



LONDON PLAN 2018

SHA LONDON RESPONSE

Compiled by Jos Bell, (Chair) on behalf of SHA London, with collective input from numerous London-based members working in a variety of specialist areas of health practice and policy and local govt function. (March 2 2018.)

Introduction

We very much approve of the aim of the New London Plan to plan for ‘good growth’ on the basis of a potential to improve the health and quality of life of all Londoners, to reduce inequalities and to make the city a better place to live, work and visit.

However we are disappointed that the several hundred members of the Socialist Health Assoc London were not approached as an entity for our response or input into this document before it went out. The fact that health is a stated overall aim is to be applauded, but we are perplexed that the significant knowledge and skills base of our membership has not been approached for input.

We therefore offer this paper, which we have also submitted under the key headings to the online response to offer expert opinion, both on the matters which have been included and also those which have not.

We specify our input to a Healthy London under the following areas :

Sufficient services and infrastructure to meet a growing population

Emergency services

Public health

BAME health

Mental health and wellbeing

Sexual health

Access to healthy housing

Clean air and Green spaces

Creating an accessible city

Land planning and use of NHS assets

Key Performance Indicators

Following meeting of London branch of SHA February 21st.

General comments

Such a lengthy planned period for London (2018-2041) offers an invaluable opportunity, amongst other things, to address those issues underpinning positive health and disease, unlike current NHS planning periods eg Five Years Forward View.

For example, the emphasis for positive health allowed for by a 2 generation planning cycle allows for planning to concentrate on addressing social and therefore health inequalities, more investment in opportunities for children growing up in nutrition, education, and sustainable and diverse employment, transport, housing and leisure.

The original plans of the SHA agreed by the Labour Party pre the Second World War and forming the basis of the NHS post war, included a health service founded on prevention of disease and a national occupational health service- ie a service to protect people from the ill effects of work. It would be useful for these two principles underpinning an NHS to be stated in the plan as they often seem to be forgotten.

With such a rapid pace of global change, and considerable changes predicted due to Brexit, the predictive power of the document is relatively weak. Also, a plan which concedes such a massive financial gap in the plan, at best suggests the plan may be “pie in the sky” and at worst puts London on a drive to raise cash by selling off the London public estate and to be “wide open” to businesses seeking to exploit it for profit, not for the benefit of London and the UK, and as an important World capital, in service of the World.

Overall, with a Labour London Mayor we feel that this should more obviously be a Labour London Plan.

Borrowing to invest for infrastructure in line with Labours financial plans is appropriate given the popularity of those policies at the last election. Models of cooperative ownership and nationalisation of industry, community provision transport and energy supply should be emphasised. Poverty and the impact of social inequality on health should be highlighted and the actual declines in life expectancy now being noted in the country make it legitimate to talk about a Health Emergency.

Coming on to health specifically, as well as pointing out the impact on health of broad factors covered by the plan, the small section on health needs to be addressed, in a large plan.

Primary Aim : REDUCING HEALTH INEQUALITIES

Rather than a focus on cutting services, London needs a targeted improving health plan to tackle health inequalities in our city.



**‘the forensic work of Michael Mansfield Commission on Health & Social Care in North West London is absolutely vital in enabling us understand the need to secure our NHS services’
Jon Ashworth, Shadow Secretary of State for Health Feb 28 2018**

Good Growth Policies

It is disappointing to see a London Plan guided by a Labour London Mayor does not include current Labour and SHA policy for a reinstatement of the NHS bill and driving out privatisation and the market from our health structures – rather it seems to embrace the rightly maligned STP structures.

Several things flow from this. London's health service serves a city which is and should be expanding and due to demographic changes is likely to have a population with increasing health needs. Many of its hospitals serve as regional, national and even international centres of excellence in treatment, innovation and research.

There have been almost 10 years of austerity and 7 years of an active attempt by Government to starve the NHS of funds, with year on year cuts of 5% below assessed need.

As we know, but need to point out, the market has begun the process of breaking up the NHS into bite size chunks sold off and delivered by private health companies, removed the necessary tools for national planning and resourcing an NHS, and wasted up to 20% of scarce revenue on management consultancies and expensive tendering processes.

This also when an estimated 14% of the whole NHS budget is being lost on PFI repayments.

We should be arguing in the London Plan for finding all means possible to resist private tendering and restoring public ownership and provision of health. The Naylor report should not lead to health estates leaving public ownership. Facilities closed due to austerity funding, despite increasing health need, will need to be reopened and expanded.

Land will need to be used for new step down facilities and accommodation for staff unable to afford to live in London despite being needed to fill 20,000 vacancies. New facilities for a massive expansion needed in primary and community care will need to be accommodated before the health of the population can be expected to improve and the need for fewer acute hospital placements is achieved.

Parity of mental health with physical health is still far from a reality and a real commitment for parity in London will require a short term expansion of beds, particularly for under 18's and a rapid expansion of premises and professional teams before a reduction in need for acute specialist care can be expected.

Whilst it is not the role of City Hall to run the NHS, we need the London Plan to indicate it will search for securing the NHS through political means and using the force of leverage due to London's size along with the power of the Mayor's mandate.

City Hall should strive to influence and implement with partners, a health service and public health programme on the basis of population need to ensure the health of the capital really does improve.

We note the following :

To ensure that London's growth is Good Growth, each of the policy areas in this Plan is informed by the six Good Growth policies:

- [Policy GG1 Building strong and inclusive communities](#)
 - [Policy GG2 Making the best use of land](#)
 - [Policy GG3 Creating a healthy city](#)
 - [Policy GG4 Delivering the homes Londoners need](#)
 - [Policy GG5 Growing a good economy](#)
 - [Policy GG6 Increasing efficiency and resilience](#)
- and respond as follows :

RESPONSE TO CHAPTER 2

Reference to -

Policy GG2 Making the best use of land

GG2

To create high-density, mixed-use places that make the best use of land, those involved in planning and development must:

- A. prioritise the development of Opportunity Areas, brownfield land, surplus public sector land, sites which are well-connected by existing or planned Tube and rail stations, sites within and on the edge of town centres, and small sites.
- B. proactively explore the potential to intensify the use of land, including public land, to support additional homes and workspaces, promoting higher density development, particularly on sites that are well-connected by public transport, walking and cycling, applying a design-led approach.
- C. understand what is valued about existing places and use this as a catalyst for growth and place-making, strengthening London's distinct and varied character.
- D. protect London's open spaces, including the Green Belt, Metropolitan Open Land, designated nature conservation sites and local spaces, and promote the creation of new green infrastructure and urban greening.
- E. plan for good local walking, cycling and public transport connections to support a strategic target of 80 per cent of all journeys using sustainable travel, enabling car-free lifestyles that allow an efficient use of land, as well as using new and enhanced public transport links to unlock growth.
- F. maximise opportunities to use infrastructure assets for more than one purpose, to make the best use of land and support efficient maintenance.

USE OF LAND FOR HEALTHY LIVING

As a plan for London based on the need to address the spatial design of a world city, there is a greater need to compare and contrast with views on city planning around the world. For example in China and elsewhere, views are moving in the direction of much larger and more populous cities for efficient economies. Should London be scaling up to 13 million people living in a centre more dynamically one with centres of new technologies and research to the south, east west and north with transport to match?

Specialists in land planning who number amongst our members have also pointed out the course of land grabbing and privatisation of land over centuries, and its acceleration over the last 40 years. We feel compelled to point out the risk of this continuing to underpin many negative developments in London, and the danger of this continuing in the future – in particular with respect to sales of NHS land without due regard to either implications or alternatives.

The Naylor report on NHS estate recommends a massive sale of NHS land and facilities that are 'underused' or no longer required. But Naylor's definition of 'underused' is critically flawed and, equally, he recommends sale of NHS land in the absence of any overall strategy for NHS estate and before there has been any consideration of future NHS and associated needs. For these reasons, any current designation of NHS estate or properties is unwarranted and unsafe, and current NHS estate must not be included in any plans for alternative use.

It is crucial for London that the Naylor Report for NHS estates is not swallowed whole if we are to prevent the NHS sell off to be irredeemable.

We also refer you to our response in 11.1.40.

We hope to see London's land used to ensure that neighbourhoods have access to multi-purpose facilities which support healthy lifestyles – in particular the use of NHS land.

London needs to retain GP and community health services that are close to where people live, so they are convenient and easily accessed, particularly by people with young children, elderly people and disabled people. Our NHS needs to be assessed in terms of ease and equality of access as well as clinical excellence. However this is not recognised in current plans for NHS services.

The NHSE / Government Plan for (UK-wide) NHS services envisages a reduction in annual spending of £26bn pa by 2021 compared with 2015 levels of spending. The main way this level of reduced spending can be achieved is through a massive reduction in the number of local GPs and community healthcare sites as well as closure of hospitals, beds and A&E services.

Reduction of sites will mean longer, problematic journeys involving great inconvenience or hardship particularly for people with young children, elderly and disabled people, who often need to make regular visits to surgeries.

Although a small number of procedures of course require specialist facilities, the vast majority of healthcare appointments can be carried out in local, non-specialist sites. The London Plan must ensure that London retains local healthcare services, and that convenience of access to healthcare and travel to facilities are given a high priority in all planning.

We hope to see London's land used to ensure that key workers in the medical field, the emergency services and children's services have access to decent affordable homes close to where they work.

We hope to see London's land used to create multi generational facilities where children and older people are cared for on the same site eg. <http://unitedforallages.com>

Where much needed housing is planned this needs to be developed in a health oriented way which allows for sufficient green space and public transport access. We explore this in more detail later in the document.

Policy GG3 Creating a healthy city

GG3

To improve Londoners' health and reduce health inequalities, those involved in planning and development must:

- A. ensure that the wider determinants of health are addressed in an integrated and co-ordinated way, taking a systematic approach to improving the mental and physical health of all Londoners and reducing health inequalities.
- B. promote more active and healthy lifestyles for all Londoners and enable them to make healthy choices.
- C. use the Healthy Streets Approach to prioritise health in all planning decisions.
- D. assess the potential impacts of development proposals on the health and wellbeing of communities, in order to mitigate any potential negative impacts and help reduce health inequalities, for example through the use of Health Impact Assessments.
- E. plan for improved access to green spaces and the provision of new green infrastructure.
- F. ensure that new buildings are well-insulated and sufficiently ventilated to avoid the health problems associated with damp, heat and cold.
- G. seek to create a healthy food environment, increasing the availability of healthy food and restricting unhealthy options.

Creating a Healthy City

A.

We very much approve of the expansion the ‘determinants of health’ categories and recognition that this can – and should - be shaped into and then by the planning system.

Transport, housing, education, income, working conditions, unemployment, air quality, green space, climate change and social and community networks can have a greater influence on health than healthcare provision or genetics.

We approve of the recognition of the urgent need to reverse rising inequality

We urge all local authorities in London to pay attention to their responsibility for HEALTHY planning

We regret the way in which public health has been forced by central govt into a non ring-fenced function rather than a real service which can fully protect and promote public health.

However, if we seek to be positive influencers upon the place in which we live and work, in order to do so, we need to take a stronger approach than that currently proposed in the London Plan.

>> Mechanisms for promoting healthy lifestyles

Questions : What form will these take? Who will deliver them?

Comment : the health KPI is very weak and vague

- we explore this later in the document

London STPs covering Londonwide LMCs' boroughs

- ☒ North Central
- ☒ North East
- ☒ North West
- ☒ South East
- ☒ South West



B.**This is the reality of the public health challenge :**

We note that in June 2015, the Treasury announced a reduction in the public health grant to local authorities by £200 million, this is to be followed by further government cuts in public health funding of at least £600 million by 2020/21.

Kings Fund January 2018

We acknowledge that local authorities are facing significant austerity and being forced to make difficult choices with cuts in services across the board.

The reduction in Public Health budgets has led to cuts to children's 0-19 community health services budgets, specifically Health Visiting and School Nursing services which are commissioned by local authorities. Providers (largely NHS in London) therefore have been urged to 'Transform' services to fit reduced budgets.

So-called 'Transformations' have led to care being provided by fewer qualified health visitors, and a greater proportion of less qualified and professionally unaccountable staff.

We consider this a risk to the health, growth and wellbeing of children under 5 especially missed opportunities to detect post-natal depression and parenting problems and to provide education about healthy eating. Low Vitamin D intake, immunisation and stimulation of appropriate development may contribute to poor outcomes for London's most vulnerable children.

A vital element of a healthy city is ensuring that everyone, particularly the most vulnerable, have easy access to GPs and other primary healthcare facilities. People with young children, elderly and disabled people especially need access to GPs and other routine primary healthcare that is nearby and does not involve lengthy and inconvenient journeys. However the Government's plans for healthcare involve a massive reduction in local NHS sites (in order to reduce NHS spending by £26bn p.a. by 2021 compared with 2015 levels). This reduction of local sites will mean great hardship for the most vulnerable and huge inconvenience for most people. Long journeys to GPs and clinics will mean that many of the most vulnerable people will simply 'do without' the healthcare they need.

Government justifies the policy by pointing to the need to create larger hubs with specialist facilities. Of course specialist facilities are needed - but not at the expense of convenient local care. Ease of access to health is as important a criterion of good healthcare as clinical excellence.

The London Plan must tackle this by ensuring that ease of access to GPs and primary care - as well as to hospitals and A&E, including length and complexity of journey, must be given a high priority in any planning consultation and local decisions.

How to involve local communities.

Will there be funded posts or will this be left to communities to build or add to existing voluntary structures? Is there a capacity issue to deliver this effectively ?

We have models where this has already been effective such as the integrated multi-purpose health centre in Somers Town which has been developed with community input – yet at the same time this community is at risk of increased ill health due to the HS2 works impacting air quality and noise pollution and general community upheaval.

BAME Population

Some of the areas of London with highest levels of inequalities happen to also have most of our black and minority ethnic communities. These most diverse areas of our city have some of our most challenging health needs which can be addressed with more outreach and education with preventative public health programmes.

