Transcript of Agenda Item 4
Question and Answer Session – The London Health Commission

Roger Evans AM (Chairman): This afternoon we are looking at the work of the London Health Commission. I welcome our guest, Professor the Lord Darzi, who is the Chair of the London Health Commission, and your colleague, Simon Weldon from NHS England.

Professor the Lord Darzi (Chair, London Health Commission): Thank you very much, Chairman, and thank you very much to all of you for inviting me here today. Just to set the context, some of you will have heard me talk about this. I did discuss this with the Health Committee at the last meeting, and I gave the context to this Commission. It was launched in December of last year to look at London's healthcare, reporting to the Mayor. We are halfway through, we have another four months to go, so I very much hope that after this session I will pick some of the ideas from the discussions that we may have.

Just to go very briefly through what we have done so far, we have listened to about 5,000 Londoners through different polls. We have had about 250 submissions to our call for evidence which closed around 14 February. We have extended that for another couple of weeks as the evidence submissions kept coming from a wide-range of stakeholders, which is of interest, unlike the previous one in 2006/07, which I will revisit as we talk about London. We had about 50 roadshows across the capital and some of you in this room were part of these, so I am grateful for that. We have had nine oral hearing sessions. All of these are on YouTube and, as I said, we are producing one report in October.

We have heard the following from our London residents: we need to improve population health, we need to focus on children - and I will highlight to you some of the challenges in relation to child health in this capital city - we need to work together to provide better care and we also need to seize the opportunity from the life sciences industry. We have three of the best universities in the world; we are not necessarily translating the evidence and the discoveries out of these universities into clinical practice.

The clear messages are: how do we bring the National Health Service (NHS), social care and the Mayor together? That is really the difference this time around. The stakeholders involved in delivery of healthcare and the enthusiasm that I have seen, whether that is from the boroughs or the local authorities, have been exceptionally helpful and supportive in this agenda. I suspect we are in a different place from where we were in 2006/07, as far as their interest in health. We also have NHS England, the London office. We certainly have the Mayor and the Greater London Authority (GLA) and so the idea of how we cross these boundaries and how we provide this cohesive leadership has been, certainly from my perspective, one of the exciting things about this review. Then how do we solve the practical problems and what are the enablers that need to be worked through?

Halfway through, I should have at least a framework of what this thing will look like in October and what this framework is based on. Firstly, there is a strong emphasis in this Commission on

better health: the public health agenda, the health and wellbeing agenda. How do we have a better deal for London's children? How do we improve areas we know that we could do better in providing healthcare? What are the enablers that we need to work on? This is not a strategy that is going to be published without a very clear idea of what we need to do to enable that change, and what else could we do to really drive the health and economic growth in terms of impact in London? Finally, leadership for better health, which I am sure you will have some interest in.

If we look specifically at London's adults, these are the figures in front of you: 70 deaths per day are linked to smoking. Despite all the interventions we have done in this capital city and elsewhere in England, we still have 70 deaths a day. Of adults, 21% are eating five servings of fruit and veg a day - that is a very small percentage - and 57% of our adults are overweight. As you can see, near enough 450 admissions a day to the accident and emergency (A&E) departments are related to alcohol and it continues.

If we are going to have impact, let us look at the areas of the biggest risk. As you can see, a third of the deaths in London over the last ten years are related to heart disease, stroke and lung cancer. To tackle these, we really have to focus on obesity, smoking and inactivity. Only 18% of adult Londoners actually have any form of exercise, about 30 minutes of exercise, per week, and that really puts us in a very different place to the rest of the country.

If we move to the children, we still have 15% of mothers smoking during pregnancy, 60% higher infant mortality than Tokyo, and 37% of our children are overweight and obese, which is another area which I am sure you will have interest in. Then, as you can see, for some reason or other, our in-hospital standardised mortality rate (HSMR) - which you have heard a lot about in the last 12 months or so - is actually increasing in children since 2006 and 2007 when I did the London Framework for Action.

What do we need to do in terms of helping London's children? You can see we really need to start thinking about effective, evidence-based, high impact interventions to deal with childhood obesity. We have to make young people think healthy is the right thing to do, the right choice to make - healthy eating, I am talking about. How do we tackle the vulnerable children in London? There are about 15 families, if you segment the population, that if we really intervene, we probably will see a significant impact.

What about healthcare, in other words, healthcare delivery, what our delivery systems are doing? This is probably the most exciting piece of work that I have been involved in as far as strategy, for a long, long time, which is population segmentation, which I will come back to. Of Londoners, 81% are mostly healthy. We are spending about £20 billion on health and social care. As you can see if you segment the population, we are spending about £1.4 billion on 62,000 Londoners with serious and enduring mental illness. The challenge with this is that if you ask that subgroup of patients with serious and enduring mental illnesses, they will tell you, "We are not getting the right treatment in the right place". We can see 54% of our expenditure is on adults with long-term conditions.

If we are really going to think about what population health is and how we really tackle the needs of our population in London, we have to look through the lens of physical health, mental health has to be the thread that goes across all pathways of care, and also social care. Therefore, it is all about integration between the three different stakeholders who commission services.

We looked at the population of London. This is based on a very innovative piece of work which was led by North West London, which is a joint work between the Clinical Commissioning Groups (CCGs) and the boroughs. We segmented the population in London to 15 groups based on four age groups. That gives you an idea of the size of the population we treat and their different conditions. The reason that is important is because it gives you a rough idea of what we are spending on these different disease categories. On mostly healthy adults - in other words, one of us may require an admission to A&E tonight with a sprained wrist or a groin hernia, whatever it happens to be - we are spending about £6.3 billion on 5.2 million who are in that category.

Let us take this with a degree of caution, these definitions of mostly healthy: there is an overlap with other groups. If I could take you to the third, which is adults with long-term conditions, we have one million patients in London. Nationally, we have 17 million with long-term conditions. One million of them are in London, and we are spending £3 billion on patients with long-term conditions. Of all the people with long-term conditions, on even a smaller group, 190,000, we are spending £1.6 billion, so if you add the £3 billion and the £1.6 billion we are spending £3.6 billion on long-term conditions.

If you look at learning disabilities and serious physical disabilities, you can see the expenditure for these different groups. What is unique about this group and the polls we have done, and if you ask, for example, mostly healthy adults what type of services they are looking for, their answer is, "I want quick access, convenient, urgent access, to primary care. I am happy to see any general practitioner (GP). I need to make sure that I am treated as far as my vaccinations, advice in relation to whatever condition I have". If you go to the group below, which is the patients or people with long-term conditions, it is a completely different ask. They want a longer consultation. They want the same GP because they do know, they have been through this journey together and their need is mostly about co-ordination of care and the integration of care around them.

If we go to the third group, the severe and enduring mental illness, what they are looking for is outreach and outbound services, and if you ask them, despite that expenditure I made a reference to before, in the majority of the cases they do not believe that the care provided to them meets their needs.

This is an interesting piece of work on this population segmentation.

Roger Evans AM (Chairman): Thank you for that.

2014/2282 - Access to primary and community healthcare

Steve O'Connell

How can access be improved to primary and community healthcare, and how will this benefit patients and healthcare in London?

