AGENDA

Meeting	**Health Committee**
Date	**Wednesday 24 June 2015**
Time	**10.00 am**
Place	**Chamber, City Hall, The Queen's Walk, London, SE1 2AA**

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Members of the Committee

Dr Onkar Sahota AM (Chair)
Andrew Boff AM (Deputy Chair)
Kit Malthouse AM MP
Murad Qureshi AM
Valerie Shawcross CBE AM

A meeting of the Committee has been called by the Chair of the Committee to deal with the business listed below.

Mark Roberts, Executive Director of Secretariat
Tuesday 16 June 2015

Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: David Pealing, Committee Officer; Telephone: 020 7983 5525;
Email: david.pealing@london.gov.uk.

For media enquiries please contact: Lisa Lam; Telephone: 020 7983 4067;
Email: lisa.lam@london.gov.uk. If you have any questions about individual items please contact the author whose details are at the end of the report.

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Certificate Number: FS 80233

Agenda
Health Committee
Wednesday 24 June 2015

1 Apologies for Absence and Chair's Announcements

To receive any apologies for absence and any announcements from the Chair.

2 Declarations of Interests (Pages 1 - 4)

Report of the Executive Director of Secretariat
Contact: David Pealing, david.pealing@london.gov.uk, 020 7983 5525

The Committee is recommended to:

(a) Note the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, as disclosable pecuniary interests;

(b) Note the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s); and

(c) Note the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at Agenda Item 2) and to note any necessary action taken by the Member(s) following such declaration(s).

3 Membership of the Committee

The Committee is recommended to note the membership and chairing arrangements for the Committee, as agreed by the London Assembly at its Annual Meeting on 13 May 2015, as follows:

Dr Onkar Sahota AM (Chair)
Andrew Boff AM (Deputy Chair)
Kit Malthouse AM MP
Murad Qureshi AM
Valerie Shawcross CBE AM

4 Terms of Reference

The Committee is recommended to note its terms of reference, as agreed by the London Assembly at its Annual Meeting on 13 May 2015, as follows:

1. To examine and report from time to time on –

- **the strategies, policies and actions of the Mayor and the Functional Bodies**
- **matters of importance to Greater London**

as they relate to the promotion of health in London.

2. To consider health matters on request from another standing committee and report its opinion to that standing committee.

3. To take into account in its deliberations the cross cutting themes of: the health of persons in Greater London; the achievement of sustainable development in the United Kingdom; climate change; and the promotion of opportunity.

4. To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

5 Standing Delegations

The Committee is recommended to note the following decisions taken by the London Assembly at its Annual Meeting on 13 May 2015, namely:

(a) That Andrew Boff AM be re-appointed as a rapporteur for the Health Committee on access to health services for d/Deaf people; and

(b) That a general authority to Chairs of all ordinary committees and sub-committees be delegated to respond on the relevant committee or sub-committee's behalf, following consultation with the lead Members of the party Groups on the committee or sub-committee, where it is consulted on issues by organisations and there is insufficient time to consider the consultation at a committee meeting.

6 Minutes (Pages 5 - 8)

The Committee is recommended to confirm the minutes of the meeting of the Committee held on 11 March 2015 to be signed by the Chair as a correct record.

7 Summary List of Actions (Pages 9 - 10)

Report of the Executive Director of Secretariat
Contact: David Pealing; david.pealing@london.gov.uk; 020 7983 5525

The Committee is recommended to note the completed and outstanding actions arising from previous meetings of the Committee.

8 Tuberculosis in London (Pages 11 - 18)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Note the recent action taken by the Chair, in consultation with the Deputy Chair, under delegated authority, namely to agree the scope and terms of reference of an investigation into tuberculosis in London, as set out in Appendix 1 to the report;

(b) Put questions to invited guests on tuberculosis in London and note the subsequent discussion;

(c) Recommend to the GLA Oversight Committee that expenditure of up to £5,000 be authorised from the Scrutiny Team's 2015/16 External Services Budget to commission a survey by an external contractor for this investigation; and

(d) Note that the Executive Director of Secretariat, in consultation with the Chair, will commission the external contractor to carry out the technical advice and support, subject to the decision above and a further decision by the GLA Oversight Committee.

9 Access to GP Care (Pages 19 - 54)

Report of the Executive Director of Secretariat
Contact: Steve Wright; scrutiny@london.gov.uk; 020 7983 4390

The Committee is recommended to note its report *Access to GP Care*, as agreed by the Chair under delegated authority, in consultation with the Deputy Chair.

The appendix to the report set out on pages 23 to 54 is attached for Members and officers only but is available from the following area of the GLA's website: www.london.gov.uk/mayor-assembly/london-assembly/health.

10 Access to Health Services for Deaf People (Pages 55 - 92)

Report of the Executive Director of Secretariat
Contact: Steve Wright; scrutiny@london.gov.uk; 020 7983 4390

The Committee is recommended to note its report *Access to health services for deaf people*, as agreed by the Chair under delegated authority, in consultation with the Deputy Chair.

The appendix to the report set out on pages 59 to 92 is attached for Members and officers only but is available from the following area of the GLA's website: www.london.gov.uk/mayor-assembly/london-assembly/health.

11 Health Committee Work Programme (Pages 93 - 94)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Agree its work programme; and

(b) Delegate authority to the Chair, in consultation with the Deputy Chair, to agree the topic, scope and terms of reference of the October meeting of the Committee.

12 Date of Next Meeting

The next meeting of the Committee is scheduled for Wednesday, 8 July 2015 at 2.00 pm in Committee Room 5, City Hall.

13 Any Other Business the Chair Considers Urgent

GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Declarations of Interests

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 24 June 2015**
This report will be considered in public	

1. Summary

1.1 This report sets out details of offices held by Assembly Members for noting as disclosable pecuniary interests and requires additional relevant declarations relating to disclosable pecuniary interests, and gifts and hospitality to be made.

2. Recommendations

2.1 **That the list of offices held by Assembly Members, as set out in the table below, be noted as disclosable pecuniary interests[1];**

2.2 **That the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s) be noted; and**

2.3 **That the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at below) and any necessary action taken by the Member(s) following such declaration(s) be noted.**

3. Issues for Consideration

3.1 Relevant offices held by Assembly Members are listed in the table overleaf:

[1] The Monitoring Officer advises that: Paragraph 10 of the Code of Conduct will only preclude a Member from participating in any matter to be considered or being considered at, for example, a meeting of the Assembly, where the Member has a direct Disclosable Pecuniary Interest in that particular matter. The effect of this is that the 'matter to be considered, or being considered' must be about the Member's interest. So, by way of example, if an Assembly Member is also a councillor of London Borough X, that Assembly Member will be precluded from participating in an Assembly meeting where the Assembly is to consider a matter about the Member's role / employment as a councillor of London Borough X; the Member will not be precluded from participating in a meeting where the Assembly is to consider a matter about an activity or decision of London Borough X.

Member	Interest
Tony Arbour AM	Member, LFEPA; Member, LB Richmond
Jennette Arnold OBE AM	Committee of the Regions
Gareth Bacon AM	Chairman of LFEPA; Chairman of the London Local Resilience Forum; Member, LB Bexley
John Biggs AM	Mayor of Tower Hamlets (LB)
Andrew Boff AM	Member, LFEPA; Congress of Local and Regional Authorities (Council of Europe)
Victoria Borwick AM MP	Member of Parliament; Member, Royal Borough of Kensington & Chelsea
James Cleverly AM MP	Member of Parliament
Tom Copley AM	Member, LFEPA
Andrew Dismore AM	Member, LFEPA
Len Duvall AM	
Roger Evans AM	Deputy Mayor; Committee of the Regions; Trust for London (Trustee)
Nicky Gavron AM	
Darren Johnson AM	Member, LFEPA
Jenny Jones AM	Member, House of Lords
Stephen Knight AM	Member, LFEPA; Member, LB Richmond
Kit Malthouse AM MP	Member of Parliament
Joanne McCartney AM	
Steve O'Connell AM	Member, LB Croydon; MOPAC Non-Executive Adviser for Neighbourhoods
Caroline Pidgeon MBE AM	
Murad Qureshi AM	Congress of Local and Regional Authorities (Council of Europe)
Dr Onkar Sahota AM	
Navin Shah AM	
Valerie Shawcross CBE AM	
Richard Tracey AM	Chairman of the London Waste and Recycling Board; Mayor's Ambassador for River Transport
Fiona Twycross AM	Member, LFEPA

