HEALTH OVERVIEW AND SCRUTINY COMMITTEE AGENDA

| 7.30pm | Wednesday 25 June 2008 | Havering Town Hall Main Road, Romford |

Members 6: Quorum 3

COUNCILLORS:

Ted Eden (C)  Barbara Reith (VC)
Gary Adams   Linda Hawthorn
Kevin Gregory Fred Osborne

For information about the meeting please contact:
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NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Council is committed to protecting the health and safety of everyone who attends meetings of its Committees.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.

2. MOBILE COMMUNICATIONS DEVICES

Although mobile phones, pagers and other such devices are an essential part of many people’s lives, their use during a meeting can be disruptive and a nuisance. Everyone attending is asked therefore to ensure that any device is switched to silent operation or switched off completely.

3. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Committee, they have no right to speak at them. Seating for the public is, however, limited and the Council cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Council will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Committee Officer before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.
AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building’s evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (if any) - receive.

3 DECLARATION OF INTERESTS

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any time prior to the consideration of the matter.

4 MINUTES

To approve as a correct record the minutes of the meeting of the Committee held on 29 April and to authorise the Chairman to sign them.

5 NELMHT – PRESENTATION ON MENTAL HEALTH ISSUES

Members are asked to receive a presentation from Fiona Weir Borough Operations Director (Havering) North East London Mental Health Trust.

6 QUEEN’S HOSPITAL UPDATE (BHRT)

7 HEALTH OVERVIEW & SCRUTINY COMMITTEE ANNUAL REPORT 2007/08

Report attached

8 PAN – LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Report attached

9 URGENT BUSINESS
To consider any other item in respect of which the Chairman is of the opinion, by reason of special circumstances which shall be specified in the minutes, that the item should be considered at the meeting as a matter of urgency.

Cheryl Coppell
Chief Executive
MINUTES OF A SPECIAL MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall, Romford
Tuesday 29 April 2008 (7.30 pm – 9.20 pm)

Present: Councillors Ted Eden (Chairman) Linda Hawthorn (Vice-Chairman) Gary Adams, Kevin Gregory, Pat Mylod and Fred Osborne were present.

John Goulston, Chief Executive, Barking, Havering and Redbridge Hospitals’ NHTS Trust (BHRT) Ralph McCormack, Chief Executive, Havering Primary Care (PCT) and Paul Kennard, Head of Corporate Affairs, Havering PCT were also present.

No Member declared an interest in the business considered.

The Chairman advised those present of action to be taken in the event of emergency evacuation of the Town Hall becoming necessary.

19 MINUTES

The minutes of meetings of the Committee held on 8 November 2007, 4 March 2008 and 26 March 2008 were approved as a correct record and signed by the Chairman.

20 MATTERS ARISING

Ralph McCormack clarified that the PCT was spending at least £330 million on healthcare for Havering over the next five years.

Parking at Queens Hospital – BHRT had reviewed this issue and had applied to the Council to change the car park layout. Security was now available to assist with barrier problems and the car park signs should also indicate when capacity has been reached. The ice rink car park was also available as an overflow facility.

21 QUEENS HOSPITAL ISSUES – BHRT

The Committee expressed sympathy over the sad loss of Trust Chairman – Dr. Eric Nath. John Goulston agreed that the Trust as a whole was devastated at the loss of such an excellent Chairman. Discussions were ongoing with NHS London and the NHS Appointments Commission and it was hoped to announce the new Interim Chairman by 9 May.

The current Trust deficit was around £35 million. This was an improvement of £5 million on the previous reported figure due to a technical adjustment in the way in which charges were levied on PCTs for hospital stays. The planned deficit for the current (2008/09) financial year was £23 million. The
Trust’s business plan predicted a £1.5 million surplus for 2009/10 and the required 2% surplus being achieved in 2010/11.

311 new staff had started across the Trust since January 2008 with a further 100 needed overall. 14 additional doctors and 6 extra nurses had been recruited across the 2 Trust A & Es (Queens and King George). 30 more nursing staff were still needed in A & E with a larger shortfall at Queens than at King George. 19 therapists had been appointed as had 16 health scientists in the Trust’s pathology laboratories. More administration staff were also being recruited including medical secretaries and administration staff.

Expenditure on agency staff was running at £30 million per annum with 60% being spent on agency nurses. The recruitment of further permanent staff should act to reduce this figure. A development programme had also been introduced for senior nursing staff.

The Trust Chief Executive admitted that meeting of the 4 hour A & E wait target had not improved as much as he would have liked. The latest figure was that this target was met in 87% of cases. The Trust had updated its joint action plan with the PCT in an attempt to improve this. Part of the problem was a shortage of senior nurses. The extra step down beds at St. George’s Hospital had not had an impact as yet as their opening had coincided with a 10 day closure of a ward at Queens due to an outbreak of sickness. This ward had now reopened and it was hoped that the benefit of the extra beds at St. George’s would now be seen.