Professor the Lord Darzi (Chair, London Health Commission): You have very kindly asked me what the issues are in access to primary and community services. We have significant challenges facing us in London in primary and community services and that goes back, even to 2006 and 2007, when I had the privilege of being part of that review. If you look at our access figures, we are worse than the rest of the country. If we look at our utilisation of information technology, like email consultations or email access or web access bookings, we are doing worse than the rest of the country.

If we look at the access in terms of the estate in primary and community services, these were the new figures. You may or may not know that a third of our primary care estate does not meet the Disability Discrimination Act [1995]. Two-thirds of our primary care estate and community estate is in urgent need of refurbishment or even a complete rebuild. We have been talking for a long time about shifting care to the community, getting primary care more involved, having an impact on reducing the accident and emergency admissions, but we are spending in London - nationally, as well - less than 8% of our budget in primary care. There are challenges in terms of the capital expenditure and in terms of the recurrent expenditure.

We also have significant variations in the quality and article framework between different practices. In London we have some of the best and some of the worst, and these variations actually could be in the same borough, so there is an issue of tackling quality. Access is one of the attributes of quality, so we need to look at it as a whole package.

This Commission is very much focusing on what the enablers are and what we need to do to address these very serious challenges of quality, access and safety when it comes to the use of primary care.

Roger Evans AM (Chairman): Thank you.

Steve O'Connell AM: Yes, thank you very much. It is alarming to hear that our access is far worse than other parts of the country and, particularly around the estates, a third do not have disability access.

There is or has been a new structure of healthcare following the Health and Social Care Act [2012] and I would ask you what opportunities and benefits have been offered with the new structure and how can these opportunities be fully exploited to improve the healthcare of Londoners?

Professor the Lord Darzi (Chair, London Health Commission): In terms of what the landscape looks like now, there is more emphasis on localism, which I have always supported, and I could see certainly early shoots of collaboration at a local level between the CCGs and the boroughs, for example. In the patch I am in, in north west London, they are coming together,

including in the creation of these academic health sciences networks in which the commissioners and the primary care providers are actually members, and they are taken on themselves in tackling these variations in the quality when it comes to primary care. They also, in north west London, have looked at this population segmentation and more or less are asking themselves, "If this is what we are spending on this subgroup of patients and these are the patient experience data that we have, we probably should start thinking about our primary care provision in a completely different way".

Most of the forces are really driving towards enablers in terms of core commissioning between the boroughs and the CCGs, or core commissioning between NHS England, which commissions primary care services, and CCGS. All of these things take time to mature. These changes, which were to happen about two years ago, are just about coming together and they are starting to think about how to really bring core commission services together, based on the patient pathway rather than the historical structures or buildings that we provide services from.

Steve O'Connell AM: When you form your recommendations, you will be looking at these strategic questions about the success of the change in landscape?

Professor the Lord Darzi (Chair, London Health Commission): I am not looking at the actual structures that we have, but I am more or less identifying what the gaps are, what needs to be done and what are the things that have worked that could be disseminated. The NHS is a very unique organisation. If you woke up this morning, despite all that we say about it, headlines from the *Washington Post* saying that the Commonwealth Fund - the only thing they got wrong that it is Washington-based; it is not, actually, it is a New York-based NGO - has rated the NHS as the number one health service in the world. The NHS has this ability to morph itself whatever structure change we have seen over the last 20 years, and eventually focus on what matters most; that is patients.

Steve O'Connell AM: Thank you. I would like to move toward something slightly more specific, which is about what can be done to reduce the need for patients to attend A&E at their general hospitals. We will all have experiences in our boroughs and our wards of the pressures on A&E. At your halfway mark, where are your thoughts heading towards there?

Professor the Lord Darzi (Chair, London Health Commission): It has been a challenge for a long time, even back to 2006. We have one of the worst inflationary rates in A&E attendance than anywhere in the country. Pointing the finger at one thing is the wrong thing to do. There are a number of different issues here that could be at least addressed by firstly the commissioners in terms of access to primary care, access to urgent care provision out of hours. You are fully aware of the expansion of the opening hours from 8.00am to 8.00pm that I had something to do with a long time ago in one primary care centre per borough - now it is expanding to a larger number of primary care centres - expansion of primary care access out of hours in certain geographical areas up to 10.00pm seven days a week. All of these things will help from a primary care perspective. There are also some misaligned incentives in terms of hospital setting, which actually brings the patients in, its activity.

Thirdly and most importantly, how do we build the confidence of the public and the patients that in actual fact you do get as good care in your primary community setting that you may get going and sitting in an A&E department like St Mary's where I work, to be seen with something that could probably be sorted out better by your GP?

I just add that there are a large number of other things: use of information technology, getting access, email consultations, making your bookings on the web. There are all sorts of other things that every Londoner is able to do when they book their flights, they do their banking; we need it really to work in relation to healthcare so you do not have to go and wait at 10.00pm but you book your appointment for the next morning at 8.00am or whenever it happens to be.

Steve O'Connell AM: Your comment earlier was that the access for Londoners to their health services is, comparatively, probably the worst in the country. Your last point was around how Londoners interact and access health services. Could you elaborate a little bit more about how health services can become more accessible and user-friendly, and what sort of recommendations may you be moving towards in that particular aspect?

Professor the Lord Darzi (Chair, London Health Commission): The population segmentation is a great start. Asking the patients what they need, what care they are looking for, what experience they are looking for. Before, we did ask all patients to tell us, but I make the point that the needs of my son, who is in his second year in a university, are very different than the needs of his grandfather. It is fascinating. I am in the business myself; I had not really thought about it in that way. London is a very unique city because it does have a young population. It also has, in actual fact, a group that is aging and the demographics are very different from the rest of the country, so London has a bigger challenge than the rest of the country to meet the different age groups and the different categories of disease, or illness - 'disease' is the wrong word - in terms of their needs.

To do that, I am not coming up with new models that I will describe. That is not the work of the Commission. The Commission is saying, "This is the burden of illness. This is what the patients want. This is how much we are spending. Providers need to be much more flexible, much more customer-focused, much more dynamic and creative in coming up with the delivery models". That is really the way forward. The idea that the Commission will dictate what a provider will do would take us to the wrong place.

Steve O'Connell AM: You commented on the fact that different Londoners with different levels of conditions expect different sorts of access, which is an interesting recommendation.

Professor the Lord Darzi (Chair, London Health Commission): Absolutely.

Andrew Dismore AM: I would like to raise with you the challenge of a growing population. It does not seem to figure in your charts. In London the Office of National Statistics (ONS) estimates that we are going to see a 13% growth in population up until 2022. If you channel that down, you see in Barnet, one of the areas I represent, that the population is one of the fastest growing in the country, sixth highest in the country, going from 264,000 to 422,000. If we narrow that down even further to one ward, Colindale, the population there is going to go

up, doubling to 35,300-odd, 11,000 new homes in one ward. In fact, it is not just one ward, it is one polling district; it is that concentrated.

The real problem seems to be that NHS England - maybe this is a question for your colleague - does not seem to understand that. Our CCG tell me - and I have the figures from NHS England and them - that the funding always lags way behind the growth in population. Although we are getting above average increases, it is not matching the above average growth in population that goes with it. What has happened for these people in Colindale - and you talk about a postcode lottery - they did not have a ticket in the lottery because there is no new GP provision at all in that area for these additional people.