[Note: LB - London Borough; LFEPA - London Fire and Emergency Planning Authority; MOPAC – Mayor's Office for Policing and Crime]

3.2 Paragraph 10 of the GLA's Code of Conduct, which reflects the relevant provisions of the Localism Act 2011, provides that:

- where an Assembly Member has a Disclosable Pecuniary Interest in any matter to be considered or being considered or at

    (i) a meeting of the Assembly and any of its committees or sub-committees; or

    (ii) any formal meeting held by the Mayor in connection with the exercise of the Authority's functions

- they must disclose that interest to the meeting (or, if it is a sensitive interest, disclose the fact that they have a sensitive interest to the meeting); and

- must not (i) participate, or participate any further, in any discussion of the matter at the meeting; or (ii) participate in any vote, or further vote, taken on the matter at the meeting

UNLESS

- they have obtained a dispensation from the GLA's Monitoring Officer (in accordance with section 2 of the Procedure for registration and declarations of interests, gifts and hospitality – Appendix 5 to the Code).

3.3 Failure to comply with the above requirements, without reasonable excuse, is a criminal offence; as is knowingly or recklessly providing information about your interests that is false or misleading.

3.4 In addition, the Monitoring Officer has advised Assembly Members to continue to apply the test that was previously applied to help determine whether a pecuniary / prejudicial interest was arising - namely, that Members rely on a reasonable estimation of whether a member of the public, with knowledge of the relevant facts, could, with justification, regard the matter as so significant that it would be likely to prejudice the Member's judgement of the public interest.

3.5 Members should then exercise their judgement as to whether or not, in view of their interests and the interests of others close to them, they should participate in any given discussions and/or decisions business of within and by the GLA. It remains the responsibility of individual Members to make further declarations about their actual or apparent interests at formal meetings noting also that a Member's failure to disclose relevant interest(s) has become a potential criminal offence.

3.6 Members are also required, where considering a matter which relates to or is likely to affect a person from whom they have received a gift or hospitality with an estimated value of at least £25 within the previous three years or from the date of election to the London Assembly, whichever is the later, to disclose the existence and nature of that interest at any meeting of the Authority which they attend at which that business is considered.

3.7 The obligation to declare any gift or hospitality at a meeting is discharged, subject to the proviso set out below, by registering gifts and hospitality received on the Authority's on-line database. The on-line database may be viewed here: http://www.london.gov.uk/mayor-assembly/gifts-and-hospitality.

3.8 If any gift or hospitality received by a Member is not set out on the on-line database at the time of the meeting, and under consideration is a matter which relates to or is likely to affect a person from whom a Member has received a gift or hospitality with an estimated value of at least £25, Members are asked to disclose these at the meeting, either at the declarations of interest agenda item or when the interest becomes apparent.

3.9 It is for Members to decide, in light of the particular circumstances, whether their receipt of a gift or hospitality, could, on a reasonable estimation of a member of the public with knowledge of the relevant facts, with justification, be regarded as so significant that it would be likely to prejudice the Member's judgement of the public interest. Where receipt of a gift or hospitality could be so regarded, the Member must exercise their judgement as to whether or not, they should participate in any given discussions and/or decisions business of within and by the GLA.

4. Legal Implications

4.1 The legal implications are as set out in the body of this report.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

Local Government (Access to Information) Act 1985 List of Background Papers: None	
Contact Officer:	David Pealing, Committee Officer
Telephone:	020 7983 5525
E-mail:	david.pealing@london.gov.uk

GREATERLONDONAUTHORITY LONDONASSEMBLY

MINUTES

Meeting: Health Committee
Date: Wednesday 11 March 2015
Time: 12.37 pm
Place: Chamber, City Hall, The Queen's Walk, London, SE1 2AA

Copies of the minutes may be found at:
www.london.gov.uk/mayor-assembly/london-assembly/health

Present:

Dr Onkar Sahota AM (Chair)
Andrew Dismore AM
Roger Evans AM
Joanne McCartney AM

1 Apologies for Absence and Chair's Announcements (Item 1)

1.1 Apologies for absence were received from Andrew Boff AM (for whom Roger Evans AM substituted), Kit Malthouse AM and Fiona Twycross AM (for whom Joanne McCartney AM substituted).

1.2 The Chair announced that since the publication of the agenda, he had received a letter from the Deputy Mayor of London, Victoria Borwick AM, informing him that the Health Committee was to be consulted on the proposed Mayor's Health Inequalities Strategy Delivery Plan refresh.

1.3 Given that the Committee was not due to meet again before the end of the proposed consultation period, the Chair announced that, should he receive a consultation document, he would use the authority delegated to him as Chair of the Committee at a meeting of the London Assembly held on 1 May 2013 to respond on the Committee's behalf, in consultation with the other party Group Lead Member, to issues it is consulted on where there is not time to do so at a meeting of the Committee. Any action the Chair may take under the authority delegated to him would be reported to the next appropriate meeting of the Committee.

2 Declarations of Interests (Item 2)

2.1 The Committee received the report of the Executive Director of Secretariat.

2.2 **Resolved:**

That the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, be noted as disclosable pecuniary interests.

3 Minutes (Item 3)

3.1 **Resolved:**

That the minutes of the meetings held on 12 January 2015 and 14 January 2015 be signed by the Chair as correct records.

4 Summary List of Actions (Item 4)

4.1 The Committee received the report of the Executive Director of Secretariat.

4.2 **Resolved:**

That the outstanding actions arising from previous meetings of the Committee be noted.

5 Health Committee Work Programme (Item 5)

5.1 The Committee received the report of the Executive Director of Secretariat.

5.2 **Resolved:**

(a) That the summary of the topics the Committee covered during 2014/15 be noted;

(b) That the Committee's priority topics for 2015/16 be agreed;

(c) That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree:

(i) the terms of reference and scope of the proposed review on communicable diseases;

(ii) the Committee's report on access to GP care; and

(iii) the rapporteur report on access to health services for d/Deaf people.

6 Date of Next Meeting (Item 6)

6.1 Subject to confirmation at the London Assembly's Annual Meeting on the 13 May 2015, the next meeting of the Committee was scheduled for Wednesday, 24 June 2015 at 10.00 am in the Chamber, City Hall.

7 Any Other Business the Chair Considers Urgent (Item 7)

7.1 There were no items of business that the Chair considered to be urgent.

8 Close of Meeting

8.1 The meeting ended at 12.40 pm.

Chair

Date

Contact Officer: David Pealing, Committee Officer
Telephone: 020 7983 5525; Email: david.pealing@london.gov.uk.

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Subject: Summary List of Actions

Report to: Health Committee

Report of: Executive Director of Secretariat | **Date: 24 June 2015**

This report will be considered in public

1. Summary

1.1 This report sets out the actions arising from previous meetings of the Committee.

2. Recommendation

2.1 **That the Committee notes the completed and outstanding actions arising from previous meetings of the Committee.**

Meeting on 11 March 2015

Minute item	Subject and action required	Status	For Action
5	**Health Committee Work Programme** That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree the Committee's report on access to GP care; and the rapporteur report on access to health services for d/Deaf people.	Completed. Further detail can be found at Item 8 (Action Taken Under Delegated Authority)	N/A
	That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree the terms of reference and scope of the proposed review on communicable diseases.	Completed. Further detail can be found at Item 9 (Tuberculosis in London)	N/A

Meeting on 14 January 2015

Minute item	Subject and action required	Status	For Action
8(a)	During the course of the discussion, the Committee heard that the following information would be provided by NHS England: • A copy of the findings from the inquiry carried out at London North West Healthcare NHS Trust showing what impact there had been from the closures of Central Middlesex and Hammersmith Hospitals' A&E departments; and • A copy of the findings from the work to be commissioned on the reasons behind the higher number of attendances at hospitals, and the higher percentage of those people presenting as more sick than in previous years, in London during the 2014/15 winter period.	In progress.	NHS England

Meeting on 3 September 2014

Minute item	Subject and action required	Status	For Action
5	Public Health England committed to provide Members with the following information: • What comparisons between London boroughs' mental health services had been made; • Any available data that might be held on how the mental health of young people in London might be affected by either: ○ Overcrowding; ○ High-rise living; ○ Temporary accommodation; and/or ○ Status as recent immigrants or refugees.	In progress.	Public Health England

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List of appendices to this report:
None

Local Government (Access to Information) Act 1985
List of Background Papers: None

Contact Officer: David Pealing, Committee Officer
Telephone: 020 7983 5525
E-mail: david.pealing@london.gov.uk

Subject: Tuberculosis in London

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 24 June 2015**
This report will be considered in public	

1. Summary

1.1 This report sets out a proposed investigation into tuberculosis (TB) in London, and asks the Committee to recommend the commissioning of external technical advice and support for the investigation.