Levels of tuberculosis, heart related problems and diabetes are higher in BME communities and conditions such as sickle cell anaemia occur exclusively.

C

Healthy Streets

- >> We note that other respondents have cited the lack of neighbourhood ethos or planning as being problematic for future healthy lifestyles.
- >> Good health at centre of planning is an excellent intent. This needs to be done with best practice advice from organisations such as the Town and Country Planning Assoc.
- >> How to include local residents and other stakeholders most effectively?
- >> How will this be managed?

Working with local communities must not be tokenistic but taken back to the original ethos of consultation and regeneration.

Data from After Grenfell : We refer to this because Kensington and Chelsea is the focal point of inequality in the Capital :

Average child poverty in London is 28%, but in K&C it is 27%. This is made up from a level of just 2.8% in Queen's Gate, and an appalling 58% in Henry Dickens Court, Norland ward. This is worse than Glasgow's Gorbals, at 49 %.

The Child Poverty Action Group states that there are over 4,500 children living in poverty in the borough costing the economy £49m a year; that's £10,000 per child per year. In Kensington two-thirds of children living in poverty come from working families, with half of them earning less than £7.50 per hour. Incidence of diabetes, chronic heart and pulmonary disease and even TB has risen exponentially in the past six K&C is blessed with parks and green space, tennis courts and other sporting facilities. However over the years many of these publicly owned assets have been privatised. Funding for primary school sports activities has been decimated, and free swimming for children and over 60s ceased in 2010.

Physical activity for school aged children is unaffordable to many and is dropping, while obesity in Year 6 children has more than doubled, from 8.6% in 2010 to 20% in 2016

Income inequality is extreme. The median income in K&C is £140,000, the highest in the country, though this is still not enough to buy a home at the average cost of £1.5m.

The Index of Multiple Deprivation shows the score for Queen's Gate is 8.4, and it is the 'least deprived ward in England'. Swinbrook Estate off Portobello Road however has an IMD of 53, and is in the 4% worst deprived wards in England

Two thirds of the adult population in K&C are in employment, and a third of them work over 49hrs per week. Nearly 5,000 are seeking work.

In Pelham Crescent, South Kensington only 1.4% are unemployed, but if you cross the road to Samuel Lewis Buildings, this rises to 13%.

Shockingly, since 2010 in Kensington and Chelsea -

There has been a 6 year drop in life expectancy in Golborne ward since 2010.

Child obesity linked to poverty in Yr 6 pupils has doubled in seven years

Hip fractures in over 65's have doubled since 2010

Under 75's cancer mortality has increased by one third

These extracts from **After Grenfell (Nov 2017, Emma Dent Coad MP)**

[file:///C:/Users/Jos%20Bell/Downloads/After%20Grenfell%20\(2\).pdf](file:///C:/Users/Jos%20Bell/Downloads/After%20Grenfell%20(2).pdf)

show us the stark reality of inequality in London – but how far will what is planned in the new London Plan really make a difference? The only way to achieve this is with

- a. proper use of current resources
- b. additional resources in line with population trends
- c. a reversal of funding models which reward longevity instead of supporting areas with avoidable early mortality

Malnutrition

Malnutrition is an increasing problem – it can take several forms, from the severely underweight to obese. Incidents of rickets and hypo-calcaemic shock have been reported in children for the first time in decades. Older people living in poverty are at great risk of being severely underweight and it is a major factor in hospital admissions in this age group.

Food banks are now a common feature of almost every neighbourhood. These are indicators of a failing health strategy at central government, but local government can intervene.

There are two key areas of concern which we would like to highlight in this comment.

The first is the failure to address the public health emergency of child obesity in the context of the Mayor’s responsibility for a strategic approach to reducing inequalities in health. The second is the absence of attention to supporting structures and practices that extensive work on takeaways by Public Health England has shown would engage with barriers to healthy eating in low-income areas.

Access to Takeaways

Healthier food should be made affordable for low income children and young people to tackle inequalities in obesity. This is a demanding challenge in light of the market failure which has been found in studies of takeaways serving such populations. The major thrust of recent policy advice on fast food outlets is for local authorities to use current or enhanced planning powers to control the spread of takeaways near schools, to encourage or require healthier options, and to make information about healthfulness clearer. It is an urgent matter for the London Plan to promote a healthier food environment. Policy E9 is devoted to Retail, markets and hot food takeaways. We comment on the London Plans’s (LP) policy proposals on takeaways as it is the only health issue for which a topic paper is supplied. Its insufficiency exemplifies policy weaknesses in public health in the LP.

We are told that the “Mayor’s Food Strategy prioritises the need to help all Londoners be healthier and for the food system to have less of a negative environmental impact” (8.8.4 p319). Policy E9 (pp257-8) is based on evidence in the Health Topic Paper devoted to Hot Food Takeaways. Under the heading

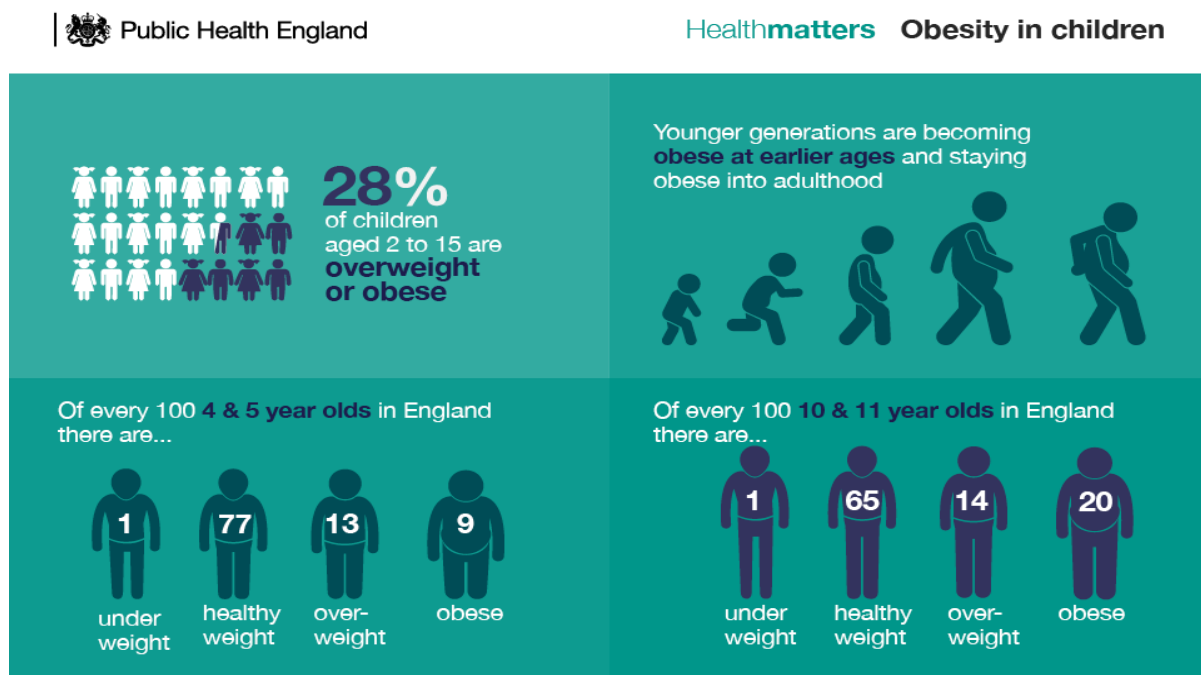
Impact on mental and physical health and well-being:

C. New A5 hot food takeaways will not be permitted within a 400 metre walking distance of existing or proposed primary or secondary school. In addition, local authorities will be able to limit the concentration of takeaways where “sufficiently justified”.

D. Where permission is given, the operator is required “to achieve accreditation, and operate in compliance with the Healthier Catering Commitments standard”.

These proposals do not address key public health issues. The Mayor’s statutory responsibility to address inequalities in health and the 2010 Equalities Act should inform all policy proposals in the LP. These requirements should shape, as well, the monitoring function ie in selection of KPIs and measurement. There is no direct reference to these requirements in respect of the proposals on Takeaways. The London Health Inequalities Strategy, still in draft form, does not have an implementation framework and is not grounded in an upstream social determinants of health approach. This accountability deficit should be remedied.

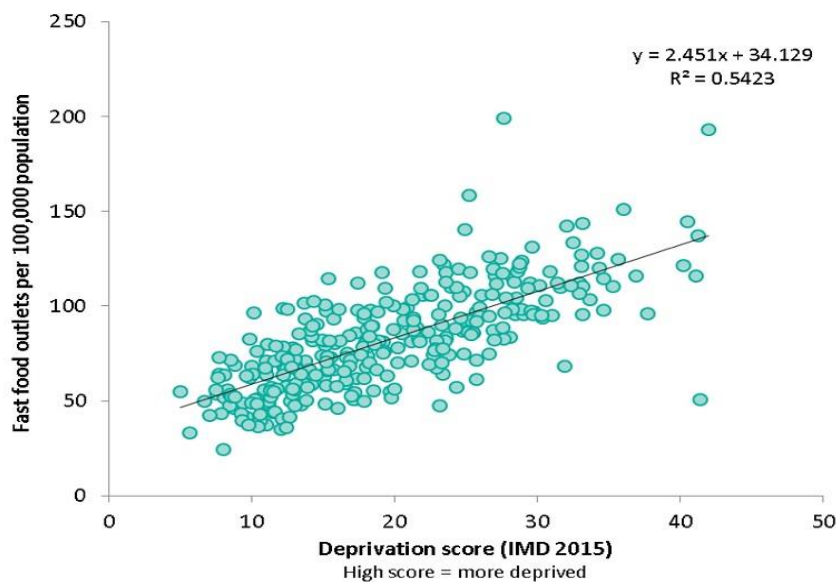
Overweight and obesity amongst children is a major public health threat.



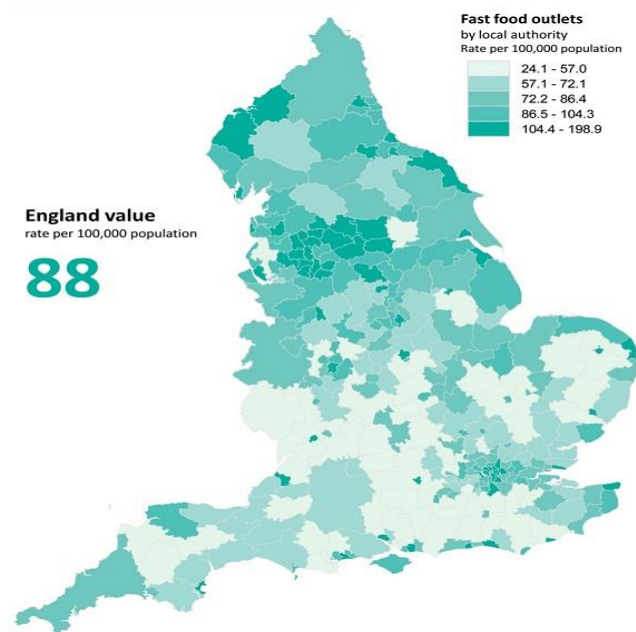
Those most at risk of developing obesity-related health problems disproportionately experience poverty. Their economic and social position shapes their food behaviour. “People from certain ethnic groups, such as south Asians, are more likely to be overweight and obese, and have a higher susceptibility to particular diseases linked to excess weight, such as type 2 diabetes “(Health Matters PHE).



Relationship between density of fast food outlets and deprivation by local authority



The policy proposed in the London Plan would be met if every new takeaway meeting the distance criterion were a Planet Organic or a Leons as these outlets, which tend to provide healthier options do not provide inexpensive menus and do not set up outlets in low income catchments.



Research led by Susan Bagwell of London Metropolitan University with the Chartered Institute of Environmental Health, funded by the ESRC, looked at healthy catering schemes across the UK to identify how to make such schemes support access to healthier food by people on low incomes (Encouraging Healthier Takeaways in Low-income Communities: https://responsibilitydeal.dh.gov.uk/wp-content/uploads/2015/.../Takeaways_toolkit.p...)

The research focussed on small independent providers in deprived neighbourhoods, as previous work had shown that these outlets were likely to be run by and to employ people who were themselves on the economic fringe. The research investigated barriers to offering healthier AFFORDABLE food and showed steps local authorities could take to make Healthy Catering Schemes actually work. Surprisingly, it showed that supply chains for independent takeaways were highly concentrated.

Only 3 suppliers dominated provision across the whole of London. Such concentration opens opportunities for local authorities to help independent takeaways by using their public procurement powers to accomplish several aims . Firstly by negotiating directly with these providers they can achieve economies of scale potentially reducing the cost to the takeaways and secondly they can exercise leverage to negotiate lower prices for healthier ingredients for fast food businesses across their catchment area. This research highlighted the importance of support and cooperation from agencies involved in environmental health, community nutrition and trading standards. Unfortunately, these sections of the local authority public health workforce are being cut across London.

Bagwell's research showed that some proprietors of fast food outlets have been able to take steps to offer healthier menus to customers and explored the factors which enabled them to do so as well as the barriers they faced.

Public policy must take into account the fact that food provision in the UK is marked by concentration of suppliers and segmented markets. Public policy should engage with the fact that the takeaway landscape is highly fluid and is changing rapidly. Some outlets can accommodate changes required by those customers who can afford to buy healthier takeaways. This is difficult to achieve for businesses with a low-income client base. Here the higher costs for healthier ingredients make independent outlets serving low income customers financially precarious. They can only improve what is on offer if their efforts in doing so are at least cost-neutral.