For reasons that were uncertain, there had been a rise of 25% in ambulances coming to Queens with patients needing resuscitation. These were mainly respiratory cases and there had been a similar rise at other local hospitals. It was possible to divert ambulances from Queen’s for up to 2 hours at times of serious bed shortages. This had occurred twice at Queen’s in the last month as well as once at Whipps Cross and once at Newham Hospital.

A paper was tabled explaining the Trust’s intention to move to 4 overall clinical divisions. Directors of each division would be clinicians who would report direct to the Trust chief executive and each division would also have a divisional manager and divisional nurse. Initial internal recruitment had begun for the director posts.

It had been established that the flooding earlier in the year in the Queens pathology department had been caused by an unidentified member of staff disposing of waste incorrectly. A similar problem had occurred last week in the phlebotomy section although this had only caused delays of around 30 minutes. Reports of patients having to be left on trollies in the hospital’s reception area were incorrect. Clear notices instructing staff on waste disposal had now been put up.
There had not been a reduction in service to the Healthy Weighs anti-obesity group. BHRT consultants led by Rodney Burnham were keen on nutrition services and there were a need to improve the existing service. John Goulston undertook to respond formally to the separate correspondence with the Committee on this matter.

The Trust Chief Executive agreed that the blood testing clinic at Queens was overcrowded and sometimes had lengthy waits for patients. There had been a rise in the number of GP referrals for blood tests. One option was to move the clinic from Queens to the Victoria Centre although parking at this site may be difficult. Another option could be to have a second phlebotomy clinic at Queen's although there was no reason that blood tests had to be undertaken in a hospital facility. Ralph McCormack added that there were now more phlebotomy clinics in the community e.g. at Harold Hill and Cranham health centres. Further community provision may however be needed to meet demand.

In response to reports of people having to repeatedly give their details in different parts of Queens A & E, John Goulston explained that the hospital had been due to open with the new NHS care records computer system but this would not be ready until at least late 2009. Thus the existing patient administration system at the hospital was, in part, 25 years old and it was in fact quicker to ask patients questions than go through computer screens. Wheelchairs were normally available to help people move around A & E although these sometimes moved location during the day. Initial assessments are undertaken at the Urgent Care desk and triage should be undertaken almost immediately on arrival at the Majors and Minors units. The triage nurse was responsible for dealing with any blood on patients etc.

The Chief Executive agreed to check the position with student nurses who may be wearing their uniforms off site. Spot checks were undertaken on other nurses arriving or leaving in their uniforms. Members reported they has observed this regularly occurring and the Chief Executive agreed to report this to the Trust Director of Nursing.

Smoking was banned throughout Trust sites including hospital grounds although it was noted that smoking in hospital grounds was not in fact a criminal offence. Staff smoking on hospital grounds would be considered as a disciplinary offence.

John Goulston agreed to investigate reports of very poor lighting in outpatients team 3 at Queens and also asked for minutes of the meeting to be forwarded once they were available.
22 AUTONOMOUS PROVIDER ORGANISATION PILOT – HAVERING PCT

Ralph McCormack explained that Havering was one of seven London PCTs piloting arrangement to separate the Trust’s commissioning and providing functions. This was part of a longer term move by NHS London to ensure that no PCT dealt with both commissioning and provision. The four month pilot consisted of self-assessment and a series of challenge meetings. The PCT had to demonstrate competency in the separation of these arrangements. A provider board with separate functions had existed at the PCT since April 2007. The PCT intended to continue to work towards full independence for provider services over the next 18-24 months.

The Chief Executive also confirmed that the PCT was continuing to assess stroke services. An internal review had indicated some concerns but didn’t conclude that immediate change was needed. There had been no further deterioration in services to date. Ralph McCormack agreed to forward the analysis of strokes that had been produced by the PCT’s public health department. There was no reason why a local centre of excellence for stroke care could not be developed over time but it was necessary to improve current service levels first. The Chief Executive felt that previous problems with the service had been due to poor organisation and a lack of clinical leadership. The current care pathway for stroke was not correct.

Ralph McCormack felt that his personal responsibility extended to every part of the system including commissioning, provision, GPs, health visitors etc. The finances of the Trust were now good with an end year surplus of £300,000. The Trust had been repaid £3.5 million operating plan support funding this year and was keen to spend this for the good of Havering residents.

23 POLYCLINICS – HAVERING PCT

The PCT Chief Executive explained that the Darzi model would have 5 polyclinics for Havering but he felt that this was too many. The Trust was working with GPs on a strategic plan to allow Havering residents to access good quality, local care. The aim was to arrange GP access from 8 am to 8 pm, Monday to Saturday. It was also noted that some of the best Havering GPs were single practice and it was therefore difficult to completely rule out these types of services. Discussions on possible structures for GP provision in Havering were currently in progress with both the GPs themselves and wider stakeholders.

The PCT was also investigating the possibility of locating a polyclinic at the St. George’s Hospital site in conjunction with the other services already there. This would take approximately three years to deliver. A polyclinic could cover primary care, parts of secondary care as well as minor procedures. Some practitioners currently operating from a hospital could
work more locally in a polyclinic.