2. Recommendations

2.1 **That the Committee notes the recent action taken by the Chair, in consultation with the Deputy Chair, under delegated authority, namely to agree the scope and terms of reference of an investigation into tuberculosis in London, as set out in Appendix 1 to this report.**

2.2 **That the Committee puts questions to invited guests on tuberculosis in London and notes the subsequent discussion.**

2.3 **That the Committee recommends to the GLA Oversight Committee that expenditure of up to £5,000 be authorised from the Scrutiny Team's 2015/16 External Services Budget to commission a survey by an external contractor for this investigation.**

2.4 **That the Committee notes that the Executive Director of Secretariat, in consultation with the Chair, will commission the external contractor to carry out the technical advice and support, subject to the decision above and a further decision by the GLA Oversight Committee.**

3. Background

3.1 The Committee has agreed to use its meetings in June and July 2015 for an investigation into TB in London. The terms of reference for this investigation are:

- To examine how the new national TB Strategy will be implemented in London; and
- To consider how the Mayor and the GLA could further support the reduction of TB in London.

3.2 On 4 March, Members of the Committee visited the TB Centre at the Whittington Hospital in preparation for the launch of an investigation into TB in London. Members toured the facilities and met with clinical and nursing staff to talk about the current challenges around managing and controlling TB in London. Members also had an opportunity to meet patients currently undergoing treatment at the centre to discuss their experiences. The visit highlighted a number of areas of focus for the Committee's forthcoming investigation.

4. Issues for Consideration

Scope of the investigation into TB in London

4.1 The paper agreed by the Chair, in consultation with the Deputy Chair, containing the proposal, scope and terms of reference for the Committee's investigation into TB in London is attached at **Appendix 1**. The Committee will use its meetings in June and July 2015 to gather information for this investigation and will seek to produce findings by October 2015.

4.2 The Committee's investigation will focus on practical steps that can be taken by the Mayor and other agencies in London to support and improve the prevention, diagnosis, and treatment of TB across London. This relates both to the Mayor's statutory duty to reduce health inequalities in London, and the acknowledgement in the national TB strategy[1] that local government has an increasingly crucial role to play in TB control. The investigation will seek to identify the particular elements of the strategy which would benefit from a pan-London strategic focus, and how the Mayoralty can further use its influence and existing policy levers to tackle TB in the capital.

Remit of the discussion

4.3 This first evidence session will set out the broad issues relating to TB prevention, diagnosis and treatment, the specific challenges around delivering the national strategy in London, and identify areas in which the Mayor and other agencies can support better control and management of TB in London.

Invited guests

4.4 The following guests have been invited to attend the discussion on TB:

- Lynn Altass, National TB Strategy Implementation Manager, NHS London;
- Yvonne Doyle, Regional Director, London, Public Health England;
- Dr Marc Lipman, Consultant Physician, Royal Free Hospital; and
- Jacqui White, Lead Nurse, North Central London TB Service.

Proposal for external survey support for the investigation into TB in London

4.5 It is proposed that the Committee's investigation should include a population-wide survey of London residents, to establish current levels of awareness of, and attitudes towards, TB as a public health issue for London. The survey will seek to examine potential attitudinal barriers to prevention and diagnosis. This will identify areas to develop communications strategies for challenging misconceptions about TB which can delay diagnosis and affect treatment outcomes.

[1] *Collaborative Tuberculosis Strategy for England,* Public Health England, January 2015.

4.6 It would not be possible to undertake this work in-house due to a lack of expertise and resources. An external contractor would have the relevant expertise and experience to design, conduct and analyse critically a properly weighted survey in order to produce findings for the Committee to pursue in its investigation.

4.7 Discussions with TB researchers in London, and a literature review of existing work, have indicated that there are few examples of population-based surveys on awareness and attitudes to TB on a city-wide level. Studies on awareness and stigma have tended to be small scale, qualitative studies, focusing on specific national or community groups. By contrast, there have been population-based (national) comparative surveys on attitudes to, and awareness, of HIV dating back to at least 2000.[2]

4.8 Undertaking a statistically representative survey will allow the Committee to gauge the level of understanding of TB at a city wide level, while also allowing for more granular analysis at borough level and within specific population groups. This could potentially inform future targeted awareness-raising activity, supporting the outcomes of the national TB strategy.

4.9 The Assembly has recently used external contractors to conduct surveys for its investigation on taxi and private hire, which worked well. This proposal has been developed in light of that experience. In summary, the external contractor would be required to:

- Design and conduct a survey of Londoners' attitudes to, and awareness of, TB;
- Set out the findings from the analysis of data in a written report; and
- Present the findings from the analysis of data to the Committee.

4.10 Subject to the Committee's approval, the GLA Oversight Committee would be asked to approve expenditure for the external work at its meeting on 30 June 2015, and the tender process would begin thereafter. The external contractor would be appointed from July 2015, with the survey conducted over the summer so findings could be produced to inform the Committee's output from the investigation in the autumn.

4.11 The Assembly's Decision Making Framework includes a requirement that all four of the following criteria be considered by committees in deciding whether external technical assistance is required and appropriate on any given project:

- That the proposed project requiring technical assistance is clearly and tightly defined. This would ordinarily mean that the consultant would be used for a discrete piece of technical analysis or research rather than simply as an adviser for the whole of a scrutiny;
- That the proposed project cannot be readily undertaken by in-house staff, either because of a lack of necessary expertise or because of a lack of capacity;
- That the analysis required from consultants is not readily available and cannot be acquired elsewhere; and
- That the information required from consultants would be a significant contribution to the aims of the scrutiny.

[2] See: www.nat.org.uk/media/files/publications/jan-2011-hiv-public-knowledge-and-attitudes.pdf

4.12 Paragraphs 4.5 to 4.9 of this report are designed to demonstrate that all four of the criteria set out in the previous paragraph have been addressed and that the proposed external support is necessary and appropriate.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 All costs arising from the appointment of an external contractor to provide technical advice and support for the Health Committee's investigation into TB in London would be met from the 2015/16 scrutiny programme budget. Subject to approval, there is provision of £5,000 for commissioning this external support during 2015/16.

6.2 The contract would be let and managed in accordance with relevant GLA policies and procedures. As this project is consultancy based, the requirements of the GLA's Expenses and Benefits Framework and the Financial Regulations would also be adhered to.

List of appendices to this report:
Appendix 1 – Scoping paper for investigation into tuberculosis in London

Local Government (Access to Information) Act 1985
List of Background Papers: Member's Delegated Authority Form 583

Contact Officer:	Lucy Brant, Assistant Scrutiny Manager
Telephone:	020 7983 5727
E-mail:	lucy.brant@london.gov.uk

Health Committee investigation

Tackling tuberculosis (TB) in London

The Health Committee is using its meetings on 24 June and 8 July to investigate tuberculosis (TB) in London. The scope and terms of reference for the investigation have been agreed by the Chair in consultation with the Deputy Chair.

Terms of reference

The proposed terms of reference for the investigation are:

- To examine how the new national TB Strategy will be implemented in London
- To consider how the Mayor and the GLA could further support the reduction of TB in London

Scope

It is proposed that the Committee's investigation focuses on practical steps that can be taken by the Mayor and other agencies in London to improve the prevention, diagnosis, and treatment of TB across London. This relates both to the Mayor's statutory duty to have regard for health inequalities in London, and the acknowledgement in the national strategy that local government has an increasingly crucial role to play in TB control. The investigation will seek to identify the particular elements of the strategy which would benefit from a pan-London strategic focus, and how the Mayoralty can further use its influence and existing policy levers to tackle TB in the capital.

