

MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 28th March 2008

London Borough of Merton, Council Chamber
London Road, Morden, Surrey SM4 5DX

PRESENT:

Cllr Marie West – London Borough of Barking & Dagenham
Cllr Richard Cornelius – London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr David Abrahams – 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 Mick Hayes – London Borough of Greenwich (substituting)
Cllr Rory Vaughan – London Borough of Hammersmith & Fulham
(substituting)
Cllr Gideon Bull – London Borough of Haringey
Cllr Margaret Davine – London Borough of Harrow (substituting)
Cllr Ted Eden – London Borough of Havering
Cllr Mary O'Connor – London Borough of Hillingdon (Chairman)
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 Allan Burgess – London Borough of Redbridge
Cllr Nicola Urquhart – London Borough of Richmond
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden – London Borough of Waltham Forest
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)

ALSO PRESENT:

Cllr John Bryant – London Borough of Camden
Cllr Margaret Brierly – London Borough of Merton
Cllr Maxi Martin - London Borough of Merton

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Shama Smith – LB Camden
Trevor Harness – LB Croydon
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
Anthony Clements – LB Havering
David Coombs – LB Hillingdon
Guy Fiegehen – LB Hillingdon
Deepa Patel – LB Hounslow
Katie Cohen – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Nike Shadiya – LB Lewisham
Barbara Jarvis – LB Merton
Jonathan Shaw – LB Newham
Kris Hibbert – London Councils

Speakers:

Gail Findlay – London Health Commission
Sandra Husbands – London Health Observatory
Sir Cyril Chantler – Chair, Great Ormond Street Hospital NHS Trust, Chair,
Clinical Advisory Group, End of Life Care
Stephen Richards – Director, Macmillan Cancer Support

Jessica Crowe, Executive Director, Centre for Public Scrutiny

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr Janet Gillman – London Borough of Greenwich
Cllr Peter Tobias – London Borough of Hammersmith & Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Jon Hardy – London Borough of Hounslow
Cllr Meral Ece – London Borough of Islington
Cllr Christopher Buckmaster – Royal Borough of Kensington & Chelsea
Cllr Megan Harris Mitchell – London Borough of Newham
Cllr Christopher Pond – Essex County Council

2. DECLARATIONS OF INTEREST

None received.

3. CHAIRMAN'S WELCOME AND INTRODUCTION

Councillor Gilli Lewis-Lavender, Merton's Chair of the Health & Community Care Scrutiny Panel, welcomed the Joint Committee members, officers and the public to Merton's council chamber and the meeting. Cllr Lewis-Lavender mentioned some of Merton's famous former residents and advised that Merton has a considerable east/west divide in terms of health inequalities.

The Chairman thanked Cllr Lewis-Lavender for her welcome and thanked Merton for hosting the meeting. The Chairman outlined the programme for the day's proceedings, advising that this meeting was the 6th evidence gathering meeting of the Joint Committee.

4. MINUTES

The members were informed that the minutes of the meeting held on 14th March in Ealing and of this meeting will be presented for approval at the next meeting on 25th April 2008. However, the Chairman verbally summarised the key points which had emerged from the meeting on 14h March by way of a reminder to members.

5. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

Written submissions contained within the agenda were received.

6. WITNESS SESSION 1: Healthcare for London – Health Impact Assessment

Speakers: Gail Findlay, London Health Commission and Dr Sandra Husbands, London Health Observatory.

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

- The London Health Commission leads work on health inequalities and the wider determinants of health and was established in 2000. Health Impact Assessments are the particular approach identified as a key public health tool to inform policies related to health and to take into consideration the maximum and minimum impacts.
- The London Health Observatory established a steering group to look at the Healthcare for London consultation document. The timeframe for this health impact assessment was very short and the key areas for maximum impact on health inequalities were identified as:-
 - primary care
 - maternity care
 - stroke pathway in terms of prevention and rehabilitation
- The London Health Observatory has produced a Health Equality Profile for London. Ben Cave Associates also undertook a review of the evidence for Healthcare for London and a policy appraisal.
- A stakeholder workshop with 50 delegates was held and other consultation information was gathered from Healthcare for London, NHS London, Healthlink, IPSOS Mori and PCTs.
- The overall recommendations within Healthcare for London are ambitious and exciting, with the opportunity to improve most elements of healthcare and health outcomes as a whole. However, success will depend on how the proposals are implemented and the

impact on health inequalities. It was considered there is a danger that that there will be overall improvement to health but that specific groups may continue to suffer.

