Health, Adults & Older People’s Services
Overview and Scrutiny Sub-Committee

Wednesday 4th June 2008

Council Chamber
Waltham Forest Town Hall
Forest Road
Walthamstow E17 4JF
at 7.30 p.m.
All Council/Committee Meetings are held in public unless the business is exempt in accordance with the requirements of the Local Government Act 1972.

Most meetings are held at Waltham Forest Town Hall which is an accessible venue located in Forest Road E17 between Waltham Forest Magistrates Court and Waltham Forest College. The nearest underground and railway station is Walthamstow Central, which is approximately 15 minutes walk away from the Town Hall. Buses on routes 275 and 123 stop outside the building.

There is ample parking accommodation for visitors for meetings held at Waltham Forest Town Hall including parking bays for people with disabilities.

There is a ramped access to the building for wheelchair users and people with mobility disabilities.

The Council Chamber and Committee Rooms are accessible by lift and are located on the first floor of Waltham Forest Town Hall.

Induction loop facilities are available in most Meeting Rooms.

Electronic copies of agendas, reports and minutes are available on the Council’s website. The link is www.walthamforest.gov.uk/index/council/committees. Copies of agendas, reports and minutes are also available for inspection at Waltham Forest Town Hall and local libraries.

Contact officers listed on the agenda will be able to provide further information about the meeting and deal with any requests for special facilities. Contact details for report authors are shown on individual reports. Report authors should be contacted prior to the meeting if further information on specific reports is needed or if background documents are required.
Dear Member,

This is formal notice advising you of the above meeting. The Agenda is set out below. Supplementary Items will only be added if pursuant to the Council’s Constitution.

Roger Taylor
INTERIM CHIEF EXECUTIVE

MEMBERSHIP:

Chair: Councillor R. Sweden
Vice Chair: Councillor J. Beanse
AGENDA

1. APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS

2. DECLARATIONS OF INTEREST

   Members are asked to declare any personal or prejudicial interests they may have in any matter that is to be considered at this meeting.

3. PUBLIC PARTICIPATION - REQUESTS TO SPEAK AT THE SUB COMMITTEE.

   There have been no requests to address the meeting.

4. MINUTES OF THE LAST MEETING

5. PAN LONDON DARZI HEALTHCARE FOR LONDON JOSC REPORT

   For noting. This report was previously circulated to the committee on 1st May 2008.

6. COMMISSIONING STRATEGY REPORT

7. CONFIDENTIAL AND/OR EXEMPT REPORTS NOT TO BE DISCLOSED TO THE PRESS AND PUBLIC

   To pass a resolution to exclude the press and public from the meeting during the consideration of Appendix 3 of the following item in accordance with Section 100 (A-H) of the Local Government Act 1972 and Schedule 12A, as amended, on grounds that the information involves the likely disclosure of exempt information as defined Part 1, paragraph 3, as the information relates to the financial or business affairs of any particular person (including the authority holding that information) and the disclosure would not be in the public interest.

8. RESIDENTIAL HOME CARE REPROVISION FOR SOCIAL SERVICES

9. ANNUAL FORWARD WORK PROGRAMME 2008/2009
AGENDA

1. APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS

2. DECLARATIONS OF INTEREST

Members are asked to declare any personal or prejudicial interests they may have in any matter that is to be considered at this meeting.

3. PUBLIC PARTICIPATION - REQUESTS TO SPEAK AT THE SUB COMMITTEE.

4. MINUTES OF THE LAST MEETING (Pages 1 - 8)

5. PAN LONDON DARZI HEALTHCARE FOR LONDON JOSC REPORT (Pages 9 - 82)

6. COMMISSIONING STRATEGY REPORT (Pages 83 - 131)

7. CONFIDENTIAL AND/OR EXEMPT REPORTS NOT TO BE DISCLOSED TO THE PRESS AND PUBLIC

To pass a resolution to exclude the press and public from the meeting during the consideration of Appendix 3 of the following item in accordance with Section 100 (A-H) of the Local Government Act 1972 and Schedule 12A, as amended, on grounds that the information involves the likely disclosure of exempt information as defined Part 1, paragraph 3, as the information relates to the financial or business affairs of any particular person (including the authority holding that information) and the disclosure would not be in the public interest.

8. RESIDENTIAL HOME CARE REPROVISION FOR SOCIAL SERVICES (Pages 132 - 192)

9. ANNUAL FORWARD WORK PROGRAMME 2008/2009 (Pages 193 - 204)
Health, Adults and Older Persons Services Overview & Scrutiny Sub Committee

Minutes of Meeting 24th April 2008

PRESENT:

Chair: Councillor R Sweden (RS)
VICE CHAIR: Councillor J Beanse (JB)

Members: Councillors:
L Braham (LB)
M Broadley (MB)
A Mbachu (AM)
G Walker (GW)

Also Present:
Madge Bergman (MBN) Representative, PPI Forum, Waltham Forest PCT
Neil Collins (NC) Representative, PPI Forum, North East London Mental Health Trust
Malcolm Wilders Co-opted Member
John Morton Deputy Chief Executive & Chief Operating Officer, Waltham Forest Primary Care Trust
Viktoria King Head of Corporate Affairs, Waltham Forest Primary Care Trust
Robert Caldeira Assistant Director for Risk Management & Clinical Governance, Whipps Cross University Hospital Trust
Pauline Newnham Director of Nursing & Quality, Whipps Cross University Hospital Trust
Jacqui Van Rossum Borough Director for Waltham Forest, North East London Mental Health Trust
Marian Lawrence Associate Director of Performance Improvement, North East London Mental Health Trust
Alex Horne Medical Director, North East London Mental Health Trust

Officers in Attendance:
1 APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS

Apologies for absence have been received from Cllr Liz Phillips, Sally Gorham (Chief Executive, Waltham Forest Primary Care Trust), Sheena Dunbar (Age Concern)

2 DECLARATION OF INTEREST

There were no declarations of interest.

3 PUBLIC PARTICIPATION – REQUESTS TO SPEAK AT THE SUB COMMITTEE

There were no requests received.

4 MINUTES

4.1 MINUTES – 9TH JANUARY 2008

The minutes of the meeting held on 9th January 2008 were confirmed as a correct record subject to the following amendments: -

Item 5 – Para 9
NC had commented that he found the report complacent because we were not able to safeguard people in the Council’s own homes.

4.2 MINUTES – 13TH FEBRUARY 2008

The minutes of the meeting held on 13th February 2008 were confirmed as a correct record subject to the following amendments: -

Item 1
To note that Sheena Dunbar (Age Concern) attended the meeting.

Item 5
Comment MJ I am very concerned that in some parts of the borough mortality rates are high. It is important to look into the reasons why this is the case.

4.3 MATTERS ARISING FROM THE LAST MEETING

To note that the information on Carers requested by Members at the January meeting was still outstanding. Members asked Officers to contact Mimi Koningsberg/Sandra Howard and forward a response to members.
5. ANNUAL HEALTH CHECKS

The Chair outlined the procedure for the meeting as follows: -

The Trusts to respond to questions which members had submitted in advance on the Core Standards that had been identified by the Annual Health Check Sifting Work Group for further scrutiny. The Chair agreed to allow questions from Members for clarification where required.

Responses were received from the following 3 Trusts: -

- North East London Mental Health Trust
- Waltham Forest Primary Care Trust
- Whipps Cross University Hospital Trust

The Chair wished to record his thanks to the 3 Trusts for their engagement in the scrutiny of the Annual Declaration, particularly for answering questions and producing reports within a very tight time frame.

5.1 NORTH EAST LONDON MENTAL HEALTH TRUST

The Chair had asked the North East London Mental Health Trust to provide evidence in respect of 8 standards as follows: -

1. C6 - Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

2. C7a - Healthcare organisations apply the principles of sound clinical and corporate governance.

3. C7b - Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

4. C7c - Healthcare organisations undertake systematic risk assessments and risk management.

5. C8a - Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment and management
that they consider to have a detrimental effect on patient care or on the delivery of services.

6. C9 - Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment the record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

7. C17 – The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

8. C22a - Healthcare organisations promote, protect and demonstrably improve the healthcare of the community served, and narrow health inequalities by ensuring the local Director of Public Health’s annual report informed their policies and practices.

Officers presented on the above standards and illustrated with examples on how these standards had been met.

The Overview and Scrutiny Committee agreed the following comments, which are to be forwarded to the Healthcare Commission: -

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met/Not Met</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C6</td>
<td>Met</td>
<td>Members agreed that in general terms the standard had been met and noted that negotiations were in place to commission perinatal services</td>
</tr>
<tr>
<td>C7a&amp;c</td>
<td>Met</td>
<td>Members recognised that there were strong systems of governance in place but had concerns about the delegation by the Board and the monitoring of performance. They also commented on an apparent lack of willingness to question matters at Board level.</td>
</tr>
<tr>
<td>C7b</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C8a</td>
<td>Met</td>
<td>Members agreed that there was incontrovertible evidence of good practice to illustrate that this standard had been met.</td>
</tr>
<tr>
<td>C9</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C17</td>
<td>Met</td>
<td>Members agreed that this standard had been met and look forward to the further development of the positive initiatives that had been established.</td>
</tr>
<tr>
<td>C22a</td>
<td>Met</td>
<td>-</td>
</tr>
</tbody>
</table>

5.2 WALTHAM FOREST PRIMARY CARE TRUST
The Chair had asked the Waltham Forest Primary Care Trust to provide evidence in respect of 9 standards as follows:

1. C6 - Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

2. C7a - Healthcare organisations apply the principles of sound clinical and corporate governance.

3. C7b - Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

4. C7c - Healthcare organisations undertake systematic risk assessments and risk management.

5. C8a - Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment and management that they consider to have a detrimental effect on patient care or on the delivery of services.

6. C9 - Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment the record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

7. C17 - The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

8. C18 - Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

9. C22a - Healthcare organisations promote, protect and demonstrably improve the healthcare of the community served, and narrow health inequalities by ensuring the local Director of Public Health's annual report informed their policies and practices.

Officers presented on the above standards and illustrated with examples on how these standards had been met.

The Overview and Scrutiny Committee agreed the following comments, which are to be forwarded to the Healthcare Commission:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met/Not Met</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C6</td>
<td>Met</td>
<td>Members agreed that the freeze on posts may have affected ability to meet need and support interagency collaboration. They applauded the</td>
</tr>
</tbody>
</table>
increase in investment in health visiting staff and noted examples of successful partnership with the local authority including ‘Intercare’ for long-term conditions.

Members were mindful of efforts to increase choice however, concerns were raised that in making available new options for delivery, other existing options may be sidelined.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C7a&amp;c</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C7b</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C8a</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C9</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C17</td>
<td>Met</td>
<td>Members agreed that the standard had been met and noted that appropriate procedures were in place and noted good examples of consultation and client driven service provision. Members felt however, that the unfinished ‘Fit for Future’ reconfiguration sought opinions but was not responsive to them.</td>
</tr>
<tr>
<td>C22a</td>
<td>Met</td>
<td>-</td>
</tr>
</tbody>
</table>

5.3 Whipps Cross University Hospital Trust

The Chair had asked the Whipps Cross University Hospital Trust to provide evidence in respect of 9 standards as follows:

1. C6 - Healthcare organisations cooperate with each other and social care organisations to ensure that patients’ individual needs are properly managed and met.

2. C7a - Healthcare organisations apply the principles of sound clinical and corporate governance.

3. C7b - Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

4. C7c - Healthcare organisations undertake systematic risk assessments and risk management.

5. C8a - Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position,
concerns over any aspect of service delivery, treatment and management that they consider to have a detrimental effect on patient care or on the delivery of services.

6. C9 - Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment the record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

7. C17 – The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

8. C19 – Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

9. C22a - Healthcare organisations promote, protect and demonstrably improve the healthcare of the community served, and narrow health inequalities by ensuring the local Director of Public Health’s annual report informed their policies and practices.

Officers presented on the above standards and illustrated with examples on how these standards had been met.

The Overview and Scrutiny Committee agreed the following comments, which are to be forwarded to the Healthcare Commission: -

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met/Not Met</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C6</td>
<td>Met</td>
<td>Members agreed the standard had been met and The Margaret Centre was a good example of this.</td>
</tr>
<tr>
<td>C7a&amp;c</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C7b</td>
<td>Met</td>
<td>-</td>
</tr>
<tr>
<td>C8a</td>
<td>Met</td>
<td>Members agreed that this standard had been met with concrete examples.</td>
</tr>
<tr>
<td>C9</td>
<td>Met</td>
<td>Members agreed the standards had been met in terms of medical records and note improvements that had addressed past difficulties, but there were some concerns regarding efficient delivery of referrals.</td>
</tr>
<tr>
<td>C17</td>
<td>Met</td>
<td>Members agreed that this standard had been met but would like to draw the Healthcare Commission’s attention to the reduced frequency of meetings of the Board in public.</td>
</tr>
<tr>
<td>C19</td>
<td>Met</td>
<td>Members noted that this was a good</td>
</tr>
</tbody>
</table>
account of management procedures and the standard was met however, they were concerned that ambulances have had to divert. The Healthcare Commission may wish to compare the frequency of diverts with similar hospitals.

| C22a | Met | Members agreed that not only had this standard been met but it appears to be an example of excellent practice. |

CONCLUSION

The Chair concluded that all the standards had been met but the committee had raised reservations where appropriate.

The Committee: -

RESOLVED: -

1. To send a formal response to the Trusts to forward to the HealthCare Commission detailing the Committee’s comments as outlined above, before the deadline of 30th April 2008.

The Chair thanked all Members and Officers for a very productive year and the Vice Chair Councillor John Beanse, in particular, for his support during his term in office.

Members also wished to record their thanks to the Chair for his excellent work during the past municipal year.

The meeting started at 7.40 pm and closed at 10.10pm.

Chair’s Signature_____________________

DATE_________________________________
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Person</th>
<th>Deadline for Comments</th>
<th>Matter to Be Raised</th>
<th>Item No.</th>
<th>Agenda Action Arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Officers to send a formal response to the Health and Social Care Trusts, to forward to the Health and Wellbeing Committee</td>
<td>Officers</td>
<td>30/04/08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Members to submit a report on the Trusts' performance to date</td>
<td>Members</td>
<td>29/04/08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Members to submit a report on the Trusts' performance to date</td>
<td>Members</td>
<td>7/05/08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Item No. 4.3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Action Sheet 24 April 2008

Agenda:
Health, Adults and Older People's Overview and Scrutiny Subcommittee
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
Joint Overview & Scrutiny Committee (JOSC) to review ‘Healthcare for London’

Final report of the Committee

Contents

Joint foreword from the Chairman and Vice-Chairmen ..................1
Introduction ....................................................................................3
Conclusions and recommendations ...............................................6
Findings........................................................................................16

Appendices

Appendix 1: Witnesses attending the JOSC .................................i
Appendix 2: List of written submissions to the JOSC .................iii
Appendix 3: Legal basis to the JOSC ..........................................v
Appendix 4: Glossary .................................................................vi

Written submissions to the JOSC and minutes of the meetings are available in a separate volume
Joint foreword from the Chairman and Vice-Chairmen

We are delighted to present the findings of our ground breaking scrutiny review. This is the first time a joint authority overview & scrutiny committee (JOSC) has operated on such a scale, representing a population of over seven million Londoners and residents of parts of Essex and Surrey, who together speak hundreds of languages and live in 33 Primary Care Trust areas. We believe it demonstrates the role elected Councillors can play in tackling the democratic deficit in the NHS.

In this report we present our findings, concerns and recommendations unanimously agreed by the JOSC. These are based on a substantial body of evidence.

We transcend geographical, political and social divides, and this unanimity sends a powerful message. Our report must stimulate action and we expect the NHS to do more than politely ‘note’ our findings. We will meet again in the autumn to hear how the NHS is incorporating our recommendations into its proposals for developing London’s health services.

Lord Darzi presents a compelling case why London’s health services must change. Many of these reasons are not new, and past attempts to address these and reform London’s health services have failed. The doubling of resources for London’s NHS since 2000 means reform cannot stall this time: the NHS must deliver a lasting return on this historic investment.

Lasting change will require the NHS to commit expenditure to areas recently squeezed in times of financial pressure, including workforce development and public health. Failure to fund new services properly will lead to another round of mere tinkering.

Sustainable reform will require effective partnerships - particularly with local authorities - as the distinction between ‘health’ and ‘social’ care becomes increasingly blurred. Thankfully the NHS has realised the gaping omission in the original HfL review and is now working closely with London Councils to quantify the impact on social care. ‘Money follows the patient’ in the modern NHS, and we are sure London Councils will press
hard to ensure that local authorities are funded for increased demands for social care services following the proposed reductions in hospital treatment.

Reform must also overcome the inequalities in London’s health; we cannot continue with such variations in the health of our residents. London has some world class health services: the challenge we set to the NHS is to ensure that these become the norm across the capital.

Furthermore, all care must be designed around the needs of the patient and not those of NHS institutions. To deliver a truly ‘patient centred’ NHS, all reforms must improve access to, and the accessibility of, health services.

Finally, the NHS must be bold and make difficult decisions about much loved institutions. However it must also be honest and open. Early and meaningful dialogue with local people and their elected representatives will improve proposals to reform London’s health services and smooth their implementation.

Our final message is to those running London’s health services: you are privileged to oversee an exceptional range of services accounting for a budget larger than the economy of many countries. With this power comes a massive responsibility to those living in London and the thousands of dedicated professionals working in these services. Please do not let Londoners and those dedicated to our NHS down; working together we can deliver an NHS of which everyone in this great city can be proud.

Cllr Mary O’Connor
Chairman

Cllr Barrie Taylor
Vice-Chairman

Cllr Meral Ece
Vice-Chairman
Introduction

This report presents the formal response of the Joint Overview & Scrutiny Committee (JOSC) established to respond to the ‘Healthcare for London: Consulting the Capital’ consultation undertaken by the Joint Committee of Primary Care Trusts (JCPCTs) between November 2007 and March 2008.

The JOSC was established under the regulations governing joint authority health scrutiny and comprised of representatives from all of the London local authorities as shown below:¹

- LB Barking and Dagenham: Cllr Marie West
- LB Barnet: Cllr Richard Cornelius
- LB Bexley: Cllr David Hurst
- LB Brent: Cllr Chris Leaman
- LB Bromley: Cllr Carole Hubbard
- LB Camden: Cllr David Abrahams
- City of London: Cllr Ken Ayers
- LB Croydon: Cllr Graham Bass
- LB Ealing: Cllr Mark Reen
- LB Enfield: Cllr Ann-Marie Pearce
- LB Greenwich: Cllr Janet Gillman
- LB Hackney: Cllr Jonathan McShane
- LB Hammersmith and Fulham: Cllr Peter Tobias
- LB Haringey: Cllr Gideon Bull
- LB Harrow: Cllr Vina Mithani
- LB Havering: Cllr Ted Eden
- LB Hillingdon: Cllr Mary O’Connor
- LB Hounslow: Cllr Jon Hardy
- LB Islington: Cllr Meral Ece
- RB Kensington and Chelsea: Cllr Christopher Buckmaster
- RB Kingston upon Thames: Cllr Don Jordan
- LB Lambeth: Cllr Helen O’Malley
- LB Lewisham: Cllr Sylvia Scott
- LB Merton: Cllr Gilli Lewis-Lavender
- LB Newham: Cllr Megan Harris Mitchell
- LB Redbridge: Cllr Allan Burgess
- LB Richmond upon Thames: Cllr Nicola Urquhart
- LB Southwark: Cllr Adedokun Lasaki
- LB Sutton: Cllr Stuart Gordon-Bullock
- LB Tower Hamlets: Cllr Marc Francis
- LB Waltham Forest: Cllr Richard Sweden
- LB Wandsworth: Cllr Ian Hart
- Westminster City Council: Cllr Barrie Taylor

¹ Further information on the legal basis of the JOSC is contained in appendix 3.
The local authorities that provide social services in the Strategic Health Authorities neighbouring London were also invited to participate in the JOSC. This reflected an invitation from the NHS for the PCTs in these areas to participate in the Joint Committee of PCTs. Essex and Surrey County Councils appointed the following Members to the JOSC:

- Essex County Council: Cllr Chris Pond
- Surrey County Council: Cllr Chris Pitt

The JOSC held its first formal meeting on 30th November 2007 at the London Borough of Hammersmith & Fulham. This meeting appointed the Chairman and the two Vice-Chairmen of the JOSC (drawn from each of the three major political groups represented in London) and agreed the following terms of reference:

ii) To consider and respond to the proposals set out in the PCT consultation document 'Healthcare for London: A Framework for Action';

iii) To consider whether the 'Healthcare for London' proposals are in the interests of the health of local people and will deliver better healthcare for the people of London;

iii) To consider the PCT consultation arrangements, including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive.

Our review focused on examining the proposals outlined in the consultation document. We note the variation in the local consultation process across London but do not comment further. We will reconvene in the autumn to consider the NHS’ formal response to our recommendations and the latest work to develop options for change.

We are aware of the varied audience for this report and present our recommendations at the start for ease of reference. For those seeking more detailed information on our work we then present our main findings from each meeting, followed by details of the witness sessions and evidence gathered. All of the written submissions to the Committee, along with the minutes of each Committee meeting, are available in volume II.

Acknowledgements

The JOSC would like to thank all of the witnesses who gave up their time to attend our meetings; the stakeholders who submitted written evidence to us; and to the Boroughs that hosted, clerked and provided hospitality for our meetings.
We thank the ‘officer support group’ consisting of Louise Peek (Bexley), Tracey Anderson & Ben Vinter (Hackney) and Gavin Wilson (Kensington & Chelsea) – assisted by Guy Fiegehen and David Coombs (Hillingdon) – who gave high quality advice and support to the JOSC whilst also continuing to support Overview & Scrutiny in their Boroughs.

We would also like to thank the Centre for Public Scrutiny (CfPS) for their ongoing support and guidance.

This unprecedented scrutiny review has operated without a dedicated budget, and this has only been possible by the shared desire of everyone involved in the JOSC to ensure London has top-quality health services. Future work of the JOSC may depend on a more formalised solution for resourcing the Committee.

*******************************************************************************
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.

*******************************************************************************

Joint Overview & Scrutiny Committee to review ‘Healthcare for London’
Final report: April 2008
Page 6

Page 17
1. Financing the reforms

We have not heard any evidence that the appropriate resources exist (or have even been identified) to establish and then support the major changes proposed in HfL. 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 partners 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 HfL. 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 ‘teething 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 HfL 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 HfL 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 HfL 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.
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.

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.

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 (OSCs) to discuss the appropriate level of consultation required.
We do not believe that Londoners, including those working in the NHS, appreciate the impact that the reforms proposed in HfL 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 HfL states are essential to ensure the NHS meets London’s needs.

*****************************************************************************
Findings

In this section we present the main findings from our evidence gathering sessions. We summarise the discussions with our witnesses and then highlight what we believe are the key points. These findings underpin our recommendations presented in the previous section.

The findings are produced on a meeting-by-meeting basis.

- 30th November 2007: LB Hammersmith & Fulham
- 7th December 2007: LB Camden
- 18th January 2008: City of London
- 22nd February 2008: LB Tower Hamlets
- 14th March: LB Ealing
- 28th March 2008: LB Merton

Minutes of each meeting are available in volume II of the report along with the written submissions considered by the JOSC.
30th November 2007: LB Hammersmith & Fulham

Witness session: Context of the Healthcare for London review, consultation process and next steps

Richard Sumray: Chair of the Joint Committee of Primary Care Trusts (JCPCT)

In his opening comments Richard Sumray stated that PCTs will be responsible for implementing reforms arising from the consultation given that they are the NHS Trusts responsible for commissioning services for their local area. He said that the decision making process will be flexible with PCTs taking as many decisions as possible locally. Decisions will only be taken at a higher level if absolutely necessary.

PCTs are therefore undertaking this initial consultation which is about the vision and direction of travel in Healthcare for London (HfL), not specific NHS facilities. At the end of the consultation all of the information will be gathered and analysed. There are likely to be subsequent consultations on specific proposals for implementing the vision.

The JCPCT, which has been set up specifically for the purpose of the first stage consultation, will meet monthly. Meetings will be in public when decisions were being made i.e. at the start and end of the consultation. The JCPCT will seek to ensure that all PCTs give the same message and undertake a similar level of consultation, but there will be some local variations to meet specific Borough circumstances.

Questions to Richard Sumray

In the ensuing ‘Question and Answer’ session, the following main points were made:

- There needs to be clarity about the funding allocated both for the consultation and the subsequent implementation of any proposals. Richard Sumray said that funding had been allocated for the consultation. There has been a broad financial appraisal of the end costs, and he believed the proposals are affordable given the continued increases in funding for healthcare in London (significantly above inflation). NHS finances have turned around in the last 18 months, although a few Trusts still have deficits.

- Local authorities must be included in developing proposals for health services in London. Richard Sumray acknowledged that the original HfL review had not fully considered the implications on social services and there will be further consultation with local authorities to address this.
In response to concerns that the reorganisation of PCTs could distract from the implementation of HfL, Richard Sumray said that he was not aware of any move to reorganise PCTs in the short to medium term. However there is likely to be increased joint commissioning with local authorities, and a reduction in PCTs’ role as a service provider.

Consultations on the future of health services are already underway in parts of London and it is essential to ensure that these are compatible with the Healthcare for London proposals.

**Ruth Carnall: Chief Executive, NHS London**

Before answering questions from the JOSC Ruth Carnall gave a brief presentation on the background to Healthcare for London. She said that the review sought to identify future models of healthcare based around care pathways and not existing institutions or providers.

Changes to health services will require sufficient attention to be given to the ‘enablers’ of reform. For example, it will be essential to use the training and education budgets to develop the skills required to deliver new care pathways, and there are also opportunities to use the NHS estate more effectively.

HfL presents a case for why London’s health services need to change and it will be important to balance the need for consultation with maintaining the momentum of reform.

**Questions to Ruth Carnall**

In the ensuing ‘Question and Answer’ session, the following main points were made:

- An incremental implementation of reforms could lead to a gradual loss of services for certain health service providers, particularly local hospitals. However, a ‘big bang approach is not possible given that further work is required on certain aspects of the proposals.

- It is important to ensure there are financial incentives in place to deliver the reforms. NHS London believes that many of the levers for reform are already in place, but these need to be used properly. Foundation Trusts are accountable to PCTs through their contracts, and have been supportive and engaged with HfL so far.

- With respect to pathology services, the development of a larger facility will deliver cost efficiencies, but local x-ray facilities, for example, could be provided and improve access times.
• Members highlighted local concerns about NHS London ‘top-slicing’ PCT budgets. Ruth Carnall said that NHS London does not plan to top-slice PCT budgets again and some £135 million has already been returned. Additionally, PCTs will be allowed to retain surpluses, and through the commissioning process will be able to direct resources to services that best meet local need.

• NHS London will challenge PCTs on their use of resources without interfering, and will provide greater freedom to good performing PCTs.

• In relation to the JOSC’s involvement with the work to develop proposals for London’s health services, Ruth Carnall said that NHS London would welcome any advice from the JOSC as to the success or otherwise of the work so far.

• Mental health providers have so far been enthusiastic about ‘polyclinics’ and integration with primary care services. There has been significant progress in the provision of care outside of hospitals. Furthermore, there will be a further review of mental health and children’s services as these were not covered in adequate depth by the original HfL review.

• NHS London is currently developing an estates plan that will include requirements for Trusts wishing to gain foundation status. Members stressed that it is important to ensure Trusts are not forced to sell off land in order to balance their books. Ruth Carnall responded that NHS London does not want this to happen and added that it costs money to own and maintain underused assets.

**Key points:**

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

• Healthcare for London presents an opportunity to ensure health services meet the future needs of London. Successful implementation of reform will require sufficient attention to be given to key issues such as workforce development, ICT and estates.

• The autonomy of Foundation Trusts may complicate the implementation of the reforms outlined in HfL.

• There are concerns and uncertainty about how the proposals could be implemented and in what order. There is a danger of a ‘salami slicing’ of services away from some district hospitals and this could lead to uncertainty for Trusts undertaking financial and service planning.
There are still some uncertainties about the future of PCTs: another round of organisational restructuring of PCTs could undermine or distract from the implementation of proposals arising from HfL.
7th December 2007: LB Camden

Witness session 1: Background to and rationale behind ‘Healthcare for London’

Dr Chris Streather: Medical Director, St George’s Healthcare NHS Trust and Member of Healthcare for London Acute Care Working Group

In some initial remarks, Dr Streather recognised that the Darzi review has certain features which distinguish it from previous reviews of healthcare services in London. In particular:

- HfL is based on a ‘pathways for patients’ approach which aims to deliver a high quality of care and not on suggesting new configurations of institutions;

- There had been a high level of involvement from clinicians, leading to a greater likelihood of ‘buy-in’ and effective implementation of the final proposals. All five ‘clinical pathways’ working groups were clinician-led;

- HfL is far more evidence-based than previous reviews: a good deal of diagnostic work had been carried out in the course of the Darzi review, and MORI had been commissioned to seek people’s views;

- HfL accepted the existence of health inequalities across London, and recognised the need to address the improvement of the quality of care for all patients, wherever they live.

In terms of accessing acute care, it is often very complicated for patients to decide what to do if they have an emergency condition (e.g. abdominal pain). A number of options currently existed (including NHS Direct, which redirects over 70% of calls). The guaranteed treatment at Accident & Emergency (A&E can help explain increased attendances to these in recent years.

Darzi’s solution is to make patient choice simpler by introducing, for example, a single telephone number for health emergencies. A need also exists to provide more accessible ‘emergency’ care in a community setting closer to where people live.

Whilst Darzi’s principle is to provide care in a community-based setting where possible, it was recognised that some elements would have to be centralised (e.g. treatment of complex trauma and specialised stroke care). It is likely that, in time, further centralisation of other specialist treatments will follow.

Evidence shows that mortality rates are lower at centralised, specialist stroke centres, and presently a large number of centres handling strokes are not meeting standards. Dr Streather considered therefore that the principle of
centralising specialist stroke care for all Londoners is to be welcomed. However, the vast majority of stroke treatments (75-85%) are undertaken in local stroke units, and there was no reason why, if Darzi's proposals were implemented, this should not remain the case.

Darzi proposes these principles be applied in a similar fashion to trauma cases with the small number of highly complex cases being carried out in (perhaps three) specialist settings across the capital, and the vast majority of other cases still being handled at district general hospitals (DGHs).

Dr Streather took the view that setting up a small number of specialist treatment centres should not be allowed to destabilise 'local' hospitals (DGHs) across London. It is important to maintain skills and an appropriate quality of care in DGHs. He therefore cautioned against a highly centralised model, whereby DGHs' existing functions are gradually lost; much will continue to be undertaken in a local hospital.

In general, he believed that Darzi's report conveyed poorly the continuing role for local hospitals under his proposals – in particular, where it stated: 'The days of the DGH seeking to provide all services to a high enough standard are over...'.

Dr Martyn Wake: GP and Joint Medical Director, Sutton and Merton PCT and Chair of HfL Planned Care Working Group

Dr Wake believed that although the standard of health services generally in London is not poor, overall there was a considerable variation in standards, and in some areas provision is poor. He considered that the provision of specialist care can be improved by a degree of centralisation. However, much care could be moved out of a traditional hospital setting (i.e. DGH), for example, minor surgery and routine diagnostics into a more local setting. Travelling significant distances to a hospital (e.g. for a routine blood test) did not make sense.

Centralising elective (i.e. planned) care can be achieved in several ways. Some care (e.g. hip replacements and cataract surgery) could be located in an area physically separate from emergency care. He also considered that there is much potential for routine specialist treatment currently carried out in large hospitals to be undertaken in a community setting.

Darzi's vision recognises that it is important to provide better community health services in a number of areas (e.g. end-of-life care). Community support and enhanced rehabilitation have tended to be overlooked as a component of effective health provision, and have suffered from under-investment. Greater investment would help promote independence and support early discharge from hospital, and help avoid admission for conditions where hospital-based treatment is inappropriate.
A greater emphasis on community health provision should also improve 'end of life' support, allowing more people to choose to die at home. Currently, around 20% of Londoners die at home, but research consistently showed that over 50% of people had this as their preferred option.

Dr Wake emphasised the need for better integration of pre- and post-operation 'pathways' (i.e. treatments): e.g. integration of nursing care, intermediate care and social/end of life care. The present situation can be confusing for patients and GPs alike. A shared commitment from all agencies involved is required, with the focus on the patient as an individual.

Darzi offers a commitment to providing a 'polyclinic' at every hospital site – recognising the large number of patients who attend A&E with symptoms that could be treated by GPs: medical staff at these sites (GPs and specialist nurses) are likely to require some up-skilling.

Polyclinics are likely to require longer travel times (1-2 kilometres) in many cases and therefore discussions involving local authorities will be crucial.

Loss of continuity of care is likely to be an issue for some, principally patients who wanted to be seen quickly and those who wanted to see 'their' GP.

'Heart of Hounslow' experience demonstrates the key importance of polyclinics being fully accessible for people with mobility difficulties. Close working with local authorities will be needed regarding: a) individual premises b) suitable parking c) infrastructure, supported by adequate transport links.

Regarding the cross-London border question, there is the possibility that London might have many polyclinics but, for example, the three Essex PCTs might (initially) have none – thus causing possible tensions, including travel implications into London, and the need to ensure that greater health inequalities were not unwittingly created.