Background
TB is a bacterial infection. It can affect any part of the body, but most commonly the lungs (pulmonary TB). It is an airborne disease, although transmission is most likely to occur among close contacts of an infected person. . TB is a serious condition but it can be effectively treated in most cases. However, multiple drug resistant TB is on the rise and compliance with medication is important. Early diagnosis, effective treatment and contact tracing are essential to control the spread of this disease.

TB has been identified as one of Public Health England's key priorities, and in January 2015 it launched a collaborative national strategy to address TB across England. London has among the highest incidences of TB disease of any western European city and almost forty per cent of all UK cases occur in London. In 2013 there were 2,985 cases of TB disease notified in London, compared to 2,719 new diagnoses of HIV in the same period. The World Health Organisation (WHO) defines a disease rate of 40 per 100,000 people as high. London's overall rate is 39.6 per 100,000. However, there is significant variation across the city: eleven boroughs currently exceed the 40/100,000 threshold. High incidence in London strongly correlates with areas of high deprivation.

Role of the Mayor
The link between TB and health inequality is clearly defined, with significant variation in incidence and prevalence across different boroughs and in different communities. TB experts place a strong emphasis on the need to address the social factors that contribute to London's high TB caseload, alongside clinical

interventions. This brings aspects of TB control directly into the focus of a number of Mayoral priorities and work streams beyond the health remit, including housing, diversity & social policy, planning and community relations, relating the issue directly to the Mayor's duty to have regard for health inequalities in London when developing his policies. Beyond this, the Mayoralty is ideally placed to consider the issue at a pan-London level and provide strategic leadership on efforts to tackle TB.

Focus of investigation
The Committee would seek to understand the current challenges facing authorities trying to tackle TB in their local areas and at a citywide level. This could include looking at best practice in areas that have made positive practical steps in reducing TB incidence, at a local, national and international level. The investigation would seek to identify areas in which the Mayoralty could influence and engage with other agencies and the wider public to raise awareness of TB in London as an area for sustained focus.

The Committee would seek to examine how both clinical and community-based service providers in London can be supported to deliver the national TB strategy. It will look at ways of strengthening links between key agencies on issues beyond the immediate reach of clinicians, such as raising awareness of TB as a public health issue for London, the implications for policy makers and commissioners, challenging stigma and discrimination, and engaging with hard to reach groups.

The Committee will also seek to engage with people who currently have, or have had, TB, to determine how the experience of service users can be used to achieve better outcomes for TB in London in the future.

Methodology

Members of the Committee attended a site visit to the Whittington Hospital TB Centre to meet patients and clinicians working on TB (March)

Key questions
A call for written views and evidence would be launched as part of the investigation. Key questions would include:

- Why is it important to focus on TB in London now?
- What are the main challenges for improving prevention, diagnosis and treatment of TB in London?
- Which agencies and organisations need to be involved in tackling TB?
- How can the Mayor and the GLA support the delivery of the national TB strategy in London?
- How do stigma and discrimination affect TB control in London?
- What examples of good practice are there in London (and further afield) in TB control?
- How can we engage London's communities to tackle TB?
- How can agencies work together more effectively to tackle TB in London?

Key stakeholders

The Committee would seek to engage with a broad range of stakeholders during this investigation, including:

The Mayor
TB healthcare workers
Patient representatives
London Councils/boroughs
Clinical Commissioning Groups (CCGs)
Public Health England
NHS London
Third sector/voluntary organisations supporting efforts to tackle TB
Other third sector organisations working with high-risk groups
Department of Health
Public Health England - London
Academic and research organisations
Faith/community/outreach groups

Meetings

The Committee will use its formal meetings in June and July to investigate this topic:

- The first meeting will consider, with TB clinical practitioners and Public Health England, the current landscape for TB control in London, including how the national strategy might be implemented in London.

- The second meeting, with TB peer advocates, and representatives from local authorities and the third sector, will focus on the role of the Mayor and other agencies in addressing the wider social factors which contribute to London's high rates of TB, and practical steps to increase community engagement and public awareness.

Further informal meetings and/or site visits could be arranged with key stakeholders.

Assessing public awareness and attitudes

The Committee will commission a population-wide survey of London residents, to establish current levels of awareness of, and attitudes towards, TB as a public health issue for London. The survey will seek to examine potential barriers to prevention and diagnosis, and identify areas for future targeted awareness raising and communications strategies for challenging misconceptions about TB which can delay diagnosis and affect treatment outcomes.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Access to GP Care

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 24 June 2015**
This report will be considered in public	

1. Summary

1.1 This paper sets out for noting the committee's report on access to GP care in London.

2. Recommendation

2.1 **That the Committee notes its report *Access to GP Care*, as agreed by the Chair under delegated authority, in consultation with the Deputy Chair.**

3. Background

3.1 The Committee first met in February 2014 to discuss access to GP care in London. After a further formal meeting in July 2014 and desk based research by officers, a report was drafted making recommendations based on the work the Committee had undertaken.

4. Issues for Consideration

4.1 In March 2015, the Committee delegated authority to the Chair, in consultation with the Deputy Chair, to agree the Committee's report on access to GP care. Following the Chair's agreement, the Committee published its report in March 2015.

4.2 The full report is attached for Members and officers only, but can be found on the London Assembly website at: www.london.gov.uk/mayor-assembly/london-assembly/publications/access-to-gp-care.

4.3 The report made the following recommendations:

Recommendation 1
We urge NHS England (London), in partnership with Health Education England, to commission work to evaluate the reasons for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession, and encouraged to remain. We recommend that money be set aside for this from the proposed London Transformation Fund, recommended by the London

Health Commission, to fund investment in strategic change to improve care.

Recommendation 2
NHS England (London) should conduct a wholesale review of its Information Technology Strategy in the capital, and explore how it might provide general practice with the digital capability it needs, to improve patient access and care. We recommend that the review include an evaluation of the impact of technology, on demand for GP appointments.

Recommendation 3
NHS England (London) should commission and facilitate general practice to explore and embrace alternative ways of working, to ensure inclusive patient access that meets the need of London's diverse population. These can include the adoption of alternate service models, and better use of technology, where appropriate.

Recommendation 4
The increasing demands on NHS services, including primary care, necessitate a whole-system review so that services and financial flows can be integrated. Changes to one part of the NHS system will inevitably have an impact elsewhere and could lead to unintended consequences. We recommend that NHS England (London), in its review of general practice, incorporates analysis of the impact changes to the wider primary and community care infrastructures could have, on general practice service provision.

Recommendation 5
Alongside the need to develop and increase the primary care workforce, improving existing GP premises, and investing in new ones will be essential to enable the increase in capacity needed, to cope with the demographic and service challenges faced by general practice. As the largest land owner in London, the Mayor can, through better planning, play a major role in relieving the crisis in general practice premises. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 There are no direct financial implications arising from this report.

List of appendices to this report:
Appendix 1 – *Access to GP care*

Local Government (Access to Information) Act 1985 List of Background Papers: Member's Delegated Authority Form 584	
Contact Officer:	Steve Wright, Scrutiny Team Manager
Telephone:	020 7983 4390
Email:	scrutiny@london.gov.uk

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LONDONASSEMBLY

Health Committee

Access to GP care

March 2015

Health Committee Members

Dr Onkar Sahota (Chair)	Labour
Andrew Boff (Deputy Chair)	Conservative
Andrew Dismore	Labour
Kit Malthouse	Conservative
Fiona Twycross	Labour

Role of the Health Committee

The Health Committee is tasked with reviewing health and wellbeing across London, including progress against the Mayor's Health Inequalities Strategy, and work to tackle public health issues such as obesity and alcohol misuse. The Committee will consider the Mayor's role as Chair of the new pan-London Health Board and the impact that recent health reforms are having on the capital, notably NHS reconfiguration and the decision to devolve public health responsibilities to local authorities.

