The consultation document *Healthcare for London - Consulting the capital* \(^1\) was launched on 30 November 2007. It outlines ways in which health services in London could be changed over the next ten years and asks for views.

This paper sets out a consultation response (for the Royal Borough) in Appendix A. A draft response was circulated to all OSC on Health colleagues for their input and comment.

**FOR DECISION**

1. **CABINET RESPONSE**

1.1 Cllr Fiona Buxton is the Cabinet Member responsible for the Borough's consultation response. The final deadline for responding to this consultation is 7 March 2008. A consultation response will need to be sent to email: consultingthecapital@ipsos-mori.com

2. **JOINT OVERVIEW AND SCRUTINY COMMITTEE**

2.1 Councillor Buckmaster has been appointed as the Royal Borough's representative on the Joint Overview and Scrutiny Committee of all London Boroughs (JOSC). The attached consultation response can be fed into this work before the deadline is 29 February 2008.

3. **RECOMMENDATION**

3.1 This paper seeks approval (with any additional suggestions) for the consultation response as set out in Appendix A.

**FOR DECISION**

**Background papers used in the preparation of this report:** None apart from those mentioned.

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APPENDIX A:

CONSULTATION RESPONSE
HEALTHCARE FOR LONDON – CONSULTING THE CAPITAL
THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

1. WELCOME FOR HEALTHCARE FOR LONDON

1.1 In the interest of patient care, there is a strong case for changing how some services are provided in London over the next ten years.

1.2 A great deal in Healthcare for London is to be welcomed: its emphasis on outcomes, the experience of patients, and inequalities, as well as its search for a solid evidence base to drive decisions about health care services. The plan has the potential to transform London’s stroke and Chronic Obstructive Pulmonary Disease (COPD) services for the better. We endorse the general five principles for the models of care put forward in the consultation document and direction of travel they signal.

Healthcare for London outlines five principles underpinning change:

i) Services should be focused on individual patients' needs and choices, and patients should feel in control of their care;

ii) Routine healthcare should take place as close to the patient’s home as possible, while more complex care should be centralised in specialised units to ensure high standards;

iii) There must be better communication between the community and hospital branches of the NHS, and between health and social care services, to prevent patients "falling between the gaps" in provision;

iv) Preventing people falling ill in the first place should be integral to everything the NHS does;

v) Change should focus on tackling health inequalities in the capital, and new facilities should be located in areas of greatest health need.

1.3 However, this endorsement does not pre-empt our response to any specific proposals for changes which we will consider on a case by case basis.

2. EVIDENCE BASE
2.1 The Healthcare for London evidence-base is incomplete in some areas (polyclinics are an untried model for delivering healthcare in the UK, which have faced public opposition where there have been attempts to introduce them [e.g. plans to amalgamate GPs surgeries in Warrington] and how much evidence is there that polyclinics are the answer for every locality?) or absent in others (there are huge gaps in our knowledge of which interventions deliver best outcomes for such an ethnically diverse population).

2.2 Healthcare for London illustrates world class practice for strokes but for other conditions, such as arthritis, diabetes and dementia, pathways need to be explored to capture what can be done in the community to prevent or delay the onset of conditions.

2.3 There is a lack of an evidence-based approach to the implications of the Darzi proposals on demand and costs of social care. For example, there may be an increase in demand for social care from shifting care out of hospitals. The impact on social care costs needs to be spelt out.

3. POLYCLINICS

3.1 The implications for primary care are that GPs in group practices would in the main have to collaborate in the delivery of the comprehensive multidisciplinary care envisaged for the polyclinic. We support the concept of GPs working together in larger groups and practices providing a wider range of services where it is in the best interest of the patients. Polyclinics should be viewed as a substitute for Accident and Emergency and provide accessible health services for those not registered with a GP.

3.2 The co-location of health and local authority services in one site, or hub and spoke model, is attractive. Integration of health care delivery from these clinics with a range of local authority services would be a positive move forward for seamless service delivery for our shared community. We would welcome further exploration of the opportunities.

