues. 'Polyclinics' would have to serious review this issue if they

intend to deal with mental health - with separate rooms for mental health assessments. Noting it would be “tragic” if this did not happen.

6. *Cllr Bass (Croydon) asked if Darzi would lead to the greater empowerment of nurses, break down the boundary between primary and secondary care and improve the level of care provided by nurses.*

   Bernell Bussue replied that one of the benefits of Darzi is that it will lessen the hold that GPs have on primary care and emphasise how nurses can help. In regards to diagnostics, he said this is currently only a service in acute care but its better provided in communities. In regards to the patient experience, the meeting noted that the intervention of qualified nurses helps reduce mortality rates. He said that stories of failure are at the more extreme end and these experiences are not the rule.

7. *Cllr Reen (Ealing) asked whether there would be workforce transfer implications if nurses are asked to move to areas of high deprivation and if they would be happy to do this.*

   Tom Sandford, replied that the merging of two trusts into one in Nottingham, resulting in over-provision and a subsequent analysis of how the nursing contribution could be changed, is evidence that it can be done.

   Bernell Bussue said the “jury’s out” as to whether nurses will move from primary to secondary care and vice versa and there is a nervousness amongst nurses. They would need to develop an entirely new set of skills and the key to how it happens would be in the re-education and training process.

8. *Cllr Callaghan (Camden) said that they have had to deal with a private sector provider, United Clinics, in Camden and asked how such companies should be dealt with in the future.*

   Bernell Bussue said that there is increased involvement of the private sector in health care provision, with around 30% of RCN’s members working in that sector. In regards to discussions about their continued involvement, he said that he doesn’t think there is evidence that the private sector do better than the public sector.

9. *Cllr O’Malley (Lambeth) noted that the closure of the emergency clinic at the Maudsley was broadly contested but still the NHS went ahead and the closure of beds has also been argued against. With this in mind, she asked how the situation should be moved forward.*

Tom Sandford, replied that the closure of the emergency clinic, despite the torrent of opposition to closure, is why he is sceptical about mental health services being located within 'polyclinics'.

10. *Cllr Urquhart (Richmond) asked why bed closures are linked to foundation trust applications and queried whether the Henderson Hospital is earmarked for closure.*

    Tom Sandford, replied that Monitor looks at financial management in foundation trusts and in his opinion this is why trusts become conservative at the time of a foundation trust application. Examples were provided where he thought this has happened and may happen in the future.

    He said that campaigns were currently underway to keep both the Cassel and Henderson Hospitals open and that he thinks that services at the Henderson are particularly at risk.

    Bernell Bussue commented that foundation trusts, such as the Academic Health Science Centre, have more freedom than other trusts and stressed that it is incumbent on all the people in attendance to analyse the plans that emerge at the next stage and to look at the "nuts and bolts" of changes.

11. *Cllr Francis (Tower Hamlets) asked what would be a reasonable time to wait before the impact of 'polyclinics' is assessed.*

    Bernell Bussue replied that there should be an element of caution with some sort of testing to establish whether 'polyclinics' deliver or not. He suggested there should be a couple of pilots and refined before the plans are fully rolled out. He said that 'polyclinics' would take some time to bed down (up to 5 years) but there may be a political urgency to move the process forward more quickly.

*The Chairman thanked Tom Sandford and Bernell Bussue for their evidence and it was agreed that any further questions could be forwarded to RCN for a response.*

## 10. Witness Session 5: Healthcare for London – the implications for Public Health

The Chairman introduced Dr Bobbie Jacobson, Director, London Health Observatory and Dr. Sandra Husbands, Specialist Registrar. The following points were made during the presentation and ensuing discussion.

- The London Health Observatory (LHO) has decided, because the framework is massive, to focus at this meeting, on one care pathway that Darzi proposes to address, and draw out some

common principles. The meeting noted that the LHO have chosen to examine the stroke care pathway, the third largest cause of mortality in London, because there is strong evidence about what works.