Contact

Carmen Musonda, Scrutiny Manager
Email: Carmen.Musonda@london.gov.uk
Contact: 020 7983 4351

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Chair's foreword

General Practice is the core of the NHS and holds it together. As many as 90 per cent of all the consultations in the NHS are through GPs – our family doctors we know and trust. Yet in London we are seeing cracks and fractures which, if left unattended, could have disastrous results for patients and doctors.

In recent years, the number of consultations a GP performs has doubled but the number of GPs has not. This is completely unsustainable. To meet the needs of a rapidly-growing population, London needs to attract more doctors to the specialty of General Practice and retain the GPs it already has.

In England, 40 per cent of GPs are over 50 and in London almost 16 per cent of GPs are over 60 years old. With increasing demand on General Practice, many GPs are planning and taking early retirement. The smaller practices will be forced to close. Without GPs replacing those retiring, the patient lists will be dispersed, putting even more pressure on practices that are already stretched.

Progressive GP practices are embracing technology and new ways of locality-based working to improve patient access. However, more needs to be done and more can be done. We need to invest more in the premises and IT systems of General Practice, we need to develop networking between social care and healthcare, and we need to make general practice more attractive to new entrants so that they feel emotionally rewarded for their work.

Londoners expect and deserve a first class health service and General Practice is at its foundation. London is a growing city with a population of nearly nine million and a unique set of challenges. These require a co-ordinated strategic approach to new ways of working, embracing technology and ensuring that the frontline staff feel valued.

This report is not just ringing the warning bells; it also sets out some recommendations which we believe are constructive and useful in improving access to General Practice.

Social Care and Health Services need to work together, seamlessly, to ensure we have a NHS fit for the 21st Century. This is a challenge for all of us.

Dr Onkar Sahota AM MBA FRCGP
Chair of the Health Committee

1. A mandate to shift care out of the acute hospital setting

Key issues

Shifting clinically appropriate care out of acute hospital settings into the community is welcome and necessary for cost-effective use of resources. But to work effectively the shift will require integrated care pathways across the range of providers involved in patient care. General practice has a pivotal role to play in an integrated care model and in providing care in the community.

1.1 Pressure on Accident and Emergency (A&E) departments in London has reached unprecedented levels with annual attendances increasing by nearly a third over the last decade to 3.6 million.[1] In November 2013, the Committee published a report on risks to A&E services, which included an analysis of how London A&E departments had performed against the Government-set four hour waiting time target.[2] The analysis showed that in the 52 weeks leading up to November 2013 over half of London Trusts had missed the target. Since publishing our report, the landscape for A&E provision in the capital has changed, but a re-run of the analysis for the year to November 2014 shows that some London Trusts continue to struggle to meet the four hour waiting time target, and in some cases performance has deteriorated.[3] (Appendix 1)

1.2 As in the past, the Government provided additional funding to help support A&E departments through the winter months. In September 2013 departments under most pressure were earmarked to receive £500 million over a two-year period (2013/15). This funding has since been topped up by a further £300 million to provide more bed space and pay for additional clinical staff.[4] Ten London NHS trusts were included in the initial allocation, destined to receive a share of the funding totalling £55.4 million between them.[5]

1.3 Unsurprisingly, there is an increased focus in London, and nationally, to shift care from hospital settings into the community, and alongside that, broad acceptance that general practice (GP) has a pivotal role to play in providing that care. The Government's announcement last November, on increased funding to cope with winter pressures included a £25 million allocation to improve access to GP practices.[6] This is a welcome commitment in light of the findings of the Care Quality Commission monitoring report on GP

practices, which shows that 20 per cent of London GP practices fall within the two greatest perceived risk ratings.[7] Poor access to GPs or practice nurses is one of the main reasons for the negative ratings.

1.4 Several factors are necessary for an effective shift in care. There will need to be a simultaneous bolstering of primary and community care infrastructures, and the development of truly patient-centred integrated care pathways across the range of care providers. As expressed by GPs themselves, NHS England, the London Health Commission, private healthcare providers and many others, the shift can only be achieved by re-examining healthcare delivery and taking bold steps to make the changes needed. This will need to include an honest assessment of the financial investment required to bring about change.

1.5 Shifting care out of hospitals into the community is necessary, if we are to build a sustainable health service over the long-term. There are benefits to be gained, including improved health and wellbeing of patients, greater patient satisfaction and more cost-effective provision of healthcare. Research shows that mortality rates can be reduced by 45 per cent, emergency admissions by a quarter, A&E visits by 15 per cent, and bed days by 14 per cent.[8] It also shows that most people would prefer to receive treatment at home.[9]

Integrated care
A term that reflects a concern to improve patient experience and, achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.
Nuffield Trust

1.6 The recently published report by the independent London Health Commission, convened by the Mayor of London, and chaired by Lord Ara Darzi, recognised a critical need for investment in infrastructure to realise a shift of care from hospitals, and, the reorganisation of more integrated models to fit around individual patient care. It recommends establishing a transformation fund for investment in strategic change and the launch of a five-year, £1 billion capital investment in GP premises. It also recommends revenue investment to rebalance expenditure from specialised services to primary and community services, to address the past decline in spending. It says, *"There should be an increase in the proportion of expenditure on primary care each year for the next five years."*

1.7 The Committee recognises the key role general practice has to play in the shift of care out of hospitals and into the community. Statistics show that "90 per cent of patient contact with the NHS takes place in general practice."[10] At its best, general practice can provide a holistic approach to care, from prevention and diagnostics, to treating and managing illness and long-term conditions. GPs, practice nurses and other staff who provide health and care services in general practice, are quite rightly regarded as the cornerstone of the NHS. General practice needs to be proactively supported to play its part in any revision to health care delivery involving a greater focus on care in the community.

1.8 Fourteen integration pioneer models have been established across the country, four of which are in London.[11] These models were developed from pilot schemes started as part of a Department of Health two-year Integrated Care Pilot programme. The programme aimed to explore different ways of providing health and social care services to improve the health and wellbeing of elderly people, people with long-term conditions, dementia and other mental health problems, and people engaging in substance misuse.

1.9 The largest scale integrated care model in London spans eight boroughs and a population of two million people in the North West.[12] The model is designed to improve the coordination of care for people over 75 years of age, and adults living with diabetes. Establishing professional multi-disciplinary teams has played an important part in facilitating a collaborative working model, and nurturing a shared sense of purpose and objectives in patient care. Conclusions drawn from self-evaluation of the model confirm, that while the model of care has demonstrated increased staff commitment and motivation, and patient satisfaction, it has not been without difficulties. GPs particularly, have found the time commitment challenging.

Greenwich Coordinated Care Model

Open to all adults living in the borough, the model aims to assist them to maintain independence in the community and prevent unnecessary A&E attendances, hospital and care home admissions and delayed discharges. The care model has helped to prevent A&E and hospital admissions, and reduce admissions to care homes. The model, first established in April 2011 has evolved and expanded to broaden the range of integrated services provided and demographic covered.

1.10 According to National Voices, the national coalition of health and social care charities in England, the lack of availability of joined-up care is a source of frustration for patients, service users and carers. They

say: *“achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety...If executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality, innovation, prevention and productivity (QIPP) challenge in the longer term.”*

2. Addressing capacity in general practice

Key issues

As it stands, general practice in London does not have the capacity to accommodate the proposed shift of care. Its ability to continue to provide an accessible, quality service is already compromised; fuelled by, among other things, the steep rise in patient demand. London's complex demography adds to the challenge to deliver optimal care and facilitate patient flow through general practice, and this should be factored into how care is structured, and delivered in London. Any proposals for change must be underpinned by action to address current supply and demand problems in general practice.