Questions to Dr Chris Streather and Dr Martyn Wake

In the ensuing 'Question and Answer' session, the following main points were made:

- PCTs will have the freedom to negotiate contracts for extended GPs' hours – 'polyclinics' will allow PCTs to look in detail at GP contracts to achieve desired provision to best meet public need. Effective monitoring of GP contracts will be important.

- There is a need to ask NHS London what consideration has been given to the implications – particularly financial – of a shift from existing healthcare models to greater community-based health service provision. This covers the likely impact on local authorities, community/voluntary sectors, and carers. The support of local
authorities in this area is crucial if Darzi’s vision is to be translated effectively into practice.

- A realistic cost assessment (both for health service providers and local authorities, principally as social care providers) is needed. The cost of this significant change has to be managed realistically – under-investment would be a false short-term economy, with negative long-term implications.

- There is a legitimate argument for additional Government funding for the ‘transitional’ period (i.e. from the existing situation to the Darzi model of healthcare provision).

- Mental health care and children’s care services had not been sufficiently addressed in Darzi’s report, but it is welcome that further work is being carried out in these areas.

- There is a need to guard against an over-prescriptive centralised model of healthcare provision, with the viability of DGHs threatened by the piecemeal removal of functions. The implications of redistribution of existing provision (e.g. adequate transport links) needed to be considered carefully, in close consultation with local authorities and local people.

- NHS London must recognise the need to explain clearly to ordinary people how they can access care for different health needs.

**Key points:**

- Changes to arrangements for accessing healthcare need to be explained clearly to Londoners.

- Darzi’s proposals must not lead to any greater centralisation of care than is absolutely necessary. GP surgeries are the primary source of contact for most people with the NHS; moving all existing GP surgeries into ‘polyclinics’ would be a source of concern.

- Developing ‘polyclinics’ must be carried out flexibly – not on a ‘one size fits all’ basis.

- Implementation must be strategically planned to ensure that services are not ‘salami-sliced’ from District General Hospitals (DGHs) as a result of the creation of ‘polyclinics’ and the centralisation of some specialist services in a small number of hospitals.
Witness session 2: An independent view of ‘Healthcare for London’ and the way forward for the JOSC

Fiona Campbell: Independent consultant on health and social care policy and Board Member of the Centre for Public Scrutiny

Dr Campbell commented upon the context, consultation, underlying principles, main findings and conclusions of the Darzi report. She also highlighted a number of key questions which the JOSC might wish to consider. These detailed points are contained in the minutes of the meeting which are available in volume II and are not repeated here.

Some supplementary issues raised are set out below:

- Turning the NHS into a 'health' rather than a 'sickness' service is an aspect of Darzi's report which Dr Campbell considered had not received a great deal of emphasis so far, but the 'preventative' healthcare agenda is a key part of the overall equation.

- Darzi referred to 'incentives in the system' to allow a shift towards greater investment in health improvement. Dr Campbell cautioned that it is important to be clear as to whether such incentives are capable of achieving what they are intended to.

- There had been no clinical working group set up under the Darzi review to specifically address the needs of older people who represent a significant and growing part of the population. The JOSC might want to take account of this in seeking views from this sector.

- Similarly, the JOSC might wish to consider the impact of the proposals on carers (who were often elderly) when people are discharged early from hospital.

- One significant issue is that Darzi's proposals assumed an extension of healthcare service provision whilst local authority patterns of social care provision (driven by restricted finance) had for a number of years been focusing resources on fewer individual cases (those with the greatest needs).

Questions to Fiona Campbell

In the ensuing 'Question and Answer' session, the following main points were made:

- Further evidence from NHS London is needed in order to demonstrate its capacity to deliver Darzi's vision. However, the involvement of clinicians bodes well for its successful implementation.
- Investing in an approach which gives suitable emphasis to 'prevention' of health difficulties represents sound long-term financial sense.

- The overarching focus in the Darzi report had been on clinicians' issues, and 'lifestyle' factors had been largely sidelined. However, it is important to stress the full integration of Darzi's vision into the health agenda of recent years (as set out in 'Our health, Our Care, Our Say') and the importance of joined-up health and social care.

- It is important to achieve clarity between urgent care and emergency care in terms of contact points and healthcare access, so that members of the public know where to go for different health conditions.

- The accountability of Foundation Trusts (FTs) and how their role might change under Darzi’s proposals are issues that might usefully be raised with the FTs' regulating body 'Monitor'.

- Account should be taken of the difficulties experienced nationally by the NHS in introducing a large new computer system, in terms of the potential implications for implementing Darzi's proposals for London.

- Darzi's report indicated that savings from reconfiguring acute services could be reinvested in preventative healthcare, or alternatively the NHS should be prepared to subsidise local authorities' social care costs.

---

**Key points:**

- The involvement of clinicians in developing the ‘Healthcare for London’ review is welcome. Equally, it is vital that NHS London commit to include those involved in delivering social care in developing proposals, since models of care in the review will clearly have a significant impact on social care.

- The NHS must not simply be a ‘sickness service’. Resources should be used to prevent health problems, including through health promotion.

- A shift to greater use of day-case surgery and reduced length of stay for other surgery will impact on local authorities, and require extra investment – this must be recognised and addressed by NHS London.

- Closer working between the NHS and local authorities (e.g. through 'polyclinics') could present problems in that NHS services are universal, whereas financial pressures have led to many social services being restricted to those with the highest need.
Money will be required for implementing the proposals in the review. Releasing under-used estates might help pay for new services, but existing services will still be required until these new services become operational.
18th January 2008: City of London

Witness session 1: Partnerships, infrastructure and economics

Steve Pennant, Chief Executive, London Connects

Mr Pennant referred to the fact that there are no clear processes in place to govern partnerships between the NHS and local authorities, and consequently partnership accountabilities between the NHS and London Boroughs need developing.

He drew attention to the critical role that programme and project management have in the successful operation of complex, large-scale ICT programmes. Equally important is the incorporation of users' views and requirements into ICT systems by those developing these systems.

ICT security raises important questions (in view of certain high-profile national cases in the recent past) and management procedures for managing data need to be sound.

Effective operation of a single non-emergency telephone number for booking GP appointments would be complex across thirty-two London Boroughs and the City of London. However, this should not hinder 'common access' being taken forward in discussions with the NHS.

Well-developed electronic connections between health and social care bodies are important if seamless care is to be achieved. Difficulties could exist when different networks are used (e.g. when local authority social workers need to access NHS information): 'codes of connection' are needed to avoid verification problems. Staff training and security are crucial elements.

Costs of hardware and network costs are reducing as technology advanced – therefore costs of 'joining up' health/social care ICT infrastructure are capable of being broadly contained within existing budgets. Bigger issues in this context are: political will; proper management of change and secure management of sensitive data.

Boroughs can add value to the NHS through providing more and easier-to-navigate links from Council call centres and websites to health service information. Also, it is important to aim to provide easy access to NHS information through Council 'one-stop shops'.

A good framework for closer joint PCTs/Boroughs working is needed. This is likely to involve suitable motivation/incentives being built into the system, to encourage managers to work in partnership with an 'outside' body. Good training is also an essential ingredient.
Questions to Steve Pennant

In the ensuing 'Question and Answer' session, the following main points were made:

- The NHS does have appropriate capacity to deliver increased NHS/Local Authority connections; however, further consideration to incentives for NHS management may be needed as a catalyst for change.

- A key issue is whether the political will existed to implement a new NHS/Local Authority e-interface system. A top-down national approach is unlikely to prove the best way forward, based on experience to date (big risk; potential loss of customer service etc). Instead, incremental development might be better building on, and developing, existing systems.

- Training is a vital element. local authorities needed to recognise the need for adequate ICT and training budgets for social care staff who work with health professionals, and similarly for Boroughs' customer care staff.

- A big 'software cost shunt' (as Boroughs purchase necessary software to connect to NHS systems) should not happen, though councils may have to buy 'smart card' readers for their PCs. However, Boroughs need to be speaking to the NHS about such issues.

**Key points:**

- Seamless services will require increased partnership working between the NHS and local authorities. This in turn will require political and senior managerial support, and adequate budgetary and staff resources. Care must be taken to ensure that joint agreements on developing and implementing services are robust, and are adhered to.

- Ensuring that those actually delivering an ICT service are involved in designing new models of care, and also how these reforms are implemented, is essential. Stakeholder management is a key ingredient in successful programme management.

- Health and social care organisations will only be able to provide a viable joined-up service if they are able to communicate effectively electronically. This might involve costs around ICT software, but also presents challenges around data security.
David Walker: Editor, The Guardian’s 'PUBLIC' magazine

During the presentation and the ensuing 'Question and Answer' session, the following main points were made:-

- In formulating its recommendations, the JOSC should consider the broader political canvas and developments in healthcare policy.

- Options for the future provision of primary care need to be considered carefully – to what extent, and how, might primary care services be reshaped?

- How best might the 'primary care deficit' (between the public's wishes and what GPs provide) be addressed? Is direct employment of GPs by local authorities (or bodies directly accountable to them) a realistic possibility?

- Local Government might wish to reflect on its experience of sophisticated professional management (e.g. teachers) before advancing a serious case for extending its sphere of operations into the provision of primary care services. Would Local Government be prepared to 'take on' the power-base of the British Medical Association (BMA) for example?

- If Local Government does wish to extend its role into primary care, an incremental approach, based on trailing by individual councils would be sensible.

Niall Dickson: Chief Executive, King's Fund

John Appleby: Chief Economist, King’s Fund

The King's Fund's recognised that, in an international market of improving healthcare, the means of delivering London’s healthcare has to change. Key issues raised by the Darzi report include: access to the healthcare system, quality and safety, health inequalities and cost.

Darzi's commitment to tap into clinicians' expertise was very sensible. His vision should not be regarded as an inflexible blueprint to be implemented, rather as providing a first step(s) in a desired direction of travel which should take account of local circumstances, and how local services are currently delivered.

Evidence for centralising certain services (e.g. stroke) is considered pretty sound.

However, evidence for moving GPs into bigger centres (i.e. 'polyclinics') is less clear. Whilst there might be some benefits for patients (e.g. quicker
access to diagnostics), the case for this model of health provision had not yet been convincingly made.

Evidence for GPs carrying out more specialised work is mixed – this could sometimes be more costly than if carried out by hospital consultants.

Darzi’s report has not demonstrated that the public are supportive of his proposals, and whether clinicians broadly support his proposals is likely to prove critical to securing broad public acceptance.

Reconfiguration of services alone (a ‘bricks and mortar’ approach) will not be enough to achieve what ‘Healthcare for London’ intends – changes in skills and culture within the NHS will also be important.

The King’s Fund had looked at a possible future budget for the provision of healthcare services in London up to 2016. This investigation showed that the existing model could be as affordable as Darzi’s proposals. Financial figures supporting this scenario would be included in a critique currently under preparation, which would be presented to NHS London.

Attention was drawn to question-marks over Darzi’s cost estimate of implementation (over 50% of savings being derived from implementation of polyclinics) which, at £13.1 billion for 2016/17, is exactly the same as the projected NHS cost based on current models of provision.

Polyclinics had been costed on an average size of approximately 2,000 sq. metres. However, the ‘Heart of Hounslow’ centre (one of the few currently in existence) is around 8,500 sq. metres.

Transitional costs are likely to represent a critical issue, though these were not identified by Darzi. However, he had the expectation that some of the NHS estate would need to be sold, and the sale of hospital buildings was likely to be very unpopular with local people.

There are important issues around access. Darzi estimated that around 70% of GPs would be located in polyclinics, and this has implications for travel distances for many people – particularly the elderly.

Questions to the King’s Fund

In the ensuing ‘Question and Answer’ session, the following main points were made:

- There is no clear model of how primary care services might best evolve, although the speakers expect single-GP practices to become virtually extinct over the next twenty years. Federating smaller GP practices might be one model for development. A variety of models is required, best-suited to local needs. Incorporating a greater element of
competition into provision will allow patients to move more easily from one GP to another.

- The NHS is moving towards capturing more effectively patients' perceptions of whether NHS treatment has benefited them. In this context it will be important to evaluate the effect of Darzi’s proposals ‘x’ years after implementation.

- It was recognised that a tension existed between the NHS's free service to all, and the means-tested social care provided by local authorities. However, arguments put to the Government by the King's Fund in 2006 for greater funding of social care appear to have been accepted. The Government have committed to a Green paper to investigate issues, and to try and achieve a cross-party consensus on the way forward. This points to the possibility of NHS funding and local authority funding systems being made more compatible.

- It would be a mistake to focus too much on ‘polyclinics’ and their role, at the relative exclusion of other elements in Darzi's report, such as the future role of District General Hospitals. ‘Polyclinics’ might not be a panacea – but equally they were unlikely to prove a disaster.

- In preparing its critique to be presented to the NHS (referred to above), the King's Fund are looking abroad and assessing international evidence (including the USA and Germany).

- It is important for the broader clinical community (including nurses and auxiliary staff etc) to be engaged effectively in the consultation process on Darzi's proposals.

- It was noted that Darzi’s report has little to say about how the proposals fit in with evolving models within the NHS (e.g. Foundation Trusts) and mechanisms and incentives to achieve change which had already been introduced (e.g. Payment by Results) but these are important factors to consider.

- Darzi's model appears to rely quite heavily on removing certain functions from DGHs (e.g. to specialist centres and ‘polyclinics’), and the proportionate reduction in hospitals’ funding is a factor which required consideration.

- With the increasing reliance on care in the home under Darzi’s proposals, there is likely to be a serious challenge posed by a likely diminishing pool of carers in the future. Whilst greater use of telecare might help, this will not be enough on its own.
Key points:

- Long-term reforms to London’s health services will require commitment to workforce development.

- There is an increasing tension between universal provision of NHS services and increasingly means-tested social care services.

- It is important to examine how the reforms relate to the new financial regime in the NHS. (e.g. ‘Payment by Results’ will mean that shifting care out of hospitals will impact on the finances of hospital trusts – while Foundation Trusts have a larger degree of autonomy over their service provision and may be less willing to reduce the amount of activity they undertake).

- Increased care in the community will increase the burden on carers.

- When considering whether to establish ‘polyclinics’, it is important to balance the benefit of grouping together a larger range of services with the disadvantage of reduced accessibility in terms of greater travel distance.

Witness session 2: Local authorities and social care

Cllr Merrick Cockell: Chairman, London Councils
Mark Brangwyn: Head of Health and Social Care, London Councils

The NHS in London is currently not operating in a number of respects as well as Londoners have the right to expect, for example, in providing equity of service and access to its services across all areas of the capital.

A greater role for health education, emphasising the role of ‘prevention rather than cure’, is needed as well as suitable emphasis on the benefits of leading a healthy lifestyle.

The proposals will bring extra costs for local authorities, and the strategy which emerges to implement Darzi’s proposals must take account of this, with an appropriate transfer of resources from the NHS to the Boroughs. London Councils want to see a strong commitment to investment in home care through joint commissioning and NHS investment in costs.

Local solutions (e.g. ‘polyclinics’ and good transport links) should be developed in a way which take full account of local people's views.

The implementation of proposals should allow for a greater range of care and support to be provided for people with mental ill-health.
London Councils expect to see more effective use of the NHS estate, with the full engagement of London Boroughs (and the Greater London Authority) in the development of options for the future use of land and buildings.

**Hannah Miller: Director of Adult Social Services, London Borough of Croydon**

Hannah Miller said that sadly, the preparation of the Darzi report lacked serious engagement with social care professionals. A further weakness in the proposals was the lack of predictive modelling to gauge likely additional burdens on social care. It was essential that joint research was commissioned to scope the demand for social care and associated costs.

There are a number of issues around home care and its potential impact on social care which need to be considered, including changing people’s expectations about how they receive quality care. Also, caution needs to be exercised about potential cost savings, since a properly resourced multi-agency team will be required to provide ‘home’ support.

Various aspects of the ‘polyclinic’ model (such as co-location of health and local authority services and the development of genuine ‘healthy living centres’) appears attractive. However, based on experience in Croydon, ‘polyclinics’ might not be so popular with the public, who often place considerable importance on personalised and truly local services that a ‘polyclinic’ serving a large population (e.g. 50,000) could struggle to provide.

Whilst Darzi addresses world-class practice for stroke treatment, a similar approach is needed for conditions such as respiratory problems and diabetes. Similarly high standards in terms of discharge, support and rehabilitation should be aimed for.

The lack of capital costings in Darzi’s report is a flaw, and greater clarity over funding issues generally is required since the potential existed for greater care costs to fall upon local authorities. The forthcoming Green Paper is unlikely to resolve the situation where health services are free at the point of use and social services are often means-tested.

If funding released from acute hospital care is passed to social care and community health services, specific longer-term funding for social care may not be required. However, in the short-term, specific Government grants will be essential if local authorities are to develop the levels of care needed to support the models of healthcare proposed in Darzi’s report.

Moving care out of hospitals through the prevention of admissions and/or early discharge is likely to increase the pressure on social care services, as could elective centres that have high throughput and short length of stays.
Local authorities have a role to play jointly with the NHS in assisting individuals and their families to take care of themselves; again, however, adequate funding (e.g. for individualised budgets) will be a consideration. They also have a potentially significant role (working with the NHS, the 'third sector' and business) to promote a 'preventative' approach, as part of a move away from the NHS being primarily a 'sickness service'.

**Questions to Hannah Miller**

In the ensuing 'Question and Answer' session, the following main points were made:

- Without predictive financial modelling of social care costs, it is impossible to properly take into consideration the cost implications of increased early discharge in an overall cost assessment of Darzi's proposals.

- Good management covering joint working arrangements between health and social care staff – as well as proper funding mechanisms – is important. Pilot projects to explore joint health/social care working (e.g. in delivering intermediate care) can play a valuable role.

- A move towards fewer and larger PCT areas (favoured by some within the NHS) is likely to have a detrimental impact on achieving better healthcare in various respects; existing coterminous local Authority/PCT boundaries helps deliver effective local commissioning.

- If there was to be increased early discharge, sufficient consideration needs to be given to additional social care support to the individuals concerned. Government monitoring of early discharge has to continue. Adequate funding to meet the needs of all individuals/families must be provided and joint local protocols can serve a useful purpose.

- LB Croydon is an example of a local authority that is developing many of the elements of an integrated health/social care model of provision (e.g. jointly managed intermediate care service). There is a good strategic agreement, 'joint badging' and multi-agency partnerships groups through which all matters are channelled. However, there remains a need for greater investment. Darzi's agenda is likely to provide further impetus to develop closer joint working.

- Differences in health (e.g. obesity) in different parts of London (the 'health inequalities' agenda) serves to underline the very local nature of population needs. Stage two of NHS London's consultation on implementing Darzi's proposals (which is expected to make specific proposals affecting individual areas, e.g. new healthcare centres and possible hospital closures) will be a crucial exercise in seeking to
achieve a balance between local circumstances and needs, and effective pan-London provision.

Key points:

- Further work is required on the financial implications of the models of care. Similarly, it is essential to undertake work to model the impact of the Darzi reforms on social care. This modelling could suggest that funding will need to be reallocated from the NHS to social care.

- There must be flexibility in how models of care are implemented: ‘one size does not fit all’. Decisions around the provision of services need to be taken as locally as possible. However, this must not be at the expense of achieving differing levels of quality in healthcare provision across London.

- It is important to ensure that the public are kept informed about any proposed changes in health services; clinicians will have a key role in explaining the rationale behind changes (i.e. that reforms are not cost-saving cuts).
22\textsuperscript{nd} February 2008: LB Tower Hamlets

Witness session 1: Primary care

**Dr Clare Gerada: Vice-Chair, Royal College of GPs**

Dr Gerada began the evidence session by giving a brief introduction noting that the Royal College of GPs represents around 30,000 GPs. It is the view of the Royal College that the NHS works because of GPs, working in small teams in community settings, often over a long period of time. GPs are successful as they are often able to form relationships with patients from the cradle to grave.

The Royal College is not in favour of the single-site 'polyclinic' model, but it is supportive of joint working through a federated model. Individual practices serve different communities and patient groups, each with their own differing needs and thus the Royal College believes that a ‘one size fits all’ approach will not work.

**Dr Tony Stanton: Joint Chief Executive, London-wide Local Medical Committees (LMCs)**

Dr Stanton began by offering a brief explanation as to the role of London-wide LMCs. Each PCT area in London nominates a body of GPs which serve on a local medical committee. Each local committee is banded together centrally under the umbrella of London-wide LMCs.

Dr Stanton shared Dr Gerada’s observation that general practice is most people’s main point of contact with the NHS. Only 10% of patients end up in a secondary care setting. The elderly, chronically sick and parents with young children are the most frequent users of GP services. GPs are generalists, tasked with managing demand and keeping people out of hospital.

In relation to Healthcare for London (HfL), Dr Stanton noted that changes to acute services as proposed by Lord Darzi are based on clinical evidence. There was concern that changes to the provision of primary care appear to have little evidence base from within the primary care arena; rather the changes could perhaps be seen as a clinician’s preferred view of primary care.

Dr Stanton welcomed many of the proposals in HfL, although he also had concerns about the single-site 'polyclinic' model that has dominated local consultation discussions. Based on the original assumptions in the HfL report, a polyclinic would be based on a single site and each polyclinic would serve around 50,000 patients with the average Borough therefore having five polyclinics. Currently, GP practices are often regarded as the heart of local...
communities and Dr Stanton would not want to see the loss of buildings and services in the heart of communities.

Questions to Dr Claire Gerada and Dr Tony Stanton

In the ensuing 'Question and Answer’ session, the following main points were made:

- There appears to be a very strong clinical evidence base for changes to the delivery of acute care across London. However, the evidence appears to be less strong for the introduction of 'polyclinics' – and there would appear to be no adverse effect on patient safety should they not go ahead.

- GPs are not opposed to change but are pushing for the highest possible standards, with a view to stronger relationships with boroughs and more visible support of continuity of care.

- In relation to strengthening primary care, the Royal College of GPs is pushing for practice accreditation, which would set standards on access and quality of care and would require practices to meet minimum standards. An investment in good buildings, midwives, community nurses and more health visitors to support primary care is greatly needed as they are currently undervalued services.

- The profession recognises that access to GPs, particularly for working people, is a problem for the general population. Services should be tailored to the needs of the particular population.

- There appears to be support for a federated or 'hub and spoke' polyclinic model, which would allow highly skilled teams to work together to deliver the best service to local populations. This could help to increase accessibility and the range of services available. A 'one-size fits all' polyclinic model should not be introduced wholesale across London, but only where this would secure the best outcomes for local people.

- Care is needed to avoid polyclinics merely re-inventing local district general hospitals. Rather than installing new diagnostic equipment in polyclinics, it may be more cost-effective to use this money to improve access to hospital-based equipment (e.g. longer opening hours).

- Specialists located in community settings may find their role scaled down, with general cases being seen that might not require a specialist. GPs may not also see specialist cases (diabetes, for example) and so they then lose that part of their knowledge base, which is difficult to claw back.
- There is evidence in London of care successfully being delivered across Borough boundaries, for example the existing specialist hospitals.

- Consideration also needs to be given to dentistry and how this could fit in with the delivery of primary care in London.

**Key points:**

- GPs play a central role in the NHS and account for many people's main or sole contact with the NHS.

- Polyclinics are not a 'one-size fits all' model. GP practices serve communities with differing needs and problems. They are accessible and are often based at the heart of their community. Some areas and local populations may benefit from new large polyclinics with extended hours, whereas others may prefer to keep a structure that ensures a personalised GP/patient link. Polyclinics should only be introduced where there is local need and where this would result in the best outcomes for local people.

- The federated polyclinic model may offer greater flexibility, allowing for a range of services and specialisms to be provided across a number of sites, with extended opening to reflect local need.

- A practice accreditation scheme could strengthen primary care and overcome concern about differences in quality of care.

- Polyclinics must not be 'mini-hospitals'. The financial effectiveness of polyclinics needs careful examination. For example, X-ray equipment is costly to provide, and it may be more economic to instead extend the opening hours for such existing, hospital-based diagnostic services.

- There is a fine balance between specialism and general practice in primary care. GPs need to maintain their wide-ranging skill base. Moves to expand the number of GPs with special interests ('GPSIs') must not dilute the strengths of general practice.

Witness session 2: Maternity services

**Louise Silverton: Deputy General Secretary, Royal College of Midwives**

Ms. Silverton noted that HfL builds on the key issues as set out in ‘Maternity Matters’, namely birthing choice, one-to-one care and choice in post-natal care. Ms Silverton’s presentation then focused on providing contextual...
statistical information on maternity services and birthing rates and on the challenges facing midwives in London.

In 2006 nearly 20% of all births were to women in London. London has the fastest rising birth rate in England, and the number of women in London of childbearing age (15-44 years) is projected to increase 11% by 2016, although these increases fluctuate across the capital.

Midwives care for a woman during birth and sustain her beyond giving birth for a period of time. All women need a midwife, and some also need a doctor. The number of visits a woman receives after going home varies across London. This is linked to the number of midwives per thousand of the population.

The Royal College of Midwives faces many challenges, most of which are generic, although some are more acute in London. Ms Silverton said the maternity sector is being starved of resources with the current spend level reduced by 2% (equating to £55m).

Most maternity units in London do not have enough midwives to provide the level of one-to-one care that the Government has pledged to provide for women by 2009. Birthrate Plus recommends a ratio of 1 midwife for every 28 deliveries for hospital births. This equates to approximately 36 midwives for every 1000 deliveries. Currently Whittington and Guy’s & St Thomas’ are the only hospitals to exceed the recommendation.

London has the highest midwifery vacancy rates in England. The average vacancy rate in 2006/7 was 8.5%. Some hospitals have put a freeze on recruitment to help address their financial deficits. During 2006/7 maternity services were suspended on 51 occasions, four times being related to medical/midwifery staffing. 18% of Midwives are working beyond the age of 55. 17.5% are in the position to retire now, 30% in 5 years and 53% in 10 years.

London also has Caesarean rates above the national average, and home birth rates below the national average. There are a rising number of complex births amongst women from overseas.

Questions to Louise Silverton

In the ensuing 'Question and Answer' session, the following main points were made:

- Every woman should have a choice about where to give birth. Some women with complications or social needs will need to access obstetric support. However, most women do not need medical intervention. Midwife-led services or home births might be the best option for them.
- Free-standing birth centres without obstetrics need to be properly staffed and require clear protocols for transferring patients.

- More midwives need to be based within the communities that they serve, with information clearly available as to where a person can find their local midwife. Post-natal care could effectively be delivered in local settings. This would have a particular impact in deprived communities where maternity services may be least accessible.

- The future health of a child is determined as a foetus. With sufficient resources, midwives could play a major role in offering preventative care and healthy living advice to expectant mothers.

- The theory that all mothers should receive care from the same team from early pregnancy until after the birth, and one-to-one midwifery care during established labour, is a good one. But there are not the midwifery resources in London for this to be the reality for all expectant mothers.

- In order to give women choice, PCTs will have to consider the way that they commission maternity and newborn care, which is currently hospital-focused. The Royal College of Midwives will be looking for commissioners to take a lead in commissioning the right type of care.

- If choice is to be properly funded, care should be paid for where a woman receives it. Host PCTs currently commission (and funding is allocated) based on the number of births it expects in a given year.

- Cultural considerations have a huge influence in maternity care, and it is important that midwives are culturally sensitive.

- In areas identified for significant future population growth (e.g. the Thames Gateway) it is important that dialogue occurs between local authorities and local PCTs on the projected plans for these areas.

**Key points:**

- Services need to respect the importance of cultural background and the impact this can have on women’s preferences for maternity care.

- Midwifery faces many challenges in relation to the workforce, for example the large proportion of older midwives who will retire soon. But midwifery has seen a reduction in its share of the NHS budget despite its ageing workforce and the challenges it faces in London from the fastest rising birth rate in England.

- Every woman should have a choice about where to give birth.
- The commissioning of maternity services needs to move away from the current focus on hospital-based services. Some women with complications or social needs will need to access obstetric support, but most women do not need medical intervention. Midwife-led services, either in hospital or stand-alone units, or home births are medically possible for women with no complications.

- Midwives need to be accessible, based in local communities and be able to draw on professional translation services so they do not have to rely on interpretation by other family members.

Witness session 3: Paediatric care and child health

**Dr Simon Lenton: Vice-President for Health Services, Royal College of Paediatrics and Child Health**

Dr Lenton noted that there are a number of factors signalling that reform of paediatric and child health services is needed, including the findings of UNICEF on children’s health in the UK, rife inequalities in services and the view of the Healthcare Commission that acute services are poor. It is important that this reform is undertaken in the right way to allow the right decision to be taken at the right time with the right outcomes. Children are not mini-adults and have different needs and requirements.

The basic premise of the report that poor health with appropriate health care leads to better health was welcomed, but this needed to be broken down into the following steps: prevention – identification – assessment – short-term interventions – long-term support – palliation. Parents need to know where they can go to access the right level of care.

In current service configurations for inpatient and acute children’s services, there are insufficient numbers of children passing through to retain the expertise of clinicians. Consideration needs to be given to the services that need to be co-located with specialist centres to deliver the best outcomes for children. Clinical services needed to be delivered by teams working in integrated networks, with a focus on collaboration not competition.

There are not currently enough trained staff to deliver children’s health services across the primary sector. Only 40% of GPs are specifically trained in paediatrics, and the Royal College would want to see more GPs competent in dealing with childhood diseases.

There is a need to take a holistic view of children’s needs, from treatment itself to the environment this takes place in, and the needs of the child’s family; yet this does not always sit easily with a market-orientated approach to
the provision of care. Paediatricians would prefer to treat children in environments which they are exposed to during their daily lives. This could include children’s centres and extended schools.

The HfL report seems to consider paediatrics and child health as an afterthought and takes a piecemeal approach, which gives little focus to mental health services, disabled or disadvantaged children. There needs to be a clear vision so that decisions taken along the way can be aligned with that vision. The Royal College would want to see world-class commissioning, regulation and improvement and national innovation centres (which seem to have been lost from the original report).

Questions to Dr Simon Lenton

In the ensuing ‘Question and Answer’ session, the following main points were made:

- There was not much dialogue with the Royal College of Paediatrics and Child Health before HfL was produced, though it is hoped that a meeting will take place in the near future.

- There are no simple solutions, and it would not be appropriate to introduce a single model across the board. A set of core values had been presented that the Royal College would like to see delivered.

- There are different ways of delivering treatment and these need to be assessed on an individual basis. Broadly speaking, there is a need to move away from traditional settings when caring for children and integrate services into their day-to-day lives, by providing care in homes and schools. In some cases families would have to travel for specialist treatment at centres of excellence.

- There is a need for more paediatric nurses.

- Local authorities could consider a range of interventions, from looking at local targets and working more closely with the PCT, to reducing speed limits in residential areas to cut down on the numbers of children injured in road traffic accidents.

- In relation to increasing immunisation of children, it is noted that there are specific issues in the capital due to the transient nature of the population. There is a definite need to upgrade computer systems in some boroughs to be able to keep an accurate track of children’s records. Much work is also needed to educate parents around the benefits of immunisation. It is also important to ensure that health professionals provide consistent messages, particularly around MMR.
Key points:

- Children’s health is determined by a wide range of social, economic and environmental factors.

- It is vital to reform services and not simply the location where they are provided. Co-locating on a single site (e.g. a polyclinic) may help improve coordination but this will also require services to share more information and change the way they work.

- Moving children’s services away from traditional settings and integrating them into children’s day-to-day lives may also help. This could include children’s centres and extended schools.

- In a small number of cases, specialist treatment at centres of excellence could lead to improved care.

- The HfL report seems to consider paediatrics and child health as an afterthought and takes a piecemeal approach, that gives little focus to mental health services, disabled or disadvantaged children. Further consideration must be given to these aspects.

Witness session 4: Surgery

Mr David Jones: Council Member, Royal College of Surgeons

Mr Jones explained that the Royal College of Surgeons (RCS) exists to enable surgeons to achieve and maintain the highest standards of surgical practice and patient care. In practice this meant training the surgeons of the future and handing on skills from one generation to the next. He noted that his comments related to surgery generally and that individual specialities would have their own ways of working.

The College’s Patient Liaison Group (PLG) are a part of the College Council and exists to keep the College’s ‘feet on the ground’. The PLG lobbies for continuity of care and named doctors throughout a patient’s care.

Surgery is best provided through integrated networks of teams which can decide on the provision of general and specialised surgery within that network. Specialised care would ideally be provided in a specialised centre. Routine surgery could be provided closer to home where this is safe and possible. There are already good examples of such networks within trauma and paediatric surgery.
In relation to trauma care, it is reasonable to identify a small number of specialised centres. But this is important only for the minority of patients who are seriously injured; minor injuries and fractures could be treated locally. The Royal College of Surgeons welcomes the recommendation for three such trauma centres in London.

Surgeons need a level of throughput to achieve and maintain their skill levels. Within networks, surgeons have particular skills and the best outcome for the patient may be achieved by referring a patient to a particular doctor outside of their own local area.

Questions to Mr David Jones

In the ensuing 'Question and Answer' session, the following main points were made:

- Surgery is a craft and practice is essential, particularly for newly-qualified surgeons. The European Working Time Directive reduced surgeons’ hours. Thus it is not always possible to gain sufficient levels of skill through practice and young surgeons are trained to a level of competence rather than excellence. The training of young doctors is in crisis, with a large number of young people competing for a small number of places. There were no guidelines at present as to the revalidation of senior professionals.