They will probably come under your mostly healthy people. The people moving in tend to be young families and young people, but inevitably that therefore feeds through into this impact on the local A&E departments. You know yourself about the Barnet and Chase Farm problem; the woeful performance of its A&E and its other services is a result of this. When is NHS England, hopefully through your good offices, going to realise that they have got to have resources for these new developments in place before or as the people move in, not lagging behind? You will never solve this A&E crisis until we have the primary care in place. The way the funding system works, it is always after the event.

Professor the Lord Darzi (Chair, London Health Commission): I could not agree more; you are making a very, very good point here, and that is that health is always behind when it comes to planning, whether that is a population increase. Schools, education, has a challenge too; when your population is increasing by 30% we need to start really looking at the health provision, the educational provision, and all sorts of other infrastructure things. I think, coming back to the point I made earlier, a closer co-operational, co-production of plans between the boroughs and the CCGs is the way to address that. If you are a commissioner looking at the local population through the lens of health only without actually knowing and getting the intelligence about the increases in population, you are always going to find yourself on the back foot, and in many ways this will help us plan.

I think planning is also coming up quite interestingly in terms of health being not just about health provision. Health is about housing, as well, which we need to address, too. To my surprise, we looked at the NHS's footprint, the estate. It is three times the size of Hyde Park. A significant percentage of that estate is either underused or misused. In the capital we are spending £60 million on the estate. It is not even used for clinical purposes. There are a number of issues here that we need to look at very carefully. How do we utilise that estate to build new primary care centres, to enhance housing, to start thinking about education? That NHS estate is one very important enabler.

Andrew Dismore AM: That is a very important point because one of these enormous, very dense developments in Colindale is actually being built on the site of the former Colindale Hospital. The original idea was that there was going to be a primary care centre as part of that development, but that has been shelved by the developer, by the council and by the Mayor. The problem here, as you identified correctly, is, unless the Mayor when he allows these developments to go ahead, which are very, very dense - so although it may be a high standard

of housing they are very, very cheek-by-jowl, to say the least, very small properties - unless the Mayor is going to start getting tough and saying to developers, "You cannot have this until the health provision is in place", and until NHS England starts to put the cash in terms of the running costs to match the capital, which the developer may well provide, we are not going to solve this problem.

Professor the Lord Darzi (Chair, London Health Commission): Good point. I will hand over to Simon, but just to say from the Mayor's perspective I suspect there is a reason why I am doing this, so his priorities are absolutely in the right place when it comes to an exemplar in your patch, because historically I do not think there has been an alignment between the Mayor being actively involved, at least to seeing what the local vision is.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): To make a couple of points, firstly, every CCG would acknowledge the challenge that you have just made, actually. At the moment, every CCG across London is thinking about its long-term plan, and you are exactly right that it has to demonstrate that the services that it is proposing to commission in its local community have to demonstrate that there is an offer that is compelling, real and available to patients so that they would feel confident in going to their local services rather than to an A&E department or feeling the need to always go there. I would say confidently that, having spoken to all of the CCGs across London, they recognise that as their central challenge.

To add a couple of further points, just emphasising what Lord Darzi has said, in making those plans it will be an essential test that they come together with local government colleagues. A great deal of the services that we are talking about here will give people confidence and also help keep people out of hospital will need to be commissioned with local government, who are increasingly important partners in those plans.

The last point: we are asking and working with CCGs to plan for the longer term. A lot of fixing these problems involves planning for the longer term. These are not short-term fixes that can be applied quickly. You have to allow CCGs to think over the longer term. They are all planning for a five-year time horizon, precisely to address some of the problems that you have just raised.

Andrew Dismore AM: That is interesting because I know my CCG has been in contact with NHS England, as have I, and the response I have had from the Chief Executive Officer (CEO) of NHS England makes it quite clear there is a significant time lag between the growth in population and the NHS England funding catching up. There we are.

Professor the Lord Darzi (Chair, London Health Commission): It is back to what I said earlier: we need to be much more proactive whether that is in customer service in terms of the patients or planning.

Joanne McCartney AM: I was just going to pick up on something you said earlier, that when we are changing any aspect of the health system it is essential that we build the trust and confidence of the public and patients. We have all been out supporting our local hospitals that are at risk of closure, and it is very emotive when you talk about changing healthcare provision.

I know from my experience of Chase Farm, for example, that one of the requirements of the Independent Reconfiguration Panel was that primary care and access to primary and community care had to be dramatically improved before the A&E services went. As far as the public in Enfield are concerned, the A&E was taken away before those promises had actually been kept. We would say that that community healthcare is not good enough even now.

Can I just add, given that - I can see some of you nodding at that - is there a case for actually having a programme of upfront investment in primary and community care before you take away A&E and other services? It seems to me only that way will you actually convince the public that the alternative provision is actually there in the first place.

Professor the Lord Darzi (Chair, London Health Commission): I may ask Simon to talk about Chase Farm because I do not really know the details. Even forgetting about reconfiguration of services, we need a significant investment in primary care. It is nothing to do with changes of services. It is to do with what I said earlier. Two-thirds of our primary care estate is not fit for purpose and we need to do something about that. If we have an aspiration, based on the aspiration of our patients in whom we are spending £3.6 billion for near enough one million people with long-term conditions, they are asking us, "I want longer consultation. I want it in primary care. I want the care integrated around me. I would like to see the same GP as much as possible". To do that we have to invest in primary care, both capital and recurrent. That is the model of care that is emerging from here. That is irrespective of the hospitals and the services provided around us.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): I would just agree with what has just been said. I will give you the example, let me just say, about north west London.

The slide on segmentation is not something that people sat in a darkened room and invented by themselves. It was actively by engaging with patients and saying, "What do you find good or bad about your GP services at the moment? What do you want to see changed?" Broadly speaking, they said three things. One was that they wanted care that was more appropriate to their needs. They wanted to be able to access that care when they wanted to, as opposed to having to ring up first thing in the morning and sit in a long queue. They wanted to be able to have appointments that were longer than ten minutes, so that they could properly talk about their healthcare needs. To do that, as Lord Darzi has said, we need to make investment and we need to demonstrate to the members of the public, to patients, right across London, that those services are making a difference and can offer them the healthcare that they need. It is only that way that you build the confidence you are talking about.

Joanne McCartney AM: You are right. If you can do that, it then means that changes, for example, to hospitals become a lot easier because people can see that there is good provision. Can I just ask you where that investment is going to come from? Are you confident it will be there?

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): We have to make a case both for more investment as Lord Darzi has said, and look again at how we fund services in London.

There is no denying that the financial settlement that we face in the health service is going to remain tight. There is also evidence that we can make better use of the resources that we have got. We have given an example just now about the estate, how under-utilised the estate is, and how if we made better use of that, that would enable us to provide better services to people more locally.

As we change the burden of care, as we build services outside of hospitals, we believe that we can release some of the money that has been currently invested in acute care to support the development of better primary care services.

Joanne McCartney AM: Can I move on as well to the Better Care Fund? It is not new money; it is just a reworking of old money both from CCGs and local authorities. The Better Care Fund was delayed because a Whitehall review said there was serious concern at arrangements merely to protect protracted battles between local authorities and the CCGs in order to protect their respective services.

