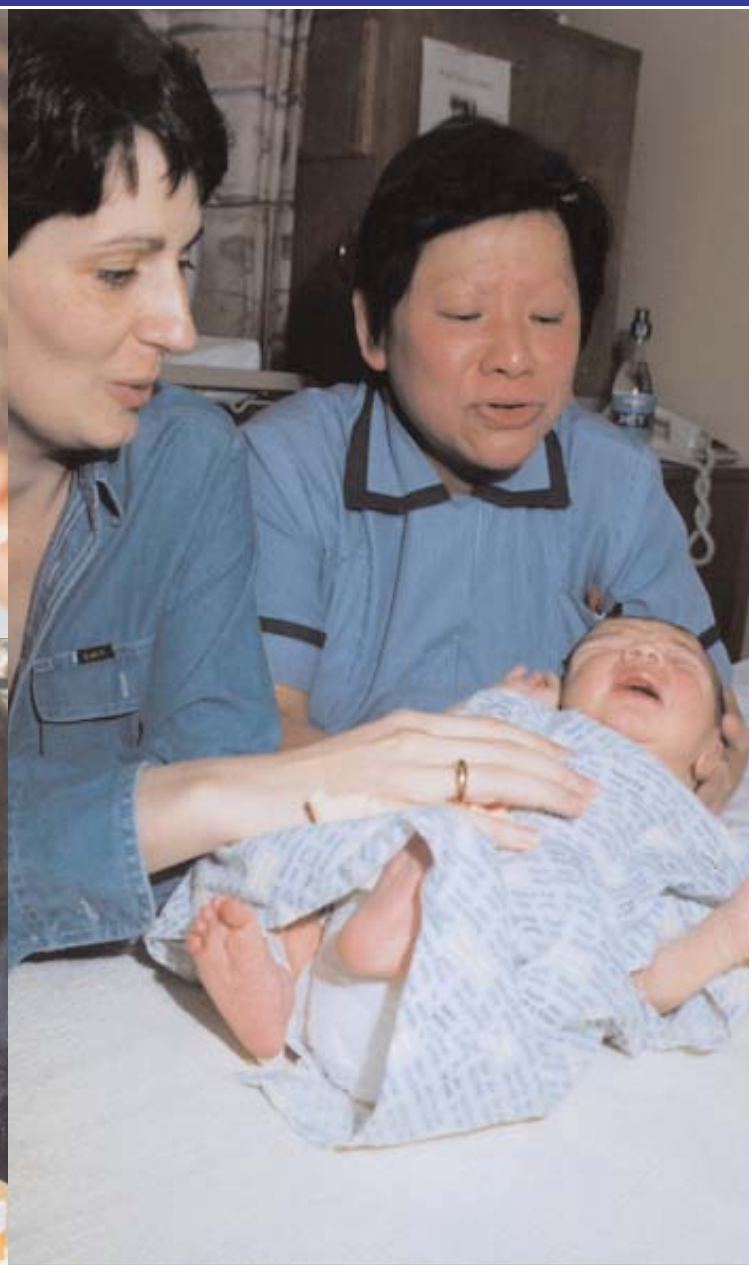
LONDON ASSEMBLY

MAYOR OF LONDON

Access to Primary Care

A joint London Assembly and Mayor of London Scrutiny Report

April 2003



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The Access to Primary Care Advisory Committee

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Professor Adrian Eddleston	Chair, Bromley Primary Care Trust
Elizabeth Manero	Chair, London Health Link
Professor Brian Jarman	Emeritus Professor of Primary Health Care Imperial College School of Medicine

The terms of reference of the Committee are as follows:

- To identify public perceptions of factors determining access to primary health care;
- To identify real and perceived inequalities in access to primary health care across the capital;
- To make recommendations to both Primary Care Trusts (PCTs) and strategic health authorities as to how planning and delivery of primary health care services might be shaped to improve access and reduce inequalities.

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Foreword by Ken Livingstone, Mayor of London

I have been pleased to support this joint scrutiny as part of my ongoing commitment to improving health and influencing access to health services in London. Primary Care is an essential pathway in to the National Health Service, as well as being the service most Londoners rely on for health advice, support and treatment in the community. The staff who provide these services make an essential and valued contribution to improving health, but we know there are not enough doctors, nurses, other health professionals or support staff to meet the needs of London's diverse communities. Demands on our NHS staff are growing, and many are working in challenging circumstances with limited access to the resources they need.

This scrutiny has enabled us to more clearly describe the particular challenges for London including considering the specific issues for different communities and locations. Throughout the process we have been committed to ensuring our investigation adds to the existing body of evidence about access to primary care, and identifies recommendations that may be of use to Primary Care Trusts and other parts of the NHS responsible for developing and delivering primary care in London.

The scrutiny process has benefited from the ongoing involvement of three primary care experts appointed to represent me on the committee – a General Practitioner, a PCT Director of Operations and Nursing, and the Chair of a Community Health Council. In addition, the London Health Commission identified a Primary Care Trust Chair and a patient involvement expert to advise the scrutiny committee at key points in the process. I would like to thank all these external colleagues for making their time and expertise available to the scrutiny committee. In addition, we were pleased to receive evidence from such a wide range of organisations as well as hearing from Londoners who participated in consultation events.

This report demonstrates the complexity of meeting the NHS targets in London and of delivering improvements in access to this essential part of health service delivery. Encouragingly, it also identifies that progress is being made, and that there is optimism about the potential for further improvement as changes to the NHS continue to be made. However, it also highlights the huge challenges to be faced in recruiting and retaining staff, improving premises, and finding new and better ways of working in partnership within the NHS and with patients, local authorities, and others. I will be making use of relevant findings in my contact with national government and regional partners, and look forward to further opportunities to review progress in delivering primary care services to all Londoners.

I commend this report to those working regionally on health issues, and look forward to ongoing work with the Department of Health and other partners to support implementation of the recommendations. I also encourage those working at local level to make use of this report to understand primary care issues better and to support further development of their emerging scrutiny arrangements.

Ken Livingstone
Mayor of London

Chair's Foreword

The Access to Primary Care report is the result of the first joint scrutiny collaboration between the London Assembly and Mayor.

The NHS has been undergoing an enormous structural and cultural change, which is moving this large public service from an acute service to a primary care driven health service; this was the catalyst for our scrutiny. One question to be addressed is whether this re-organisation will benefit and enhance health care services for Londoners and I conclude that, for our times, this is the direction that the NHS should take.

However, ultimately the success of this reorganisation relies on improved recruitment and retention of skilled health-care professionals, crucially general practitioners. The NHS has a work force that any organisation would die for in its brightness, how well its trained and its commitment, but more must be done to ensure that it remains an organisation that people want to work for.

This must be combined with an improvement to surgery premises which will enable more health care to be conducted in GP surgeries with multi disciplinary teams providing a wider variety of health services. Providing these services within the primary care setting will therefore take the pressure off hospitals. The NHS must make sure that resources get to the front line, ensuring that people are not prevented from accessing the care they need; developing premises which are physically accessible and allowing patients to see a health care professional of their choice. There must be an end to GP closed lists; and there must be easily accessible translation and interpretation for all primary care services especially in the GP surgery. Patients must be allowed more freedom to be referred to a hospital either of their own, or their doctor's choice and we must see an end to the 'postcode referral' which has been allowed to continue for too long.

I am grateful to all members of the committee for their hard work and their commitment to conducting a thorough scrutiny of all the issues involved and the in-house health scrutiny team for their dedication to the project . I would particularly like to thank the elected members; the Mayor's appointees – Dr Sam Everington of the Bromley-By-Bow health centre; Ruth May, Director of Operations and Nursing for Havering Primary Care Trust; Mansukh Raichura, Chair of Brent Community Health Council and Neale Coleman, Mayor's Policy Director, for their generous time. The expertise of our two advisors - Professor Adrian Eddleston and Elizabeth Manero - has been invaluable.

My special thanks must go to Professor Sir Brian Jarman, Emeritus Professor of Primary Health Care, Imperial College for his editorial guidance and help with the final report.

Finally, but not least, I must pay tribute to all the people who gave so generously of their time and expertise to inform the committee during the evidence sessions.

Elizabeth Howlett
Chair, Access to Primary Care Advisory Committee

Contents

Executive Summary

Every day tens of thousands of Londoners have contact with dentists, GPs, health visitors, high street chemists and opticians. The role these primary care services play in maintaining and promoting health cannot be overemphasised. Primary Care is fundamental to our well being and as such is indeed the 'jewel in the crown of the NHS'.

Primary care services are crucial to the health of Londoners. In London the health divide between the most affluent and deprived communities has widened. It is a city experiencing highly complex health needs. London has much higher levels of tuberculosis, HIV /Aids, and mental illness than the rest of the country. Life expectancy and infant mortality rates vary across London boroughs.

The recent reorganisation of the NHS has involved changes in the structure for the delivery of primary care. The shift of health care from the acute sector to primary care is emphasised by the development of a range of initiatives that we hope will deliver much needed improvements. This has included the establishment of new structures including Primary Care Trusts, development of policies such as the NHS Plan and strategies for meeting specific health needs such as the National Service Frameworks.

In consideration of these issues The Mayor of London and the London Assembly decided to undertake the first London-wide focussed consideration of access to primary care in the capital and how access might be improved. At the heart of this scrutiny is the consideration of whether these new structures will deliver the improved primary care services that London so desperately needs. We have brought together a wealth of best practice and data from all over London and beyond, and have heard the views of NHS organisations, patient and community groups and many others. We have fully considered a wide and varied range of issues that go to the heart of primary care services.

Our main recommendations can be found in the body of the report and are listed in full at Appendix B.

Our principle findings are:

- **Unequal Access**

Even though NHS primary care is free at the point of delivery, there is no equity of access for Londoners and the quality of care varies. The Primary Care system is failing some members of vulnerable groups. Language and translation needs are not always met and this is a major barrier for London's increasingly diverse population. New services such as NHS Direct and NHS Walk-In centres are under-used by these groups. Prejudice and discrimination are still experienced by some people trying to access primary care services, including those with complex medical problems and long term illnesses. GPs can close their lists to patients or de-register them without having to provide reasons for doing so. There is a need for Primary Care Trusts to prevent this from happening.

❖ Workforce Shortages

The biggest constraint to the improvement of health services in the capital is the significant shortfall in the primary care workforce. There are difficulties in recruiting and retaining the range of primary care staff including GPs, nurses, pharmacists and support staff such as receptionists and practice managers. In London this problem is likely to get worse before it gets better due to the high number of GPs who are due to retire in the next few years. Factors such as transport difficulties, the cost and availability of housing and the challenge of working in deprived areas are also adversely affecting recruitment and retention in the capital.

❖ Poor Quality Premises

London has a high number of GPs working out of premises that do not meet the Department of Health minimum standards. There are poor premises with inadequate facilities, largely based in old residential properties. The shortage of sites for development, the expense of acquiring land and the complexity of planning issues further compounds this difficulty. We have concerns about how GPs operating out of poor premises will meet the physical access obligations placed on them by the Disability Discrimination Act 1995. Physical access is one of the most fundamental issues that needs to be addressed. We are hopeful that the new LIFT (Local Improvement Finance Trust) Initiative will provide an opportunity to tackle some of these problems and facilitate the development of health centres that can accommodate the range of primary care services and social support needed by Londoners.

❖ The Need for Openness and Dialogue

Primary care services will not improve without a change in the culture of the NHS. There is a need for openness and dialogue with ordinary members of the public. This must go beyond traditional consultation exercises, which seek the views of the public but may not deliver real outcomes for patients. We want to see full use of the new arrangements for patient and public involvement. This will include encouraging participation from traditionally marginalised communities and greater use of voluntary sector organisations. We particularly want to see more public involvement in the strategic planning and design of health services in London. London needs tangible and measurable outcomes from public involvement structures that will result in real benefits for ordinary members of the public. For this to happen the new arrangements for patient forums, patient advice and liaison, and health scrutiny must be adequately resourced and supported by the Department of Health and the Government.

1. Introduction

1.1 The Mayor of London and the London Assembly are working in a variety of ways to improve the health of Londoners. The Mayor has a statutory duty to improve the health of Londoners and is engaged in a number of partnership initiatives to tackle health inequalities. The London Assembly is empowered by law to scrutinise any issue considered to be important to Greater London and carries out the scrutiny of health issues primarily through its Health Committee.

1.2 This is the first scrutiny that the Mayor and the Assembly are carrying out jointly, and it has provided an opportunity for us to contribute to the improvement of the health of Londoners by :

- identifying, the challenges involved in delivering primary care in London;
- highlighting the human and organisational resources required to deliver primary care in London;
- exploring different public perceptions of the changes proposed by the NHS plan;
- identifying ways of improving the accessibility of primary care and of reducing inequalities in access.

1.3 There has been significant interest and a willingness to engage with this process. We have received a wide range of oral and written evidence from a variety of organisations and individuals. We are grateful to all the organisations and individuals who submitted written evidence and we also wish to thank those who attended our evidentiary hearings, either to answer our questions, or to listen to the proceedings. We are particularly grateful to the staff at Bromley-By-Bow Health Centre for providing us with an opportunity to visit an excellent example of a primary care service that is responding to the diverse needs of the local community.

1.4 We recognise that since the start of this process many Primary Care Trusts will have made progress towards improving services for their local communities. We intend to take account of these improvements when we conduct the follow-up to this report. Our report reflects the concerns and experiences of ordinary Londoners and we hope that by highlighting these concerns we will assist the National Health Service (NHS) in London to take account of these issues in their policy implementation and service planning.

The Scrutiny Focus

1.5 In order to prevent the scrutiny from becoming unwieldy and losing focus, we decided to concentrate on primary care services provided by General Practitioners (GPs), nurses, pharmacists and allied professions (such as midwives and therapists). We have therefore excluded dentistry and optical services on this occasion. The evidence we have received is largely focussed on primary care services provided by GPs, and this report in many ways reflects this emphasis. We are aware that there are issues of access to services provided by allied health professionals that are not fully reflected in this report. We intend to consider these roles in future Health Committee scrutiny work.

1.6 The scrutiny has concentrated on five main themes:

- The recruitment and retention of primary care staff;
- The changing roles and responsibilities in primary care;
- Patient involvement and information issues;
- Equitable access to primary care; and
- The developing role of Primary Care Trusts (PCTs) as commissioners of primary care services.

How We Conducted the Scrutiny

1.7 The scrutiny process has included a wide range of activities and initiatives including:

- Two consultation events in May 2000. The first with members of the public and the second with representatives from voluntary sector organisations across London, and a focus group with members of the Black Londoners Forum.
- The consideration of written evidence from a wide range of organisations including those representing various professional groups, those that work with patients, NHS organisations in London, and various voluntary sector organisations. A full list of these organisations can be found in Appendix C.
- Examining existing research on access to primary care through a rapid review prepared by Queen Mary's and St Bartholomew's Medical School and The London NHS Trust.
- A series of public evidentiary hearings, which have provided an opportunity to consider particular issues in greater detail. A list of these hearings can be found in Appendix C. The minutes and transcripts of the hearings can be found at www.london.gov.uk/approot/assembly/health/index.jsp
- A visit to Bromley-by-Bow Health centre in order to consider their innovative model of health care delivery.

Limitations of the Scrutiny Process

1.8 Conducting a scrutiny of this size is not a task that we have underestimated. We recognise that the issue of access to primary care is a very complex one and our broad scrutiny focus reflects this. The aim of the scrutiny is not to cover every aspect of primary care, but to focus on some of the main issues, particularly those that impact on disadvantaged and vulnerable communities. The London Assembly Health Committee will continue to carry out further work on improving access to primary care, as part of the scrutiny follow up process. We also envisage that the London Health Commission will assist, where possible in follow-up work and the Mayor's health policy programme will support further work on implementation as appropriate.

What is Primary Care?

1.9 Put simply, Primary Care is the first contact people have with the health service. Patients present themselves directly for a consultation instead of being referred by another organisation.[1] It is generally taken to mean:

- General practice and the services provided there by doctors, nurses, receptionists, practice managers and allied health professionals (physiotherapists, chiropodists, etc.)
- Community nursing such as district nursing and health visiting services where these are not based in GP surgeries.
- Community pharmacists (i.e those working in pharmacies or health centres, not hospitals)
- Dentists (except those working in hospitals)
- Optometrists (opticians)

Although we are aware of the importance of primary care provided by dentists and opticians, in order to prevent the scrutiny losing focus, we did not actively consider access to these services.

Our Definition of Access

1.10 For the purpose of this scrutiny we have defined access as:

- Knowledge of services (e.g understanding how to enter the health system);
- Availability and use of services;
- Physical access (including waiting times)
- Accessibility for different population groups;
- Quality of service being accessed. (Is the service relevant and effective?)

Is There a Problem?

1.11 London has a highly mobile and ethnically diverse population of 7.4 million. It is a city where wealth and privilege exist alongside poverty and deprivation. There are various social factors that contribute to the health problems of the capital. These include substance misuse, homelessness, rough sleeping, and crime and disorder. London experiences higher levels of these social problems than are found elsewhere in the country.[2] London also has a large influx of people coming into the capital on a daily basis, both to work and as tourists.

1.12 The health divide between the most affluent and deprived communities in London has widened over the past 10 to 15 years.[3] London has higher numbers of cases of tuberculosis, a bigger concentration of people with HIV and AIDS, and significantly higher levels of mental ill health than the rest of the country. Across the capital there are wide variations in life expectancy and infant mortality rates both at borough and ward levels.[4] The important role that

[1] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[2] Dr Sue Atkinson: Report to the Health Committee on London's Health 24th October 2002
[3] Memorandum: London Health Observatory
[4] Dr Sue Atkinson: Report to the Health Committee on London's Health 24th October 2002

primary care plays in meeting these complex needs and improving the health of Londoners cannot be overemphasised.

Improving Primary Care

1.13 It is clear that providing health services that can successfully address both social disadvantage and health inequalities is an immense challenge. This will necessitate developing health services built around mechanisms and processes that tackle disadvantage at every level, from high-level strategic planning to the point of the customer interface.

1.14 In July 2000 the Government published the NHS Plan which sets out the vision and targets for all parts of the NHS and defines new national standards.[5] This aims to develop patient focused services that are responsive to local need, whilst at the same time ensuring national standards. The Plan is committed to the modernisation and reform of NHS services, with greater responsibility being given to frontline staff, and greater decision-making power being given to patients. Central to delivery of the NHS plan are the changes being made to the way that primary care is provided and organised. These changes include the introduction of NHS Direct and NHS Walk-In Centres, and the ongoing reform of health care professions.

1.15 The Department of Health is also implementing other improvement strategies including:

- enlarging primary care capacity by increasing the numbers of GPs and GPs in training (GP registrars),
- increasing multi-disciplinary and team working, including extending nurse roles and developing the role of nurse practitioners;
- targeting resources at under-served areas and under-served population groups by extending the number of sites offering Personal Medical Services (PMS);
- improving quality aspects of access by implementing waiting time targets, e.g. by the end of 2004, patients should be able to see a GP within 48 hours and a health professional within 24 hours.[6]

Patient Satisfaction

1.16 Nationally, satisfaction with general practice is high.[7] This is higher than for almost any other public service. The Audit Commission found that satisfaction levels for general practice are about 80% higher than for almost any other public service.[8] A MORI poll commissioned by the Audit Commission showed that 62% of respondents rated general practice as the most important public service. In 2001 the British Medical Association commissioned a MORI poll which showed that 89% of patients were either very satisfied or fairly satisfied with their GP.[9] This figure has now risen to 91%.[10]

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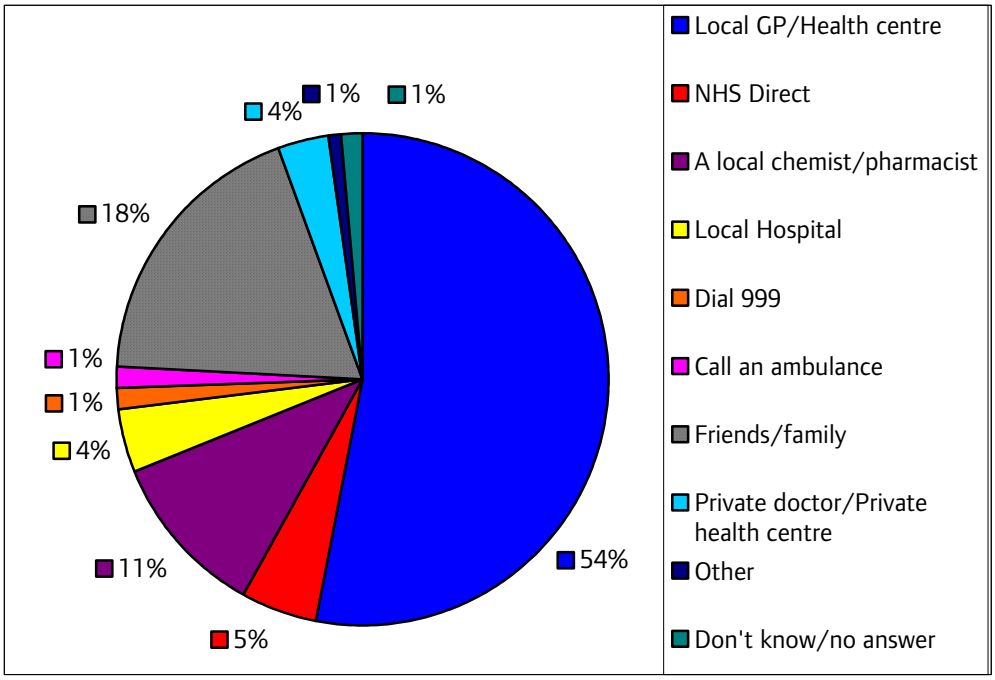
[5] The NHS Plan Department of Health July 2000
[6] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[7] NHS Executive, National Surveys of NHS Patients: General Practice 1998, NHS Executive, 1999
S Exley and L Jarvis, Trends in Attitudes to Health Care 1983 to 2000, report based on results from the British Social Attitudes Surveys, National Centre for Social Research, 2001.
[8] A Focus on General Practice in England. Audit Commission, July 2002
[9] BMJ 2001; 322:694 (24 March)
[10] www.mori.com/polls/2003/bma.shtml

1.17 This high level of patient satisfaction was also evident in the 2001 London Survey. This survey was conducted by MORI on behalf of the Greater London Authority. The aim of the survey was to see how Londoners view the capital and what they feel should be the priorities for improvement. The survey also showed that 82% of Londoners are satisfied with the information given by GPs. This is broadly in line with results from other parts of the country.

Who Do We Contact for Primary Healthcare?

1.18 The 2001 London survey highlighted, that for most Londoners, the first point of contact for health care in a non-emergency situation is the GP. However, it also shows that some Londoners rely on ambulance or hospital services, even in a non-emergency, which may suggest some Londoners have difficulty accessing primary care services.

Table 1: First Contact for Primary Care Services[11]



1.19 Although surveys show that people are generally happy with the services they receive from general practice, they also show that the greatest source of dissatisfaction is the time they have to wait for an appointment. Waiting times accounted for 55% of the dissatisfaction in the Audit Commission MORI poll.[12] The 2000 British Social Attitude Survey showed that 51 per cent of respondents reported that the GP appointment system was in need of improvement. The Government has introduced waiting time targets for general practice and we discuss these in later chapters.

[11] Taken from the 2001 London Survey
[12] A Focus on General Practice in England. Audit Commission, July 2002

Improving Access in London

1.20 In spite of these high levels of patient satisfaction, our research shows that there are several reports and studies into primary care services in London that paint a different picture.[13] These studies show that the structure and availability of primary care services in London is generally inferior. Challenges include:

- difficulties in recruitment and retention of staff.
- A high proportion of single-handed practices (42% of London GPs)
- the lack of extended primary care teams working from health centers.
- inadequate practice premises.
- a lower proportion of practices reaching targets for preventive care.
- a lower level of child health surveillance.
- the budgetary implications for primary care of funding numerous large teaching hospitals.

1.21 In addition to the general problems of access (waiting times), Londoners also experience problems of access particularly associated with deprived and minority ethnic communities. In order to improve access to primary care for all, there is a clear need to address both issues of general access and issues that are specific to traditionally marginalised communities in the capital. We believe that this is part of the larger remit that the NHS has to undertake, in order to tackle health inequalities successfully.

[13] Department of Health. Independent Inquiry into Inequalities in Health, chaired by Sir D Acheson. 1998. The Stationery Office.
Jarman B,.Bosanquet N. Primary health care in London - changes since the Acheson Report. *BMJ* 1992;305:1130-6.
King's Fund. King's Fund Commission on the Future of Acute Services in London 1981.
Turnberg L. The Health Services in London: A Strategic Review. 1997. London, Department of Health.

2. The Primary Care Workforce

The Problem of Recruitment and Retention

2.1 The problem of public sector recruitment and retention in London is a well known one. It is particularly acute in the health and social care sector. Difficulties with recruitment are not restricted to the clinical areas of healthcare, but are also encountered in recruitment for supportive roles such as health care assistants, receptionists and administrative staff.