- The London Ambulance Service is already good at taking patients to the place where they will receive the most appropriate care. They are used to contending with traffic congestion in the capital as part of their decision-making processes when referring cases to hospitals. Consideration will need to be given to the transfer of non-emergencies between sites.

- In terms of funding, quality and safety – rather than activity – should be rewarded. Surgeons are used to high-volume surgery, but resources needed to be put in place to allow surgeons to deal with issues such as nurse shortages, infections and the ‘target’ culture.

- It was suggested that London-wide networks of surgeons could ensure that patients are sent to the right place to receive surgery.

- Further detail needed to be added to the Darzi report, and this would need to be discussed locally.

- Equity of care, irrespective of which part of London someone lives in, needed to be achieved.
Key points:

- Surgery is a craft that needs practice. It is best provided through integrated networks of teams which can decide on the provision of general and specialised surgery within that network. Specialised care should ideally be provided in a specialised centre. Routine surgery can be provided closer to home where this is safe and possible.

- Within networks, surgeons have particular skills and the best outcome for the patient may be achieved by referring a patient to a particular doctor outside of their own local area.

- 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 London Ambulance Service 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.

- It is reasonable to identify a small number of specialised centres for severe trauma.

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

Professor Gilmore opened by stating that the Royal College of Physicians (RCP) is an organisation supporting physicians throughout their career by championing the values of the medical profession, developing standards of patient care, education and training for junior doctors and by helping consultants keep up to date with developments in their field. He said that physicians are usually closely involved in cases involving surgery as well as the surgeons themselves. The RCP has produced research looking at acute services and at integrating staff from primary and acute care.

A key driver for quality and improvement is clinical leadership. If clinicians take a leadership role and are set meaningful development targets, service improvements will follow. Clinicians acknowledge the positive influence they can have over service changes e.g. where GPs talk to hospital doctors about best service for patients. Service improvements do not work well when driven by managerial/budget pressures alone.

It is important for healthcare reforms to avoid a ‘one size fits all’ approach. Success will depend upon different solutions for different areas and circumstances.

**Acute Care**

RCP recognise merits in more complex surgery gravitating toward larger, more centralised hospitals. The vast majority of patients will continue to be treated by physicians, not surgeons. There is a difference between A&E and Surgery (trauma), and non-elective surgery can be located in specialist centres.

Local hospitals have a place within the community and in dealing locally with emergency care. These must be supported by intensive care facilities which are distinct from acute care. Local hospitals must be able to treat and stabilise patients and refer them elsewhere when more specialised care is needed.

**Integrating Primary and Acute Care Staff - Teams without walls**

Clear potential for patient benefit exists from the integration of primary and acute care staff, enabling improved treatment nearer to a patient’s home.

Making a success of such integration rests on developing effective reforms for unplanned care, supported through centralised trauma provision but with localised ‘core hours’ emergency care and on delivering integrated care including social care in community-based settings appropriate for the patient.
Getting treatment for the patient right early in their treatment is usually more cost effective.

Questions to the Royal College of Physicians

In the ensuing ‘Question and Answer’ session, the following main points were made:

- ‘Buy in’ from primary care is essential; physicians see few challenges with working in the community if this is evidenced as best for the patient, cost-effective and specialist care is provided when needed. The RCP is sceptical about training GPs as specialists.

- It is essential to have an effective interface with social care for successful integration of ‘teams without walls’.

- The vision for polyclinics means they will not be relevant for acutely ill in-patients.

- It is essential to keep targets relevant and not static, and they need clinical buy-in.

- Proposals to move services from central towards local provision will need to maintain a critical mass of patients to maintain expertise. If not supported by an agreed and managed process, patient care may suffer through diluted expertise.

- There can sometimes be a tension between clinicians and management about service changes, but this can be overcome by improving working relationships and encouraging clinicians to take up management positions.

- Considering how the facility is developed (whether via a polyclinic or health centre model) means looking at the clinical structure and what is needed in a particular area.

- Specialist acute expertise and intensive care services are needed with good diagnosis to stabilise patients so they are ready for specialist care wherever it is located.

Key points:

- Surgery is only a small part of hospital activity: centralisation of specialist surgery does not necessarily require the centralisation of non-surgical activity. A&E and surgery are different and can be located at different sites.
- Centralisation of specialist care will only work if specialist trusts are able to discharge patients to local hospitals once the initial treatment is provided. A lack of beds at local hospitals (and the staff to support them) will lead to ‘bed blocking’ and undermine the care pathway.

- Providing care closer to home can improve the patient experience by reducing travel times. However, there may be instances where asking patients to travel further will improve care.

- Local hospitals may be able to provide specialist care at peak times, with patients travelling to specialist centres at evenings and weekends when travel times are less.

- Moving patients between different care settings will also lead to greater transport needs.

- Full operation of ‘teams without walls’ will require integration of primary and secondary care including social care.


Michéle Dix: Managing Director (Planning), Transport for London

TfL is the main provider of transport services in London and plays a key role in ensuring appropriate access to healthcare services. Where and how health services are provided impact on London’s travel patterns.

TfL is responsible for ensuring safe and accessible public transport, working with Boroughs to deliver door-to-door transport by public transport or other means and providing services such as Dial a Ride, Taxi Card and Capital Call.

TfL and Boroughs fund Taxi Card, and its most significant use is for NHS appointments. Given this, TfL believe the NHS should consider shared funding for this service.

TfL argue that transport consequences need to be considered during the planning and scoping stage of every decision on health infrastructure. Ms Dix highlighted the closure of Chase Farm A&E as an example where TfL should have been consulted earlier to ensure the impact on the highway network, bus services, patient access and active travel were considered in addition to London Ambulance Service (LAS) mapping. Any decisions by health trusts to place health facilities away from transport hubs can pose big problems for patients and can also be very costly to TfL.
Analysis shows health-related journeys represent less than 5% of the total trips made in London. Of these 51% are by car, 19% by walking, 14% by bus and 10% by tube/rail. There are currently 1600 GP practices in London, and the average travel time to the nearest GP is 8 minutes. At present more than 80% of people access their GP by walking. Changes to the location of healthcare facilities can therefore also affect people’s health if there is a shift in emphasis away from walking. TfL believe work on developing active travel will assist in the development of Darzi’s vision that ‘prevention is better than cure’.

TfL and Boroughs have no powers to request that more detailed impact assessments are carried out. TfL, NHS London, Boroughs and PCTs should work together to develop criteria for optimising access to polyclinics, hospitals and other large facilities.

Ms Dix gave two examples of the ways the proposals could impact on transport:

- travel to 33 London hospitals could reduce if 40% of out patient activity is moved to the predicted 150 polyclinics
- in contrast, if 70% of GP services – there are currently 1600 GPs in London – moved to the predicted 150 polyclinics this could increase the travel needs of London.

TfL are developing a new health facilities travel model with NHS London to allow different health service configurations to be tested for their transport impacts. This will provide more information about the accessibility implications of changing health services and help TfL plan the bus network to cope with the expected additional trips and population groups affected.

TfL believe the Darzi proposals must:

- reduce the need to travel, especially by car
- help to influence a shift towards more sustainable modes of transport for able-bodied patients
- encourage access to services on foot or cycle through the design of healthcare sites
- reduce inequalities in access to healthcare.

TfL support the principle of enhancing patient choice in NHS services but want NHS London to consider as an integral part of the decision-making process how people will access health services. Providing more centralised specialist services could lead to more patients travelling longer, presumably by car thus impacting on highways.
Questions to Transport for London

In the ensuing 'Question and Answer' session, the following main points were made:

- Engagement with TfL has been more reactive than proactive, and TfL want to be involved earlier. TfL are developing a travel model to inform decisions about locations of sites. If it appears costs will be borne by TfL and the Boroughs, this should be identified and NHS London lobbied to meet those costs.

- Without detailed proposals it is hard to say how Darzi’s proposals will impact on Londoners’ travel needs.

- TfL’s role is to look at the accessibility of the proposed polyclinics and try to influence their location.

**Key points:**

- Proposals should encourage access to healthcare facilities by foot or sustainable public transport options.

- All health changes must be required to have travel plans beyond the current NHS transport assessment.

- The past lack of TfL involvement at an early enough stage to influence planning is improving. The NHS must enforce Trusts to involve TfL and local authorities to avoid the risk of shunting transport and infrastructure costs to these partners.

**Jason Killens: Assistant Director of Operations, London Ambulance Service**

Jason Killens highlighted that the London Ambulance Service (LAS) is the only pan-London NHS trust, providing services to approximately one million emergency requests for assistance per year. Their principal service focus is accident and emergency, although they also provide non-emergency services via contracts with the individual health trusts.

Demand for ambulances is managed by an operator telephony system supported by a diagnostic assessment system which determines the type of service dispatched to an incident.

Major trauma represents approximately 10% of cases. LAS do not oppose proposals to have major trauma centres. If these go ahead, London’s helicopter emergency medical service (HEM) will need to be reviewed as it is currently based in only one location.
Jason Killens stated that the LAS support the Darzi principles. Implementation of specific proposals needs to consider availability and extended journey times for ambulances to ensure changes in care services do not reduce ambulance availability levels. National standards (as delivered by LAS) should be protected.

Historically, LAS staff have usually taken patients to the nearest hospital. Now LAS staff can decide which hospital the patient goes to based upon their need assessment. The importance of those decisions to saving lives is likely to increase under Darzi. LAS believe there is strong evidence to support specialist centres for stroke treatment.

Mapping and understanding of patient flows must take place but can only happen when specific proposals are developed. A comparable assessment of training and development requirements for staff is also required to ensure LAS can meet care expectations.

Questions to London Ambulance Service

In the ensuing 'Question and Answer' session, the following main points were made:

- Assessments of ambulance cover needs will depend on the envisaged service level required. LAS can then identify the extent of up-skilling staff may be required. If the training required is significant, it could mean a 12-24 month dedicated programme for LAS staff which would need to be funded.

- LAS have no definitive figures in relation to projected ambulance response times and London’s traffic, but it was noted speed humps and traffic calming measures present problems to LAS as they slow vehicles down with an adverse impact on response times.

- Some LAS staff have become more skilled, carry more equipment and can therefore diagnose more conditions in the field than previously. The potential exists for further improvement in the service but depends upon design and good practice.

- If primary healthcare resources were sufficient to receive patients for rehabilitation, over half the patients LAS presently taken to A&E could be redirected.
Key points

- The NHS must ensure that any additional costs to the LAS arising from re-modelling of care pathways or additional transport burden is properly funded so that national standards continue to be applied. Mapping the full consequences for the LAS can only be done after detailed proposals are made. NHS London must ensure resources are available for modelling ambulance requirements.

- Centralisation of major trauma services will require the NHS to examine funding for the LAS.

- Training and re-skilling may be required for LAS staff as a result of any proposals emerging from HfL. Such training could be costly and require a significant period of time. This time lag must be built into the planning of new care services.

Witness session 3: Further evidence on the proposals including mental health

Bernell Bussue and Tom Sandford: Directors, Royal College of Nursing

Bernell Bussue opened by highlighting that the Royal College of Nursing (RCN) have approximately 50,000 members in London and the largest Black and Minority Ethnic (BME) membership for a professional organisation. RCN believe NHS London have made good efforts to engage the public and professionals in the development of the HfL proposals but feel that engagement in the consultation has not been as high as expected.

RCN believe HfL proposals do not adequately capture all the areas of healthcare need. More attention must be given to areas such as learning difficulties or long term conditions.

Access
NHS London should seek to improve hospital services and avoid creating polyclinics as ‘mini-hospitals’. HfL seems to entail a vision of health services for the able sick as opposed to the sick/sick. Health inequalities could widen if access for people already able to access health services improves but not for people who already experience difficulties.

Workforce
Realising the HfL vision requires a shift in how the workforce is organised. RCN estimate 30% of staff may need to move from acute to primary care setting. This will present major challenges. Many nurses feel ill equipped to move into the community without re-training and a clear communications plan and rationale.
RCN support an NHS London review of workforce planning capability and capacity. Overview and Scrutiny needs to engage with TfL and local authorities in relation to transport changes.

Tom Sandford opened by highlighting that the physical health of mental health patients is very poor. Life expectancy is 10 years less for a person with mental health conditions and high rates of mental ill-health are associated with poverty, housing issues and drugs.

Access to mental health support and specific services are still not adequate, though improving. Whilst PCTs have made recent improvements and spend approximately 12% of their budget on mental health services more assessment is needed for mental health, including the development of shared protocols for GPs.

Black and Minority Ethnic groups (BME) are less likely to use mental health services, with an estimated 60% of BME patients accessing mental health care through the police – suggesting access to mental health services is not adequate.

Polyclinics could be a means of de-stigmatising mental health. They should be designed to accommodate mental health needs, providing services that meet the range of mental health needs and include appropriate identification and fast-track referral. It is equally imperative to avoid distress and disturbances for other polyclinic users.

It was noted the provisions for appropriately accessible mental health services are decreasing with a number of facilities having closed or are closing. HfL needs to establish a means of effective provision for mental health.

It had been suggested that some mental health bed closures (resulting in further reduction of accessible facilities) were linked to trusts applying for foundation trust status and the need to balance the books.

RCN queried how appropriate and timely access to psychiatrists will be guaranteed and fit with the two models HfL envisages – community and more specialised care.

Early mental health intervention saves costs elsewhere e.g. Children and Young People Mental Health, and Child and Adolescent Mental Health Services (CAMHS). Early interventions may save large costs arising later when such children become young people not in education, employment or training.

Questions to the Royal College of Nursing

In the ensuing ‘Question and Answer’ session, the following main points were made:
- Mental health services are not always attractive to patients and need to be culturally sensitive. Specific challenges exist in addressing high suicide rates amongst young men.

- It is believed there are not enough nurses in London to move to care being fully delivered in the community setting, even more so for care in specialist areas.

- At present there is a poor understanding of how to access mental health services. A high number of BME patients access services for the first time when coming into contact with the police rather than the preferred route via health professionals.

- Given the issues of social isolation and poverty it can often be difficult to ensure that patients access mental health services unless they are an in-patient. Early treatment can prevent escalation of less pronounced conditions. The Darzi proposals did not focus on this issue, nor the physical health of mentally ill patients.

- Although A&E services have changed they have not changed sufficiently to accommodate a mentally-ill patient in distress.

- Caution was expressed about adopting a ‘big bang’ approach to HfL reforms which must be seen as a 10-year framework. There will be benefits from establishing a number of trials.

- The Darzi proposals should be helpful for diagnostics and could create new opportunities for nurses. It is well established that the intervention of qualified nurses improves mortality rates.

### Key points:

- Funding should be focused upon the most deprived areas.

- The Darzi proposals will mean significant reorganisation and relocation of nursing staff with up to 30% of staff moving from acute to primary care.

- There are concerns about the closure and uncertain status of some mental health facilities in London. HfL pays insignificant attention to mental health needs. The NHS needs to establish appropriate and integrated provision for mental health patients.

- Access for those requiring mental health services is inadequate. Over 60% of people from BME communities accessing mental health services do so through the police.
Polyclinics must provide suitable facilities for mental health patients e.g. suitable waiting and treatment areas for people who may be suffering from severe dementia or drug/alcohol problems.

Witness session 4: Equalities and public health

Dr Bobbie Jacobson: Director, London Health Observatory (LHO)
Dr Sandra Husbands: Specialist Registrar, LHO

The LHO was set up by NHS London to monitor health and healthcare in London from a public health perspective. Prevention, improving general health levels and the impact on health inequalities are key concerns. Assessments of any healthcare proposals need to consider the whole population evidence base.

As a starting point to understanding the possible impact of the Darzi proposals, LHO analysed the proposed stroke care pathway in terms of two main principles in the HfL framework:

- prevention is better than cure
- there must be a focus on reducing differences in health and healthcare across London.

Whilst LHO welcome the proposed care pathway for stroke, LHO believe greater focus is needed ‘upstream’ i.e. on more and better preventative work. Research suggests, that reducing population risk factors such as smoking is effective and achieves value for money. The Darzi proposals will only affect patient health once a stroke has occurred.

LHO identified five stages relevant to the stroke pathway, of which three occur before HfL kicks in and where improved prevention methods could help reduce the number of strokes:

- Healthy community – population prevention through health education and lifestyle modifications.
- Management of risk factors in individuals – high blood pressure affects 1.7 million people in London with approximately 63% of cases untreated.
- Rapid Access Transient Ischaemic Attack (TIA) management - there are approximately 1000 per year in London.
- New Stroke Centres (Darzi proposals commence) - acute stroke management including CT scans and thrombolysis.
- Return to independent living / long term disability – Rehabilitation hospital and community.
Missed opportunities for preventing strokes include untreated high blood pressure, which is a major risk factor, and where less than 20% of the affected population receive adequate treatment.

LHO advised each stroke costs the NHS an average of £15,000 over 5 years. The average cost of the community care involved is £1,700 p.a. The costs to patients, their families and carers come to £7,000p.a.

LHO has identified a broad spectrum of factors associated with inequalities for stroke and highlighted the following examples of ethnic inequalities:

- 60% higher incidence of strokes in black people than white and also higher for Pakistani and Bangladeshi communities than the general population
- higher prevalence of high blood pressure among black people – more likely to be diagnosed, but less likely to be adequately treated
- TIA more important risk factor for white people than for other groups.

LHO believe health services need to think about how they can make their services more culturally appropriate.

Statistics on stoke treatment at borough level show 22 PCTs have a significant issue to address. Variations in general quality of primary care need to be minimised, as well as a more even distribution of the primary care workforce.

If polyclinics are to be developed to fit local circumstances, a pan London approach to prevention and initiatives prior to the commencement of existing care pathways needs to be developed.

Questions to the London Health Observatory

In the ensuing 'Question and Answer' session, the following main points were made:

- Of those diagnosed with high blood pressure less than 20% are being treated correctly. This did not include people who have a problem but have not been diagnosed.

- Only the tip of social care need is addressed by social care services. The polyclinic model could facilitate some of the homecare needs of a patient if agreed between providers.

- The cross-over to primary care will be challenging along with delivery of full integrated care. It is likely there will be continuity of care for clinics whether care in the future is through polyclinics or another model.
Key points:

- Many of the proposals may well deliver improved outcomes, but they concentrate too far down the care pathway to be optimally effective e.g. stroke. The NHS needs to give greater focus to prevention and general health improvement.

- Innovative ways of encouraging greater public awareness of health (e.g. blood pressure tests in large supermarkets) need to be evaluated.

- London faces specific challenges as a result of its highly mobile population. This can make it difficult to ensure high rates of childhood immunisation, for example. The NHS and its partners need to address this.
28th March 2008: LB Merton

Witness session 1: Health Inequalities Impact Assessment for ‘Healthcare for London’

Gail Findlay: Coordinator, London Health Commission
Dr Sandra Husbands: Specialist Registrar, London Health Observatory

In their opening remarks to the JOSC, Gail Findlay and Dr Sandra Husbands outlined the background to the London Health Commission (LHC) and its work on Healthcare for London (HfL).

The LHC is a multi-agency partnership established in 2000 to examine health in London, and includes the London Health Observatory (the organisation that gave evidence to the previous JOSC meeting).

Health Inequality Impact Assessments (HIIs) seek to ensure that policies and strategies do not increase health inequalities, and are applied to major policies and plans across the Greater London Authority (GLA) Group (e.g. the Mayor’s transport strategy).

Given the short timescale for undertaking the HIIs for HfL, the LHC focused on aspects that could have the biggest impact on health inequalities: primary care, maternity care and the proposed new stroke pathway.

Gail Findlay and Sandra Husbands said that HfL is an ambitious project and presents an exciting opportunity for change. On the whole, the proposals in HfL are likely to improve health outcomes in London and reduce inequalities. However, much will depend on how HfL is implemented. They added that the care pathways must be implemented in full otherwise inequalities could worsen e.g. if patients are discharged into the community after a shorter hospital stay without the necessary additional investment in community services to support rehabilitation. There is currently a shortage of primary care staff in certain parts of London and HfL also provides an opportunity to develop a skilled workforce that helps disadvantaged groups.

They advised that it is important to focus resources on areas/communities with the greatest unmet need: reform must recognise that there are pockets of deprivation in areas that are perceived as affluent. Priority must be given to helping disadvantaged groups overcome barriers to accessing health services. However, the witnesses highlighted that the lack of high quality data can make it hard to understand the needs of priority groups. Much better data collection and evaluation will be required if the impact of the reforms in tackling health inequalities is to be monitored.

Finally they said that it is essential to undertake future impact assessments when further detail is available on the proposals, and to also evaluate the
impact of new care pathways once these have been implemented. This information must be used to inform the roll-out of similar pathways across London.

Questions to Gail Findlay and Dr Sandra Husbands

In the ensuing 'Question and Answer' session, the following main points were made:

- It is vital to move beyond a ‘sickness service’ and ensure sufficient resources are allocated to promoting healthy lifestyles and preventing hospital admission. Although prevention and tackling inequalities are two of the seven principles underpinning HfL, it was noted that the NHS has diverted resources from these services in order to address past financial problems. Resources for this work must become part of PCTs’ core expenditure to avoid the need for projects having to bid for new resources every few years.

- PCTs alone cannot overcome the health inequalities in London. Central and local government will have a key role to play in relation to providing suitable housing and amenities. It was noted that the recent cross-government obesity strategy demonstrates the growing acceptance that the NHS cannot deliver public health by itself.

- Carers are already facing huge challenges, and there is a danger that the proposals could lead to them facing further disadvantage.

- It is appropriate for the NHS to seek to influence people’s decisions about their lifestyle, e.g. help to stop smoking, for this can prevent illness and the need for expensive medical care.

- Concerns were raised whether the NHS should wait until further work is undertaken to address gaps in the proposals before implementing any reform. However, it was noted that the extent of need in some areas means that it is not possible to wait several years for new services, and that pilots could help refine the proposals. Any evaluation of pilots will require good quality data (i.e. to demonstrate the impact of the reforms). However, data collection varies across organisations and professions.

- Overview & Scrutiny Committees will have a key role in ensuring that the NHS undertakes impact assessments once further detail is available on the proposed care pathways.
**Key points:**

- HfL could reduce health inequalities if fully implemented. However, poor or partial implementation of the proposals could increase inequalities.

- Resources must be focused on communities with greatest need. However, further work is required to improve the collection of the data that will help identify these priorities.

- Health Inequality Impact Assessments must be undertaken once further information on the care pathways is available and after the reforms have been piloted.

- Resources for health promotion and preventing hospital admission must be part of mainstream NHS expenditure and not diverted in times of financial difficulty.

- The NHS alone cannot ensure London is healthy.

**Witness session 2: End of life care**

**Sir Cyril Chantler: Chair of Great Ormond Street Hospital, Chair of the Healthcare for London Clinical Advisory Group and the End of Life Working Group**

In his opening remarks Sir Cyril highlighted that the demands currently facing the NHS are very different to those when it was established 60 years ago. Advances in medicine mean that 80% of the NHS’ workload relates to supporting people with chronic conditions whereas in the past people would survive for far less time once they became ill. In addition, people now tend to develop multiple conditions which further increases the challenge to the NHS. The NHS cannot afford to maintain the status quo: existing models of service will become unaffordable.

The poor and unemployed have more difficulties accessing health services than the population as a whole, and polyclinics could provide an opportunity to improve well-being for these groups and the wider population. This will involve extending polyclinics beyond simply health services. He added that the idea of a polyclinic is not new and similar services were previously proposed.

In relation to end of life care, he stated that the majority of people want to die at home or in a hospice. However, 70% of Londoners die in hospital, which is much higher than the rest of the country.

Sir Cyril said that the Healthcare for London End of Life Working Group found end of life care is fragmented in London. Their proposed reforms seek to ensure greater coordination. Under the proposed models, there would be five
zones for commissioning end of life care for adults, while end of life care for children would be organised on a pan-London basis (due to the lower number of patients). The PCTs within these zones would produce a specification of the required services to meet the needs of their population and commission two providers for that zone. These service providers would arrange for discussions to take place with individuals to find out their wishes for end of life care and then arrange for these services to be delivered (as far as possible). The Working Group believe it is unlikely that the service provider will directly provide all of the care and instead commission many of the required services from other organisations.

The service providers could be drawn from the NHS, or may be from the independent or voluntary sectors. Marie Curie deliver a similar service in Lincolnshire and this demonstrates the plans should roughly be cost neutral given the anticipated reduction in the number of people dying in hospital.

Questions to Sir Cyril Chantler

In the ensuing ‘Question and Answer’ session, the following main points were made:

- The proposals will require people to overcome the taboo of talking about death. It will also require decisions to be taken to identify when someone is approaching the end of their life. It is not always straightforward to accurately predict life expectancy, although one option would be for people to be referred to end of life services when diagnosed with terminal illnesses.

- The proposals could impact on social care services, and like other aspects of chronic disease management it would be vital to ensure that the service specification for the end of life service providers include both health and social care.

- There was concern that the five zones could undermine local authority/PCT relationships, and that this could conflict with the HfL principle of localising care. Sir Cyril highlighted that it would be for the PCTs to decide whether to work together to commission end of life care. It is proposed to group PCTs into zones because it is unlikely individual PCTs will have enough patients to commission services on their own.

- It was highlighted that these proposals (like other aspects of HfL) could again raise problems in that social care services are increasingly means-tested while health services are universal.

- Some London residents live in very poor quality accommodation and it is essential to ensure that these people are not forced to die at home.
was agreed that protections would need to be built into the system so that people who want to die at home are able to do so, while those wishing to die in hospital are able to also. In this respect, the proposals will seek to provide services that meet individual need and circumstance.

- It can be very difficult to find terminally ill patients a place in hospices, and individuals may be too poorly to be transferred by the time a space is available. Care homes may often refuse to take a very ill resident back after hospital treatment despite this being the person’s home. This may be because the care homes do not feel they have the expertise to support a very sick resident or because they feel the death of a resident will affect their reputation. It was agreed that any proposals must address this situation.

**Key points:**

- It is essential to tailor services to individual circumstance and preference. ‘One size does not fit all’ and it may not be appropriate for everyone to die at home.

- Individuals and NHS services may be reluctant to talk about death but these conversations will be essential if services are to meet individual need.

- Care/nursing homes are people’s homes and therefore reforms must ensure that people are able to die there if that is their wish.

**Stephen Richards: Director, Macmillan Cancer Support**

In his opening comments to the JOSC, Stephen Richards outlined the range of services provided by Macmillan. The organisation spends approximately £6 million on cancer and palliative care in London each year and employs 600 staff. Macmillan offers a range of support to people starting from when they suspect they may have cancer right through to the end of life.

Clinicians should change their approach to giving a life expectancy and should instead ask themselves whether they would be surprised if a patient dies within a set time. In addition, patients need to be given more information about their life expectancy to enable discussions on end of life care. It would not be appropriate to routinely tell people how long they have to live, but doctors should be prepared to give more information than is sometimes the case. He highlighted that bereavement is less stressful for relatives when end of life care is discussed prior to death.

Cancer can have a huge impact on a person’s life, particularly their finances. Patients will have to pay for parking during frequent hospital visits and may
struggle to pay bills and other living costs while unable to work. Significantly, over half the number of people who die from cancer did not claim the Disability Living Allowance and Attendance Allowance to which they were entitled. The Healthcare for London review does not outline how it will address these issues.

In relation to the proposals, Stephen Richards said that any reform must ensure appropriate out of hours care services are in place. He highlighted that when faced with severe pains or complications many cancer patients currently attend Accident & Emergency (A&E) when other health services are closed.

He said that further work is required to develop the palliative care skills of those working in general practice, and doctors may require additional training on how to offer emotional support to patients diagnosed or living with cancer. He highlighted that carers must be identified and their views incorporated into end of life plans.

Questions to Stephen Richards

In the ensuing ‘Question and Answer’ session, the following main points were made:

- Hospices do not receive guaranteed funding from PCTs and fund raising activities account for much of their income.

- The end of life proposals could impact on carers. It is vital to identify the needs of carers early on and ensure they have the support to cope in their role. Government policy can mean that carers receive less state financial support once they reach pensionable age. Macmillan employ support workers to help people claim benefits and this has been very effective at increasing benefit take-up.

- The proposals in HfL will require a significant transfer of nurses from hospitals to community care. It may take several years to ensure that nurses have the different skills required to work in the community. In addition, current experience highlights that it is difficult to recruit nursing staff in certain areas and roles. Nursing jobs often need to be advertised up to four times before an appointment is made.

- Disagreements between organisations as to what is ‘health’ and what is ‘social’ care can undermine the quality of care provided to individuals. Very sick people may not have time to wait for lengthy discussions to be resolved.
**Key points:**

- Clinicians must be encouraged and become willing to start discussions with their patients about their life expectancy when diagnosed with terminal illness.

- The proposals for end of life care will require additional community nursing staff. This will not happen overnight. However, a failure to ensure these staff are in place will increase the burden on carers.
Appendices

Appendix 1: Witnesses attending the JOSC
Appendix 2: List of written submissions to the JOSC
Appendix 3: Legal basis to the JOSC
Appendix 4: Glossary
Appendix 1: Witnesses attending the JOSC

Friday 30 November 2007: London Borough of Hammersmith and Fulham

Context of the Healthcare for London review, next steps and plans for consultation and engagement with stakeholders
- Richard Sumray: Chair, Joint Committee of PCTs (JCPCT)
- Ruth Carnall: Chief Executive, NHS London

Friday 7 December 2007: London Borough of Camden

Background to and rationale behind ‘Healthcare for London’
- Dr Martyn Wake: GP and Joint Medical Director, Sutton and Merton PCT and Chair of Healthcare for London Planned Care Working Group
- Dr Chris Streather: Medical Director, St George’s Healthcare NHS Trust and Member of Healthcare for London Acute Care Working Group

An independent view of ‘Healthcare for London’ and the way forward for the JOSC
- Fiona Campbell: Independent consultant on health and social care policy and Board Member of the Centre for Public Scrutiny

Friday 18 January 2008: City of London

Partnerships, infrastructure and economics
- Steve Pennant: Chief Executive, London Connects
- Niall Dickson: Chief Executive, King’s Fund
- John Appleby: Chief Economist, Health Policy, King’s Fund
- David Walker: Editor, Guardian Public Magazine

Local authorities and social care.
- Cllr Merrick Cockell: Chairman, London Councils
- Mark Brangwyn: Head of Health & Social Care
- Hannah Miller: Director of Social Services, London Borough of Croydon
Friday 22 February 2008: London Borough of Tower Hamlets

**Primary, secondary and specialist care**
- Dr Clare Gerada: Vice Chair, Royal College of GPs
- Dr Tony Stanton: Joint Chief Executive, London-wide Local Medical Committees
- Louise Silverton: Deputy General Secretary, Royal College of Midwives
- Dr Simon Lenton: Vice President for Health Services, Royal College of Paediatrics and Child Health
- David Jones: Council Member – Royal College of Surgeons

productName

Friday 14th March: London Borough of Ealing

**Access, accessibility, equalities, public health and further evidence on primary, secondary and specialist care**
- Professor Ian Gilmore: President, Royal College of Physicians
- Martin Else: Chief Executive, Royal College of Physicians
- Michele 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

Friday 28th March: London Borough of Merton

**Health Inequalities Impact Assessment for ‘Healthcare for London’**
- Gail Findlay: Coordinator, London Health Commission
- Dr Sandra Husbands – Specialist Registrar, London Health Observatory

**End of life care**
- Sir Cyril Chantler: Chair, Great Ormond Street Hospital, Chair of the HfL Clinical Advisory Group and End of Life Working Group
- Stephen Richards: Director, Macmillan Cancer Support
Appendix 2: List of written submissions to the JOSC

1. Submissions from London Boroughs
   - LB Bexley
   - LB Camden: Health Scrutiny Committee
   - LB Croydon: Health & Adult Social Care Scrutiny Sub-Committee
   - LB Hackney: Health in Hackney Scrutiny Commission
   - LB Hammersmith and Fulham
   - LB Harrow: Overview & Scrutiny Committee
   - LB Havering: Health Overview & Scrutiny Committee
   - LB Hillingdon: External Services Scrutiny Committee
   - LB Hounslow: Adults, Health and Social Care Scrutiny Panel
   - LB Islington: Overview Committee
   - LB Lambeth: Health and Adult Services Scrutiny Sub Committee
   - LB Lewisham: Healthier Communities Select Committee
   - LB Newham
   - Royal Borough of Kensington and Chelsea
   - LB Sutton: Health & Well Being Scrutiny Committee
   - LB Waltham Forest: Health, Adults and Older Persons Services Overview & Scrutiny Sub-Committee
   - Westminster City Council
   - Outer North East London Joint Health Overview & Scrutiny Committee
   - London Councils

2. Submissions from key stakeholders and professional organisations requested by the JOSC
   - Age Concern London
   - College of Occupational Therapists
   - London Travel Watch
   - London Voluntary Service Council
   - Mind
   - Royal College of Radiologists
   - Royal Pharmaceutical Society of Great Britain
3. Submissions presented to the JOSC by the Chairman and Vice-Chairmen

- Black and Minority Ethnic Forum in Kensington & Chelsea and Westminster Response
- London Forum of Pharmaceutical Committees
- London Network of Patients’ Forums
- National Pensioners Convention, Greater London Region

These submissions are available in volume II of the JOSC report along with minutes of each meeting.
Appendix 3: Legal basis to the JOSC

Under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, the Secretary of State for Health issued a Direction about joint health OSCs in July 2003 relating to consultations by NHS bodies under the Health and Social Care Act 2001 where people from more than one local authority area may be affected by proposed variations or developments to NHS services. In these circumstances, all health OSCs consulted must decide whether they consider the proposals to be “substantial”. Those health OSCs that do consider them to be substantial must form a joint health OSC to deal with the consultation and to respond on behalf of their communities.