Polyclinics would not replace all current GP practices. There would be mixed provision with access points and referral centres. The role of pharmacists was also important for basic health care and advice. The polyclinic at St. George’s Hospital would also include urgent care access although this wouldn’t necessarily be the case at other polyclinics in Havering.

24 UNDERDOCTORED AREAS – HAVERING PCT

The PCT Chief Executive explained that the rising local population would lead to an increase in demand for health services. Pilot arrangements for longer GP opening hours were in operation and permanent proposals for extended opening hours would be introduced next month.

The PCT was aware of pressures caused by the rising population in areas such as Harold Wood, Rainham and Central Romford. Whilst the immediate priority was Harold Wood, dialogue was also underway with GPs in the Rainham area. It was possible that sites for new GP surgeries in Rainham could be announced within the next 18 months. As regards Romford and the pressure being placed on health services by new developments in the town centre, it was possible that a 2 GP practice could be opened at the current LIFTCO site in London Road. This would be a short-term solution to the longer-term need for a more extensive health infrastructure in Romford town centre.

Longer GP opening hours were part of the solution. Some GP practices could also use their existing resources better. The new GP contract meant the PCT could not stipulate the number of GPs per unit of population or the hours of face to face contact with patients. There was therefore an issue of relationship management although the PCT’s relationship with GPs was better than it had been previously.

Members noted that Ralph McCormack was now also a Governor of the North East London Mental Health Foundation Trust (NELMHT). Mr. McCormack emphasised that his Governor role was not one of decision making but concerned stewardship and strategic direction.

The position of PCT Chairman had been advertised nationally without gaining much interest. The Chief Executive was open to advertising locally if this was allowed by NHS London and the NHS Appointments Commission.

25 URGENT BUSINESS

Officers informed the Committee that the final report of the Joint Pan-London Health Overview and Scrutiny Committee had now been published. This would be presented to the Joint Committee of PCTs on 6
May and they were due to respond on 12 June. The Joint Committee itself would meet again in the autumn in order to consider this response and further developments. The Joint Committee’s report would be presented to this Committee at its next meeting and officers would also circulate this to Members for their information.
REPORT OF THE CHIEF EXECUTIVE

SUBJECT: COMMITTEE’S ANNUAL REPORT 2007/08

SUMMARY

This report is the annual report of the Committee, summarising the Committee’s activities during the year ended May 2008.

It is planned for this report to stand as a public record of achievement for the year and enable Members and others to compare performance year on year.

There are no direct equalities or environmental implications attached to this covering report. Any financial implications from reviews and work undertaken will be advised as part of the specific reviews.

RECOMMENDATION

1. That the Committee note the 2007/08 Annual Report.

2. That the Committee agree the report be referred to full Council.

Staff Contact: Anthony Clements
Principal Overview and Scrutiny Support Officer

Telephone: 01708 433065

Cheryl Coppell
Chief Executive

Background Papers

Correspondence between Health Overview and Scrutiny Committee and Health Trusts.
ANNUAL REPORT FOR THE YEAR ENDED MAY 2008

During the year under review, we have met as a Committee on 6 occasions (including 1 special meeting) and dealt with the following issues:

1. CORRESPONDENCE WITH HEALTH TRUSTS

1.1 A principal method of working for the Committee has continued to be the exchange of correspondence of health scrutiny matters with local health Trusts. In excess of 60 letters have been undertaken this year, principally with the three Health Trusts covering this Borough – Havering Primary Care Trust (PCT) Barking, Havering and Redbridge Hospitals’ NHS Trust (BHRT) and North East London Mental Health Trust (NELMHT).

1.2 A wide range of issues have been covered ranging from fire procedures at Queen’s Hospital to readiness for an influenza pandemic and a number of issues relating to diabetes services. All letters sent are copied to each member of the Committee as are any responses received and this has proved an effective method of gaining information and of the Committee learning about the quality of local health services.

1.3 Responses from the Health Trusts have remained variable throughout the year and, in general terms, somewhat slower than the Committee requires. It should be noted that responses from BHRT have improved in both their speed and quality since the arrival of a new Chief Executive and Chairman in late 2007.

2. QUEEN’S HOSPITAL ISSUES

2.1 The Committee placed great emphasis this year on investigating reported problems and issues relating to Queen’s Hospital in Romford. A large number of issues have been raised with BHRT including cancelled operations, a lack of intensive care beds and details of security arrangements at the hospital. Responses from the Trust in the first half of the year were not of a standard considered acceptable to the Committee and formal action was close to being taken by the Chairman. As stated above however, the Committee is pleased to
note an improvement in this situation since the new Trust Chief Executive and Chairman took over responsibility.

2.2 In January, members of the Committee met informally with the BHRT Chief Executive – John Goulston and the Trust’s then Chairman – the late Dr. Eric Nath. The Members present were impressed by the openness displayed by both Trust officers and their willingness to discuss, in some detail, the problems they and the Trust were facing. The Committee were pleased to welcome to this meeting Councillor Allan Burgess, the Chairman of the Redbridge Health Scrutiny Committee as well as the Redbridge Health Scrutiny Coordinator. Mr. Goulston also attended a meeting of the full Committee in April in order to update on the issues that had been raised.