GP Numbers in London[14]

2.2 The table below shows the GP numbers in London (based on the former Health Authorities)

Health Authority	Average list size	GPs per 100,000 – headcount (wte)	Number of single-handed GPs	% single – handed of total
Barking & Havering	2,237	34.18	54	55%
Barnet, Enfield & Haringey	1,950	54.76	93	44%
Bexley, Bromley & Greenwich	2,132	48.42	58	41%
Brent & Harrow	2,056	51.82	46	39%
Camden & Islington	2,039	55.58	44	45%
Croydon	2,230	47.75	27	40%
Ealing, Hammersmith & Hounslow	2,034	50.26	89	47%
East London & The City	1,990	53.75	75	47%
Hillingdon	2,067	50.04	19	36%
Kensington, Chelsea & Westminster	2,176	58.27	46	46%
Kingston & Richmond	1,936	54.98	15	25%
Lambeth, Southwark & Lewisham	1,446	69.91	56	35%
Merton, Sutton and Wandsworth	2,009	53.40	32	28%
Redbridge & Waltham Forest	2,104	50.42	63	52%
TOTAL/AVERAGE	**1,985**	**52.65**	**717**	**42%**

(Table 2)

2.3 The figures are based on unrestricted principal equivalents, thus excluding salaried and assistant GPs.[15] The national average number of patients per GP principal in 2001 was 1,841.[16] The total average number of patients per GP principal in London is 1,985. The figures also show that London has a high proportion of single handed practices and we discuss the implications of this in chapter three.

[14] Department of Health and Social Care London November 2002 (Based on NHS GP Census 2001)
[15] Please see appendix I for definitions.
[16] A Focus on General Practice in England. Audit Commission, July 2002

2.4 The NHS Plan highlights the fact that the biggest constraint facing the NHS today is no longer a shortage of financial resources, but a shortage of human resources.[17] The Plan sets a number of workforce targets for increases in the numbers of GPs and other health care staff. The Plan envisages that by 2004 there will be 2,000 more GPs, 20,000 more nurses, and over 6,500 more therapists and other health professionals.[18] Apart from GPs, the NHS Plan targets for healthcare staff do not differentiate between the primary and acute sectors.

2.5 At the hearing on the 6th November 2002, Duncan Selby informed us that retaining staff in the NHS is also an issue that needs to be tackled. *"We have a workforce in the NHS that any organisation would die for, in its brightness, how well it's trained, and its commitment. I see this every day, in and out of hospitals, and primary care. What we don't do consistently is look after it as well as we might….. something about retaining our own people has to have, I think, more importance…."*,[19] Dr Khan of the Muslim Council of Great Britain, echoed this view and highlighted the problem that the low morale of healthcare workers is having on recruitment across the sector. *"The NHS has relied and benefited for too long on the good nature and sacrifice of the medical and nursing profession. The sooner these professionals are treated the same as their counterparts in Europe and the US, the better it will be for the entire service."* In France, where there is considerable concern about the present lack of doctors, the OECD data shows that for 1998 France had 3.0 physicians per 1000 population and UK had 1.7 physicians per 1000 population.[20]

2.6 The issue of staff recruitment and retention is crucial to the success of all NHS strategies and targets. **There must be sufficient numbers of staff to implement the various strategies for improvement. Without sufficient numbers of qualified staff services will be seriously compromised.** We outline below some of the recruitment difficulties, the impact these are having on service delivery and some of the solutions that are being employed to address this problem.

The Shortage of Primary Care Staff

2.7 The evidence we have received shows that the recruitment of GPs is a problem that is experienced across London. The majority of Primary Care Trusts (PCTs) report that the current shortage of GPs and difficulties recruiting GPs is a key concern. The NHS Plan target for recruiting an extra 2000 GPs has been distributed across England to match regional needs. The table below shows the implications of this distribution for London. The Directorate of Health and Social Care have informed us that by April 2004, an extra 255 GPs are essential for the capital.[21]

[17] The NHS Plan Department of Health July 2000
[18] Memorandum: Directorate of Health and Social Care
[19] Minutes 6th November: Duncan Selby (Chief Executive, South East Strategic Health Authority)
[20] OECD Health Data, 2001: Practising physicians – Density/1000 population
[21] Memorandum: Directorate of Health and Social Care

Strategic Health Authority	GPs in post 1999	GPs in post March 2001	2004 Target	Shortfall
London North West	1091	1093	1149	56
London North Central	747	751	779	28
London North East	846	855	916	61
London South East	866	875	922	47
London South West	725	727	764	37
Total	4275	4301	4530	229

Source: Workforce Development Confederation CEO Bulletin Annex A, 19/03/2002
(Table amended to show shortfall based on 2001 figures) (Table 3)

2.8 Since 1995 GPs have been able to retire from the age of 50 onwards because of the way their pensions are organised.[22] A study of GPs trained in South Asia and practising in England projects that two thirds of these GPs will retire by 2007, resulting in the loss of up to one in four GPs from some inner city areas.[23] A recent survey of GPs found that 45% of GPs planned to retire between the ages of 50 to 59 and 45% between the ages of 60 and 70 years.[24] Nationally, 34% of GP Principals are aged 50 or over. The figure for London is 44%. Unless action is taken, the current shortage of GPs will be exacerbated by the number of GPs who are due to retire over the next few years, even with the recruitment envisaged by the NHS Plan.

2.9 Newham Community Health Council informed us that 25% of their local GPs are aged 60 and over. **"** We have recently received feedback from a number of people in the Stratford area of Newham whose GP has retired. They have been transferred to a GP in Manor Park, a considerable distance away from where they live. Some of those affected were elderly and were extremely concerned about how they were going to get to their GP."[25] Redbridge Community Health Council reported that the ratio of GPs to patients in their area is below the national average and the fact that many GPs are retiring or are close to retirement age will exacerbate this. Barking and Dagenham Primary Care Trust report that over 50% of the GPs in their area will be eligible for early retirement in the next 5-10 years.

2.10 *"GP retirements do create planning problems. A substantial number of GPs across Brent are due to turn 70 over the next 5 years, of course this does not provide the complete picture as many are choosing to retire earlier…"*[26] In addition, increasing numbers of GPs are choosing to aim for retirements before the age of 65, which is a profound change from the situation in 1990 when the current GP contract was introduced.[27] The Government targets (NHS Plan) for GP recruitment do not take the impact of GP retirement into account. In addition to retirements in some areas of London, many GPs leave before retirement age. According to evidence from North East London Strategic Health Authority, more GPs leave the area than retire. **The current GP shortage**

[22] A Focus on General Practice in England. Audit Commission, July 2002
[23] Taylor DH Jr, Esmail A: Retropsective Analysis of Census Data on General Practitioners who Qualified in South Asia : Who Will Replace Them as They Retire? BMJ 1999; 318: 306-10.
[24] British Medical Association, National Survey of GP Opinion, BMA, 2001.
[25] Memorandum: Newham Community Health Council
[26] Memoranda: Brent PCT
[27] Minutes of Evidence 23rd October 2002

together with retirements and the number of GPs leaving the capital has serious implications for primary care services in London. Unless a further new core of doctors who will take up general practice as their main vocation can be identified, Londoners will face increasing difficulties accessing general practice, particularly in the inner city areas.

2.11 In order to give this serious issue more in-depth consideration the Health Committee of the London Assembly is conducting a separate scrutiny into the problem of GP recruitment. We envisage that the Health Committee will publish the scrutiny findings in the spring of 2003.

2.12 The majority of our submissions stress that there are also difficulties in recruiting to nursing positions in the primary care sector. Several PCTs state that the recruitment and retention of nurses is as problematic as that of GPs if not more so. Westminster PCT reported that they have 73 practice nurses in post and 14 vacancies. Their turnover of practice nurses in 2001 was 28%.[28]

2.13 There is also a national shortage of community practitioners (health visitors, district nurses), which is affecting London. Westminster Primary Care Trust stated that there are high vacancy and turnover rates for community practitioners, particularly in the more deprived areas where recruitment is difficult and the turnover is high. This is resulting in long periods with unfilled posts and heavy workloads for other staff who may have to provide cover.

2.14 These recruitment problems are exacerbated by the fact that community practitioner professions tend to have older age profiles and young people are not joining in sufficient numbers to counteract the effect of retirement.[29] The National Society for Prevention of Cruelty to Children (NSPCC) is concerned that this is reducing the opportunity for community health practitioners to develop personal relationships with the families of young children, especially the mother. It also reduces the opportunity for community practitioners to identify any potential problems, particularly around the issue of child safety.[30] Ealing Primary Care Trust reports that as a result of the shortage of health visitors in the area, in certain parts of the borough it is unable to provide routine 30 month checks or baby clinics in GP surgeries.[31]

2.15 There are also staff shortages in other allied primary care professions such as pharmacists, occupational therapists and counsellors. Croydon Primary Care Trust states *" as is the case nationally, there are vacancies for community pharmacists. The vacancy level has been exacerbated by the extended working hours of pharmacists in supermarkets and the recent extension of the degree course from three to five years."*[32] The lack of occupational therapists and counsellors is also mentioned as having a detrimental effect on the provision of health care to people with multiple needs. [33]

[28] Memoranda: Westminster Primary Care Trust
[29] Memoranda: Hammersmith and Fulham Primary Care Trust
[30] Memoranda: NSPCC
[31] Memorandum: Ealing Primary Care Trust
[32] Memorandum: Croydon Primary Care Trust
[33] Memorandum: Great Chapel Street Medical Centre

2.16 The crucial role played by non-clinical staff, in particular administrative staff, is also emphasised in several submissions. These staff are identified as having particularly uncompetitive rates of pay as compared to many other sectors. *"Services need clinical staff – but they also cannot be run without administration and non-clinical support staff. These staff are often the least well paid and need the support of any initiatives which provide housing and transport for clinical staff."*[34]

What Causes Recruitment and Retention Problems?

2.17 The main reasons given for recruitment and retention problems in London are quite clear. Transport difficulties, housing, the undesirability of inner city areas, the perceived lack of availability of good schools, the complexities of working with underprivileged communities, and the general cost and quality of living, make London an undesirable place to live when compared to the rest of the country.

Transport

2.18 The transport difficulties in London are well known *"The high cost of transport into London combined with long travelling times, has a significant effect on the retention of staff, especially the more mature staff with family commitments."*[35] As a result of transport difficulties, many primary care staff look for jobs that are near their homes in order to reduce the amount of time spent travelling. Whilst we do not consider this bad practice, it adds to the difficulties of recruiting and retaining staff, particularly in the inner city areas. Westminster Primary Care Trust surveyed their practice nurses that were leaving. Of those surveyed 57% gave the reason for leaving as securing a post nearer home, outside central London. 60% of nurses working in Westminster practices live outside central London. The effect of congestion charges for workers within the congestion zone will also need to be monitored.

2.19 For many primary care staff the use of a car is vital because they need to take medical equipment or drugs to patients. They may also have to carry out a series of visits and using their car enables them to travel quickly. *"Local public transport does not provide an efficient method for community staff and GPs to travel to patient homes. Many staff wish to use their own cars or car pools, but parking charges are high."* [36] Parking difficulties were also highlighted as a problem, making it difficult for primary care staff to conduct visits to housebound patients, thereby affecting the access to primary care services for such patients.

2.20 We conducted a telephone survey to find out if London boroughs issue parking permits to GPs and community practitioners (health visitors and district nurses). Half the boroughs do not provide parking permits, and the majority of permits that are provided are only for emergency visits from GPs. There are only eight boroughs that offer some form of parking permits to both community practitioners and GPs. This survey clearly shows that across London there is no standard practice as it varies from borough to borough. Some of the boroughs that issue permits informed us that they only do so if the GP resides or has a surgery in the parking zone. This means that for GPs and community

[34] Memorandum: Westminster Primary Care Trust
[35] Memorandum: Westminster Primary Care Trust
[36] Memorandum: Hammersmith and Fulham Primary Care Trust

practitioners who have patients in different local authority parking zones or indeed across different boroughs, parking to conduct home visits for patients remains a difficulty.

Recommendation 1

The Association of London Government must work together with London local authorities to establish schemes that will facilitate the provision of parking permits in all London boroughs for all primary care staff who conduct home visits to patients.

Housing

2.21 Exit interviews conducted by Wandsworth PCT indicate that the cost and availability of housing in London is the single biggest cause for staff leaving. At the hearing on the 6th November, Julie Dent told us that there is a mismatch between the types of housing currently available and the types of housing some key workers actually want, in that currently key worker schemes are generally targeted at single people.[37] There is a need to ensure that primary care staff with families are able to gain access to affordable accommodation. This will provide a way of retaining primary care staff as their families grow and will therefore prevent the flow of mature staff leaving the capital. There needs to be a more targeted and consistent approach to health care professionals requiring family size accommodation to support the retention of primary care staff in London.

Recommendation 2

The Office of the Deputy Prime Minister must review the various housing initiatives for key workers to ensure that all healthcare workers can have access to both affordable single and family size accommodation in London.

Pressures of General Practice Workloads in London

2.22 The Audit Commission report highlights that over time GP workloads have become more complex.[38] This is demonstrated by the shifting of workloads from hospitals to primary care, patients growing health and social care needs, more complex drug regimes, exacting clinical standards, greater scrutiny, high patient turnover and growing patient expectations. On average, people throughout the UK, consult their GP four times a year.[39] In certain areas of London this figure is much greater and consultations may be far more complex due to the social and economic deprivation experience by patients. The shift in workload from the hospitals acute care to primary care has not been accompanied by a shift in resources from acute care.

2.23 Nationally, GPs receive deprivation payments for 4 million patients.[40] 31 % of these patients are registered with GPs in London, thus signifying the large proportion of the London patient population that is classified as deprived. As we highlighted at the beginning of this report, this high level of deprivation

[37] Minutes: 6th November Julie Dent (Chief Executive, South West London Strategic Health Authority)
[38] A Focus on General Practice in England. Audit Commission, July 2002
[39] Office of National Statistics 2000/01
[40] Memoranda: Dr Diane Gray Kings Fund

results in higher levels of ill health and complex health needs, particularly in the inner city areas. Coupled with an increasingly complex workload, this places an additional burden on primary care services and adds to the difficulty of recruiting staff. The intensity of the workload in deprived urban areas often acts a disincentive for primary care staff.

Terms and Conditions of Employment

2.24 There are particular problems in London with variations in pay and terms and conditions of employment between staff employed by the NHS and staff employed directly by practices. The fact that London weighting is not paid to many practice staff is mentioned specifically in several submissions. This means that whilst community nurses (who are employed by the NHS) will be paid London weighting, many practice nurses will not. A number of PCTs are investigating the feasibility of developing a generic nursing role across the primary care spectrum.

2.25 Representatives from the Royal College of Nursing expressed concerns about these variations and informed us that the pay and terms and conditions of practice nurses in London is a significant problem, particularly for single-handed GPs with no practice managers. *"GPs that can afford better premises, provide opportunities and good salaries will attract nurses, and the surgeries that are unable to offer comparable terms and conditions will encounter recruitment and retention problems."*[41] They expressed hope that as PCTs develop, some of these differences in employment practices will be addressed.

2.26 Ian Ayres confirmed that this is an issue that PCTs will need to resolve. He informed the Committee that whilst PCTs are unable to do much to influence national pay scales, they can work with practices to improve the quality of GPs as employers.[42] He also said that in the long term in Sutton and Merton, he envisages moving the employment of practice nurses to the PCT in order to integrate the skills mix, development, training and support of community nursing with practice nursing. This would enable the PCT to ensure consistency in employment practices across the primary care sector.

2.27 Bromley Primary Care Trust has carried out a preliminary analysis, which confirms a wide variation in practice nurse salaries, with many salaries below the levels of what are perceived to be comparable roles in the NHS. The Trust is carrying out further work to assess the extent to which these variations are due to the complexity of roles, and how far similar roles within primary care differ in pay rates. The Trust intends to work closely with GPs to address the outcomes of this research.

[41] Minutes 13th of June Royal College of Nursing (Eileen Sutton and Jayne Tierney)
[42] Minutes: 25th September Ian Ayres (Chief Executive Sutton and Merton Primary Care Trust)

Recommendation 3

All Primary Care Trusts should provide support to practices in their areas to develop appropriate terms and conditions of employment for practice nurses, with the aim of developing generic nursing roles across the primary care spectrum. This should include measures to ensure primary care staff have appropriate access to London Weighting, and to training and development opportunities. This work should be co-ordinated across London by the Strategic Health Authorities and Workforce Development Confederations, to ensure a degree of uniformity across the Capital.

Staff Shortages – the Impact on Primary Care

2.28 Recruitment and retention problems impact on both on the availability and quality of healthcare services in London. Earlier in the report we provided details of the numbers of GPs for the London population. Table 2 shows that GPs in London have lists that are larger than the national average. As well as providing health care for larger numbers of patients, GPs and other primary care staff have to provide services to meet the complex health needs of London's diverse, and in some areas highly deprived population.

2.29 A number of these patients will require extra support in terms of translation and interpretation, a great number may require more specialised care due to long term illnesses and disabilities, such as mental health and HIV/AIDS which are illnesses that are more prevalent in the capital than in the rest of the country. Lambeth Primary Care Trust report that recent influxes of refugees and asylum seekers, along with a large proportion of hostel residents with extremely complex health and social needs, is placing severe strain on primary care in the area.[43] This complex problem is also true of other areas of London.

2.30 We have heard evidence that primary care staff shortages particularly for GPs, is resulting in closed lists. People are therefore unable to register with a GP. Newham Community Health Council report that registering with a GP is a continual problem for new arrivals to the area, and changing GP is virtually impossible. Although a recent pilot 'Find a Doc' project undertaken by the former East London and the City Health Authority, made it slightly easier for people to register with a GP, it did not improve the situation for those wishing to change GPs.[44] As well as new arrivals, the GP recruitment problem is also affecting people who move within the capital.

2.31 **Closed GP lists are a major barrier to primary care for some of the most vulnerable in the capital, particularly highly mobile populations such as the homeless, refugees and asylum seekers, travellers and young people.** This was highlighted in our consultation events and in evidence from a range of community organisations, many of which perceive this as an issue of GPs being selective about who they will register. In addition, community and patient groups have significant concerns about the fact that GPs can remove individual patients from their lists, without having to explain their reasons for doing so. PCTs also identify this as an area of concern and some are increasing their focus on the need for "assisted registration" for people experiencing

[43] Memorandum: Lambeth Primary Care Trust
[44] Memorandum: Newham Community Health Council

problems registering with a GP in their area. We believe that urgent action needs to be taken to address this issue in more depth, particularly in view of the fact that some of the most vulnerable within our community are clearly facing disadvantage as a result. We are considering this as part of the London Assembly scrutiny on GP recruitment.

Recommendation 4

GPs should be required to inform both patients and the Primary Care Trust of the reasons for the removal of a patient from a GP's list.

Extending the Roles of Healthcare Workers

2.32 There are various initiatives which are developing ways of making primary care professions more attractive. These include enhancing job roles so that people derive greater career satisfaction from them. It is hoped that these initiatives will increase the number of primary care workers entering the various professions, and also act as an incentive for people to remain in London. We consider some of these strategies and initiatives below.

2.33 Skills mix and professional development have been key themes in the development of primary care throughout the past two decades. One result of this has been the extension of the work of a wide range of healthcare practitioners leading to the development of roles such as practice nurses, health visitors and other types of nurses that are now taking the lead on delivering some primary care services.[45] The NHS Plan states that appropriately qualified nurses, midwives and therapists are to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe certain drugs.[46] Other developments include expanding the role of pharmacy services, such as the development of Local Pharmacy Service Pilots, which will test out new approaches to community pharmacy, such as repeat dispensing [47]

Nurses

2.34 Historically, the nurse practitioner movement arose in the UK in the 1980s as a response to the lack of appropriately qualified and experienced medical practitioners, patients' general dissatisfaction with their quality of care and difficulties with access to primary health care.[48] The Directorate of Health and Social Care (London) (DHSC) informed us that Trusts in London are using these roles in service planning and when developing nursing strategies to take forward the NHS modernisation agenda. Nurse practitioners are being used by Primary Care Trusts as part of the process of developing patient centred nursing, midwifery, health visiting and therapy services.[49]

2.35 In London it is anticipated that by 2004, 1,308 nurses will be able to prescribe as independent prescribers. In May 2001, the extension (extended formulary) to

[45] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[46] The NHS Plan July 2000
[47] Memorandum: Directorate of Health and Social Care
[48] Fawcett-Henesy A. The British Scene Nurse Practitioners: Working for Change in Primary Health Care Nursing, London: King's Fund, 1991
[49] Memorandum: Directorate of Health and Social Care

nurse prescribing was announced to enable nurses prescribe a wider range of medicines for a broader range of medical conditions (minor injuries, minor ailments, promoting healthier lifestyles and palliative care.) It is envisaged that 436 nurses in London will be able to train in 2002/03 and 2003/04. The DHSC envisages that a number of these nurses will be working in primary care. [50]

2.36 Research shows that the use of nurses in primary care does not compromise the quality of patient care. A study of nurse-led telephone consultation in primary care showed that nurses were able to provide safe and effective care and were able to manage a high proportion of primary care calls at night (as well as during evenings and weekends), without an increase in patients attending daytime surgeries within the next three days. The studies showed that this actually led to a reduction in GP workload.[51] [52] In addition, participants at our consultation events were broadly in favour of an increased role for nurses, although some highlighted the need to allow patients time to build confidence in nurse interventions.

2.37 A nurse-run depression pilot in a primary care practice in South London was set up in an attempt to manage patients needing longer consultations, regular contact and who have a tendency to drop out of treatment. The project has identified several key points for further research. The results from the pilot show that nurses have been able to encourage some patients to seek help who otherwise may have been marginalised by the healthcare system. Secondly, patients valued the fact that the nurse practitioner was their first point of contact instead of a receptionist.[53] On the 25th September, Andrew Burnett informed us that there is robust evidence that nurses can reduce GP workloads by up to 50% and that these extended nursing roles should be used in such a way that GPs are able to spend longer with the patients who specifically need GP care.

2.38 Extending the roles of nurses in primary care is not without problems. Several PCTs expressed concerns about difficulties with recruitment and retention, logistical problems in releasing nurses to undertake training, and the danger that over specialisation could erode the general nursing role. Andrew Burnett informed us that although he wanted to increase the number of nurses involved in extended roles, it is proving as difficult to recruit nurses as it is doctors.[54] Ian Ayres informed us that with extended nurse prescribing there are difficulties getting clinicians to mentor because at the moment mentoring is run on a voluntary basis. He is considering ways to provide the mentoring resource from within the trust.[55]

2.39 Redbridge Community Health Council informed us that although they support extending roles for appropriately qualified nurses, midwives and therapists, Redbridge has particular problems with staffing levels for existing services, and

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[50] Memorandum: Directorate of Health and Social Care

[51] Lattimer V et al. Safety and Effectiveness of Nurse Telephone Consultation in Out of Hours Primary Care: Randomised Controlled Trial. BMJ 1998;317: 1054-9

[52] Thompson F et al. Overnight Calls in Primary Care; Randomised Control of Management Using Nurse Telephone Consultation. BMJ 1999;319

[53] Symons, L. An Open Access Nurse Led Primary Care Pilot Depression Service in South London: Report to the Charlie Waller Memorial Trust 2001.

[54] Minutes of Evidence: 25th September Andrew Burnett (Director for Health improvement and Medical Director Barnet Primary Care Trust)

[55] Minutes of Evidence: 25th September Ian Ayres (Chief Executive Sutton and Merton Primary Care Trust)

nursing and therapy staffing establishment levels are low.[56] This will therefore affect the ability of nurses to take on these new roles. Some PCTs expressed concerns that extending the role of nurses will not improve the accessibility and quality of primary care services, because nurses already have full caseloads. [57] Several point out that actual prescribing rates by nurses remain very low as a result of the limitations in what they can prescribe, difficulties in securing professional support and adherence to traditional professional boundaries. [58]

2.40 The Audit Commission report on General Practice, found that nationally, while there has been a large increase in the number of practice nurses, there is still no national strategy to support their progress and development.[59] The report states that the numbers of practice nurses has grown in a piecemeal fashion with varied job descriptions depending on the local policy of the practice. There is no consensus on the scope of practice nursing or the degree of specialisation. As we highlighted above, terms and conditions vary widely between practices, as do both access to training and development and clinical supervision. The report highlights the fact that at present, there are no agreed national standards for the role of nurse practitioners or the skills, competencies and training required by these extended roles. **We hope that some of these difficulties will be addressed by extending the range of medicines that they are able to prescribe, and through the commitment of PCTs to the successful extension of these roles.**

Community Pharmacists

2.41 London has a density of 2.8 community pharmacies per 10,000 of the population, which is higher than the national average (approx. 2.1 per 10,000 population).[60] Community pharmacists work in high street chemists dispensing drugs to patients, mainly from GP prescriptions. Patients also visit community pharmacists for non-prescription medicines and general and specific advice. Since chemists are normally open at weekends and for longer hours than GPs, community pharmacists often provide primary care services direct to patients without an appointment or a charge.