Lord Darzi, you said earlier that in north west London it seems to be working quite well and there is lots of collaboration. Are you seeing that across London or are there areas where there does seem to be some retrenchment and resistance to the pooling for the benefit?

Professor the Lord Darzi (Chair, London Health Commission): No to the latter question. In fact I would say that local partners have come together absolutely in the spirit of the endeavour. I think we showed you a slide that said the future of planning has to be between partners. The Better Care Fund is a key tool to enable that to happen.

The point that you make is how do we make sure that we actually see the benefits flow into the system so we do not end up paying for the same thing twice? The challenge that we have got to work with local partners to make sure they are in a position to deliver, is when they say they want to put in place a Better Care Fund scheme that is going to save admissions or reduce delayed transfers of care or prevent admissions to hospital, it will actually result in savings to the system. That is the challenge that we face.

In terms of the spirit in which local partners have entered into that endeavour, no, all I have observed is that people have been absolutely willing to rise to that challenge and see it as central to their long-term delivery.

Joanne McCartney AM: Thank you.

2014/2283 - Strategic Health Authority
Dr Onkar Sahota

Do we need a London Strategic Health Authority to give leadership and co-ordinate health services across London to address the health needs of London's diverse population?

Professor the Lord Darzi (Chair, London Health Commission): If I could just revisit the past for a second and how the Strategic Health Authority was created, I actually did the London Framework for Action in 2006/07. Then there were five Strategic Health Authorities that merged into one.

London is a very, very different place now from where it was in 2006 and 2007. To be fair, the Strategic Health Authority did drive and provide the leadership in some major changes at the time. If you look at stroke care, 200 lives a year were saved by having the eight comprehensive stroke centres. Most of the impact areas have been around the centralisation drivers at the time. We are in a completely different era seven years later. That is one.

The second is, you know this, because I led a major review when I had the privilege when I was in office 2008-9 which was High Quality Care for All. I am one of these guys who strongly believes that if you really want to drive change, focus on transformational change rather than structural change. Throughout governments we have seen structural change. I gave you an example during 2006/07 when five Strategic Health Authorities became one. We had 350 Primary Care Trusts (PCTs) and they became 135. Then we move back again to no Strategic Health Authority.

We should really park this on the side and look at how we get cohesive leadership in London. How do we get the three major actors in London; the local government, CCGs and NHS England, to come together and commission services based on the needs of the patients? Most of the demand, and as the patient segmentation work suggests, is mostly about care nearer to the patient within the primary and community setting. That needs local engagement. You cannot have someone higher up there sending commands down saying, "Shift there". That is my own thoughts and views about this.

What is missing is that engagement with the patients, the public and the clinicians. It is that social mobilisation that has been missing. I hope with the Commission we can get that up and really drive this change. Again, we have seen elements of that. If you look at the submissions, people are desperately keen to be heard, to be given the opportunity of making change happen. That is where I stand on that.

Dr Onkar Sahota AM: Lord Darzi, you talk about this huge agenda for transformational change, therefore leadership must be an enabler of this.

Professor the Lord Darzi (Chair, London Health Commission): Absolutely.

Dr Onkar Sahota AM: I was more concerned about the idea of giving strategic leadership across London rather than what you could call the body, to bring together this force that is

needed. I am a practising GP and I am at the sharp end and not just sitting in a NHS England office somewhere; I see patients.

We now have 32 CCGs in London. We have public health sitting in NHS Public Health and also local authorities. I see people's care getting fragmented rather than being fully integrated. I really want to ask how you think there is a mechanism for improving the patient journey. The patient is already concerned about getting the right care, the right place, right time, every time. How do we make that change right across London? We have issues of patients living in Ealing. If they are registered with a GP in Ealing they cannot get care there if they live in Hounslow, for example. Those sorts of boundary changes are really impacting on this and we have a new agenda across London. How do we get us all together?

Professor the Lord Darzi (Chair, London Health Commission): To be fair I have heard these challenges, not from you, from others who produced the evidence and submitted the evidence. Is the answer the creation of another big bureaucracy?

Dr Onkar Sahota AM: No.

Professor the Lord Darzi (Chair, London Health Commission): I do not think that ticks the box. I think what we need to do is give these organisations time of maturity, number one. Number two is how could we drive the cohesive leadership between these different organisations? There is a mind-set, whenever you create an organisation or structure, of silo working. Unless we are going to get local government, health and wellbeing boards, CCGs and also primary care commissioning -- I think you talked about airports this morning. You have to commission the whole journey. You cannot just say, "This is the guy building the planes. This is the guy doing the things and we are going to do it separately".

The leadership that is required is to bring people at a local level and start really thinking about how we commission services based on what the patients need. As I say, I have four months to go. As it stands at the moment I do not have the evidence that we need another bureaucracy. We may, however, look at the different organisations and say, "What do you need to fill the gaps?" I remember famously four or five years ago when I was on one of my tours around, people kept saying, "Stop looking up. Just look out towards the patient. They will tell you where you should be heading". I think that is the mind-set change that is required at a local level. For the Commission, what are the enablers to bring them together?

Dr Onkar Sahota AM: The other thing, looking at the patient, you talked about what the patient wants. They want to have longer appointments. They want to have care given near their home. They want to be able to have continuity of care. This requires two things. It requires, as you have already touched on, the estates.

Professor the Lord Darzi (Chair, London Health Commission): Correct.

Dr Onkar Sahota AM: Secondly, it requires human resources, the doctors, the nurses to give this care. We also know that we have investment in primary care of only 8% and we need to do more.

The mantra has been so far, keep the patients out of the hospitals, save the money and then we will invest money in primary care. I was in a discussion about co-commissioning. One of the arguments being put forward for co-commissioning was to release money from the hospital budget so we could make investment in primary care. What we really need to do is, of course, catch up on this game. Who is going to enable that shift in investment into primary care?

Professor the Lord Darzi (Chair, London Health Commission): Absolutely. I take your point. I think there are some pan-London, even national, things that need to be addressed here. NHS England has a very important role to play here in terms of -- talking about the estate, for example. The estate issue cannot be resolved by the local borough and the CCG without a very clear set of proposals that we need to think through within the next four months and say, "We need a better disposal of estate. We need better investment in estate." NHS England also needs to hear there is a significant challenge with their expectations of primary care provision if we are spending 8% on estate. There are very clear sets of proposals that only NHS England has to address and deal with.

Let us not forget there is also the GLA and mayoral moral pressure, per se, not necessarily legislative powers, but how he could at least speak for London's health is the purpose of this document.

I agree with you, none of these big things could be done at a local level. NHS England needs to address those.

Dr Onkar Sahota AM: Thank you.

Fiona Twycross AM: I have a question on co-commissioning. I have a point of clarification before I ask my question which is on co-commissioning which, is about the examples of groups with different needs and whether you have it broken down.

Professor the Lord Darzi (Chair, London Health Commission): Yes.

Fiona Twycross AM: Is it possible for us to have the figures on it broken down by race and gender, for example, and when can we get that?

Professor the Lord Darzi (Chair, London Health Commission): I do not think I have race and gender. I could tell you there are certain sub-groups of these different groups which probably will be even more disadvantaged, like ethnic minorities and the severe and enduring mental illness.