- A firm recommendation from the work undertaken is that both health impact assessment and equality impact assessment must be ongoing and that the proposals in Healthcare for London must be implemented in full because partial implementation would increase risk in terms of health inequalities. For example, the stroke pathways and discharge would lead to additional pressure on carers, who are already a vulnerable group.
- On prioritising and meeting unmet needs, there is a need to identify mainstream mechanisms to seek out and address this.
- Data collection issues are key in relation to equalities groups in terms of monitoring impact on health improvement. It is difficult to evaluate the needs of disadvantaged groups because data collation for this was incomplete. Health inequalities need to be measurable before they can be addressed.
- It is vital that priority is given to disadvantaged groups and services targeted to overcome inequalities; language support is key.
- The final report from the above work will be produced shortly.

Questions

Q The Chairman asked whether the proposals represent a suitable balance in expenditure between health service provision and health promotion/prevention, or will the NHS remain a sickness treatment service?

It was responded that the proposals represent a very high level framework and the principle of prevention is included in the document. However, the NHS has difficulties in diverting mainstream resources towards prevention and so it will need a fundamental change with tangible shifts in resources towards prevention, and not just for the short term.

Q The Councillor for Haringey asked about mortality rates and health inequalities and whether it should be for PCTs to address this or whether it should be central government-led.

It was responded that the London Health Commission is working towards raising awareness of health inequalities across all sectors. But it is important not to 'let the NHS off the hook' because a person with a life expectancy of eight years less than others still needs help in the present.

Q A supplementary issue was raised about tackling obesity in schools, with reference to the lack of strategic vision - through developments built on open land and playing fields, which reduced the opportunities for sport.

It was agreed that there is the need for a more strategic approach, but that strategies such as the one for tackling obesity in schools is a real step forward, but there is still a long way to go.

Q The Councillor for Merton firstly questioned whether the recommendations from the health impact assessment work would be implemented, and secondly whether the help with benefits for stroke patients would be available when a patient was sent home (as this is not a voluntary sector role).

It was responded that in this huge change process, the issue of health inequalities could get lost, but Government had asked for the health impact assessment and so should take note of the recommendations and there could be some monitoring of key actions twelve months on. The whole process of health impact assessments must be ongoing as the proposals represent a real opportunity to make a difference.

On the issue of stroke pathways, it was important that the wider context was highlighted and it was considered that polyclinics should be able to offer all the necessary advice. It was accepted that there may need to be a more specific recommendation in relation to outreach services to make this stronger. Local PCTs should be held to account to make sure that the work is ongoing at local level.

Q The Councillor for Havering questioned where the additional carers would come from to provide help for the 20% of disadvantaged people identified.

It was responded that the overall aim of Healthcare for London is to have the most effective models of care and that hopefully the 80% of people who are satisfactorily treated will increase. In terms of who the disadvantaged people are, carers are recognised as an inequalities group but are at risk particularly if the proposed stroke pathway is not properly implemented. There are also workforce issues with a shortage of primary care staff and Healthcare for London will provide an opportunity to acquire a more skilled workforce to help disadvantaged groups. There is also a need to identify other groups, including those relating to specific illnesses.

Q The Councillor for Croydon asked which issues needed to be resolved first?

The response was that, if schemes can be piloted first, then there is an opportunity to get things right. It would be beneficial to monitor and evaluate any pilots in terms of their impact on health and on health inequalities.

Q The Councillor for Camden asked who was responsible for the problems relating to the lack of data and what recommendations the

Joint Committee could make on this? Also, how can data be collected for those people who are not attending a GP surgery?

It was responded that there is a cultural issue with data collection and that more mandatory collection was required, with sanctions for non-collection. But this is difficult to achieve without government intervention. However, where PCTs are performance managed they will collect data to demonstrate good performance, so it can be achieved. GPs also have a lot of patient information but are not required to report all of it. So a cultural change is needed with information collated into large data sets for wider use. Even if people do not visit a GP, they interface in other ways, through benefits, schools etc and very few people are entirely 'off the radar'.

Q The Councillor for Hammersmith and Fulham asked firstly when assessments should happen, and secondly how unmet need is measured if there is lack of data, and what data would be most useful to address this, as health impact assessments are not statutory requirements.