There is scope for improvement in takeaways. Since the publication of the Foresight Report 2007, local authorities have led the way in establishing collaborative working across agencies which engage with the health impact of takeaways. They have developed procedures and processes for using the planning system to limit the expansion of unhealthy takeaways and have been widely commended for doing so. They carried this development work when child obesity was given prominence in the national government agenda. The London Plan proposes to build on local authority developments, but it does not address barriers identified by Susan Bagwell's recent research for Public Health England. It doesn't make use of the wide ranging examples of good practise regarding public procurement and/or supply chains which she identifies:

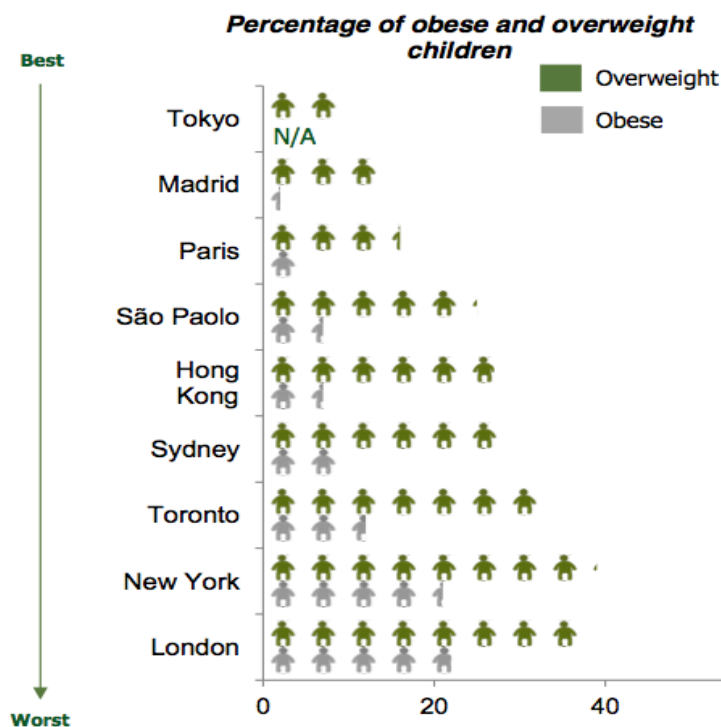
Brighton and Hove council has set up a Good Food Procurement Group "for all major public sector food purchasers..to collectively promote the procurement of sustainable and healthy food" with minimum standards set for public sector purchase. In Warrington local authority staff work with local manufacturers on reformulation and front-of-pack labelling. In London, The Healthier Catering Commitment (HCC) network is working with one of the three major suppliers identified in Bagwell's earlier research, JJ Food Supplies. This supplier highlights healthier products, prices healthier options at the same or similar or price as less healthy options, and is piloting a 10% discount to network members on such options. (<https://www.gov.uk/.../Encouraging healthier out of home food provision toolkit...www.gov.uk/phe>)

Identification of obesogenic environments shaping unhealthy food consumption, and evidence regarding the popularity of fast food outlets serving energy dense food to young people require the attention of policy makers. Non-communicable diseases such as diabetes are increasing alarmingly in local, national and global populations, threatening to make health care systems unsustainable. The evidence from the Global Burden of Disease Study takes diet as a crucial risk factor for diabetes and urges us to take preventive action. The NHS Chief Executive notes that "...Bad diet has overtaken smoking as the principal health risk in this country. About 40% of the disease burden the NHS faces comes from potentially preventable conditions. And diet has edged ahead of smoking." He argues that we should go "upstream...[with]..ambitious targets for added sugar and to hold the food industry to account, with regulatory action if it doesn't happen by a certain date."

<https://www.theguardian.com/society/2016/jan/18/simon-stevens-trying-save-nhs-from-mother-of-messes>.

The London Health Commission's recent work on health in London provides evidence regarding approaches that are being taken around the world to address health and health

care problems. The Commission, set up by the London Mayor, refers to child obesity in London as a “health emergency”.



International comparison of overweight and obesity in cities shows London performing worst for children, and third worst for adults (Lord Darzi 2014 Better Health for London The London Health Commission Report <https://www.healthy london.org>).

There are many examples of good practice already in these cities which should be incorporated into London’s planning. Importantly, in accord with the Commission’s proposals, there is a need to depart from simplistic oppositions between individual choice and government control and to avoid having single solutions to a complicated problem such as limiting the spread of takeaways to address obesity.

New York continues to have very high rates of child obesity but has taken steps credited with halting its increase. New York acted on a ten year public health strategy, established nutritional standards for food procurement by public agencies, and provided free school meals. Following consideration of a wide range of nutrition strategies in cities, the London Commission concluded that for London “A combined “Carrot & stick” approach is most effective: tax unhealthy food; provide access to affordable healthy food” (LHC 2014: 29). The London Plan has included the London Health Commission’s proposal to exclude permission for new fast food outlets within 400 metres of schools. But it does not come up with a strategy comprising the wide suite of interventions being developed elsewhere.

Thus Public Health policy in general and takeaways policy in the London Plan should:

1. Be informed and monitored by reference to impact on health equity especially in respect of children.
2. Be embedded in a strategic approach to building a healthier food environment incorporating best practise from cities across the UK and internationally

Community Health

Far from community health having additional resourcing to cover the gap resulting from cuts and overloading to the acute sector, there is increasing concern about the oversight in current community provision for the frail, sick and for those with disabilities. DWP rulings and the Bedroom Tax and cuts to social care have hit many very hard.

For those with disabilities entering the system through the A&E route there are added challenges and huge pressures on the service, which are resulting in individuals being returned to day unit/ care at home when they are not equipped to deal with it. here is a significant lack of strategic thinking about this cohort.

Overall there is a a severe lack of backup services which places even more pressure on A&E and creates potentially more complex health situations.etc etc

One recently discharged patient told us

'I'll never forget the old lady collected by Brighton Ambulance services at 7am to attend a day unit appointment at 3pm, nor the two mothers on sick leave from companies like McD having daily 30 mins/ 1 hour IVs that took all day because of the pressure caused by the 'Winter crisis'. One fretting every min over collecting her kids from childcare cost her £60; the other who could drive and was being crippled by daily car parking fees. '

The care at home/ in day units are supposed to save the NHS money but this seems to unfairly redistribute costs onto patients and particularly onto patients who might have long term and chronic illnesses, and those in low income groups, like the young mothers this patient encountered.

We all know from the winter headlines that there is no planning for capacity and this has a knock on for families as well as the individual patient.

Transport is a health issue too - the cuts to our transport infrastructure by government eg. Eltham to Victoria via Kings College Hospital make it difficult to get to essential out-patient appointments, particularly in terms of basic access for those with mobility challenges when patient transport services are overstretched.

The Mayor of London should again push for more of the transport infrastructure to come under the TFL umbrella.

Public Health and Migrant Charging for NHS Services

Although there is a trend in recent years for notifications of Tuberculosis to be gradually declining, health professionals are concerned that where the fields of both TB and HIV are concerned that the true incidence of these diseases is masked by the fear among non UK nationals that by requesting hospital or primary care

- they may be charged large amounts of money for healthcare
- their details and immigration status will be shared with the Home Office

The public health implications of this are serious

The same fears are expressed by pregnant women who are non UK nationals. Healthcare professionals state that such women are often vulnerable and risk health problems to themselves and their developing babies by not coming forward for antenatal care or even worse, missing timely obstetric intervention during childbirth

These are fears which no Londoners should face

As Mayor of a multicultural and international city we ask that City Hall lobby against these government measures which disproportionately affect the population of London.

Wound Care and Management

Our elderly population can become prone to skin integrity issues. Poor wound care management can lead to other complications and confine once actively elderly to home. - sometimes permanently, as these skin issues become infected ulcers etc. NB Plymouth Wound Care

There needs to be a proposal to increase specialist on the job nurse training, continued professional development for said nurses and greater emphasis on continuity of care and focus on not maintaining the status quo but healing wounds before complexity sets in. The expertise exists it just needs to be brought into NHS.

Skin integrity is often over looked or seen in isolation, in fact as a complex organ it can undermine a person's whole health and well being. – this also has a causative/preventative link with diet and lifestyle.

Preventing and Addressing FGM

We support the detail in this GLA report but urge for more rapid preventative action –

‘Of the 12 local authorities with the highest volumes of FGM, the majority were in London: Brent, Southwark, Enfield, Ealing, Lambeth, Camden and Greenwich were among the 12 local authorities nationally with the highest incidence of newly recorded cases between April 2015 and March 2016; and Brent, Harrow, Ealing, Southwark, Enfield, Lambeth, Camden and Hillingdon were among the 12 local authorities nationally with the highest incidences of total attendances during the same period.

The most recent published data on FGM confirms the overall picture.

It shows that between October and December 2016, almost one out of every two newly recorded women and girls were from London (620 out of 1,268 or 49 per cent). Similarly, 49 per cent of the 2,332 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure for FGM was undertaken were from London. ‘

These figures demonstrate the need for a focused effort to tackle FGM in London, including peer to peer education and more effective prosecutions.

https://www.london.gov.uk/sites/default/files/london_assembly_report_-_tackling_fgm_in_london.pdf

Safe Housing

This is clearly a public health issue of the most pressing kind.

Safe housing - see Emma Dent Coad report : After Grenfell

After Grenfell Housing and inequality in Kensington and Chelsea: “The most unequal borough in Britain” [file:///C:/Users/Jos%20Bell/Downloads/After%20Grenfell%20\(2\).pdf](file:///C:/Users/Jos%20Bell/Downloads/After%20Grenfell%20(2).pdf)

We also know that there are many similar homes across London. City Hall must continue to put pressure on the government along with the Parliamentary Labour Party to address all the issues which continue to emerge from the Grenfell disaster.

Grenfell residents who are still in hotel rooms rather than a decent home say they feel abandoned by the government.

City Hall should also increase support for campaigns for safety of white goods and recall of faulty models as led by Andy Slaughter MP following the Shepherd’s Bush and Grenfell fires.

GG4

To create a housing market that works better for all Londoners, those involved in planning and development must:

- A. ensure that more homes are delivered.
- B. support the delivery of the strategic target of 50 per cent of all new homes being genuinely affordable.
- C. create mixed and inclusive communities, with good quality homes that meet high standards of design and provide for identified needs, including for specialist housing.
- D. identify and allocate a range of sites, including small sites, to deliver housing locally, supporting skilled precision-manufacturing that can increase the rate of building, and planning for all necessary supporting infrastructure from the outset.
- E. establish ambitious and achievable build-out rates at the planning stage, incentivising build-out milestones to help ensure that homes are built quickly and to reduce the likelihood of permissions being sought to sell land on at a higher value

Decent Housing in place of poor housing

>>> Contracts should not be agreed with developers such as Capco which have a track record in poor practice or the route taken under the controversial Haringey HDV project.

The Earls Court and West Kensington Opportunity Area Risk Assessment commissioned by the Save Earl's Court Campaign highlighted the then probable and now actual risks of this project going ahead. It is an abject lesson in the failings of latterday so-called regeneration which has sold out whole communities to foreign investors. Regeneration needs to go back to its original roots of community engagement and community improvement - not detriment for profit.

We also know that the Earl's Court project has just about ground to a halt because of the glut of similar high end property and the economic uncertainties of Brexit. Whilst the latter was inconceivable in 2013, the former most definitely was not. The local community and London have suffered a significant loss to absolutely no good purpose.

<http://www.saveearlscourt.com/uploads/1/5/8/1/15819512/earls-court-opportunity-area-risk-assessment-copy-pdf-1.pdf>

>>> It is possible to identify green developers who follow a community friendly regeneration programme with a sustainability agenda who work effectively with local communities, rather than purely driven by a profit motive no matter what the long term negative impact. This should be the baseline of all new developments.

For example with respect to Earl's Court, there is now the opportunity to rescue the situation in part by turning the whole project into a green development – although it will never replace generate the kind of revenue (£1.5bn pa) the lost halls once did, it could instead become a landmark project for real community regeneration and supporting healthy lives.

Please also refer to our section on AIR QUALITY – see Page 27

Policy GG4 Delivering the homes Londoners need

GG4

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HOUSING IS A HEALTH ISSUE

We know from the work we have done with the Town and Country Planning Assoc on previous projects that it is possible to plan in a healthy way – we recommend their work described in several reports such as **Planning Out Poverty and Planning for Green, Built Today, Treasured Tomorrow, Nothing Gained by Overcrowding – as well as their Planning for Affordable Housing currently in process.** <https://www.tcpa.org.uk>

The Grenfell tragedy has put the spotlight on not only the lack of safe homes in the capital but also on the huge inequality and imbalance in housing development and access to decent homes.

We draw your attention to the report **After Grenfell by Emma Dent Coad – housing and inequality in Kensington and Chelsea : ‘the most unequal borough in Britain’.**

We also refer to the recent success of Karen Buck MP in gaining cross party support for her PMB on landlord responsibility with respect to decent homes.

Health is the common denominator and in one ward, life expectancy had dropped 6 years since 2010 while a man living in the ward containing Harrods has an increased life expectancy. For a Moroccan man in a poor part of K&C, LE is now a mere 55, while for an affluent British man it is towards 90.

Cuts in public health budgets are also to blame – and the reversal of funding models which reward longevity rather than compensate poverty.

The market should never be the driver in any of this.

The Grenfell tragedy is the flip side of the land grab projects such as the Heygate and Earl's Court where local people have been robbed of their homes and livelihoods to build high end housing with the results which were just as we predicted from the outset.

Moreover, since the devastating demolition of Earls Ct, which had previously generated £1.5 bn pa to the London economy, not only have residents had to deal with extreme dust nuisance and many small traders have lost their livelihood, but following the first tranche of flats being sold solely to offshore purchasers, the market has changed such that Capco has now ceased building and the whole project is up for review. The campaign is now asking for a fully green development to take on the wasteland that is now the Earl's Court site.

<http://www.saveearlscourt.com/uploads/1/5/8/1/15819512/earls-court-opportunity-area-risk-assessment-copy-pdf-1.pdf>

We know that not one single part of the new Heygate accommodation has been taken by previous residents, but every unit sold to overseas and often absent owners. This is not a mixed or inclusive development and we hope that the new approach will avoid a repeat of such a housing travesty in the future.

Meanwhile too many workers and families live in appalling conditions for which the state often pays landlords an extortionate rent. Others are a step away from homelessness – sleeping on sofas and floors. Too many families now have to rely on foodbanks – often because so much of their weekly budget is spent on housing which is in turn often substandard, which in turn detrimentally affects their health – both physical and mental. This is a vicious cycle which we need to break.