Fiona Twycross AM: It was just about checking the equalities aspects of patients would be embedded in the --

Professor the Lord Darzi (Chair, London Health Commission): Absolutely. I do not have the exact figures on that but I do know that they are significantly more disadvantaged in terms of their care.

Fiona Twycross AM: Absolutely. Thank you. I was really pleased to hear you talking so much about co-commissioning and what patients need. I was just interested to hear a little bit more on your thoughts about the tension between what patients want and what clinicians determine patients need, which does not always match. Some of the issues that have been to the forefront of debate around health in London, around hospital closures, have shown there has been a real mismatch.

I just wondered how far you thought patients should have a role in determining the type and shape of health services that should be delivered locally and across London.

Professor the Lord Darzi (Chair, London Health Commission): This is the long-standing question that goes back to the day I qualified. How do we move from this paternalistic relationship between a clinician and a patient into an empowered patient? To be fair, it is not unique to us, it is a global issue. How do you empower the patient? You can only empower a consumer as long as you give them the knowledge and information, which comes back to the example which you raised in Chase Farm, for example.

Most patients do want the latest treatment, the best treatment, and they will go wherever that treatment is, as long as you communicate that and you actually stand up and explain why the change is required. In many ways, having some of the budget going to local government in terms of health in itself is a democratic organisation driving that. In many ways the CCGs - and I am sorry to come back to north west London because I have seen examples of that - did engage the population and the public in terms of the changes required. That is not something you do when you are doing a strategy, may I just say. That is actually something you do when you go to work every day.

That is the culture that we need to bring back in terms of change or transformation or co-commissioning. The integrator and the enabler of co-commissioning is the patient. Ultimately you are all focusing on the individual receiving the sets of interventions, whether it is hospital setting or a preventative measure in primary care or their housing or their employment or whatever it happens to be. It is a bit like I say information technology is the integrator of care, but the patient is the integrator of co-commissioning, or at least the driver of co-commissioning.

Fiona Twycross AM: All right. Thank you. It does seem that patients do have a preference for the district hospital model, notwithstanding the fact that they want the best care. Given the recent comments by NHS England Chief Executive Simon Stevens that healthcare services have become too far centralised, do you think there is more of a case for the district hospital model than previously in the last couple of years has been made by healthcare professionals and clinicians?

Professor the Lord Darzi (Chair, London Health Commission): To be honest, we are going in to taxonomy and definition and district general hospitals, specialist, whatever. What patients are telling us is in areas that we know we can deliver care nearer to the home, they need locality, whether you call that a local hospital, local primary care centre, it is the locality

they are looking for rather than the name. I do not think district hospital is a brand name or a specialist term. It is the locality. They would like as much of their care as possible to be delivered locally. Simon Stevens, who is someone I know and has astonishing intellect and leadership, is very much into the idea of looking at what could be provided at a local level, but not at the expense of areas in which we know we need highly specialised delivery models, for example stroke care. We have seen the impact of that, of 200 lives a year. Again, coming back to what was in the newspaper today, if you go to the Harvard Business School, London's stroke care changes in services is part of their curriculum. It is a taught course as an exemplar in the Harvard Business School as far as how change could happen in the health service. They will eat off our hands in the United States of America if they have the opportunity to do that. That is where Simon Stevens obviously led big organisations.

I think he is absolutely right - and everyone here will support it - that there is a big burden of health delivery that should happen nearer to the patient.

Fiona Twycross AM: Obviously for patients to be involved in the co-commissioning and co-design of the services, they do need to have that level of information that you have referred to. What is the best mechanism to deliver that? I used to work for Diabetes UK and we did a checklist of what patients should be demanding, almost. It should not necessarily, in my view, be down to the long-term condition charities to do that. How would we make sure that patients have all the information they needed in order to be part of that decision making process?

Professor the Lord Darzi (Chair, London Health Commission): This needs a new rethink, to be honest. In this building on Saturday 5 July we will have 100, 200, 300 patients here, public, coming here to talk through with them what this discourse should look like in the future. I think we need to do better than we have done in the past. The Commission will have something to say on patient information, patient engagement. It needs to be a much more mature discussion.

Let us not forget, if we are spending £3.6 billion on one million patients with long-term conditions, we are also losing the opportunity that those one million actually are expert patients. They know more about their condition than many of the clinicians looking after them. In many ways I consider those as part of the workforce, which we do not pay. They are big contributors. We really need to look at this in a completely different angle, especially in a capital city like ours where the dynamics are very different from some parts of NHS England.

Fiona Twycross AM: Thank you. That is very helpful.

Murad Qureshi AM: I am just going to bring up issues around the A&E services in London. Is not the ongoing all-year crisis with A&E services in London good evidence that we need pan-London leadership to get the situation under control?

Professor the Lord Darzi (Chair, London Health Commission): It is the same answer I gave to Onkar [Sahota] earlier. To reinforce what I have just said, there are huge variations in A&E attendance in different parts of London. There is no one-size-fits-all and I learnt that eight years ago. I gave you three reasons why that might happen to be the case. One is

primary care access; the estate and opening hours. The second is engaging the public, in terms of what is available to them out of hours and how could they utilise that.

The bit that we can deal with at a higher level is the misalignment in centres. That is something that we could look at. For example, there is a tariff for A&E attendance so in many ways the cost of that is significantly greater. I am not talking about serious ambulance arrival; I am talking about the sub-group of patients who are attending A&E who could actually have most of their problems dealt with at a local level if they had an out-of-hour or urgent care provision.

Murad Qureshi AM: I hear what you say about the specifics, but there are some general trends. In 2013, last year, we had over 200,000 Londoners waiting over four hours in A&Es to get service. We had A&E pressures during the winter which meant something around 3,500 operations were cancelled; and almost 6,000 ambulances waiting for three hours. It does sound to me as if there has been a lot of disconnect.

The best example I can highlight is the London Ambulance Service (LAS). They lost over 200 paramedics when patients were expected to travel more and they had to take on that demand. It is not quite clear where and when they fit in to the whole picture of London, yet they are a very important service to make sure people can get to their A&Es. This is at the same time that the Care Quality Commission has suggested they actually do not need to enact cuts of £53 million but they actually need to take on more paramedics.

Professor the Lord Darzi (Chair, London Health Commission): I will bring Simon in to address that. To be fair, the inflationary increase in A&E attendance goes as far back as 2006. It has been increasing year by year. There is nothing new about that. It is not something that happened last year. The only thing that I will read in to that is we should have done something about this for the last eight years --

Murad Qureshi AM: It is demographics.

Professor the Lord Darzi (Chair, London Health Commission): -- and we would not be here talking about this subject. I absolutely agree and support that.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): A couple of points, the first is just to return to something in the longer term because we tend to focus on A&E because it is right in front of us and it is a very immediate pressure.

Some of what Lord Darzi had to say about some of the preventable causes of admission are important and we need to start taking action now if we are going to see and contain and manage demand in the longer term. Think about the number of people who turn up to A&E with a cause of admission or problem that could be prevented, like drinking, like smoking. Some of the public health challenges, some of the issues there, are profoundly important. If we do not start acting on them now we will continue to see the rises in A&E admissions and attendances that we have seen over the last number of years. It is a problem that we need to act on both now and in the longer term.