2.3 The Committee visited Queen’s Hospital in March and toured parts of the site including a detailed viewing of the Accident & Emergency facilities. Further discussions were held on this occasion with Mr. Goulston as well as with the Trust’s Director of Nursing and other senior BHRT officers.

2.4 The Committee wishes to take this opportunity to express its condolences at the sudden death during the year of the BHRT Chairman Dr. Eric Nath. Equally, the Committee also wishes to express its sadness at the unexpected death of Len Smith, Chairman of Havering PCT. Both these officers were well known to Members and had worked extensively with the Committee in the past.

3. **FIT FOR THE FUTURE**

3.1 The Outer North East London Joint Health Overview and Scrutiny Committee has continued to operate extensively during the year. The first part of the year was spent dealing with the Fit for the Future proposals to alter local health services. Members received detailed briefings on this issue from NHS officers. The Committee also met with Professor Sir George Alberti, the independent medical expert brought in to conduct an external review of the quality of the plans. Members of the Joint Committee are shown overleaf during discussions with Professor Alberti.

(Clockwise from left: Ann Smart (Fit for the Future team) Professor Alberti, Councillor Allan Burgess (Redbridge) Councillor Ralph Scott (Redbridge) Councillor Filly Maravala (Redbridge) Jilly Mushington (Redbridge) Tony Fuller (co-opted member) Councillor Fred Osborne (Havering) Councillor Ted Eden (Havering) Pam Kaur (Havering).
3.2 Professor Alberti concluded his review and found that there was insufficient leadership and detailed planning undertaken to make the proposed reforms effective. These were concerns that had been expressed by the Joint Committee and the Committee was pleased to note the subsequent decision by NHS London to place the reform programme on hold until these areas had been addressed.

4. NELMHT FOUNDATION TRUST APPLICATION AND SERVICE REPROVISION

4.1 The other major item of work for the Joint Committee this year was the scrutiny of the above NELMHT proposals between July and October. The Joint Committee met formally on six occasions as well as informally on three other occasions during this period. Detailed discussions were held with senior NELMHT officers on several occasions and evidence was also taken from a number of other parties including local PCTs and Social Services Departments, the Mental Health Foundation and the HUBB and Together service user groups.

4.2 The Committee’s report contained a total of 38 recommendations covering the Foundation Trust application as well as acute services, primary care and other aspects of the proposed service reprovision. This report was presented to NELMHT in October.
4.3 There has since been a detailed exchange of correspondence between the Joint Committee and NELMHT concerning issues raised by the report, some of which has been quite negative in nature. The Committee is pleased to note however that the most recent discussions held direct with the NELMHT Deputy Chief Executive and Chief Operating Officer in April were more productive in nature.

4.4 NELMHT will update the Joint Committee on progress during the new municipal year and the Joint Committee will also continue to scrutinise mental health issues as part of its work programme.

5. PAN-LONDON SCRUTINY OF HEALTHCARE FOR LONDON PROPOSALS

5.1 In November, the first Pan-London Joint Health Overview and Scrutiny Committee was established to scrutinise the proposals of the Healthcare for London report submitted by Lord Darzi. This Committee met on six occasions between November and March and Havering was represented by Councillor Eden with Councillor Osborne as a substitute.

5.2 The Pan-London Committee received evidence from a wide range of stakeholders on the proposed changes to health services in London including GPs, surgeons, midwives and Transport for London. Written submissions were also made to the pan-London Committee by both the Havering and Outer North East London Health Overview and Scrutiny Committees.

5.3 The Pan-London Committee’s report was finalised in May and this is currently being considered by the NHS. An initial response from the NHS is expected in mid-June and the Joint Committee will meet again in the autumn in order to consider the latest situation.

6. NELMHT DRUG REHABILITATION UNIT

6.1 In July, the Committee was contacted by a group of parents protesting that NELMHT had opened a unit for the treatment of people with drug addiction and related problems opposite Harold Court Primary School in Harold Wood. Parents at the school were concerned that there had been little consultation on the opening of the unit and that drug users may be visiting the premises at times when children would be entering or leaving the school.

6.2 In response, the Committee facilitated a meeting between a group of the concerned parents and the Chief Executive and other senior officers of NELMHT. Local ward Councillors were also present as was a representative of the local MP. The meeting enabled a positive and constructive discussion of the issues and the NELMHT officers undertook to cease seeing service users at this site within six months. Thus the scrutiny process had produced a workable solution for all parties.
7. HEALTHCARE COMMISSION ANNUAL HEALTHCHECK

7.1 The Committee held a special meeting in March to consider the self-assessment declarations of the Health Trusts for the Healthcare Commission Annual Healthcheck. Representatives from Havering PCT, BHRT and NELMHT attended and gave a summary of their Trust’s self-assessment. The Committee was also pleased to welcome for the first time a representative of London Ambulance Service to discuss that Trust’s self-assessment.