The Health of the Homeless

It is well known that the health and life expectancy of the homeless is extremely poor – with an average life expectancy of 30 years below average – due to the obvious effects of rough sleeping and added lack of access to medical help/GP registration etc

Homelessness is horribly on the increase – 134% increase nationally since 2010

It is well known that London is a Homeless Hotspot. 32 areas cited with the largest homeless population are in London. The worst affected is Newham where 1 in 25 residents are classed as homeless – and that, like all homelessness data, does not include the hidden homeless.

London's ten worst areas for homelessness

1. Newham; London; 13,607
2. Haringey; London; 9,717
3. Westminster; London; 8,054
4. Enfield; London; 10,057
5. Kensington and Chelsea; London; 4,401
6. Waltham Forest; London; 7,634
7. Brent; London; 8,905
8. Barking and Dagenham; London; 5,578
9. Tower Hamlets; London; 7,428
10. Hackney; London; 6,167

Whilst we applaud the increase in bad weather shelters, but for longevity, we recommend increasing support for innovative homeless housing projects which are already being adopted by some local authorities such as Lewisham.

We also recommend resurrecting the Foyer model where residents are offered training and education on the same site as their accommodation.

We applaud those councils who have begun to once again build social housing and urge others to follow suit.

Policy GG5 Growing a good economy

GG5

To conserve and enhance London's global economic competitiveness and ensure that economic success is shared amongst all Londoners, those involved in planning and development must:

- A. promote the strength and potential of the wider city region.
- B. seek to ensure that London's economy diversifies and that the benefits of economic success are shared more equitably across London.
- C. plan for sufficient employment and industrial space in the right locations to support economic development and regeneration.
- D. ensure that sufficient high-quality and affordable housing, as well as physical and social infrastructure is provided to support London's growth.
- E. ensure that London continues to provide leadership in innovation, research, policy and ideas, supporting its role as an international incubator and centre for learning.
- F. promote and support London's rich heritage and cultural assets, and its role as a 24-hour city.
- G. maximise London's existing and future public transport, walking and cycling network, as well as its network of town centres, to support agglomeration and economic activity.

THE CONTRIBUTION OF THE HEALTH ECONOMY MATTERS TOO –

A healthier population is a more productive population/community/city/economy

We note that the Mayor does not have a Healthy London Deputy

All measures possible should be undertaken / facilitated / encouraged to support a healthy London health economy which includes housing support for health workers, challenging the government on its dismantling of the NHS and supporting measures to overturn that as follows :

- ensure that City Hall does not undertake measures which undermine the preservation of sufficient health services in the capital
- Just as Boris Johnson was vocal in his support for dismantling Lewisham Hospital – until the campaign persuaded him otherwise, there is far more potential for the current Mayor to speak out for the securing of London's health infrastructure
- support for the social care sector, highlighting innovative means adopted by some local authorities eg. Hammersmith & Fulham and pressing for an integrated system which lifts social care out of the funding doldrums and puts it on a par with a re-nationalised NHS.

The Key Performance Indicator (KPI) relating to health in the London Plan is highly insufficient for proving the case for either supporting a healthier population or measuring outcomes from measures planned/taken.

Policy GG6 Increasing efficiency and resilience

GG6

To help London become a more efficient and resilient city, those involved in planning and development must:

- A. seek to improve energy efficiency and support the move towards a low carbon circular economy, contributing towards London becoming a zero carbon city by 2050.
- B. ensure buildings and infrastructure are designed to adapt to a changing climate, making efficient use of water, reducing impacts from natural hazards like flooding and heatwaves, and avoiding contributing to the urban heat island effect.
- C. create a safe and secure environment which is resilient against the impact of emergencies including fire and terrorism.
- D. take an integrated approach to the delivery of strategic and local infrastructure by ensuring that public, private, community and voluntary sectors plan and work together.

RISKS TO HEALTH & WELLBEING

Climate change

Climate change is the gravest risk to the future of the planet and to Londoners.

This involves use of transport, home utilities, refuse disposal and recycling as well as increasing green spaces and green buildings design. Also best practice within public sector buildings and private businesses must be encouraged and enabled.

We all have to act responsibly and many factors in this report relate to this in a profound way.

Our responses to green housing, air quality management and transport relate to this point.

We endorse and recommend the work of the Town and Country Planning Assoc in this regard.

<https://www.tcpa.org.uk>

Rather than write extensively on this we recommend the work of our fellow Soc Soc SERA in this area <http://www.sera.org.uk>

Emergency response capacity

See P 32

Buildings design

As above – we recommend the work of the TCPA.

Overall, for healthy living, we recommend green design and development which works and which does not take advantage of nor let down communities

Policy SD10 Strategic and local regeneration

We hope that this will include an increase in local stakeholder involvement.

Working with communities is vital – and not tokenistic.

HOW CAN WE BE SURE THAT LOCAL AUTHORITIES WILL ACT IN LINE WITH REQUIREMENTS?

eg Affordable and accessible housing

Planning in green space

Ignoring GLA safe construction works guidelines etc.

Public Health Penalties where developments risk health of local people

Policy D1 London's form and characteristics

AIR QUALITY

[Air pollution: England's chief medical officer calls for focus on health threat](#)

Dame Sally Davies rightly says the issue is not just environmental and calls on UK government to bring in tougher standards to tackle toxic air

>> Management of construction sites is a vital part of air quality control. Where developers flout best practice in order to cut costs and local authorities turn a blind eye, the LA should be penalised – with so much construction work ongoing, this is a significant public health issue.

>> For instance the dust nuisance related to the demolition of Earl's Court was significant - as predicted. When residents rightly complained, with the help of the local MP, measures were taken by Hammersmith and Fulham Council to ensure that the developers took steps to reduce the pollutants in situ. It did not entirely relieve the situation, but there were improvements.

Hammersmith & Fulham Council have facilitated a local Air Quality Commission which is chaired by a local resident <https://www.lbhf.gov.uk/environment/pollution-and-air-quality/air-quality-commission>

>> Westminster has very strict guidelines for developers operating in the borough, which ensure that construction/demolition nuisance is reduced as far as possible.

Good practice example : Westminster, Hammersmith & Fulham

Poor practice example : Lewisham Gateway

>> large mounds of stockpiles were kept in situ in a densely populated area for more than a year without any covering or reduction in size as recommended by the GLA Guidelines for construction site management. This caused enormous public health nuisance to the locality and resulted in some residents being forced to leave their homes.

All boroughs should be held to account to ensure that GLA Guidelines (which should be regularly updated with best practice) are implemented. Some LAs do so, but for those which do not, there should be penalties for those local authorities who flout the need for public safety and wellbeing in this regard.

Private households :

>> Unless in an emergency, where private householders are planning works, **it should be a requirement for them to notify neighbouring properties up to 200 yards away, at least one month beforehand.** This is not just in terms of planning permission but to warn residents in advance who may suffer from respiratory conditions for which such works can prove detrimental or dangerous and allow them time to make arrangements. **ALSO BASEMENTS***

Traffic

We applaud the current Mayor of London's endeavours and achievements in cleaning up our toxic air so far. We also **recommend that the Mayor of London follows the example of Paris and some other cities where diesel free days (obviously not as yet to incl public transport) and even car free days have been introduced.**

The location of schools close to areas of high traffic is a cause for concern – some councils are already **acting to reduce the exposure of pupils to traffic and other pollutants** and City Hall should share these examples and do everything possible to hold local authorities to account in the way they deal with this issue - or not.

We note that **Hammersmith & Fulham Council has brought in innovative electric car hire/share schemes** which should be on the City Hall website as examples of best practice - likewise for other projects of this calibre.

We recommend that that all black cabs are facilitated to change to an eco friendly fuel supply at the earliest opportunity - this is not just about new cabs. Conversion to electric is possible but quite expensive, but there are bio-friendly fuels which can be used instead.

A project to supply all black cabs with such a fuel should be central to London's air clean-up.

Also with respect to black cabs (and mini cabs too) - the air inside a cab can be toxic. The trend for so-called 'air fresheners' which are sometimes used in multiples inside cabs is challenging for any passengers who have respiratory conditions and allergies. These items, which are usually manufactured abroad, are soaked in a range of untested chemicals - which

include *formaldehyde, BHT, synthetic acetaldehyde - and embalmers glue* which when inhaled in turn can glue the heavily perfumed particulates to the lining of lungs.

These 'air fresheners' are not subject to safety checks, but installed by valet services who provide them for free, imported from abroad.

We would prefer that these toxic items are forbidden in hire vehicles – in particular black cabs. This should be a condition of registration.

We are concerned that the **impact of another Heathrow runway will dramatically overload West London with additional toxic particulates** - as well as added noise pollution, This is not the right site for additional runway capacity.

We are concerned that there are real inconsistencies between boroughs as to the safe management of construction sites. Some of these occupy large amounts of space and their impact on local air quality can be huge - and where they are badly managed causing additional ill health in the neighbourhood and even necessitating some to leave their homes - all of which is a public health issue.

Following the landfill tragedy in Spelthorne in 2014, **we trust that City Hall ensures that any landfill sites if such exist in London are subject to proper safety checks and maintenance** - particularly where flooding may potentially occur.

Green spaces in place of overcrowding :

>> Avoid giving permission to developments where the need for additional green space has not only been ignored but existing green space is also lost in the planning process!

eg. Lewisham Gateway

As outlined in the tall building sections : avoid tall building clusters which also block out light and access to essential levels of Vitamin D

eg. Lewisham Gateway, Distillery Tower Deptford.

Local authorities who flout good practice and damage public health should be penalised.

Smoking

Smoking is responsible for 50% of the difference in life expectancy between rich and poor and a major driver of inequality and poverty.

It is the major cause of reduced life expectancy in people with mental health problems.

It's also a key issue for sustainability of services – loss to councils can be calculated here: <http://ash.org.uk/category/information-and-resources/local-resources/>

>> London should promote smoke free spaces (playgrounds, touchlines, public spaces, around schools)

Enforcement is important too – there has been a big cut in trading standards since 2010 and we need to find ways to offset that.

Nationally, we should have a “Polluter pays” policy with a levy on tobacco industry profits to fund tobacco control etc.

Policy D13 Noise

NOISE pollution can have a significant effect on mental health – this needs to be:

Monitored

Complaints acted upon

New developments which may increase noise pollution need to be either discouraged or properly managed. The major example is the proposed new Heathrow runway which if developed will significantly increase both air pollution and noise pollution in West London, beyond any reasonable saturation point. If realised, this will have a detrimental impact on the people of West London.

RECYCLING – this is a health and environmental issue.

All local authorities need to follow best practice guidelines and households given more help in identifying how to follow this – including disposal of larger items or items such as old saucepans/clothes to prevent them being wrongly included in with other materials or fly tipped.

More help should be offered to the disabled to engage in recycling and safer refuse disposal.

Local authorities who cut costs and leave large amounts of refuse on pavements eg Kensington & Chelsea should be penalised

Policy D2 Delivering good design

We encourage all new design to include reference to INCLUSIVITY & ACCESS

We also recommend that PLAY SPACE is given additional attention

- one new development observed in S London includes a tiny play space squeezed between two tower blocks next to a railway bridge and right on top of high density traffic

Policy D5 Accessible housing

The disabled have suffered enormously from the impact of the Bedroom Tax – many have lost purpose built accessible homes as a result.

Accessibility needs to be built into all new build projects.

Sufficient emergency exits also need to be accessible.

Policy D6 Optimising housing density

Point already made in this regard – see also :

Policy D8 Tall buildings

We are concerned that the positioning of tall buildings may rob other properties and locations from essential light and Vitamin D giving sunlight, causing additional ill health.

eg. Paddington Pole / Cube campaign

We are also concerned that some of these developments – such as the Paddington Pole, now Cube, will obstruct ingress and egress to A&E facilities as is the case at the St Mary's Paddington.

While Imperial have at least asked that ambulances should be able to get to St.Mary's A&E Department by the quickest and safest route possible, the former Chair of Westminster's Planning Committee seems to have been more concerned to announce decisions which coincide with the wishes of the property developers and lobbyists who have showered him with their favours.

There are also mental health implications for people living in overcrowded developments.

We know from the experience of Grenfell that safe construction of high rise property is essential.

We note that some recently built tall structures have included insufficient fire escapes

Policy D9 Basement development

We refer to Karen Buck MP's work on what can be a public nuisance in terms of air quality, noise pollution, mental health and general nuisance to neighbours – as well as potential damage to surrounding structures.

Policy D10 Safety, security and resilience to emergency

Some of our members are involved with the London Ambulance Services Forum – indeed the chair of the Forum is a member. We are very concerned that despite the best efforts of dedicated staff, the service continues to be in the Requires Improvement category – we hope that City Hall can press for more government funding and training resources. Staff numbers are also badly affected by the cost of London housing.

We are also concerned about the re-categorisation of emergencies by government which essentially downgrades certain patients in terms of response time.

These are vital aspects of our readiness to deal with an emergency - when large numbers of units are taken to one area to deal with an emergency, the impact on other parts of the capital can be significant.

London Ambulance Service data :

Winter pressures in the NHS

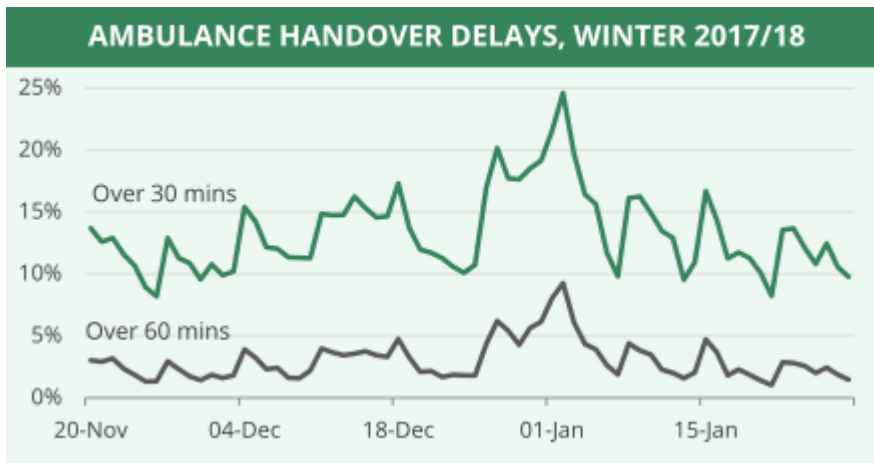
Published Tuesday, February 6, 2018 - House of Commons Library

Pressures on the NHS in England in winter 2017/18, including ambulance handover delays, bed occupancy, norovirus bed closures, and accident and emergency diverts.