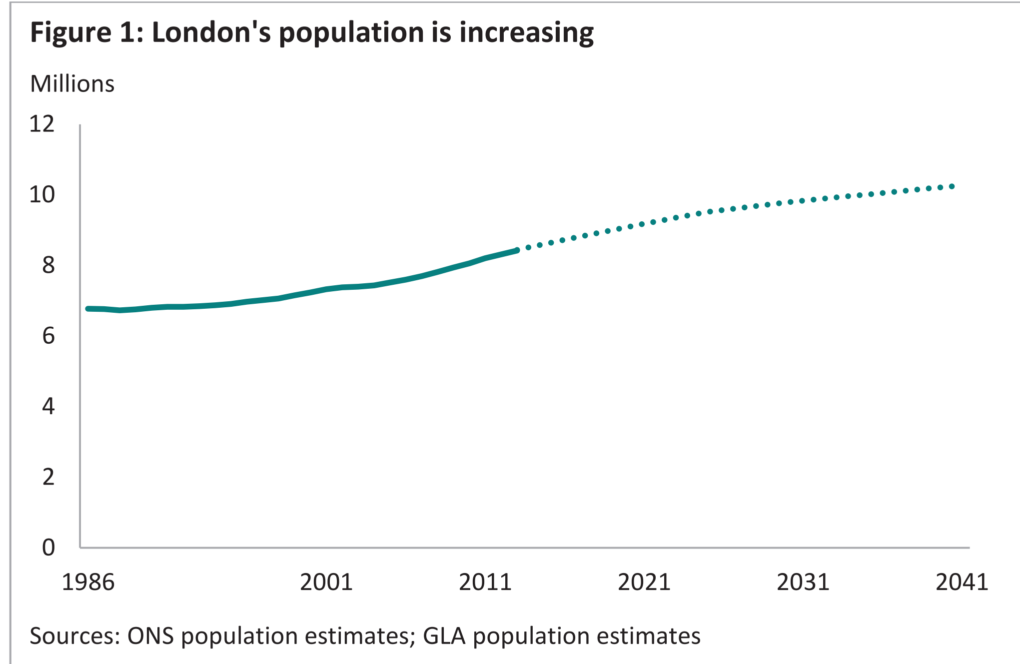
2.1 Patient demand for general practice care has increased significantly over the last decade. GPs now see 340 million patients annually, compared with 21 million who attend A&E each year.[13]

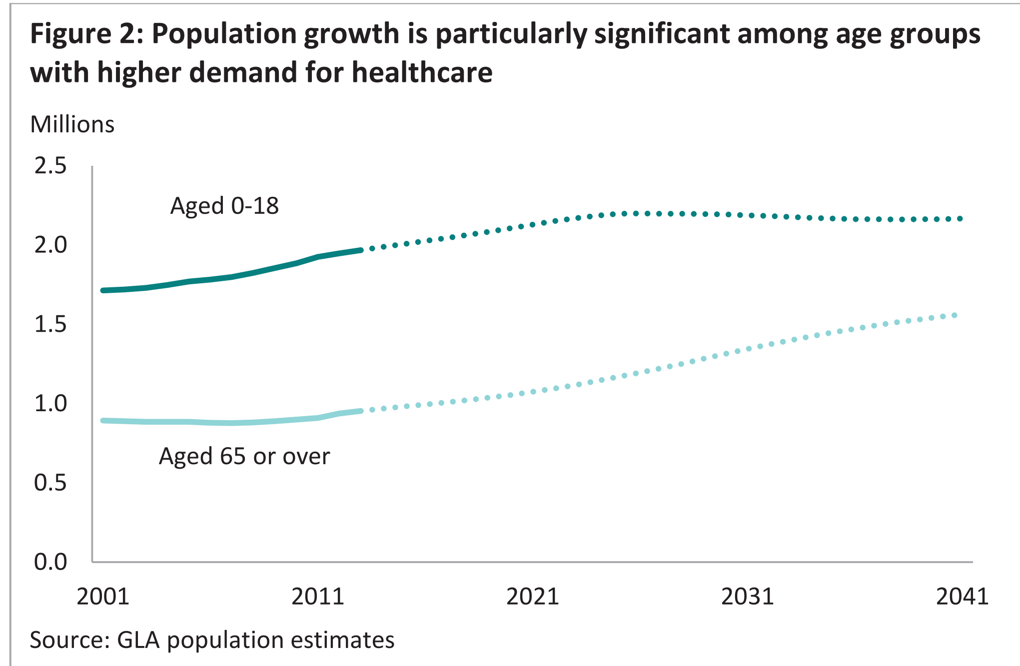
2.2 Dr Chaand Nagpaul, Chair of the British Medical Association, told the Committee that while patient consultations had doubled in London over the last decade, growth in GP capacity had not kept pace.[14] He said *"there has not been any commensurate increase in GP or nurse numbers, so there is already this issue of demand not being matched by increased capacity."*[15] The number of patients seen has risen by 40 million year-on-year.

2.3 The rise in patient demand in London is unsurprising. The capital's population has grown exponentially since the 1980s, and at a much faster rate than elsewhere in the country. In 1986 the population stood at 6.7 million, it is currently around 8.6 million, projected to increase to nine million by 2020, and ten million by 2030.[16] The most rapid growth will be seen in the number of people over 65 years – over fifty per cent in less than 25 years.[17] London's relatively young population, of around two million people aged 18 years and under, is set to increase by almost ten per cent by 2035. Both of these groups use healthcare services more intensively than any other age group.

2.4 However, the "gate keeping" role of general practice is being undermined, as patients choose to bypass their GP when accessing medical care. The indication is that general practice is progressively viewed as a chronic disease

management service, rather than one which can provide immediate and urgent care.





Meeting the needs of a complex demography

2.5 London's complex demography adds to the challenges faced by GPs, and should be factored into how care is structured and delivered, if equality of access to general practice care is to be achieved.

2.6 Language difficulties are just one of a range of factors contributing to the increased complexity of GP consultations. Census data suggests that over 300 languages are spoken in the capital, more than 300,000 people cannot speak English, and nearly 1.7 million do not have English as their first language.[18] Language barriers, and the need for the use of interpreters, make patient-clinician consultations more complex.

2.7 A growing older population with greater, multiple morbidities, adds to the challenge. Projections show a doubling in the number of patients between 2009 and 2018, and data suggests that 50 per cent of GP consultation time relates to patients with long-term conditions. The ten minute consultation time allotted for such patients is not sufficient to deal with their problems, leading to further reduced capacity to meet the needs of patients requiring immediate or urgent care.

2.8 A highly transient population, with an estimated 10 per cent of households moving home each year, brings its own challenges and can disrupt continuity of care.

2.9 Some communities are at greater risk of certain illnesses: for example, the high and early prevalence of diabetes in the south Asian community. With some 40 per cent of Londoners coming from Black Asian and Minority Ethnic (BAME) backgrounds, managing high risk illnesses and the consequent challenges can demand protracted consultation time.

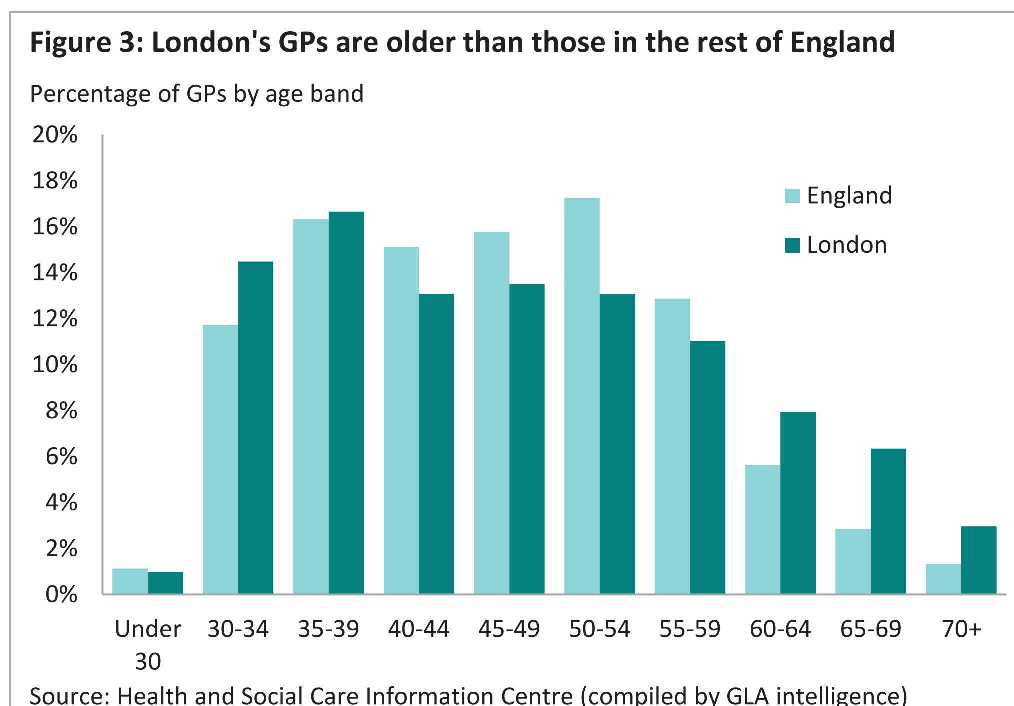
2.10 A Department of Health study was clear that solutions to better access for BAME individuals will need to embody the provision of a flexible, personalised model of care, as part of mainstream healthcare. The findings suggest more flexibility in patient consultation times where appropriate. It says *"Many patients say they feel the GP is pushed for time and rushes investigation into their condition. This points to a need for a more flexible appointment process, that can accommodate longer consultations, for those with complex and multiple issues or other needs such as advocacy or language support."* [19] The growing imbalance in the equation of supply and demand over the years has served to intensify GPs' struggle to provide the flexibility needed. According to Dr Nagpaul, GPs *"are not able to provide patients with, not just the appointments, but the time they need."*