7.2 Positive discussions were held about the various Trusts’ self-assessments and these formed the basis of the Committee’s written comments to each Trust. These written comments have been incorporated into the final Healthcheck Assessment return for each Trust. The Committee was pleased to receive a response to their comments from the Chief Executive of NELMHT thanking the Committee for its support and looking forward to continuing this productive working relationship into the next year.

8. OTHER ISSUES CONSIDERED

8.1 Havering PCT Financial Issues – In June, senior PCT officers including the Chief Executive and Director of Finance explained in detail the past and current financial issues facing the Trust. This gave Members a useful overview of PCT finances and also served to illustrate for Members the workings of the NHS internal market.

8.2 Other PCT Issues – Throughout the year, the PCT has briefed the Committee on numerous issues including its commissioning role, its recently awarded status as an Autonomous Provider Organisation and its plans for dealing with the rising population in parts of the borough.

8.3 Delayed Transfers of Care – The Committee received a presentation from the Head of Adult Services giving his views on the causes of delayed transfers of care from hospital into care facilities.

8.4 Queen’s Hospital Parking – The Committee was approached during the year by a relative of a patient who had died at Queen’s Hospital. During discussions with the relative and senior BHRT staff, it emerged that although Trust policy was to waive parking charges for relatives of gravely ill patients, this was not in fact happening in practice, principally due to the policy not being communicated adequately to Trust staff. Following this situation being brought to the Trust’s attention by Members, BHRT has agreed to communicate the policy on parking charges in these instances to all relevant staff. The Trust has also indicated that the relative concerned has been reimbursed for the charges they incurred.

The following comments have been submitted by members of staff:

Financial implications and risks:
There are no financial implications or risks arising directly from this report.

**Human Resources implications and risks:**

There are no human resources implications or risks arising directly from this report.

**Legal implications and risks:**

There are no legal implications or risks arising directly from this report.

**Equalities and Social Inclusion Implications and Risks:**

There are no equalities or social inclusion implications or risks arising directly from this report.
REPORT OF THE CHIEF EXECUTIVE

SUBJECT: PAN-LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

SUMMARY

The Committee is asked note the work undertaken by Members on its behalf as part of the Pan-London Joint Health Overview and Scrutiny Committee looking at the Healthcare for London proposals. The Committee is also asked to note that further Healthcare for London proposals are likely to be brought forward in due course and that these will also require scrutiny.

RECOMMENDATION

1. That the Committee notes the work undertaken to date by the Pan-London Committee as exemplified by the Committee’s conclusions and recommendations shown as Appendix A.

2. That the Committee notes the likelihood of further scrutiny work being required as specific proposals for services affecting Havering are finalised
1 At its meeting in November 2007, the Committee agreed that it should be represented on the planned Joint Pan-London Health Overview and Scrutiny Committee. This Committee had been set up in order to scrutinise the proposals in the Healthcare for London report that had been complied by Lord Darzi. It was agreed that the Committee’s representative on the joint body would be Councillor Eden with Councillor Osborne as a substitute. The Committee met on six occasions between November 2007 and March 2008 and received evidence from a large number of witnesses ranging from the Royal College of Nursing and Transport for London to the Royal College of Surgeons and GP representatives.

2 The Pan-London Committee completed its report in May 2007. The main body of the report has been circulated to Members previously but the conclusions and recommendations of the Committee are shown as Appendix A for reference. Members will note the large variety of issues that have been covered.

3 The report of the Joint Committee was presented to the Joint Committee of London Primary Care Trusts (JCPCT) on 6 May and all London PCTs are currently considering their response to the report. The JCPCT are due to present their response on 12 June and officers will give an update on the situation to this Committee at the meeting on 25 June.

4 It is planned for the Pan-London Committee to meet again in autumn 2008 in order to consider the latest situation. It is expected that, with effect from autumn this year and potentially continuing for a number of subsequent years, specific proposals for healthcare changes will be brought forward by the NHS in London. These could be specific to Havering (for example the introduction of one or more polyclinics by Havering PCT) affect the North East London region as a whole (for example changes affecting Queens Hospital) or cover the whole of London (for example changes in the operation of London Ambulance Service). It should be emphasised that no specific proposals have been released so far and that the Healthcare for London report which the Pan-London Committee scrutinised looked purely at overall strategies and direction. As specific plans are submitted for scrutiny, the Committee will need to consider the best method of scrutinising these, whether alone, via the existing Joint Committee for North East London or on a pan-London basis. A consideration of these options will be the subject of a further report or officer briefing once the specific proposals are known.

Financial Implications and risks:

The costs of the pan-London Committee were shared amongst the lead borough (LB Hillingdon) and those involved in clerking or hosting the meetings. Other than travel expenses for Members and officers to get
to the venues, there was therefore no direct cost to the Council of this review.

**Legal Implications and risks:**

There are none.

**Human Resources Implications and risks:**

There are none

**Equalities and Social Inclusion Implications and risks:**

All 32 London Boroughs were represented on the Pan-London Joint Committee as well as City of London, Essex and Surrey County Councils.