In the winter months, NHS England releases '[daily situation report](#)' data which measures pressure on acute hospital services. For 2017/18, the data currently covers the period 20th November to 28th January. This short briefing (from the House of Commons Library) summarises the data and will be updated periodically during the winter.

Ambulance handover delays

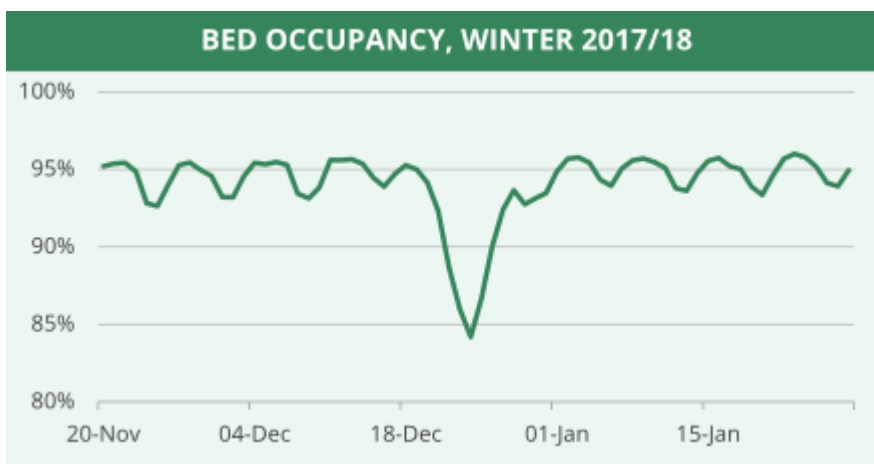
127,000 ambulance arrivals at hospital have had their handover delayed by more than 30 minutes since November 20th. This is just under one in seven ambulance arrivals. The chart below shows performance on each day during the period. On 2nd January, one quarter of ambulance handovers were delayed for over 30 mins, and 9% were delayed for over 60 mins.



It's not possible to compare this data directly with previous years. During the equivalent period in 2014/15, there were 73,000 recorded ambulance handover delays - 43% fewer than this winter. However, data isn't available to calculate the percentage of handover delays in 2014/15, meaning we can't be sure of the true increase.

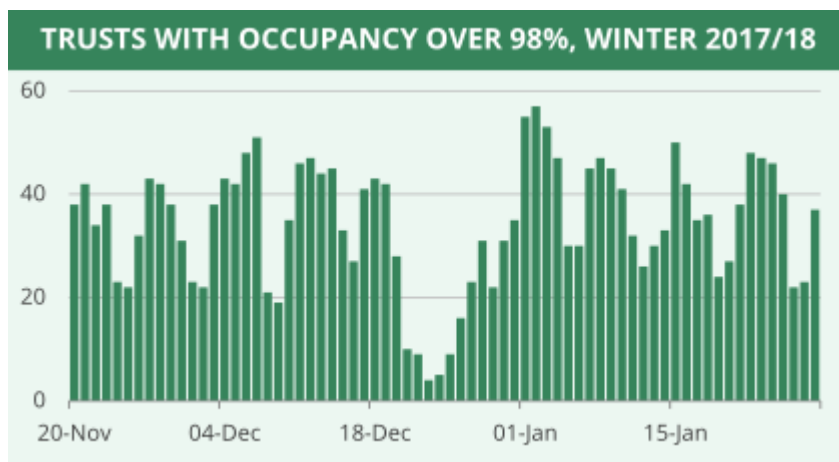
Bed occupancy

General & acute bed occupancy in England's hospitals has been above 90% for all but four days since 20th November. On Tuesday 23rd January occupancy was 96% - the highest so far this winter. Occupancy was below 85% on only one day - Christmas eve. Occupancy has been above 95% for 30 of the 70 days in the winter period.



Bed occupancy was slightly higher than last winter over the Christmas and New Year periods. However, in recent weeks there has been little difference.

Occupancy levels vary substantially at different hospitals. On most days, over 20 NHS trusts have recorded bed occupancy over 98%. On 2nd January, 57 of 137 trusts had bed occupancy above 98%.

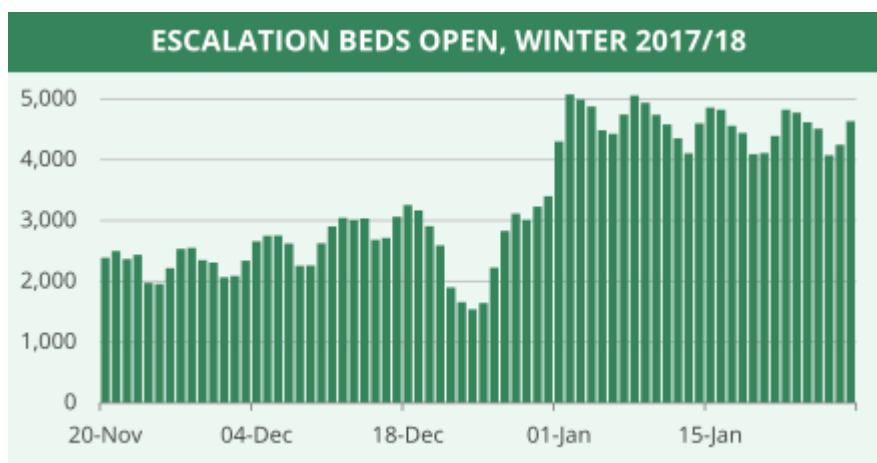


Walsall Healthcare NHS Trust has reported 100% occupancy for 55 of 70 days this winter. Seven other trusts have been at 100% occupancy for more than 20 days: **North Middlesex, Hillingdon**, James Paget (Great Yarmouth), Barnsley, Princess Alexandra (Harlow), Leeds, and Weston Area.

Escalation beds open

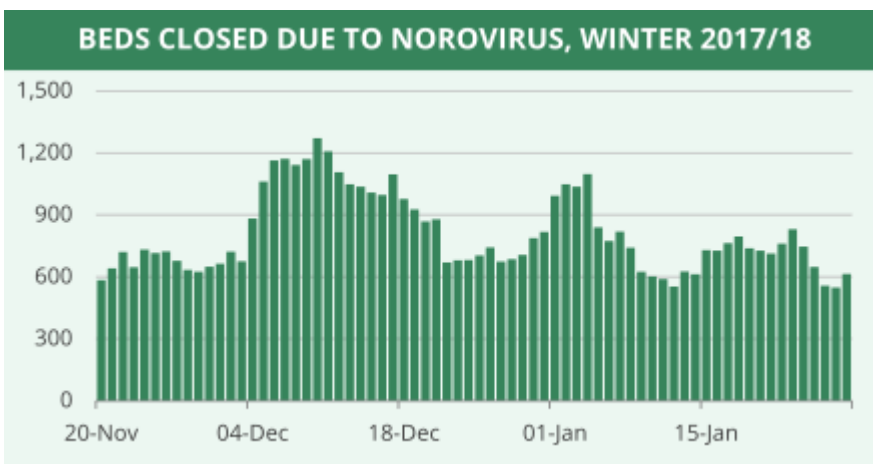
An escalation bed is a designated ward bed that is usually closed as it is additional to a trust's funded and staffed bed stock. The number of escalation beds open is, therefore, one measure of pressure in the NHS.

The number of escalation beds peaked on 2nd January at 5,075 - 5.1% of all beds open on that day.



Norovirus bed closures

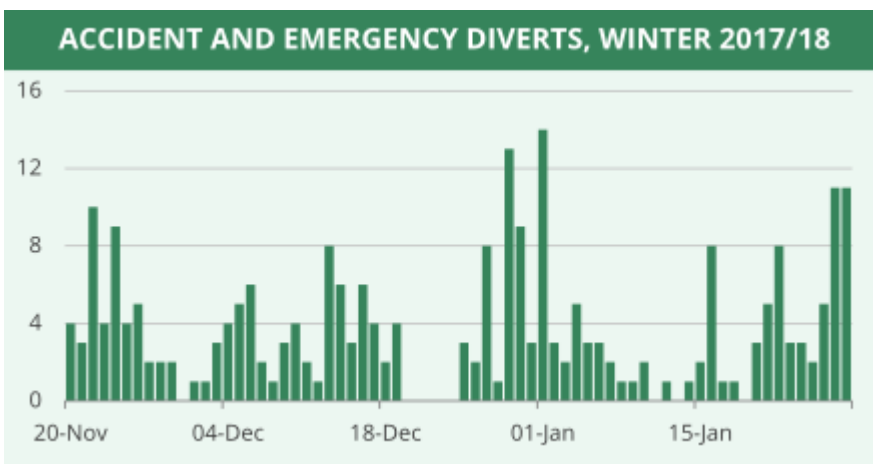
There have been 56,424 bed days lost to [norovirus](#) closures since 20th November. Over comparable dates, the level of norovirus closures has been 9% higher than last winter.



St George's University Hospital NHS Foundation Trust, King's College London NHS Foundation Trust, and Taunton & Somerset NHS Foundation Trust have had the highest number of bed days lost to norovirus closures. As a proportion of beds available, closures have been highest at Weston Area NHS Trust. Ten trusts account for almost 40% of closures.

Accident and Emergency Diverts

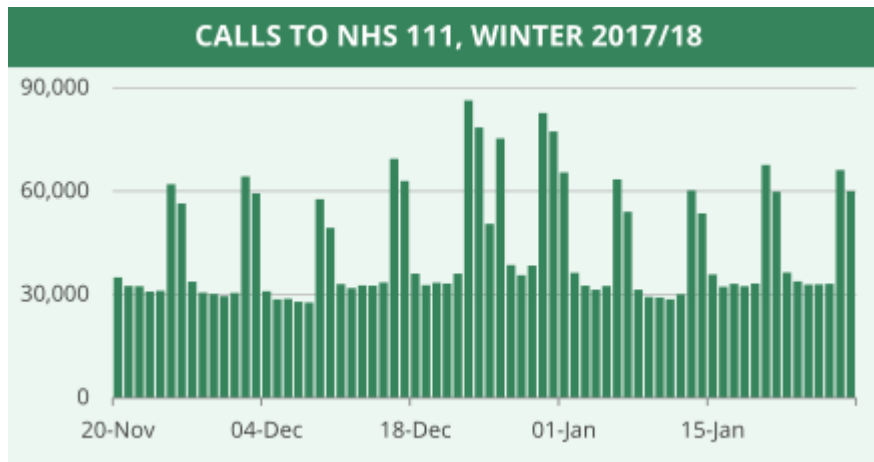
Since 20th November, there have been 251 occasions where a temporary divert between A&E departments was set up to alleviate pressure. Over comparable dates, diverts are 37% lower than last winter. This difference was particularly pronounced in the first two weeks of January. However, 2017/18 diverts increased again at the end of January.



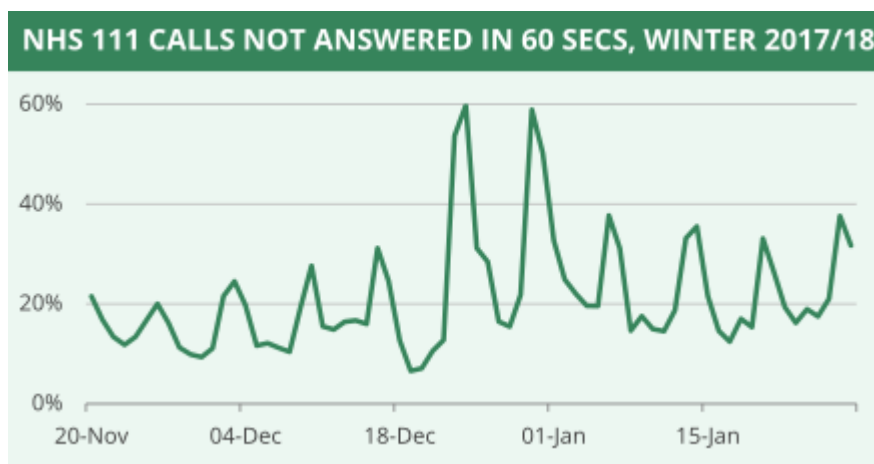
32% of diverts in England this winter are due to two NHS trusts: Worcestershire Acute Hospitals NHS Trust, and Gloucestershire Hospitals NHS Foundation Trust. Twelve trusts have had five or more diverts this winter.

NHS 111

NHS 111 is a non-emergency telephone line for healthcare advice. The number of calls answered by NHS 111 this winter has been around 30,000 on weekdays, and around double this number on weekends. The highest number of calls was 86,359 on Saturday 23rd December.



The percentage of calls not answered within 60 seconds has been higher than last winter. So far this winter, 25% of calls have taken longer than 60 seconds to answer, which is higher than in 2016/17.



On Christmas eve, 60% of calls took longer than 60 seconds to be answered. This compares with a peak last winter of 36% on 27 December.

In 2016/17, information on which NHS trusts have declared [OPEL pressure alerts](#) each day has been published. This was billed as a way to streamline reporting and "[provide a common language](#)" of pressure. However, this data is not being released in the public dataset in 2017/18.

NHS England has stated in the past that the winter dataset is subject to only minimal validation because it is turned around quickly, but that it is nevertheless "fit for purpose".

This briefing will be updated periodically as new data is published during winter 2017/18.