2.42 It is widely recognised that community pharmacists are an underused resource in the primary care sector. The Government published *'Pharmacy in the Future'*[61] which recognises the role of pharmacists in making services more accessible to patients and reducing pressure on GPs. This publication also considers ways in which community pharmacists can help to implement the NHS Plan. The NHS Plan states that pharmacists will be able to take on a new role as they shift away from being paid mainly for the dispensing of individual prescriptions, towards rewarding overall service. Proposals will be invited for Personal Medical Services (PMS) type schemes that pilot alternative contracts for community pharmacy services. [62] Pharmacies will provide extra help to patients to help them get the best from their medicines and will cover areas such as medicines management and repeat prescribing. The Plan also states that by 2004 all NHS Direct sites will refer people, where appropriate, to help from their

[56] Memorandum: Redbridge Community Health Council
[57] Memorandum: Brent Primary Care Trust
[58] Memorandum: Brent Primary Care Trust, Hammersmith and Fulham Primary Care Trust
[59] A Focus on General Practice in England. Audit Commission, July 2002
[60] National Statistics Community Pharmacies in England and Wales: 31st March 2001, Department of Health, 2001.
[61] Pharmacy in the Future – Implementing the NHS Plan, Department of Health, 2000
[62] A Focus on General Practice in England. Audit Commission, July 2002

local pharmacy. The DHSC informed us that the first PMS type pilot schemes will be approved in 2002. It is thought that these schemes will provide opportunities to address areas of inequality of access to pharmacy services and improve out of hours access to medicines.

2.43 We were informed that whilst there has been some expansion of the roles and responsibilities of community pharmacists, this has occurred within the confines of the current national contract for community pharmacy. These confines include the requirement for a pharmacist to be on the premises during opening hours to supervise sales of medicines and the dispensing of prescriptions, and the scarcity and high cost of locum pharmacists. Examples of successful initiatives where the role of community pharmacists has been extended, include pharmacists operating as smoking cessation advisers, voucher schemes for minor ailments, and pharmacists operating patient group directions appropriate for the community pharmacy setting.[63]

Recommendation 5

There is a need to substantially expand the delivery of health care and prescribing by pharmacists. Each primary care Trust should ensure that there is at least one facility in their area that provides 24 hour pharmacy services to match the 24 hour services provided by GPs and hospitals.

Croydon Minor Ailment Voucher Scheme[64]

2.44 We were told about a successful way in which extending the role of community pharmacists has benefited the local community. Patients are identified in the GP surgery as they book an appointment. If the appointment is for one of the minor ailments covered by the scheme (athletes foot, back pain, colds, cough, flu, fever, headache, hayfever, headlice, diarrhoea, sore throat, sprains, strains) the patient is offered a referral to the local community pharmacy. The referral is not the only option for the patient and if they wish to see the doctor they are given an appointment in accordance with the surgery's normal procedure.

2.45 If the patient chooses to accept the referral to the pharmacist they are issued with a voucher by the reception staff. This voucher has a section, which is identical to the back of the prescription form (FP10), therefore, if the patient is eligible for free prescriptions they will be eligible for free medication using the voucher. If the patient pays for prescription charges they can buy them direct from the pharmacist, since most of the medicines covered under the scheme are cheaper if bought direct.

2.46 The scheme benefits the patient in the following ways:

- It increases patient choice with respect to which healthcare professional they should consult for minor ailments.
- Those eligible for free prescriptions still receive their medicine free of charge, without having to see the GP for a prescription.
- There is a provision for rapid referral of the patient back to the surgery where

[63] Memorandum: Helen Hill Croydon Primary Care Trust (Community Pharmacy Adviser)
[64] Memorandum: Helen Hill Croydon Primary Care Trust (Community Pharmacy Adviser)

necessary.

- The waiting time between the decision to consult a healthcare professional and the consultation is reduced, thus allowing medication to be started sooner.
- More GP appointments are available for patients with chronic conditions or urgent healthcare needs.

2.47 We were informed that the Croydon voucher scheme has led to a reduction in the waiting time for routine appointments. During the first six months of the scheme 78% of the vouchers issued were redeemed at a local pharmacy and approximately 1350 additional appointments were made available. Due to the success of the scheme it has been extended to the North Croydon area.

2.48 There is substantial enthusiasm within the pharmacy profession for extending their roles.[65] Unfortunately there are a number of barriers, which need to be overcome:

- Lack of pharmacists. We were informed that this is particularly acute in the South East of England and has occurred because there are not enough places in the universities for pharmacy students.
- The extended opening hours of pharmacies and the increase in primary care pharmacy opportunities has lead to an increase in the number of pharmacist hours required to operate the business.[66]
- There is an increasingly female workforce who may be working part-time.
- There is a lack of trained pharmacy technicians and assistants. [67] [68]

2.49 Concerns have also been expressed regarding the issue of patient confidentiality. Redbridge Community Health Council informed us that they are aware that many people already approach pharmacists to discuss medication, but one practical problem in developing this role is that there is usually little privacy on pharmacy premises to discuss intimate health concerns and this may act as a disincentive for the public.

Patient Attitudes to Extended HealthCare Roles

2.50 The success of these schemes largely depends on patients. If patients feel happy to use other healthcare practitioners instead of seeing a GP, then as experienced in Croydon, some of the pressure on GPs may be relieved, therefore allowing GPs to use appointments for patients with chronic conditions or urgent healthcare needs. A MORI poll of 1,972 adults commissioned by the British Medical Association (BMA) in early 2002 found that 87% of people would be happy to see a nurse rather than a doctor, if they felt their condition was not serious. [69] Another survey conducted by Bexley Primary Care Trust, has indicated that the 68% of the public would be happy to be treated by a properly qualified nurse or paramedic rather than a doctor.[70]

[65] Memorandum: Helen Hill Croydon Primary Care Trust (Community Pharmacy Adviser)
[66] Memorandum: Croydon Primary Care Trust
[67] Memorandum: Croydon Primary Care Trust
[68] Memorandum: Helen Hill Croydon Primary Care Trust (Community Pharmacy Adviser)
[69] A Focus on General Practice in England. Audit Commission, July 2002
[70] Memorandum: Bexley Primary Care Trust

2.51 Our commissioned research has shown that:[71]

- Patients were more satisfied with nurse-led care than that from a GP.
- Patients reported receiving more information about their illness from the nurse practitioner than the GP, which is perhaps related to the fact that nurses gave longer consultations.
- Nurse practitioners conducted more tests than GPs.
- No differences were found in re-consultation or referral rates between nurse practitioners and GPs.
- No significant differences were found in health service costs for GP consultations and nurse consultations.[72]

2.52 Research has also revealed that nurses appear to be much better than GPs in supplying information to patients to promote self-care and patient confidence. Nurses may also be more likely to improve uptake of health prevention measures such as in coronary heart disease.[73] It is important to recognise that longer consultations and more investigations have resource implications, and the benefits of these longer consultations therefore have to be balanced against the benefits to the patient.

2.53 At our consultation event, whilst delegates supported the extension of healthcare roles in primary care, they emphasised that patients should reserve the right to choose the healthcare practitioner they see.[74] Redbridge Community Health Council, also endorse this approach, *"We support the expansion of clinical tasks for appropriately qualified practice nurses, providing that an element of choice remains, whereby patients retain the option to access a GP."*[75] We believe that this approach should be adopted as a matter of practice as is done with the Croydon Voucher Scheme.

Recommendation 6

We welcome the different initiatives and strategies to extend the roles of primary care health care workers. PCTs and GPs should ensure patients have access to clear information about the new range of options for accessing primary care, including advice about the extended roles of nurses and other staff, and reassurance about the training and support being provided to enable staff to fulfil new responsibilities. In implementing these initiatives at local levels, we urge that patients be given the option of seeing a GP if they so choose.

2.54 Although several submissions point out that they are unable to confirm that extending roles reduces GP workloads, they state that this may possibly be because of levels of unmet need in their systems at present. Concerns were also expressed that the shift to delivery of care by multi-disciplinary teams may result

[71] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[72] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[73] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[74] Access to Primary Health Care Services in London; Findings from the Public Consultation Event 18th May 2002
[75] Memorandum: Redbridge Community Health Council

in a loss of continuity of care and individual patient/GP relationships. We explore the issue of continuity of care in the next chapter.

2.55 There are of course teaching implications and a need for clarity and standardisation of these roles. In their evidence the NSPCC highlighted this as a concern. It is essential that appropriate training and support for child protection is extended to staff working in these new roles and to those working in new primary healthcare settings such as NHS Direct and Walk in Centres.

Increasing Workforce Capacity – NHS Initiatives

2.56 The NHS is aware that recruitment and retention problems will affect their ability to deliver NHS targets and to improve access to primary care. *"If we don't have the workforce we can't achieve the targets and its as simple as that. We are very aware of that."*[76] Aware of this immense challenge the London Directorate of Health and Social Care is implementing a range of initiatives both at strategic health authority level and through individual primary care trusts. We explore some of these initiatives below.

The Role of the Workforce Development Confederations

2.57 Workforce Development Confederations (WDCs) bring together local NHS and non-NHS employers to plan and develop the whole healthcare workforce. This approach recognises that the NHS is not the only employer of healthcare staff, and that local authorities, private and voluntary sector providers, and others need to work together if workforce planning and development is to be effective.[77]

2.58 The WDCs play a key role in driving forward work to increase staff numbers. An important part of their role is to develop and spread improved ways of working that tackle problems of recruitment and retention. Workforce Development Confederations (WDCs) have boundaries that are co-terminous with Strategic Health Authorities. This enables the Strategic Health Authorities to both performance manage WDCs and work closely with them to modernise the healthcare workforce in their areas.

2.59 North East London Strategic Health Authority informed us that all NHS organisations have to develop robust workforce plans. All the workforce plans for local NHS organisations are brought together into a single workforce plan for the Strategic Health Authority. The plans identify growth targets, strategies for recruitment and retention, and plans for education and training.[78] A Pan London Action Group oversees the achievements of the different Workforce Development Confederations towards their action plans. The primary care trusts that submitted written evidence confirmed that this approach is spread across London.

Teaching Primary Care Trusts (PCTs)

2.60 The Government has allocated £25m over three years towards developing teaching PCTs in disadvantaged and under-privileged areas. It is envisaged that teaching PCTs will be able to create new, attractive posts, offering wider career development opportunities linked to part time teaching/ learning roles. It is

[76] Minutes of Evidence 29th May 2002 Pippa Bagnall(Head of Primary Care DHSC)
[77] www.doh.gov.uk/workdevcon/guidance.htm
[78] Memorandum: North East London Strategic Health Authority

hoped that by establishing teaching PCTs in disadvantaged areas, it will facilitate the recruitment of high quality staff and bring much needed capacity in to areas of need. It is hoped that the creation of these teaching PCTs will go some way to addressing the disincentive of working in deprived urban areas.

2.61 In 2001, the London Directorate of Health and Social Care (DHSC) supported the development of three applications. The North Central Strategic Health Authority was successful and Haringey teaching PCT was established in April 2002. Greenwich, on behalf of the South East Strategic Health Authority and City and Hackney, on behalf of the North East Strategic Health Authority were approved in principle to start in April 2003. The DHSC has provided funding to support the development of applications from South West and North West Strategic Health Authorities. The DHSC is working towards establishing a teaching PCT in each Strategic Health Authority in London.[79]

Strategies to Improve the Provision of Childcare[80]

2.62 The DHSC is developing several strategies to improve childcare for health practitioners across London:

- Capital money has been awarded to 14 organisations which will result in 487 new nursery places in London becoming available from February 2002. These places will be gradually introduced as capital developments come on stream.
- Each Strategic Health Authority in London is working on a strategy for the development of Childcare Co-ordinators. There are currently 12 staff undertaking the childcare co-ordinator role across London and these roles will be developed further.
- £3million is available for 2002/3 for establishing Workplace Nurseries.
- DHSC is developing opportunities for staff to access more flexible forms of childcare including after school clubs and holiday play schemes. They intend to develop a subsidised approach to these and other forms of childcare beyond the workplace nursery initiative including using childminders and childcare vouchers.

The Return to Practice Programme[81]

Nursing and Midwifery

2.63 Between April 2001 and May 2002, 29 midwives and 450 nurses returned to NHS employment. We were informed that 121 nurses and 17 midwives would have finished their return to practice training by 2002.

Allied Health Professions, Scientists and Technicians

2.64 Since April 2001 13 radiographers, 11 physiotherapists, 5 occupational therapists, 3 speech and language therapists, 2 dieticians, 1 pharmacist, 2 scientists and 3 technicians returned to work with the NHS in London. Whilst this paints a positive picture we were not provided with a breakdown of those returning to work in primary care.

[79] Memorandum: Directorate of Health and Social Care
[80] Memorandum: Directorate of Health and Social Care
[81] Memorandum: Directorate of Health and Social Care

Refugee Doctors

2.65 In their written evidence the DHSC informed us that there is considerable untapped potential in recruiting refugee doctors to work in primary care and other healthcare settings. As of January 2002, there were 484 refugee doctors on the database held by the British Medical Association with a considerable percentage living in London. As part of the action plan to deliver NHS Plan targets for increases in GPs, plans to recruit refugee doctors have been included within the remit of the DHSC Pan London Action Group, established to oversee the recruitment of GPs.

2.66 **We recognise the importance of accrediting appropriately qualified refugee doctors in London and view their skills as a resource which could be used to address some of the recruitment and retention problems in the capital.** This is also a way of developing a workforce that is reflective of the community it serves.

2.67 The DHSC recognise that there are benefits to be gained from the medical accreditation of appropriately trained refugees. *"There are multiple benefits to be gained from supporting refugee health professionals back into employment in their original or related professions. One in twenty Londoners is a refugee and having refugees who are members of staff promotes understanding of the needs of these patients"*. [82]

2.68 The DHSC also informed us that:

- It costs less to accredit a refugee nurse or doctor than to train one from scratch.
- Whilst international recruitment is needed as a temporary stopgap, there is clearly an argument for investment in the accreditation of London residents with overseas qualifications. In the long term this may prove to be more cost effective, since they are more likely to remain in London, and have fewer accommodation needs, than those brought in through international recruitment.
- Refugee doctors have a first hand understanding of the cultural and socio-economic background of patients in multicultural London.
- Refugees are five times more likely to be unemployed. Employment brings economic independence and has a positive impact on the mental and physical health of both adults and children.[83]

2.69 We were informed that funding for the necessary conversion courses and exam fees can prove prohibitive, particularly where the refugee is on benefits. Some refugees have been able to overcome this financial burden by securing financial support from Single Regeneration Budgets, the European Social Fund and some specialist charities e.g. Ruth Hayman Trust.[84] We will continue to consider the issue of the recruitment of refugee doctors as part of the Health Committee scrutiny into GP recruitment and retention.

[82] Memorandum: Directorate of Health and Social Care
[83] Memorandum: Directorate of Health and Social Care
[84] Memorandum: Directorate of Health and Social Care

Increasing Capacity – Personal Medical Services (PMS)[85]

2.70 The 1997 NHS Primary Care Act, enabled the creation of Personal Medical Services (PMS) pilots. PMS pilots are based on contracts negotiated with the PCT, in contrast to the usual GP contracts which are more complex and nationally determined. Personal Medical Services (PMS) pilots (have enabled different arrangements from those of traditional general practice). They have employed a number of strategies to both improve GP recruitment and retention, and improve access to primary care services. These include allowing participating GPs the option of being salaried; allowing nurses and former community trusts to take a lead on providing primary care for the first time; allowing GPs the option of providing extended services; providing primary care services in areas where care has been previously unavailable and targeting services to the needs of local vulnerable and disadvantaged groups. *"The take-up of PMS has been particularly popular in London, with a fifth (21%) of all PMS pilots in the country being based in the capital. London PMS pilots have particularly focused on nurse-led models of care with three of the thirteen pilots being led by nurses."* [86]

2.71 PMS pilots have provided opportunities to:

- Make primary care more locally responsive
- Address problems of recruitment and retention of GPs. In London ten of the thirteen live PMS pilots stated that recruitment was an objective.[87] Research suggests that salaried posts in PMS contracts have the ability to realise the potential of the GP workforce, including inactive GPs and locums.
- Enable closer working relationships within the primary care team thereby introducing greater flexibility in general practice.
- Address inequalities in the provision of health care.

2.72 Evidence suggests that first wave PMS pilots are successful at increasing access to primary care. "Access to primary care has been improved in London as a result of PMS pilots. In addition to the recruitment of extra clinical staff at most sites, five pilots involved the establishment of wholly new primary care services. These were in areas where access had been identified as a problem or where particular populations (e.g homeless people or refugees) were perceived to be under-served by general medical services (GMS contracts)[88]

2.73 The introduction of PMS is identified in many of the submissions from PCTs as a positive development. PMS has enabled the development of relationships between PCTs and practices that are based on clinical quality, rather than on relationships with individual GPs. PMS has also helped to alleviate some of the problems caused by the shortage of GPs by enabling practices to employ salaried GPs.

[85] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[86] Kings Fund; Review of the First Wave Personal Medical Services in London, R Lewis, C Jenkins and S. Gillam.
[87] Kings Fund; Review of the First Wave Personal Medical Services in London, R Lewis, C Jenkins and S. Gillam.
[88] Kings Fund; Review of the First Wave Personal Medical Services in London, R Lewis, C Jenkins and S. Gillam.

2.74 Some PCTs have reported significant variations in the uptake of PMS. For example, Ealing PCT only has two PMS schemes, and reports a general lack of engagement *"due to a perceived loss in independence amongst GPs"*.[89] However, most PCTs report that PMS is proving popular and many have high rates of participation, for example, in Lambeth 70% of practices work to PMS.[90]

2.75 Lewisham PCT has been involved in PMS since the launch of the first wave in October 1998. *"The PMS pilots range in their objectives dependent on the needs of the local population. They include mental health pilots and specific work to address the high levels of teenage pregnancies within the borough. Many of the pilots are in areas of high deprivation and seek to provide new models of care and support to high need patients."*[91]

2.76 Lewisham PCT also report that:

- 40% of all practices within the borough are part of a PMS pilot, with others currently applying.
- PMS has encouraged the establishment of over 15 new GP and Nurse Practitioner posts within the borough.
- PMS has led to the innovative development of a cluster PMS pilot bringing six local single-handed or small practices together to work on shared local objectives and to tackle the complex issue of professional isolation.

2.77 Newham Community Health Council (CHC) informed us that a high number of GP practices in Newham have applied to become PMS pilot practices. The CHC has been fully involved in the consultation process and considers PMS to be a useful way of providing services specifically designed to meet the needs of many disadvantaged communities. For example, one of the PMS projects in Newham has established a Transitional Primary Care Team. This team provides a primary care service to people currently unable to register with a GP in their local area. Monitoring by the CHC has shown this to be an excellent project, providing appropriate primary care services for those who would not otherwise have been able to access primary care. They state that they would like to see more PMS projects such as this, both in Newham and in other parts of London.[92] **We welcome the fact that PMS is having a positive impact on primary care services, particularly for vulnerable communities.**

Recommendation 7

We are pleased to hear that the implementation of Personal Medical Services (PMS) is successful in London, providing primary health care services to vulnerable communities and addressing some of the recruitment and retention problems of primary care staff. We call upon the Strategic Health Authorities and Primary Care Trusts to continue to actively promote PMS across London.

[89] Memorandum; Ealing Primary Care Trust
[90] Memorandum; Lambeth Primary Care Trust
[91] Memorandum; Lewisham Primary Care Trust
[92] Memorandum; Newham Community Health Council

Increasing Capacity – The New GP Contract[93]

2.78 The new GP contract, currently under negotiation is identified as crucial in many PCT submissions. The proposed new contract contains a range of measures (some new and some already established) to improve GP employment conditions nationally.[94] It is intended to help recruitment and retention throughout the country by providing additional resources for primary care, together with more family friendly policies and encouragement for GPs to remain in practice for longer. These include:

- Increased flexibility in GP employment options and career development, including a salaried option and higher professional training following completion of vocational training.
- Support for the concept of GPs with special interests.
- Removal of the responsibility of 24-hour care of patients.

2.79 We were informed that the formula for the contract takes the increased staff costs of delivering services in London and also high patient list turnover into account, and that premises' costs will be reimbursed outside the formula and this should take into account any increased costs in that area. In addition, there will be access to other funding through new National Enhanced Services for the homeless, asylum seekers and non-English speakers.[95] If it adequately covers the problems of practicing and living in deprived urban areas this new funding formula will have a major impact on the number of GPs practicing in London.

2.80 Practices will have the ability to opt out of providing some services (for example out of hours services) or offering additional services. If these measures help the recruitment and retention of GPs in London, then access to primary care services is likely to improve, but the withdrawal of some currently provided services may lead to breaks in the present continuity of care.**[96]** (e.g. if health visitors take on immunisation roles relinquished by GPs). The new contract for GPs envisages that resources for NHS general practice are set to rise by 33 per cent over the next three years and this should help to fill current vacancies. We hope that this will provide some form of incentive enabling the capital to retain GPs.

2.81 At one of the evidentiary sessions Dr Gillian Braunold told us that GPs do have concerns about the new contract, *".. the biggest concern I have heard from colleagues is that with all the necessity to look at the quality framework, targets and validity indicators,, that which is special about general practice, will be lost. We'll be busy hunting access and skill mix and nurses and putting things on the computer, and the fact that Mr Jones came in and said in passing that he hasn't slept since Mrs Jones died, will get lost in them saying, "But you haven't had your blood pressure checked for five years"… the fear of management forcing all these extra targets and losing what makes general practice special…."*[97] Dr Gillian Braunold also informed us that there is important work that needs to be done in terms of helping practices to implement the new contract, and it would take time before the benefits of the new contract arrangements were felt.

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[93] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[94] General Practitioners Committee. Your Contract Your Future. 2002.GMC
[95] British Medical Association 20/01/2003
[96] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[97] Minutes of Evidence 23rd October 2002 Dr Gillian Braunold

Increasing Capacity – Reflecting the Local Community

2.82 Throughout the hearings and across the written evidence we heard that it is important that NHS organisations reflect the composition of local populations in their workforce. It was recognised that this will assist in overcoming some of the barriers around language and translation, and also assist NHS organisations to develop healthcare services that are culturally appropriate for the local communities that they serve. The DHSC informed us that in pursuance of this they are creating opportunities for career development for all staff. They are specifically creating assistant and support roles, linked to accredited staff development with career paths, to create an effective careers skills escalator for local people, with routes to professional status for those who want it.[98]

2.83 Across London several NHS organisations, in partnership with a range of organisations, are developing and implementing other initiatives:[99]

- Several PCTs have introduced healthcare assistants into primary care, with development routes through Access to Care NVQs: (Barnet, Camden and Islington, South West London and others)

- Some have provided supervised practice for refugee nurses, and are pleased at quality of nurses they have gained (Tower Hamlets PCT Elderly Services)

- Tower Hamlets PCT is developing work with PATH, a black training organisation, to offer management and other training placements to unemployed ethnic minority graduates.

- Tower Hamlets Social Services has capacity built several local community organisations to become preferred providers to provide culturally appropriate homecare services. These are Bengali, Somali and Vietnamese organisations. One now has a turnover of £1m and is providing employment for 100 local people.

- South West London Workforce Development Confederation and South West London Mental Health Trust have worked with South Thames College to provide the new Certificate in Mental Health with additional basic skills provision, to Health Care Assistants in mental health. This is an accepted qualification for entry to Nursing Diploma. It is intended that this will be extended to train social care, voluntary and NHS mental health support workers together in the future.

- West London Learning and Skills Council has developed a package for Investors in People, linked to NVQ and management training, to meet clinical governance requirements in local GP practices. To date 26 GP practices have benefited.

2.84 We welcome the development of these initiatives and would like to see more of them established, particularly for young people. London has a young population. The proportion of young people in the capital's population is higher than is seen nationally. In 2000, approximately 41% of England's population was aged between 16 and 44, compared to 47% of London's population.[100] Our young population is therefore a potential workforce that could be used to

[98] Memorandum; Directorate of Health and Social Care
[99] Memorandum; Directorate of Health and Social Care
[100] Memorandum; London Health Observatory

address both current and future recruitment and retention shortfalls in the capital.

2.85 In order for youth recruitment strategies to be successful there is a need for the NHS in London to market itself as a 21st century employer amongst London's school leavers and graduate population. This will include providing relevant work experience opportunities to secondary school pupils and setting up volunteer schemes so that interested young people are able to familiarise themselves with the health service and view it as a viable career option.

2.86 The challenge to develop and maintain a primary care workforce for London is by no means an easy task. We are pleased that the NHS have recognised this. It is clear that there is a need to look very closely at what the workforce in London requires and how the London primary care jobs can look more attractive when compared to the same roles in the rest of the country. Although much is being done by the different Strategic Health Authorities and Workforce Development Confederations, **there is a need for a comprehensive strategic pan London approach to recruitment and retention, based on a regular evaluation of local staffing requirements and an evaluation of the progress made across London.**

2.87 This pan London evaluation should also take the following into account:

- The needs of both the primary and the acute sectors. The recruitment and retention needs of both sectors should be balanced so that they are not in competition with each other.
- The need for close partnership work to ensure that different organisations within the health and social care sector (for example, local authorities and the NHS) do not compete against each other for the same pool of staff.
- The need to ensure that recruitment initiatives are developed in such a way that staff will be attracted to work in deprived areas of London, thus preventing these areas losing out to the more popular areas of the city.