With this in mind the proposals arising from the Darzi report were considered substantial changes to the NHS services in London. Therefore a joint overview and scrutiny committee (JOSC) comprising of 1 Member representative from each London Borough’s health overview and scrutiny committees (OSC) was constituted.

Upon formation of a JOSC the scrutiny powers held by each London Borough Health OSC relating to requiring information and the attendance of NHS witnesses at meetings is given to the JOSC. Individual Health OSCs may choose not to participate in the JOSC. If so, they are not prevented from considering the issues which is the subject of JOSC review, but they lose their statutory powers of calling for information and witnesses in respect of the particular topic being considered by the JOSC. They do not, however, lose the power to refer the issue to the Secretary of State. As specific practical proposals emerging from the Darzi report are not yet known, it is not clear at what level future consultations would need to be held. However, Health OSCs should be prepared for the possibility that further joint committees may be necessary – either at a pan-London (and possibly beyond) level, or at a sub regional level similar to the old SHA regions, or among a smaller regional group of Health OSCs whose boroughs are particularly affected by certain proposals.
## Appendix 4: Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>DGH</td>
<td>District General Hospital</td>
</tr>
<tr>
<td>FT</td>
<td>Foundation Trust</td>
</tr>
<tr>
<td>GLA</td>
<td>Greater London Authority</td>
</tr>
<tr>
<td>GPSIs</td>
<td>General Practitioners with Special Interests</td>
</tr>
<tr>
<td>HEMS</td>
<td>Helicopter Emergency Medical Service</td>
</tr>
<tr>
<td>HfL</td>
<td>Healthcare for London</td>
</tr>
<tr>
<td>HIIAs</td>
<td>Health Inequality Impact Assessments</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communications Technology</td>
</tr>
<tr>
<td>JCPCT</td>
<td>Joint Committee of Primary Care Trusts</td>
</tr>
<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>LAS</td>
<td>London Ambulance Service</td>
</tr>
<tr>
<td>LHC</td>
<td>London Health Commission</td>
</tr>
<tr>
<td>LMCs</td>
<td>Local Medical Committees</td>
</tr>
<tr>
<td>OSCs</td>
<td>Overview &amp; Scrutiny Committees</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trusts</td>
</tr>
<tr>
<td>PLG</td>
<td>Patient Liaison Group</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>RCS</td>
<td>Royal College of Surgeons</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>TfL</td>
<td>Transport for London</td>
</tr>
</tbody>
</table>
1. SUMMARY

1.1 This report seeks endorsement of the Adult Social Care Commissioning Strategy. The strategy (Appendix A) has been developed to set the direction of travel for social care and health in Waltham Forest for the 5 year period, 2008-2013. It has been a result of close working between the Council and the Waltham Forest PCT, and consultation with stakeholders representing the voluntary, community and independent sectors.

1.2 Implementation of the strategy will make a significant contribution to the Council’s ambition to achieve an excellence in Adult Social Services which contributes towards the Council’s ambition in being an “Excellent” rated Authority.

1.3 Health, Adults & Older People’s Services Overview and Scrutiny Sub-Committee is requested to endorse the Commissioning Strategy and the approach to social care and health as detailed within it.

2. REASON FOR DECISION

2.1 The Adult Social Care Commissioning Strategy is a key decision as it will impact on people working in the borough, residents and service users.
3. **PROPOSAL**

3.1 The Department of Health Circular “Transforming Social Care” (See Appendix 2) sets out a radical change programme for social care and health provision. It states:

“that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.”

3.2 The circular builds on the “Putting People First” protocol which sets outs a shared vision and commitment to the transformation of Adult Social Care. To achieve this vision Adult Social Care will have to work cohesively with all other Council services including housing, safer communities, sports, leisure, health promotion in order to deliver better quality of live outcomes to service users.

3.3 The purpose of the Adult Social Care Commissioning Strategy is to set out how the Council will design and plan services to meet the health and social care needs of the area.

3.4 The strategy is aimed at several different audiences to:

- Raise awareness and aspirations in service users & their carers.
- Give providers a clear view of what services the Council intends to commission and decommission over the next 5 years.
- Give confidence to Commission for Social Care Inspection (CSCI), DH and other Inspectors that the Council has clear plans to modernise and improve its adult care services.
- Be used internally with staff for target and performance setting.

3.5 In addition to the published strategy a short complimentary film (DVD) has been produced. The DVD is very much aimed at service users, carers and the wider community in order to communicate the Council’s plans.

3.6 The ‘Commissioning Intentions’ and ‘Implementation Plan’ at sections 13 & 16 of the strategy, set out a structured approach to transforming social care in Waltham Forest. The plan and intentions give a clear time-table of what is going to happen and when.

3.7 Fundamental to the success of the strategy is working with Waltham Forest PCT to jointly plan and commission services. Discussions between Adult Social Care and the PCT are now well advanced.
3.8 An agreement was reached on the principles for joint commissioning and the service areas where there could be a collaboration and proposals on how joint commissioning could be structured considered.

3.9 The strategy is focussed on improving the health, well being and independence of all people living in Waltham Forest with service users, patients and their carers at its core. It also sets out how services will be transformed over the next 5 years so that service users are given more choice, higher quality support and greater control over their lives.

3.10 The strategy is not only concerned with service provision to vulnerable people, but it is about delivering benefits across the whole community. Central to this is to make the aspirations of the Sustainable Community Strategy a reality. This will be achieved through contracts which require the delivery of specific community benefits.

3.11 The implementation of the strategy will assist the Council in achieving the following:

- Delivering its priority for improving health and well being of local people.
- The ambition of the Sustainable Community Strategy.
- Delivering the Local Area Agreement.
- Effective use of resources and VFM services.

3.12 The strategy helps to demonstrate the Council’s performance over a number of CSCI outcomes including ‘Commissioning’ and ‘Leadership’.

4. ALTERNATIVES CONSIDERED

4.1 The alternative is to continue with a range of individual service plans. Although these service plans will continue, they do not allow a cohesive approach to the development of adult social care in Waltham Forest that a strategy provides.

4.2 The Council needs to demonstrate to CSCI clear plans to modernise and improve its adult care services with a strategy.

5. CONSULTATION

5.1 A Core Drafting Group, comprising stakeholder representatives, was established to formulate the strategy. Waltham Forest Carers Association, Disability Action, Age Concern and BME Alliance provided valuable representation to this group and helped to ensure that outcomes to service users and the community were central to the aims and objectives of the strategy.

5.2 A series of Commissioning Workshops were held. The purpose of these workshops was to raise awareness of commissioning; discuss the future direction of commissioning and receive contributions and ideas for the strategy. Over 30 Stakeholders were in attendance.
5.3 An early draft of the strategy was also circulated to the Council’s preferred providers of homecare and to all CSCI regulated providers in Waltham Forest.

6. IMPLICATIONS

6.1 Financial

6.1.1 The strategy assumes the 2008/09 Adult Social Care budgets of £73.5m gross as the base budget and is affordable within it. The Strategy proposes shifting resources into preventative services. It is proposed that over time, this will serve as an “invest to save” initiative, with the outcome that people do not continue to deteriorate to point that they require higher cost care.

6.2 Legal

6.2.1 There is no statutory duty to have an Adult Social Care Commissioning Strategy. However, the proposals within the strategy aim to ensure the Council meets its statutory duties to service users to a high quality standard whilst meeting its fiduciary duty to achieve value for money.

6.2.2 The strategy also seeks to support service users in achieving greater independence and promotes their right to family life in line with the Human Rights Act.

6.2.3 A number of the priorities within the document will have other legal and contractual implications, and will be subject to compliance with the Councils Contract Procedure Rules and procurement rules of the PCT and Disability Discrimination and equality legislation. The Council and PCT (and other NHS bodies) are also under a duty to co-operate in order to secure and advance the health and welfare of the people in England and Wales under Section 82 of the NHS Act 2006.

6.3 Human Resources

6.3.1 Comments to Follow.

6.4 Health Impact Assessment

6.4.1. As set out within the strategy it has been designed with the objective of improving the health and well-being of local people.

6.5 Equality Impact Assessment

6.5.1 Given the nature of its work Adult Social Care would impact on the whole community in Waltham Forest and directly on service users and their families/carers. Service users have a range of needs, dependant on the level of either their vulnerability or disability. Service users fit broadly into the following categories, being: Learning Disability, Physical Disability and Sensory
Impairment, Older People, Mental Health & Substance Abuse.

6.5.2 There is no typical service user within any of the client groups and having a ‘disability’ or being an ‘older person’, will impact differently on different people. Additionally, carers reflect the diversity of the community as a whole.

6.5.3 The strategy has been developed through extensive collaboration including with local community groups. The BME Alliance who have ensured that the strategy is both comprehensive and diverse to meet the needs of the people of Waltham Forest.

6.5.4 A full Equality Impact Assessment of the strategy is due to be undertaken during June 2008, including the identification of key performance indicators.

6.6 Climate Change Impact Assessment

6.6.1 Through the Commissioning Strategy Adult Social Care will actively encourage both the reduction of CO2 emissions and the overall carbon footprint of the service. It will achieve this through its procurement and contract management processes. As a part of the re-commissioning of outcome based homecare, reduction in the environmental impact of the current 1 million miles travelled annually in the delivery of the service will be addressed.

6.6.2 Additionally, through its Provider Forums Adult Social Care will highlight the benefits of energy efficiency and the benefits of a “green” supply chain.

7 CONCLUSION

7.1 The implementation of the Commissioning Strategy brings benefits to service users of social care and health and their carers and is in line with the Government’s approach to the delivery of adult social care.

Documents

Appendix: A. Final Version of Commissioning Strategy
**Foreword Page**

This Commissioning Strategy is about improving the health, well being and independence of all people living in Waltham Forest. It sets out how services will be transformed over the next 5 years across adult social care and health, so that people are given more choice, higher quality support and greater control over their lives. It also links to the Waltham Forest Primary Care Trust (PCT) Commissioning Strategy Plan which promotes greater patient choice, health and well being.

Investment will be made in a new service model of prevention, independent living and improved life chances, whilst over time reducing the dependence on long-term residential and secondary care. This mirrors the work that the PCT is doing with earlier interventions in patient care and the initiative that the PCT and Council are jointly undertaking in respect the Care Outside Hospital Plan.

By undertaking an assessment of needs within the Community, the Council and its NHS Partners will invest in services which give best outcomes for those with 'needs'. Those with 'needs' not only include Service Users and Patients, but also those dedicated families, friends and neighbours without whose care the formal social care system would be unable to cope.

We believe that, through the use of Direct Payments and Individualised Budgets, Service Users and their Carers will be better placed to make their own decisions regarding their care and support arrangements. This may mean employing their own personal care assistants, joining local clubs rather than attending day centres and choosing to go to hotels or on package breaks as opposed to respite care in a residential home.

These freedoms will be new to Service Users and, in order to provide support and information, the Council will commission an independent Care Brokerage service to assist them to be their own ‘Commissioner’ and secure services which meet the outcomes in their care plans.

Although many Service Users and Carers will be excited at the prospect of taking control, others may not. We recognise that confidence will need to grow over the next 5 years and that the take up of Direct Payments and Individualised Budgets will not change overnight and that it will be an incremental process.

Therefore, the Strategy identifies that the Council will still directly commission services. In doing so Adult Social Care will develop a local social care and health economy that meets the needs of people living in Waltham Forest. This will include generating employment and training opportunities through its service providers and in promoting caring as a career.
Cllr Liz Phillips (Portfolio Member Adult & Community Services)
Cllr Michel Lewis (Older People’s Champion)
**Contents Page**

1. Purpose of the Strategy (page 5)
2. Aims and Objectives of the Strategy (page 6)
3. National Context (page 7)
4. Local Context (page 9)
5. Links to Other Strategies (page 12)
6. Needs Analysis, Demand Forecasting and Service Planning (page 14)
7. Principles of Commissioning (page 17)
8. Service Standards (page 23)
9. Budgetary Context & Medium-Term Financial Plan (page 23)
10. Public & Service User Involvement & Accountability (page 29)
11. Access to Services & Care Management (page 32)
12. Market Development (page 33)
13. Headline Commissioning Intentions and Time-Scales 2008-2012 (page 39)
14. Contracts & Commissioning (page 39)
15. Effectiveness of the Strategy (page 40)
16. Implementation (page 41)
1) Purpose of the Strategy

1.1 The purpose of this Adult Social Care Commissioning Strategy is to set out how the Council will design and plan services to meet the health and social care needs of the area. It will do this in partnership with a range of stakeholders including Waltham Forest Primary Care Trust (WFPCT), Third Sector and its Independent Sector Providers.

1.2 The needs of the area will be informed from a number of sources, including through a Joint Strategic Needs Assessment undertaken jointly by the Council and WFPCT (PCT). In doing so, the Strategy details a community-focused approach and how its Citizens will be involved in both the design and development of services.

1.3 Through commissioning the Council will specify, secure and monitor services to meet the needs of its community. This includes a strategic approach to managing the local and regional care markets with the PCT in order to meet existing and future needs. Additionally, commissioning includes the procurement process through which contracts are awarded to providers.

1.4 The Strategy identifies that the Council will be a commission-focused organisation, whilst re-configuring its existing provider role, particularly in respect of home care services and residential provision. It will also set out a framework by which business decisions will be made and the principles and service standards, which shall be applied to all services that are commissioned.

1.5 This separation between provision and commissioning has already been achieved by the PCT through the establishment of an “arms length” provider Unit. The PCT is also well advanced in setting up discreet finance and governance arrangements for this provider arm.

1.6 The Council is committed to achieving a mixed economy of public, independent and third sector providers in order to deliver the wide-ranging needs of its citizens. It also recognises the strength of the existing relationships with the voluntary sector and community groups and the contribution that they make to building a sustainable community.

1.7 The Strategy details how services will be planned in response to the current and future needs of the Community. This will then allow the Council and PCT to set out what services it wishes to buy and what it will spend on them. The things that will be taken into account when determining these services will include statutory duties, citizen and community priority, national and local drivers, the PCT Commissioning Strategy Plan, national standards and historic/anticipated demands.
1.8 The Strategy describes the national context and the vibrant agenda for change running across the public sector. The fundamentals to these changes are that services deliver not only better value for money, but also that they offer Service Users and Carers improved participation, choice, accountability and outcomes. Over time the Strategy seeks to put the commissioning role ultimately under Service User control allowing them directly to shape and specify the services which they receive.

1.9 This will then change the Local Authority’s commissioner role into that of an enabler, ensuring the strategic management of the health and social care economy in Waltham Forest. This will mean that there is sufficient care of the right type and quality to meet Service User demands. There will also be a need to ensure that Service Users are appropriately advised and supported in order to help them make informed decisions about their care and to ensure that they are suitably safeguarded. It is anticipated that this will be met through a Care Brokerage, which will be externally procured by the Council.

2) Aims and Objectives of the Strategy:

2.1 The primary objective of the Strategy is to transform the types and quality of services provided to Service Users and their Carers over the next five years. The ultimate objective is to transfer the commissioning role to service user control through the provision of direct payments and individualised budgets, and achieve the ambition of “Putting People First”. This is all about increasing service user choice and control and is explained in greater detail in the National Context Section below. The Strategy sets out how this will be achieved and how the transformation will take place on an incremental basis between 2008 and 2013.

2.1 Other aims and objectives in order to achieve this 5 year vision include:

- Shift the emphasis of service delivery from long-term residential and secondary care to a new service model of prevention, earlier health interventions, independent living and improved life choices.
- Expand the range of social care and health services available, particularly in Primary Care.
- Increase Patient/Service User choice over what services they receive and how those services are delivered.
- Recognition of the role and contribution of unpaid carers, through increasing the number of carer assessments and the range of services available to them.
- Improved commissioning of integrated health and social services jointly with the PCT and other Local Authorities.
• Better forecasting and identification of future needs based on the best available information, including identifying both hidden demand and hard to reach groups.
• Better planning and development of the health and social care economy in Waltham Forest, to ensure that there is sufficient care of the right type and quality to meet future needs.
• Use commissioning as a means to achieve other additional community benefits including economic, social and environmental well being.
• Improve outcomes, quality, safety and value for money of services, through improved procurement and contracts management.
• Safeguarding people whilst allowing them to retain independence and decision-making regarding risks.
• Ensure an improved dialogue with stakeholders in all aspects of service planning and design, including service users, patients, public, providers and voluntary & community groups. This is to be undertaken jointly by the Council and PCT to ensure a cohesive approach to the planning of services.
• Create an environment in which creativity, innovation and calculated risk-taking can flourish
• Achieve financial balance and prioritise resources to where they will achieve best Value For Money outcomes to service users. Establish and implement a range of service principles to be applied to all the services which are commissioned.
• Develop a set of core service standards which Service Users can expect when they receive any service.
• Improve information and communications in terms of the range of services that are available and how they can be accessed.
• Demonstrably improve the quality of service provision by working with providers to raise the CSCI rating of regulated care service to good and excellent.

3) National Context

3.1 There is a very vibrant agenda for change and modernisation running across all public sector services, none more so than within the areas of health and social care. The past ten years have seen a flurry of new policy and guidance all of which is centred on empowering patients and service users. This is in order to give them improved access to a wider range of higher quality services which suit their needs, as opposed to the needs of the provider. These initiatives have included:

• NHS Plan
• Health Reform in England: Commissioning Framework
• A Stronger Local Voice
• Choosing Health
• Our Health, Our Care, Our Say
3.2 This direction of travel has culminated in the publishing of a Protocol “Putting People First” (Dec 2007) which sets outs a shared vision and commitment to the transformation of Adult Social Care. The signatories to this protocol include a range of Government Departments, Local Government, the NHS and a range of other national social care stakeholders.

3.3 At the core of the plan is the allocation of a personal budget to every individual assessed as eligible for social care services. This may be provided in cash as a direct payment, or alternatively held by the Council to be spent in accordance with the Service User’s wishes once their care plan has been agreed. It will not only include monies for social care but also budgets from other Government sources including the NHS and the Department of Work and Pensions, when and as the legislative framework is changed.

3.4 The alignment of funds by the Council and PCT is already being undertaken in Waltham Forest at a service level, particularly in Mental Health, Learning Disability and Care out of Hospital. A fully pooled budget is already in operation for the Integrated Community Equipment Service. The next step will be therefore to look at this at an individual Patient/Service User level as soon as the regulatory freedoms allow.

3.5 With the freedom of personal budgets, Service Users will be empowered to make their own care arrangements, employing their own personal care assistants, joining local clubs rather than attending day centres and choosing to go to hotels or on package breaks as opposed to respite care in a residential home.

3.6 This is a positive revolution not only in social care, but also in terms of the relationship between the Government and its Citizens. It signals a change from a paternalistic and centralist approach to one of giving people real choice and control over their own lives. The Protocol also recognises the need to review fundamentally how social care is funded.
in England as a part of the Government’s Comprehensive Spending Review. In the meantime it identifies additional funding of £520 million to Local Authorities over the next three years in order to help to implement this new model of care.

3.7 The LB Waltham Forest allocation of these monies is £2.3 million for the 3-year period and the budget will be under the management and direction of the Head of Adult Social Care and Health.

4) Local Context

4.1 At a local level the agenda for change in Waltham Forest is equally as vibrant and exciting as that at national level. Central to these is the Sustainable Community Strategy, which draws on the aspirations of all voices in the community in order to improve the quality of life of its residents. The Local Strategic Partnership comprising some 30+ partner organisations is leading this work and, through extensive consultation across the community, the following priorities have emerged:

- Plan for population growth and change.
- Create more wealth & opportunities for our residents.
- Retain more wealth within the borough.

4.2 Although Waltham Forest has its own specific problems, the majority of them mirror national problems reflecting the high incidence of deprivation in some parts of the area. Indeed the Director of Public Health’s Annual Report compares the health inequalities of Waltham Forest, not just against the rest of the country but also between different Wards within the Borough.

4.3 The health-related issues facing adults and older people in the area include:

- Dementia
• Heart Disease
• Drug and Alcohol Misuse
• Diabetes (particularly Type II)
• Smoking & Respiratory Disease (e.g. COPD)
• Healthy Eating & Physical Activity
• Mental Health
• Falls
• Incontinence
• Obesity

4.4 The changing demographic in the area through immigration means that the health problems are not static, for example the high numbers of the Eastern Europe immigrants whom are smokers.

4.5 The social inequalities for the Borough directly correlate with those for health and include:

• Housing
• Employment Opportunities
• Fear of Crime
• Poverty
• Wards with high levels of Deprivation
• Increased Social Isolation and Exclusion
• Ageing Population

4.6 All Leaders within Waltham Forest are agreed that only a joint approach to improving the health and well being of the area will succeed. Additionally, that one of the key success factors will be a planned development of the environment, economic regeneration, safer communities, education and housing infrastructure of the borough.

4.7 Very much in the area’s favour is that the economic prospects for London continue to strengthen, as does its position as a “World Class City”. Waltham Forest needs to capitalise on this, and ensure that it secures inward investment and makes it an attractive place both to live and work. Comparative to other parts of London, property prices are still low and it enjoys excellent transport links to central London and other parts of the UK. Additionally, the Council is one of five London Boroughs which will be hosting the 2012 Olympic Games. The Games provide a wonderful platform to promote Waltham Forest and provide employment opportunities, both in the medium-term and the long-term as a part of the Games’ legacy.

4.8 The Council can greatly influence the prosperity of the area through its own purchasing activity as it spends approx £225 million with external providers of goods and services. The Council and Adult Social Care through this Strategy will turn that “spending” into an investment, which
will give long-term community benefits over and above the goods and services which it buys.

4.9 For Adult Social Care, this means turning its £40 million annual spend into developing, and investing in, the health and social care market within the Borough and creating life chances for its Service Users.

4.10 All of this local ambition will be brought together not only through the Sustainable Community Strategy but also through a Local Area Agreement. The Local Area Agreement (LAA) will allow the Council to shape Waltham Forest through agreeing community priorities with its Partners and agreeing stretched targets with the Government which, if achieved, would result in the payment of reward grants. The Council and its partners may choose up to 35 from 198 indicators, which range across Adult Health & Well Being, Stronger Communities and the Local Economy.

4.11 The timetable to finalise the LAA with the Government is June 2008, so it is not possible to publish the indicators in this document. However, once it is finalised this Strategy will be flexible in supporting the achievement of the targets which are agreed.

4.12 The PCT Commissioning Strategy Plan (CSP) sets the direction for health care in Waltham Forest for the next five years to 2012. The principle of care closer to home, which underpins this plan, draws on the views of public as expressed both locally and nationally in the consultation exercise known as ‘Your Health, Your Care Your Say’. The plan has also been informed by the large scale stakeholder and clinical engagement events that have been held as part of the development of thinking about the future of services across Outer North East London known as ‘Fit for Future’.

4.13 In addition to this, local events have been held including a stakeholder workshop to help identify the priorities from a service user/carer perspective. As well as considering the future of health care from a patient perspective, the Fit for the Future programme considered the impact of new technology and the best clinical practice. The Waltham Forest CSP builds on this work and sets out how these principles of best practice will be applied locally.

4.14 Out of Hospital Care Plan is about the PCT and Council working in partnership to deliver services in order to support patients and Service Users experiencing difficult in regaining the level of independence that they previously enjoyed before a period of hospitalisation, for example.

4.15 These services are designed to provide alternatives to emergency admission and support early discharges back to the community. Evidence shows that between 5 and 10% of emergency admissions are capable of being streamed into intermediate care schemes from
home, or from Accident & Emergency Departments and Medical Admission Units.

4.16 Significant reductions in hospital stays result from timely access to Intermediate Care Schemes, with development of the number, type and range of schemes available supported by allied health professionals, nurses, social workers and General Practitioners with a special interest in the care of older people. Critical to the process is the early involvement of the Physicians for Elderly Medicine and Specialist Nurses to enhance decision making.

4.17 These services are free at the point of use for a period of up to six weeks and can be pre-hospital (admission avoidance) or post hospital (discharge support). In Waltham Forest it is proposed to build on the existing Intermediate Care services to provide a wide range of Out of Hospital Care Services.

5) Links to Other Strategies

5.1 The “golden thread” is a concept which enables corporate priorities and objectives to be cascaded down through departments, services and teams to an individual level. This allows members, managers and staff to see a clear link between the work they do and what the Council is trying to achieve.

5.2 Maintaining this golden thread means that everything the Council does can be related to the Community’s priorities. The links for this Commissioning Strategy are extensive and cut across not only the Authority but also our Health and Voluntary Sector Partners. The following diagram sets out the relationship for internal strategies. Of particular note for external strategies are the PCT Strategies, NELMT and Third Sector Strategies.
5.3 In Adult Social Care, this Commissioning Strategy will act as the overarching policy for the Department with all other strategies and policies recognising and informing the service principles and standards within it.

5.4 Although it is easy to make a policy promise to work in a joined up way with both internal and external partners, we are under an absolute duty to our Citizens to ensure that we do and that the prize of a vibrant community is achieved.

6) Needs Analysis, Demand Forecasting and Service Planning

6.1 The Council has access to a wealth of data in respect of its population’s demographics and health and social care needs. Its also has significant information about the historic demand for its services. This information comes from a variety of sources including:

- 2001Census
- Projecting Older People Population Information System (Poppi)
- Insurance Companies
- Deprivation Indicators
- Proprietary Products (Dr Foster, Experion etc)
- Service and Spend Analysis
- Annual Report - Director of Public Health
- Commission for Social Care Inspection (CSCI)
- Department of Health
- Local Voluntary Sector Knowledge & Intelligence
- Special Interest Groups (e.g. Age Concern, Mencap)
- Public and private representations

6.2 In addition to this the Council and WFPCT are required by the Department of Health to undertake a Joint Strategic Needs Assessment (JSNA) of health and social care needs in Waltham Forest. It is anticipated that this work will be completed by the summer of 2008, and will then inform future decision-making and service planning.

6.3 Although the Government has not been prescriptive about the assessment, it has said that the outcomes of a good JSNA will:

- Define achievable improvements in health and well being outcomes for the local community.
- Send signals to existing and potential providers of services about potential service change.
- Support the delivery of better health and well being outcomes for the local community.
• Inform the next stages of the commissioning cycle.
• Aid better decision-making.
• Underpin the Local Area Agreement and the choice of local outcomes and targets.

6.4 The current demographics within Waltham Forest are as set out as follows, but the Strategy recognises that the population is in a constant state of flux and that it will be vital to keep abreast of changes within the community. However, that does not prevent the long-term planning of services and the identification of underlying trends and needs.

6.5 The following graphs and facts are intended to give some high level information about the current and future population of Waltham Forest:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ethnicities</td>
<td>222,144</td>
<td>226,275</td>
</tr>
<tr>
<td>White</td>
<td>131,572</td>
<td>127,017</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>19,531</td>
<td>20,567</td>
</tr>
<tr>
<td>Black African</td>
<td>14,733</td>
<td>15,955</td>
</tr>
<tr>
<td>Black Other</td>
<td>8,624</td>
<td>9,202</td>
</tr>
<tr>
<td>Indian</td>
<td>7,868</td>
<td>8,184</td>
</tr>
<tr>
<td>Pakistani</td>
<td>20,188</td>
<td>22,324</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2,444</td>
<td>2,644</td>
</tr>
<tr>
<td>Chinese</td>
<td>1,839</td>
<td>2,139</td>
</tr>
<tr>
<td>Other Asian</td>
<td>8,351</td>
<td>9,529</td>
</tr>
<tr>
<td>Other</td>
<td>7,014</td>
<td>8,712</td>
</tr>
</tbody>
</table>

Total population, population aged 65 and over and population aged 85 and over as a number and as a percentage of the total population, projected to 2025

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>218,700</td>
<td>218,300</td>
<td>218,700</td>
<td>220,500</td>
<td>222,600</td>
</tr>
<tr>
<td>Population aged 65 and over</td>
<td>23,900</td>
<td>23,800</td>
<td>24,700</td>
<td>25,500</td>
<td>27,300</td>
</tr>
<tr>
<td>Population aged 85 and over</td>
<td>3,100</td>
<td>3,000</td>
<td>3,000</td>
<td>3,100</td>
<td>3,600</td>
</tr>
<tr>
<td>Population aged 65 and over as a proportion of the total population</td>
<td>10.93%</td>
<td>10.90%</td>
<td>11.29%</td>
<td>11.56%</td>
<td>12.26%</td>
</tr>
<tr>
<td>Population aged 85 and over as a proportion of the total population</td>
<td>1.42%</td>
<td>1.37%</td>
<td>1.37%</td>
<td>1.41%</td>
<td>1.62%</td>
</tr>
</tbody>
</table>

*Figures are taken from Office for National Statistics (ONS)
• Christianity is the largest faith group in the Borough. This is followed by a significant number of Muslims (faith: Islam). Incidentally, Waltham Forest has the second largest number of Pakistani people in London, second to the London Borough of Newham (17,295). This is also reflected in the high number of Muslims in the borough, making up the third largest grouping across London (Tower Hamlets and Newham being the first and second).

• Life expectancy within Waltham Forest varies according to which part of the borough people live in. In Grove Green Ward male life expectancy is 77.7 years. Meanwhile in neighbouring Cathall Ward, men have a life expectancy of 72.4 years. There is a strong correlation between life expectancy and deprivation. The Index of Multiple Deprivation (IMD) score in 2004 was 38.6 in Cathall Ward, and 28.6 in Grove Green Ward.

• A total of 18,823 people provide unpaid care in the borough. This is defined as looking after or giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age. The figures are in line with the London average: 8.6% of the WF population compared to 8.5% of the average London borough. Distribution is also fairly evenly split amongst the localities.

• At the census in 2001, 54% of older people reported a ‘limiting long-term illness’. The average for London was 50% in this age group. This varies according to ethnicity, from 35% in ‘Mixed White and Black
• Caribbean’ and ‘Mixed White and Other’ communities to 67% in Asian communities.
• Waltham Forest has a youthful population, ranking highly (6 out of 33) against other London Boroughs. However, the percentage of older people in the borough ranks rather lower (21 out of 33) against other London boroughs. The Greater London average for persons aged 60 and over is 16.4%.
• Cardio-vascular disease, which includes coronary heart disease and stroke, is the main cause of death in Waltham Forest, and cancer is the second most common cause of death.
• Housing tenure can be viewed as an indicator of affluence and is consequently linked to better health outcomes and well being. The northern part of the Borough has the highest number of homes owned outright and also reports a lower number of people describing their health as ‘not good’.

7) Principles of Commissioning

7.1 For all services, which are commissioned the following overarching principles will be applied.

<table>
<thead>
<tr>
<th>1) Use of Demographic &amp; Other Data</th>
<th>It is essential that any service which is commissioned is done so on the basis that there is an identified need and that the potential demand for services is assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>As set out in Section 6), the Council has access to a wealth of information in respect of its population and their needs. This information must be used appropriately in the overall planning of services and in respect of individually commissioned services.</td>
</tr>
<tr>
<td></td>
<td>This analysis not only includes the planning of new services but also the take up of existing ones. For example it is known that the per capita take-up by some black groups, e.g. Asian, for some older people’s services is low. Therefore, this Strategy must actively seek to lessen the care burden on the local BME community.</td>
</tr>
<tr>
<td></td>
<td>It will not be necessary to use all of the information on all occasions, but demographic information should back up the decision making of any service provision.</td>
</tr>
<tr>
<td></td>
<td>Additionally, as part of the contract management and review arrangements for any service, the information should be periodically updated in</td>
</tr>
</tbody>
</table>
order to be flexible to any changes in needs or demography.

| 2) Safeguarding | All services which are commissioned should protect vulnerable Service Users. Services will be designed in a way that supports this. 
All providers of service will be subject to “due diligence” checks to ensure that their systems, staff and operations have the protection of vulnerable adults at their core. 
All the Council providers and partners will be required to adopt the Council’s safeguarding policy “Dignity in Care”. This sets out that joint training and partnership working with all partners is essential in preventing abuse. 
As a part of contract management, audits of providers’ safeguarding training will be undertaken. |

| 3) Equality & Diversity | Waltham Forest is lucky to benefit from a very vibrant and cosmopolitan community. The community is diverse not only in terms of black and ethnic minorities, but also in terms of the age and gender profile of its people. The borough also enjoys a significant gay and lesbian community. 
Coming with this diversity is the challenge to ensure that there is an equality of access to services and that those services meet the specific requirements of the user, be those requirements related to age, culture, gender, faith, disability, race or sexual orientation. 
Services must be designed to take account of these differences and the health & social care market developed where there are gaps in provision. 
Equally the workforce should reflect the diversity of the community and Adult Social Care will work with the market in respect of creating employment opportunities across the whole of the community. |

| 4) Service User Satisfaction | It is essential that we know what our Service Users and their Carers think about the services |
which we provide to them. Through this feedback we can positively improve the services they receive. Additionally, we can use their suggestions and ideas in the development and design of new services.

A key part of any future service specification will be the requirement for the assessment of Service User satisfaction. This assessment will be undertaken usually by providers as part of their Quality Assurance systems, but validation and audit will be undertaken by the Council.

Ultimately, it is the intention to link satisfaction and other quality measures into the payment mechanisms of contracts, therefore to incentivise good customer services.