In the immediate term, to your point around the LAS, I recognise that they are one of the most highly utilised ambulance services in the country, probably the most highly utilised ambulance service in the country. They have more calls and they show increasing rises for demand in their services year on year.

Some of the same points apply. I work regularly with the Ambulance Service and I spent quite a lot of my time from an operational delivery perspective looking with them at how to make sure their services are best deployed. What they tell me is, again, they have a high number of calls where their resources could be deployed more effectively elsewhere. We do have a very important job to make sure that for those people who do not need to call an ambulance, we make them more aware of what the alternatives are, how they can access those alternatives, and how they will get them to where they want to. People at the moment, fundamentally, still believe that ringing 999 is the best thing to do for every problem, ranging from something incredibly trivial to something absolutely life-threatening.

You made an important point about workforce. I do think that we strategically have to address the fact that at the moment we have got to train more paramedics nationally. The evidence is, not just in London but when we look at ambulance services across the country, that there is an insufficient supply of paramedics to manage the total ambulance demand that we have. We are looking, with ambulance services across the country, ambulance service commissioners, at how we start addressing that.

London also has its own special needs. It is a more expensive place to live here, and we need to recognise that in attracting and retaining paramedics to the LAS we have got to think about the unique challenges of how we get people to come and work in London. I completely agree with all the points. We are actively engaged with the LAS upon those very issues.

Murad Qureshi AM: I am reassured to hear that. I do accept the year-on increases but that is largely due to demographic changes. We are getting older and obviously the demands on the health service as a result are greater. In some ways this should have been predictable since 2006 where we were getting to. Yes, we do need to know a bit more about our physical needs and our physical bodies, and when it is an emergency and when it is not.

Nonetheless, it is actually quite glaring. My nearest A&E is in St Mary's and where, Lord Darzi, you are a consultant. Those of us who have been involved in the consultation with the closures of A&Es in the rest of the North West Health Authority were always saying that actually in Paddington, St Mary's, we are not convinced they could cope with the additional demand. It has quite clearly been established recently that it is at maximum utilisation. We have two A&Es, one in Hammersmith and one in central Middlesex, closing on 10 September. Surely this kind of stuff should have been planned from a strategic perspective right from the outset, possibly in 2006.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): They have been. I would say further that every organisation in north west London, every medical director, every CCG has supported the implementation of those changes as delivering better quality care. It has to deliver all the points that people have been making around this

table. It has to deliver compelling and better primary care, deliver out of hospital so people do not need to go to A&E. It has to deliver great A&E services when people need them. The evidence is that clinicians have led these changes. Clinicians have supported them. That, for me, is one of the most compelling reasons for us to get behind them. It is there that we can make the difference.

Murad Qureshi AM: My litmus test is that you have one quarter before 10 September and it does need increased resources and facilities particularly. I am not sure we are going to see that over the summer.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): I would say that colleagues in north west London are actively engaged in making sure these plans can be implemented, and be implemented safely.

Murad Qureshi AM: In this quarter, over the summer?

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): Even as we speak, even now, people are making plans to make sure that the changes that are proposed on 10 September can go ahead, and go ahead safely. That is the litmus test. You are absolutely right. We should not proceed with changes that cannot be implemented safely.

The clinicians are in the lead for making these changes happen. It is their judgement. It is they who we turn to, to ask for their support in saying, "Is this change sufficiently strong enough to go ahead?" At the moment that is what they are saying to us.

Joanne McCartney AM: I just want to come back to the role of strategic oversights of health services in London. Lord Darzi, you said earlier that issues cannot be dealt with by local boroughs and commissioning groups or the health and wellbeing boards. You gave estates as an example. You have also stated that one of the legacies of the strategic oversight for London was the reconfiguration of stroke services. I am just wondering, in the future, given that we have national and local, what is there now in London to deliver that pace of change? If we do not have that we are going to be failing patients.

When answering that, one of the things that was very good about the London Strategic Health Authority was that we saw a lot less of the postcode lottery that we had seen before because there were priorities set for our city as a whole. Where is that leadership now on that level if we do not have some other body in place? Are we going to go back to postcode? Where is the accountability as well? We have seen with the debacle with Lewisham Hospital; the intervention of the Secretary of State has actually not provided any confidence to local residents down there, in fact it has done exactly the opposite.

Professor the Lord Darzi (Chair, London Health Commission): You have thrown a large number of questions there, which in many ways I did touch on before.

Firstly to say we do have a NHS England office in terms of managing the estate. Coming back to the stroke and trauma, that was the output of *London: A Framework for Action*. The people

who made that change were the clinicians on the ground. It was not a Strategic Health Authority who banged heads around and made sure that it was happening.

Joanne McCartney AM (Chairman): Where is that city-wide oversight in future? Where is the accountability?

Professor the Lord Darzi (Chair, London Health Commission): It is a different world. It is not just health. It is not just one organisation called the Strategic Health Authority. It is a different world. It is a world in which local government has a big say and boroughs have a big say in what happens at a local level. It is a bit like saying, "Who is going to co-ordinate the 32 boroughs?"

Joanne McCartney AM (Chairman): There is. It is London Councils.

Professor the Lord Darzi (Chair, London Health Commission): We are seeing clusters of CCGs in certain parts, coming in and working together. I absolutely agree with the question. I am trying to find out does that actually give the following answer is the issue. I still have four months to think about this.

Simon Weldon (Regional Director of Operations and Delivery, NHS England (London)): I would add to that, to think that 32 CCGs sit in splendid isolation and do not talk to one another is, of course, not the case. They collaborate together all the time. Look at north west London. The eight CCGs have worked entirely together to deliver *Shaping a Healthier Future*. That is not something that could be led by one CCG. It is something that has been led by them altogether. Look at the South East London CCGs. Despite the issues around the Trust Special Administrator process, what was really evident in that was that the CCGs came together to provide leadership for their local community, and try to make the best of what they found in that process.

The fact is that CCGs are working together, not only in their local systems; they are developing much stronger relationships. When I ask CCGs what has been a big benefit of the new system, they say they have immeasurably strengthened their relationships with local government. That has been a real benefit for them. They would absolutely own to that. They also recognise that to get some of the changes that they need to happen, they are going to have to work together.

The second point I would make is that they are often collaborating together around clinical standards and around how they set frameworks to make sure that clinical care, when it is delivered, like we did with stroke, like we did with trauma, is delivered in the same way across London. We work with them regularly as a group, right across London, to deliver that. We are embarking upon a piece of work, for example, to look at how we can improve the quality of mental healthcare; again, doing that collaboratively between NHS England and the CCGs.

2014/2284 - Impact of air pollution on Londoners' health
Stephen Knight

What steps has the London Health Commission taken to investigate the impact of air pollution on Londoners' health?

Professor the Lord Darzi (Chair, London Health Commission): Thank you. This is a significant challenge, again a unique challenge, facing London in terms of the air pollution than the rest of the country.

The Commission should have a view about this. The way we have done it is: what is the impact of pollution on health? That is question one. The second is: what is the impact of the current set of interventions that the Mayor is leading on? Third is: what could this Commission do to accelerate the impact of these interventions? That is the way I am thinking when it comes to pollution.