Commons Briefing papers CBP-8210

Author: Carl Baker

Topics: [Ambulance services](#), [Emergency services](#), [Health services](#)

Fire Rescue and Fire Safety

The General Secretary of the Fire Brigades Union recently addressed a meeting of SHA London.

96-97% of London firefighters are members of the LFBU.

Since Boris Johnson accusing Andrew Dismore of talking ‘cobblers’ about the dangers of shutting fire stations, we now need to be sure that we maximise on our fire service, both in terms of infrastructure and the welfare of personnel.

Clearly Grenfell has put the service into the spotlight that it always deserved.

50% of fire service capacity has been lost since 2005

The Met’s investigation involves interviewing 1,000 fire personnel.

‘This is a resourcing challenge all round’ Mat Wrack.

There is a great risk that Grenfell will be consigned to a decades long battle like Hillsborough families have had to endure.

Questions :

How do we stop this happening again?

How ready are we to intervene ? What if this occurred in an area with poor resourcing?

Fundamentally, how can homes – or indeed any building, be covered in petrol cladding?

How can there be no recognised fire safety standards when buildings are assessed ?

The Public inquiry Terms of Reference are insufficient to ensuring the risk is minimised and the families affected are respected and looked after.

This includes fire fighters who were exposed to toxic substances and extreme mental health stresses at the incident – as they often are, but Grenfell was much more extreme.

Shockingly, there is no formal route for fire service workers to raise concerns.

It is clear that an incident of the size, scale and shock of Grenfell has left a considerable amount of toxic particulates in the locality. This is also a concern for local residents who are also battling with their own emotional impacts.

Major health concerns for firefighters are :

PTSD – which can emerge over months and years.

Even after the shock of Grenfell it may emerge much later.

Cancers – from exposure to contamination and toxins

>> We recommend that City Hall set up a specialist route for fire fighters to report health issues and other concerns

Chapter 4 Housing

We feel that this issue is so important that we repeat the same information under different headings to ensure this is not lost in any form of silo discussions which may ensue :

The London Plan must reject the uninformed use of NHS sites for housing as proposed in the Government’s Naylor Report – but instead take on board the specific tests for constructive and sustainable use that we have included in this paper.

The Naylor report recommends that up to £5.7bn of NHS sites (the most valuable being in London) be sold and much of the space used for new housing development.

However the proposals represent what amounts to a potentially scandalous firesale of precious NHS property and sites. The definition of ‘underused’ (set out in the Carter report on efficiency) is based on a meaningless measure – such that, for instance, laboratory space or play space for children can result in a building being designated ‘inefficient’ and categorised for sale. Most importantly, the sale of NHS estate is **proposed in the complete absence of any national or local NHS estate strategy.**

Local authorities are encouraged to support the sale of NHS land through the promise of land for housing. The London Plan must take on board informed planning with respect to use of NHS land instead of falling into the trap of a wholesale sell off.

The umbrella group Health Campaigns Together (HCT), which includes a range of organisation and campaign groups with specialists in the field of land use have proposed the following strategy for use of NHS land. We hope this approach will be adopted within the London Plan.

We ask for the following sensible and sustainable uses of NHS land :

Any NHS land that is not in clinical use at present should be used for health and wellbeing purposes, to be considered in priority order, as follows:

1. The NHS should consult fully and agree plans with local people. It should identify any land that may be required for expansion or rebuilding of existing hospitals or clinics, or needed for publicly-provided shared health and social care. This land cannot be sold.
2. The NHS should build “step-down care” and rehabilitation centres to care temporarily for the 6,000 patients who are medically fit, but still need care and are occupying expensive acute care beds. Figures show that this would pay for itself in only one or two years, and is far better value for money than selling land.
3. Land not needed for NHS care should be considered for publicly-provided social care, or used to build low rent housing for NHS employees. This would improve recruitment, reduce length of journeys to work, and reduce fatigue for NHS staff, so improving patient safety, and releasing the housing presently occupied by the rehoused staff.
4. Publicly-owned supported accommodation for elderly and vulnerable people should be developed on remaining NHS land, near to medical facilities, to meet the acute need for such homes. This would also free up housing occupied by vulnerable people for use by others.
5. Any remaining NHS sites should be used for social housing, provided at genuinely affordable rents. The destructive “right-to-buy” policy that has depleted the affordable public housing stock since the Thatcher era should not apply, and in any case should be abolished by legislation.
6. Any NHS land that is not suitable for the purposes above should be included in a local public land bank, to be considered for land swaps under the direction of the local planning authorities to improve the quality and allocation of public land.

Only after full consideration of all these uses (in priority order) should NHS land be released for commercial sale. All money from sales should be paid into NHS capital accounts and used for buildings and maintenance, not to compensate for NHS revenue underfunding.

>> We recommend that all sales of NHS land are halted until national and local estate strategies are agreed with public consultation and Parliamentary debate.

S2 5.2.2. Excellence in healthcare depends as much on people's ability to access healthcare as it does on clinical excellence. However the Government's plans for health as set out in NHSE's 5YFV pay little or no attention to the need for local services. ('Care nearer home' simply means moving care out of hospitals and into community settings. It does not mean locally available services).

Current government proposals for NHS services involve a massive reduction in the number of local GP and NHS community sites (with proposed sell-off of this valuable NHS land), and involve development of much larger, but many fewer community sites. This will mean much longer journeys and greatly increased travelling times to access GPs and other community facilities which will make it extremely hard for many vulnerable elderly and disabled people, or those with young children, to access primary and community care services.

Government justifies this by talking about the need for community hubs that can deliver specialised services. We accept this. However the great majority of healthcare can be delivered appropriately and safely in local non-specialist settings. The real reason is that Government intends to underfund the NHS by £26bn per year by 2021 compared with 2015 funding levels, and cutting the number of healthcare sites is the main way they intend to achieve this reduction (as well as providing a one-off windfall through the sale of lucrative NHS buildings and sites). We cannot accept that patients will be expected to make long and inconvenient journeys in future. Local GPs and healthcare facilities must remain a very high priority.

S2 5.2.4

A major aim of the Government's Sustainability and Transformation Plans / Partnerships is to reduce the NHS budget by £26bn per year by 2021 compared with 2016 levels. A major way they intend to achieve this is through making a massive reduction in the number of local sites at which NHS care is provided. Plans set out in the Government's Naylor report involve proposed sale of £5.7bn of NHS property and sites (in part to fund revenue gaps and with profits from sale shared by private developers). The UK already spends far less on healthcare than comparable economies, and these proposals will massively degrade our NHS. The London Plan must stand out against this proposed destruction of the NHS in London and nationally. Whilst it cannot directly affect Government funding for the NHS, the Plan can highlight the destructive nature of Government proposals and encourage people to challenge these.

The proposed sell-off of NHS sites will result in people expected to make lengthy and very time-consuming journeys to access GPs and other community healthcare. This will be hard for everyone, but exceptionally difficult for those with small children, elderly people and disabled people - who are generally high users of GP and community healthcare services.

The London Plan and local plans must ensure than any proposals to change sites for healthcare take account of the impact this will have on journey times and access, particularly for the most vulnerable people.

In the instance that this report may be divided up between different work groups we continue this well researched advice in the following chapter :

Enabling Infrastructure

LOCAL GOVT FINANCE

FUNDING SHORTFALL

With a £1.23 trillion infrastructure projection it is deeply concerning to note that In 2015/16, London government only had direct control over 5.1 per cent of the tax it raised (council tax and 50 per cent business rates).

The Mayor is seeking clarity from Government on the availability of investment for much-needed infrastructure in the capital, and more fundamentally, is seeking further devolution of fiscal powers in line with the recommendations of the London Finance Commission.

‘Because of the scale of the funding gap, the Mayor is also exploring other potential sources of funding, such as land value capture, and looking at how private investors can play a bigger role in investing in the upfront costs of infrastructure. He has also, through this Plan and other strategies, set out how to make more creative and efficient use of existing infrastructure assets, for example, by managing demand for utilities and transport, using new technologies and changing user behaviours.’

Whilst we completely appreciate that the Mayor has a huge funding challenge on his hands, we do not want to see essential NHS assets used as a means to a short term gain but a long term loss.

We endorse the informed words of our member Jeff Lever

‘We acknowledge the London Plan’s aspiration to create thousands of new homes. However, we consider that the concept put forward in the Chancellor’s Autumn Statement of 2015, that a sell-off of NHS land be carried out so as to release land for 26,000 homes, is simplistic and damaging, even if echoed uncritically in other quarters.

There exist more nuanced opportunities for NHS land to deliver housing gain at the same time as providing health and welfare benefit to Londoners, and preserving the estate assets of the NHS.’

We hope that the Mayor will pay due regard to these well informed suggestions in future planning –

Health Facilities

11.1.36 The demand for health services in London is increasing due to a growing and ageing population and an increase in complex and long-term health conditions. As described in paragraphs 5.2.1 to 5.2.9 of this Plan, the NHS has set out the need to undertake a higher proportion of healthcare in community rather than hospital settings. However, many hospital sites contain old, poor-quality stock and there is a need for both replacement and maintenance. Investment is also needed in the workforce and digital technology to deliver service change.

As previously stated, we applaud the expansion of the determinants of health categories to include a much wider reach in the London Plan, however we ask you to note that the word INTEGRATION has been misappropriated by central government.

The promised funding for improving and expanding community provision has not been forthcoming – for instance, only 2 district nurses were trained last year. Meanwhile they continue to plan for further downsizing of an already drastically underfunded and under resourced NHS at all levels – including mental health, which has experienced severe cuts with young people having to travel hundreds of miles from home to obtain crisis care or even being held in police cells. Waiting lists for CAMHS, which used to offer early intervention, are now lengthy and often too late to prevent crisis.

Any planned downgrading or downsizing of health provision in the face of a significantly increasing population is to be protested.

When we refer to integration, we mean the best means of rescuing social care to bring it into alignment with the NHS as a national service, funded and free at the point of need via taxation.

When the government refer to integration, they mean integration of the private sector as we have now seen in almost every facet of health function via Section 75 of the Health & Social Care Act.

This must be addressed by City Hall – instead of signing up to this disaster we need you to CHALLENGE as so many others are doing in the London health sector and local authorities. Please listen to those who understand the abject danger these plans hold for the capital and indeed how they will completely undermine so much of what you aim for in terms of a healthy London. If you do not do so you will let London and Londoners down very badly.

We all know that Social Care is in crisis. It is now well recognised that the near obliteration of dedicated social care funding has had a disastrous impact on the use of hospital beds – councils, already subject to significant cuts of even as much as 60% of their 2010 budgets are now using budgets designated for other functions to provide what are in effect skeleton social care services and families are suffering badly as a result.

City Hall must urgently press the government for additional funding

The social care sector is also on the brink of a staffing precipice due to the numbers of these workers who come from the EU – they do not earn more than £35k and are not in a protected occupation. **City Hall must press the government on this point.**

The nursing sector is also similarly impacted.

According to Royal College of Nursing (Feb 2018) FOI figures show that the number of vacant nursing posts in the Capital is now over 12,719, up from 10,1140 in 2015.

The end of the nursing bursary and an unaffordable housing stock has already had a dreadful impact and Brexit is significantly adding to the problem.

City Hall must press the government on this point.

11.1.37 Across London, developer contributions are used to fund the capital costs of new or expanded primary and community care facilities in order to meet the increasing demand for services which arises from population growth in new developments. Boroughs should use the London Healthy Urban Development Unit Planning Contributions Model (HUDU Model) to calculate the capital cost of the additional health facilities required to meet the increased demand. Boroughs should also work with Clinical Commissioning Groups and NHS England to determine what investment is required by monitoring housing and population growth, keeping infrastructure plans up to date and working together to identify and develop projects towards which Section 106 and CIL contributions could be used.

>> we seek more information on the London Healthy Urban Development Unit Planning Contributions Model (HUDU Model)

11.1.38 Section 106 in-kind contributions can be used to support the provision of new health facilities, particularly in Opportunity Areas where there is little or no existing infrastructure. Examples of in-kind contributions include: transfer of land to provide new primary and community care facilities; construction and fit-out of new health facilities; and provision of 'shell and core' space at peppercorn rent. Funding sources for health buildings also include direct capital from central government and private funding through a variety of public/ private joint ventures. A specific fund for Primary care estate, the Estates and Technology Transformation Fund (ETTF) is in the second of a four-year programme (to 2020).

A specific fund for Primary care estate, the Estates and Technology Transformation Fund (ETTF) is in the second of a four-year programme (to 2020).

We would definitely like to see 106 PG being utilised for local health projects as long as any money generated then goes back into the community, rather than to private corporations eg. we would not be happy with Virgin etc benefiting from this!

11.1.39 London's Sustainability and Transformation Plans (STPs) were published in October 2016 to set out how health and care services would evolve and become financially sustainable over the 5-year period to 2020/21. The plans outlined a requirement to spend £4.8 billion on existing health infrastructure in London just to keep it operationally functional. Further capital investment in NHS infrastructure of £2.1 billion is needed to meet the costs of transforming health services in London and accommodating population growth. Therefore, a total 5-year investment of £6.9 billion is required.

>> CLEARLY THE ABOVE IS OUT OF DATE <<

With reference to the above, we are very disappointed that City Hall has signed up to the STP re-configuration which is acknowledged by most people involved in the health sector as well as leading local authorities in London to be a disaster.

Additionally, since the document was written, there has been a rapid shift from STP's to the development of ACO's or equivalent financial structures rebranded as Integrated Care Systems . Successful moves in the High Court to demand parliamentary scrutiny before STPs/ACOs/ ICO's can be signed off are for very good reason

What is more – a good number of London's councils have heavily rejected these re-configuration models for a very obvious reason :

They will not improve the health of their population – quite the opposite.

North West London Plan was rejected by Hammersmith & Fulham and Ealing Councils, building as it did on the so-called Building a Healthier Future Plan which was soon shown to be set to result in quite the opposite. Just this week, Shadow Secretary of State for Health, Jonathan Ashworth flagged up the dangers with both this plan and its latest incarnation the ACO and ICO. He stated that it would be extremely dangerous to close Charing X Hospital either now or in 2021 (which is the current end point ie precipice used by Imperial and the local CCG) and endorsed the analysis within both the Mansfield Commission inquiry ' Health and Social Care in North West London' – a review of Shaping a Healthier Future and the North West London STP – as well as by local Save our Hospital campaigns.