The response was that the ongoing process of health impact assessments is recommended and the overall framework for this needs to be examined. The lead is with the PCTs and they need to ensure overall plans include health impact assessments. On identification of unmet need, it could be reasonable to assume that people with unmet need would express this to patients forums. The difficulty is establishing the level of need. There are no specific recommendations on the type of data needed and local needs vary including in terms of age, ethnic mix etc, which is already locally known. There is a lot of in-depth work on unmet need, e.g. on the homeless and on immunisation and screening, where people present very late.

Q The Councillor for Richmond raised the issue of the growing need for mental health care and the fact that there is no model included in the proposals for this.

The response was that mental health is an area requiring stronger focus and this has not been fully worked up yet, but work is ongoing.

Q The Councillor for Ealing asked what limits there are to influence lifestyle choices e.g. on smoking and, if health is a finite system, how far can the NHS spread resources before its core function is affected.

It was responded that the issue is not just about lifestyle but about unhealthy choices which may be made by people living in difficult circumstances, e.g. smoking to relieve stress. By mainstream investment and tailoring resources, an impact can be made e.g. through smoking cessation. But there must be targeting and increased investment. On the spread of resources, the Wanless report stated that if we prevent illness, it would save the NHS money and allow for

more investment on highly technical equipment etc. So there is a good economic case for tackling health inequalities and reducing illness to allow for resources to be used elsewhere. It is not about forcing people to change but enabling them to make healthy choices with access to the right services.

7. WITNESS SESSION 2: Healthcare for London – End of Life Care
Speaker: Sir Cyril Chantler, Chairman, Great Ormond Street Hospital NHS Trust; Chair of Clinical Advisory Group, End of Life Care

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

- There are three main pillars to the Darzi report: managing chronic illness; access to healthcare; and staying healthy. 80% of health services focus on chronic illness and this is where most of the resources are allocated. End of Life care is management of another chronic illness.
- Polyclinics, or community care hospitals, are not a new idea and they are mentioned in the 1962 Building Plan and in the Lancet in 1967.
- There must be more focus on health promotion and improving health or we will not be able to afford a health service.
- On health inequalities, the less advantaged people do worse in all areas, with the worst access to health services. Polyclinics/community care hospitals will be a means to address that inequality and healthy living centres/well-being centres are ambitious proposals underpinning the document.
- The majority of the population want to die at home or in a hospice, but 70% of Londoners die in hospital. Some people would prefer to die in the care home in which they live, but are moved to hospital on the basis that the home cannot or will not deal with the issue.
- The full End of Life report from the End of Life Clinical Working Group is on the King's Fund website and the NHS London website.
- End of Life care is fragmented and 54% of complaints to the Healthcare Commission relate to the death of a relative. So there is a need for integrated and co-ordinated care.
- The report recommends and there should be End of Life care in the locality, but on a larger than borough or individual PCT basis, with five zones for London adults (children's care would be on a London wide basis). These zones will provide an adequate population base with which to be able to deliver appropriate end of life services. It is recommended that two End of Life service providers are sought in each area to co-ordinate the service – these might include voluntary sector organisations or charities.
- The Marie Curie Trust has operated a pilot service in South London – if people are supported to die at home, the costs are likely to be roughly neutral.

- The service requirements/entitlements for mortal illness should be:-
 1. to be on a register
 2. to have a conversation with a qualified professional
 3. to have a service plan
 4. to have the service co-ordinated by an End of Life service provider
 5. to have 24 hour access to the service
- The individual's plan would continue after the death for benefit of the relatives, and it is important for PCTs to audit the performance of the End of Life care service provider.
- This is an ambitious proposal within HfL and one which requires a methodical approach, with lessons learnt from pilots before the plan is rolled out.

Questions

Q The Councillor for Southwark asked when the service should 'kick in' for terminally ill people

The response was that some countries certify a length of remaining life but clinicians are generally not very good at this and so there is no clear definition.

Q The Councillor for Lewisham asked what the impact on social services departments would be.

The response was that the service specification should cover both health and social services and an End of Life provider might be a social services provider. Social care would remain a very important aspect of the care provided.

Q The Councillor for Ealing queried the PCT/local authority boundary and how a larger zone would work. He also raised the issue of the eligibility criteria for social services and the need for movement of resources.

The response was that it was recommended that PCTs consider working together with boroughs to provide this care, but it was not a directive. However, to provide the service on a borough basis would result in resources being spread too thinly. A population level of 100,000 is generally needed to get all the people needed together to provide an effective and responsive service. The PCTs need to want to work together though. On the issue of resources, the health budget represents 9% of the GDP. But it is not just about levels of resource, as countries such as Japan, Singapore and Denmark spend less on health care but achieve better health outcomes. It is not clear where health ends and social care begins, but some transfer of resources to social care would not be unreasonable.