Recommendation 8

We call upon the Department of Health to develop a pan London evaluation of the effectiveness of all their recruitment and retention initiatives. This evaluation must show how the Department of Health is balancing both the staffing needs of the primary and acute sectors, and the staffing needs of different healthcare providers. We believe that such an approach will provide a clearer picture of recruitment requirements and the success of recruitment and retention strategies across the capital.

3. Improving General Accessibility

3.1 One of the ways the Government is trying to improve access to primary care is by setting targets for waiting times and introducing other interventions such as Walk-In- Centres, NHS Direct and NHS Direct online. It is hoped that these targets will improve access, by reducing the time that people have to wait before they see their GP or other primary health care practitioners. The Audit Commission report highlighted the fact that although patients are generally happy with their GP, their greatest source of dissatisfaction is the length of time they spend waiting for an appointment.[101]

Improving Access - Waiting Times

3.2 In 1999 the King's Fund conducted some research on general practice. It reported that over 80% of those interviewed, expected to have to wait more than two days to see a GP, and this figure was even higher two years later.[102] [103] The findings from the National Survey of NHS Patients also confirmed that people are experiencing long waiting times to see a GP.[104]

Key findings from the National Survey of NHS Patients

- 81% of all respondents had seen their GP in the last year and 52% had consulted their practice nurse in the last year.
- 15% of respondents (and 20% of those in work) reported that they put off a visit to their GP at least once in the last 12 months because of inconvenient surgery hours.
- 29% of respondents said that they usually had to wait between two and three days to get an appointment with the GP *of their choice* and a further 25% reported that they had to wait more than four days.
- 55% of women thought it was important to see a GP of their own sex and 37% felt it important to see a GP of their own ethnic group.

Source: National Survey of NHS Patients: General Practice 1998: Summary of Key Findings 1999

3.3 The written evidence we received shows that waiting time to see a GP is also of concern to disadvantaged communities in London. *" Alienated groups like homeless people, refugees and asylum seekers are unlikely to respond well to a system which requires them to undergo potentially long delays in a waiting room or otherwise in order to see a GP for a few minutes."*[105]

[101] A Focus on General Practice in England. Audit Commission, July 2002
[102] Malbon G, Jenkins C, and Gillam S. What Do Londoners Think of Their General Practice? 1999. London, King's Fund
[103] Mulligan JA. What Do Londoners Think of Health Care? 2001. London, King's Fund
[104] National Surveys of NHS Patients: General Practice 1998: Summary of Key Findings. 1999. NHS Executive
[105] Memorandum: Three Boroughs Primary Health Care Team Access to Health Care for Homeless People, Asylum Seekers and Other Socially Excluded Groups.

3.4 The NHS Plan states that by 2004, patients will be able to see a primary care professional within 24 hours, and a GP within 48 hours.[106] Several PCTs point out that they are experiencing greater difficulties in reaching the NHS Plan target for an available appointment with a primary health care professional within 24 hours, than an available appointment with a GP in 48 hours. Enfield PCT reported that 65% of practices in their area can offer an appointment with a GP within 48 hours, but only 46% can offer an appointment with a primary health care professional within 24 hours.[107]

3.5 The responses from PCTs also indicate a significant geographical difference of attainment levels between PCTs and higher levels of disparity on progress in reaching the 24 hour target than the 48 hour target. Kingston PCT has already met both targets, whilst in Lambeth 43% of practices are able to offer an appointment with a health professional in 24 hours and 51% with a GP in 48 hours.[108] **A number of responses have suggested that this target is not an effective indicator of access to primary care, as it measures percentages of practices complying rather than numbers of patients receiving access.**

Recommendation 9

Strategic Health Authorities should ensure that the performance management of Primary Care Trusts does not focus exclusively on targets for access times, but includes consideration of patients' experiences of services provided.

Advanced Access

3.6 Several responses from PCTs refer to participation in the "Advanced Access" initiative which is being led by the Primary Care Collaborative. Advanced Access supports practices in looking at how to use existing capacity more efficiently. Some PCTs report early indications that participating practices are successfully reducing waiting time. *"The practices within Hillingdon PCT operating Advanced Access have found that patients are happier, patient flow is smoother, practice staff are less stressed and clinicians are more in control of their workload."* [109] The London National Primary Care Development Centre (part of the DHSC) is working with all Primary Care Trusts across London to roll out the model of advanced access in order to improve access to primary care in London. [110]

3.7 As at April 2002 there were nine PCT areas that were part of the National Primary Care Collaborative Programme. A significant number of practices within these areas are piloting the model of advanced access. These practices have shown rapid improvements in waiting times within primary care over the past year. On average these practices are reducing their waiting times for patients to see a GP and nurse by well over 50% in one year. The remaining 25 Primary Care Trusts are piloting the model of advanced access in approximately 5-10 practices within their PCT area. (120 practices across London). This work started in Autumn 2001.[111]

[106] NHS Plan July 2000
[107] Memorandum: Enfield Primary Care Trust
[108] Kingston Primary Care Trust; Lambeth Primary Care Trust
[109] Memorandum: Hillingdon Primary Care Trust
[110] Memorandum: Directorate of Health and Social Care
[111] Memorandum: Directorate of Health and Social Care

3.8 The system of Advanced Access involves the following:

- Understanding demand: gathering intelligence on the profile of daily demand i.e. volume and type of appointments requested on different days of the week/times of the year.
- Shaping the handling of demand: reducing the demand for face-to-face appointments by handling demand differently e.g. work going to other health care professionals in the team, telephone management, email consultation, patient self-help.
- Matching capacity to demand: balancing appointment capacity with demand.
- Contingency plans: being prepared for planned and unplanned changes in demand and capacity. [112]

3.9 At the hearing on 6th November we asked representatives from the National Primary Care Development Team, if patients had noticed any improvements due to the implementation of Advanced Access. Siobhan Harrington informed us that there were definite improvements as a result. *"I would actually say that patients are a bit shocked at the beginning, because they don't believe it, they ring up and they can be seen that day or the next day… So, I would say it's very positive from a patient's perspective"*.[113]

3.10 Findings from our commissioned research suggest that collaborative sites have achieved a 50% reduction in waiting times for GPs and nurses. This research also shows that the implementation of Advanced Access should increase access to primary care particularly for those who need urgent medical attention.[114]

3.11 On the 23rd of October we took oral evidence from a group of GPs and we questioned them about waiting times and the NHS targets. Dr Gillian Braunold informed us that the reasons for long waiting times are quite complex and hinge on workforce issues. She said the fact that there are so few doctors and so many patients is a crucial one and is impacting on access. This, coupled with the increasing complexity of consultations compared with consultations of ten or fifteen years ago, is the reason for long waits to see a GP. She also informed us that in London this problem is further exacerbated by the large number of part time GPs. *"Access is only going to be sustained if we have a sufficient workforce able to see people…We can work smarter, we can have skill mix changes with nurses, we can look at chronic disease management and splitting off what we do in consultation - we can do all of that - but you need to have sufficient workforce."*[115]

3.12 Although Dr Braunold acknowledged that some GPs were successfully implementing Advanced Access, she said that *" it only takes a little nudge - a doctor off sick, a doctor on maternity leave - and suddenly they're struggling with demands of advanced access and the quality of clinical care."*[116] She expressed concern that in striving to meet the requirements of advanced access the quality of consultation could be compromised. [117]

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[112] Memorandum: Directorate of Health and Social Care
[113] Minutes of Evidence 6th November 2002 Siobhan Harrington (Head, London National Primary Care Development Team)
[114] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[115] Minutes of Evidence 23rd October 2002, Dr Gillian Braunold
[116] Minutes of Evidence 23rd October 2002, Dr Gillian Braunold
[117] Minutes of Evidence 23rd October 2002, Dr Gillian Braunold

3.13 Dr Michael Taylor expressed a contrary view. Although he acknowledged that he was in the minority, he felt that rapid access is compatible with quality consultation, but agreed that it needed to be appropriately resourced. *"I know that there are some practices who are able to deliver 24-hour access and quality care, but they are few and far between, so you can have both but it does demand some thinking about"*[118].

3.14 We thought that this was an interesting issue requiring further consideration. We were concerned to hear that the quality of consultations could be compromised by the need to provide rapid access for patients. We recognise that some of the most vulnerable in our community (for example, those who do not speak English, people with learning difficulties and the physically less able) need longer consultations. Written submissions from MIND and Mencap highlighted the fact that those with learning difficulties and mental ill health, often have their health needs mis-diagnosed and need longer consultations.[119] We were also informed that most people with learning difficulties can communicate with the appropriate methods and patience, but more tests may be needed due to communication problems and this necessitates longer consultations.[120] In their evidence the DHSC acknowledged some of these concerns. *"There are a number of practices within London who are understanding the profile of their demand and the needs of specific patient groups to ensure equitable access to primary care for all patient groups"* .[121]

3.15 For some patients continuity of care, in terms of being treated by the same Doctor with whom they are familiar, is essential. This is particularly true of older patients. Dr Maureen Baker told us that whilst continuity of care, and the difference this ongoing doctor-patient relationship can make to the quality of care, and to health outcomes, is very important, she felt that with current workforce capacity, traditional continuity of care cannot be met along with all the other demands that are now being made of GPs. *"I think one of the major disadvantages of the Advanced Access model is the lack of opportunity it gives to people who wish to be seen at a specific time or with a specific doctor…..practices that have gone down the advanced access route are often less able to give that sort of flexibility in their appointment times, so, there is a lot to be learned from the Advanced Access model but sadly it's not the complete answer to everything."*[122]

3.16 An article about this by Siobhan Harrington in Capital Doctor of 18th December states: *'the normal assumption is that demand outweighs capacity; in reality this is not the norm even in London… some of the core practices are now finding after six months that they have spare capacity within their surgeries… others are looking at how they can design their systems by having longer consultations.'* We are pleased to see that advanced access is improving waiting times. Whilst we acknowledge that implementing advanced access might prove a challenge for some practices, we recommend that the implementation of advanced access in London be promoted by PCTs and the outcomes monitored.

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[118] Minutes of Evidence 23rd October 2002, Dr Michael Taylor (Chair, Small Practice Association)
[119] Memorandum: Mind Memorandum: Mencap
[120] Memorandum: Mencap
[121] Memorandum: Directorate of Health and Social Care
[122] Minutes of Evidence 23rd October 2002 Dr Maureen Baker (Honorary Secretary Royal College of General Practitioners)

Recommendation 10

Primary Care Trusts should support the implementation of Advanced Access and periodically evaluate its impact on patient accessibility to GP services.

Use of GP Time

3.17 In developing ways to improve access, one of the issues that must be considered is the appropriate use of GP time. Representatives from Social Action for Health informed us that anecdotally, they are aware that 50% of all GP consultations are for non-medical reasons. [123] Representatives from the London Borough of Hackney gave examples of GPs writing letters in support of housing applications as an example of how GP time is wasted, since the letters have no bearing on the outcome of housing applications.[124] *"When I talk to GPs they complain about being made to sign off orange/blue badges, and a whole tranche of things which they need to do in order to help their patient access services, but where they're not required to make any clinical intervention or assessment.*[125]

3.18 Although this role undertaken by GPs enables people to access other services such as welfare benefits, there is a need to look at whether GPs should actually be carrying out such services, because it is a clear misuse of valuable clinical skills and time. We have heard how Advanced Access provides a means of understanding and handling demand, thereby enabling non-medical work to be diverted from GPs and passed to other members of the primary care team such as the practice manager. We believe that this system therefore provides a mechanism for reducing the amount of time that GPs spend on non-medical issues.

3.19 We were informed that another way for GPs to reduce the amount of non-medical issues they are consulted on is by developing an understanding of their local council and how it works. That way they would know whether or not they should write letters in support of various applications. Local authorities also have a main role to play in facilitating this. Nick Johnson, informed us that one way of enabling this is to use the practice manager to deal with such enquiries.[126]

3.20 The National Association of Citizens Advice Bureaux, informed us that in London there are now forty-five advice services placed in health settings and it expects the number to grow, although the rate of growth does depend on the success of securing funding. It states that research has shown that where advice workers are placed in health settings patients who visit GP based advisers visit their doctor less often and receive fewer new prescriptions, and that the provision of welfare advice in health settings reduces stress and improves the well being of patients who make use of such services.[127] Chris Bull confirmed Southwark Council and Southwark PCT have funded a number of welfare rights workers in GP practices which have made a tremendous difference by providing somewhere for social issues to be diverted to.

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[123] Minutes of Evidence 26th June 2002 Elizabeth Bayliss (Director, Social Action for Health)
[124] Minutes of Evidence 30th October 2002 Caroline England (Health and Social Care Policy Manager LB. Hackney)
[125] Minutes of Evidence 30th October 2002 Chris Bull (Director for Social Services LB. Southwark)
[126] Minutes of Evidence 30th October 2002 Nick Johnson, (Director of Social Services, LB Bexley)
[127] Memorandum: National Association of Citizens Advice Bureaux

Recommendation 11

Local authorities must take the lead as the main providers of community information. This should also involve working with PCTs to ensure that staff in surgeries are informed about where to send people for advice about council services.

The Challenge Facing Single - Handed Practices

3.21 Whilst the methods of dealing with non-medical issues outlined above are commendable it is unlikely that they will be appropriate for single –handed GPs. London has a large proportion of single-handed practices. [128] We wanted to know how this impacts on the ability of the GPs to meet demand and provide rapid access. We asked several witnesses what their opinions were. All the witness we questioned about this felt that single-handed practices provide a valuable service, but will find it a challenge to deliver NHS targets.

3.22 Our commissioned research found that many patients appear to prefer single-handed or two partner practices to large group practices, regarding them as providing greater continuity of care and more likely to provide same day treatment. *"… however small practices tend to offer reduced access to other primary care professionals as they are less likely to employ practice nurses, counsellors, physiotherapists, chiropodists and practice managers, and are less able to accommodate district nurses and health visitors. Furthermore single-handed practices may offer limited access to certain aspects of care, as they find it harder to attend professional development and training which can update and refresh their skills and knowledge."*[129]

3.23 On 23rd October we asked a group of GPs whether they thought single-handed practices have the capacity to deliver the NHS Plan. Dr Michael Taylor told us that in his opinion they did and there is no evidence to suggest the contrary. *"There are a couple of things which are traditionally levelled at single-handed GPs, the most pre-eminent of which is that they fail to provide the breadth and the range of services that can be provided and are provided from larger practices… if you look at it from the structural level of the general practice, that can be the case, but whenever it's looked at from the patient's perspective there isn't any evidence to suggest that patients who are part of a small single-handed practice do not have access to the range of services".*[130] Dr Taylor also informed us that single-handed practices will now have to find new ways of working with each other such as co-operative and collegiate working to overcome professional isolation. This way they will be able to meet the complexity and the breadth of the work that GPs are now required to do.

3.24 Dr Maureen Baker informed us that the Royal College of General Practitioners agrees that there is no evidence that single-handed practices per se offer poorer services to their patients, and that there are some factors and some features of general practice that are done better in single-handed practice. She stated that

[128] 42% - NHS GP Census September 2001
[129] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[130] Minutes of Evidence 23rd October 2003 Dr Michael Taylor (Chairman, Small Practices Association)

overall the evidence is that patients are not disadvantaged by belonging to a single-handed practice.[131]

3.25 Dr Burnett informed us that there is the potential for single-handed practices to work together more closely, particularly under the new GP contracts and that this may also be a way to reduce professional isolation and also to provide higher quality care for more specialist areas.[132] Dr Maureen Baker felt that PCTs would be able to facilitate closer working, and that this was an issue they should address.[133] We found that Lewisham PCT is already doing this through PMS arrangements. *"PMS has led to the innovative development of a cluster PMS pilot, bringing six local single-handed or small practices together to work on shared local objectives and to tackle the complex issue of professional isolation."*[134] Julie Dent also confirmed this position, *"..it is about how those single-handed doctors work together to provide the services that need to be provided. That's one of the reasons I am a huge fan of PCTs, they have the ability to manage and plan across primary care in a way that the NHS has never been able to before."*[135]

Improving Access - NHS Walk-In-Centres

3.26 Walk-In-Centres (WICs) were established as a way of improving access to primary services by increasing the points at which people can access such care. They offer extended opening hours and walk-in access, and are staffed by nurses supported by protocols for care and medical advice. By September 2001, 39 WICs had been established nationally, nine of those in London.[136]

Key features of Walk-In-Centres (WICs)

- Extended opening hours (usually 7am to 10pm every day)
- Walk-in access (no appointments)
- Provision of information and treatment for minor conditions
- Offer of health promotion and support
- Key roles for nurses
- Computerised clinical decision software
- Services that are developed to meet the needs of the local population

Adapted from: Salisbury et al, 2002[137]

3.27 Our research shows that there is evidence to suggest that WICs do enhance access to health care for a minority of the population and that they provide an acceptable service.[138] The research shows that:

- WICs do appear to improve access for young and middle-aged men, who generally access primary care less than other population groups.

[131] Minutes of Evidence 23rd October 2003 Dr Maureen Baker (Honorary Secretary Royal College of General Practitioners)
[132] Minutes of Evidence 25th September 2003 Dr Andrew Burnett (Medical Director, Barnet Primary Care Trust)
[133] Minutes of Evidence 23rd October 2003 Dr Maureen Baker (Honorary Secretary Royal College of General Practitioners)
[134] Memorandum: Lewisham Primary Care Trust
[135] Minutes of Evidence 6th November 2003 Julie Dent (Chief Executive, South West London SHA)
[136] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[137] Salisbury et al, The national Evaluation of NHS Walk-in-Centres. 2002 Bristol, University of Bristol.
[138] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002

- People chose to attend WICs because of their convenience, because they feel their GPs are too busy, and due to the anonymity that the WIC offers.
- The quality of care delivered at WICs is highly satisfactory in comparison to both NHS Direct and general practice.
- Even though WICs are nurse-led, people are more satisfied with care received at WICs than at GP surgeries (although high numbers are satisfied with care received in both locations).
- The majority of patients consulting WICs are managed at the centre and only a small minority are referred to their GP or to Accident & Emergency (A&E), although referral rates to secondary care from WICs (and NHS Direct) are higher than those from general practice.
- Users generally view the WIC as an alternative route to care (most users would have consulted a GP or A&E had the WIC not existed) however there is an indication that one third of all users intended to make a GP appointment following their WIC appointment.
- WICs incur significantly higher financial costs per consultation than other primary care services.

3.28 Our research suggests that although WICs are filling a service gap (in that they are seeing patients who would not necessarily consult other primary care services) they appear to be attracting the more affluent of our population and may therefore not contribute to reducing inequalities in access, particularly if they employ staff who might otherwise work in conventional primary care settings in under-served areas.[139] The research also shows that at present there does not appear to be any significant impact on the workload of other local service providers. Newham Community Health Council report that although their walk-in-centre is well used and is a welcome service, there is no information as yet to show what impact the service has on the workloads of GPs in the area.[140]

NHS Direct (NHSD)

3.29 NHSD is a 24-hour nurse-led help-line providing confidential advice. NHSD aims to fill information gaps related to:

- education and skills in basic self-care,
- health education,
- chronic disease management,
- what services are available and how they can be accessed.[141]

[139] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[140] Memorandum: Newham Community Health Council
[141] Donaldson L. Telephone Access to Health Care: The Role of NHS Direct

3.30 Some facts about NHS Direct[142]

- NHS Direct is the first point of contact with the health service in 5% of all episodes of ill health where unscheduled care is sought
- NHSD call handlers field roughly 7.5 million calls per year
- The online website (viewable through even extremely old browsers) was launched in November 2001; in January alone, it had over a quarter of a million visitors
- NHSD is used mostly by young adults and on behalf of children
- The majority of calls to NHSD (65%) occur during the out of hours period

3.31 Our research shows that there is evidence to suggest that NHSD does increase access to health care advice for some population groups. In particular, NHSD appears to be an important service for parents of young children and for those who cannot easily leave their homes (incurring fewer financial and opportunity costs for the patients). However it is not clear whether NHSD is providing a necessary service and whether it is successfully reaching already marginalised communities.[143] Unfortunately (at this time and similar to Walk-In-Centres) NHSD callers appear to be the same people who already make use of pre-existing health services (white, middle class). NHSD appears to be under-used by older people, possibly reflecting a lack of awareness of the service, perceived incompatibility of the service with health needs or sensory difficulties.[144] Richmond Community Health Council reported that an Age Concern Study conducted in their area showed that out of thirty-nine older people twenty-two had not heard of NHSD, and after an explanation of how it worked, fifteen people said they would still not use it.[145]

3.32 Our research confirms that there are inequalities of access to NHSD and WIC for people whose English is limited and for those with sight, hearing or learning disabilities. Other research has found that the majority of a sample of people from black and ethnic minority groups did not find NHSD sensitive to their needs, nor an appropriate source of health information. Though they welcomed the use of Language Line (interpreting service), concern was expressed about the difficulty of requesting an interpreter (due to the inability to speak English) particularly in an emergency. An additional point raised was the belief that NHSD nurses are not familiar with the symptoms or presentations of conditions such as thalassemia and sickle cell disease, which are more common among some minority ethnic groups.[146]

3.33 Representatives from the DHSC informed us that NHS Direct is available in 30 languages and there are 200 languages that people can access. Their concern is not therefore that the language support isn't there, but that those who do not speak English are not accessing NHS Direct in the first place. NHS Direct have therefore identified a pilot in South East London to look at ethnic monitoring.

[142] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[143] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[144] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002
[145] Memorandum: Richmond Community Health Council
[146] Patel, M and The Afiya Trust. Black and Ethnic Minority Communities: Information About and Access to NHS Direct. 2001

With that information they will be able to see who is not accessing the service and start developing ways to target such groups.[147]

3.34 We asked a group of GPs whether they thought that NHS Direct or NHS walk-in centres had relieved pressure on general practice. **We were informed that at present there are 75 GP consultations to 1 call to NHS Direct, and 8,500 GP consultations for 1 walk-in centre attendance, and that although it is a useful service and meets patient need, it is still developing and does not yet have the capacity to handle the volumes of primary care health need that exists.** We were also informed that NHSD was not set up to relieve pressure on other parts of the NHS, but was set up to provide a specific service.[148]

3.35 While NHSD makes efficient use of skills mix by employing nurses, well-trained call handlers and only a small number of GPs, the service is very expensive costing roughly £90 million per year to run.[149] There are consequent concerns that NHSD is not cost-effective, and that it may actually generate demand with patients calling to receive reassurance regarding self-care.[150] We are concerned that the added health benefits that NHSD provides have not been measured.

3.36 The Department of Health intends to develop NHSD in the following ways:[151]

- NHSD integrated access: NHSD can seamlessly pass a caller to an Out of Hours (OOH) doctor, social services, a community pharmacist or mental health care staff).
- NHSD outreach: nurses will proactively call people who may need help or advice, eg. older people, people coming out of hospital, and they may call with reminders for flu vaccination and appointments.
- NHSD online: interactive self-care guide to accredited information.
- NHSD information points in surgeries, pharmacies, post offices, accident & emergency departments, healthy living centres.
- NHSD healthcare guide: to provide information on common ailments.
- NHSD healthcare programme: training for the public.

It is hoped that the integration of NHSD with Out of Hours GP co-operatives and ambulance services will help reduce demand faced on other immediate care services.

3.37 Andrew Burnett informed us that from 2004, all GP out-of-hours calls will be handled by NHS Direct. *"Whatever number you call, whether you call the out-of-hours co-op or the GP surgery, you will be automatically diverted to NHS*

[147] Minutes of Evidence 29th May 2002 Karen Dinsdale (Directorate of Health and Social Care)
[148] Minutes of Evidence 23rd October 2003 Dr Maureen Baker (Honorary Secretary Royal College of General Practitioners)
[149] George S. NHS Direct Audited. BMJ 2002;324;558-559
[150] Florin D, Rosen R. Evaluating NHS Direct: Early Findings Raise Questions About Expanding the Service. BMJ 1999;319;5-6
[151] Department of Health. New Opportunities for NHS Direct: Pioneering NHS Helpline Breaking New Boundaries, Driven From Grassroots Experience Reference 1999/0227.2002

Direct."[152] He felt that coupled with the fact that GPs under the new contract would be able to opt out of providing out-of-hours care, NHS Direct is going to have substantial difficulty in coping with the very large increase in workload that it will need to take on. He also pointed out that although NHS Direct is a very important service it is no good if a person does not have a phone, or if a person is living in an unstable household or on the streets.