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<tr>
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Cheryl Coppell  
Chief Executive

**Background Papers and Appendices**

Background Papers – None.

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

A joint authority health scrutiny committee comprising all of the London Boroughs and the City of London, Essex and Surrey County Councils

Final report of the Committee
April 2008

Conclusions and recommendations
Conclusions and recommendations

The JOSC welcome the opportunity to comment at this early stage on the models of care outlined in “Healthcare for London” (HFL). We share Lord Darzi’s diagnosis that there is a clear need for London’s health services to change in order to meet the demands of the next ten years and beyond.

However, HFL is a vision, not a detailed strategy or plan, and we are deeply concerned about significant gaps in the review. It is not acceptable that mental health and children’s services were added as an afterthought. The JOSC expect the same opportunity to analyse proposals for these services as with the services originally included in HFL.

Similarly, we heard that further work is underway on key areas to develop the vision outlined in HFL, including the impact on social care and the implications for NHS estates and finances. As this important information is not yet available, we – the scrutiny Members of London’s local authorities and surrounding areas participating in the JOSC – reserve our position to comment on specific proposals when this detail becomes available.

The varying response to the HFL consultation across London demonstrates the NHS must work harder to develop the public’s understanding that turning the HFL vision into reality will fundamentally change the way their health services are provided. The NHS must rise to this challenge and deliver meaningful engagement in future discussions on specific changes.

We now present our recommendations in response to the HFL consultation which highlight issues that cause us concern, areas in which further work is required and aspects of the review that we believe are positive. A recurring theme is the need to ensure reforms improve the accessibility of healthcare services and the physical access to facilities where these are provided. We are pleased that NHS London has already accepted the key role that local authorities play in this process, and we look forward to authorities being invited to take part in further detailed considerations on this and all other aspects of Healthcare for London.

The JOSC has unanimously agreed these recommendations, demonstrating the strength of shared feeling across all London’s local authorities. In line with health scrutiny legislation we look forward to receiving an appropriate response from the NHS and will reconvene in the autumn to discuss this response and examine NHS London’s next steps.
1. Financing the reforms

We have not heard any evidence that the appropriate resources exist (or have ever been identified) to establish and then support the major changes proposed in HtL. Selling under-used estates may help pay for new facilities, but such sales can only take place once the new services are operational. We have not heard whether additional ‘pump-priming’ resources will be available to solve this dilemma and run the existing services at the same time as pilot pathways are developed and tested.

(a) We recommend that NHS London states how and when the money will come from to develop new services in order to address concerns about whether the NHS has the resources available to deliver major reform.

Resources for providing health care are finite. The proposals are likely to lead to primary and social care providing treatment currently undertaken in hospitals.

(b) We recommend that the NHS ensures that ‘the money follows the patient’ and resources are reallocated from acute trusts to primary and social care to reflect changes in the way that patients are treated.


It is unacceptable that local authorities were not part of the original review. The NHS and local authorities must work together in partnership, and steps must be taken to prevent partnerships working to different (and potentially conflicting) priorities. Disagreements about who pays for which aspects of care can undermine patient well-being.

(a) We recommend that London Councils is involved in developing further detailed proposals for London’s health services, including fully quantifying the impact on community care services. Partners must have a shared understanding of their required contribution to avoid disputes over ‘cost-shunting’.

Providing world-class health services for London will require ever-closer working between health and social care providers, including increased joint commissioning between these organisations. The NHS budget for London has more than doubled in the last eight years; however funding for social care services has seen nothing like this rise. The 2007 Comprehensive Spending Review will continue this trend with the percentage growth in allocations for the NHS being four times that of the increase for adult social care. This will exacerbate the focus of local authorities on individuals with acute social care need.
(b) We demand that NHS London outlines how seamless care will be provided in the context of the hugely differing budget increases for health and social care that have sharpened the distinction between universal health services and means-tested social care services. Future funding allocations must give equal weight to health and social care budgets.

3. Health Inequalities

Lord Darzi correctly highlights that there are significant inequalities in the health of London's residents. Much of this is due to the way that the location of services has evolved over the years in an unplanned manner.

(a) We recommend that the NHS focuses resources on communities with greatest health and social care need, and ensures reforms overcome inequalities by improving access to health services. Funding allocations to PCTs must reflect the challenges of providing services to that population.

Health inequality assessments are key to ensuring this happens, and we therefore welcome the impact assessment undertaken on the broad proposals in Hft. This must not be a one-off piece of work.

(b) We recommend that NHS in London carries out further health inequalities impact assessments (i) once detailed proposals have been developed, (ii) a year after implementation of each new care pathway to demonstrate that reforms have reduced not increased inequalities, and (iii) and on a regular basis to monitor the long-term impact of the reforms on health inequalities.

4. A Staged Approach to Reform

‘Big bang’ reform can be risky, and ‘leaking problems’ with new health services could have fatal consequences.