- It was explained that their example would link to two themes, “prevention is better than cure” and “focussing on reducing differences in health and healthcare across London”.
- Looking at the ‘Stroke care pathway: opportunities for preventing deaths and disability’, coronary heart disease (CHD) stroke’s poorer cousin and there is a need for the population to be more health-literate (green stage).
- At the yellow stage, primary care prevention, it’s important for risk factors to be identified.
- At the next stage (red), patients should have rapid access to TIA management.
- At the final stage, acute stroke management, (Darzi introduces proposals) but only 45% of people that have a stroke in London return to independent living.
- The cost of strokes to the NHS is large costing approximately £15k over five years - community care £1.7k per annum and individuals and their families £7k per annum.
- There is a spectrum of inequalities relating to stroke in London. Inequalities overlap with geography but this doesn’t explain the distribution alone.
- Less than 20% of Londoners with high blood pressure are adequately treated. The message from this is that we are doing a bad job managing risk factors.
- Looking at information presented at the meeting ‘Detecting Stroke and TIA – Actual to Expected in London’, not only are there geographical inequalities but there is also under-recording.
- Darzi’s proposals can help get the basics right by ensuring all Londoners are able to register with a GP. Insisting on seeing the best deployment of the GP and wider primary health and social care workforce in relation to need and by ensuring that the variations in the general quality of primary care are minimised.
- In conclusion, whilst the stroke unit proposals are welcome, there is a need to focus “further upstream” to get better value for money and recognise that prevention pays.
- Local reconfiguration plans will need to address two distinct sets of problems if health outcomes are to be improved for all:
    1. how local models can overcome the four basic challenges facing London (e.g. mobile and unregistered populations, culturally inappropriate and variable quality primary care, and an unequally distributed primary care workforce); and
    2. how local models can ensure that the missing parts of the stroke pathway are addressed (e.g. wider community and primary care prevention, fast access to TIA management in addition to the proposed stroke unit network).

- Some of the basic challenges may need more pan-London solutions that support the polyclinic model, but go beyond it in terms of population covered, (e.g. a pan-London approach to identifying, and offering un-registered populations the opportunity to register with a GP and helping practices develop proactive systems to ensure long term prevention and care).

**Questions**

1. *Cllr Urquhart asked if the vast majority of people with high blood pressure do know they have it.*

   Dr. Husbands confirmed that less than 20% of people diagnosed with high blood pressure are adequately treated. Dr. Jacobson said that she estimates around 160,000 people in London don't know that they have high blood pressure.

2. *Cllr Lewis-Lavender (Merton) suggested that the FAST (Facial, Arms, Speech Test) should be advertised in public places such as supermarkets.*

   Dr. Jacobson replied that, from the LHO's perspective, there are 2 key challenges, getting the basics right (see last bullet point) and looking at the specifics of the stroke care pathway to see what's missing.

   Dr Jacobson referred Councillors to look at where their own PCT on the 'Red List' showing all London PCTs highlighted what areas they had significant issues. Explaining not was a blaming exercise as the issues pertain to local populations as well as health services. It was noted that getting children out of poverty is one such issue that 22 PCTs have as a "significant issues" to address.

3. *The Chairman asked a question about the tracking of patients who receive treatment before moving on.*

   Dr. Jacobson replied that this information should be monitored and the meeting noted that, in regards to diabetes, when patients attend hospital their details should be captured and added to the appropriate register. It was recognised that it is a huge IT systems challenge to track moving communities.

4. *Cllr Hurt (Bexley) asked what impact stroke has on social care provision.*

   Dr. Jacobson said that although this issue is beyond her expertise, she thinks that "only the tip of" social care needs for stroke patients are addressed. She said that she thought 'polyclinics' could help with home care if there's a joint commitment and understanding amongst commissioners but these issues would need to be faced locally.

5. *Cllr Cornelius (Barnet) asked whether, given the government's bad record on ICT projects, it has the capability to introduce, back up and make the proposals work.*

   Dr. Jacobson replied that there are big expectations of NHS IT programmes and it may be advisable to test some examples first. Noting how IT had moved on in hospitals, so that you can easily see when patients were last tested or treated, but connecting primary and secondary care remains a key issue. She said that she did not know whether the process would be seamless but clinical involvement would be needed.

   Dr. Husbands said that there are 2 issues, access to notes and continuity of care. The meeting noted that patients might see different doctors in 'polyclinics', as it's not so important that you see the same person. But at a diabetes clinic you are likely to see the same doctor.

6. *Cllr Lewis-Lavender (Merton) asked if LHO information could be filtered down to borough health scrutiny panels.*

   Dr. Jacobson replied that if the LHO do pan-London work, information is provided to each borough and the LHO are also invited to comment on local scrutiny issues.

7. *Cllr Bass (Croydon) asked what percentage of the population is screened for hypertension. He provided an example of blood tests that he recently saw being carried out in a supermarket and stated that this information should be fed through to the appropriate contact so that it can be acted on.*

   Dr. Husbands replied that she doesn't have specific data on the percentage but it's a target to screen all adults that are registered with a GP. Dr. Jacobson said, in regards to blood tests in venues such as supermarkets, she agreed that staff needed to be trained to collect and pass through the information. She said that screening is unethical unless the whole system is set up.

*The Chairman thanked Dr. Husbands and Dr. Jacobson for their evidence and it was agreed that any further questions could be forwarded to the LHO for a response.*

**11. Any other Oral or Written Items which the Chairman considers urgent.**

The Chairman said that she has received a letter from the London Ambulance Service PPI Forum requesting that each local authority gives £2k to support its continuation. Members noted that overview and scrutiny committees are unable to make this decision and it may

be appropriate to forward the request onto the officers procuring Local Involvement Network (LINk) in each borough.

The meeting finished at 4.28pm.