With a projected population increase of 20,000 in the area, it is nonsense to suggest that a loss of 500 beds and 800 staff (acknowledged as being true in an Imperial Board meeting where this evidence was presented) is going to support a healthier population.

In addition, we know that the original plans were worked up by the previous Conservative led 'Cameron flagship' local authority with a view to selling off most of the Charing X site to develop luxury flats and more of the same planned on other sites. Lately, Imperial NHS Trust have added beds due to their struggle to cope. We are told the 'no closure' approach will all be in place until 2021 – but then what.....

As a result of these plans, the hospitals have hit a traditional malaise which affects provision under threat in terms of staff recruitment, services in decline and generally poor morale (as identified by the last CQC report). Maternity Services at St Mary's Paddington have deteriorated into Requires Improvement from Good – and this also impacts on mothers and babies from the recently closed unit in Ealing.

This does not benefit anyone. Although it is obviously not City Hall's job to run hospitals in the way the devolved model in Manchester involves, the Mayor of London has a duty to the health of Londoners and can usefully support the need for maintaining sufficient health infrastructure in the capital.

The UK has already lost 50% of hospital beds since 1990 and is thus considerably under resourced. The UK lags behind European counterpart economies in terms of %GDP invested in health as well as provision – and even then, spend is currently dropping at a rate of 0.3% per person.

East London Plans have been critically examined and found seriously inadequate by a report from the Centre for Health and Public Interest (attached)

On that basis the 3 local authorities concerned did not sign up to the Transforming Services Together Document (inner boroughs) nor to the North East London STP which covers the 7 Outer North East London Boroughs – City of London Corporation; Hackney; Barking & Dagenham; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

Within the North East London Plan is included the re-structure (i.e closure to blue light ambulance cases and transformation to Walk in Centre) the A+E dept and closure of 270 acute beds at King George Hospital Ilford, despite predicted local population growth of 345,000 by 2021. This is an equation which does not add up in any way.

Councils in the other two areas – SE and SW have also quizzed and queried those plans and none have been fully ratified.

Please note also – the STP clause is now completely out of date. The government shifted these to **Accountable Care Organisations** (ACO's)
<file:///C:/Users/Jos%20Bell/Downloads/Accountable-care-systems-briefing.pdf> and then, when these were revealed by Shadow Secretary of State for Health Jon Ashworth and many health experts to be dangerous and unworkable 'Trojan Horses for Privatisation' – which has not only been taken up in a legal case involving Prof Allyson Pollack and Stephen Hawking no less, but also has caused Jeremy Hunt to call a pause in their roll-out.

<http://www.nationalhealthexecutive.com/Health-Care-News/hunt-to-pause-accountable-care-roll-out-after-mps-voice-great-deal-of-concern>

However those of us who watch Jeremy Hunt's every move (almost) have spotted that he suddenly change the term to **Integrated Care Systems** - none of these terms is honest. STPs did not offer sustainable health provision, ACO's are not accountable and integrated in this context protects neither the NHS, social care or anyone who needs or works in either.

We urge City Hall to take a look at what is really planned and challenge these dangerous constructs along with the PLP.

ICOs are dangerous in several ways. Contracts are long-10-15 years, making it easier for the government to hand over NHS services wholesale to the private sector and making reinstatement of a locally accountable service difficult and protracted; they do not offer comprehensive care to a local population but specified care for those individually signed up through their GP- those off lists or moved off lists because they are most costly, are the most vulnerable; they devolve medico-legal accountability away from the NHS for the first time, and they employ staff on a different basis not bound to NHS terms and conditions including pension rights.

ICOs are relatively simple to convert into an insurance based health care delivery vehicle- the failed US model- where those at relatively lower of serious and chronic conditions requiring costly and ongoing care, can band together to pay insurance fees for care of a limited kind.

Women's health too must be given particular attention with the restructuring of maternity provision and sexual health services in proposed STPs/ACOs – with already the loss of some beds such as in Ealing, and measures which put the health of mothers and babies at risk. The recent CQC report on maternity services at St Mary's Paddington which shows a slide to Requires Improvement is a key indicator of the risks in this regard.

Imperial College NHS Health Trust is in rapidly increasing deficit and has pretty much declared the local STP/ACO etc plan to be undeliverable, and is now looking for its third CEOs in almost as many months.

<file:///C:/Users/Jos%20Bell/Downloads/Public%20Trust%20board%20papers%2031%20January%202018.pdf>

Sir Bob Kerlake, the former head of the Civil Service and much respected Chair of King's College NHS Trust recently resigned saying 'it cannot be done!'

<https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit>

These are key signs that the government's austerity strategy is at complete variance with any form of good health management. We ask that the Mayor highlights this, rather than sign up to a London Plan which just seems to nod through STPs and the like.

The public will not thank a City Hall which does not take this on.

Nor is any of this is being offset by the community improvements which were promised as many proposals for alternative home care for all but the sickest patients emerged as being unrealistic in terms of resourcing.

In terms of **Social Care** funding cuts via Central Government cuts cannot always be the main reason/excuse for local councils not fulfilling their duties –it is certainly true for some who have experienced cuts of 60%, but London contains other councils such as worst offender Kensington & Chelsea which has runs itself like a 'bank on steroids', sitting on huge reserves and spending an 'eyewatering £250,000 on paintings....' rather than attend to civic duties - and which has resulted in the worst health inequality in the country and the horrific disaster at Grenfell Tower.

Emma Dent Coad MP's report After Grenfell highlights the damage this ideology has done to the borough. Her report on Social Care will be published shortly. Prelude :

The state of social care in Kensington and Chelsea is a classic example of how a casino economy is incompatible with health equality. Kensington and Chelsea Council has outsourced all care facilities, despite the fact that they ran a budget surplus year on year due to underspending. Many facilities were soon handed a default notice as they were unable to fulfil basic standards due to poor staffing.

The issues relating to an aging population are only part of the problem – and improving public health is most definitely a very relevant target which needs to be properly resourced, planned and delivered with coherent KPIs.

For those councils who have lost so much central government that they are keeping social care afloat by taking non ring fenced funds from other duties – including public health. This is negatively impacting on any form of a healthy ethos for said boroughs.

The London Plan should be echoing these voices of experience, and challenging the government, not including a section which reads as though it accepts/approves Secretary of State Hunt's damaging measures.

For these reasons it is obvious that City Hall should be challenging these models all the way down the line, rather than signing tacit approval to them in this key document for the future.

11.1.40 ETTF and developer contributions represent only a relatively small proportion of the capital funding required, so additional sources need to be identified. **The London Health and Care Devolution Memorandum of Understanding** offers significant opportunities to address health and care estate challenges. **These include innovative approaches to realising value from underused and unused NHS land and buildings; working more collaboratively with the Mayor and London's boroughs; and taking the One Public Estate approach to health and care developments.**

The London Estates Board and London Estates Delivery Unit aim to support the effective delivery of local and sub-regional estates plans, including more efficient estate utilisation. This will better meet the health and care needs of Londoners now and in the future.

We are deeply concerned that central government is subjecting the public sector to such extreme financial cuts and constraints in an ideological pursuit of low taxation and minimal public services.

We are deeply concerned by the funding shortfall cited in the London Plan and will support City Hall in any endeavours to obtain a fair funding allocation for London.

We are at the same time deeply concerned about the stated aim to sell off NHS land in London without any detail or consultation. What does this mean? Does this relate to buildings currently in use? Does this relate to assets which could be put to better use for the health and wellbeing of Londoners rather than a sell off? Has any consideration been given to London's expanding population in this context? What are the plans for the land? Who will scrutinise this? Will the funds achieved by any sale be invested in dedicated health projects?

We would strongly recommend that the best use of unused NHS buildings in the capital is firstly to explore the potential for renovating buildings into housing stock for medical students, nurses and other medical workers, including paramedics. Thus the dearth of key worker homes can be addressed under the aegis of NHS estates which is surely a good priority solution to the matter.

We would also strongly advocate the approach taken by the Sure Start programme, which is holistic in nature and not only looks after the education, play, health and wellbeing of pre-school children but also parents and families too. Nationally, more than 500 centres have been dismantled due to central government funding cuts, but some local authorities are managing to keep at least a proportion of these going. These can also be linked up with local GP surgeries, libraries etc. Our Chair previously worked with Prof Sir Norman Glass and developed / evaluated 32 Sure Starts so we are very conversant with the benefits of the model.

At the same time we are also deeply concerned by the recent appearance of DWP 'advice' personnel being based in libraries. Given the current regime at the DWP, this is highly inappropriate use of community space.

We also draw your attention to the intergenerational work of United of All Ages, where the health and wellbeing benefits of multi-purpose sites offering childcare in older people's settings are fast emerging.

You will recall that Jeremy Hunt wanted to sell off 60% Lewisham Hospital land which quickly resulted in the highly informed and effective Save Lewisham Hospital Campaign. Quite simply, this would have resulted in the closure of the hospital and endangered thousands, resulting in just one A&E for 750,000 people with resultant extreme pressures on neighbouring hospitals – just as has already happened at Northwick Park following the closures at Hammersmith & Central Middx. Thankfully the High Court and the Court of Appeal noted in the first instance that Hunt acted unlawfully but the method of his consultation also emerged to be insufficient and even duplicitous.

In order to prevent these situations being repeated, we strongly recommend that before any NHS land assets are sold off, we ask that these are mapped out for consultation with local communities to ensure best use – initially at least to explore the following :

- step-down care to relieve pressure on expensive clinical beds by patients who are no longer in need of in-patient treatment.
- residential accommodation for medical staff, to help recruitment and relieve housing need,
- the construction of older peoples' homes, helpfully co-located near health care,
- the future expansion of health premises,
- social housing.

All these uses would generate more income in the long run for the NHS or the public sector than the once-only receipt of land sale money, and so offer better value for money."

Overall, the key is surely to repeatedly challenge the government – not sign up to their plans which are essentially designed purely to dismantle the NHS.

In 2012 we knew that the Health and Social Care Act would be a disaster. This report was written by our Chair <https://www.scribd.com/document/81678939/Breaking-the-Nhs-through-Reckless-Reforms>

Three years ago we knew that this emergency was pending – and many of our members input into the inquiry which resulted in London's Health at the Crossroads <https://www.healthemergency.org.uk/peoplesinquiry/pdf/SecondReport.pdf>

We ask that City Hall supports us in Labour Party health policy which is statedly focused on overturning the Health and Social Care Act, reinstating the NHS to original principles in the way it functions and also helps us to offset the Tory scheme to dismantle our NHS infrastructure rather than support the Hunt approach as seems to be the case in the current version of the London Plan.

You will also please note that the Health Motion and speech which we presented to London Regional Conference, which was unanimously adopted, particularly cited the need to safeguard NHS sites. (See addendum)

We also endorse the Enfield Southgate CLP paper which goes into this in more technical detail with expert input from Jeff Lever, South Bank University expert in land management.

Sir Robert Naylor's report on the future of NHS land¹ revealed that years of careless reorganisation and neglect have left the NHS without a national estate strategy, and lacking the capability to create one.² Therefore he recommended setting up a powerful Board to produce such a strategy. We agree with this conclusion, subject to the strategy being exposed to full and meaningful public consultation, including from Local Government and in Parliament.

However, Naylor then proposed the brisk sale of £5.7bn-worth of NHS land, much of it (by value) in London. We consider this conclusion to be unsupportable, given Naylor's logical inference that an estate strategy needs to be in place before one can know what land is surplus to requirements, and why.

Therefore, we are concerned at the damage that would be done to the NHS estate, and to the contribution of planning to London, if any sale of NHS land in London takes place before a strategic framework is in place that has been subject to meaningful public consultation.

Most NHS land and buildings originate from hundreds of years of charitable donations and legacies by local people and institutions. Londoners and their Councils have a strong right to be consulted, and to influence, the future of this valuable public asset that was provided by our forbearers.

MAJOR CONCERNS

We acknowledge the London Plan's aspiration to create thousands of new homes. However, we consider that the concept put forward in the Chancellor's Autumn Statement of 2015, that a sell-off of NHS land³ be carried out so as to release land for 26,000 homes, is simplistic and damaging, even if echoed uncritically in other quarters. There exist more nuanced opportunities for NHS land to deliver housing gain at the same time as providing health and welfare benefit to Londoners, and preserving the estate assets of the NHS.

Failure to consider other reasonable alternatives

In the first place such sales would be irrational unless other reasonable alternatives to sale had been considered and compared. In our view, there are several options that provide better value for money, and more public benefit, as well as housing gain, than a straight sale of NHS land. We propose such alternatives, below.

The value of co-location

Since the London Plan is a spatial strategy, it is important that the value of co-location of NHS facilities and other health- and welfare-related uses is given due weight when considering the future uses and ownership of NHS land. Co-locating these uses on NHS land brings significant gains in functionality, efficiency, convenience, sustainability and value for money. Moreover, these gains are captured for the foreseeable future. This means that where there is the potential for co-location, NHS land carries a premium which would be lost upon a sale at market value: such land is of greater value to the NHS and to the public than it is to potential private purchasers for other, non-related uses.

PRIORITY USES FOR NHS LAND

Enfield Southgate CLP therefore proposes that the following estate priorities should be promoted by the London Plan alongside the Mayor of London's role in the promotion of good health in London.

When any NHS land is identified as not being in clinical use,⁴ the Mayor should encourage the NHS to adopt a sequential test to appraise the use options for the land. NHS land should be safeguarded from sale into the private sector unless and until it has been demonstrated that all the following potential uses, listed below in a suggested 6-step priority sequence, have been considered, and rejected for good reason.