3.3 There is a risk however that just because polyclinics are attractive to service providers that they will not be equally attractive to service users. There has been little attempt to balance the supposed efficiency of the new polyclinics against the legitimate wishes of patients. The recent NHS GP patient
survey revealed that patient satisfaction was higher in smaller practices, as in these practices patients felt that they were more likely to be able to get to speak to someone or get an appointment quickly. One thing that would increase the attractiveness of polyclinics to the public is if they not only provide a wide range of services but also at the times people want them. There are concerns that patients may be less likely to see the same doctor every time at a polyclinic. There are also issues around access for the ill, disabled, elderly and individuals with limited mobility as the polyclinics are potentially further away from patients’ homes. It is interesting to note that in Education the DCSF is requiring Children’s Centres to be within buggy walking distance for mothers.

3.4 Local authorities will play a key role in supporting the NHS estate developments associated with this strategy in the development of polyclinics. There will need to be early engagement on this issue, in particular to build in requirements to the Local Development Framework.

4. THE MOVE FROM SECONDARY TO PRIMARY CARE

4.1 The White Paper “Our Health, Our Care, Our Say” in the chapter “Care closer to home” outlines the need for health spending to be shifted towards preventative primary, community and social care services in order that those requiring services can access them closer to home. The need for disinvestment from secondary care was a major part of the White Paper.

4.2 The co-operation of local councils is essential if there is to be a shift away from secondary to primary care as social services are increasingly being involved in supporting primary care. If the shift is to be successful, the impact and role of social care in delivering this needs to be acknowledged at a financial level. Funding released from acute hospital care should flow through to primary, community and social care via normal spending allocations. These funds would be best used jointly to commission the required health and social care services based upon Joint Strategic Needs Assessment (JSNA). We believe that the nature of service provision should depend on, and be led by, the local needs of the individual London boroughs.

4.3 Extending community services should be developed by building on, and investing in, the current models that are working well.
4.4 Healthcare for London envisages more prevention, diagnostics, treatment and rehabilitation in people's own homes. More needs to be done to make the case to the public. And, we would not want the family or carers to feel the burden of care is falling on them.

4.5 The expansion of both rehabilitation and end of life care at home will have an impact on social care services and carers. Successful implementation will require strong partnerships and joint working with social care commissioners/providers and carers. This essential point is expanded in the sector below headed The Role for Local Authorities.

5. SOCIAL CARE

5.1 We are disappointed the review was not entitled “Health and Social Care in London” and at the lack of engagement with Social Care professionals in the Darzi clinical working groups. Healthcare should not be seen as a stand-alone concept without coupling it with social care. The planning and implementation of change should be jointly carried out across the whole of the health and social care economy in London.

5.2 There is a lack of any predictive modelling of the proposals in order to gauge potential additional burdens on social care. The Healthcare for London review should be clear about its effects.

6. PREVENTION

6.1 Healthcare for London would benefit from greater detail about the delivery of preventative services. We believe that, in partnership, health and social care organisations must take bold measures to redirect resources towards community based services in order to promote health and wellbeing and ultimately to diminish the future requirement for costly acute services.

6.2 Healthcare for London would also benefit from a greater and more explicit recognition of a partnership approach to tackling health inequalities and improving public health. The Council plays a key role in improving the health and wellbeing of the population in the Royal Borough of Kensington and Chelsea. The Council also plays a key role in tackling the wider determinants of ill health through education, housing and economic development and this role should be more strongly
reflected in this work programme. The Council and Kensington and Chelsea Primary Care Trust have been jointly producing public health strategies over the last 14 years. The current strategy for Kensington and Chelsea is called “Choosing Good Health – Together”\(^2\) and was published in September 2007.

7. **MENTAL HEALTH**

7.1 Healthcare for London has little new to say on the provision of mental health services in London apart from saying a new working group has been set up. This looks like an after thought after the publication of Lord Darzi report. Much more consideration has to be given to this critical area of Healthcare, if the residents of London are to be better served.