3.38 Elizabeth Manero, felt that some of these issues about accessibility to NHSD and its usage would have been addressed if there was adequate consultation at the beginning. *"When it was introduced, there was no consultation on it. It has gone very well and they have done a good job of setting it up, but it has not reached every minority or socially disadvantaged group. If they had consulted properly at the beginning on how to reach those groups, it is much more likely they would have managed to do so."* [153]

3.39 We feel that in view of the fact that NHS direct will be playing a major role in the provision of out of hours services there is a need for the Department of Health to specifically address the issues of under-use by some parts of the community.

Recommendation 12

We recommend that the Department of Health evaluates the cost-effectiveness of NHS Direct and Walk-In-Centres compared to other ways of increasing access; and monitor the extent to which they relieve pressure on General Practice; and benefit patients before further expansion of these services.

Health Promotion and Screening Uptake

3.40 Our research shows that there is very good evidence relating to effective and relatively cheap ways of increasing the number of women screened for breast cancer, however we cannot confirm from this evidence that the same is applicable to other services such as cervical or prostate screening. Successful methods of increasing breast screening included follow-up letters, personal contact with the practice receptionist (who had received training), nurse visits to non-attenders and the "flagging" of medical records. There was a significant increase in uptake among women who had their medical records flagged, so that health professionals would opportunistically initiate a discussion about screening when they visited the surgery for another reason.[154]

3.41 Consultation events and evidence from community organisations highlighted the need for additional access to health promotion advice and support about a range of issues. Several respondents described this in relation to wanting to be better informed and so better able to influence their own health, rather than having to waiting to become ill before being able to access primary care. This seemed to be an area where there is additional potential for a range of

[152] Minutes of Evidence 25th September 2002: Dr Andrew Burnett (Medical Director Barnet Primary Care Trust)
[153] Minutes of Evidence 15th May 2002: Elizabeth Manero (Chair, London Health Link)
[154] Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002

healthcare professionals and specialist patient organisations to be involved, rather than expecting GPs to take on additional work.

4. Responding to Specific Access Needs

Improving Physical Access

4.1 One of the main challenges facing primary care providers in London is the improvement of primary care premises. The Disability Discrimination Act 1995 places an onus on GPs to ensure that by 1st October 2004, their premises are fully accessible for disabled people.[155] The written evidence we received describes the accessibility to primary care premises for disabled people as being an area of concern. Primary care premises such as surgeries and health centres may not be wheelchair accessible and may not have facilities for hearing loops or other modifications.

4.2 Several responses referred to an estates survey recently undertaken by the Directorate of Health and Social Care (DHSC) and several PCTs provided information on the accessibility of their practices based on this survey. The purpose of the survey was to assess the physical quality, utilisation of space, future flexibility and compliance with the Disability Discrimination Act 1995, within London.

4.3 The Directorate of Health and Social Care informed us that their audit has assisted in targeting those premises, which need to be renovated or renewed, and has formed the basis for the Estates Audit Tool to be included in the Local Improvement Finance Trust (LIFT). At the same time the DHSC/NHS Estates are responding to the Unitary Development Plans for each borough in London, as previously the provision of Health Facilities within new developments was very rarely considered. They are also providing the London Boroughs, when their Unitary Development Plans are being reviewed, with representations supporting health care, in particular Primary Care as part of planning gain in new developments.[156] We particularly want to see local authorities and PCTs working together over planning issues. This is an area that is crucial to the success of the NHS LIFT programme.

Recommendation 13

Boroughs must ensure that they reflect the need for primary care premises within their Unitary Development Plans, and undertake health impact assessments for all major building developments.

4.4 Local Improvement Financial Trust (LIFT) is a new public private partnership which will build and refurbish primary care premises and then lease them on favourable terms to GPs and PCTs. The LIFT schemes are being taken forward by a new company, Partnerships for Health, made up of the Department of Health and Partnerships UK. NHS LIFT is concentrating its efforts on the areas of greatest need where premises are often in the worst condition. In London, Camden and Islington and East London and City (ELCHA) were successful in the first wave and more recently, Redbridge and Waltham Forest, and Barking and Havering have been approved as LIFT sites. The DHSC informed us that they are

[155] The Disability Discrimination Act 1995
[156] Memorandum: Directorate of Health and Social Care

supporting the development of additional LIFT bids and are aiming to have LIFT sites established across London. [157]

4.5 LIFT will own and lease premises to GPs, dentists etc, maintaining and servicing them. Currently, pharmacists, dentists, opticians and 84% of GPs own or lease premises as independent contractors. LIFT will enable the co-location of services such as GPs with pharmacies, housing advice or leisure facilities. Most premises that will be improved under LIFT are set out in the individual Strategic Health Authority Service Development Plans (SSDP) and there is the flexibility to amend this plan of investment as it is considering a long-term vision.

4.6 **Pan-London Position:** LIFT schemes are in three waves. In London there only two PCT's which are not covered by LIFT and these are Kensington and Chelsea PCT and Westminster PCT.

First Wave February 2001	**Third Wave August 2002**
East London & City	Barnet, Enfield & Haringey
Camden & Islington	Bromley, Bexley & Greenwich
	Ealing, Hammersmith & Hounslow
Second Wave February 2002	Lambeth, Southwark & Lewisham
Redbridge & Waltham Forest	Wandsworth, Kingston, Richmond & Twickenham
Barking Dagenham & Havering	Brent & Harrow

4.7 The GP census for 2001 shows that in London 471 (70%) of GP premises were below the Department of Health minimum standard which includes having a proper treatment room, disabled access heating, lighting and safe storage for records etc . The majority of PCT responses describe poor premises and inadequate facilities, with large numbers of practices based in old residential properties. Several PCTs report problems regarding the shortage of sites for development, the expense involved in acquiring land, and the complexity of dealing with planning issues. We are very concerned about the accessibility of GP surgeries and health centres. Chingford, Wanstead and Watford PCT informed us that out of the 29 main GP premises in their area. 16 practices failed to meet the minimum standard for the Disability Discrimination Act. Enfield PCT reported that 80% of their premises are below the minimum standard prescribed by the Department of Health. They report that most premises are converted residential houses which are difficult to adapt to enable the provision of a wider range of primary care services.

4.8 Other submissions do not quantify the extent of the problem, but they acknowledge that GP premises is an issue of concern for them. Physical access is one of the most fundamental issues that need to be tackled in order to improve access for patients. This also impacts on recruitment and retention issues. If we are to attract newly trained GPs into London we need to provide them with modern facilities which they are not having to self-finance. Inadequate premises prevent primary care professionals working as a team. Where GPs, practice nurses, administrative staff and other allied health professionals such as physiotherapists are all working from the same premises it provide more seamless and responsive health care services for the patient. It also allows enables the primary care team to work across professional boundaries as envisaged by the NHS plan.

[157] Memorandum: Directorate of Health and Social Care

Recommendation 14

Primary Care Trusts should facilitate provision of support and advice to GPs and Practice Managers about the development of primary care premises, including specialist advice around site acquisition and planning issues.

4.9 We are also concerned that there is comprehensive data on the state of GP premises in London which is not being made public. We are pleased to recognise that the Department of Health are taking the issue of premises seriously and are seeking to improve a number of GP premises across London through LIFT, but we urge the Department of Health to publish the findings of their GP premises survey. **We believe this will facilitate the external scrutiny of the implementation of LIFT across London and enable Local Authority Overview and Scrutiny Committees to monitor the progress of LIFT in their respective areas.**

Recommendation 15

We call upon the Department of Health to publicise the findings of the Regional Premises Survey that took place in 2002, so that the London Assembly and London Local Authorities will be able to monitor the accessibility of GP premises in their areas and the impact of the current redevelopment work under LIFT and other regeneration schemes.

Registering With a GP

4.10 The written evidence we received raises concerns about access for those who are not registered with a GP. The difficulties of accessing primary care due to closed GP lists is referred to in several responses from PCTs. Most of these responses do not provide numbers of the population affected by closed lists, but several PCTs indicate that these are significant, for example, Wandsworth PCT estimate that up to 30% of their local population are not registered in some parts of the borough.[158] Difficulties with registration effectively removes patient choice, as patients are then assigned to a GP by the PCT. Tower Hamlets PCT report that in the E1 area 1000 patients are assigned to a GP every quarter.[159]

4.11 The written evidence cites patient mobility as a barrier to registration. Refugees, asylum seekers, families in temporary accommodation and homeless people, as a result of their high mobility, have problems accessing GP services. Unfortunately in London people who do not belong to these groups, but may have newly moved into an area also experience difficulties with registration. Registration problems impact on the continuity of patient care.

4.12 Some patients, particularly those that are highly mobile, are often refused permanent registration, and are give temporary registration. People registered as temporary patients are only placed on a GPs list for a period of three months.

[158] Memorandum: Wandsworth Primary Care Trust
[159] Memorandum: Tower Hamlets Primary Care Trust

Whilst being registered as a temporary patient the GP is unlikely to receive a copy of the patients medical notes from the previous GP.

4.13 Refugee Access report that in one case it took two years for a person to find a GP. *"I had a list of GPs. I had already tried five or six – they told me that they were full. I was diagnosed HIV positive and I was pregnant. I was desperate to find a GP. The GP who took me in only did so because I sat in their surgery crying so much."*[160]

4.14 In January 2001, the British Medical Association (BMA) issued a guidance note entitled "Access to Health Care for Asylum Seekers." The BMA was concerned by the uncertainty that existed amongst health care professionals as to asylum seekers' rights to access health care. They were also concerned by reports that some practices only agree to register them as temporary patients or refuse to register people with very poor English.

Recommendation 16

Primary Care Trusts should take a more rigorous approach to quantifying and monitoring the extent to which patients are having difficulty registering with GPs locally. This should include information about closed lists, and consideration of whether patients perceived as having more complex or challenging needs experience this as more of a problem than others.

4.15 The lack of a permanent address due to homelessness is also cited as a barrier to registration. Homeless Link informed us that homeless people usually access health care through accident or emergency, through specialist services or not at all. Shelter estimates that nationally, 28% of homeless people are not registered with a GP, whilst the level of non-registration for the rest of the population is 3%.[161] In a recent report Crisis recommended that all homeless people should be enabled to permanently register with a GP so that they can receive appropriate healthcare.[162]

Language and Translation Needs

4.16 Language and translation needs are highlighted by the majority of respondents as a barrier to primary care. The organisations working with refugees and asylum seekers identified difficulties in accessing language support as a particular problem. In a survey of refugees and asylum seekers in Barnet, satisfaction with local health services was closely linked to how well they could communicate in English and the provision of interpreters. The survey found that use of family members as interpreters was common and concluded that it was unclear whether the lack of use of interpreters was due to a reluctance to use them or an actual shortage of interpreters. [163] The use of family members as interpreters was identified as a particular problem, as it sometimes causes a strain on family relationships particularly where children are involved in the interpreting of confidential medical issues.

[160] Memorandum: Refugee Health Access Project, Barnet
[161] Memorandum: Homeless Link
[162] Critical Condition Vulnerable Single Homeless People and Access to GPs. Crisis December 2002
[163] Memorandum: Refugee Health Access Project, Barnet

4.17 The written evidence also shows that patients who speak other languages at home are more enabled and have shorter consultation times when they are able to consult with a doctor in their own language.[164] The majority of the PCTs that responded informed us that they do provide interpreting services. There are a number of different ways these services are provided including Language Line, local providers or a combination of both.

4.18 The Directorate of Health and Social Care told us that across London there are contracts in place with Language Line to provide a translation services as required.[165] This does not guarantee that interpretation services will be available from all primary care providers, particularly district nurses, health visitors and pharmacists. The evidence shows that people still encounter difficulties in accessing language and translation services.[166] Where basic translations services are available they are of variable quality and this makes an accurate assessment of health needs difficult.[167] Without proper language support patients are being denied access to safe diagnoses and treatment. In many cases this is life threatening.

4.19 Language line may not prove to be cost effective in an area where a sizeable proportion of the population require interpretation. In such case it might be better for the PCT to either establish permanent interpreters that can assist primary care providers, or specifically recruit bilingual staff. We asked whether PCTs are able to provide an assessment of the percentage of consultations in primary care that require interpreting. We were not given definite figures.[168] **There must be an accurate identification of the interpreting needs within each PCT. This will then assist in developing cost effective and appropriate interpretation services.** We believe that this is an area in which PCTs and local authorities should work more closely together.

Recommendation 17

Primary Care Trusts should identify the interpretation needs of each general practice in their area and publish a strategy which will identify how each general practice will meet these identified needs.

Long Term Illnesses and Disabilities

4.20 Both the oral and the written evidence highlight specific difficulties that people with long term illnesses or disabilities face in accessing primary care services. Mencap report that people with learning disabilities suffer from a lack of appropriate information about health care and advice about how to recognise symptoms. They may experience the lack of a supportive environment; be dependent on benefits; have little choice of home or life companions; be vulnerable to abuse, or experience problems with transport and employment. All of these issues can impact on their ability to access appropriate primary care services. The needs of those with learning difficulties are often overlooked by

[164] Memorandum: Professor George Freeman, Imperial College
[165] Memorandum: Directorate of Health and Social Care
[166] Memorandum: Three Boroughs Primary Health Care Team
[167] Memorandum; Sainsbury Centre for Mental Health
[168] Minutes of Evidence 25th September 2002

health promotion and screening programmes. Mencap reports that only 3% of women with learning disabilities get a smear test, compared to 85% amongst women who do not have learning disabilities. In order to meet the needs of this patient community, primary care services must aim to provide health education both for the individual and for the individual's support network.

4.21 In their written evidence, the Royal National institute of Deaf People (RNID) reported that in the main, deaf people experience barriers to primary care services because of the lack of understanding of the implications of deafness amongst hearing people. Hearing aid wearers may require lip reading and contextual clues to make sense of conversation. They also benefit from good lighting and loop systems, because these transmit sounds directly to hearing aids. A significant proportion of people are profoundly deaf and to communicate require the use of speech to text transmission or a British Sign Language interpreter. RNID report that in most GP surgeries deaf people have no access to interpreters or other communication support, few working loop systems and few visual alerting systems in receptions. The result of these difficulties is that deaf people do not attend surgery as often as hearing people and as a result are likely to be in poorer health.[169] GPs themselves have expressed difficulties in dealing with deaf patients since they do not come across sign language users frequently[170] RNID state that the needs of deaf people should be specifically identified and included in the modernisation of primary care, as mainstreaming will ensure that a wide range of patients can obtain an accessible and responsive service.

4.22 Ensuring access to appropriate primary care services for people with mental illness is a crucial issue for London because of the high levels of mental illness in the capital. Representatives from the Sainsbury Centre for Mental Health highlighted the fact that people who have mental illnesses are likely to require a lot of support to engage with services and face specific challenges when attempting to stabilise and remain within their communities. They emphasised that the combination of deprivation, mobility, severe mental illness, and significant physical health problems make providing primary health care to this patient group very complex. Several consultations are often needed to identify mental health problems, using time as a tool to improve relationship between patient and doctor.[171]

4.23 The Government has established National Service Frameworks including one for mental health which focuses on services for adults of working age. The aim of the National Service Framework (NSF) is to establish clear national standards for health services in order to improve quality and reduce unacceptable variations in standards of care and treatment. The mental health NSF focuses on services for adults of working age in England. It has seven standards which are applicable to health and social service providers. Standard two highlights the importance of identifying the needs of patients with mental health problems and ensuring that they are offered effective treatments. This responsibility lies heavily within primary care.

[169] Memorandum: RNID
[170] Naish and Clark in Deaf Worlds, vol 14, 1998
[171] Minutes of Evidence 4th July 2002 Dr Alan Cohen and Dr Andrew McCulloch (Sainsbury Centre for Mental Health)

4.24 MIND has developed a specific model to improve primary care services for those with mental health issues. The model highlights the need for ensuring that effective psychological therapies including cognitive therapy and psychotherapy, are available to those that want them, as well as the need for the provision of sufficient information about medication to enable people make informed choices before drugs are prescribed and throughout treatment.[172] We welcome the development of this model.

Communicating With the Patient

4.25 Much of the written evidence highlights the prejudice and discrimination experienced by some people trying to access primary care services. The reasons for this were cited as the additional workload associated with clients with complex problems, stereotyping and historically low priority attached to services for certain groups. The evidence shows prejudice and discrimination is experienced by people with special health needs such as those who are mentally ill, HIV and AIDS patients, patients with learning difficulties etc. Refugees, asylum seekers and the homeless also report experiencing such disadvantage.

4.26 Confidentiality was cited as a particular problem for people diagnosed as HIV Positive and it was noted that GP practices do not have to adhere to such strict guidelines about confidentiality as in Genito-urinary medicine (GUM)/HIV clinics. Many of the respondents mentioned that their client groups experienced difficulties with reception staff. In relation to people diagnosed with HIV, the respondents highlighted the intrusive questions they were asked by reception staff and the fact that these reception staff, often members of the same community, had open access to medical records.[173]

4.27 People who have encountered the justice system often suffer from mental disorders (95% of imprisoned young offenders, and over 70% of adult prisoners.) When released back into the community these people face particular difficulties accessing primary care. If they have had a short sentence or have been on remand they are not assigned a probation officer and are therefore left to resolve their own problems. *"Communication between clients and care providers is poor. GPs perceive clients as difficult and potentially dangerous while clients feel patronised and unwanted in surgeries. Reception staff are not trained to communicate effectively with clients causing frustration and hostility, while clients are disruptive in waiting rooms and can upset other patients"*[174]

4.28 As highlighted earlier, other patient communities have also encountered difficulties communicating with primary care staff. Mencap reports that within primary care, poor communication with their client group leads to less screening and health promotion for people with learning disabilities.[175] RNID report that within both the primary and the acute sectors there is a poor staff attitude to deafness.[176] Gay men wanted to see that their GP was 'gay friendly', *"Gay men do not particularly want their GP to be lesbian or gay, but they do expect a GP*

[172] The Mind Model for Choice in Primary Care. Mind 2002
[173] Memorandum: Pan London HIV/AIDS Providers Consortium
[174] Memorandum: Revolving Doors Agency
[175] Memorandum: Mencap
[176] Memorandum: RNID

to be welcoming and to show signs of this in all their publicity materials and in leaflets on display." [177]

4.29 We were also informed that the way primary care providers communicate with children is also very crucial to their healthcare. Poor communication acts as a barrier to children and prevents them from accessing primary care services. Nancy Kelly informed us that an ideal surgery for children would be one that *"offers good child-friendly information available to take away, including information about how to complain about the service in the practice if you did not like it.* The issue of confidentiality is also important to children. *"… one of the things that stopped young people seeking professional, adult advice was that they felt that Social Services would immediately be contacted and that they would be taken out of their family or that their friend would be. I think there is a real need both for confidential and anonymous ways of children and young people talking about any child protection concerns they have."*[178]

4.30 One way that communication difficulties within primary care might be overcome is by the expansion and development of advocacy and advice services. This was highlighted as a way of assisting patient involvement and challenging discrimination. There is particular concern that with the demise of the community health councils, the patient advocacy role previously undertaken by them will not now be properly resourced and organised. We consider patient involvement issues in chapter six.

Providing Information for Patients

4.31 The NHS Plan envisages that healthcare providers will provide a wide range of information for patients which will increase the accessibility and effectiveness of both acute and primary sector health services.[179] The plan states that patients will have greater information about treatment that is being planned for them and that letters between clinicians, about an individual patient's care, will be copied to the patient.

4.32 The NHS Plan also states that patients will have the choice of e-mailing or phoning their practice nurse or GP for advice. The DHSC informed us that nearly all GP practices in London are computerised with the ability to send e-mail. They also informed us that direct e-mail advice over the internet may present confidentiality problems in some cases, and practices may need to change their ways of working to cope with any increased demand. Some practices have their own websites, but practice information is now available through NHS UK and its associated local service information. [180]

4.33 We explored the issue of patient information needs, recognising the need that for access to primary care to be improved patient information must be provided in a way that is appropriate and meaningful for the patient. We asked how the information needs of patients are currently being met, particularly those, that cannot read and write, even in their first language. Elizabeth Manero informed

[177] Memorandum: Pan London HIV/AIDS Providers Consortium
[178] Minutes of Evidence 26th of June 2002 Nancy Kelly (Office of the Children's Rights Commissioner for London)
[179] NHS Plan July 2000
[180] Memorandum: Directorate of Health and Social Care

us that at present within the NHS there is no standard approach to the provision of information for patients, and it varies between NHS organisations.[181]

4.34 Elizabeth Manero also informed us that the Patient Advice and Liaison Services (PALS), if properly funded, have a great potential to provide appropriate information for patients. She highlighted the need for PALS to employ staff who represent significant sections of the local community, particularly, where there are cultural and language issues. *" If you cannot communicate or write in your own language, but can actually sit down with someone who speaks the same language as yourself and is familiar with your cultural background, and they explain the issues that you need to be considering, and the choices that you have, this is probably the best approach."* [182]

4.35 Nancy Kelly informed us that for children it is very important to have clear rights-based information. *"Children and young people are very frightened about issues of confidentiality, particularly in relation to the health service. They are also very unclear about issues relating to consent to treatment and these kinds of quite dry, legal concepts, can be something that puts them off speaking to someone or accessing a service. I would want to see that kind of information very clearly available to them."*[183]

4.36 In terms of information issues for people with learning difficulties we were informed that there is a need for plain English to be used. Alan Cohen informed us that one of the best ways to provide individual patient information was to deal with each person as an individual and find the best way to communicate with them. *" I think the difficulty with talking about either learning disability or mental illness is that it is such a spectrum of disorder. We, as general practitioners, need to have a number of different opportunities to communicate in different ways because people have different needs, so it is less about having a single system but knowing that there are different systems that we can access."*[184] Carol Herrity, also informed us that to communicate effectively with patients with learning difficulties, primary care practitioners need not do anything different by way of good practice, but needed to allow for longer consultations and that this is something that GPs find difficult to deliver.[185]

4.37 There are particular difficulties for those people with learning difficulties who are unable to read. Their information needs are not catered for, and they therefore find it difficult to access health promotion materials such as leaflets and posters. We were informed about work done in St George's hospital to improve communications with people who have fairly severe learning difficulties. They are able to absorb information purely through a visual medium of pictures that actually tell a story and engage them with healthcare issues. The hospital has developed a whole series of information explaining issues around physical health care, sexual abuse etc for people with fairly severe learning disabilities.

4.38 Respondents working with refugees and asylum seekers highlighted the need for more accessible and appropriate information about primary care services and patient's rights.[186] In addition to the language and translation needs that we

[181] Minutes of Evidence 15th May 2002 Elizabeth Manero (Chair, London Health Link)
[182] Minutes of Evidence 15th May 2002 Elizabeth Manero (Chair, London Health Link)
[183] Minutes of Evidence 26th June 2002 Nancy Kelly (Office of the Children's Rights Commissioner for London)
[184] Minutes of Evidence 4th July 2002 Dr Alan Cohen (Sainsbury Centre for Mental Health)
[185] Minutes of Evidence 4th July 2002 Carol Herrity (Mencap)
[186] Memorandum: Refugee Health Access Project

have highlighted above, there are particular problems for new arrivals in the UK. We were informed that newly arrived families often find it difficult to decipher how different agencies work together and find it hard to trust professionals especially in the statutory sector.[187] There is therefore a need for regular health information for refugee community organisations and the production and the need for the dissemination of information about health rights and services across a range of locations and in a variety of languages and formats.[188]

4.39 In their written submission, Great Chapel Street Medical Centre reported that the lack of appropriate advertising and publicity of health services is a problem for homeless people. A survey of their clients identified the need for information and publicity on health promotion, keeping clean, infections and where to go for help when medical centres shut.[189]

Staff Awareness

4.40 One of the ways we think access could be improved, is to increase staff awareness of the needs of different patient groups. Elsewhere in the report we have highlighted the advantages of having a workforce that reflects the local population, but there are also wider issues about all primary care staff developing a proper understanding of the needs of the people they serve.

4.41 Nearly all the evidence comments on the lack of awareness about the varied and often complex needs of different patient groups. This includes not only a lack of understanding of the different health needs, but also an ignorance of clients' different experiences and ways of life. The problems with staff awareness were attributed to a lack of training and the low priority placed on the health needs of some groups. Some of the written submissions recommend training for all health professionals on the needs of the groups they work with. In addition, many respondents emphasised the need for training reception staff, whose importance in assisting people to access services cannot be overemphasised.

Recommendation 18

GP appraisal schemes and other approaches to professional development should be used to raise the awareness among primary care staff of the needs of different communities and of people with a range of specific needs.

Responding to Specific Needs

4.42 The Directorate of Health and Social Care informed us that increasing access among specific groups and communities has focussed on ensuring that the NHS implements its duties under the Race Relations Amendment Act 2000 and the Disability Discrimination Act 1995. PCTs are subject to the general and specific duties of the Race Relations (Amendment) Act 2000. Each PCT is therefore required to produce a Race Equality Scheme that will set out how it intends to meet the requirements of the Act, which includes a specific duty to ensure

[187] Memorandum: Pan London HIV Providers Consortium
[188] Memorandum: Three Boroughs Primary Health Care Team
[189] Memorandum: Great Chapel Street Medical Centre

equitable access to services and information for people of all racial and ethnic groups.[190]

4.43 We were also informed that PCTs are required to reach performance managed targets on ethnicity monitoring in all aspects of service delivery and employment. This target states that at least 95% of all patient records will include valid ethnic origin categories. This information will be linked to the Race Equality Schemes which will explain how the organisation will use ethnic monitoring information in improving access for Black and Ethnic Minority communities. This information will be used to influence services such as the Patient Advice and Liaison Services (PALS) and provide a regular measure of access.