This approach is being mirrored in health with the PCT making it a priority for 2008/09 to improve engagement and feedback, through patient surveys for example.

| 5) Outcome Based | When designing any service it should be specified in such a way that the outcome to the Service User is the goal. This will mean a shift away from input related specifications, which set out the tasks which should be undertaken. Similarly, in health the PCT is linking the delivery of care to outcomes for patients.

In Home Care services, for example, in place of “assist with getting up, wash and dress” would be “maintain service user’s independence and improve quality of life through helping them to live at home”.

This is a significant change, which will allow the service providers to agree with the Service User how best the service can be delivered in order to meet their needs. |

| 6) Service User Choice and Control | Every service should be designed around the Service User, giving them maximum choice and control over the services which they receive.

Fundamental to this will be a dialogue with the Service User (and their advocate) as a part of the assessment process. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>As a main objective of this Commissioning Strategy we wish to increase substantially the number of Direct Payments and Individualised Budgets, to the extent that it will be a presumption that a Service User will be allocated one, unless it is their choice not to receive one or there are other exceptional reasons.</td>
<td></td>
</tr>
</tbody>
</table>
| **7) Quality Assurance** | There are 2 aspects to Quality Assurance when commissioning services. The first of these is to identify any quality standards or regulation requirements of a service and to identify providers’ performance against these standards.  
It is the Council’s stated ambition only to purchase services from providers who are either in the ‘good’ or ‘excellent’ categories, where they are CSCI regulated.  
The second aspect of quality assurance is in respect of the contract management arrangements for services. This means having quality systems in Adult Social Care in order to assess periodically the quality of services being delivered and for providers to provide quality management information for Adult Social care to assess.  
This information may include feedback on services, customer satisfaction, staffing levels, staff training audits and other quality performance indicators. |
| **8) Wider Community Benefits** | When commissioning any service, thought should be given to how the service can be designed in a way to give wider community benefits, over and above those directly enjoyed by the service user.  
The Local Area Agreement should be the focus of this and the benefits should be capable of inclusion under the single set of national indicators, which includes performance indicators for:  
- Stronger Communities*  
- Safer Communities  
- Children & Young People  
- Adult Health & Well Being |
- Tackling Exclusion and Promoting Equality
- Local Economy
- Environmental Sustainability

Particular thought may be given to employment opportunities for disadvantaged groups, training schemes in order to promote caring as a career and developing the local health & social care economy.

In respect of environmental sustainability, Adult Social Care will actively encourage both the reduction of CO2 emissions and the overall carbon footprint of the service. It will achieve this through its procurement and contract management processes. As a part of the re-commissioning of outcome based homecare, for example, bidders will be asked to set out proposals on how they would reduce the environmental impact of the current 1 million miles travelled annually in the delivery of the service.

Additionally, through its Provider Forums it will highlight the benefits of energy efficiency and the benefits of a “green” supply chain. This may include helping them access an energy efficiency advisor, or undertaking a collaborative approach to the appraisal and purchasing of supplies, such as continence pads.

As with other Council reporting requirements, contracts will require contractors to provide information and data. In the case of NI 185 in respect of “CO2 reduction from local authority operations”.

(*) e.g. NI 6 - Participation in Regular Volunteering)

| 9) Value for Money (VFM) | All services should be capable of demonstrating that they are delivering effective value for money. This may be achieved in 2 main ways:

1) Benchmarking
2) The invitation of competitive offers (Tendering)

The VFM test is not just about comparing cost, but considering the equation of:
<table>
<thead>
<tr>
<th>Quality/Outcomes</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following on from any initial assessment of a service or Tender, regular evaluation of what change in value for money (+/-) has actually been achieved should be undertaken as a part of the regular contract management arrangements.</td>
<td></td>
</tr>
</tbody>
</table>

**10) Effective Use of Resources**

Adult Social Care has a responsibility to use its resources not only wisely, but also to best effect. It therefore needs to undertake strategic budgeting, which links resources to outcomes and performance.

It also needs to get the best return in terms of the numbers of service users supported, good comparative performance against other Local Authorities and the delivery of its Statutory obligations.

In addition to these responsibilities, Adult Social Care must look to the future and “Invest to Save”. This is particularly in preventive services, where collaboration with the WFPCT and Voluntary Sector will produce long lasting benefits. This will result in an improvement in the overall health and well being of the Waltham Forest Community.

The Council will also learn from the success that the PCT has already achieved through the use of an effective invest to save initiative.

The Voluntary Sector Compact has helpfully already set out the protocols and principles which have been agreed by the Local Strategic Partnership in regard to resource allocation and a common approach.

**11) Evidenced Based**

For any service commissioned there needs to be evidence to demonstrate that it delivers real and measurable benefits / outcomes to Service Users.

This may be evidenced in 3 main ways:

1) Track Record
2) Case Studies
3) Published Research
<table>
<thead>
<tr>
<th>12) Calculated Risk Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>When pursuing new services, commissioners should “cast their nets widely” to find out what different services may be being provided elsewhere in order to meet the specific Service User need.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12) Calculated Risk Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although the principles of ‘Safeguarding’ and ‘Evidence Based’ set out how the risks of unsafe or unproven services should be managed, that does not eliminate the taking of calculated risks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12) Calculated Risk Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the case of Service Users they should retain the right to make decisions about their care, even if some of the decisions are unwise and expose them to a level of risk. Indeed, living an independent life is all about considering and taking risks based on individual choice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12) Calculated Risk Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>In respect of Evidence Based, there would be no innovation or continuous improvement if we were just to stick to what had gone before. Therefore, the Council should be prepared to commission cutting edge services, some of which may not be wholly successful.</td>
</tr>
</tbody>
</table>

8) Service Standards

8.1 The Council is committed to improving the service standards of both the services it provides directly and those delivered through its external providers. In respect of direct provision, Adult Social Care has published “Better Care, Higher Standards” which is a Customer Charter.

8.2 The Charter sets out the Council’s service values and a set of standards which Service Users can expect as a minimum level of customer service. These standards include for example:

- “When you meet us we will…
  <ul>
  <li>Treat you with courtesy and respect</li>
  <li>Keep information about you confidential</li>
  <li>Treat everyone equally</li>
  <li>Take account of your racial, cultural, religious and communication needs</li>
  <li>Provide an interpreter where needed or requested</li>
  <li>Do our best to provide information and advice about other local services.”</li>
  </ul>
8.3 When commissioning services through external providers as a part of the service specification there will be an agreed level of customer service. These standards will be then issued to all Service Users in a written or other appropriate format. As a part of the customer satisfaction monitoring, Service Users will be asked to rate the Providers’ performance/compliance against those standards.

9) Adult Social Care Budgetary Context & Medium-Term Financial Plan

9.1 Local Authorities funding from Central Government has changed over the past 5 years from single year settlements to a new regime that gives improved financial certainty. This then allows for medium-term financial planning, typically over a 3 year rolling period. The benefits of this change to service planning are substantial. Fundamentally, it allows Councils to be more strategic and ambitious in their goals, as opposed to short-term contractions or expansions in service provision depending on how much money is available.

9.2 For the London Borough of Waltham Forest this has been a positive change and it has seen the implementation of a medium-term financial plan. The financial plan is based on individual Directorates bidding and making a case for financial resources. These bids can be to maintain existing levels of service provision and performance, increased/decreased levels of services, or indeed new services.

9.3 The bids are made to an annual “Star Chamber”, which comprises the Leader and Chief Executive of the Council and other senior Councillors and Directors. They then apply the priorities of the Council to the bids and evaluate how they would assist in meeting the Corporate Plan and Sustainable Community Strategy. Funding is then allocated on this basis and is incorporated into a “Budget Book”, which sets out all Directorate budgets, which is then resolved by the full Council.

9.4 For the medium-term financial plan for 2008/09 – 2010/11 matters are complicated by an underlying funding issue at Waltham Forest. To resolve this, an Efficiency Review has been undertaken by KPMG which has identified saving of £8 million a year for each of the 3 years of the plan. These savings will not only resolve the funding issue but will also count against the 2½ % annual efficiency gains which Local Authorities are required to make by the Government.

9.5 For Adult Social Care the challenge of the Efficiency Review is substantial, particularly given that for the financial year 2007/08 certain budgets were already subject to in-year cost pressures. However, the savings from Adult Social Care were successfully identified through a combination of reducing spend with external providers of services and redesigning internal services, systems and processes.
9.6 In respect of realising a lower spend with external providers, the key strategic objective is to shift the emphasis of service delivery from expensive long-term residential to a new service model of prevention, independent living and improved life choices. At the heart of this model will be 3 main components which will assist in reducing the number of people in residential care by 100 by 2011 through expanded service provision within the Community:

**Home Care Services** – Changing from a task orientated service to an outcome based service which achieves improved value for money.

**Direct Payments & Individualised Budgets** – Empowering and supporting Service Users to undertake their own commissioning, through which services may be more responsive, flexible to their needs and deliver better value for money.

**Care out of Hospital** - The PCT and Council working in partnership to deliver services in order to support patients and Service Users experiencing difficult in regaining the level of independence that they previously enjoyed.

9.7 Direct payments are an alternative to Council commissioned services and give the opportunity for a Service User to receive a cash payment. Instead of receiving services, a Service User would use the money to arrange for their own care and support in accordance with their Care Plan, as determined by way of a Community Care assessment.

9.8 The payment may be used in a variety of ways, so long as it is in accordance with the assessed care needs. This may mean that expenditure can be made on services such as personal care, respite services, childcare, cooking, shopping, domestic tasks, gardening, social and leisure activities as well as assistance to access education, training and employment.

9.9 In terms of individualised budgets (IBs) these take Direct Payments to an enhanced level of control for Service Users. IB’s are designed to help people to take control of their own social care budgets, manage their support and choose the services that suit them best. They put the user at the centre of the planning and support delivery processes, and recognise that they are the person best placed to understand their own needs. IBs will bring together support to help people stay in their own homes and adapt their homes to make life easier.

9.10 IBs combine funding streams overseen by the Department of Health, Department for Work and Pensions and Department of Communities and Local Government. Service Users who access IB’s will not have to provide repeatedly the same information to different agencies. The funding will go directly to the individual service user. The Local Authority can support the service user in accessing the required
services, or individual service users may opt for support via brokers, advocates, Carers, or family members

9.11 Relevant funding streams include the Independent Living Fund (ILF), Disabled Facilities Grant (DFG), Supporting People (SP) Grant, Local Authority budgets, Integrated Community Equipment Service (ICES), and Access to Work.

9.12 The following tables seek to set out how strategic budgeting will be applied to social care services over the next 3 years, and how budgeting and performance will be linked. As an introduction to performance, Adult Social Care is evaluated by CSCI against a Performance Assessment Framework (PAF). This PAF has a number of individual performance indicators including for e.g. C32 – “The Number of Older People Helped to Live at Home”. CSCI collects the performance of all Councils with an Adult Social Service Responsibility (CASSR) and publishes comparative performance data.
<table>
<thead>
<tr>
<th></th>
<th>Preventive Services</th>
<th>Home Care</th>
<th>Independent Living</th>
<th>Direct Payments</th>
<th>Residential Care</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2008/09 Base Budget Gross Expenditure (£m)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older People &amp; Physical Disabilities</td>
<td>2.0</td>
<td>4.2</td>
<td>0.6</td>
<td>1.7</td>
<td>12.4</td>
<td>20.9</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>-</td>
<td>0.9</td>
<td>3.6</td>
<td>0.3</td>
<td>6.6</td>
<td>11.4</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.7</td>
<td>0.5</td>
<td>0.4</td>
<td>0.1</td>
<td>1.8</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2.7</td>
<td>5.6</td>
<td>4.6</td>
<td>2.1</td>
<td>20.8</td>
<td>35.8</td>
</tr>
</tbody>
</table>

<p>| <strong>2009/10 Projected Gross Expenditure (£m)</strong>       |                     |           |                     |                 |                 |         |
| Older People &amp; Physical Disabilities              | 2.7                 | 4.2       | 0.6                 | 2.3             | 11.1            | 20.9    |
| Learning                                          | -                   | 0.9       | 3.6                 | 0.3             | 6.6             | 11.4    |</p>
<table>
<thead>
<tr>
<th>Disability</th>
<th>2010/11 Projected Gross Expenditure (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Old People &amp; Physical Disabiliities</td>
</tr>
<tr>
<td></td>
<td>Learning Disability</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>3.4</td>
</tr>
<tr>
<td>Older People &amp; Physical</td>
<td>3.4</td>
</tr>
<tr>
<td>Disabilities</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>4.1</td>
</tr>
<tr>
<td>PAF - Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>C29</td>
<td>Physical Disability 18-64 helped to live at home</td>
</tr>
<tr>
<td>C30</td>
<td>Learning Disability 18-64 helped to live at home</td>
</tr>
<tr>
<td>C31</td>
<td>Mental Health 18-64 helped to live at home</td>
</tr>
<tr>
<td>C32</td>
<td>Older People 65+ helped to live at home</td>
</tr>
<tr>
<td>C62</td>
<td>Services for Carers, including young carers</td>
</tr>
<tr>
<td>C51</td>
<td>Direct Payments</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>4177</strong></td>
</tr>
</tbody>
</table>

* All figures at 07/08 Population Baseline
9.13 Where LB Waltham Forest is under-performing, then budgetary provision may be allocated in line with Council priorities to ensure improved performance. A growth bid of £1 Million for 2008/09 to Star Chamber in order to improve the Council’s performance in respect of Direct Payments is an example of this.

9.14 The last 2 major considerations in terms of the budgetary aspects for commissioning are Charging Policy and alternative sources of funding. In respect of Charging Policy, the Council applies a scale of charges to Service Users in receipt of adult social care services. These charges are applied to a range of services including home care, day care, respite care and meals on wheels. Service Users have a financial assessment as to what level of charges they will pay, if any.

9.15 The current charging policy generates an annual income of circa £1 million and therefore is significant in terms of the financial context of Adult Social Care. However, the charging policy is in need of review and needs both to be fair and not to create a barrier to people taking up a service which might result in a higher cost to the Authority at a later date.

9.16 In terms of alternative sources of funding, it is most important that these are firstly identified and secondly maximised. Adult Social Care therefore must work with its corporate and Voluntary Sector colleagues both to identify and to bid for these monies. This funding may be received directly by a Service User or via the Voluntary Sector or the Council. Particular consideration should be given to the following sources of funding:

- Skills for Care
- Futurebuilders
- European Social Fund
- Independent Living Fund
- Disabled Facilities Grant

10) Public & Service User Involvement & Accountability

10.1 Both the National and Local Contexts set out at the start of this Strategy put the Citizen at the centre of the Council’s purpose and activities. Additionally the Principles of Commissioning set out how Service Users and their Carers will be practically engaged in the design and planning of services.

10.2 However, Adult Social Care wishes to engage much more widely than just with its existing Services Users and their Carers. Indeed it wants to connect to the whole area, in order that its activities can achieve much wider Community Benefits.
10.3 In order to develop relationships and communications with the whole community, there must be a strategic approach to engagement. Currently the Council and PCT communicate with different categories of citizens through the following means:

<table>
<thead>
<tr>
<th>Category</th>
<th>Mechanism</th>
</tr>
</thead>
</table>
| The whole community | • Citizen Panel  
• Council Newspaper  
• Other Media  
• Annual Survey  
• Statutory Plans  
• Cabinet, Scrutiny & Council Meetings |
| Specific Groups (e.g. older people, adolescents, patients groups, individual neighbourhoods) | • Local Involvement Network (LINk)  
• Surveys and Focus Groups  
• Annual Personal Social Services User Survey  
• Older People’s Forum |
| Trade associations, pressure and lobbying groups, business community. | • Budget Consultation  
• Petitions  
• Specific approaches |
| Providers, across the public, private and third sectors. | • Providers Forum  
• Council representation on local Voluntary Group Boards. |
| Annual Events | • World Aids Day  
• Carers Week  
• World Mental Health Week  
• International Day of Disabled People. |
| Carers and support groups | • Carers Week  
• Carers Local Implementation Team (LIT)  
• Mental Health LIT  
• Annual General Meetings  
• Service User Groups |
| Individuals and their families. | • Customer Satisfaction Surveys  
• Care Plans  
• Individual Patient Requests  
• Feedback (Complaints & Compliments) |
10.4 In order to improve engagement and give the community “A Stronger Local Voice” the Council will seek to refine the existing methods of communication and in particular will:

- Ensure service specifications are flexible and responsive to feedback from Service Users.
- Use targeted bolster groups of the Citizen Panel in order to consult on specific issues.
- Consider the use of specialist companies both in terms of marketing and consultation.
- Consider the commissioning of specific studies into needs (e.g. by a University or Voluntary Group).
- Ensure better use of existing national data and surveys.
- Ensure greater use of individualised budgets and the involvement of service users in the design of their services.
- Ensure greater accessibility to citizens through regular forum and individual approaches.

10.5 The Department will continue to develop the role of the Local Implementation Teams (LIT’s) by both strengthening their membership and increasing the influence that they have over the decision making process. The current LIT’s include:

- Mental Health
- Learning Disability
- Older People and Physical Disability
- Carers

10.6 The terms of reference for these Groups will be reviewed, particularly in respect of the commissioning and decommissioning of services and in the evaluation of the effectiveness of existing services. Indeed, in respect of existing services, the LITs should work in a way which complements the work of the Council’s Health, Adults & Older People’s Services Overview and Scrutiny Sub-Committee.

10.7 One of the ways that this could be achieved is by way of reports to Scrutiny regarding particular contracts, say those for Home Care Services, including comment from the relevant LIT.

10.8 Additionally, although the Third Sector of voluntary and community groups has its role as provider of services, it also has an equally important role as a representative of the Community, especially for those most vulnerable and excluded. This connection with the Community must not be under-estimated and the Third Sector must be allowed a voice with which to influence both the Council’s and the PCT’s commissioning intentions.
10.9 In order that the relationship between the Third Sector, Council and PCT can flourish, all parties recognise that they must invest time in building trust, understanding and positive & open communications. It is intended that some early work undertaken in 2008 with the Third Sector in building these relationships is further developed. It is anticipated that a formal and scheduled forum will be set up as the vehicle to drive the common purpose of health and well being for the Community of Waltham Forest.

10.10 Last, and by no means least, a Local Involvement Network (LINk) will be established. The LINk will be the key community group with whom the Council and PCT will have a Statutory Duty to consult with in respect of the planning and delivery of health and social care within Waltham Forest. The LINk will have representation from across the Community from voluntary organisations, business groups and individuals. The work of the LINk will be co-ordinated by a “Host” who will act on behalf of the LINk in both an independent and a neutral way.

11) Fair Access to Services & Care Management

11.1 Fundamental to ‘Fair Access to Care’, is that people are aware of both what services are available and how they can access them. This cannot be taken for granted and requires a specific communications plan. The presumption that this need can be met by publishing and distributing a number of leaflets regarding different services, even be they multi-lingual, has not proven to be wholly successful in Waltham Forest. A much more inclusive and innovative approach is required in order that all potential Service Users and their Carers are informed.

11.2 In terms of the communications plan, this will include media, such as radio and posters, and facilitators such as the Voluntary Sector. Indeed, the Voluntary Sector will play a vital new role in case finding, referrals and in the assessment process itself. This may only be at an initial screening or sifting level, but will complement the Single Assessment Process (SAP) which will be further developed between Adult Social Care and its NHS partners.

11.3 In terms of the Fair Access to Care (FACs) Criteria, being - Low; Moderate; Substantial; Critical, it is an objective of the Commissioning Strategy to shift resources, over time, from the higher to the lower criteria. This is in pursuit of the preventive agenda and improving the quality of life and life chances of people within Waltham Forest.

11.4 Additionally, it is the aim to increase the number of Carer assessments and the range of services available to Carers, be they provided through the Council or by a Direct Payment to the Carer. Either way, Care Management Teams will seek to assess and support a higher number of Service Users and Carers, including young carers, through a much expanded menu of services.
12) Market Development

12.1 Given the intention of this Commissioning Strategy to move to a new model of care, Adult Social Care needs to set out the types, volumes and quality of care that it wishes to purchase from the market over at least the next 5 years and, having done so, ensure that the market responds with the corresponding services, so that there is a match between the services the Council is demanding and what the market is capable of supplying. Additionally, the market needs to develop in such a way as to be capable of providing services directly to Service Users as they take on increasing levels of Direct Payments and Individualised Budgets in pursuit of ‘Putting People First’.

12.2 This is a significant challenge as there is already a large imbalance between the demand and supply sides. This can be demonstrated in several ways, including:

- Large numbers of Out of Area residential placements for specialist services.

- Insufficient capacity of certain types of care within Waltham Forest, such as older people mental health nursing.

- Insufficient quality of residential and nursing homes in the Borough rated as either good or excellent by CSCI.

- Patchy provision for preventive and independent living services, as Adult Social Care hasn’t previously bought them in any great volumes.

- Significant levels of service still provided by ‘in-house’ providers within the Department including residential care, home care and day care services.

- Limited affordable home care provision for Service Users wishing to purchase services by way of a Direct Payment.

12.3 In order to be able to “set its stall out” fully to its service providers, the Council needs to analyse what it buys now and say how that will differ from what it wants to buy in the future. This will give a clear indication of what the profile of services will to look like by 2013.

12.4 Providers then can clearly see what Adult Social Care’s future commissioning intentions are. Equally, providers can see what services won’t be required in future and thereby what will be decommissioned, and look at potentially diversifying their business into the new areas of activity. Key areas for new market development include preventive services, home care and independent living as set out later in this section.
12.5 In terms of residential and nursing care the profile of services is already changing. There is a reduced requirement for the lower levels of care, particularly for elderly dependents, as it is very much this level of need which we wish to support through independent living. However, there needs to be an expansion in other categories of care, particularly in older mental health and nursing care.

12.6 One of the clearest messages that the Department is already communicating to the market is in respect of CSCI regulated services. That message is that the Council will not be purchasing services in the future from providers whom are either red or amber rated ('poor' or 'adequate'). In late 2007 the decision was taken not to make any new placements with red rated providers and this is likely to be extended to amber rated providers by 2009. In terms of any future procurement exercise, such as for Home Care, providers will have to be a minimum of green rating ('good') before they are invited to tender.

12.7 Additionally, the Council has a Policy commitment in its Procurement Strategy to developing a mixed economy of providers across the public, private and third sectors. Adult Social Care therefore needs to consider how it will package its various requirements in order to allow the different sectors opportunities both to bid for and to win contracts. It is the Department’s aim that this leads to a spectrum of arrangements, with lower value Service Level Agreements at one end and major high value and long term partnerships at the other.

12.8 Adult Social Care recognises that to achieve the mixed economy there is a considerable investment needed in order to undertake supplier development. In respect of the third sector and SME’s (small and medium sized enterprises) this is both about making them aware of potential opportunities and encouraging them to bid. It is also about equipping them to bid, through explanation of the tendering process and guiding them on how to join together as consortia in order to win contracts for which they would otherwise be too small to compete.

12.9 The reason that the Council is so keen to achieve the mixed economy of providers is that each sector brings different attributes and a range of skills, experience and services, which together meet our Community’s needs. Some of these attributes are as follows:

For the Independent Sector

- Willing to share or take on risk
- Speed of being able to set up new services (comparative to the public sector)
- Access to commercial funding
- Arrangements are at arms length (as opposed to being ‘in-house’)  

- Flexible and innovative
• Significant capacity and growth potential
• Track record and experience of providers
• Structured relationships, underpinned by contractual agreements.
• Better value for money may be achieved through competition

For the Third Sector

• High Levels of Public Trust
• Focused on the needs of the local community and of its service users.
• Capable of engaging and being accessible to the most marginalised
• Flexible and responsive to new ideas
• Access to commercial funding (Social Enterprises)
• Specialist knowledge and skills
• Significant capacity and growth potential
• Entry into the workplace for disadvantaged people

12.10 For the public sector, again there are strong attributes none the least of which are the public service ethos and certainty of provision. It is very much Adult Social Care’s intention to continue to procure services from a number of public sector partners. However, it is the Department’s plan to reduce significantly the level of services which it provides directly itself. In terms of home care services, it is in the process of re-configuring the ‘in-house’ provider, the Community Support Team, to deliver a more specialist service, which in return will deliver better value for money.

12.11 In respect of residential care, a major project is under way to re-commission the 7 local authority operated homes. The intention is to replace the homes with 2 new-build independently operated facilities, which include a resource centre, extra care housing and residential care. It is anticipated that this project will be completed in 2011/12.

12.12 Other considerations in terms of developing the market include a Workforce Development Strategy for health and social care across the borough. This will ensure that that the workforce is suitably skilled and experienced in order to be able to deliver the new model of care. Also, to develop caring as a career so that people can be recruited and retained in the health care economy.

12.13 In terms of the Workforce Development Strategy, this must be undertaken jointly with our independent, voluntary sector and NHS colleagues. Central to this will be building on the successful “Partners” initiative, which has already brought Council and Independent Sector social care training together in Waltham Forest. Additionally, workforce planning needs to be undertaken to ensure that staff are capable of
working not only across a diverse community but also across both health and social care.

12.14 In respect of the wider local economy, the Department will be looking for its providers to commit to the Sustainable Community Strategy through investing in both the people and the infrastructure of Waltham Forest. This may include, for example, employing those with a learning disability or establishing fully disability accessible premises in the Borough.

12.15 In order to make these investments commercially viable, the Department will move to 3 year minimum term contracts. This will give greater financial certainty and allow organisations to develop longer-term business strategies. This is particularly so for the third sector organisations, who have been subject to annual contracts with the attendant uncertainties as to whether they would be extended or terminated.

12.16 Although Adult Social Care cannot be prescriptive about which sector it lets its contracts to, the table following sets out its general intentions and additionally the indicative procurement process that it will use:
<table>
<thead>
<tr>
<th>Client Groups</th>
<th>Preventive Services</th>
<th>Home Care</th>
<th>Independent Living</th>
<th>Direct Payments and Individualised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People</td>
<td>Mental Health &amp; Substance Misuse</td>
<td>Mental Health &amp; Substance Misuse</td>
<td>Mental Health &amp; Substance Misuse</td>
<td>Mental Health &amp; Substance Misuse</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>Learning Disability</td>
<td>Learning Disability</td>
<td>Learning Disability</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>Physical Disability &amp; Sensory Impair</td>
<td>Physical Disability &amp; Sensory Impair</td>
<td>Physical Disability &amp; Sensory Impair</td>
<td>Physical Disability &amp; Sensory Impair</td>
<td>Physical Disability &amp; Sensory Impair</td>
</tr>
<tr>
<td>Carers</td>
<td>Carers</td>
<td>Carers</td>
<td>Carers</td>
<td>Carers</td>
</tr>
<tr>
<td>Services</td>
<td>Befriending</td>
<td>Community Alarm</td>
<td>Meals on Wheels</td>
<td>Adult Placement Scheme</td>
</tr>
<tr>
<td></td>
<td>Handyman Services</td>
<td>Laundry Service</td>
<td>Disabled Adaptations</td>
<td>Extra Care Housing</td>
</tr>
<tr>
<td></td>
<td>Hydration Project</td>
<td>Telecare</td>
<td>Telemedicine</td>
<td>Supported Living</td>
</tr>
<tr>
<td></td>
<td>Gardening</td>
<td>Dementia Care</td>
<td>Dementia Care</td>
<td>Day Care</td>
</tr>
<tr>
<td></td>
<td>Light Housework</td>
<td>Respite Care</td>
<td>Respite Care</td>
<td>Advocacy</td>
</tr>
<tr>
<td></td>
<td>Assisted Shopping</td>
<td>End of Life Care</td>
<td>End of Life Care</td>
<td>Counselling Support</td>
</tr>
<tr>
<td></td>
<td>Benefits Advice &amp; Information</td>
<td>Occupational Therapy</td>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling Service</td>
<td></td>
<td></td>
<td>Personal Assistants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transport</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Leisure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Entertainment &amp; Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Assistance to Work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Accommodation Costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Education and Skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Training</td>
</tr>
<tr>
<td>Health Living</td>
<td>Physical &amp; Social Activities Services for Carers</td>
<td>Psychological Therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Services</td>
<td>Re-enablement Services</td>
<td>Intercare Services (Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-enablement Services</td>
<td>Rehabilitation Services</td>
<td>Specialist Services (Mental Health)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***Services such as Advocacy, Services for Carers, Advice etc will cut across all Categories***

<table>
<thead>
<tr>
<th>Providers</th>
<th>Services for Carers</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Groups</td>
<td>Independent Sector</td>
<td>Voluntary Sector</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>Independent</td>
<td>Social Enterprises</td>
</tr>
<tr>
<td>Social Enterprises</td>
<td>Education</td>
<td>Independent Sector</td>
</tr>
<tr>
<td>Public Sector</td>
<td>Families</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Grants</th>
<th>SLA</th>
<th>Negotiated Contract</th>
<th>Competitive Tender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Arranged Care Brokerage</td>
<td>Competitive Tender</td>
<td>SLA</td>
<td>Competitive Tender</td>
<td>Care Brokerage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>Contract Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Groups</td>
<td>Negotiated Contract</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>Competitive Tender</td>
</tr>
<tr>
<td>Social Enterprises</td>
<td>SLA</td>
</tr>
<tr>
<td>Public Sector</td>
<td>SlA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>Self Arranged Care Brokerage</th>
<th>Competitive Tender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Groups</td>
<td>Negotiated Contract</td>
<td>Care Brokerage</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>Competitive Tender</td>
<td></td>
</tr>
<tr>
<td>Social Enterprises</td>
<td>SLA</td>
<td></td>
</tr>
<tr>
<td>Public Sector</td>
<td>SlA</td>
<td></td>
</tr>
</tbody>
</table>

**Page 127**
### 13) Headline Commissioning Intentions and Timescales 2008-2013

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Activity</th>
<th>Timescale</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care Services</td>
<td>Procurement Exercise</td>
<td>10/07 to 03/09</td>
<td></td>
</tr>
<tr>
<td>Re-provisioning of Residential Care and Extra Care Housing</td>
<td>Procurement Exercise</td>
<td>10/06 to 03/11</td>
<td></td>
</tr>
<tr>
<td>Individualised Budgets</td>
<td>Developing a range of services to support individuals through independent living and increased life chances (education and employment opportunities)</td>
<td>2008/2013</td>
<td></td>
</tr>
<tr>
<td>Day Care Services LD</td>
<td>Procurement Exercise</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>Disability Services</td>
<td>Review</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>Out of Hospital Care</td>
<td>Implementation of Plan</td>
<td>2008/2012</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>Expanded Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Brokerage Service</td>
<td>Establish</td>
<td>2008/09</td>
<td></td>
</tr>
<tr>
<td>Carers Support Services</td>
<td>Expanded Provision and range of services</td>
<td>2008/2013</td>
<td></td>
</tr>
<tr>
<td>Integrated Community Equipment Store</td>
<td>Review</td>
<td>TBA</td>
<td></td>
</tr>
</tbody>
</table>

### 14) Contracts & Commissioning

14.1 In order to deliver the ambition of this Commissioning Strategy, Adult Social Care needs to have a commissioning capability which is of sufficient size, experience and skill.

14.2 The functions which need to be undertaken as a part of Commissioning, include:

- Demand & Service Planning
- Market Development
- Joint Commissioning with other Local Authorities and the PCT
- Development of Business Cases
- Support to Best Value Reviews
- Benchmarking of Service Costs and Performance
- Procurement & Tendering
- Quality Assurance Framework
- Contract Management & Monitoring
- Co-ordination of Feedback (concerns, compliments, complaints)
- Complaints Investigation and Safeguarding
• Chairing of Placement Panels
• Brokerage and Placement Activity
• Budgetary Control
• Relationship Management with Providers
• Facilitation of Relationships between Providers
• Joint Working with Regulators.
• Supplier Development
• Support to Workforce Development Strategy

14.3 The current structure and skill set of the Contracts and Brokerage Teams does not wholly meet the demands of this new Commissioning Strategy, and it is therefore in need of review.

14.4 The review will determine a new “fit for purpose” structure which is capable of implementing the Strategy, alongside establishing any ongoing professional development needs of the team.