Workforce issues

2.11 There is a national shortage of GPs. By 2021, around 16,000 more GPs will be needed than are currently available.[20] Almost 16 per cent of London GPs are over 60 years old, compared with 10 per cent nationally. The percentage of

GPs over 60 is typically higher in areas where there are many single-handed practices, which according to NHS England, also tend to be areas of greater deprivation.

Figure 3: London's GPs are older than those in the rest of England



Source: Health and Social Care Information Centre (compiled by GLA intelligence)

2.12 Many GPs are taking early retirement, and General Medical Council (GMC) figures suggest that growing numbers of them are considering emigrating. Applications to the GMC for Certificates of Good Standing (CGS), a document which enables GPs to register with an overseas regulatory body or employer, have risen by over 12 per cent since 2008. A total of 4,741 UK-trained doctors obtained CGSs in 2013.[21]

2.13 GP practices are failing to recruit partners. Vacancy rates have quadrupled in the past two years, and as many as one position in 12 is unfilled nationally.[22] Anecdotal evidence suggests a growing reluctance to take on the liability of owning a practice, employing the staff, and the extra work that comes with being an employer, along with the workload demands.[23] Young doctors are opting for salaried or locum positions.[24]

2.14 There is a case for NHS England (London) to consider developing a salaried GP service in London to extend the provision of service where needed, and to facilitate a career choice which newly qualified GPs are increasingly making. The workforce in general practice has seen a noticeable shift towards increasing numbers of salaried GPs, since the turn of the century. There was a 12-fold increase in salaried GPs nationally between 2000 and 2010.[25]

Practices also experienced increases in locum fees over the same period, averaging 9.5 per cent in 2012.[26] The rise in locum positions has implications for care continuity and quality, and for the long-term stability of GP care provision.

2.15 There is also a need to attract new talent. In 2013, there was an increase of 95 medical graduates starting a GP placement in England, bringing the total to 2,764. But there is still a large shortfall before the Government's target to train 3,250 new GPs a year is met; this is the quantity needed to sustain supply and demand. The British Medical Association's General Practice Committee says the shortfall is unsurprising given the crisis in recruitment and retention of GPs across the UK. It has called for urgent action to address issues of workload and demand on practices, to make the profession more attractive to junior doctors.[27] Anecdotal evidence suggests that student and foundation year doctors are not generally considering general practice as a career option, and when they do, they are opting to practice abroad.

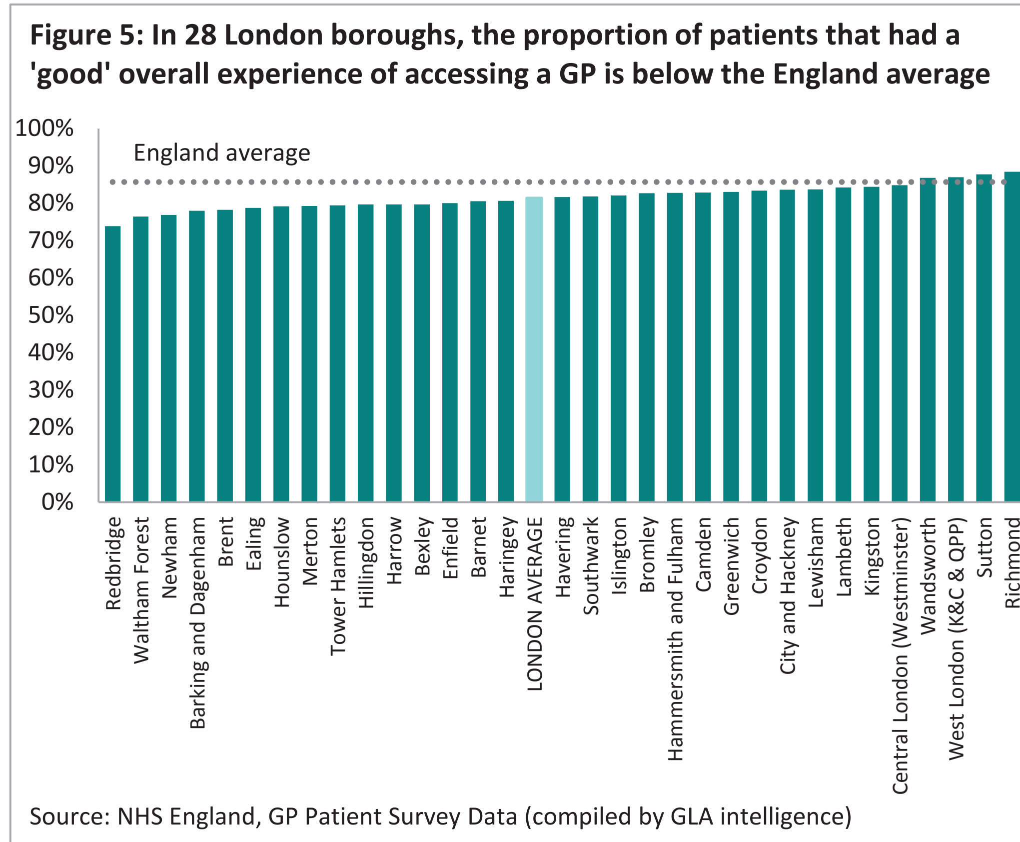
Figure 4: The number of GPs joining the profession in England is below the Government's target

Source: NHS England, GP Patient Survey Data (compiled by GLA intelligence)

2.16 If erosion of quality care and patient confidence is to be avoided over the longer-term, the supply and demand problem currently facing general practice must be addressed, alongside any proposals for service change. Understanding the drivers for early departure from the profession, and underlying reasons for the apparent reluctance to enter general practice, should be a first step towards a wholesale drive to addressing the recruitment and retention dilemma it faces. We would urge NHS England (London), in

partnership with Health Education England, to commission work to evaluate the drivers for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession.

Figure 5: In 28 London boroughs, the proportion of patients that had a 'good' overall experience of accessing a GP is below the England average



Source: NHS England, GP Patient Survey Data (compiled by GLA intelligence)

2.17 We accept that this research will require yet more outlay from what is already a constrained budget, but believe it to be a necessary short-term expense to generate long-term gain. The London Health Commission has recommended that a London Transformation Fund, jointly managed by NHS England (London) and the Clinical Commissioning Groups, be set up to fund investment in strategic change to improve care. Money from this fund could be set aside for research.

Recommendation 1

We urge NHS England (London), in partnership with Health Education England, to commission work to evaluate the reasons for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession, and encouraged to remain. We recommend that money be set aside for this from the proposed London Transformation Fund, recommended by the London Health Commission, to fund investment in strategic change to improve care.