(a) We recommend that a staged approach is undertaken to implementing new care pathways with, for example, ‘polyclinics’ piloted in a selected number of sites. Results from these pilots and existing examples of the proposed care pathways must be evaluated with learning fed into any subsequent roll-out across London. NHS London must also ensure lessons are learnt from work to implement Lord Darzi’s vision in the rest of the country.

The NHS must be clear and open so that it cannot be accused of implementing the Hft vision in a piecemeal fashion.
(b) *We recommend* that the NHS publish a transparent timetable for implementing the HfL vision which will enable Overview & Scrutiny Committees to hold the NHS to account.

5. Helping people stay healthy and out of hospital

Admission to hospital is not always in the best interest of patients or their families. Staff working in the community (e.g. community matrons) along with pharmacists can help people manage their long-term conditions and prevent the need for emergency hospital admission.

Sufficient resources will be required to fund key professionals such as physiotherapists and occupational therapists who will provide rehabilitation and treatment in the community following the proposed earlier discharge from hospital.

Much of HfL focuses on ensuring patients receive high quality care once they become sick. However intervention ‘upstream’, e.g. helping people quit smoking, can prevent the need for hospital treatment later.

*We recommend* that NHS London sets a minimum level of expenditure that PCTs must commit to (a) helping people lead healthy lives and (b) helping patients manage their long term conditions. This approach will involve close working with partners such as local authorities.

6. Carers

In addition to impacting on social care, greater care in the community will place additional demands on unpaid carers. According to calculations by Carers UK unpaid carers save the NHS £87 billion a year, more than the annual total spend on the NHS, which stood at £82 billion in 2006/7.

*We recommend* that NHS London analyses the impact of the HfL proposals on carers in London, and states the action that the NHS will take to ensure any proposals arising from this consultation will not increase the burden on this often ‘hidden army’ of dedicated individuals.

7. Maternity services

We are concerned that HfL is likely to require further midwives at a time when the profession is already under severe strain.

(a) *We recommend* that NHS London re-examines the allocation of funding for midwifery and commits expenditure to expand the number of midwives in London (i.e. through improved recruitment and retention).
We support the principle of maternal choice where this is practical, but we have encountered mixed views about stand-alone midwife-led units.

(b) We recommend that NHS London ensures that there is a range of birthing options available to meet varying local need, and reconsiders the proposals for stand-alone midwife-led units given the mixed experience so far.

8. Children’s health

We are unable to give a substantive view on how children’s health services should develop given the omission of this important area from the original HTL review. We again express our dissatisfaction that children’s services were an afterthought in the review: children are not simply ‘mini-adults’ and have distinct health needs.

(a) We recommend that if specialist care is further centralised then the NHS examines how it will manage the impact on children’s families during the treatment at more distant specialist hospitals.

As with adults, hospital treatment should be a last resort for children, and non-NHS community facilities should be used to promote good physical and mental health.

(b) We recommend that the NHS works with local authorities to ensure that Children’s Centres and Extended Schools are equipped and resourced to provide community health services for our young residents.

9. Centralising specialist care

We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes. However, we will not give blanket approval to all proposals for centralising specialist care at this stage, and expect future consultations to set out prominently the clinical benefits of each particular proposal.

(a) We recommend that clinicians have a major role in developing proposals, and expect them to be involved in explaining to the public that proposals strive to improve patient care rather than save money.

London is a congested city for much of the day. At peak times it may take a long time to travel short distances.
(b) We recommend that the London Ambulance Service (LAS) and Transport for London (TfL) are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS London must work with these organisations to agree a travel plan to underpin any expansion of a hospital’s services.

(c) We recommend that the NHS adopts a ‘hub and spoke’ model that involves local hospitals treating less complicated cases of specialist care in the daytime with specialist centres providing treatment out of hours when travel times are shorter.

Centralisation of specialist care may involve critically ill or injured patients spending longer in ambulances.

(d) We recommend that any centralisation of specialist care can only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require.

10. The future of the local hospital

The proposals could lead to local hospitals (often referred to as District General Hospitals or "DGHs") losing services either to specialist centres or to polyclinics providing more general care. However, sufficient beds will be required in local hospitals to enable discharge from specialist centres once the initial treatment has been provided, as well as continuing to deliver the majority of hospital treatment that does not need to be undertaken at a specialist centre.

(a) We recommend that NHS London provides a firm commitment that reforms arising from HfL will not threaten the concept of local hospitals which must provide a sufficient range of services to make them economically viable. Reforms must be planned as to prevent a "salami-slicing" of services that create diseconomies of scale.

Specialisation must not undermine care for patients who have several health problems (e.g. the elderly).

(b) We recommend that NHS London outlines how increased specialisation of hospital care will improve the care for people with multiple health needs (often referred to as ‘co-morbidities’).
11. GP services and ‘polyclinics’

We agree that Londoners could benefit from the provision of a broader range of services in the community. It is unacceptable to expect people to travel to a hospital to have a routine blood test, for example. However, it is expensive to provide certain diagnostic services and resources must not be duplicated with polyclinics becoming ‘mini-hospitals’.