Q The Councillor for Westminster stated that he could see the rationale for a register to be established, but for the poorest people with issues such as poor housing conditions, he queried what protection there would be on the level of standards and on advocacy, and how registered social landlords would be convinced to invest in the process?

The response was that the living environment matters greatly and poor housing affects health. But End of Life care can only play a part in that. There must be improved care in the community, localised where possible. We need integrated care with improved quality and safety in healthcare. Healthcare for London will be providing health service direction for the next decade.

Q The Councillor for Camden queried how people could be sent home to die when the home is not to a decent standard, and added that five zones would not really provide local care. Also, there could be resistance to having a conversation about dying.

It was responded that there are both practical and political issues and a lot of homes might not be suitable for end of life care. The service might be delivered in different ways depending on where a person lives, but the fundamental problem is scale, which needs a large enough population base and therefore coordination across borough boundaries. On the issue of having a conversation, the majority of people want to know the truth about dying, but in a sympathetic way. Information can be used to improve the remaining lifespan and time matters. People need knowledge and advice to be able to take a view on their situation. It is really about supporting people and hearing their views.

Q The Councillor for Barnet asked about whether a poor person having to take a longer journey would really be better off.

The response was that the service should not interfere with local GP services but there should be a network with better availability, or areas where the GP services are sparse and remote could be targeted.

Q A supplementary question on the proposal to move GPs into polyclinics was posed.

The response was that this notion is not what is intended and that interpretation of the document was incorrect.

Q The Councillor for Waltham Forest raised the issue of what happens if people are too ill to move, if there needs to be negotiations with district nurses and health visitors, highlighting that it could lead to conflict over resources for continuing care. He also queried whether there are sufficient hospices and whether money for End of Life care would be ring fenced.

The response was that there may not be enough hospice places overall, although this is not clear, but also worrying is the number of residential care beds. So we need to ensure that there is the best provision possible. It was agreed that there should be a defined budget spend for End of Life care.

Q The Councillor for Bexley asked about palliative care nurses, who were the first to be made redundant in his local NHS trust. End of Life coordinators were also made redundant and so there was little evidence of support for this service area.

It was responded that the service needs to be recognised as an important one, and lack of support is not good enough.

Q The Councillor for Lambeth asked about the 54% complaints level and the added family guilt on End of Life care. There can be a slow decline in health, but if End of Life care is institutionalised, people lose the personal contact and they need an advocate.

The response was that the proposals are not institutionalism but everyone should get the sort of support they need and deserve and the service enables providers to find out what they actually want. Nurse led beds are also for respite purposes as well as for health needs.

Q The Councillor for Ealing asked about the huge workforce implications behind the Darzi proposals and the challenges of this and whether there is too much emphasis on the responsibilities for commissioning in terms of whether there is sufficient expertise.

It was responded that the workforce implications are a challenge and NHS London is looking at this for the next 10 years. The historic dispute between hospital based consultants and community based GPs in the UK persists and there needs to be a move towards the sharing of expertise – but this will not happen overnight. On commissioning, the problem is how you think about the service that you believe customers need and then how to deliver it. Health agencies must work together to commission and deliver services to avoid the process being done 31 times across London.

Q The Councillor for Southwark raised the issue of voluntary euthanasia.

The response was that this is outside the remit of the proposals and outside the current legal framework. Essentially the law must be adhered to.