4.44 The Disability Discrimination Act 1995 also requires action on the part of all public bodies including PCTs to ensure access to services for people with disabilities. The Directorate of Health and Social care informed us that very practical issues such as physical access, as well as access to communication support will have to be addressed as part of this action. [191] We have highlighted our concerns about physical access at the beginning of this chapter.

4.45 A number of PCTs describe how Personal Medical Services(PMS) has enabled the development of schemes which focus on providing primary care services to vulnerable groups including asylum seekers, homeless people, and those who have been unable to register with a GP. In these circumstances it is clear that the health care systems are designed to meet the needs of patients rather than staff. Earlier in the report we highlighted the benefits of PMS, particularly for disadvantaged communities. **We welcome the use of PMS to improve access to primary care for traditionally disadvantaged communities in London.**

[190] Memorandum: Directorate of Health and Social Care
[191] Memorandum: Directorate of Health and Social Care

5. The Challenge of Commissioning for London

5.1 As part of the restructure of the NHS, Primary Care Trusts (PCTs) were given the esponsibility for providing and commissioning health services. The aim of this devolvement is to enable decisions about the services that are needed and how they should be provided, to be taken at local levels. It is thought that by such devolvement PCTs will be able to use their knowledge of local communities to develop and provide services that meet the needs of the local population.

5.2 In its written evidence the Directorate of Health and Social Care (DHSC), informed us that by 2003 PCTs will hold 75% of the local health economy budget, including that for the acute sector, community services, general medical services (GMS) and prescribing. PCTs will therefore utilise new operational flexibilities such as pooled budgets with local authorities, PMS arrangements and GMS local development schemes to provide health and social care services.[192]

5.3 The written and oral evidence shows that generally this development is viewed as an opportunity to make a difference to health provision at local levels. One respondent felt that it is an opportunity to improve standards, by involving GPs in the commissioning process. However across the written evidence, a general concern was expressed about how this devolvement fits with the development of a pan London health agenda and how the consistency of health services across London would be ensured. We explore some of these issues below.

Balancing Primary and Acute Sector Needs

5.4 We wanted to ascertain whether the ability of PCTs to commission primary care services, is hampered in any way by the need to adhere to centrally set targets and strategies. We were informed that the majority of targets that PCTs have been given to focus on, have been to address hospital waiting lists and access to accident and emergency services. In oral evidence we were told that, a large amount of the new NHS funding had gone into the secondary sector. Witnesses stated that unless primary care, and its impact on secondary care is given sufficient priority all that will be done over the next few years is to continue to build secondary care capacity to reduce waiting lists.[193]

5.5 In oral evidence we were told that as well as some of this new funding going into secondary care to pay deficits left over from the previous financial year, there were also PFI projects attracting high costs, and PCTs have to contribute towards these costs. In addition to this expenditure there are also other costs to meet such as generic rises for pay. A substantial amount of funding has gone straight through primary care into secondary care.[194] *"At our Professional Executive Committee meeting, one of the GPs made an interesting point…. for many years more and more money has been poured into the secondary care sector at the expense of the primary care sector with the result that you have a highly qualified and able workforce in primary care with very few resources, both in terms of premises, staff and access."* [195] We were informed that this is leading

[192] Memorandum: Directorate of Health and Social Care
[193] Minutes of Evidence 25th September 2002
[194] Minutes of Evidence 25th September 2002
[195] Minutes of Evidence 25th September 2002

to considerable frustration in the primary care sector, making development more difficult.[196]

5.6 We asked whether, under the new commissioning arrangements, it is now possible for PCTs to develop closer working relationships between the primary and acute sectors, so that financial resources are more evenly shared. We were told that this could be done if PCTs encourage clinicians from both sectors to work together to determine how care can be provided differently. It was emphasised that this also requires money, and when PCTs are under pressure to invest in the acute sector there is less money to invest in primary care. *"Although in theory PCTs are there to determine what is invested where and what is commissioned where, there is still some considerable control over that freedom."*[197] Not only are there limits on financial resources for primary care, we were informed that there is not always the flexibility to commission. *" I think there is scope for changing an old style of working, and improving things. That flexibility is there in theory, but it doesn't feel like it's there in practice."*[198] We question the extent to which the extra money given to the NHS has actually reached frontline primary care services with sufficient flexibility to meet local needs.

5.7 Representatives from the Strategic Health Authorities felt that this issue is far wider than just the idea of the two sectors competing against each other for resources, and that although some degree of competition was inevitable, the health sector should be looked at holistically with resources being used across both sectors to create a better deal for patients, ensuring that care for the patient is provided in the appropriate setting. *"Out-patients is a really good example. If you can manage the way, who and how people are referred to out-patients, you can reduce the pressure on acute services. You can offer people treatment and follow-up in primary care, which is often preferable for them and relieves the financial pressure on the acute hospitals."*[199]

5.8 We were also reminded that large investments such as personal medical services pilots, had also been made into primary care. *"One of the biggest investments inprimary care, year on year, are the drugs that are prescribed in primary care. One of the financial problems we have in the NHS in London at the moment is directly as a result of huge increases, 13% increase, in the cost of drugs being prescribed in primary care this year. There are huge efforts to control and rationalise prescribing, but a lot of the improvements seen in the health service over the last 20 years, has been as a result of new drugs."*[200] We were informed that in the past investment into primary care had not been very controlled or planned in a strategic way and this had contributed to the perception that the acute sector had been resourced at the expense of the primary sector.[201]

5.9 Duncan Selby, argued that PCTs are young organisations with an immense range of responsibilities but will, as they develop, become more flexible in their commissioning of services.[202] Pippa Bagnell agreed with this view and felt that the new NHS structure provides the opportunity to address financial difficulties

[196] Minutes of Evidence 25th September 2002 Andrew Burnett (Medical Director, Barnet PCT)
[197] Minutes of Evidence 25th September 2002
[198] Minutes of Evidence 25th September 2002
[199] Minutes of Evidence 6th November Christine Outram (Chief Executive, North Central Strategic Health Authority)
[200] Minutes of Evidence 6th November Christine Outram
[201] Minutes of Evidence 6th November Christine Outram
[202] Minutes of Evidence 6th November Duncan Selby (Chief Executive, South East Strategic Health Authority)

and not just assume that deficits are inevitable.[203] They emphasised that with this new structure PCTs will be able to reshape how care is provided and move away from the primary and acute divide. Julie Dent informed us that this was already happening in Kingston, where the PCT is leading on work looking at the pressures in hospitals. We heard that the PCT has found that if they provide some diagnostic services (pathology, simple x-ray, ultra sounds etc) in primary and community care settings, then this will cut down delays in primary care treatment.[204] We feel it is important for these new managing boards to ensure that they appoint people on the board with relevant skills that will enable them to manage large budgets.

Recommendation 19

Ongoing investment is needed to train and support Primary Care Trust Board and Professional Executive Committee members to take on new commissioning roles and responsibilities with increasing confidence and competence.

Commissioning Pan London Services

5.10 In the written evidence concerns were expressed about the elimination of ring-fenced budgets which took place as part of the restructuring of the NHS. It is feared that as a result certain health needs will be marginalised and specialist services will be affected. There was also concern expressed across the written evidence that this devolvement of commissioning powers to PCTs will create inconsistencies in the quality of service provision across London.

5.11 At the hearing on the 4th of July, Gary Alessio informed us that medical HIV services will not be affected by these changes because a commissioning consortium had been set up and this would enable the PCTs within the consortium to collaborate with each other. He told us that this would be similar to the arrangements that existed for some specialised services before the restructure where health authorities and boroughs in South London agreed the services they wanted and commissioned them collaboratively.[205]

5.12 He expressed concern that although a commissioning consortium had been set up for the provision of medical HIV services, there are no collaborative arrangements for the provision of HIV prevention services, and that although PCTs could set up a similar system for HIV prevention they are under no obligation to do so. He felt that pressure should be put on PCTs to work together to prevent the fragmentation of vital services. This would also facilitate the sharing of good practice.[206] *" The example I always give is of a member organisation of my consortium called Positively Women, which works right across London. It's ludicrous for them to have to negotiate with 32 PCTs for their funding. There needs to be ways of getting PCTs together to commission services from the voluntary sector and for prevention and health promotion services for groups that don't fit a local approach."*[207]

[203] Minutes of Evidence 6th November Pippa Bagnall (Head of Primary Care, London DHSC)
[204] Minutes of Evidence 6th November Julie Dent (Chief Executive, South West Strategic Health Authority)
[205] Minutes of Evidence 4th July Gary Alessio (Pan London HIV/AIDS Providers Consortium)
[206] Minutes of Evidence 4th July Gary Alessio (Pan London HIV/AIDS Providers Consortium)
[207] Minutes of Evidence 4th July Gary Alessio (Pan London HIV/AIDS Providers Consortium)

5.13 Barbara Meredith also expressed similar concerns about pan London cross-boundary working and how services like HIV and AIDS will be monitored across boundaries. She said that the issue of service fragmentation also applies to the development of services to address the health needs of people from different ethnic groups, particularly since ethnic groups are spread across PCT boundaries. *"There is going to be a major question about how we co-ordinate different PCTs working together in different ways for different needs. It's not just HIV/AIDS. There may be other* [commissioning] *combinations that are needed for other specialisms or groups of people."*[208]

Commissioning Mental Health Services

5.14 Much of the written evidence expressed concerns about the commissioning of mental health services across London. It was noted that there is little regional control or direction in the commissioning of mental health services, resulting in an ad-hoc approach. Once again concern was also expressed about the complexity of service provision and the problem of managing deficits associated with some Trusts.

5.15 The tension between the cost of providing services for people with severe mental illnesses and for those with common mental illnesses was also mentioned, namely that in line with the National Service Framework for Mental Health, the new investment in mental health services is in the acute sector not primary care. *"The majority of new investment in mental health services has been in secondary services, with a priority on providing for people with a severe mental illness. This has meant that primary care organisations can only find the resources to commission a new talking therapy service from within current financial budgets, a difficult task when having to manage deficits in acute trusts and mental health trusts."*[209]

5.16 We were also informed that the management capacity is insufficient to meet the aspirations for commissioning mental health services. A survey carried out by the Sainsbury Centre for Mental Health looked at the knowledge, skills and attitudes of those managers who commission mental health services. That report showed that mental health commissioners were over worked, under skilled and underpaid to commission services effectively.[210] *"If you wish to commission health care in a rational way and to work up a service model, regionally or locally, that is influenced by public health and local stakeholders, the international evidence is that you have to devote about 5% of your health care budget to that process, which is probably about two to three times as much as we are devoting. PCTs are very tightly controlled in their management costs. I think they are very limited in terms of what they can do in commissioning. I do not think we will get away from that situation and I do not think it is the intention to get away from it on the part of government."*[211]

5.17 We asked representatives from the Sainsbury Centre if there are ways they could work with PCTs to improve primary care access for people with mental illnesses. Dr Alan Cohen informed us that the Sainsbury Centre run action learning sets and have developed a set of standards for PCTs to enable them commission

[208] Minutes of Evidence 4th July Barbara Meredith (Age Concern)
[209] Memorandum: Sainsbury Centre for Mental Health
[210] Memorandum: Sainsbury Centre for Mental Health
[211] Minutes of Evidence 4th July Dr Alan Cohen (Director of Primary Care Sainsbury Centre)

more effectively. He also informed us that the Regional Development Centres, which are branches of the National Institute of Mental Health can also assist PCTs in their commissioning of mental health services.[212] We were informed that commissioning health services in London would be more effective if PCTs worked together, establishing networks of stakeholders or experts across PCT boundaries.

5.18 We believe that such collaborative working would enable PCTs to effectively address some of the health needs that are particular to London. *"One of the characteristics of London, as opposed to elsewhere in the country, is that we have large numbers of refugees and asylum seekers, often with deeply disturbing backgrounds, and we have great difficulty knowing how to address and deal with them."*[213] **It is clear that there is a need for the DHSC to explore how to make effective use of PCT commissioning, ensuring that it is accountable particularly with regard to the mainstreaming of ring-fenced budgets and the issue of ensuring the quality of health service provision across London.**

Partnership Working

5.19 Most of the PCTs who provided written responses, refer to positive and developing relationships with local authorities. The Local Government Act 2000 provided local authorities with new powers to promote or improve the economic, social and environmental well-being of their area. Local authorities are now required to prepare community strategies with local strategic partnerships and to fully involve local people in this process. This places local authorities under statutory obligation to work together with other local public and private bodies, voluntary and community groups, as well as local people to come together to improve their areas.

5.20 A number of PCTs provide example of how they have worked with local authorities in developing Local Strategic Partnerships and Community Plans. Several PCTs provide examples of how their Health Improvement Plan forms part of the local Community Plan. The majority of PCT responses also describe active engagement with a variety of renewal initiatives such as the Single Regeneration Budget, Sure Start and New Deal for Communities. The evidence also shows that there are a variety of arrangements with local authorities for joint commissioning and provision of services. These include children's mental health services and services for people with learning disabilities.

5.21 Chris Bull informed us that in the new planning guidance for NHS organisations, there is an expectation that local authorities will be involved in joint work with PCTs, but this can only take place if there are good local partnership systems such as local partnership boards with real executive powers.[214] We were told that the London Borough of Hackney has established a Health and Social Care Partnership Board with a number of sub-boards; one for each major client group and also one for health improvement. All major work is conducted through those boards and these arrangements facilitate joint work between the council and the PCT.[215]

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[212] Minutes of Evidence 4th July Andrew McCulloch (Sainsbury Centre)
[213] Minutes of Evidence 4th July Dr Alan Cohen (Director of Primary Care Sainsbury Centre)
[214] Minutes of Evidence 30th October 2002 Chris Bull (Director of Social Services, LB.Southwark):
[215] Minutes of Evidence 30th October 2002 Caroline England (Health & Social Services Policy Manager, Hackney)

5.22 Christine Outram told us about different partnership and joint working arrangements that currently exist within the North Central Strategic Health Authority.[216] These include a Care Trust, a PCT with integrated management where directors of the PCT report to both the chief executive of the PCT and the local authority director of social services. She informed us that some PCTs that do not have formal joint management arrangements are also working very closely with local authorities. Stephen Longford informed us that within the North East Strategic Health Authority one of the PCT chief executives is also the director of social services, which helps the communication between the PCT and the local authority. He also noted that under the Health and Social Care Act there are a whole range of ways in which health authorities and local authorities can work together ranging from core budgets delegated to commissioners, to integrating health and social care providers.[217] We welcome the development of Local Strategic Partnerships and Community Plans. We believe this is a mechanism which can be used by both PCTs and local authorities to ensure that health issues are incorporated into the wider community agenda.

Voluntary Sector Involvement in Primary Care

5.23 We also explored the issue of PCTs working jointly with the voluntary sector. Jane Belman told us that at present there are some joint working arrangements between PCTs and the voluntary sector at strategic levels, where voluntary sector agencies are feeding into health and social care planning boards and also at client group levels, but she expressed concerns that across London such arrangements are very patchy.[218]

5.24 She informed us that one of the difficulties voluntary agencies currently face is the real lack of clarity about accessing resources from the Primary Care Trust, particularly around accessing mainstream resources and being formally commissioned to provide services, rather than just having access to marginal or special money which might be good for one-off projects but not for sustainability. [219]

5.25 We were informed that what is needed is very clear processes for seeking funding, and a recognition by the NHS of the value of the voluntary sector, as agencies that are worth funding to enable people from all communities have access to services. Jane Belman provided us with examples of joint PCT/voluntary sector work that is achieving this. *"In Camden, there is an established project which brings together all agencies concerned with providing better health services for black and minority ethnic communities, not just the voluntary groups themselves. The project trains workers and volunteers from black and minority ethnic organisations on health issues, and these workers then go and inform their communities about health issues in their own language. One recent example is that the project informed the community workers about the services provided by NHS Direct, including Language Line services and self help booklets.* ***These community workers then spread this information to local***

[216] Minutes of Evidence 6th November Christine Outram (Chief Executive, North Central Strategic Health Authority)
[217] Minutes of Evidence 6th November Stephen Longford (North East London Strategic Health Authority)
[218] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council
[219] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council

people. The feedback was that the local people had not known anything about NHS Direct until that piece of work was done."[220]

5.26 Camden PCT is funding a Somali refugee doctor, who is not able to practise at the moment, to give health promotion advice to the Somali community, and a Bengali GP who, again, cannot practise to give advice sessions to Bengali women's organisations.[221] *"Lambeth PCT have a couple of community involvement workers funded through the Health Action Zone, who have done some work with black and minority ethnic community groups on identifying some of the barriers to accessing primary care. A working group has now been set up, involving people from those community groups, the Voluntary Action Council, and the PCT, to start identifying how some of the barriers can be overcome"*.[222]

5.27 Whilst these are clear examples of how PCTs can work with the voluntary sector to improve access for traditionally disadvantaged groups, we are concerned that the implementation of such initiatives appears sporadic and does not form part of the mainstream provision of primary care services. In London there is a need for these types of projects to be central to the provision of primary care services.

5.28 We recognise that PCTs are currently at an early stage of their development. We asked in what ways voluntary sector organisations or London-wide voluntary sector networks could facilitate engagement with PCTs, particularly at present when PCTs are establishing themselves. We were told that at a pan-London level there is a lot the voluntary sector can do, in partnership with the NHS, to identify and exchange good practice so that there is a sharing of learning, and that although this would require resourcing it would have a positive impact on health and the provision of primary care services[223] We support the establishment of accredited and sustainable service level agreements, or other contract arrangements with quality voluntary sector services.

Trends in Resourcing Primary Care

5.29 The work of this scrutiny has not sought to reach conclusions on the level of expenditure that may be necessary to deliver the high quality primary care services that patients desire. Instead, through the written and oral evidence received, we have sought to paint a clear picture of what Londoners' experiences are in accessing primary care services. However, we are aware of the general trends in the resourcing of primary care services:

- Over the past 10 years, real growth in General Medical Services current expenditure (which includes GPs) has been significantly lower than that on hospital and community services
- Similarly, the number of GPs has not increased by as much as the number of hospital medical and dental staff[224]
- Nationally, the increase in the number of GPs has only just kept up with population growth. There are 61 GPs per 100,000 population. The same figure as in 1994.[225]

[220] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council
[221] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council
[222] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council
[223] Minutes of Evidence 26th June Jane Belman London Voluntary Sector Council
[224] A Focus on General Practice in England. Audit Commission, July 2002
[225] OHE Compendium of Health Statistics, 2001

- The drugs budget absorbs an increasing proportion of the expenditure on Family Health Services. The number of prescriptions per patient continues to rise.[226] As does the cost of those prescriptions[227]

5.30 In London, there are additional pressures on resources

- London has particular health problems not found in the same degree as elsewhere across the country – London accounts for 43% of TB cases in England and Wales, London has by far the biggest concentration of people living with HIV in the country, there are significant raised levels of mental ill health in parts of London and London has significantly higher numbers of drug misusers than other regions.
- There are only 58 GPs per 100,000 population in London.[228]
- Significant annual fluctuations in population upset long term resource planning.
- GP list sizes in London are on average some 8% larger than the national average. In some areas the list size is over 20% higher than the national average; in Southall and Ealing the list size is nearly 30% higher. [229]
- The latest BMA survey indicates that on average PCTs had 3.4% of their posts vacant.[230]
- London receives 31% of the nation's deprivation payments, signifying the large proportion of the London patient population classed as deprived.

[226] In 1999 there were 9.7 prescriptions per patient up from 6.6 in 1979
[227] The per capita cost of NHS prescriptions has risen by 20% between 1996 and 2000
[228] Department of Health: General and Personal Medical Services Statistics, 2001
[229] All General Medical Practitioners (1), Unrestricted Principals and Equivalents (UPEs)(2) and Patients in London DHSC as at 30 September 2001(DOH data)
[230] BMA: GP Vacancy Survey, 28th January 2003

6. Encouraging Patient and Public Involvement

6.1 Encouraging patient and public involvement at every level of healthcare provision is the best way of ensuring that health services are designed in a way that meets the needs of the patient. Developing the structures and mechanisms to facilitate such involvement is not without difficulty, but these mechanisms play a valuable role in the health delivery process. The Department of Health is reforming patient and public involvement. The aim of these reforms is to ensure that patients and local communities are empowered to become involved in the way these health services are designed and provided.

New Arrangements for Patient and Public Involvement

Statutory duty on the NHS to consult and involve patients and the public[231]

6.2 A statutory duty to consult and involve patients & the public has been placed on the NHS. Section 11 of the Health and Social Care Act 2001 places a duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities, to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes. This is a new statutory duty, which means consulting and involving:

- not just when a major change is proposed, but in ongoing service planning
- not just in the consideration of a proposal, but in the development of that proposal; and
- in decisions about general service delivery, not just major changes.

6.3 This new duty to involve and consult starts from the 1 January 2003. The DHSC informed us that guidance implementing the legal duty for all NHS bodies to involve the local community in planning and delivery of local health services is being developed. It builds on a body of existing work, including good practice guidance developed in London.[232]

Patient Advice and Liaison Services (PALS)

6.4 All NHS trusts, GP practices and frontline community health should now have a patient advice and liaison service (PALS). Patients, their families and carers can use PALS whenever they wish to air concerns about their treatment, care or support. PALS have direct access to the chief executives of the Trusts, and the power to negotiate solutions to patient concerns. PALS can also feed patient complaints back into the system for evaluation and identification of lessons to be learnt and to ensure problems are tackled.

6.5 The Directorate of Health and Social Care informed us that Patients Advice and Liaison Services (PALS) are being established in all Primary Care Trusts across London. They will focus on engaging with patients of GPs and other primary

[231] www.doh.gov.uk
[232] Memorandum: Directorate of Health and Social Care

care providers. This will assist in resolving individual concerns, learning lessons and influencing change and the quality of services. PALS will make themselves accessible to all sections of the community, including historically excluded groups. They will work with individuals, as well as local community and voluntary groups.[233]

6.6 Elizabeth Manero, informed us that at present the development of PALS is very patchy. Only 75% of Trusts across the country have them because there is no dedicated funding. In order for PALS to provide an effective service across London they must be adequately resourced. This is particularly important because the patient advice and advocacy role previously undertaken by Community Health Councils will cease to exist when the Community Health Councils are abolished on 1st September 2003.

6.7 It is proposed that patient forums will be established in all Trusts including PCTs. The membership of each patient forum will be required to reflect the social composition of both patients and the local community. Made up of local people, their main role will be to provide input from patients on how local NHS services are run and could be improved. Each patient forum will have a representative on the trust board.[234] The DHSC informed us that several pilot schemes exploring these issues have already been established in London, including Bexley and Wandsworth Primary Care Trusts. [235]

6.8 We have been informed that neither of these pilot forums has been independently evaluated, although some evaluation is now planned.[236] We believe that these patient forums should be independently evaluated and the lessons learnt from the pilot studies be made public. We believe that this will enable other patient forums to incorporate lessons from the pilots into their own structures, thereby providing more effective patient participation.

Independent Complaints Advocacy Services (ICAS)[237]

6.9 The Health and Social Care Act 2001 places a duty on the Secretary of State for Health to make arrangements for advocacy services to be provided to people wishing to make a complaint about their NHS care or treatment. The service has been piloted this year and will be introduced nationally once patients' forums are established in 2003/04.

Commission for Patient and Public Involvement in Health[238]

6.10 The Commission will oversee these new arrangements for public and patient involvement. It will set up fund and manage patient forums and the delivery of ICAS. It will also:

- provide advice and training material to patients' forums and set standards for them.

[233] Memorandum: Directorate of Health and Social Care
[234] Memorandum: Directorate of Health and Social Care
[235] Memorandum: Directorate of Health and Social Care
[236] Elizabeth Manero Chair, London Health Link
[237] www.doh.uk
[238] www.doh.gov.uk

- ensure that local people can have a say in decisions made about their health service
- report to the Government on how the system of patient and public involvement in the NHS is working.

6.11 Our evidence shows that in London many PCTs are already establishing, or working with, a variety of patient and public involvement initiatives. For example, Hounslow PCT works with a primary care forum which was established by local voluntary groups. Similar groups exist in other boroughs.[239] Some responses refer to practice based patient involvement initiatives. *"One GP practice has piloted the development of a Patients' Panel within the practice. This has now been functioning for over a year and is made up of patients and some of the GP practice staff . The panel is chaired by a patient. Issues raised by the Panel about the practice are addressed in house."* [240]

6.12 The evidence highlights a variety of activities under the heading of patient involvement. The activities described fall into four broad categories:

- Those providing patients with information about health; well-being and available services;
- Those providing patients with advocacy services;
- Those seeking feedback from patients on their experience of using services; *"We are launching a quality roadshow scheme whereby 2 staff will attend a stand in the foyer of health centres and clinics, asking clients to agree to being called later that day and asked about the service they have received."*[241]
- Those seeking patient involvement in mechanisms to plan and develop services.