7.2 If polyclinics are established it would be essential for them to have a mental health nurse or specialist mental health staff available on the premises, due to the reported long delays experienced by some patients in accessing Mental Health Trusts.

8. **THE ROLE FOR LOCAL AUTHORITIES**

8.1 We regret that local authorities were not party to the original work in preparing the report but welcome the opportunity to participate at this stage. Successful implementation of these healthcare proposals should lead to greater efficiency and hence cost savings within the secondary and tertiary sectors. Recognising this there is the aim of a switch in funding from secondary to primary care. However it is local authority Social Services which will be picking up additional costs in both homecare and prevention services.

8.2 This comes at time when most local authorities in London are “on the floor” as regards grant funding for the next three years. Unlike the NHS, where services are free at the point of use, local authorities have a means tested provision of services. With increasing financial restraints this is leading some local authorities to restrict even these services to those with the greatest need. Under present financial conditions it is difficult to see how local authorities will be able to pick up the additional costs on them which implementation of Healthcare for London will entail. This could, without structural funding change, dilute Healthcare to Sickness-care.

8.3 To overcome this problem it is essential that there is a unified financial model for the provision of primary and social services/community care and to drive forward the needed changes in the delivery of preventative services. Any switch of resources from secondary provision must go both to primary and social services care. It is recommended that this should be negotiated locally, within clear guidelines, rather than imposed centrally.

9. IMPLEMENTING THE PROPOSALS

9.1 Healthcare for London is vague in terms of costs and where the services would be located. Not knowing costs is a major oversight. The plan seems to involve cost increases at a time when overall health spending increases are going to slow.

9.2 Healthcare for London also says little about how the levers of system reform in the NHS can help to realise this vision. It will be crucial to understand how the multiple and sometimes conflicting incentives that have already been built into the system will help or hinder the implementation of this plan. Payment by results (the mechanism to pay NHS providers a fixed price for each individual case treated), for example, has created powerful incentives for hospitals to pull in patients, but it may undermine collaboration between organisations or create conflicts between NHS trusts and Primary Care Trusts. The evidence so far on practice based commissioning (where general practices are given control over their commissioning budgets for secondary care and community services) indicates that as yet only modest efforts have been made to redesign primary care services to counteract the pull of hospitals.

9.3 There is talk of realising surplus assets within the NHS estate to help fund necessary change. However we are unclear how easy to implement this will be in practice when Foundation Trusts have the right to retain funds to themselves from any realisation of property.

9.4 We encourage the use of strong commissioning and in particular, joint commissioning across PCTs and local authorities. JSNA will identify the local needs and population trends in each area and joint commissioning strategies should follow on from JSNAs. It will be vital that there is enough autonomy and flexibility in the NHS to deliver services that meet the assessed needs of the population in each individual local area.
9.5 We believe the reaction of the medical profession to Healthcare for London will be of utmost importance. There is a general feeling that there have been too many recent NHS reforms and without the full engagement of NHS, GPs and Social Service personnel this review could be viewed as “top-down”. The history of delivery of reports into London's health services is not a good one. Neither the 1992 Tomlinson report nor the Turnberg one of 1998 were ever fully carried out. In the past, institutional vested interest - dressed up as protecting local services for local people - prevented the emergence of a rational pattern of secondary and tertiary hospital services.

10. CONCLUSION

10.1 Healthcare for London has been essentially developed from a clinician’s point of view. This is a good starting point but all parts of London’s health and social care economy need to be positively engaged within the process before implementation. We believe that the nature of service provision should depend on, and be led by, the local needs of the individual London boroughs.

10.2 The Healthcare for London review should be clear about its effects, for example the potential impact on social care costs needs to be spelt out.

10.3 We are pleased to have been given the opportunity to respond to the Healthcare for London consultation. We agree that change is necessary to secure better health outcomes for Londoners in the future.

Cllr. Fiona Buxton
Cabinet Member Housing Services, Adult Social Care, Public Health and Environmental Health

Cllr. Christopher Buckmaster
Chairman, Overview and Scrutiny Committee on Health

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