15) Effectiveness of the Commissioning Strategy

15.1 It is most important that the effectiveness of this Commissioning Strategy is reviewed, on an at least annual basis. The review would be by way of an annual report to the Joint Partnership Board Executive Group. In the same way that reports on individual services or contracts are intended to be presented to the Health, Adults & Older People’s Services Overview and Scrutiny Sub-Committee, the annual report will set out the following:

• Progress against the Implementation Plan
• Effective Use of Resources Assessment
• How Outcomes to Service Users have Improved (including case studies)
• How the Market has been Developed
• Value for Money Assessment
• Additional Community Benefits which have been Delivered
• Progress against Targets for Performance Indicators

15.2 Additionally, the report may include recommendations for refining the Strategy in terms of emerging issues such as ‘Putting People First’, or changes in the needs of the Community. On that last point, it must be recognised that the Community in Waltham Forest is fluid, therefore the Strategy needs to be able to adapt accordingly to these changing needs.
### Implementation Plan – Commissioning Strategy

<table>
<thead>
<tr>
<th>Component</th>
<th>Action</th>
<th>Timescale</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications Plan</td>
<td>The promotion of social care services to the Community, with particular emphasis on raising awareness with hard to reach groups. Additionally, to expand the routes through which people can access services.</td>
<td>September 2008</td>
<td>Corporate Communications Manager</td>
</tr>
<tr>
<td>Increase Number of Carers Assessments</td>
<td>Increase the number of assessments undertaken for Carers and to provide carers with a range of services or a Direct payment in order to meet their particular needs.</td>
<td>March 2009 (and annually thereafter)</td>
<td>Head of Assessment &amp; Care</td>
</tr>
<tr>
<td>Establish Local Involvement Network (LINK)</td>
<td>Appoint Host to co-ordinate the establishment and activities of the LINK. The LINK being the new statutory body for local consultation on health and social care matters.</td>
<td>May 2008</td>
<td>Head of Adult Social Care &amp; Health</td>
</tr>
<tr>
<td>Review Local Implementation Teams</td>
<td>Review of terms of reference and memberships for the Groups,</td>
<td>June 2008</td>
<td>Head of Adult Social Care &amp; Health</td>
</tr>
<tr>
<td>Restructure of Contracts &amp; Commissioning</td>
<td>Review with the PCT the structure of the commissioning function to ensure that it is “fit for purpose” and capable of implementing the new model of care.</td>
<td>October 2008</td>
<td>Head of Adult Social Care &amp; Health</td>
</tr>
<tr>
<td>Commissioning Intentions &amp; Work Programme.</td>
<td>To undertake the delivery of the Commissioning Strategy and associated work programme.</td>
<td>2008-2013</td>
<td>Head of Strategic Commissioning</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Market and Gap Analysis</td>
<td>To establish a baseline of current social care provision and its relationship within Waltham Forest and set out how that needs to change in order to meet future needs.</td>
<td>September 2008</td>
<td>Head of Strategic Commissioning</td>
</tr>
<tr>
<td>Provider Development</td>
<td>Devise and implement a provider development programme. This in order to raise the quality of providers and to equip them to respond to the changing social care health and needs, and the way in which these services will be commissioned.</td>
<td>December 2008</td>
<td>Head of Strategic Commissioning</td>
</tr>
<tr>
<td>Establish External Funding &amp; Bid Group</td>
<td>Establish post within Adult Social Care on “an invest to save” basis to identify external sources of funding and co-ordinate the activities of a multi-agency Bid Group.</td>
<td>December 2008</td>
<td>Head of Adult Social Care &amp; Health</td>
</tr>
<tr>
<td>Workforce Development Strategy</td>
<td>To undertake the workforce planning, training and development for the health and social care economy in Waltham Forest. Ultimately, to ensure along with our partner organisations that the workforce is sufficiently skilled, experienced and of the right capacity to meet the needs of the Community.</td>
<td>2008-2013</td>
<td>HR Manager</td>
</tr>
<tr>
<td>Annual Report to the Joint Partnership Board Executive Group</td>
<td>Report setting out the effectiveness of the Commissioning Strategy and what improvements, particularly in respect of outcomes to service users, have been achieved.</td>
<td>March 2009</td>
<td>Head of Adult Social Care &amp; Health</td>
</tr>
</tbody>
</table>
1. SUMMARY

1.1 This report:

1.1.1 Provides an update of progress on the Residential Care Homes Re-provision Programme (RCHRPP); and
1.1.2 Sets out indicative procurement and site options for Overview and Scrutiny to comment on prior to Cabinet consideration on 17th June 2008. The procurement options through a process of competitive dialogue aim to enable the Council to manage the market and receive the most innovative and cost effective proposals for consideration.

2. RECOMMENDATION

2.1 For Cabinet Decision

That Cabinet

2.1.1 Agrees the Business Case and Recommendations attached at Appendices 2 & 3;

2.1.2 Agrees the preferred site locations for two new best practice residential care home resource centres to be built in the Borough. The northern site to be the Chingford Municipal Office site. The southern site to be Wood Street precinct;

2.1.3 Agrees to commence a preferred procurement route, via a Public Private Partnership, where the partner is invited to participate in the redevelopment of the resource centres and Extra Care Sheltered Housing in addition to providing the service delivery. The scope of the partnership will be investigated during the Competitive Dialogue stage of the tender process to deliver the two new resource centres; and
2.1.4 Delegates authority to the Executive Director for Adults and Community Services to take any action to give effect to the decision in 2.1.3, in consultation with the Portfolio Holder for Health, Adults and Older people and upon advice on the Director of Finance and Director of Governance & Law.

3. REASON FOR DECISION
3.1 Improving residential care services in the borough is a key decision as it will have a significant impact upon the service users, relatives, staff and other stakeholders. It will also result in significant financial expenditure.

4. PROPOSAL
4.1 National Context
4.1.1 The Government has set local authorities a challenging agenda to transform adult social care to deliver personalised services that are tailored to meet the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive.

4.1.2 The National Strategy for Housing in an Ageing Society states that more good quality specialised housing of different types is needed to promote greater choice. The vision is to have specialised housing for older people at the heart of the community, offering services for the whole community. The RCHRP provides Waltham Forest with the means to achieve this vision and to set standards that serve to lead rather than follow the best of services.

4.2 Local Context
4.2.1 The Residential Care Homes Project complements a number of the ambitions and priorities for the Council and its partners as set out in the Sustainable Communities Strategy to:

(a) Improve housing quality and choice
(b) Cultivate civic participation, cohesion and independent living
(c) Improve the quality and design of public space

4.3 Background
4.3.1 On 18th October 2005, Cabinet agreed that the residential care homes in the borough were no longer fit for purpose to meet the future needs of residents. A decision was taken to pursue a development option that envisaged a smaller number of residential homes and the development of extra care sheltered accommodation in the borough. The value of existing residential care home sites was ring fenced toward the costs of this re-provision. The Adults and Older People Overview and Scrutiny Committee endorsed the report received by Cabinet and made a number of agreed recommendations at a meeting on 17th October 2005.
4.3.2 On 17th October 2006 a Cabinet decision was taken to provide two new homes with between 160 to 180 beds in total and to close up to five Waltham Forest Residential Care Homes, subject to consultation. The Health, Adults and Older Persons Scrutiny Sub-Committee endorsed the report received by Cabinet and made a number of agreed recommendations on 10th October 2006.

4.3.3 A senior officer Programme Board spanning Adult Social Care and Health, Housing, Legal, Procurement, Property and Asset Management, Finance, Centre of Excellence and Primary Care Trust representation was established to take forward the Cabinet decision. The board and its project groups have applied the Council’s Project Management Methodology to all stages of the project.

4.3.4 Following an Office of Government Commerce 4Ps Gateway Review 1 to clarify the business case the vision for care homes re-provision was strengthened to focus on a resource centre model to deliver 2 ninety bed residential care homes targeted on the most vulnerable and needy older people with dementia and nursing care needs reflecting current and future demand.

4.3.5 To supplement the new residential care home provision the review recommended developing extra care housing capable of providing for older people with borderline care needs that might otherwise be referred for unnecessary admissions to residential care. This is in line with Commission for Social Care Inspectorate recommendations to increase extra care provision in the borough.

4.3.6 In addition to new build extra care a service evaluation of existing frail elders services has been undertaken and it has been confirmed with providers that future allocations will meet the local authority’s extra care criteria (a 10 hours plus care package). Existing frail elder provision consists of 248 units, which through time, when voids arise, can be reconfigured into extra care provision. A successful pilot scheme for extra care housing has already taken place at Baytree House in Chingford. The new extra care facilities include an on site care team, more staffing and access to day services through activity clubs for new and existing residents.

---

1 The Gateway Review process examines a project at critical stages in its lifecycle to provide assurance that it can progress successfully to the next stage.

More details here: [www.4ps.gov.uk/PageContent.aspx?id=40&tp=Y](http://www.4ps.gov.uk/PageContent.aspx?id=40&tp=Y)
4.3.7 Alongside Residential Care Home and Extra Care Provision the vision provides for the development of resource centres for people in the community as well as homes for its residents. This model means that the homes can contribute to the broad spectrum of preventative and supportive care within the Borough. It reduces the isolation of the units and ensures their familiarity to potential future service users. Initial discussions with the voluntary sector and health partners are very positive and indicate that the resource centres would be best utilised as a Healthy, Living and Ageing Campus and for the location of the Adult Social Care and Primary Care Trust Joint Inter-Care Team.

4.3.8 Development of a resource centre model for residential and extra care requires adequate building space and appropriately located sites. An options appraisal was conducted and presented to the Council’s Strategic Investment Board in July 2007, which endorsed the use of the Chingford Municipal Office site, an excellent site for purpose. The Strategic Investment Board on 2nd May 2008 endorsed a second site in Wood Street subject to financial viability. The existing residential homes are unsuitable for the new model. Further details on both preferred sites are set out in the Business Case Options Appraisal attached at Appendices 2 and 3.

5. ALTERNATIVES CONSIDERED
5.1 All the alternative options for site selection and procurement are set out in the Business Case at Appendices 2 and 3 to this report.

6. CONSULTATION

Please see Appendix 1

7. IMPLICATIONS
7.1 Financial
7.1.1 Indicative Detailed costs for the proposed new provision are set out in the Business Case attached at Appendices 2 and 3 to this report. The estimated revenue cost of providing the resource centre service is within the budget remaining following policy review.

7.1.2 The policy review process for 2006/07 recommended a 3-year forward plan of savings. Savings of £750,000 in Year 2 and £850,000 in Year 3 were agreed to be delivered through the closure of 2 residential care homes. Edith Pearson Lodge, is set to close in early May following consultation and Cabinet approval. A further report to Cabinet in September 2008 will set out options for a second home closure to make the agreed policy review savings.
7.1.3 The capital cost of the project is expected to be met from anticipated capital receipts and prudential borrowing. The loss of foregone capital receipts to the overall capital programme from the CMO and Wood Street proposed sites will be offset by the expected receipts from the sale of the existing homes' sites. The capital financing costs of the prudential borrowing are expected to be met within the revenue budget.

7.1.4 It is anticipated that the development of a Resource Centre on the Wood Street precinct site will be a positive contribution to the regeneration of the area. There is currently no anticipated capital receipt from this site built into the capital programme.

7.1.5 At this stage of the project, it is not to possible to quantify exact costs. The Outline Business Case includes indicative costs and resources. These will be tested during the procurement phase of the project and before any final decisions are taken, a final business case will be produced. The final business case will include full costings, risks, VFM and affordability of the whole project. The project specification may therefore change during the process due to affordability constraints.

7.1.6 The development costs of the procurement phase are expected to be £700k. This is offset against the capital receipts as a cost of the project.

7.2 Legal
7.2.1 The Council has a duty to make arrangements to provide residential accommodation for older persons who are in need of care and attention, as defined by statute, not otherwise available to them. There are however constraints on arrangements involving the provision of nursing care by a registered nurse.

7.2.2 Care homes for older people must meet the national minimum standards, monitored by the Commission for Social Care Inspectorate.

7.2.3 Final decisions on proposals, including the closure of homes associated with the programme, will not take place until after consultation. Any final decision must take into account the outcome of the consultation in order to respect the rights of residents under the Human Rights Act 1998 and domestic case law. In assessing the proposals, the Council should also be mindful of its statutory duties under Disability Discrimination Act and equalities legislation. It is aimed to deliver the new resource centres by end 2011 and most of the existing residential care homes will remain open until that time.

7.2.4 The proposals will have other legal and contractual implications, and will be subject to compliance with the Council's Contract
Procedure Rules and Property Procedure Rules. Any key decisions arising from the RCH program will need to come back to Cabinet for a decision. Legal advice will be available to the RCHP Team in relation to this and all other respects.

7.3 Human Resources
7.3.1 Consultations are taking place, including a regular staff bulletin and fora with staff and their representatives.

7.3.2 A training programme for staff is being implemented to ensure a smooth transition into new service provision.

7.4 Health Impact Assessment
7.4.1 This strategy is centrally focused upon meeting the needs of older people, their carers and relatives. Development of a resource centre model and extra care sheltered housing options will support people in their own homes and is in line with expressed stakeholder preferences, recent policy developments and Waltham Forest's strategic priorities.

7.5 Equalities Impact Assessment
7.5.1 An Equalities Impact Assessment for the project was submitted to the Adult and Community Services Equalities Board in November 2007.

7.5.2 The RCHRP is targeted on older people, 65 years and above (55 for people from BME communities). The service will provide help to people resident in the resource centres and in the community suffering from disabilities associated with ageing. This resource will provide services to both men and women and take into account demographic projections for an increase in males requiring residential care in future provision.

7.5.3 This service will provide help to people from minority and majority populations. Minorities are currently underrepresented in our residential homes. The commissioning of specialised units for people from Asian language speaking and African Caribbean groups will help to ensure that our provision better reflects our demographics. Our outreach work must also target people from less numerically significant minorities and acknowledge their needs.

7.5.4 This is a significant modernisation of services based on the views and respecting the expertise of service users, carers and older people with regard to the shape of future services, design and tender issues. This process will recognize the diversity of our community by developing specialized units for BME and other currently under represented user groups, to train staff to work more effectively with older people with a range of disabilities and to develop services for younger dementia sufferers.
7.5.5 The building design parameters, service specification and training programme associated with re-provision will specifically address issues of diversity and equality.

7.6 Climate Change Impact Assessment
7.6.1. The new resource centres will comply with the Council's Climate Change Strategy (once finalised).

7.6.2. The project will seek to deliver buildings which maximise energy efficiency and innovative design which could unlock additional Housing Corporation funding and follow the London Development Association "Sustainable Development Guide: Implementing Sustainable Design & Construction". Work will be undertaken with planning a urban design on detailed planning briefs for each site to incorporate these aspects.

7.6.3. A home food growing project will be part of the care package for the residents.

8. CONCLUSION
8.1 Waltham Forest is on course to completely modernise its provision for older people. The vision for residential care home provision is grounded in recent policy developments and strategic priorities.

8.2 Linking this with preventative strategies to empower older people to remain within their communities will ensure Waltham forest is in a strong position to deliver some of the best older people services in London.

Background Information
1. Our Health, Our Care, Our Say: a new direction for community services. Department of Health, January 2006
2. Putting People First, HM Government, December 2007
4. The Adults and Older People Overview and Scrutiny Sub-Committee meeting papers from 17th October 2005
5. The Health, Adults and Older Persons Scrutiny Sub-Committee meeting papers from 10th October 2006.

This report has been cleared after discussion with the Portfolio Member.

Signed .............................................. Date .................................

Portfolio Member for ........................................

Page 139
Appendix 1:

Consultation

1. Consultation with stakeholders is built into the project through application of the Council’s Project Management Guidelines and as a fundamental part of Adult, Social Care and Health service delivery to ensure Waltham Forest delivers excellent services that put people first with the aim of enabling users/carers to live as independently as possible. All key partners across statutory and voluntary services along with service users are driving the specification for services to be delivered within the new resource centres.

2. Waltham Forest Local Implementation Teams have and will continue in the future to receive regular briefings on the project.

3. Overview and Scrutiny has fed into the project to date at all key stages with positive recommendations for ensuring service users receive the best possible service. The Health and Older Person’s Scrutiny Sub-Committee considered a copy of this report on 4th June.

4. A members briefing was held on 29th April to update on progress and answer questions prior to Cabinet consideration. Members were advised on preferred sites and funding routes for the project followed by a question and answer session. Members expressed a particular interest in receiving regular updates on extra care housing, designing for dementia and resource centre sites. A newsletter for the project updating on these issues is being prepared for publication in September 2008.

5. Two Stakeholder Conferences to shape service provision at resource centres have been held with the voluntary sector, residents and health partners and a stakeholder reference group is being constituted to advise on specification for the resource centre element of the project. A copy of a report from the reference group held on 7th December 2007 is attached overleaf.

6. Final decisions on proposals, including the closure of homes associated with the programme, will not take place until after consultation with residents and the stakeholder reference group.
London Borough of Waltham Forest

Shaping Resource Centres to Need

Report on a conference held in Leyton on 7th December 2007
1 Introduction

A conference was held at Leyton Orient FC, on Friday 7 December 2007, to follow up on an earlier event in May to explore how resource centres should be shaped by local needs in the Borough of Waltham Forest. The stated objectives of the activity were:

- A detailed specification of services and activities that will best support local older people in the community, and their carers, on the basis of options suggested at the last stakeholder conference and in comparison with services being offered at Tower Hamlets. This may include advice and guidance, information, and social activities as well as health and personal care advice.

- Specification of what services residents in homes would like to have available to them, and the extent to which these can be provided in the context of a resource centre located on site. Also explore the balance to be struck between convenience and privacy.

- Possible inputs from health that would support the planned services and achieve synergies achieving health objectives and targets

- Clearer definition for the reference group: composition, objectives and action planning

Specific questions that might be addressed were also identified:

- Ensure everyone has a common understanding of what we mean by “Resource Centre” in this context.

- Specify a menu of services that would be sought /preferred, looking for synergies with health targets

- What are the considerations we’d need to be aware of in designing a space that could be used by older people outside the homes as well as within them, ensuring privacy and freedom of access?

- How would the use of such a space be managed and prioritised?

A total of 44 delegates attended the event; these were a good mix of service users, provider agencies and their staff, and carers, and the activity took place in a constructive and positive atmosphere.

The programme included a mix of presentation, questions, group discussion and plenary sessions, and was led by Phil Back, an independent adviser brought in for
this purpose, who facilitated the plenary discussions and also developed the group work materials.

A copy of the programme for the day is appended to this report.

The day was also supported by an exhibition, showing some photos of existing resource centres and sheltered housing (two schemes were showcased, one from Caerphilly and the other in Banchory) and some other material on dementia care from the Methodist Housing Association.

The report structure follows the programme through the day.
2 Opening presentations

After an initial welcome, the morning opened with a presentation from Sandra Howard, Head of Adult Social Care and Health for the London Borough of Waltham Forest, examining progress to date on the re-provision programme. Sandra explained the background to the decision to provide real homes for older people that interface effectively with the local community in which they are situated.

The re-provision programme responds to the stated desires of older people and other stakeholders for an emphasis on independent living, but with support for those who need care in a home environment that will provide dignity, space and privacy, without isolating people from the community.

Sandra explained that the programme would require the closure of Edith Pearson Lodge, a home which has been subject to vandalism and in which major work is needed to bring it up to defined national minimum standards. The consultation on this ends soon and Sandra encouraged those who had not already done so to let the consultation team have their views on this proposal.

A copy of Sandra’s presentation is attached as an appendix to this report.

Phil Back then gave a short presentation on resource centres, reminding delegates that this term has a specific definition in relation to the re-provision programme. He explained what a ‘resource centre’ means in this context, and how the centre might relate both to the home in which it is located and to the wider community. He also explained what a resource centre is not, with particular reference to the privacy and dignity of residents.

A copy of Phil’s presentation is attached as an appendix to this report.

The third presentation of the morning was delivered by David Cowell (formerly from the London Borough of Tower Hamlets) and Debbie Walker (Age Concern Tower Hamlets). David and Debbie set out the origins and activities of LinkAge Tower Hamlets, a programme developed through a local partnership to meet the needs of older people in the borough from which useful lessons could be drawn to help the re-provision programme.

LinkAge is not an exact match for what is being planed for Waltham Forest, but it spans a network of centres working on a similar basis to what is envisaged for this area. It functions to provide advice and peer group support to older people. It is based on feedback from older people, stressing the need to find a way into services, the difficulties of a plethora of different access points for different services, and the need for provision to go beyond health and social care. The vision for Linkage therefore talks about a holistic response, a network of easily accessible services, and the promotion of inclusion.
David and Debbie explained the challenge of delivering this vision, which has meant blurred boundaries for agencies and others and a willingness to work in ways that promote mutual understanding and new ways of relating between partners. There has had to be a willingness to go beyond traditional models and to test the limits of partnership working.

Several lessons have been learned from the Linkage project, including the need for a radical culture change in the way services are provided and used. The challenges have been daunting, but ultimately very rewarding. The programme has also been successful in increasing attendance and take up.

However, this is a pilot project and sustainability beyond the pilot period is an anxiety.

David and Debbie’s presentation is appended to this report.

Questions were invited after this presentation and David and Debbie were also available to delegates for further discussion during breaks.
3 Would the LinkAge model work in Waltham Forest?

A group discussion then took place examining whether or not the approach commended by linkage would work in the context of the resource centre planned for Waltham Forest. Delegates were invited to set out what they saw as the advantages and obstacles to this approach and to seek ways of overcoming these. Each group was invited to feed back on its conclusions.

Specific benefits for care home residents include
- Strengthening a sense of community
- Reduces isolation whilst protecting privacy
- Improving knowledge of services, both statutory and voluntary, across the borough – all groups know what others are doing
- Encouragement of independence for those able to access services
- Opportunity to access services at home
- An information centre that can direct you where you need to go
- Social benefits and peer groups support
- Co-ordination of services within the wider community
- Services in one place – a single point of access
- A sense that people are contributing their own ideas to their care

For community-based need, the benefits include
- Many of the same benefits as for home residents
- An awareness of what is happening (and available) across the whole borough and not just in one’s own locality
- Barriers broken down between homes and the community
- Greater familiarity with the options before the time comes to make a decision
- Friendship links
- Reduced trauma and stress
- Assistance for carers supporting older people at home
- Short term respite care (eg for 2hr shopping trips)
- Events, and more than one event simultaneously to promote choice

For organisations and providers, the benefits include
- Increased partnership working
- Increased communication
- Breakdown of organisational boundaries
- Sharing resource between voluntary groups
- Rationalisation of services and resources into a more cost-effective way of delivering
- Saving time for agencies by reducing red tape
Potential difficulties include

- People who are unwell or immobile may find the resource centre difficult to access
- It may be problematic getting all the necessary partners to work together, given that everyone has their own priorities
- Location and transportation issues – these are interlinked but could be critical to success or failure of the scheme
- Ensuring privacy and security in hosting homes
- Access and referral arrangements
- Communication: information getting to where it’s needed
- Security of funding

Potential solutions include

- Good communication with partners
- Getting all partners on board with a shared vision at the outset
- A shared understanding of what a successful resource centre is
- Awareness and responsiveness to the geography of Waltham Forest, and in particular the north-south split
- Using transport during existing ‘downtime’ during the day
- Training for staff

In discussion it became clear that delegates had strong positive feelings about the proposal and felt that it could be made to work; the benefits were genuine, rather than aspirational, and could be secured. The main problem area considered was transport, which links into accessibility and location; unless there were a number of resource centres planned, careful thought would need to be given to transportation or people at a distance from the chosen site would be effectively excluded.

Communication was also stressed both as a means of keeping people informed and as a means of bringing partners together and maintaining the openness and co-operation that characterise the LinkAge scheme in Tower Hamlets.
4 Services to be provided

This discussion was intended to follow on from the previous event where broad service areas were identified, and delegates were encouraged to think further about the range of services that could be provided in a resource centre and to explore which agencies and bodies might need to become involved to make this possible. Different groups were encouraged to think about different blocks of services.

The discussion had to be shortened due to time overrun on the presentations. However, delegates did come up with some clear messages about services:

- Use what’s already there. This may mean mapping existing services and determining what is provided, who is best placed to provide in the resource centre, and what the gaps are
- Those who already provide specific services should be encouraged to extend their provision into the resource centres (as opposed to inventing new providers)
- Make sure everyone knows what’s going on
- Services should be provided by specialists in the case of clinical services, and otherwise simply by those who do it well
- There are some services everyone needs – hairdressing, café, etc. – and these should be located nearby to facilitate easy access
- There are some things that must be included because they are so popular – Bingo for example
- Days should be structured around what’s available, with some regular recurring services that people can become accustomed to as well as some one-offs
- Alternative therapies, tai chi and similar activities are popular and worthwhile
- People like to meet and do things together
- Let people do what they want, but make sure there’s some experimental stuff that takes them beyond the familiar
- Advice sessions are well attended
- Use the internet to broaden horizons
- Partnerships will be critical to success – between local authority, LEA and health, and with voluntary sector and local businesses

Delegates stressed the need for partnership, and for each partner to play their part in providing services and keeping information circulating, and for using existing resources and providers in a cost effective way.
5 Reference group

A separate discussion took place around the setting up of a reference group to provide advice and consultation feedback for the project.

The discussion focussed on membership of this group. Several distinct groups were identified as possibly having something to contribute here, including

- Residents themselves
- Carers
- Representatives of people with disabilities
- Representatives of minority communities
- The wider voluntary sector
- Healthcare professionals
- Staff from homes
- The council
- Mental health services
- Advocacy services
- Police, fire and rescue services
- Housing providers

The groups looked at these broad groupings:

- Statutory sector – council, police, health
- Voluntary sector – minorities, specific needs
- Individuals – residents and others
- Those who support people – staff, carers, housing providers

It was also stressed that the group would require good chairmanship, and a minute taker, clear terms of reference and an end date to prevent it outliving its usefulness. It might even need subgroups examining specific issues in closer detail.

The group should meet on a monthly basis, and not on an as required basis which might make it more token in nature. Venues would need to be accessible, meetings should take place in the daytime (afternoons were preferred), or at different times of day to maximise possible input from people with jobs or caring responsibilities, and a sitting service might be needed to enable carers to attend. Refreshments were seen as mandatory!

In addition, the group would require support for people with hearing difficulties, an adequate temperature, and above all good transportation to enable attendance.

One group added that it might be useful for this group to include someone who has gone through a similar process of tender and commissioning previously.
6 What happens next

Towards the end of the morning, Cllr Liz Phillips (portfolio holder for this service area) summed up the activity and set out what needs to happen now. The observations made by Cllr Phillips were:

What we’ve done today

• Looked at ethos of care and seen that there are different approaches – both from Tower Hamlets and from examples in exhibition

• What we’re doing in WF isn’t completely new – other people have done it and we can learn from them, but we also need to make sure what we do fits in WF context

• But it is different and we will be learning as we go!

• Important that we listen to people and are responsive to them

• Important that we’re open to cultural change – and that other partners, and maybe residents and others, are also open to new ways of doing things

• The old partnership – social services and health – isn’t enough any more, people need more than this

• But we will need to build new partnerships if we are to succeed, and some may be challenging for us as an authority

We’ve looked at services and what we might need to do

• We’ll take your comments on board and look a new ways of providing services to residents and the wider community

• All the comments you’ve made, Phil will write up into a report for the project team.

• Things like transport, communication, training are areas we’ll need to consider as part of the overall plan

• We’ve looked at the stakeholder group and ways that residents and others can help us ensure the re-provisioning is fit for purpose
• We’ll want to make sure structures are in place to ensure people are kept informed and have opportunities to feed into this – so it’s not just a talking shop but an active group helping make this work

What now?

• Consultation on Edith Pearson runs to late Dec – your views are welcomed

• Move forward with the reference group – let us know if you’re interested in taking part in this

• Develop relations with partners to make sure we have the necessary people on board and committed - and potential access to their resources too! Some will be easier than others we think – mostly because everyone’s under financial pressure

• Continue to have events and other opportunities to maintain a dialogue with you
7 Evaluation

The morning was evaluated by delegates completing a questionnaire. Not all delegates completed this form, but a total of 27 forms were returned either on the day itself or subsequently.

Delegates assessed the programme as follows:

<table>
<thead>
<tr>
<th>Element</th>
<th>Very useful</th>
<th>Fairly useful</th>
<th>Not very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation on resource centres</td>
<td>18</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Presentation from Tower Hamlets</td>
<td>16</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Discussion on application in Waltham Forest</td>
<td>16</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Discussion on reference group</td>
<td>10</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Explanation of what happens next</td>
<td>12</td>
<td>13</td>
<td>0</td>
</tr>
</tbody>
</table>

Overall views were very positive, with almost everyone finding almost every session at least fairly useful. The best score was for the short presentation on what a resource centre is, suggesting that the clear understanding that was being sought was achieved, and the input from Tower Hamlets also seems to have been well received. Only two people found any part of the morning “not very useful” and neither found the whole morning to have been wasted by any means.

Different people found different parts of the programme the most helpful, with individuals stressing the value of the different presentations and the group discussion. This suggests that different parts of the programme made different impacts on individuals and that the overall tenor of the morning was balanced reasonably well between some people’s needs for information and others’ need for discussion and deliberation.
<table>
<thead>
<tr>
<th>Element</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall programme</td>
<td>8</td>
<td>17</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The exhibition</td>
<td>1</td>
<td>21</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>The group work</td>
<td>4</td>
<td>20</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>The balance between listening and taking part</td>
<td>7</td>
<td>17</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>The facilitator</td>
<td>7</td>
<td>18</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The length of the day</td>
<td>7</td>
<td>17</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Heating and ventilation</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Seating and comfort</td>
<td>7</td>
<td>13</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Catering and refreshments</td>
<td>7</td>
<td>14</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>The venue overall</td>
<td>7</td>
<td>13</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

Scores are generally positive, with almost everyone rating almost every aspect of the day at least good. The strongest overall scores are for the programme itself, the balance between listening and taking part, the facilitator, and the length of the activity (something that was criticised last time, and to which we have tried to respond).

The exception is the heating and ventilation, and it is clear that many delegates found the venue too cold for their comfort (though not everyone was cold, this is a common enough complaint to raise concern). After the event we discovered an open window which had clearly caused a draught, unbeknown to those at the front where its effect was less strong. Overall, though, the venue seems to have been a good choice and the cold does not seem to have damaged people’s capacity to get involved in the activity.
### Appendices:

- Workshop outline
- Re-provisioning update
- Resource centre presentation
- Tower Hamlets presentation

### Workshop outline - LB Waltham Forest Resource Centre Services

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Led by</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Arrival and set up room and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0900</td>
<td>Coffee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0930</td>
<td>Welcome</td>
<td>Phil</td>
<td>To include housekeeping, fire drill, toilets, mobile phones, comfort breaks, tea and coffee and a brief run through the programme and timings</td>
</tr>
<tr>
<td>0940</td>
<td>Introduction</td>
<td>Sandra</td>
<td>A introduction and scene setting session to set the tone and direction for the day</td>
</tr>
<tr>
<td>0950</td>
<td>What are we talking about?</td>
<td>Phil</td>
<td>Ensuring we have an understanding of what a resource centre is in this context, and what it isn’t. A short Powerpoint presentation to ensure common understanding</td>
</tr>
<tr>
<td>1000</td>
<td>Does this work?</td>
<td>David Cowell (ex LB Tower Hamlets)</td>
<td>A presentation from elsewhere where this model is being used or developed, identifying</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• What the centre offers/proposes to offer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• What the issues were in creating/designing it</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• What the issues are in developing or running it</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• How services would work and who would deliver</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• What would you do differently if you were doing it again</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• And including pictures</td>
</tr>
<tr>
<td>1025</td>
<td>Questions/discussion</td>
<td>Phil</td>
<td>Led from the front, we’ll have some questions planned to seed the</td>
</tr>
</tbody>
</table>

Page 154
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1040</td>
<td>Would this work in WF?</td>
<td>Phil</td>
<td>Table based discussion using prepared questions looking at • Positives • Possible problems • Ways of resolving those problems • Choose services and how they would work • Brown envelope suggestions</td>
</tr>
<tr>
<td>1120</td>
<td>Plenary feedback</td>
<td>Phil</td>
<td>Each group feeds back briefly on their discussion and Phil leads a short debate on any issues that arise.</td>
</tr>
<tr>
<td>1150</td>
<td>Comfort break</td>
<td></td>
<td>And an opportunity to look at exhibition material</td>
</tr>
<tr>
<td>1205</td>
<td>Stakeholder involvement</td>
<td></td>
<td>How should the reference group be established? Who should be involved and who shouldn’t be? How should they be chosen and how would they feed back to other people whose views they represent? When should it meet and what support would it need?</td>
</tr>
<tr>
<td>1230</td>
<td>Plenary feedback</td>
<td>Phil</td>
<td>Each group feeds back on its discussion and how it made its choices</td>
</tr>
<tr>
<td>1250</td>
<td>What next?</td>
<td>Councillor Phillips</td>
<td>What do we do with all this info and where is the project going now? How can you continue to be involved and informed? Issue evaluation and invite for reference group.</td>
</tr>
<tr>
<td>1300</td>
<td>Close</td>
<td></td>
<td>Lunch is served and an opportunity to revisit any exhibition or handout materials</td>
</tr>
</tbody>
</table>
Residential Care Homes Re-Provision Programme

Revised Business Case
17th June 2008
“More than just a Care home”
# Table of Contents

<table>
<thead>
<tr>
<th>Content</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Local Context</td>
<td>5</td>
</tr>
<tr>
<td>Strategic Context</td>
<td>10</td>
</tr>
<tr>
<td>Aims and Objectives</td>
<td>21</td>
</tr>
<tr>
<td>Options Appraisal</td>
<td>24</td>
</tr>
<tr>
<td>Site Location</td>
<td>24</td>
</tr>
<tr>
<td>Procurement Routes</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 2</td>
<td></td>
</tr>
<tr>
<td>Financial Assumptions</td>
<td>38</td>
</tr>
<tr>
<td>Project Appraisals</td>
<td>43</td>
</tr>
<tr>
<td>Risk and Sensitivity</td>
<td>46</td>
</tr>
<tr>
<td>Risk Mitigation</td>
<td>49</td>
</tr>
<tr>
<td>Preferred Option</td>
<td>51</td>
</tr>
<tr>
<td>Appendix 1</td>
<td></td>
</tr>
<tr>
<td>Conclusions and Recommendations</td>
<td>52</td>
</tr>
</tbody>
</table>
1 INTRODUCTION

In 2005, deciding that its residential care homes were no longer fit for purpose and could not meet future needs Waltham Forest began to consider the options for the modernisation of its residential care homes stock.

Important factors involved in this decision were changing CSCI requirements, changing client needs and higher client expectation. The primary driver was a desire to provide excellent services for clients.