(a) We recommend that the NHS demonstrates that providing complex diagnostic services in new community facilities offers better value than using this funding to expand access to existing services (e.g. greater or improved access to hospital x-ray equipment for primary care patients).

There has been much debate in our meetings about the proposal for polyclinics. We do not believe ‘one size fits all’. Partners such as local authorities must be fully involved in providing services in pilot polyclinics in order to realise the potential of these as holistic ‘well-being’ centres.

(b) We recommend that PCTs, local authorities and other partners are able to decide the appropriate models for providing access to GP and primary care services taking into account specific local circumstances.

It will be vital to balance benefits of a greater range of services with the importance of ensuring GP services are accessible.

(c) We recommend that the NHS provides a commitment that reforms will improve access to and the accessibility of GPs, and reforms will not undermine the patient/GP relationship that for many is at the heart of the NHS.

The NHS must ensure reforms take account of the fact that many GP patients do not have access to a car.

(d) We recommend that new primary care facilities (i.e. the model referred to as ‘polyclinics’) can only proceed if the NHS has agreed a travel plan with TfL and the relevant local authority.

12. Mental health

Mental health services must not be the forgotten or neglected aspect of the NHS in London. Again, we express our deep dissatisfaction that mental health (one of the largest services in the NHS) was excluded from the original HCL review, and we wish to hear how the NHS will develop services for the majority of mental health service users that do not require in-patient treatment.

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**Appendix A**

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**We recommend** that NHS London outlines how it will ensure sufficient resources will be allocated to meet the challenges facing London’s mental health services, including the establishment of talking therapies and other non-drug based treatments.

**13. End of life care**

Again, ‘one size does not fit all’ and end of life services must be tailored to individual need, circumstances and preferences. This will require NHS professionals to undertake sensitive conversations with patients diagnosed with a terminal illness. Improvements to end of life care will require joint working across health, housing and social care organisations in the public, private and voluntary sectors.

(a) **We recommend** that NHS London provides a commitment that any reforms to end of life care will not lead to people dying in poor quality housing and/or alone, and that where hospitals provide end of life care this is in an adequate and dignified setting.

(b) **We recommend** that health professionals work with patients at an early stage to help them plan for how and where they would like their end of life care to be delivered.

Nursing/care homes are people’s homes and proposals for improved end of life care must reflect this.

(c) **We recommend** that NHS London clarifies how it will ensure residents of nursing/care homes are not transferred to a hospital to die when this is driven by the needs and wishes of the care home rather than the individual.

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**14. Understanding the cross-border implications**

London is not a self-contained entity, and patients travel in either direction across the London boundary to receive NHS care.

**We recommend** that NHS London works closely with colleagues from the surrounding Strategic Health Authorities to explore the implications of any reforms on patients crossing the Greater London Authority (GLA) boundary.

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**15. Workforce**

The major changes proposed in HfL will require professionals to acquire new skills and work differently; notably up to a third of current hospital nurses could be required to transfer to the community setting. This is perhaps the greatest challenge facing implementation of HfL: reforms cannot proceed if
The workforce is not in place. Different teams of professionals must work together to achieve seamless care.

We recommend that NHS London publish a workforce strategy that will enable the delivery of any changes to London's health services: resources for workforce development must not be diverted in times of financial difficulty.

16. ICT: providing the electronic connections

Providing seamless health and social care services will also require the ability for different parts of the health and social care economy to be able to communicate electronically.

We recommend that further work is undertaken to ensure that the appropriate ICT infrastructure is in place to deliver the care pathways arising from this and subsequent consultations. The NHS must state what it has learnt from the recent attempts to implement major ICT projects.

17. Compatibility with recent reforms to the NHS

The NHS has undergone significant reform in recent years including the introduction of Payment by Results and the creation of Foundation Trusts. We are concerned that Payment by Results may encourage competition between acute trusts rather than the cooperation required to establish specialist centres, while the freedoms for Foundation Trusts may complicate the proposed shift to greater care in the community.

We recommend that the NHS London provides further reassurance on how the ability of Foundation Trusts to retain resources from the disposal of their estates affects NHS London’s proposal to use the sale of underused assets to pay for polyclinics and new community facilities.

18. Moving forward

This Committee demonstrates the value of the unelected NHS talking to local Councillors who are elected to represent and speak up on behalf of local communities. This does not happen enough and engagement of local Councillors must not be limited to formal participation in Overview & Scrutiny Committees to respond to consultations.

(a) We recommend that NHS London and PCTs are proactive in approaching local Councillors before and during work to develop local health services: the NHS must have an ongoing dialogue with Overview & Scrutiny Committees (OSC) to discuss the appropriate level of consultation required.

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We do not believe that Londoners, including those working in the NHS, appreciate the impact that the reforms proposed in HIL could have on existing services.

(b) We recommend that the NHS in London overcomes this limited awareness and outlines what action it will take to ensure widespread engagement in future consultations.

We will meet again in the autumn to examine NHS London's response to these recommendations and the consultation more generally. At that meeting we will look forward to hearing more on the strategy for implementing the reforms that HIL states are essential to ensure the NHS meets London's needs.