The most important figure is 7% of mortality in London is related to pollution. That is equivalent to 4,300 deaths a year. That is a big, big challenge if you look at it from that perspective. That, in 2012, is the data that I have. That excludes childhood asthma, exacerbation of chronic obstructive pulmonary disease (COPD), and all the other aspects of pollution.

Secondly, do we have the right sets of measures, in terms of what the Mayor is doing as far as the Clean Air Programme, alternative transport, reducing the carbon footprint. The health service does have a role to play there. I think we have one of the largest carbon footprints of any other industry because we are working, sorry to come back on the estate, and what we are working out of. The proposals that the Mayor is leading on are the right sets of proposals. There is no question about that. I do not need to go through those with you; you know them better than I do.

At the same time, one can take an oversight of what is happening in another big city across the pond. Look at New York and what [former Mayor Michael] Bloomberg has managed to achieve there in terms of air pollution. They had the worst particulate matter (PM) percentages per air. They had the sulphur levels. At one of our engagement events last week at Kingston we had the ex-Health Commissioner that worked with Bloomberg and some of the interventions that they have taken there, including some of the stuff that the Mayor is doing; getting rid of cars, taxis and public transport after a certain age. I think these are the right sorts of interventions. I think the Commission may have to say something about how we accelerate that. A 7% contribution to deaths in London related to pollution is a considerable figure that the Commission should have an opinion on. That is work in progress.

Stephen Knight AM: Lord Darzi, thank you very much for that response. I wonder if one of the issues is not around leadership, around raising the issue of air pollution and the dangers of air pollution. I do not think it has quite the same level of public awareness as some of the other causes. You do not often hear the medical profession talking about air pollution. Indeed, the presentation which you gave us earlier talked about smoking, it talked about obesity and

inactivity. You often hear clinicians talking about those kinds of health issues. Yet, we know, as you mentioned the figures suggest that air pollution is twice as deadly as passive smoking, three times as deadly as obesity.

When are we going to hear the medical profession start to speak out around the issue of air pollution, advising people to think again about buying a diesel car, or perhaps urging politicians to enact legislation to clean up our air? Clearly we have a problem. I look forward to some leadership from people like you.

Professor the Lord Darzi (Chair, London Health Commission): Thank you. It is a good point and, to be honest, I will be very transparent here. I did not know these figures, either. I work in London and I live in London. You are absolutely correct.

This whole public health agenda needs to be brought at the front of this debate. The biggest contribution the London Health Commission needs to make is some of the big, big challenges facing our health and what we need to do about this. Who needs to talk about this? Who needs to lead the change in relation to this? The Mayor has a very, very important role here. I think the clinicians should speak about it, but ultimately the Mayor could lead. If you look at what the former Mayor in New York has done in terms of pollution, in terms of obesity, in terms of smoking, all of these need a complete rethink. It is not a little paragraph here and there in some strategy, we need to talk about public health and prevention and wellbeing. We actually need to act on these things.

Stephen Knight AM: I assure you in this Chamber we spend an awful lot of time beating up the Mayor about air pollution and what more he could do about it. Of course, the boroughs have a role nowadays in terms of public health. I do not know whether you know the figures on what proportion of the borough health and wellbeing strategies even have a reference to air pollution, but I can tell you that from my figures only 9 out of the 33 borough public health and wellbeing strategies even mention air pollution as an issue.

I just wonder if that is that an issue which you could raise with the boroughs and with directors of public health in boroughs from your leadership position in London.

Professor the Lord Darzi (Chair, London Health Commission): The answer is yes, and that comes back to the third section of the framework that I described. What can we say and do to accelerate what the Mayor is trying to achieve at local level? You are right. We have the reasonable sets of proposals that the Mayor is leading on, but I think there is a scope in accelerating some of these and what we can learn from other cities that have addressed the issue of pollution. To do that, you have to start with awareness. In actual fact, I could even potentially, at the end of this piece of work, share which the worst boroughs are in terms of air pollution. We might be able to see whether that data is available as well because the intervention needs to be directed. It is interesting because that is exactly what has happened in New York City. There is a perception that pollution is usually in the most deprived areas of the big city. That is not the case. In actual fact, Manhattan being if you like the richest square mile or whatever it is of New York has the worst pollution rates.

Roger Evans AM (Chairman): Perhaps next time you give this presentation you might like to add air pollution in as a factor.

Jenny Jones AM: Thank you. Lord Darzi, I think you will find there is a lot of agreement around the table that air pollution is something that really ought to come under your Commission. I did not quite understand. Are you saying that you are undertaking work at the moment on this? You have started work?

Professor the Lord Darzi (Chair, London Health Commission): We are doing analytical work on what the problem is. We are looking at the interventions that the Mayor has been leading on, but we are also looking at other capital cities and seeing what else could be done in this field.

Jenny Jones AM: I think that is brilliant and I look forward to seeing that piece of work. It is just that air pollution, unlike overeating possibly or smoking or alcohol is entirely involuntary. We all do it regardless. I lead a very healthy lifestyle. I am still breathing polluted air so I was surprised it was not in here.

Professor the Lord Darzi (Chair, London Health Commission): You are very kind in saying that but all of us have a carbon footprint, and we also contribute to that, but you are right. There are other factors that are involuntary and we need to do something about that.

Steve O'Connell AM: It certainly is, as I have said in this Chamber from time to time, that the Mayor gets beaten up around his policy on air quality but it is reassuring to hear that your comments are that we have the right leadership and the right set of proposals, although we do indeed need to accelerate that improvement across London. I pick up your point, which I welcome, that it would be good to perhaps compare and contrast London boroughs and their performance because we very much need to drill down on how boroughs can perform and, in essence, shame those boroughs. Just to reiterate your report, your forthcoming recommendations, you will be building upon the work that the Mayor is already doing and is building, but using best practice from elsewhere – and you mentioned New York – to build upon that and to accelerate that.

Professor the Lord Darzi (Chair, London Health Commission): Correct, yes.

Steve O'Connell AM: We can expect to see that within your recommendations when published, is that correct?

Professor the Lord Darzi (Chair, London Health Commission): Correct, and the Mayor is very keen that we look at air pollution and see what else could be done from a health perspective.

Steve O'Connell AM: We need to build from the good base from this building, but improve upon it and accelerate. Thank you very much.

2014/2285 - Promoting unhealthy lifestyles

Jenny Jones

You recently conducted a poll which found education about healthy lifestyles was the most popular priority. Should the public sector therefore rule out cross-promotion and partnerships with food and drink companies strongly associated with high-calorie products linked to childhood obesity?

Professor the Lord Darzi (Chair, London Health Commission): Looking at all the challenges facing us, if we are really not going to take this issue seriously, we are going to continue to deliver healthcare through a system that is designed as being a sickness service, rather than a wellbeing service. If I could just say that is the bit that excited me most when the Mayor asked me to review this, because it is the first time that I have seen local government and the Mayoral office really taking this thing head on.

Jenny Jones AM: Lord Darzi, I do not understand how you can say that because the Mayor did start a programme called the Capital Clean-up which is a good scheme but he linked it with McDonald's, a junk food seller. How can that be okay? As part of the scheme, which again I say is a good one, they had to promote McDonald's afterwards in their literature. How can that be a good thing for children?