(1) Buildings currently in clinical use

The useful life of a healthcare building today is often as short as 30 years. Furthermore, clinical services change frequently, driving frequent internal reorganisation within buildings. Where there is a backlog of maintenance, it will be important in each case to consider, first, whether there is a business case for carrying out that maintenance. This must be compared with a business case for renovating, adapting or even replacing the building.⁵ Until these

determinations are known, there can be no responsible decision to sell any NHS land that is available for this purpose.

(2) Expansion, replacement, and new facilities

Where the NHS owns land that is convenient for expansion and replacement of facilities, this should be retained. Those who argue that efficiency will reduce the amount of estate required by the NHS are overlooking projected population increase and the ageing of the population. Furthermore, the ongoing specialisation⁶ in medicine generates a need for additional specialist equipment and facilities. Moreover, it is far more efficient to preserve the co-location of health facilities by replacing them on site than by being forced to rebuild elsewhere.⁷ Land in this category should be retained.

(3) Step-down care

Experts consider that it is bad value for money for the government to sell NHS land for private house-building when such land, much of it co-located with hospitals, or in their vicinity, could be used for “step-down” care to relieve acute beds.

The revenue benefit from this, over time, far outweighs the sale proceeds of the land ... The government is saying ‘save money first, in order to invest,’ but the more realistic approach is to invest so as to save—a pump-priming argument.

Land that is suitable for step-down care should be developed by the NHS urgently.

(4) Residential units for NHS staff

Building co-located residential units for NHS staff mitigates many problems in a single sweep.

- Housing: NHS staff, many of whom are on average to low pay, already form a significant proportion of those who are in housing need.
- Sleep: Many NHS staff work 12-hour shifts, which, according to recent sleep research, is a factor in reducing life expectancy.⁹
- Fatigue: By eliminating time spent travelling to work, co-located housing can mitigate the adverse effect of shift work, and reduce staff fatigue, thus increasing patient safety.
- Standard of living: Likewise, by eliminating travel expenses to work, resident NHS workers’ standard of living can be improved.
- Recruitment: The availability of such accommodation can be expected significantly to reduce recruitment problems faced by the NHS. Whether this housing is “social”, “affordable” or at market rents, it is clear that the NHS would be left in profit whichever of these terms of letting pertained. Moreover, the age profile of staff means that, today, more family housing is required, beyond the “nurses’ hostels” of yesteryear.¹⁰ This gives us the

opportunity to impact the housing shortage significantly and in a targeted way that multiplies the benefits.

(5) Land swaps with other public-sector land

The Mayor should encourage the NHS not to dispose of land until it has been considered for other public uses by all local stakeholders.

The Mayor should encourage the NHS, the London local authorities and other public bodies to consider land swaps and/or purchases to improve their own estates and assemble required development sites, by securing more convenient sites from other public-sector holders of land.¹¹

The Mayor should suggest a moratorium on all sales of NHS land until a clearing house is in place to prioritise the disposal of NHS land into the public sector before it is considered for sale into the private sector. This would ensure that, after NHS land has been considered for priority NHS uses, it becomes available for supported housing for elderly and vulnerable people and social housing at genuinely affordable rents, provided by local authorities.

(6) No unsuitable developments on former NHS land near hospitals

If, at the end of this sequential test, there is a case for selling any NHS site into the private sector, then the Mayor should favour a planning policy that prevents any type of development that would be unsuitable near any nearby hospital, for example by causing disturbance to patients or congestion preventing access to ambulances. Furthermore, what would be unacceptable would be for the public to be told that NHS land was to be developed into homes, only to find, later, that the dwellings so created were unaffordable by many Londoners, or had fallen into the hands of Buy-To-Let landlords via the exercise Right-to-Buy, or into the hands of international investors, to add to the current 20,000 long-term unoccupied homes in London.

Potential options for raising the required funding

11.1.64

Having had involvement in successfully challenging and adapting the previous Mayor's TfL Bill we seek clarification as to the meaning of this :
Specifically the reference to an Auction model.

- following an invitation for TfL to bring forward proposals for funding infrastructure projects from land value uplift, the Government has agreed to establish a joint task force (including the GLA and TfL) to explore the options for piloting a Development Rights Auction Model on a major infrastructure project in London.

Chapter 12 Monitoring

MONITORING – SCRUTINY – ACCOUNTABILITY

Health KPI is frankly pitiful – *ie.* Londoners engaging in active travel

For this to have any meaning it should be linked to health outcomes - such as Londoners engaging in healthy streets, healthy programmes, active travel and reporting health benefits via an online survey.

Air Quality KPI – *we recommend exploring this further with Clean Air London*



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ADDENDUM

Health Composite Motion - London Labour Regional Conference 2017 :

Conference anticipates that Local Authority and NHS budgets in London will continue to face cuts under the present government. London's NHS managers have been told to "think the unthinkable" in making yet further "efficiency savings".

A King's Fund Report on London's Sustainability and Transformation Plans (STPs) concludes that "Even if additional investment is made in community services, reductions in hospital use on the scale proposed are not credible. Heroic efforts will be needed simply to manage rising demand with existing hospital capacity".

Financially driven Sustainability & Transformation plans involve cutting thousands of hospital beds and staff at a time when London's population numbers are on the increase.

The British Medical Association recognises that STPs are "a cover to deliver cuts", and the Local Government Association condemns STPs as "secretive, opaque and top-down".

The Royal College of Nursing state that unless government intervenes in retaining skilled EU nurses and training more in Britain, then the NHS will not survive the resultant skills deficit.

The crisis in social care continues to be ignored by the government who continue drastic cuts to council funding, putting providers on the brink of closure and increasing pressure on London's hospitals. Mental health services are also in crisis.

Conference further notes that the Grenfell Tower caused Britain's largest non-wartime fire-death toll and in anticipation of the creation by a future Labour government of national, lifelong monitoring of environmental health impacts, calls on the Mayor of London to support and integrate current health monitoring initiatives, and investigate and address short or long-term health impacts.

Conference therefore calls on every section of the London Labour Party to join all other NHS supporters to campaign urgently:

- for NHS and Social Care systems in London which are properly integrated and accountable, publicly owned and adequately funded ;
- to scrap the Tories' pay-cap unconditionally;
- exposing the Tories' STPs as vehicles for cutting vital services instead of prioritising patient care ;
- to restore nursing-students' bursaries;
- to recognise EU nationals' crucial skills in London's NHS;

- to tackle the causes of Londoners' ill-health, e.g. poverty, the housing crisis and poor air-quality;
- to oppose closures (or "reconfigurations") of London's services without proper local consultation and consent.

Conference calls upon the London Labour Party to agree that clinically driven integrated solutions are urgently needed to overturn dangerously cruel austerity ideology. We will prioritise the health and wellbeing of Londoners in all areas of policy.

PROPOSER - SHA London Chair

Just imagine Jeremy Hunt in his snazzy new £44,000 office bathroom – or maybe not! - a mini Versailles in which he can admire his reflection while he limbers up for another bout of throwing false data at Ralph Little's Tweets.

Now let's just imagine a figure of 120,000 individuals – each with their own lives – or rather lives they did have.

Shockingly, **120,000 people have died too soon** as a direct result of the impacts of austerity, **30,000 since 2015** as direct result of the dreadful impact on our health and care provision.

This is what rising health inequality means in real life and death terms.

2010 was the tipping point.

Even before **Hammond's** desultory attempt to **darn an NHS patch** with his one extra day's funding and terrible decision to starve social care by £6bn, **London's NHS managers have been told to "think the unthinkable"** in making yet further "efficiency savings".

To think the unthinkable about the health of Londoners is surely a dereliction of their duty to save lives and prioritise healing?!

The BMA recognises that Sustainability and Transformation Plans – or STPS (not STD's!), are "a cover to deliver cuts" & the **LGA** condemns them as "secretive, opaque and top-down".

The King's Fund Report on London's STPs concludes that

"Even if additional investment is made in community services, reductions in hospital use on the scale proposed are not credible.

Heroic efforts will be needed simply to manage rising demand with existing hospital capacity".

HEROIC. Yes, let us recall our heroes – paramedics, doctors, firefighters and nurses, community police. First responders.

Grenfell. Every time we say the word, it hangs in the air in a pall of choking smoke.

We don't need an enquiry to know that **Britain's largest non-wartime fire death-toll** was caused by an ideological disregard for the health and safety of our fellow Londoners.

We mourn the deaths of those lost, but we must not forget the survivors – **as well as ensuring them safe and suitable homes**, we must commit to monitoring the lifelong health impacts on all those who were exposed to that toxic environment.

In the face of such avoidable tragedy, these financially driven – and in no way clinically advised, STPs involve cutting thousands of hospital beds and staff at a time when London's population numbers are rapidly increasing.

We already have 50% fewer beds per capita and a significantly falling comparative % GDP spend on our health services compared to many EU countries as well as a severe GP staffing crisis

- nor will the worsening world of **Brexit** bring those **elusive weekly NHS jackpot millions shamefully blazoned across Boris' bus.**

In West London alone, a series of FOIs from the Save our Hospitals Campaign revealed that this will entail the loss of 5,000 hospital beds and 8,000 members of staff – at a time of a projected population rise of 20,000.

This is a key reason why **Hammersmith and Fulham and Ealing councils** have refused to sign their STP, also forensically backed by the **Mansfield Commission** findings.

The Save Lewisham Hospital Campaign report shows that the so-called **Our Healthier South East London STP** disguises the reality that **'it is truly impossible to build a healthier community under austerity conditions which leaves essential services £1.25 bn short by 2020'**.

Yet while too many **Trusts continue to pay their executives phenomenal salaries while NURSING BURSARIES ARE CUT.**

The RCN state that unless government intervenes in retaining skilled EU nurses (**like Tanja Pardela**) and training more in Britain, then the NHS will not survive the resultant skills deficit.

14% of our London nurses hail from the EU

Brexit must not be the death of our NHS!

Not only must we protect our services, we must also tackle the causes of ill health – we need decent pay and decent homes for all, with breathable air, safe from an overload of harmful particulates and emissions.

The crisis in social care continues to be ignored by the government - instead pursuing drastic cuts to council funding, putting providers on the brink of closure and increasing pressure on London's hospitals.

Mental health services are also in crisis – in particular those vital early intervention services for children and young people .

The mental health of lonely carers – and **let us not forget young carers**, is also in crisis – faced with cuts in their support along with demands to do more, **84% report declining mental health.**

The only way to rescue our NHS and social care from this evolving catastrophe is to **find a clear publicly funded and consulted route to integration and resourcing**, where health and wellbeing are prioritised across all areas of policy and NHS capital assets are retained **for best long term investment, not sold off for short term profit - unless the local community approves.**

We know the public supports such measures.

Labour will prioritise the health and wellbeing of Londoners in all areas of policy.

SECONDER : Chingford & Woodford Gr & SHA member

This motion calls for every section of the London Labour Party to join all other NHS supporters to campaign urgently to defend London's NHS.

This must be a high profile, far reaching publicity campaign exposing in straightforward language just what Tory Health Plans will mean for the NHS in London... if we don't act now we stand to lose many of our vital NHS facilities before Labour Gets into power, for many Londoners it will be too late.

The NHS in London is facing a perfect storm :the RCN says: Large numbers of NHS nurses are - quitting because of staff shortages and poor pay, the situation is at its worst in London, because of the high cost of accommodation.

You have to ask why would anyone train as a nurse,? physiotherapist, radiographer , or any of the essential health care professions when training bursaries have been cut and the future awaiting them is workload overload , and a low paid job meaning that they cannot afford to live in London.

At the same time London stands to lose many health professionals from the EU who are currently holding together vital hospital services in London

Then there is the Risk posed by STPs

There are 5 of Simon Stevens STP areas in London planning to cut £ 4 billion from London's Health budget by 2021 despite predicted unprecedented population Growth.

They plan to achieve these savings by closing or downgrading busy A+E depts, cutting large numbers of hospital beds and aiming to reduce hospital use overall, at the same time as London faces a desperate shortage of GP's, NHS community services are being cut and community nursing posts are being deskilled .

An insidiously dangerous yet intrinsic part of the STP's is the implementation of the Naylor Report and Naylor 2 which relates specifically to NHS land in London.

Naylor recommends that all hospital trust must identify lands and assets to sell off as a condition of year on year capital funding ; NHS trust which *don't* sell off land will be punished by not getting access to capital funding . The seductive additional reward for complying with Naylor swiftly is that Hospital trusts who sell off land quickly in partnership with a property developer will get an additional sum from the exchequer worth half the value of capital raised through the sale BUT this will be allocated on a first come first served basis for a limited time.

In other words..the STPs and Naylor are pushing the NHS in London towards a fire sale of land. Labour's conference decisions and NHS manifesto commitments will hard to implement if high land values in London mean that essential NHS land has already been sold by the time that Labour gets into power.

Like so much Tory NHS policy this is a very well kept secret but Londoners have a right to know.

Lets make it clear, the selling off of essential NHS land is not the solution to London's housing problems : high standard healthcare accessible to all Londoners is a basic human right , just as is the right to a decent home .,but Londoners need them both...but we shouldn't be seduced into selling off one to meet the needs of the other.

So what do the voters think about all this ?

New polling suggests there is major public concern for hospital safety with seven in 10 people believing nurses are underpaid and similar numbers saying there are not enough of them.

To campaign against the Tory pay cap and to restore student nurse bursaries would be understood and well received by voters. Opinion polls have consistently shown that the NHS is the most important issue to voters.

Until now most of the Save Our NHS campaigns have been lead by local communities. Labour could be taking a leading role , especially if MP's and local councillors use their specific powers to challenge and expose Tory policy, like several have already done ...but this needs a much higher profile.

We need clear campaign materials for use in canvassing ,on street stalls, and social media, telling the story as it is, campaigning against all NHS cuts closures, reconfigurations and land sale without proper local consultation and consent.

This motion calls on every London CLP and Labour organisation, as well as all Labour councillors and MPs to work with local communities **now** to defend NHS services before it's too late and in so doing win over massive public respect and confidence , and win the local and national elections.

(Both speeches delivered November 2017 – Congress House. London Labour Regional Conference)

ENDS

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