8. WITNESS SESSION 3: Healthcare for London
Speaker: Stephen Richards, Director, Macmillan Cancer Support

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

- The Joint Committee was informed that Macmillan is supportive of the main thrust of the proposals in Healthcare for London. With regard to specialist treatment centres, it was important to have good quality specialist care and better coordinated care. The patient and carer are at the centre of care.
- With regard to End of Life care, the End of Life Care Strategy by the Department of Health includes the 'surprise question' for clinicians to ask themselves: *"Would I be surprised if death occurred in 6-12 months?"* This increases the number of patients referred to End of Life programmes.
- There is generally a lack of opportunity for people to ask what is wrong with them – leading to acute crisis at home and movement to hospital. It is easier for families if there is early discussion.
- The impact of cancer on people's financial situation is major – expenses are incurred through being off work, travelling to treatment, childcare, extra heating etc. Healthcare for London does not address this.
- Doctors are very cautious about giving a prognosis of six months or less to live and it is difficult to broach the subject, which gets in the way of people claiming benefits.
- With regard to out of hours care, the recommendation is to have 24 hours access to care and allow patients to die where they want to die, but there are training issues around nursing home staff. Nevertheless, out of hours care is crucial.
- There needs to be certain standards on factors like access to medication; communication between agencies; clarity on resuscitation criteria; sufficient education and training.
- The equivalent value of there being six million carers is £67billion annually, which needs to be borne in mind.
- The DH Cancer Reform Strategy advocates shared decision making, tailored information and involving users in decisions.
- The End of Life proposals should have a strengthening of the user voice in service design, commissioning, identifying and assessing carers early on, improved availability for bereavement and counselling provision.
- On palliative care in the community, it is important that symptom management is a key factor requiring effort, with greater importance attached to training. Doctors do not spend enough time developing communication skills and use of pain relieving drugs. So this is a very important area.

Questions

Q The Chairman asked how much funding there is for hospices and whether this will increase under the Healthcare for London proposals.

The response given was that there is no money or grant for Macmillan, but Marie Curie hospices receive 30% funding of their total revenue costs. (children's hospices are only funded to 10%) The role of the voluntary sector is underplayed in the Healthcare for London report and more money from Government would be very welcome. Hospices often have to work hard to raise adequate funds to support their continued existence.

Q The Councillor for Richmond asked how an agency like Macmillan would manage if asked to provide End of Life care along the lines set out by Sir Cyril Chantler?

It was responded that Macmillan is a charity, adding value to the NHS and therefore not directly providing services. The End of Life care providers mentioned in relation to the five zones would be keen to know more detail – the zones are likely to mirror the current five cancer networks. Clarity is needed on operating boundaries for them to be effective.

The Councillor for Havering suggested that there was not enough support for carers, which really needs to be there early on. If someone is dying at home, a range of changes is needed. It will be several years before Darzi proposals come to fruition and they will require changed attitudes and training. Fewer people are entering the caring professions and so it is not clear whether a sufficient number of people will be available. The role of volunteers may need to be explored in future but the demand on carers will continue.

Q The Councillor for Merton raised the issue of stigma attached to claiming carers allowance and disparity in terms of the allowance ceasing at age 65 years. The whole issue of benefits is a worry and queried if this might impact on the proposals.

The response was that benefits are a right and there should not be a stigma, as they can help people to stay at home.

Q The Chairman asked how the NHS can improve cancer patient care; how the Darzi proposals would improve patient care; and how the proposals could be improved.

The response was that the proposals will promote good quality care at or near home, with better coordination and linking of specialist and general services. If Darzi accomplishes this, it will achieve a great deal. In terms of how to improve the proposals, the training and upskilling of GPs is key; this is also the case with district nurses. Also the relationship between health and social care in terms of communication, and clarity on who provides what, is important.

The Councillor for Lewisham stated that some carers are children, who lose out over education and claiming of benefits. Sometimes there is a young carers support group nearby, but not always. Another omission is good quality information.

9. DRAFT CONCLUSIONS/RECOMMENDATIONS

Jessica Crowe from the Centre for Public Scrutiny joined the meeting for this item.

Councillors considered the draft recommendations put forward and commented on each one in turn. The suggested changes were noted and the amendments will be made to the proposed recommendations prior to the next Joint Committee meeting.

The point was made that the detail on mental health and on children's services is not available in the Healthcare for London document and it should be stated that this is not acceptable and these areas will require full consultation in their own right.

It was suggested that the language should be more robust in the Joint Committee's response and that there should be an introductory set of recommendations with general concerns, followed by recommendations on specific services.

It would be worth mentioning that the Joint Committee has operated without a budget and within a tight timeframe and the findings might be presented to the Leaders Committee of London Councils. Press coverage might be useful. There should also be the opportunity to reflect on the joint scrutiny process and learn from it, possibly through a questionnaire.

10. ANY OTHER BUSINESS

It was agreed that the issue of future meetings of the Joint Committee would be considered at the next meeting on 25th April, which would be a half day meeting at Kensington & Chelsea Town Hall.

11. CHAIRMAN'S CLOSING REMARKS

The Chairman closed the meeting by thanking all those members who had attended and contributed to the Joint Committee's work so far and to the officer support group who had ensured that the meetings had operated smoothly and efficiently.