Professor the Lord Darzi (Chair, London Health Commission): Could I just say I might be sitting as his Chair but I am not the Mayor.

Jenny Jones AM: No, but I ask you the question you seem to think the Mayor is doing a lot and I am telling you he is --

Professor the Lord Darzi (Chair, London Health Commission): No, I am not. I am saying I have had discussions throughout this period of the Commission, four months, and the Mayor has quite a big appetite in dealing with this issue.

Jenny Jones AM: You have not answered my question.

Professor the Lord Darzi (Chair, London Health Commission): I will answer your question. You had better ask the Mayor that the next time you see him.

Jenny Jones AM: No, no, my written question was: should the public sector therefore rule out cross commercial partnerships with food and drink companies strongly associated with high calorie products linked to childhood obesity?

Professor the Lord Darzi (Chair, London Health Commission): Could I just come back and say what we are talking about here is a behavioural issue and there is huge science now around the world which comes from behavioural economics. There are three ways in which you can deal in changing people's behaviour. There is taxation. There is regulation and there are other ways of doing it, which is nudging. You are asking me in many ways should we stop talking to industry? My advice to that would be we should --

Jenny Jones AM: No, I am not asking that. I said should we rule out cross promotion and partnerships. That is quite different. That is not talking.

Professor the Lord Darzi (Chair, London Health Commission): I think we should be working with industry to promote healthier lifestyles, healthier eating.

Jenny Jones AM: How can that be done when you are working with a company that sells high-sugar, high-fat, highly processed food and drink? How can that be done?

Professor the Lord Darzi (Chair, London Health Commission): I am not working with any company that sells high-sugar --

Jenny Jones AM: No, but the Mayor of London is. You are chairing the London Health Commission. I am asking you for your view of the fact that the Mayor is using McDonald's in schools. Does that sound like a good idea to you?

Professor the Lord Darzi (Chair, London Health Commission): I am not going to get into the politics of this.

Jenny Jones AM: It is not politics. This is facts. This is what the Mayor has done.

Professor the Lord Darzi (Chair, London Health Commission): You should be asking the Mayor this question.

Jenny Jones AM: I am asking you. You are the Chair of the London Health Commission.

Professor the Lord Darzi (Chair, London Health Commission): I am, yes.

Jenny Jones AM: In London, one in five children is obese. You have a figure of 37% overweight or obese but overweight is quite a varied figure. One in five children is obese, and the Mayor has used McDonald's in schools. I am asking you if you think that is a good idea.

Professor the Lord Darzi (Chair, London Health Commission): I really do not know what he is doing with schools or what the intervention is, so it would be most unfair for me to be giving an opinion about this.

Jenny Jones AM: Why do you not know about this and why have you not commented on it?

Professor the Lord Darzi (Chair, London Health Commission): I do not go around and find out what the Mayor is saying to whom and what. I am here to look at the evidence base, what interventions we need to do when it comes to better health. I have made it very clear. I could not agree more with you. I will make the case extremely strongly. I will give you another figure. 9% of kids going to primary school are obese, by the time they leave, 19% of them are obese. What I am trying to say is it is not just the food industry. This is a much bigger and much more complex set of interventions that you have to bring together in implementing

change, and I gave you the three headlines. You can do this through taxation, which we have seen in smoking --

Jenny Jones AM: I remember. I am terribly disappointed with your answer. I really, really am. I am presuming you have read the Academy of Medical Royal Colleges' report on obesity that they produced last year.

Professor the Lord Darzi (Chair, London Health Commission): Yes, I have. It was very good.

Jenny Jones AM: It was measuring up the medical profession's prescription for the nation's obesity crisis. We in this Chamber debated that. We put a motion to the Mayor urging him to pick up their recommendations because of the whole issue with McDonald's, and we voted it through. We feel quite strongly in this Chamber about dealing with obesity in a proactive way.

Professor the Lord Darzi (Chair, London Health Commission): Yes, yes. If you give me a chance to answer, the answer is yes. I am a Fellow of the Academy of Medical Sciences and I strongly support the output that they have given. You are asking me to specifically answer a McDonald's question, which I do not know anything about, and I am not going to answer that.

Jenny Jones AM: I will write to you.

Professor the Lord Darzi (Chair, London Health Commission): That is what I am trying to say to you. Let me just come back to what matters. What matters out there, you are absolutely right. We have a huge burden of disease, whether that is obesity and may I just say smoking as I raised it before. We have to do something about this and we have a set of different interventions that are evidence based that we can introduce into this Commission. We are thinking it through. We have a whole theme and an expert working group helping us through this in tackling the issue of obesity and I could go through some of the proposals if you wish me.

Jenny Jones AM: Do you think it is a good idea to involve junk food sellers in school projects so that the schools after that have to promote their goods? Is that a good idea? I would have thought as a doctor, as a surgeon, you would have said, no, it is not a good idea.

Professor the Lord Darzi (Chair, London Health Commission): As I said, I do not know the context of the question you are asking me.

Jenny Jones AM: No, I am asking generally.

Professor the Lord Darzi (Chair, London Health Commission): Let me just say to you, absolutely, we should be working in partnership with the food industry to ensure that we get them to change and address --

Jenny Jones AM: But introducing them to schools –

Professor the Lord Darzi (Chair, London Health Commission): -- to induce them to deal with these big public health challenges.

Steve O'Connell AM: If I could ask a question on a slightly more positive note, the other side of the coin, getting away from nutrition and American multinational companies, is about activity and exercise.

Professor the Lord Darzi (Chair, London Health Commission): Absolutely.

Steve O'Connell AM: That is something I would like you to comment on because there has been for far too long a generational shift in schools perhaps away from good activities, particularly in schools in areas of deprivation, it often is the case. Will you be commenting and observing on that in your recommendations?

Professor the Lord Darzi (Chair, London Health Commission): Absolutely, very much so and I am working with Transport for London on sets of interventions because exercise and burning the calories is the other end of this.

Steve O'Connell AM: Indeed.

Professor the Lord Darzi (Chair, London Health Commission): There are again some very, very important sets of proposals that the expert group have brought to us in terms of the evidence base supporting them. What could we do, coming back to the behavioural change, what incentives we can put in the system in accelerating or at least encourage people to walk in the parks. London, one of its biggest assets is parks. What are we doing in parks to encourage people to walk, to exercise? What are we doing in schools to really drive that change home? You are spot on. It is not just the calorie intake but it is the calories we burn out as well.

Steve O'Connell AM: Yes, certainly on the schools point I would certainly like a reversal of the trend to move away from competitive sports which we have seen over the last 20 or 30 years and if your work can help inform then it would be welcome, Lord Darzi.

Professor the Lord Darzi (Chair, London Health Commission): Thank you.

Roger Evans AM (Chairman): Thank you both very much for what has been a very useful session this afternoon. Before you leave us, would it be possible for you to let us have this in electronic form? It is a really useful presentation.

Professor the Lord Darzi (Chair, London Health Commission): Yes, we would be delighted to send it. I thank you all because this is the type of discussion that I would not have an opportunity to have and I really look forward to your support as it comes because ultimately, back to all your questions, this has to be delivered through you. I look forward to seeing you again. Thank you.

Roger Evans AM (Chairman): Thank you.