Current demand within Waltham Forest confirms research showing that older people increasingly want greater independence, dignity and choice. They want to stay in their own homes as long as possible, coming into residential care later in life, more vulnerable and with higher levels of dependency as a result. This demands an appropriate environment.

There is also a clear local need to provide care for people from black and minority ethnic backgrounds as well as care for older people with drug or alcohol problems. These groups are poorly served currently.

These factors demanded a formal review based upon the seven in-house residential care homes for older people but with a scope including helping people to remain in community settings and supporting them there for as long as possible, developing sheltered housing, broad preventative strategy and health requirements in the older community as a whole.

Tribal Secta were initially appointed to undertake an options appraisal. This mainly focused on the service delivery options, and concluded that the preferred option was that of redevelopment rather than refurbishment of the present sites.

Reports were given to the Project Group comprising key stakeholders within the Council and the PCT. These reports have since been supplemented by a stakeholder conference, Gateway review and extensive board discussions factoring in Waltham Forest’s strategic priorities.

This Business Case updates the findings and conclusions of that work, considering procurement for the Cabinet’s preferred option. It is based on re-evaluated business opportunities, careful consideration of best value and a continuing strategy of moving from simple purchasing of care to pro-active, market-shaping commissioning within the care market in Waltham Forest considered in the round.

The revised business case places a greater emphasis on new accommodation as a focus for community support, based on a resource centre model rather than a residential care model. The emphasis on developing extra care sheltered housing is retained.

This outline Business Case is a dynamic document that will continue to alter in response to circumstances. Immediate impacts are likely from soft market testing: for example, narrowing of potential partners and the setting of parameters for acceptable partnerships; maximised potential through opportunistic exploration of market options, such as PFI credits available through partnership with LIFTCo; revisions to estimated costs and revenue budgets for project, tested with partners; continuous need to update risk management and timescales.
2 LOCAL CONTEXT

2.1 CURRENT SERVICE PROVISION

Waltham Forest currently manages 6 residential homes for older people, located throughout the Borough. The homes provide services to the following care groups:

- Frail elderly
- Mental health
- Intermediate care
- Dementia

Details of the homes and the current usage of beds available in each category (total of 208 beds) are as follows:

Table 1. Current Service Provision.

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Number of beds</th>
<th>Registered for Dementia?</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walton House</td>
<td>46</td>
<td>No</td>
<td>7 beds registered for Intermediate Care</td>
</tr>
<tr>
<td>George Mason Lodge</td>
<td>39</td>
<td>Yes</td>
<td>9 beds registered for Intermediate Care, Mental Health and Frail Elders (Flexible Provision)</td>
</tr>
<tr>
<td>Flaxen Lodge</td>
<td>24</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Aliston House</td>
<td>43</td>
<td>Yes</td>
<td>Frail Elders (Flexible Provision)</td>
</tr>
<tr>
<td>Francis House</td>
<td>32</td>
<td>Yes</td>
<td>9 Beds Registered for Mental Health Provision</td>
</tr>
<tr>
<td>Mapleton Road</td>
<td>24</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Edith Pearson Lodge</td>
<td>Closed May 2008</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total number of Beds</strong></td>
<td><strong>208</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.1.1 Provision for EMI care

Demand for places for older people with dementia is growing and will continue to grow in the future. In response to this increase in demand the council has re-designated beds in several homes for this client group.

The needs of older people with dementia differ significantly from those of the frail elderly. Residents generally have more challenging needs and the built and care environment becomes more critical in managing successful care outcomes. This also applies to people with early onset dementias, a largely neglected group, for whom we should be providing.

Under present legislation the Council has to apply for any change of client group and re-designation for its homes, and CSCI make the final decision on whether to register the home/beds for older people with dementia. The re-designation usually involves a
cost to the borough in relation to capital and revenue expenditure. Capital is required to redesign the space to cope with this client group and higher revenue costs are associated with increasing the level of staffing to cater for the specialist input required. A level of specialist service is required to meet the needs of this client group. They require higher staffing levels (with additional training).

Whilst the demand for beds for older people with dementia is increasing, the demand for frail elderly beds is decreasing. This is partly due to the choice agenda and the development of intensive home care and extra care options. The choice agenda focuses on the client and their family having choice regarding their placement.

In Waltham Forest the in-house residential home stock is of less than ideal quality. Client and their relatives have shown preferences for choosing a placement where the facilities offered are more up to date and appealing (i.e. in the private or voluntary sector). The decision is often made on the basis of how the home looks rather than the quality of care available - quality of care is a difficult area for first time consumers to gauge.

However, CSCI reports have suggested that quality of interaction between staff and clients is periodically also an issue in some WF homes. There is a clear need to ensure that only best practice is transferred to new environments, reinforced by intensive training programs.

Another factor affecting the future is that the development of intensive home care packages enables clients to remain at home for longer periods. This means that when the package of care finally breaks down client dependency levels may be so high that they require nursing rather than residential care, which used to be the ‘natural’ progression.

Some nursing input will be required in resource centres to cater for increased client need and to ensure that clients can stay with Waltham Forest for longer periods. Given legal constraints on Councils nursing care can only be provided by a third party: for example, through outsourcing new resources and partnership with the voluntary sector. Clinical supervision will then be provided through the PCT.

### 2.1.2 Including NHS provision in the scope of the study

As much flexibility as possible will be built into new provision so that resource centres and sheltered housing developments can capitalise upon synergies in terms of shared goals for older people and maximise resource delivery through sharing premises. The new resource centres will offer nursing care to reflect current demand and discussions are underway with the Primary Care Trust to map care pathways and assess need for intermediate care beds in the borough. The resource centres are also being recommended as a site for co-location of the Council and PCT Inter-care teams.

### 2.1.3 Managing vacancies in the short and medium term

In an increasingly financially pressured climate any vacancies in in-house services demand rapid action. In the short term the Borough has implemented (and needs to continue to operate) a system that allows it to manage the level of vacancies across all the homes as efficiently as possible. In the medium and longer term the Borough
will only be able to fill beds if it offers appropriate services to a demographically changing community.

There are a number of possible solutions but a successful strategy is contingent on future vacancies and the capacity within the residential care market in Waltham Forest as a whole.

In the longer term the council must modernise its stock. It will otherwise have a very expensive service that does not meet the needs of the client group.

To some extent the clients and their carers had started to make their choice by not going into the Borough’s home, hence the history of vacancies. A recent change in demand has also been noticeable, with clients increasingly requiring specialised dementia care or services with a nursing care element – the demand for care for the simply frail has markedly declined. The current stock needs modernising if it is to meet the future aspirations of clients who will require specialised facilities, expect ensuite facilities, more space and modern facilities (access to e-mail, internet, digital TV etc). This will require significant redevelopment and will need to be linked to the development of extra care sheltered housing and a resource centre model for new residential accommodation, which will allow for delivery on expressed stakeholder wishes and strategic priorities.

2.2 Current state of the stock: An overview.

As part of project work all the homes within the Borough were visited and an assessment can be found in the Tribal Secta '05 report. To assist understanding of the current Council stock the report sets out below findings following our review of the council’s homes:

There are issues regarding CSCI compliance at all homes. CSCI has significant concerns regarding the suitability of the homes to meet the client’s needs in the short and medium term and are expecting significant redesign of the homes if they are to continue to operate.

Current configuration does not optimise economic efficiency in terms of client group, capacity, design or staffing.

There are questions over medium term viability and functionality of all units. Care for frail elders is provided much more cheaply by the private and voluntary sectors, so Council provision needs to add value by managing the most difficult, expensive and vulnerable clients, such as people suffering from dementia or people with mental health and/or drug and/or alcohol issues. Specialist units will be required if the Borough is to provide these services.

A flexible approach is required to ensure that the Borough has sufficient beds to meet the projected changes in population and hence demand over the next 25 years. Further details are provided later in this report.

There is a need for capital investment to bring the homes to standard. To “do nothing” is not an option. CSCI have made clear their intention to insist on raised standards, which will also be taken into account in terms of Council performance indicators. The minimal option will require ongoing substantial investment if the council is to continue to operate the homes as non-compliance will lead to closure notices being served by CSCI.
Set below are the 2008/9 costs for the current homes.

Table 2: Budget 2008/9

<table>
<thead>
<tr>
<th></th>
<th>Pay</th>
<th>Non Pay</th>
<th>Total Gross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliston</td>
<td>967,200.00</td>
<td>164,900.00</td>
<td>1,132,100.00</td>
</tr>
<tr>
<td>Edith Pearson</td>
<td>0.00</td>
<td>297,500.00</td>
<td>297,500.00</td>
</tr>
<tr>
<td>George Mason</td>
<td>1,037,300.00</td>
<td>155,000.00</td>
<td>1,192,300.00</td>
</tr>
<tr>
<td>Walton House</td>
<td>1,030,600.00</td>
<td>203,700.00</td>
<td>1,234,300.00</td>
</tr>
<tr>
<td>Flaxen Road</td>
<td>628,500.00</td>
<td>96,200.00</td>
<td>724,700.00</td>
</tr>
<tr>
<td>Francis House</td>
<td>746,800.00</td>
<td>63,000.00</td>
<td>809,800.00</td>
</tr>
<tr>
<td>Mapleton</td>
<td>618,200.00</td>
<td>91,900.00</td>
<td>710,100.00</td>
</tr>
<tr>
<td>Total</td>
<td>5,028,600.00</td>
<td>1,072,200.00</td>
<td>6,100,800.00</td>
</tr>
<tr>
<td>Unit Head</td>
<td></td>
<td></td>
<td>147500</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>6,248,300.00</td>
</tr>
</tbody>
</table>

The map below shows the current distribution of Council homes across the Borough. Geography is an important feature for local planning. Many older people and new arrivals in the Borough live in the south and the pattern for movement is toward the north of the Borough.

The Council needs to commission and sustain capacity in both areas if it is to be successful in meeting needs and aspirations of current and future generations of older people. It will also need to factor in the impact of the Thames Gateway, the Olympics developments and the likely pressure on housing resources in the South of the Borough.
Figure 1 Location of Present Homes.
3 STRATEGIC CONTEXT

This section sets out the background for considering re-provision in terms of changing needs, demographics and social milieu.

3.1 Modernisation and the White Paper

Services for older people are on the cusp of change. Demographically we are moving from the pre-World War II generation towards meeting the needs and aspirations of the ‘new old’, born in the welfare state of the late 1940’s and early 50’s. We are also moving from a group (primarily women) born before or during the First World War and surviving to old age, to an inter-wars generation. This group have wider experience of modern accommodation in terms of owner occupation, space and creature comforts. There are also likely to be more men reaching older age alongside elderly people from black and minority ethnic groups.

Care homes and sheltered accommodation in the public sector were largely built as part of the post war settlement and public spending booms of the late 1950’s, ‘60s and early 1970’s. They are showing their age and do not meet current regulatory standards. For example, en suite facilities are now required by CSCI for any new or substantially refurbished home and bedroom sizes must be increased.

Much of this drive toward modernisation is reflected in current policies and changes promoted locally and by central government and the interaction between health and social care systems overall. Most recently these have found expression in the White Paper\textsuperscript{1} with its emphasis on choice and individualised services, the expansion of direct payments and the promotion of extra care housing as an alternative to residential care.

A further dimension is added by the White Paper’s clear emphasis on links between social care and health services and the need to include a health perspective in the care and support of older people. At one level this concerns age related dependencies and the onset of ill health. This debate must centre around the compression of morbidity and what quality of life can be achieved with added longevity. There needs to be a concurrent exploration of the point at which frailty becomes highly challenging and difficult for individuals and care systems.

This involves recognition of the fact that health and social care system are closely interrelated and changes in one area have an impact on the other. For example, avoidable admissions to hospital put pressure on community resources and treatment for illness that does not include active rehabilitation may prevent an earlier discharge home or to a home.

The key aspects of the drive for change in health and social care systems, (including the accommodation needs of older people) are summarised in the diagram below.

\textsuperscript{1} Department of Health (January 2006) Our Health, Our Care, Our Say
3.2 Changing needs and preferences

There is now a growing body of research\(^2\) that is helping planners understand the wishes of older people as both citizens and as consumers of housing, health and social care services.

This shows that the expectations and requirements of older people as consumers are changing with population patterns. The Council and the PCT must base planning decisions on the needs and aspirations of tomorrow’s older people as well as on the views of current consumers.

General factors to consider include a new cohort of older people born after the war, with different expectations concerning service and quality, plus an ability to access greater financial resources. In the future many more older people may be paying for their care, either through Direct Payments or from their own resources. This is bound to influence their choices and expectations of quality.

At the same time there is a growing appreciation that older people are a heterogeneous group and that their needs should be planned for in a manner that focuses on individuality and difference rather than homogeneity and similarity.

---

The literature identifies a number of specific factors, all of which were confirmed by the project’s stakeholder conference:

Maintaining independence and control is central to well-being - even when frail; All service options need to support the maintenance of ordinary lives as far as possible. Choice about services, having a say in how those services are delivered, service responsiveness and flexibility, safety and security, help in developing and maintaining social activities and informal support networks are all seen as vital; Residential care is seen as having a place in the continuum of care but is an option almost exclusively wanted only when people have become too frail, confused or lonely to remain at home. Intermediate options such as services into the home or extra care sheltered housing are what people want prior to this point (it needs to be noted this is not an easy or inexpensive option); Physical standards allowing privacy and personal space are of growing importance; For older people in need of continuing care, low level preventative services are seen as just as crucial as personal care. Issues that came higher up than personal care in the hierarchy of service needs include suitable housing, informal support, access to good advice and information, carer support and access to leisure and transport; In making a decision about a housing move most older people want to relocate only within a very limited geographical area. In addition, where they are moving primarily for housing reasons (often in their 60s or 70s) it is often to trade down to a smaller dwelling (usually a flat or bungalow). Moves to sheltered housing generally come at a later stage, mainly for care and support or security rather than housing reasons. The average age for moves to sheltered housing has moved from the mid 60s to the late 70s and the age trend is still upwards; There is evidence of the potential to support people who become demented whilst living in sheltered housing. Clear evidence of demand is as yet unproven, however, and there is less clarity about whether sheltered housing can support people moving in as new residents who have more than mild dementia.

The WF stakeholder conference held on 18th May confirmed these findings. Attendees also stressed that they want larger rooms, homes from which they do not have to move if they develop medical problems and contact with the community.

3.3 Service implications of consumer preferences

Summarised, the service implications of national and local consumer choice and preferences are:

As much care as possible –more than at present - needs to be based around where people live. This should mean settings which allow greater independence than is currently available in residential care, where there is potential for rehabilitation built into programmes of care;
New resources need to be more than just traditional residential homes. To help meet older people’s desire to stay in the community they must offer preventative and resource help to older people and their carers. They also need to be less isolated from the community generally to reflect resident’s desires not to lose touch. New resources must reflect demand by providing services for people with dementia and people with minor nursing needs. Accessing assessment, information and support is a critical service and could be provided by a resource centre model for new residential accommodation;
Good quality extra care sheltered housing forms a useful alternative to residential care for older people with physical frailties;
New buildings for care of older people must be as flexible in arrangement as possible to meet the changing needs and preferences of users and carers;
The quality of care must continuously improve so that older people who have experienced high quality in other aspects of their lives can continue to do so when they need additional support and assistance because of physical or mental frailty.

3.4 Future demand patterns

Future predicted demand patterns and their implications are shown in detail in the next section. In summary, the strategic implications are:

Significant population growth post 2010 from the WW2 baby boomers;
Continuing service pressure from those over 85 now and for the foreseeable future;
Continuing service pressure from people with cognitive disabilities such as dementia and functional mental illness;
Growing service needs from an ageing black and minority ethnic community, who need services earlier than the white population because of economic deprivation and specific health problems associated with diabetes and other illnesses;
A short-term demographic ‘breathing space’ over the next five or six years from the ‘old elderly’ in their 70’s, which allows time to reorient and reshape services to provide more effective support for people at home;
An imperative described by Wanless\(^3\) to ensure that older people and those working with them are fully engaged with their own health and the opportunities for better health at home, in residential care and in community settings.
Referrals for residential care will involve service users with dementia and nursing problems rather than frail older people and service need to be targeted accordingly.

3.5 Whole system issues

Social Services do not and cannot operate alone. Just as individual need is experienced as indivisible, the service system set up to meet need should be co-ordinated where necessary, integrated where possible and designed to offer a holistic service.

The most important interface areas for the local health, housing and social care system are around:

Ensuring the service system is rebalanced to maintain people at home and ensure they can go home after contact with health services;
Reducing emergency admissions to hospital;
Managing delayed transfers of care;
Looking at the capacity of current sheltered accommodation to support more frail older people - and the potential for extra care housing in Waltham Forest to take pressure away from residential care, acting as an alternative to residential care for the future.
Designing and sited resource centres such that they can support older people in the communities around them, offering advice and outreach services.

These options require concerted action around intermediate care, step down and step up care and the flexibility of packages offered to older people. The process will

\(^3\) Derek Wanless (April 2002) *Final Report- Securing our future health – taking a long term view.*
also require preventative care strategies that allow relatively able older people to manage for longer periods without needing these options. These are areas in which joint work with health colleagues is both vital and potentially mutually beneficial.

In relation to housing and care at home, the Council has sought to diversify its home care usage and develop its extra care housing capacity and processes\(^4\). However, significantly more will need to be achieved in the development of an extra care strategy if the Council is to depend less on residential care options for physically frail older people. Places need to be developed both in existing sheltered housing schemes and as new builds. Extra care services need to be sufficiently robust to manage frail older people, who currently have no choice but residential care.

### 3.6 Current services, policies and regulation

The final strategic consideration is the current stock in housing and the local care market.

As has been identified, current housing stock is in need of modernisation to meet present requirements and future aspirations. The in-house residential service is also under pressure from CSCI to make improvements where it decides to re-register its homes for care of older people with dementia. This process is demographically necessary and financially prudent in the medium term but will have the immediate impact of reducing capacity whilst at the same time increasing staffing costs. Supplemental Extra Care Sheltered Housing will need to be able to manage clients who might otherwise have gone to residential care.

The unusual market in Waltham Forest constrains local action to manage and commission from it efficiently: there are low levels of provision for dementia care, low levels of nursing places and a lack of a broadly based modern corporate capacity, offering larger scale top quality accommodation. Smaller homes may well decide to capitalise on higher property prices and exit the market (the market broadly now takes the view that any home with fewer than 30 beds is not viable). There are also issues concerning the distribution of care homes and the prevailing trend for older people to move northwards in Borough. There is also the inevitable issue of some people choosing to move out of Borough to be nearer sons and daughters or realise retirement ambitions.

Current services clearly require intervention. However, the market and other constraints mean this must be managed carefully and sensitively if older peoples’ needs are to be appropriately met. Commissioners will need to retain sufficient capacity in the interim to manage placement activity and secure change. Links with the private sector will need to be strengthened on this basis and large providers encouraged to think in terms of provision within the area.

This will need to be managed in tandem with a continuing focus on purchasing based on clear Service Level Agreements for all clients. Monitorable SLAs specifying levels of service expected for our clients within the new residential environments will be necessary - and other private and voluntary providers must be treated on an equitable basis.

---

\(^4\) LB Waltham Forest (2005) *Extra Care Housing Strategy*
3.7 The strategic context in Waltham Forest: key issues

Many of the pressures for change experienced by Waltham Forest are also being faced elsewhere: failing stock, a difficult market, increasing BME demands for access to services, stronger regulation and pressures for higher care thresholds from the acute sector.

What is different in Waltham Forest is the constraint imposed by the shape and size of the current market which mean that the Council should be redesigning and reshaping its services to add new modern capacity, albeit at slightly lower volume. It would be very difficult to control the market or manage changing need appropriately without Council sponsored accommodation. It must be reviewed alongside sheltered and extra care housing if a more managed and manageable outcome is to be achieved, continuing to offer local older people choice and independence.

- Demand in Waltham Forest is focussed on people with dementia and people with nursing care needs. New resources must cater for these service users and contribute to helping older people to remain in the community.

3.8 Client needs and demands

This section sets out the estimated demand for specialist accommodation for older people over the planning cycle. We have specifically examined:

- Demographics (age profile)
- Ethnicity
- Dependency
- Social trends

We also examine the supply issues for residential and nursing care in the Borough.

3.9 Demand - Demographics

Figure 3. Over 85s by Gender.
The age profile within Waltham Forest shows modest short-term decreases and progressive increases overtime as the ‘new old’ require accommodation.

- Whilst there can be no certainty about future patterns of care or aspirations for care, it is important that the impact of numbers and the qualities associated with numbers are taken into account in planning future provision.

The key features of the above Fig., can be summarised as follows:

A decrease in all older people 65+ over next five years (-2.4%) 
Small (2%) increase in 65+ over the next 10 years but continued decrease in over 85's (-3%) Modest increases (7%) in 65+ and 85+ (3%) over next 15 years 
Real increases in 20 year's time with ‘new old’ around 15% for 65+ and 85+ 
Increased life expectancy of men changes the profile of need - i.e. higher proportion of single older men living alone.

3.10 Demand – cognitive disability dependency

- Estimates of growth in the numbers of people with a cognitive disability (CD) projected to be living in a home and those living at home who will need intensive levels of support (critical intervals of care) are drawn from material used by the Audit Commission5.

Figure 4. CD In Year 2005

| Age distribution of all people with CD aged 65+ in Waltham Forest 2005 |
|-----------------------------|-------------|---------|---------|-------------|
| 65-74 | 75-84 | 85+ | total 65+ | % all 65+ |
| Number of CD | 304 | 590 | 701 | 1595 | 6.5% |
| % of total 65+ CD | 19% | 37% | 44% | 100% |

5 Audit Commission (2000): Forget me not: mental health services for older people which identifies a model developed by Cambridge University and Cambridgeshire Health Authority as the basis for predicting need.
• The above shows that there will be a growth in total numbers from 1595 in 2005 to 1839 in 2025 (a 15% increase). The proportion per age group will remain the same. The demand for specialist services to meet the needs of this client group will continue to rise. Future developments will need to reflect this.

3.11 Demand – Ethnicity

The key features in terms of considering the ethnicity of the older population can be summarised as follows:
The proportion of older people from BME (Black and Minority Ethnic) communities will increase.
The older BME community generally have higher dependency needs.
The older BME community experience a higher level of family support at present than their white counterparts, with a smaller proportion living either in single occupancy or in pensioner-only households. However, with changing inter generational economic and care patterns this is likely to change to a closer match with the white community.
BME older people needs are higher at an earlier age because of socio-economic factors, social exclusion and poorer health.
Figure 6. GLA Ethnic Group Projections.

GLA Ethnic Group Projections: people over 64 in Waltham Forest

Figure 7. Ethnic Group and Long-Term Illness

Percentage of over 65's reporting a Limiting Long-Term Illness
The ethnic mix within the Borough is very diverse. The non-white population is not dominated by a single ethnic group, although the black Caribbean community is the largest. The very diversity of the BME communities will have implications for the range of supply that will be required.

<table>
<thead>
<tr>
<th>BME Group</th>
<th>Age Bands</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50-59</td>
<td>60-74</td>
<td>75+</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>7%</td>
<td>9%</td>
<td>2%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>5%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Irish</td>
<td>4%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Other White</td>
<td>4%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Indian</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Black African</td>
<td>3%</td>
<td>2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

3.12 Social Trends

The broad social trends in older people within Waltham Forest can be summarised as:

- Much greater heterogeneity of the older population
- Increasing expectations and aspirations of next generations
- Increased consumer awareness and better articulated demand
- Potentially increasing health and wealth
- Greater reluctance to accept institutional care

3.13 Supply

The supply of residential and nursing care in the Borough is characterised by a number of factors, most notably:

- Low levels of nursing care – especially for people with dementia
- Independent sector dominated by smaller suppliers
- CSCI pressure to register for dementia care will impact on size and price base of market in public and private sectors
- Lack of a corporate sector presence in the Borough
Table 3. Residential and Nursing Places in LBWF

<table>
<thead>
<tr>
<th>Places</th>
<th>Places per '000 over 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential - General</td>
<td>416</td>
</tr>
<tr>
<td>Residential - Dementia</td>
<td>91</td>
</tr>
<tr>
<td>Residential - Total</td>
<td>507</td>
</tr>
<tr>
<td>Nursing - General</td>
<td>108</td>
</tr>
<tr>
<td>Nursing - Dementia</td>
<td>83</td>
</tr>
<tr>
<td>Nursing - Total</td>
<td>191</td>
</tr>
<tr>
<td>TOTAL</td>
<td>698</td>
</tr>
</tbody>
</table>

In addition there are 499 sheltered housing units in the borough.

The overall limited supply is further compounded by the generally poor condition of the existing in-house residential provision and the poor state of much general needs housing in the Borough. Locally this is thought to generate a range of pressures on services (primary and secondary health care and social care services).

The primacy of small-scale residential homes in the private sector and the lack of large corporate providers, makes the current market for residential and nursing care within the Borough very unstable. The Local Authority, as a commissioner of long-term care, is not therefore able to guarantee long-term supply from the independent sector.

- However, a relatively high proportion of older people are being supported in their own homes resulting in fewer admissions to institutional care than in many other London Boroughs (see following tables).

Figure 8. Homecare Provision Across London Boroughs
4 AIMS AND OBJECTIVES

There are a number of Key Aims and Objectives for the future of Residential Care these are scheduled below. The future service will need to measure its success against indicators that are generally aligned to these objectives.

Within this context new homes would function as resource centres for their local communities, as benchmarks for providers across London and as an educative and supportive resource for private and voluntary providers within the Borough. Supported by dramatically increased extra care facilities and a broad preventative community health strategy the homes will represent a major contribution to a changed pattern of care for older people in the UK as a whole.

4.1 Excellent environments

- 2 homes, 1 in North and 1 in South of the Borough
- Minimum of 25 years maintained life, with an option on further years
- A resource centre model that allow for rehabilitative care, outreach and advice based services, developments in assistive technology and telemedicine and for support for people at home and their carers, as identified by stakeholders
- Buildings that embody architectural best practice and that facilitate meaningful activities and interaction with the community
- Buildings that maximise potential for sponsorship
- Buildings that allow for unit based living, minimising institutional feel
- Energy saving buildings with minimal destructive impact on the environment
- Buildings that meet and excel CSCI standards, achieving maximum ratings
- Buildings that allow flexibility to develop care for intermediate, dementia or nursing problems for as many beds as necessary, and which allow the management of clients whom the private sector are reluctant to take
- Rooms that allow for developments in personal digital services (e.g satellite TV)
- Buildings that maximise garden space and sense of involvement with community
- Buildings delivered on time and on budget
- Buildings that are recognised as excellent by clients, carers and the industry

4.2 Excellent client care

- Vulnerable clients protected
- No client who meets eligibility criteria declined
- Non-discriminatory environment that allows for maximum personal freedom
- Black and minority ethnic clients offered excellent services
- Mental health, drug and alcohol problems managed effectively
- Advocates available to all clients if required
- Meaningful activities available to all clients
• Counselling available to clients and carers
• Clients spiritual needs acknowledged and accommodated
• Palliative care delivered to the highest standard
• Clients and carers acknowledge excellence of service

4.3 Maximised community outreach
• Number of extra care sheltered housing places increased by a minimum of 76, with a target of 35 located adjoining one of the resource centres.
• Preventative strategies available to much broader community
• 24 hour advice available to carers
• 24 hour outreach care and logistical support (e.g. meals, aids) and emergency admission available to carers and professionals
• Carers services base at both homes
• Client links with community maximised
• Community use of buildings maximised, social space available
• Training provided to private sector
• Counselling services and memory clinics available to dementia sufferers
• Community acknowledges excellence of service

4.4 Excellent management practice
• Staff trained to above industry standard
• Career development available to all staff
• Rehabilitative and diagnostic services in house
• IT systems that allow direct transfer of SAP data to care plans
• Revenue costs minimised and risk spread
• Service Level Agreements that allow for monitoring of service delivery and transparent service delivery
• Staff and visiting care professionals acknowledge excellence of working environment

4.5 Critical Success Factors

The following are viewed as being the CSF for the delivery and future service provision within LBWF.

• Appropriate sites
  - Identification and approval to use two suitable sites within the Borough for the development of two resource centres, within the timeframe of the project

• Appropriate Procurement Route
  - With many options for procurement being available, it is critical to select a modality that is appropriate for LBWF

• Affordability
  - The procurement route selected must deliver the two resource centres within an affordable capital budget.
- The procurement route must identify a service provider that is able to deliver the service model within the available revenue budget.

- **Service Provider**
  
  - An appropriate service provider needs to be identified (through a tender process), that is able not only to meet the service requirements, but embraces the approach to the care model developed by LBWF
  
  - Existing staff that are transferred to the new provider are able to adapt to new ways of working.

- **Members Support**
  
  - With a major change to the way the service will be delivered in the future and the large capital investments required, it is critical that there is full member support for the programme
5 Options Appraisal

In the context of options appraisal, it is necessary to divide the appraisal process into a number of smaller, and specific issues which each in turn will need to be considered and appraised. The key issues in the outline business case, are:

- Site Location
- Procurement Route
- Financial Appraisal

5.1 Site Location

An earlier exercise in site identification was undertaken during November / December 2007, and was presented to the Strategic Investment Board, in order to get their decision on the use of one of the sites identified. It was important to bring that decision forward as the site in question was scheduled for disposal as it was identified as surplus to requirements. The following appraisal covers items included in the SIB report.

5.1.1 Requirements in North and South of the Borough.

The Borough is perceived by its residents and elected members as having a socio-geographic split, broadly across the North Circular. Locating a single resource centre or 2 resource centres in the South of the Borough might have economic advantages but would be perceived by residents and their representatives as unfair and would be likely to cause sustained and vociferous protests.

Older people becoming resident in care homes usually prefer to live relatively close to communities and surroundings with which they are familiar. Many would be uncomfortable with a move across the perceived North/South divide and the likely impact this would have on their social networks.

Relatives visiting relatives in care homes expect not to have to travel substantial distances.

For these reasons, it has been seen as critical to identify two sites, one in the north and one in the south of the borough.
## 5.1.2 Review of the long list of site options

<table>
<thead>
<tr>
<th>North</th>
<th>Site</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chingford Municipal Offices</td>
<td>10,200sqm (net) 11,540sqm (gross)</td>
<td>Suitable for both 90 bed resource centre and up to 50 extra care sheltered homes. 600m to local amenities on Station Road, flat access.</td>
</tr>
<tr>
<td></td>
<td>(CMO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walton House</td>
<td>5,372 sq m net 5,842 sq m gross</td>
<td>Possible site for 75-90 bed resource centre. No extra care sheltered home. Problem with phasing of development and decanting. Immediate access to local amenities.</td>
</tr>
<tr>
<td></td>
<td>Weale Road</td>
<td>Approx 6,500-8,000sqm (Net)</td>
<td>Steeply sloping site. Possible for 75-90 bed resource centre. No extra care sheltered housing. Steep access to local amenities 5-600m distance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depending upon the planning requirements for Friday Hill House.</td>
<td></td>
</tr>
<tr>
<td>Site</td>
<td>Description</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Warwick Road (North) School Site</td>
<td>10,740 sqm (net).</td>
<td>School Currently used as school. Relocation of school planned 2008. Temporary school site for 12 months 2008/9. Would be appropriate for both 90 bed resource centre and extra care sheltered housing. Local amenities very close to site.</td>
<td></td>
</tr>
<tr>
<td>Wood Street Precinct.</td>
<td>6,180 sqm (net)</td>
<td>The present precinct is in need of redevelopment and would accommodate a 90 bed resource centre, though planning would be more complex. Unlikely to be able to accommodate significant number of extra care housing. Planning Authority to determine site density and max height permitted. All local amenities adjacent to site.</td>
<td></td>
</tr>
<tr>
<td>Low Hall Dept</td>
<td>9,576 sqm (net)</td>
<td>Planning have yet to advise on the suitability to locate this residential type use on the site. Would accommodate both a 90 bed resource centre and some extra care housing. Scope to extend the site beyond that identified. Distance to local amenities approx 1 mile.</td>
<td></td>
</tr>
<tr>
<td>Pool and Track</td>
<td>Undefined</td>
<td>The future of the site has yet to be determined by the Council. If the service at that location is deemed no longer required, then this would provide appropriate space for a 90 bed resource centre and extra care sheltered housing.</td>
<td></td>
</tr>
</tbody>
</table>
Whipps Cross | Undefined – Though expected to be sufficient for a resource centre.
| The future of the Whipps Cross Hospital redevelopment is still uncertain and no positive commitment can be given as to what part of the site could be made available to the development of a resource centre.

### 5.1.3 Site Selection Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
<th>Ranking Score (10-1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>Able to accommodate 90 bed resource centre and significant number of extra care sheltered housing (min of 35).</td>
<td>10</td>
</tr>
<tr>
<td>Availability</td>
<td>Is the site available for redevelopment, and if not, when is it expected. (Deduct 2 points for each year delay).</td>
<td>9</td>
</tr>
<tr>
<td>Planning Authority</td>
<td>Acceptance of the proposed use by the Planning Authority</td>
<td>8</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Proximity to public transport links. Bus and Rail.</td>
<td>7</td>
</tr>
<tr>
<td>Amenities</td>
<td>Proximity and ease of access to local neighbourhood amenities: shops, libraries, pubs etc..</td>
<td>6</td>
</tr>
<tr>
<td>Location within Borough</td>
<td>Location of the site within the overall borough wide strategy for a northern or southern base.</td>
<td>5</td>
</tr>
</tbody>
</table>
5.1.4 Site Scoring

Some minor revisions have been made to the scoring values associated with the sites since the submission to the SIB. This is based on the following factors:

- Further consultation with the Programme Board over the limitations for locating a Resource Centre close to the North Circular.
- Proposed use of Aveling School by Children’s Services beyond 2008.
- Delays in getting both formal and informal response from the Whipps Cross Hospital Trust concerning the future redevelopment options at the site has resulted in this option being scored low. This was not considered in the earlier SIB report.