6.13 A number of responses described difficulties in getting patients involved in initiatives and indicated that this would be exacerbated when patient's forums were set up. A number of PCTs had run citizens panels and described these as useful ways of getting feedback from patients. Some PCTs reported the need to pay expenses to members of the public attending events such as citizens panels as problematic. A number of responses referred to the "Expert Patient" programme as a good way of involving patients.

6.14 We discussed these new arrangements at our first hearing. Elizabeth Manero felt that the main challenge facing these new arrangements were not the structures, themselves, but how they would actually work in practice. She stated that for them to work effectively, they must be independent and informed. *"Independent means you do not work for the NHS. It means that you are not a non-executive director. It means that you do not have a contract to provide services to the NHS. It means that, basically, you can say what you feel needs to be said and there will be no repercussions. We also feel that it must be informed. It does not just mean knowing who is who in a particular Trust, it means knowing what the patient's*

[239] Memorandum: Directorate of Health and Social Care
[240] Memorandum: Hammersmith and Fulham Primary Care Trust
[241] Memorandum: Chingford, Wanstead and Woodford Primary Care Trust

experience is across the pathways of care in a local area and being able to follow that through and influence it". [242]

6.15 Will Anderson told us that in his opinion, the NHS still viewed public involvement as a set of methods rather than a set of relationships. When treated as a set of methods the value and potential of a whole wide range of relationships is often ignored. *"It seems to me that every relationship between professionals and lay people in primary care has the potential to increase the understanding within Primary Care Trusts of their local communities. But, the NHS remains resistant to valuing those relationships, especially the informal ones, and the values of evidence-based medicine, ensure that knowledge gained through anything other than a rigorously set out process somehow does not count in NHS decision-making, even though all NHS professionals use tacit knowledge all the time. It is a real cultural problem".* [243] He informed us that for patient and public involvement in the NHS to work there needs to be an ability to listen to other people on their terms, the willingness to change and clarity about NHS priorities and values.

6.16 Will Anderson argued that public involvement work in the NHS often fails to have an impact because it produces outputs and ideas which do not connect to the pressing concerns of the people who are responsible for delivering services and managing change. *"It seems to me, the art of public involvement is to generate ideas that challenge the ways in which things are currently done, but which also connect to the current interests and organisational commitments of the NHS. That is a really tricky bridge to get right. All too often, the professionals within the organisation end up not taking something seriously because they are not putting their own agenda, their own values and their own interests on the table. I think sometimes that NHS professionals do not realise how much effort that takes. It is always easier to ignore people who do not appear to be talking your language than to really try and engage with them and find out what they are trying to say to you."* [244] We were told that lay voices should be brought into every level of NHS decision-making.

Overview and Scrutiny Committees (OSC) [245]

6.17 From January 2003, all local authorities with social services responsibilities (county councils, London Borough Councils and unitary authorities) will have the power to scrutinise health services. This will contribute to their wider role in health improvement and reducing health inequalities for their local communities. Local Authority Overview and Scrutiny Committees will be able to;

- scrutinise the work of the NHS (this includes the ongoing operation and planning of services),
- be able to refer contested service changes to the Secretary of State,
- be able to call NHS managers to give information about services and decisions,
- report their recommendations locally,

[242] Minutes of Evidence 15th May 2002 Elizabeth Manero (Chair, London Health Link)
[243] Minutes of Evidence 15th May 2002 Will Anderson (Consultant, Author of Every Voice Counts)
[244] Minutes of Evidence 15th May 2002 Will Anderson (Consultant, Author of Every Voice Counts)
[245] www.doh.gov.uk

- They will also have to be consulted by the NHS where there are to be substantial changes to health services that affect the local community.

6.18 Elizabeth Manero informed us that Local Authority Overview and Scrutiny Committees will provide an opportunity to look at how local authorities can influence the health of the local population, and work with the health service to respond to those needs. *" I do not think scrutiny will be effective on its own without the patient's voice, and without a very broad-based approach to scrutiny that says, for example, "What are we doing in this borough about the quality of housing? What are we doing about homelessness in this area?" If you have people living on the streets in the borough who are not registered with a GP, who go to A&E for a blanket and for care, and then waiting times in the A&E are so bad that the local scrutiny committee wants to address them, they need to recognise that there is a circle there and that they are part of that circle. The scrutiny function must ensure sure that such inter-relationships are faced up to from the very outset."* [246]

6.19 Will Anderson felt that scrutiny within local authorities will be a chance to try and value the range of intelligence about local communities, which is constantly emerging within health services, local authorities, voluntary sectors, which tends not to be properly valued. *"One of the issues in my work was the number of places people felt there were enormous amounts of community intelligence being generated and expressed which was not really getting to where it needed to be. It might be a good role for a scrutiny committee to try and pull some of that together, to try and develop the mechanisms in communication, rather than going out and trying to find more patient voices. Actually trying to listen to the patient voices which have already been expressed. That is a real challenge."* [247] Chris Bull, emphasised the need for scrutiny panels to maintain their independence, even though they may seek advice from local people and local organisations.[248]

6.20 We explored the issue of how London could capture some of the learning from local authorities as the scrutiny function develops. We were told that thought was still going into what mechanisms could be used to achieve this. Boroughs in south-east London were having discussions about how scrutiny panels could work together on common issues. *" .between Lambeth and Southwark, the key acute providers Kingston, Guy's and St Thomas's, provide services fairly equally to both boroughs and there may well be issues where scrutiny needs to work together and share evidence around issues which emanate from those institutions."* [249]

Recommendation 20

The Greater London Authority and Association for London Government should facilitate the sharing of evidence and learning from scrutiny processes to support emerging Overview and Scrutiny Committees in developing their capacity to effectively investigate local access to primary care.

[246] Minutes of Evidence 15th May 2002 Elizabeth Manero (Chair, London Health Link)
[247] Minutes of Evidence 15th May 2002 Will Anderson (Consultant, Author of Every Voice Counts)
[248] Minutes of Evidence 30th October 2002 Chris Bull (Director of Social Services, Southwark)
[249] Minutes of Evidence 30th October 2002 Chris Bull (Director of Social Services, Southwark)

Encouraging Participation From Disadvantaged Groups

6.21 The evidence we received highlights the lack of involvement of people with special needs and people from traditionally disadvantaged groups. Although few of the submissions commented directly on the lack of patient involvement from these groups, it was implicit in the comments on equitable access. Of those who did comment explicitly on patient involvement the majority of comments were from organisations working with children. They highlighted the lack of involvement of children and young people and the need for them to be consulted about the development of primary care services, which would encourage them to take more responsibility for their own health. *"Recent analysis of Health Improvement Programmes undertaken for the NSPCC and three other major children's charities revealed little evidence of the routine canvassing of views of children and young people on the many health-related issues that affect them."*[250]

6.22 One respondent noted that deaf and hard of hearing people found it difficult to participate in mainstream consultation due to their communication needs. They highlighted the need for need for PCTs and other Trusts to ensure that deaf people had access to the Patient's Forums and PALS. [251]

6.23 We recognise that encouraging involvement from disadvantaged groups is an area PCTs have to develop, particularly to ensure that their patient and public involvement processes are truly representative of local communities. Will Anderson informed us that presently, PCTs do not have the skills, resources and experience to engage traditionally marginalised communities. He pointed out that one way they might achieve this is by working with local voluntary organisations and local authorities to develop joint processes of consultation with these communities. This would be an effective way of engagement, because the issues arising from such communities would be of importance to all of those organisations. He felt that with the big emphasis on partnership, local strategic partnerships, and working across the sectors it would be possible to do this successfully. [252]

Recommendation: 21

Primary Care Trusts should make greater use of the potential to disseminate information to diverse communities through established community-based organisations and networks.

6.24 The new arrangements for public and patient involvement are still being developed and it is not possible to fully consider the impact of these new arrangements at this stage of their developments. Whilst we welcome the intention of the Government to create a system of patient and public involvement that is democratic and open, we are concerned about how much impact and influence these new structures will be able to have on the design and delivery of health services. We are particularly concerned that these new structure must be representative of the communities they serve. We believe that for patient and public involvement to have a real impact on health services and

[250] Memorandum: NSPCC
[251] Memorandum: RNID
[252] Minutes of Evidence 15th May 2002 Will Anderson (Consultant, Author of Every Voice Counts)

result in real outcomes and benefit the patients, there must be sufficient investment in the new structures in terms of financial resources, training and administrative support. We also want to see structures that will facilitate the involvement of traditionally marginalised communities.

6.25 We recognise that there are challenges in facilitating this type of involvement but believe that primary care trusts and strategic health authorities should work together with the voluntary sector and local authorities to ensure that patient and public involvement structures are representative and effective. **In order for patient and public involvement to have real outcomes it must be conducted at both strategic planning levels and at the customer interface. It is integral to service provision and must not be seen as an add-on.**

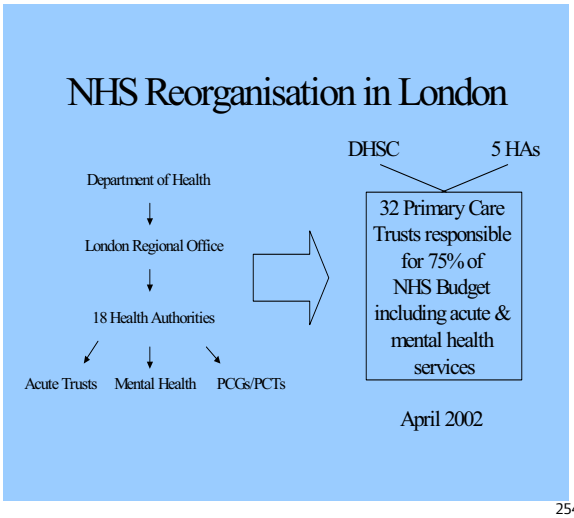
Recommendation 22

Information for patients and communities should include clear advice about patients' rights when accessing primary care, and what to do if they are experiencing problems or have concerns about current services, and how to get involved in influencing local decisions about future service provision.

Appendix A The Changing Structure of the NHS

The New NHS Structure for Primary Care

1.1 *Shifting the Balance of Power* [253] is the Government's programme of change for the NHS. It is part of the implementation of the NHS Plan and aims to give power and financial resources to frontline NHS organisations such as PCTs so that they can improve the way the NHS responds to the needs of local communities. This process has involved a major organisational change within the NHS, the aim of which is to devolve greater power and responsibilities to frontline NHS services.



[254]

1.2 Prior to April 2002, health services in London were provided through fourteen Health Authorities, which were overseen by the London Regional Office of the Department of Health. These Health Authorities were responsible for managing the acute trusts, primary care groups and mental health trusts.

1.3 At the beginning of April 2002, the London Regional Office was disbanded and a new Directorate of Health and Social Care (DHSC), part of the Department of Health, was created. The DHSC is responsible for the implementation of NHS Policy in London, this includes the implementation of the NHS Plan and the National Service Frameworks.[255] The DHSC is leading on four main areas of work; waiting times, booking and choice, reforming emergency care, intermediate care, and primary care modernisation.[256]

1.4 Also in April 2002, five health authorities were established in London, and formally became Strategic Health Authorities in October 2002. The Strategic Health Authorities are responsible for overseeing the performance and management of Trusts within a defined geographical area, and ensuring that national priorities are integrated into plans for local health services. Five Workforce Development Confederations (WDCs), with boundaries co-terminous with the Strategic Health Authorities, were also established to oversee the planning and development of the health care workforce.

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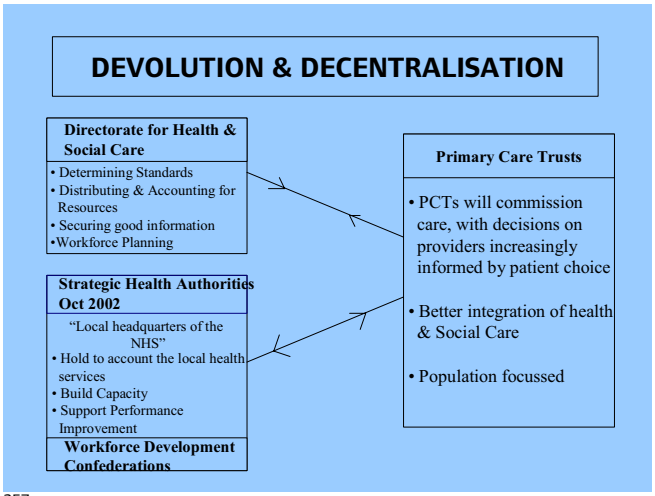
[253] Shifting the Balance of Power Within the NHS – Securing Delivery, Department of Health, July 2001
[254] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)
[255] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)
[256] Memorandum: Directorate of Health and Social Care



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1.5 The Strategic Health Authorities develop and agree franchise plans with the DHSC. These plans include service and financial frameworks, capacity plans, financial risk management strategies and the key activities that the Authority will focus on. The identification of key activities provides the Authority with the flexibility to include local issues on their agenda.[258] In addition to this the Strategic Health Authorities are responsible for performance managing both the PCTs and the WDCs within their areas.

Primary Care Trusts

1.6 In April 2002, five strategic health authorities and thirty two Primary Care Trusts (PCTs) were created in London.[259] The main feature of change has been to give these PCTs the role of running the NHS locally and improving health in their areas. The majority of PCTs in London, are co-terminus with borough boundaries.[260] The aim of this change is to foster a new culture in the NHS at all levels, putting the patient first.

1.7 Nationally, PCTs receive 75% of the NHS budget and have been charged with the responsibility of improving the health of the community through integrating local health and social care. It is Government opinion that this form of devolved health service, being best placed to have an overview of the organisations and bodies providing health and social care services in the community, will therefore be able to plan for and secure the health services that the local population needs. It is envisaged that some of these services will be provided by the PCTs themselves and others will be commissioned from other health care providers. The table below summarises the responsibilities of PCTs.

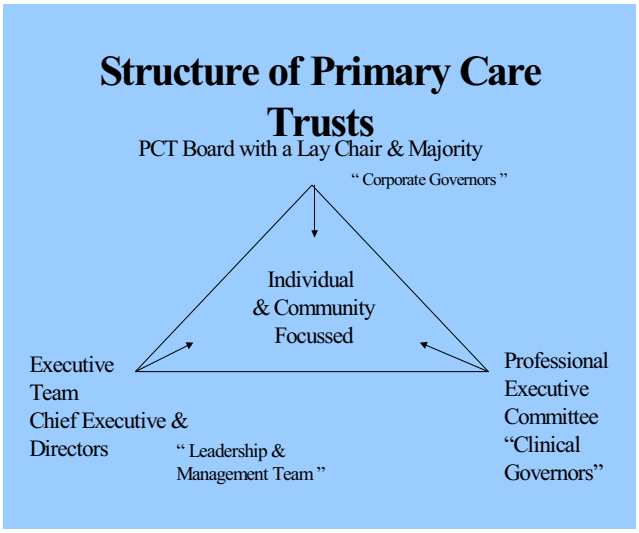
[257] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)
[258] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)
[259] Memorandum: Directorate of Health and Social Care
[260] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)

1.8 The Responsibilities of Primary Care Trusts (PCTs) [261]

PCTs will hold and decide how to deploy the local healthcare budget for the broad mass of hospital and community health services, as well as General Medical Services (GMS), infrastructure and prescribing.
PCTs will enter into service agreements with NHS Trusts in their own right.
PCTs will employ staff which will create scope for more integrated working across primary and community health services.
PCTs will acquire, own, fund and make available premises (including entering into Private Finance Initiatives deals for this purpose).
PCTs will enter into Personal Medical Services (PMS) and Personal Dental Services (PDS) contracts and establish their own GMS local development schemes (giving PCTs an important flexibility in tackling particular problems in primary care).
PCTs will develop their own incentive arrangements.
PCTs will utilise new operational flexibilities for health and social care, for example, pooled budgets and lead commissioner with local authorities.
PCTS will provide a limited or wide range of community services.

How Does a Primary Care Trust Work?

1.9 The PCT works through three key teams. In the main, strategic leadership is provided by the PCT board, consisting of executive and non-executive directors and a lay chairman. There can be a maximum of 15 people on the board.



1.10 The Professional Executive Committee is described in the table as the clinical governors.[262] Their role is to oversee the development of the clinical governance framework, ensuring that all services provided by and to the PCT are of a high standard.

1.11 The Executive Team is comprised of the Chief Executive, the Director of Finance and other directors. The Executive Team are members of the Professional Executive Committee and the Board.[263]

[261] Primary Care Trusts: Establishing Better Services NHS Executive April 1999
[262] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)
[263] Minutes 29th May 2002: Pippa Bagnall (Head of Primary Care, Directorate of Health and Social Care)

Appendix B Summary of Recommendations

Recommendation 1
The Association of London Government must work together with London local authorities to establish schemes that will facilitate the provision of parking permits in all London boroughs for all primary care staff who conduct home visits to patients.
[Association of London Government, London Boroughs]

Recommendation 2
The Office of the Deputy Prime Minister must review the various housing initiatives for key workers to ensure that all healthcare workers can have access to both affordable single and family size accommodation in London.
[Office of the Deputy Prime Minister]

Recommendation 3
All Primary Care Trusts should provide support to practices in their areas to develop appropriate terms and conditions of employment for practice nurses, with the aim of developing generic nursing roles across the primary care spectrum. This should include measures to ensure primary care staff have appropriate access to London Weighting, and to training and development opportunities. This work should be co-ordinated across London by the Strategic Health Authorities and Workforce Development Confederations, to ensure a degree of uniformity across the Capital.
[Primary Care Trusts, Strategic Health Authorities, Workforce Development Confederations]

Recommendation 4
GPs should be required to inform both patients and the Primary Care Trust, of the reasons for the removal of a patient from a GPs list.
[Department of Health]

Recommendation 5
There is a need to substantially expand the delivery of health care and prescribing by pharmacists. Each Primary Care Trust should ensure that there is at least one facility in their area that provides 24 hour pharmacy services to match the 24 hour services provided by GPs and hospitals.
[Primary Care Trusts]

Recommendation 6
We welcome the different initiatives and strategies to extend the roles of primary care health care workers. Primary Care Trusts and GPs should ensure patients have access to clear information about the new range of options for accessing primary care, including advice about the extended roles of nurses and other staff, and reassurance about the training and support being provided to enable staff to fulfil new responsibilities. In implementing these initiatives at local levels, we urge that patients be given the option of seeing a GP if they so choose.
[Primary Care Trusts]

Recommendation 7
We are pleased to hear that the implementation of Personal Medical Services (PMS) is successful in London, providing primary health care services to vulnerable communities and addressing some of the recruitment and retention problems of primary care staff. We call upon the Strategic Health Authorities and Primary Care Trusts to continue to actively promote PMS across London.
[Primary Care Trusts, Strategic Health Authorities]

Recommendation 8
We call upon the Department of Health to develop a pan London evaluation of the effectiveness of all their recruitment and retention initiatives. This evaluation must show how the Department of Health is balancing both the staffing needs of the primary and acute sectors, and the staffing needs of different healthcare providers. We believe that such an approach will provide a clearer picture of recruitment requirements and the success of recruitment and retention strategies across the capital.
[Department of Health]

Recommendation 9
Strategic Health Authorities should ensure that the performance management of Primary Care Trusts does not focus exclusively on targets for access times, but includes consideration of patients' experiences of services provided.
[Strategic Health Authorities]

Recommendation 10
Primary Care Trusts should support the implementation of Advanced Access and periodically evaluate its impact on patient accessibility to GP services.
[Primary Care Trusts]

Recommendation 11
Local authorities must take the lead as the main providers of community information. This should also involve working with Primary Care Trusts to ensure that staff in surgeries are informed about where to send people for advice about council services.
[Local Authorities, Primary Care Trusts]

Recommendation 12
We recommend that the Department of Health evaluates the cost-effectiveness of NHS Direct and Walk-In-Centres compared to other ways of increasing access; and monitor the extent to which they relieve pressure on General Practice; and benefit patients before further expansion of these services.
[Department of Health]

Recommendation 13
Boroughs must ensure that they reflect the need for primary care premises within their Unitary Development Plans, and undertake health impact assessments for all major building developments.
[Local Authorities]

Recommendation 14
Primary Care Trusts should facilitate provision of support and advice to GPs and Practice Managers about the development of primary care premises, including specialist advice around site acquisition and planning issues.
[Primary Care Trusts]

Recommendation 15
We call upon the Department of Health to publicise the findings of the Regional Premises Survey that took place in 2002, so that the London Assembly and London Local Authorities will be able to monitor the accessibility of GP premises in their areas and the impact of the current redevelopment work under LIFT and other regeneration schemes.
[Department of Health]

Recommendation 16
Primary Care Trusts should take a more rigorous approach to quantifying and monitoring the extent to which patients are having difficulty registering with GPs locally. This should include information about closed lists, and consideration of whether patients perceived as having more complex or challenging needs experience this as more of a problem than others.
[Primary Care Trusts]

Recommendation 17
Primary Care Trusts should identify the interpretation needs of each general practice in their area and publish a strategy which will identify how each general practice will meet these identified needs.
[Primary Care Trusts]

Recommendation 18
GP appraisal schemes and other approaches to professional development should be used to raise the awareness among primary care staff of the needs of different communities and of people with a range of specific needs.
[Primary Care Trusts]

Recommendation 19
Ongoing investment is needed to train and support Primary Care Trust Board and Professional Executive Committee members to take on new commissioning roles and responsibilities with increasing confidence and competence.
[Department of Health]

Recommendation 20
The Greater London Authority and Association for London Government should facilitate the sharing of evidence and learning from scrutiny processes to support emerging Overview and Scrutiny Committees in developing their capacity to effectively investigate local access to primary care.
[Greater London Authority, Association for London Government]

Recommendation 21
Primary Care Trusts should make greater use of the potential to disseminate information to diverse communities through established community-based organisations and networks. Practice, and benefit patients before further expansion of these services.
[Primary Care Trusts]

Recommendation 22
Information for patients and communities should include clear advice about patients' rights when accessing primary care, and what to do if they are experiencing problems or have concerns about current services, and how to get involved in influencing local decisions about future service provision.
[Primary Care Trusts]

Appendix C List of Written Evidence

Directorate of Health and Social Care (London)

Primary Care Trusts

Barking and Dagenham Primary Care Trust
Barnet Primary Care Trust
Bexley Primary Care Trust
Brent Primary Care Trust
Bromley Primary Care Trust
Chingford, Wanstead and Woodford Primary Care Trust
Croydon Primary Care Trust
Ealing Primary Care Trust
Enfield Primary Care Trust
Greenwich Primary Care Trust
Hammersmith & Fulham Primary Care Trust
Haringey Primary Care Trust
Havering Primary Care Trust
Hillingdon Primary Care Trust
Hounslow Primary Care Trust
Kingston Primary Care Trust
Lambeth Primary Care Trust
Lewisham Primary Care Trust
Newham Primary Care Trust
Redbridge Primary Care Trust
Richmond & Twickenham Primary Care Trust
Sutton and Merton Primary Care Trust
Tower Hamlets Primary Care Trust
Walthamstow, Leyton and Leytonstone Primary Care Trust
Wandsworth Primary Care Trust
Westminster Primary Care Trust

Strategic Health Authorities

South West London Strategic Health Authority
North East London Health Authority

Former Health Authorities

Barking & Havering Health Authority

NHS Trusts

Barts and The London NHS Trust
Queen Elizabeth Hospital NHS Trust
Whittington Hospital NHS Trust

Local Authorities

London Borough of Barking and Dagenham
London Borough of Hackney
London Borough of Hammersmith and Fulham
London Borough of Lambeth

Other Organisations

Age Concern
Breast Cancer Care
Bromley Physical Disability &Sensory Impairment Forum
Camden and Islington HAZ Community Reference Group
Crisis
Great Chapel Street Medical Centre
Greater London Action on Disability
Guide Dog for the Blind Association
Homeless Link
Independent Newham users Forum (INUF)
Islington Community Health Council
Imperial College Centre for Primary Care and Social Medicine
Kings Fund
London Hazards Centre
London Health Observatory
London Voluntary Service Council
Mencap
Mind
Muslim Council of Britain
National Association of Citizens Advice Bureaux
National Society for the Prevention of Cruelty to Children (NSPCC)
Office of the Children's Rights Commissioner for London
Pan London HIV/AIDS Providers Consortium
Queen Mary University of London
Refugee Health Access Project
Refugee Health Team-Lambeth Primary Care Trust
Revolving Doors Agency
Royal National institute of Deaf People (RNID)
Royal College of Nursing
Royal College of General Practitioners
Sainsbury Centre for Mental Health
Southwark Action for Voluntary Organisations
Sure Start GOL
Three Boroughs Primary Health Care Team
Trust Arts Project
UK Coalition of People Living with HIV & AIDS

Community Health Councils

Barnet Community Health Council
Ealing Community Health Council
Newham Community Health Council
Redbridge CHC
Richmond & Twickenham CHC
Tower Hamlets Community Health Council

Appendix D List of Hearings

15th May 2002: The Patients Voice in the Changing Structure

- Will Andersen, (an independent researcher/consultant and author of the Kings Fund report 'Every Voice Counts')
- Elizabeth Manero (Chair of London Health Link).