5.1.5 Preferred Sites

The analysis indicates that the preferred sites are:

**North of the Borough:** CMO. SIB have indicated formal approval for the use of this site. Cabinet approval will be sought at the June Cabinet. This site would be suitable for 35 Extra Care Sheltered Housing units. Additional beds could be provided in the resource centre taking the total from 90 to approximately 120. This would enable the service to generate some additional income. This latter fact is very important as the financial analysis demonstrates that the available budget will only just cover the cost of the development and operations excluding service providers profit.

**South of the Borough:** Wood Street Precinct. Early consultation with the Planning Authority, indicate that this site would be appropriate for a Resource Centre as part of the overall redevelopment of the Precinct area and the Wood Street Corridor. The site will be submitted to SIB for consideration. The planning authority are in the process of commissioning a study into the area to determine how best they can regenerate this area, and there maybe some delays in waiting for this consultancy to be completed. However, there is strong interest in the resource centre in the location as it will be able to act as an initial catalyst to support the overall redevelopment.
<table>
<thead>
<tr>
<th>Location</th>
<th>Size Score</th>
<th>Rank</th>
<th>Availability Score</th>
<th>Rank</th>
<th>Planning Score</th>
<th>Rank</th>
<th>Accessibility Score</th>
<th>Rank</th>
<th>Amenities Score</th>
<th>Rank</th>
<th>Location Score</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMO</td>
<td>9</td>
<td>10</td>
<td>90</td>
<td>10</td>
<td>90</td>
<td>9</td>
<td>72</td>
<td>8</td>
<td>7</td>
<td>56</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Walton House</td>
<td>4</td>
<td>10</td>
<td>40</td>
<td>4</td>
<td>9</td>
<td>36</td>
<td>72</td>
<td>8</td>
<td>7</td>
<td>56</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Weale Road</td>
<td>6</td>
<td>10</td>
<td>60</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>56</td>
<td>4</td>
<td>7</td>
<td>28</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Warwick School</td>
<td>9</td>
<td>10</td>
<td>90</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>72</td>
<td>8</td>
<td>7</td>
<td>56</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Wood St Precinct</td>
<td>7</td>
<td>10</td>
<td>70</td>
<td>9</td>
<td>9</td>
<td>81</td>
<td>72</td>
<td>8</td>
<td>7</td>
<td>56</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Low Hall</td>
<td>8</td>
<td>10</td>
<td>80</td>
<td>7</td>
<td>9</td>
<td>63</td>
<td>56</td>
<td>5</td>
<td>7</td>
<td>35</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Aveling Park School</td>
<td>9</td>
<td>10</td>
<td>90</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>64</td>
<td>7</td>
<td>7</td>
<td>49</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Pool &amp; Track</td>
<td>9</td>
<td>10</td>
<td>90</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>64</td>
<td>7</td>
<td>7</td>
<td>49</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>9</td>
<td>10</td>
<td>90</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>64</td>
<td>7</td>
<td>7</td>
<td>49</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
5.2 Procurement Routes

The appraisal process has considered three main routes to procure the development of the resource centres and the service delivery. Earlier studies have identified various options, however, they did not investigate the complexity of these options or test the relevance in the market. The first two options are both variations of Public Private Partnerships, though the PFI route is considered under its own heading. The three options are:

- Private Finance Initiative: PFI using the local LIFTco.
- Public Private Partnership.
- Public Sector.

5.2.1 PFI and LIFTco

This approach has been made more relevant to small-scale developments within health, with the Ministry of Health extending PFI credits to smaller scale projects. Discussions have been conducted with the local LIFTco and financial models prepared by them for an investment in the Borough. As part of the market testing, a visit was made to Medway Council to assess their progress with this approach.

5.2.1.1 Factors to consider with LIFTco.

- Minimum contract values of £25m in order to access the PFI credits. This includes VAT, though excludes land values.
- The construction costs would need to exceed £1800/m2, for the overall cost of development will reach the target £25m necessary to justify the PFI credits.
- Not appropriate for contracts that seek to bundle the service delivery with the building procurement. Thus, whilst a long-term service contract could be procured, this will need to be in a separate contract. It is more appropriate to procure short / medium term service contracts.

5.2.1.2 Advantages:

- PFI Credits might be available from the Department of Health.
- No need to follow the OJEU procurement route as the LIFT partner is pre-approved. In reality, this advantage is only minor, since the OJEU notification periods can be accommodated within the programme with little difficulty.
5.2.1.3 Disadvantages:

- Shorter service contracts with limited capital investment will make this approach attractive to the many smaller companies and charity organisations.

- Cost associated with legal and financial consultancy services can be very high.

- PFI process can be lengthy and outweigh the simplified tender advantage.

- The experience of Medway, indicated projected outturn costs that gave bed costs per week of £750+ after credits were included, this is above the target affordability cap set by LBWF.
5.2.2 Public Private Partnership

Market testing has demonstrated a strong interest in this approach from the market leading service providers. Early discussions indicate that private sector companies aim to construct the building structure for £1200-£1250/m².

The duration of the service contract is expected to be up to 25 years, the greater the financial commitment, the greater the duration.

The degree of partnership can range from:

<table>
<thead>
<tr>
<th>Option</th>
<th>LBWF</th>
<th>Partner</th>
</tr>
</thead>
</table>
| 1. Traditional Design and Build | • Supply sites and retain freehold ownership of Resource Centre sites, whilst transferring ownership of site for housing.  
• Finance the construction. | • Design, build, operate and maintain.  
• Revenue charge to LBWF for operation and maintenance.  
• Purchase of land for housing to be off set against construction of Resource Centres.  
• Service agreement approximately 10-25 years. |
| 2. Lease and Leaseback | • Supply sites and retain freehold ownership Resource Centre sites, whilst transferring ownership of site for housing.  
• Short head lease granted to partner for construction period and 25 year service period.  
Variation of terms:  
• Transfer ownership of sites to partner for duration of | • Design, build, finance, operate and maintain.  
• Lease-back to LBWF and charge lease for building payback, operation and maintenance.  
• Purchase of land for housing to be off set against construction of Resource Centres.  
• Service agreement 25 years.  
Variation of terms:  
• Design, build, finance, own, operate, maintain and transfer. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispose of sites to partner. Full market price.</td>
<td>Design, build, finance, own, operate and maintain.</td>
</tr>
<tr>
<td>Option to acquire development at end of service agreement.</td>
<td>Option to sell to LBWF on termination of service agreement.</td>
</tr>
<tr>
<td>leasing back during service agreement.</td>
<td>Service Agreement: 25 years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Deferred Sale and Leaseback with additional developments</th>
<th>Service Agreement: 25 years+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invest into special project vehicle (SPV).</td>
<td>Invest into SPV.</td>
</tr>
<tr>
<td>SPV Inputs: Transfer ownership of two development sites and remaining care home sites</td>
<td>SPV Inputs: Design, build, finance, own, operate and maintain.</td>
</tr>
<tr>
<td>Transfer income from disposal of care homes in 2008/9.</td>
<td>Ownership of Resource centres reverts to LBWF at the end of service agreement.</td>
</tr>
<tr>
<td>SPV pays Corporate for the two development sites, deferred until the sale of the competed housing developments.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Design and build with additional developments</th>
<th>Service Agreement 25 years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination of 1 and 4 Using the SPV for the development of the remaining care home sites. LBWF would contribute the land value as project company equity. Assumed rate of return 15%.</td>
<td>Design, Build, Finance (Housing sites only), operate.</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>

Page 188
5.2.2.1 Extra Care Sheltered Housing

It is proposed that on one of the sites a minimum of 35 extra care sheltered houses are provided by the development partner. The partner will be given the right to exploit the full development potential of the site. Additional housing units are expected to be developed giving the partner additional development profit potential and increasing the value of the site. LBWF will include an overage clause to ensure it benefits in any increase in site value. No additional funding will be provided by LBWF. Two possible options for the delivery of ECSH are outlined below:

Option 1.
- The partner will be required to identify an RSL with grant funding to support the development and management of the ECSH. Units will be rented to users on the basis of needs assessment.

Option 2.
- The ECSH to be provided will be for disposal on the market with conditions limiting the occupancy to persons meeting the criteria for ECSH support. This will require clear criteria on the future disposal options for the owners of the apartments.

5.2.2.2 Special Purpose Vehicle

One scenario that can be investigated during the pre-tender dialogue period is that of establishing a Special Purpose Vehicle in partnership with the developer. The SPV could be used to exploit the development potential of the existing care home sites. The major risk in the financing of the project, that of the final disposal income from these existing care homes, could be reduced by a forward commitment from the partner at the formation of the SPV.

5.2.2.3 Advantages
- Single tender process.
- The sharing of risk and reward, will give a greater incentive to the development partner to drive down cost.
- The procurement process will attract the major companies within the care industry. In a fragmented market, this will provide greater long-term certainty over the nature of the partner.
- The service provider is involved at the onset in the design and specification of the buildings, thus ensuring limited operational problems relating to the buildings.
5.2.2.4 Disadvantages

- All capital for the project to be found by the partners with no central government credits.
- SPV would involve complex legal drafting.

5.2.3 Public Sector

This procurement route involves LBWF entering into two contracts:


5.2.3.1 Advantages

- Increases the number of service providers that could tender due to the limited financial commitments.
- Short – medium term service contracts provide greater control and flexibility in service specification.
- Least complex legal arrangements.

5.2.3.2 Disadvantages

- Limited input into the Resource Centre design and operational plan from the future service provider. This could be overcome with a stage 1 service tender, however, future providers would be presented with a fixed design building.
- Lack of financial commitment by the service provider, with all capital being supplied via LBWF.
- Stage 1 tender would attract many smaller companies and care organisations that might be, or become vulnerable to future takeovers in a very fragmented market.
5.2.4 Summary

- PFI and LIFT are not an option. LBWF do not fit the desired criteria. The next round of applications is not expected until Spring 2010, by which time LBWF plan to be on site with at least one of the resource centres.

- The Public Sector Route is effectively the same as option 1 in the PPP, though carries greater risk.

- The Public Private Partnership route fits the criteria and objectives of LBWF, can mitigate our risk exposure and allows the partner to bring their fullest expertise into both the delivery of the infrastructure and the service. These options will be explored in detail.
5.3 Procurement Programme

See programme Gantt Chart.

The programme is ultimately dependent upon the form of procurement selected. The programme submitted is indicative of that required to deliver as a Public Private Partnership, using the Competitive Dialogue Process. This gives greater opportunity to discuss the development ideas with prospective contractors prior to entering into a formal contract. It is proposed to submit a Prior Information Notice (PIN), to OJEU during May, in order that the reduced OJEU notice periods can be adopted for the tender stages.

PLEASE NOW REFER TO APPENDIX 2 WHICH CONTAINS SECTION 6 OF THE REPORT EXEMPT INFORMATION
Conclusions and Recommendations:

(1) The preferred procurement route is that of a Public Private Partnership, where the partner is invited to participate in the redevelopment of the resource centres, Extra Care Sheltered Housing and the existing care home sites, in addition to providing the service delivery. The scope of the partnership will be best investigated during the Competitive Dialogue stage of the tender process.

(2) The proposed Residential Care Home Reprovision Programme is demonstrated to be affordable based on current prices, and would leave approximately £400k of surplus which should cover the service providers profit. This figure is only achievable in the baseline conditions, and any negative change in the project risks will reduce this cover.

(3) Mitigating actions are demonstrated to be sufficient to cover for changes in the risk profile and could be implemented if appropriate. In the ‘worst case’ scenario, the available surplus would be limited to approximately £200k, which at just under 7% of OPEX, would perhaps only be attractive to the Charitable service sector.

(4) The proposed sites of: CMO, and the Wood Street Precinct, should be presented in the Cabinet Report, in order to formally gain approval for the use of these resources. The Wood Street site will need to be presented to the May Strategic Investment Board, and also have the Planning Authority prepare a detailed brief for the whole Wood Street Corridor.

(5) A Prior Information Notice for the project should be submitted to OJEU, in order that reduced notice periods for procurement can be followed. This will allow an earlier start date and thus help to mitigate construction cost price increases.

(6) The procurement should follow the Competitive Dialogue route in order to investigate cost engineering and negotiate the best delivery options with prospective bidders.

(7) The Planning Application should be left until the development partner has been selected and the proposed scheme approved, this will ensure that the site utilisation is maximised, as the developer will be able to negotiate greater densities on the sites, and thus reduce the land costs and increase disposal values. Further, the proposed development will be subject to inputs from bidders which are expected to vary and will influence material selection, layouts and density.

(8) System building should be considered as a construction option; this would reduce the development cost and control construction risk.

(9) The partners in the proposed resource centre should be required to commit to the project and develop their requirement brief prior to inviting architects to prepare the overall scheme.
1. SUMMARY

This report looks at the Work Programme for the Health, Adults & Older People’s Overview and Scrutiny Sub-Committee for the forthcoming Municipal year, and invites Member suggestions regarding additional topics for Scrutiny for the period up until the end of this municipal year.

2. CONTEXT

2.1. The Committee is required to take an overview of the work being undertaken by the Council in those areas that fall within the Committee’s remit as well as the decisions being taken by the Cabinet and Portfolio Holders with regard to this work. As part of this process, and as an extension to it, the Committee may scrutinise this work to the degree it feels appropriate ranging from asking for information, calling for reports, to requesting that a sub-group or panel be formed to conduct an investigation into issues of benefit or concern covered by its remit.

2.2. Overall, the Committee’s work should have regard for the policy priorities that have been agreed by the Council. Though open to review and change, the priorities are intended as broad objectives to be attained by rolling three-year plans for service provision by each directorate and department. For the current year and up to 2010, the Council’s overriding priority is to improve residents’ quality of life by adopting six specific priorities aimed at improving: -

- The safety and quality of the environment through decreased crime
- The health and well-being of local people
- Learning opportunities and help for individuals to achieve their potential
- The local economy and infrastructure
- Community understanding and participation
- Working for Waltham Forest

2.3. Whilst considering these priorities, the Committee should also be mindful of how the Council’s services, procedures and methods meet the criteria for the Comprehensive Performance Assessment (CPA).
3. SELECTION OF TOPICS FOR SCRUTINY

3.1 In the formulation of the Work Plan Members may select subjects for Scrutiny from a number of sources (some of which are detailed below), and while this could provide a huge workload for the Committee this, in practice, will be limited by the number of meetings and amount of time available for discussion.

- Existing Member commitments
- Departmental/Service Budgets
- Service Plans
- The Cabinet Forward Plan of Business
- The Sustainable Community Strategy
- Additional Topics chosen by Members

3.2 Service Plans
Each directorate and service department produces an Annual Service Plan as part of the three year rolling plan. The annual service plan sets out the services provided, the departmental objectives, and an assessment of what has, or has not, been achieved in the past year. It then goes on to explain how the service will address the Council’s priorities by setting out what it will do (what ‘actions’ will be taken) during the current year, how each action will be assessed and to what timescale. The plan shows how people in the Borough will be informed and consulted with regard to the actions; what degree of risk has to be anticipated; whether there are budgetary considerations, and; how diversity issues are addressed. In addition, the plan shows how the service will meet national and local performance indicators, in particular those for Comprehensive Performance Assessment (CPA) and Best Value.

3.3 Cabinet Forward Plan
The purpose of the Forward Plan is to show the matters to be reported to Cabinet and the Key Decisions that the Cabinet will have to take. The Forward Plan is produced each month and looks ahead to the Cabinet business falling within the next three months.

Notwithstanding this fact, the scrutiny of Cabinet reports has thrown up a number of difficulties, namely

- Timescale problems when attempting to consider issues before Cabinet
- Format and content issues where Cabinet reports are merely re-badged for Scrutiny
- Changes to the forward plan removing the necessity to report

In certain instances, Cabinet have postponed taking a report so that it can come to the Committee first. This, though, is an ad-hoc arrangement, as is the reverse situation where Officers ask the Committee to consider their reports before sending them to Cabinet.

3.4 Members’ Own Choice of Topics
The selection of topics of investigation by Members is a matter for Members alone, although they are heavily influenced by factors mentioned above. Distinct from this is the opportunity for Members to make their own proposals for the investigation of other issues.
From the outset, the scrutiny process has been open to Members to make their own proposals regarding topics to be examined and the manner of so doing. There are some general criteria for determining the appropriateness of a topic.

- First of all, it should be significant and relevant.
- It should be an issue over which the Council has responsibility and control, or real influence through a partnership, and
- It should be of potential benefit to the Borough having regard for the Council’s priorities.

Therefore, a topic should not be an individual query or ward matter unless Members agree that it raises issues of sufficient importance to meet the above criteria. An example of a Work Plan Prioritising Toolkit is attached for Members consideration - Appendix A refers. Also attached is The Centre for Public Scrutiny’s Good Scrutiny Guide and Guide for Prioritising Topics for Scrutiny – Appendix B refers.

4. METHOD

The report above has alluded to different ways in which Members can carry out their overview and scrutiny role. Any consideration of the options available to Members has, though, to begin with the existing committee structure. The legislative changes setting up the executive and scrutiny structure were premised upon scrutiny performing a parallel role to the parliamentary select committees. In contrast, experience indicates that it has been difficult move away from the former committee pattern to the investigative and interrogatory role implicit in scrutiny.

Whilst it does not fall within the powers of the Committee to alter the present scrutiny structure, it is possible for Members to consider adopting a more investigative style. There are a number of ways that this might be achieved by an individual committee and the suggestions that follow are unlikely to be exhaustive.

4.1 Committee’s Own Reports

The Committee can, simply, call for a report on any relevant issue of its own choosing. It would need to carefully define the request and be clear about the reasons for asking Officers, Executive Members or Partners to give evidence.

4.2 Themes

A theme would be an issue that was considered over an extended period of time, perhaps over several meetings. It might take a number of forms; one might be taking an issue on which several agencies reported over time. Another could be to follow an on-going Council policy or service development with stage reports.

4.3 Sub-groups

The Committee can establish a formal sub-group of itself; one or two Members with a particular commitment to pursuing an issue could, on behalf of the Committee, undertake some research or other inquiry and then report back to the Committee which would decide on any further action.
4.4 Panels
A well-tried procedure for in-depth investigations, the Committee can set up a particular panel, which will then report to the Management Committee when it has concluded its investigation.

4.5 Information Requests
As a preliminary or alternative to reports being presented at Committee meetings, the Committee, or Members through the Chair, can ask Officers to provide information relating to the Committee’s remit. From the information received, Members can decide whether they wish to pursue the matter further and in what way, by placing the topic on the agenda of a future meeting.

4.6 Cabinet Reports
The Committee needs to continue to try and consider key Cabinet reports which concern matters within the Committee’s remit. The difficulties in scrutinising such reports have been discussed earlier.

4.7 Oral Hearings
The committee could follow the select committee example and call individual witnesses to answer questions. This is a procedure that has been adopted by panels and occasionally by earlier committees. It does though need careful preparation, with particular Members to lead on the questioning.

5. CONCLUSION
The above are only a selection of methods. A number of these suggestions could be used in combination. The Committee might also like to try one or two additional approaches when scrutinising particular topics. In so doing, the Committee will have to have regard for the degree to which the Scrutiny unit can support the work. The Draft Work Programme attached as Appendix C was formulated by the Forward Plan Working Group of the Committee at its last meeting held on 20th May 2008. Also attached as Appendix D are suggestions received to date from Members of the Committee and Topics not yet Allocated from the previous Municipal Year. The Committee may wish to amend the plan, but should have regard for those topics that have been suggested, both to avoid duplication and to ensure that outstanding matters are followed up.

The Committee is requested to consider the above report and decide whether it wishes to modify or confirm the Draft Work Programme.
APPENDIX A
Scrubiny Work Plan Prioritising Toolkit

Does this issue have a potential impact for one or more section(s) of the population of Waltham Forest?

YES

Is the issue strategic and significant?

YES

Will the scrutiny activity add value to the Council's, and/or its partners', overall performance?

YES

Is it likely to lead to effective outcomes?

YES

Will Scrutiny involvement be duplicating some of the work?

NO

Is it an issue of concern to partners and stakeholders?

NO

Is it an issue of community concern?

NO

Are there adequate resources available to do the activity well?

YES

Is the Scrutiny activity timely?

YES

PUT INTO WORK PROGRAMME
High Priority

NO

CONSIDER
Low Priority

NO

LEAVE OUT
the good scrutiny guide –
four principles of effective scrutiny

effective public scrutineers...
1. provide ‘critical friend’ challenge to executives as well as external authorities and agencies
2. reflect the voice and concerns of the public and its communities

<table>
<thead>
<tr>
<th>roles and relationships</th>
<th>process and practice</th>
<th>skills and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• constructive, robust and purposeful challenge to prompt executive reflection on policy development and decision-making</td>
<td>• constructive working arrangements supported by clear rules of engagement</td>
<td>• objective questioning</td>
</tr>
<tr>
<td>• mutual respect and 'parity of esteem' for the scrutiny function as a legitimate check on executive arrangements in exercising public accountability</td>
<td>• co-ordinated workload planning integrated into corporate processes</td>
<td>• inclusive, focused chairing</td>
</tr>
<tr>
<td>• partnership approach with 'external' agencies and authorities</td>
<td>• reporting and monitoring mechanisms to follow up recommendations made</td>
<td>• access to information and expert advice</td>
</tr>
<tr>
<td>• focused and proactive policy development in collaboration with executive colleagues</td>
<td>• non-aggressive physical environment and behaviours to create optimum conditions for investigative evidence-based process</td>
<td></td>
</tr>
</tbody>
</table>

• ensuring an ongoing dialogue with the public and its diverse communities where the voice of the public is heard and responded to
• taking a community leadership role by focusing on issues of community concern
• constructive relationships with press and media
• careful management of public expectations of change

• open and transparent processes with public access to information
• meetings conducted in public which invite public participation and 'active citizenship'
• innovative public communication, consultation and feedback
• create the conditions for plural views and concerns to be taken into account, particularly those of minority groups

• active listening and sympathetic questioning
• adequate resourcing for public dialogue mechanisms
• professional communications advice and support

For full details of The Good Scrutiny Guide and other CfPS publications, please visit www.cfps.org.uk
## the good scrutiny guide –
### four principles of effective scrutiny

<table>
<thead>
<tr>
<th>roles and relationships</th>
<th>effective public scrutineers...</th>
<th>effective public scrutineers...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3. should take the lead and own the scrutiny process on behalf of the public</td>
<td>4. should make an impact on the delivery of public services</td>
</tr>
<tr>
<td></td>
<td>• independence from the executive legitimated by the assembly, legislature or council</td>
<td>• promote community well-being and improve the quality of life</td>
</tr>
<tr>
<td></td>
<td>• champions of the value and potential for scrutiny and active promotion of its status and credibility</td>
<td>• strategic quality assurance on behalf of the public</td>
</tr>
<tr>
<td></td>
<td>• active engagement in committee, with the public and colleagues</td>
<td>• strategic scrutiny of corporate policies, plans and budgets</td>
</tr>
<tr>
<td></td>
<td>• constructive working partnership with professional officers and advisers in support of the ‘lay’ scrutineer</td>
<td>• co-ordinated and strategic reviews of policy and service performance in line with strategic objectives</td>
</tr>
<tr>
<td></td>
<td>process and practice</td>
<td>monitoring service performance against key indicators</td>
</tr>
<tr>
<td></td>
<td>• arrangements in place to ensure active engagement of scrutineers in the scrutiny process</td>
<td>• strategic scrutiny of corporate policies, plans and budgets</td>
</tr>
<tr>
<td></td>
<td>• ensure adequate public representation and, where appropriate, political balance</td>
<td>• co-ordinated and strategic reviews of policy and service performance in line with strategic objectives</td>
</tr>
<tr>
<td></td>
<td>• create conditions for deliberation and consensus building</td>
<td>• monitoring service performance against key indicators</td>
</tr>
<tr>
<td></td>
<td>• independent work programme informed by interests and concerns of scrutineers on behalf of the public</td>
<td>• strategic scrutiny of corporate policies, plans and budgets</td>
</tr>
<tr>
<td></td>
<td>skills and support</td>
<td>• co-ordinated and strategic reviews of policy and service performance in line with strategic objectives</td>
</tr>
<tr>
<td></td>
<td>• deliberative skills and consensus building</td>
<td>• monitoring service performance against key indicators</td>
</tr>
<tr>
<td></td>
<td>• reflect on the process, learn from experience and innovate</td>
<td>• clear understanding of the distinction between strategic and operational performance review</td>
</tr>
<tr>
<td></td>
<td>• acknowledged professional officer support for the ‘lay’ scrutineer</td>
<td>• access to timely and accurate performance information</td>
</tr>
<tr>
<td></td>
<td>• appropriate training and development</td>
<td>• analysis and interpretation of performance data</td>
</tr>
</tbody>
</table>

For full details of The Good Scrutiny Guide and other CfPS publications, please visit www.cfps.org.uk
Wednesday, 4th June 2008 at 7.30 p.m. Council Chamber, Waltham Forest Town Hall

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>MATTER FOR REVIEW OR INVESTIGATION</th>
<th>LEAD DEPT: (REPORT AUTHOR)</th>
<th>CHAIR’S COMMENTS/PROGRESS/ACTION TO BE TAKEN</th>
<th>DEADLINE FOR REPORTS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pan London Darzi Healthcare for London JOSC Report</td>
<td>WF PCT</td>
<td>Update to Committee – For Noting</td>
<td>21/05/08</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Commissioning Strategy Cabinet Report</td>
<td>Adult &amp; Community Services</td>
<td>Update to Committee</td>
<td>21/05/08</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Residential Home Care Reprovision Cabinet Report</td>
<td>Adult &amp; Community Services</td>
<td>Update to Committee</td>
<td>21/05/08</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Annual Forward Work Programme 2008/2009</td>
<td>Scrutiny</td>
<td>To Discuss &amp; Update</td>
<td>21/05/08</td>
<td></td>
</tr>
</tbody>
</table>

CORE PROGRAMME 2008/2009 - DATES TO BE ALLOCATED: -

Services for Carers (Health & Social Care) – Young Carers’ Panel and/or Joint Meeting with Children and Young Person’s Overview Scrutiny Committee – 3 Trusts to be invited & WF Adult & Social Care Directorate

Commissioning (PCT) – Issues around choice, acute ?, general practice, social care, primary care, specific care pathways, out of hospital care etc

Transforming Social Care – Implementation of Policy in Waltham Forest context and how the agenda is driven through the Council

Primary Care Trust – (a) Commissioning Strategy Plan (b) PCT Operating Plan (c) Future of PCT Provider Services (d) Next Stage of Healthcare for London i.e. issues around: - Trauma centres, Stroke services, Maternity, Improving Primary Care i.e. Polyclinics or Polyclinic Pilot (e) Annual Public Health Report (f) Healthcare Commission Annual Health Check

THIS WORK PROGRAMME CAN CHANGE AT SHORT NOTICE.

Members of the public should contact Gytha Chinweze before attending a meeting to ensure their item of interest is on the agenda.

Contact details: Gytha Chinweze, Scrutiny Unit, Room 101, Town Hall, Forest Road, Walthamstow, London E17 4JF
E-mail: Gytha.chinweze@walthamforest.gov.uk Tel: 020 8496 4208 Fax: 0208 496 4579 AGENDAS & MINUTES online at www.walthamforest.gov.uk
Health, Adults and Older People’s Overview and Scrutiny Sub-Committee:
Draft Core Work Programme 2008/09 Updated: 21st May 2008

<table>
<thead>
<tr>
<th>Age is Just A Number</th>
<th>– A refreshed version of what has been achieved through the Corporate Strategy (Annual Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Area Agreement &amp; Sustainable Community Strategy</td>
<td>- Performance Indicators and Objectives (Health &amp; Social Care)</td>
</tr>
<tr>
<td>Host Arrangements for LINK’S</td>
<td>– Reporting to Scrutiny and the Working Arrangements</td>
</tr>
</tbody>
</table>

THIS WORK PROGRAMME CAN CHANGE AT SHORT NOTICE.
Members of the public should contact Gytha Chinweze before attending a meeting to ensure their item of interest is on the agenda.

Contact details: Gytha Chinweze, Scrutiny Unit, Room 101, Town Hall, Forest Road, Walthamstow, London E17 4JF
E-mail: Gytha.chinweze@walthamforest.gov.uk Tel: 020 8496 4208 Fax: 0208 496 4579 AGENDAS & MINUTES online at www.walthamforest.gov.uk
<table>
<thead>
<tr>
<th>FUTURE PROGRAMME – ITEMS IDENTIFIED BUT NOT TAKEN UP DURING 2007/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The 2006 WF Public Health Report.</strong> This will cover issues identified by members as causing concern, for example tuberculosis, infant mortality and post and ante-natal depression. A meeting is being hosted by the Council where the Director of Public Health will present her findings; all members of this committee will be invited to attend.</td>
</tr>
<tr>
<td><strong>Timescale for Whipps Cross’ Foundation Trust Status</strong> – not to be allocated as such but Committee to keep a watching brief on progress and for the Chief Executive to present a report to the Committee at an appropriate time.</td>
</tr>
<tr>
<td><strong>Delivering 18 weeks.</strong></td>
</tr>
<tr>
<td><strong>Suggested by the PCT</strong> – Quality of Primary Care and Training on Standards for Better Health.</td>
</tr>
<tr>
<td><strong>Choose and Book System – PCT and Whipps Cross Hospital</strong> – Why is this not working properly and measures that are being put in place to improve matters.</td>
</tr>
<tr>
<td><strong>Social Care issues</strong> – Committee to keep a watching brief on the inclusion of social care issues in an otherwise Health dominated Work Programme.</td>
</tr>
<tr>
<td><strong>Young Carers Scrutiny Panel</strong> – chair to take this proposal to Overview and Scrutiny Management Committee for formal approval to convene a Panel (likely to be in September).</td>
</tr>
<tr>
<td><strong>Equalities</strong> – excluded BME communities. <strong>The WF Preventative Model.</strong> – Report to be presented by the Council and Age Concern.</td>
</tr>
<tr>
<td><strong>Learning Disabilities – The Time Bomb</strong> - Item suggested by Cllr O’Rourke, chair of CYP 8.10.07</td>
</tr>
<tr>
<td><strong>Healthcare for London – The Recovery and Well Being Model</strong> – Report to be presented by the PCT.</td>
</tr>
</tbody>
</table>

**THIS WORK PROGRAMME CAN CHANG- E AT SHORT NOTICE.**

Members of the public should contact Gytha Chinweze before attending a meeting to ensure their item of interest is on the agenda.

**Contact details:** Gytha Chinweze, Scrutiny Unit, Room 101, Town Hall, Forest Road, Walthamstow, London E17 4JF

**E-mail:** Gytha.chinweze@walthamforest.gov.uk

**Tel:** 020 8496 4208 **Fax:** 0208 496 4579 **AGENDAS & MINUTES** online at: www.walthamforest.gov.uk
<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitors – Joint Scrutiny with the Young People’s Scrutiny</td>
</tr>
<tr>
<td>The 3-Year Better Neighbourhood Initiative by Dr Foster</td>
</tr>
<tr>
<td>An Evaluation of the Health Impact Programme and its Outcomes</td>
</tr>
<tr>
<td>Night Cover for Palliative Care at Whipps Cross Hospital</td>
</tr>
<tr>
<td>Integrated Service for Perinatal/Antenatal and Postnatal Depression</td>
</tr>
<tr>
<td>Service Provision for Diabetes and whether Self - Management Works</td>
</tr>
<tr>
<td>Practice Based Commissioning (GPs)</td>
</tr>
<tr>
<td>Proposed Closure of the Kirkdale Centre, Leytonstone</td>
</tr>
<tr>
<td>The London Ambulance Service</td>
</tr>
<tr>
<td>Dentistry – Issues around costs for NHS Patients and Adults</td>
</tr>
<tr>
<td>Residential Care Visits – To arrange visits to the borough’s</td>
</tr>
<tr>
<td>residential care facilities in view of the current plans to build</td>
</tr>
<tr>
<td>new ones and visits to other facilities to see what innovative</td>
</tr>
<tr>
<td>models of design are out there in terms of residential care/extra</td>
</tr>
<tr>
<td>sheltered housing.</td>
</tr>
<tr>
<td>Access to Social Care Services in Waltham Forest</td>
</tr>
<tr>
<td>The Implications of the former Disability Rights Commission Report</td>
</tr>
<tr>
<td>on Access to Health Services for People with Learning Difficulties</td>
</tr>
<tr>
<td>and/or Mental Health Issues, for Health Services in the Borough.</td>
</tr>
</tbody>
</table>

This work programme can change at short notice. Members of the public should contact Gytha Chinweze before attending a meeting to ensure their item of interest is on the agenda. Contact details: Gytha Chinweze, Scrutiny Unit, Room 101, Town Hall, Forest Road, Walthamstow, London E17 4JF. E-mail: Gytha.chinweze@walthamforest.gov.uk. Tel: 020 8496 4208. Fax: 0208 496 4579. AGENDAS & MINUTES online at: www.walthamforest.gov.uk.