The issues considered included: the ability of patients to exercise informed choice about primary care within the new NHS structure; the role of the Patients Forum; and the challenges of ensuring patient consultation and patient choice in London.

29th May 2002: Reorganisation of Primary Care – Current Performance and Key Findings

- Pippa Bagnall Head of Primary Care Directorate of Health and Social Care
- Karen Dinsdale Primary Care Development Manager DHSC
- Tony Weight Assistant Director, Performance management DHSC

A wide range of issues were discussed including: the reorganisation of the NHS and the new primary care organisations; the primary care workforce; improving primary care premises; public engagement; the role of the Professional Executive Committee and NHS Direct.

13th June 2002: Maximising the Contribution of Health Professions

- Croydon Local Pharmaceutical Committee
- Croydon Primary Care Trust
- Royal College of Nursing
- South East London Health Authority

The Committee heard about the innovative Croydon Minor Ailment Voucher Scheme, the Royal College of Nursing primary care leadership programme and GP recruitment and retention issues.

26th June 2002: Improving Access - Faith Groups, Black and Minority Ethnic Groups and Children

- London Voluntary Service Council
- Office of the Childrens' Rights Commissioner for London
- Social Action for Health.

The areas considered included the role of the voluntary sector in improving access to primary care; the health needs of children, and the difficulties faced by children and young people in accessing primary care services. Social Action for Health spoke about their practical experiences in improving access to primary care and some of the projects and services that they have for improving access for communities in East London. The Committee also heard that community led initiatives are the realistic way to ensure a sustainable NHS.

4th July 2002: Improving Access - Less- Abled and those with Long- Term Illnesses or, Learning Difficulties

- Age Concern
- Pan London HIV/AIDS Providers Consortium
- Mencap
- Sainsbury Centre for Mental Health

The issues considered included the provision of patient information for those with special needs, commissioning of services, learning disability support and the implications of the 1995 Disability Discrimination Act for GP surgeries.

25th September 2002: Ensuring Primary Care Trusts Meet Local Needs

- Dr Andrew Burnett, Medical Director Barnet PCT
- Ian Ayres Chief Executive Sutton and Merton PCT

Issues included financial resources, the freedom of PCTs to commission services, balancing resources between the primary and acute sectors, NHS Direct and NHS Walk in Centres.

30th October 2002: Using Local Health Scrutiny to Improve Access

- Caroline England, Health and Social Care Policy Manager London Borough of Hackney
- Nick Johnson, Director of Social Services London Borough of Bexley
- Chris Bull, London Borough of Southwark

This included various issues such as the role of scrutiny in improving access to primary care. The challenge of balancing national targets with local priorities. Working in partnership with the NHS.

6th November 2002: Monitoring PCTs Performance and Progress

- Siobhan Harrington, Head of the London National Primary Care Development Team Centre.
- Pippa Bagnall, Head of Primary Care DHSC
- Christine Outram, Chief Executive, North Central Strategic Health Authority
- Duncan Selby, Chief Executive, South East Strategic Health Authority
- Julie Dent, Chief Executive, South West Strategic Health Authority

This focused on a range of issues including exploring the work of the Primary Care Collaborative, and other NHS strategies such as Advanced Access. We also questioned witnesses about their perspectives on issues discussed at earlier hearings e.g. GP recruitment and the challenges facing single-handed practices.

The minutes and transcript for all the hearings can be found at:
http://www.london.gov.uk/assembly/phcare/index.jsp

Appendix E Site Visit to Bromley By Bow

1. Summary

1.1 The GLA Access to Primary Health Care Advisory Committee visited the Bromley-by-Bow Centre on September 5th, 2002. The visit began with a tour before an informal meeting with the Centre's Community Care Project, its Heath Improvement Team and the Tower Hamlets Community Health Council (CHC).

2. Tour of the Centre

Nursery

2.1 Allison Trimble informed the Committee of the history and the development of the project. 17 years ago only a derelict church was present on the site. Its congregation was dwindling and it no longer represented the demography of its neighbourhood. A new minister arrived, Andrew Mawson, and it was decided to change this and to open the church up to the wider community.

2.2.1 A day nursery was established in the church. A new smaller sanctuary was created in the centre of the church and the perimeter was utilised to provide the community with the nursery facility. The project was set up with three guiding principles that offered an insight into how the whole centre has developed over the last 17 years.

- Designed flexibility. The church was now multi-purpose and not only was a place of worship and a nursery but also an art gallery, a toy library, a performance space and a venue for a wide range of community celebrations. Too often innovative ideas are hindered by a space deemed limited to one specific purpose. People are placed before structures; administrative barriers were removed. The redevelopment of the church and nursery were a deliberate attempt to avoid this trap by designing a flexible space. As the centre has developed this concept has remained.

- Permission to experiment. If an experiment fails the scientist should not be punished. New and effective ways of working can only be discovered and established in an environment where innovation is encouraged.

- Generosity. Where there are limited resources, those charged with looking after those resources need to be able to relinquish ownership and to trust partners. The more responsibility that is devolved to the community the more ownership the community has.

Committee Members at the Centre's nursery.

2.3 These approaches allowed the centre to tackle the complex problems that faced the area far more effectively.

Reception Garden

2.4 Allison Trimble drew attention to the piece of sculpture that immediately greeted anyone visiting the centre. This was placed there to create a welcoming environment – children would respond immediately to it and play on it.

2.5 The building uses high quality materials throughout. This was a conscious decision. The building should not be mediocre. It helped build up the self-esteem of the community if a high quality, well-designed and welcoming facility lay at its centre.

The Centre's Reception Garden.

2.6 Returning to the centre's development, Allison Trimble cited a case from 1995 which inspired the staff at the centre to examine the provision of statutory services in the local area. The Centre became drawn into advocacy on behalf of a young woman volunteer who helped run a gardening group for people with disabilities. The volunteer was a single parent with two young children and had limited literacy. She developed cancer. Throughout her illness she was passed between statutory services - from her GP she was referred to a hospital and from there to Social Services and then to Housing and so on. The time and energy required to keep pace with this was too demanding. Eventually she fell into no-one's exclusive remit and slipped through the net.

2.7 During the later stages of her illness, a fellow volunteer at the centre had looked after her children. Following her death a meeting was convened to discuss the situation regarding her children and no one from the centre was initially allowed to attend. Eventually, representations from the centre were permitted. The health visitor who was representing the mother could not remember the name of her child and it was at this point that the centre realised the importance the local community could play in delivering not only a support network but also primary care.

2.8 As a consequence of the above case, a new approach was adopted; one that integrated primary care services with art and sculpture classes, training opportunities and a whole raft of other activities, including the nursery. After much negotiation and hard work the Bromley by Bow Healthy Living Centre was opened in 1997.

Main Reception

2.9 Dr Julia Davis, a GP at the practice and the Director of Health at the centre informed the Committee that the healthy living centre had been built around providing a variety of services to its users.

2.10 GP's had limited tools and more often than not a patient required a response that went beyond a conventional medical response. The range of services offered by the centre has expanded to recognise this need. The centre now caters for art and sculpture classes, dance classes, gardening, interview and CV training, training in understanding the benefits system and education opportunities that had seen users gain qualifications such as Higher National Diplomas (HNDs). Users often become volunteers and therefore a sense of ownership is engendered.

The Centre's Internal Reception Area where a number of activities take place, inlcuding the Young at Art club.

Welfare and Employment Service

2.11 The centre runs a job club which is supervised by Helal Uddin, a former volunteer and now employee of the centre who has used the centre since 1995. Every morning (Mon-Fri) the centre runs one to one sessions on employment and welfare advice and every afternoon classes are run that help develop user's CV's and interview techniques.

2.12 The morning sessions mean that benefit assessments can be made in an informal atmosphere with the aid of some recently acquired software and they also provide support in form filling. Those who use the facility are a mixture of referrals from the General Practice and self-referrals. There is a wide range of users and there are usually between 7 and 15 people attending these sessions. He estimates that 500 households regularly used the service.

Members of the Committee discuss the Centre's Job and Benefits training.

2.13 Funding for the service comes from a variety of sources including Single Regeneration Budget and Helal has seven staff that are a mixture of full-time, part-time and volunteer. The facility has staff that could speak Bengali and Somali.

2.14 With regard to the Benefits session, Helal Uddin informed the Committee that 35-40 people attended in a week and of those 10 are new users. The training in the afternoon always has new people involved.

2.15 Where referrals within the centre take place, confidentiality is always kept and permission has to be given from patients for any information to be passed over.

Art Group

2.16 The Committee spoke to users of the Young at Art Club and volunteers who were supervising the group. Two of the volunteers at the centre explained how the centre had helped them.

> *She first contacted the centre when she was 16 after her son had contracted meningitis at three months. At the time, she could not read or write. Through the centre she has become literate and now has numerous qualifications including an HND. She has worked on a number of projects*

at the centre including the book tree - a project designed to encourage children to read.

A member of staff explained how she had started as a volunteer, new to the country, providing the centre with a translation service. She now concentrates on employment issues addressing the high unemployment in the area. She sees about 7-10 people a day and is in frequent contact with employment agencies regarding users at the centre.

2.17 Julia Davis explained that the reception is a joint reception for the whole centre. Any of the services than can be found at the centre can be accessed via this one reception. Primary Care was only part of a person's health and the reception was designed to reflect this as well as the high Bangladeshi population in the area. To do this health information took many different guises and the centre tries to remove the language barriers that would exist if just the usual set of leaflets were left out. Volunteers also help out in this regard by being on hand to assist with any queries patients may have.

The Chair of the Committee, Elizabeth Howlett, having a sketch done by a member of the centre's Young at Art group.

3. Informal Meeting

3.1 Dave Boice who runs the centre's Community Care Project gave a presentation to the group. The Community Care project offers daycare services for people with disabilities and has a staff team of 6 people plus a large number of volunteers.

3.2 The Community Care Project delivers its services by offering a wide range of workshops that include classes in stain glass, pottery and dance movement. The Project's timetable offers the following:

- **Monday** – Art classes. The sessions are not regarded as therapeutic art; it is felt that Art is therapeutic in itself.
- **Tuesday** – Block print sessions. These are used to produce such items as pillows and blankets, examples of which were shown to the Committee. Pottery classes are also held – examples of the classes work were also shown to the Committee.
- **Wednesday** – Furniture making sessions are being arranged for Wednesdays. It is important to engage users in long-term projects in order to get them to come back and remain interested. If something is completed in one session, there would be a lack of motivation to return.

- **Thursday –** A dance and movement group takes place on this day. This is used by people with a variety of disabilities.
- **Friday –** Mosaic sessions. Examples of mosaics were shown to the Committee.

3.3 Dave Boice drew attention to two cases that illustrated the effectiveness of the schemes being run.

A visually impaired user started to attend the pottery class. His care provision had referred him to the centre and he had a history of not settling. However, once he had bonded with a volunteer who originally come from Wapping, like himself, his enthusiasm grew and he eventually produced numerous pieces of work. This greatly helped his self-esteem. More importantly from the centre's point of view, he had taught the project something – about how to work with a visually impaired user. The mutual reluctance that had been there at the start of the relationship had been overcome.

An example of Lee Radford's work

Lee Radford had a learning disability. When he first came to the art group, his paintings were not considered anything other than a colourful mess. However, when an abstract artist volunteered at the centre he soon realised the potential in Lee's use of colour. Working with the volunteer, Lee's art developed to such an extent that his work can now be seen in the Tate Gallery and is also displayed in hospitals across London including Homerton and Westminster. Lee's work has been sold. Lee died earlier this year.

3.4 Essential to these projects is this volunteering process. Once someone volunteers to assist with a project it is noticeable that the volunteer gets a real benefit from it – it offers many people a reason to get out of bed. Dave cited an example of volunteering at the centre.

Mandy is now Assistant Manager of the Community Care Project. When she initially moved into the area in 1991 she knew nobody. She experienced great isolation and would take two trips out of the house when one would have done just to have more human contact. She eventually volunteered for the Community Care Project.

She was immediately enthused by this and began to swap numbers with users and other volunteers and developed close friendships. She

volunteered for every course going and soon found herself with a NVQ Level 2 before moving on to an HND.

When Dave was appointed to his current post, she was asked to induct him. He was so impressed with his induction and the help and insight she had offered, he decided to offer her the post of Assistant Manager. He was keen that this role went beyond being his personal assistant and that she should acquire the expertise and management skills that he brought to the project. Soon, the arrangement had bedded down. One user then remarked that "Mandy had done a good job of Dave."

This initially put Dave out. He had fostered the relationship in many ways but he soon realised that the experience had changed him as much as her and that he had learnt a great deal throughout. It had been a co-learning relationship and a change to the way he had worked in the past.

3.5 The funding for the project comes largely from social service referrals. In addition there is some charity funding. Julia Davis added that the centre was a registered charity and they had managed to receive funds from Single Regeneration Budget and the European Social Fund as well as from a variety of charitable health trusts. From a health point of view additional funding largely comes from the New Opportunity Fund as well as the Sure Start Plus Teenage Parent funding stream. The centre owns the building and the GPs rented the space from the centre.

3.6 Self-referrals into the project can be passed on to the Young at Art group and other appropriate activities.

Health Team

3.7.1 The Centre's Health Team gave a brief outline of their role in the working of the centre. The catchment area for the centre was 10,000; 25% of which accessed services available at the centre on a weekly basis. This was a significant proportion of the community.

3.8 Asha was the Centre's Health Network Co-ordinator. She looked after many arrangements at the centre on a day-to-day basis which could be anything from ensuring that tea and coffee had been ordered for a meeting to a making sure a referral is dealt with correctly. She worked closely with the practice nurse especially on health promotion projects.

3.9 Maria had been a volunteer at the centre who had lived locally for the past 20 years. She began by volunteering at the crèche from where she also began to work on community care projects. She had also helped out with the welfare classes. She had acquired an array of qualifications including a NVQ Level 2 in counselling. She was employed by the centre two years ago and of late has been working with young mothers. She added that she was also involved in home visits where depression was often a problem. She helped to break down certain anxieties by passing on her experiences.

3.10 Julia Davis cited an example where the centre had been involved in a role play exercise where the participants, including Maria, had to play themselves as they interviewed potential GP's. The view of Maria as both a health networker and also a local person living in the community was enlightening. Since then Maria

has sat in on interviews for health professionals that are being employed by the Centre.

3.11 The Committee asked what had kept Maria volunteering for such a long time. Maria felt that it was simply down to the fact that she had enjoyed the experience. Once her children were of school age and chores had been completed she found herself with a few hours to spare when she would volunteer. In turn, the experience had offered opportunities and allowed her to acquire skills she could never have foreseen before she took it up. The centre was also a social focal point and it was always open and accessible. Very few doors were locked and this in itself engendered an informal, relaxed and open atmosphere.

3.12 Lilu works on the Families Health Project dealing with the local community, social services referrals and in particular with the local Bangladeshi community. The main method of getting that community involved was to go door to door introducing herself as a friend rather than a representative from the centre. This was essential in finding out what that community needed. Of late she has focused her work on hygiene and personal health care. As part of this there has been a healthy eating scheme where local Bangladeshi's have been given lessons in healthy cooking and the results have been sold in the centre's café.

3.13 As her outreach work has developed some good relationships more volunteers from the Bangladeshi community have come forward. It was essential that the community shared experiences and offered support because the isolation could be acute and the health concerns of that particular community needed urgent addressing.

3.14 Murude has been working on the Art and Health project. Her main interest is to promote health through art. An example was illustrated when they held a painting exercise in the waiting area with GP's. This re-introduced the GP's to the patients and helped place them in a more informal context. It was hoped that this would build a different kind of relationship with patients. Her work had also included putting together various tools to illustrate the benefit of healthy eating. These could be used in the main reception area and on house calls. Another innovation was to have a resident artist who would draw pictures of patient's children. Again it was hoped that this would establish a more informal and relaxed relationship with patients and build up self-esteem.

3.15 Yvonne is the centre's practice nurse. She has been working with Lilu on the diabetes fair which helped outline the sort of foods that diabetics could eat. The problem was particularly acute with the Bangladeshi community who had a disproportionate amount of diabetics.

3.16 Lilu taught English as a second language and has been working too on the recent diabetes fair. The fair had also given advice on cooking low-fat curries and changing the size of portions. The event had been a success but was carried out a second time in order to attract more members of the Bangladeshi community. The second event was more successful in this regard. Both events had enlisted local support from shop owners and Tesco and had allowed those who attended to access relevant websites. Other work had included a smoking cessation group. The Committee thanked the centre for the tour and for the presentations given.

Appendix F Bibliography

Access to Primary Health Care Services in London 27th of May 2002 -Voluntary Sector Consultation

Access to Primary Health Care Services in London 18th of May 2002 -Public Sector Consultation

A Focus on General Practice in England. Audit Commission, July 2002

An Open Access Nurse Led Primary Care Pilot Depression Service in South London: Report to the Charlie Waller Memorial Trust 2001. Symons, L.

Black and Ethnic Minority Communities: Information About and Access to NHS Direct. Patel, M and The Afiya Trust. 2001

Critical Condition Vulnerable Single Homeless People and Access to GPs. Crisis December 2002

Evaluating NHS Direct: Early Findings Raise Questions About Expanding the Service. Florin D, Rosen R. BMJ 1999;319;5-6

Homelessness and Primary Care, Peter Molyneaux, Homeless Network

Independent Inquiry into Inequalities in Health, chaired by Sir D Acheson.1998. Department of Health.

King's Fund Commission on the Future of Acute Services in London 1981. King's Fund

Naish and Clark in Deaf Worlds, vol 14, 1998

National Statistics Community Pharmacies in England and Wales: 31st March 2001, Department of Health, 2001.

National Survey of GP Opinion, British Medical Association, BMA, 2001.

National Surveys of NHS Patients: General Practice 1998: Summary of Key Findings. 1999. NHS Executive

NHS Direct Audited. George S. BMJ 2002;324;558-559

NHS Executive, National Surveys of NHS Patients: General Practice 1998, NHS Executive, 1999

New Opportunities for NHS Direct: Pioneering NHS Helpline Breaking New Boundaries, Driven From Grassroots Experience. Department of Health. 1999

Overnight Calls in Primary Care; Randomised Control of Management Using Nurse Telephone Consultation. Thompson F et al. BMJ 1999;319

Pharmacy in the Future – Implementing the NHS Plan, Department of Health, 2000

Primary Care Trusts: Establishing Better Services NHS Executive April 1999

Primary Health Care in London - changes since the Acheson Report. *BMJ* 1992;305:1130-6. Jarman B,.Bosanquet N.

Rapid Review of Access to Primary Care: A Report to the Greater London Authority, August 2002

Retropsective Analysis of Census Data on General Practitioners who Qualified in South Asia : Who Will Replace Them as They Retire? Taylor DH Jr, Esmail ABMJ 1999

Review of the First Wave Personal Medical Services in London, Kings Fund; R Lewis, C Jenkins and S. Gillam.

Safety and Effectiveness of Nurse Telephone Consultation in Out of Hours Primary Care: Randomised Controlled Trial. Lattimer V et al. BMJ 1998;317: 1054-9

Shifting the Balance of Power Within the NHS – Securing Delivery, Department of Health, July 2001

Telephone Access to Health Care: The Role of NHS Direct. Donaldson L.

The British Scene Nurse Practitioners: Working for Change in Primary Health Care Nursing, London: Fawcett-Henesy A. King's Fund, 1991

The First Two Years National Primary Care Collaberative

The Health Services in London: A Strategic Review. Turnberg L. 1997. London

The Mind Model for Choice in Primary Care. Mind 2002

The National Evaluation of NHS Walk-in-Centres. Salisbury et al, 2002 Bristol, University of Bristol.

The NHS Plan Department of Health July 2000

Trends in Attitudes to Health Care 1983 to 2000, report based on results from the British Social Attitudes Surveys, National Centre for Social Research, 2001.S Exley and L Jarvis

What Do Londoners Think of Their General Practice? Malbon G, Jenkins C, and Gillam S. 1999. London, King's Fund

What Do Londoners Think of Health Care? 2001. Mulligan JA. London, King's Fund

Your Contract Your Future. General Practitioners Committee. 2002.GMC

Appendix G Acronyms and Abbreviations

A&E	Accident & Emergency Department
BME	Black and Minority Ethnic
CP	Community Pharmacist
DoH	Department of Health
DHSC	Directorate of Health and Social Care for London
GLA	Greater London Authority
GMS	General Medical Services
GP	General Practitioner
LA	Local Authority
HA	Health Authority
NHSD	NHS Direct
NP	Nurse Practitioner
OOH	Out-of-hours
PC	Primary Care
PCT	Primary Care Trust
PMS	Personal Medical Services
PN	Practice Nurse
SHA	Strategic Health Authority
WIC	Walk-in Centre

Vulnerable groups – we have used this term to describe the homeless, the elderly, children and young people, refugees, asylum seekers, people with long term illnesses, travellers and low income households.

Appendix H Medical Practitioners - Definitions[264]

An **Unrestricted Principal** is a practitioner who is in contract with a Health Authority to provide the full range of general medical services and whose list is not limited to any particular group of persons. Most people have an Unrestricted Principal as their GP.

Restricted Principal is a practitioner who is in contract with a Health Authority to provide either the full range of general medical services but whose list is limited (e.g. to the staff of a particular hospital or other institution), or to provide maternity medical services and contraceptive services only.

A **PMS Contracted Doctor** is a practitioner who is in a contract with a Health Authority to provide the full range of services through the PMS pilot contract and like Unrestricted Principals they have a patient list.

A **PMS Salaried Doctor** is a Doctor employed to work in a PMS pilot either by the PMS Contractor or by the PMS Contracted Doctor, and who provides the full range of services and has a list of registered patients.

An **Assistant** is a fully registered practitioner employed by a principal to act as his/her assistant.

A **GP Registrar** (previously called 'trainee') is a fully registered practitioner who is being trained for general practice under an arrangement approved by the Secretary of State.

A **Salaried doctor** (Para. 52 of the Statement of Fees and Allowances (SFA)) is a doctor employed by an Unrestricted Principal, at the discretion of the Health Authority, under the practice staff scheme.

Other PMS doctors work in PMS pilots and are the equivalents of Assistants or Salaried doctors (Para. 52 of SFA) in GMS.

GP Retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GP Retainer is allowed to work a maximum of 4 sessions of approximately half a day each week.

A UPE is an Unrestricted Principal or Equivalent, that is, a PMS Contracted or PMS Salaried Doctor.

A **Trainer** is a practitioner who has been approved as suitable to supervise and train practitioners in general practice.

A **Single Handed UPE** is one who has no partners, although he/she may have an Assistant or a GP Registrar. In this bulletin a single- handed UPE is defined as a partnership of one.

[264] Statistics For General Medical Practitioners in England 1990-2000

Estimated whole-time equivalent (WTE) UPEs (Unrestricted Principal or Equivalent) are calculated based on the results from the 1992-93 GMP Workload Survey, using factors of:
full time = 1.0 WTE;
three quarter time = 0.69 WTE;
job share = 0.65 WTE
and half time = 0.6 WTE.
WTE GP Retainers have been estimated using a factor of 0.12 per session.

A **Partnership** is a financial arrangement between two or more practitioners.

A UPEs' List Size is the number of persons for whose treatment the UPE is responsible. For UPEs in Partnerships, the **average list size** is the total number of persons for whom the partnership is responsible divided by the number of UPEs in that Partnership.

A **Dispensing Doctor** is one who is authorised to prescribe and dispense prescriptions for patients who either have difficulty reaching a chemist due to inadequate means of transportation or who live in a rural area.

Practice Staff: doctors are able to employ a wide range of staff to assist them in the provision of general medical services. Their Health Authority may reimburse a proportion of the cost of employing these staff through either the SFA or the PMS Contract.

Appendix I Principles of Scrutiny

The powers of the London Assembly include power to investigate and report on decisions and actions of the Mayor, or on matters relating to the principal purposes of the Greater London Authority, and on any other matters which the Assembly considers to be of importance to Londoners. In the conduct of scrutiny and investigation the Assembly abides by a number of principles.

Scrutinies:

- *aim to recommend action to achieve improvements;*
- *are conducted with objectivity and independence;*
- *examine all aspects of the Mayor's strategies;*
- *consult widely, having regard to issues of timeliness and cost;*
- *are conducted in a constructive and positive manner; and*
- *are conducted with an awareness of the need to spend taxpayers money wisely and well.*

More information about the scrutiny work of the London Assembly, including published reports, details of committee meetings and contact information, can be found on the GLA website at http://www.london.gov.uk/assembly/index.jsp

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