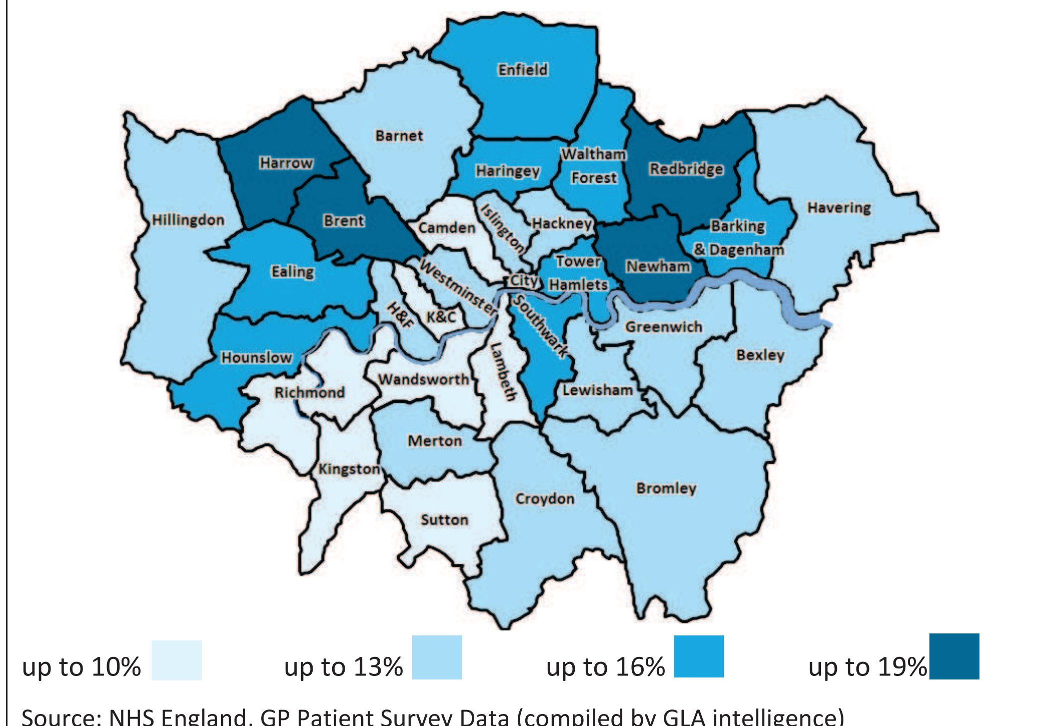
3. Addressing infrastructure and financial challenges

Key issues

There are signs that general practice is embracing technology and exploring new ways of working to better accommodate and improve access for their patients. But wholesale realisation of digital capability is slow. Ongoing financial constraints and wider infrastructure challenges add to the pressures felt by GPs. Moves to strengthen the wider primary and community care infrastructures, must underpin any shift in care to general practice, with an honest recognition of the limitations to what can be achieved.

3.1 There is a declining trend in satisfaction with GP services in London. Compared with other regions, patients in London tend to be less satisfied with access to care and the quality of care they receive. Of the bottom 30 boroughs in England for seeing a GP of choice, 22 are in London; 18 per cent of patients are unable to get an appointment in London, compared with 11 per cent nationally.

Figure 6: Percentage number of people waiting too long to see a doctor



Source: NHS England, GP Patient Survey Data (compiled by GLA intelligence)

Maximising digital capability

3.2 Digital capability could dramatically improve patient access. Dr Robinson, Medical Director INPS, told us: *"It is not that they (the technologies) do not exist. It is the uptake that is the issue. Less than half of practices offer online services to book appointments or order repeat prescriptions, and only three per cent offer online access to patient records."* The inability to contact practices through digital channels is compromising access, particularly for the young. One third of London's population is under 24 years old.

3.3 One third of patients responding to the NHS GP Patient survey said that they would like to use the internet to book appointments and request prescriptions, but only one per cent report that they are able to do so.[28] A representative from the local Camden Healthwatch also told the Committee *"there is a general sense among patients that there are some pretty basic level technological things that can be done that do not take a huge amount of investment."* Examples included being able to text the surgery to confirm that an appointment is no longer required, or to email basic enquiries, rather than calling or attending the surgery.

The telephone triage system
Evidence presented to the Committee demonstrated a smoother patient flow, following the adoption of the GP Access telephone appointment triage model, and reductions in the number of failed GP appointments and A&E attendances. Despite the positive outcomes evident from the telephone appointment triage model, it will be best suited to multiple partner practices, and is not something that can be universally applied.

3.4 Various models and examples of how technology can help improve access are being trialled and range from being able to book, cancel or check an appointment, to viewing medical records and ordering repeat prescriptions, and engaging in an email or video-style consultation.

3.5 In an age of advanced technology it is clear that more needs to be done to digitally enable GP practices. But there are limitations. Digital access may work well for younger and technology-confident patients, but may not necessarily prove attractive to older patients, whom, NHS England confirms, are typically the greater users of health services. Digital access could also exclude patients from deprived communities, who may not have online access, and who typically have higher representation from BAME groups.

3.6 GPs have also expressed concerns relating to information management and governance. They cited the confidentiality risks of email communication, and digital incompatibility across the multiple systems currently in use, including EMIS Web, TPP Systm1 and Vision AEROS.

3.7 Furthermore, while digital access may reduce the need for face-to-face consultations, these will only be suitable for a limited range of patient consultations. An evaluation of the impact of technology on demand for GP appointments will be needed. Enabling digital capability should be integral to NHS England (London)'s current review and developing programme to transform primary care in the capital.

Recommendation 2

NHS England (London) should conduct a wholesale review of its Information Technology Strategy in the capital, and explore how it might provide general practice with the digital capability it needs, to improve patient access and care. We recommend that the review include an evaluation of the impact of technology, on demand for GP appointments.

Developing GP networks

3.8 The trend towards collaborative working through networks, mergers, or federations of GP practices is encouraged by NHS England (London). London has a high proportion of single-handed GP practices - one in five, compared with one in seven, nationally.[29] Their premises tend to be smaller, and this can limit the potential to improve the service offer. The Committee recognises that collaborative models, such as GP networks could allow for more efficient use of finite resources, broaden the service offer, and reduce the professional isolation that can occur. But as highlighted by the London Health Commission, financial investment is needed to develop new ways of working. Space also needs to be created for training and supporting affected GP practices in the interim.

3.9 Striking evidence presented to the Committee during its review of diabetes care in London, and briefing on out-of-hospital care, demonstrated the benefits of collaboration for both patient and service provider. GP consortiums in Tower Hamlets formed around the delivery of diabetes health care[30] and integrated care programmes in Greenwich and Islington[31] have resulted in improved prognosis for diabetes sufferers, and reduced A&E admissions, respectively.

Recommendation 3

NHS England (London) should commission and facilitate general practice to explore and embrace alternative ways of working to ensure inclusive patient access that meets the need of London's diverse population. These can include the adoption of alternate service models and better use of technology where appropriate.

Strengthening primary and community care infrastructure

3.10 GPs provide care as part of a wider community team that includes community nurses and support staff, local authority-managed community care services, health centres, pharmacists and other specialists. The pressures of managing increases in demand for services, experienced by general practice are replicated across these other community support teams. As previously mentioned, these services are already dealing with increased workloads to cope with the challenges presented by managing long-term chronic diseases, a diverse population, and complex medical conditions. They too are seeing reductions in their workforce and to the quality and level of service they are able to offer. For example, the loss of nursing and residential home providers: 85 were lost in London during the year March 2012 to 2013.

3.11 Patients and professionals alike are confused about where and how to access care and support. Dr Michelle Drage, Chair of the London-wide Local Medical Committees, told us: "*We have totally lost the space between hospitals and general practice, the community support services, the district nurses have been decimated, and health visitors are virtually no more. Social services which used to work together in a co-ordinated …integrated way with us and with those other providers, mental health services are all fragmented. They are all reduced. General practice has nowhere for those patients to go, so as well as hospitals being perceived to be overwhelmed, actually what is happening is we are getting it from both sides.* [There is]...*a lack of places to refer patients to in the communities.*"[32]

Re-thinking funding

3.12 It is widely accepted that general practice is chronically under-funded. Funding has declined in real terms over the last decade, and is, according to the Royal College of General Practitioners (RCGP), beginning to affect patient experience. Primary care receives eight per cent of the budget, while providing 90 per cent of NHS activity.[33] RCGP estimates that at least 10 per cent of the NHS budget will be needed to maintain primary care provision; a proportion of spend not seen for almost a decade.

3.13 The transfer of care out of the acute hospital setting must go hand-in-hand with financial investment: to provide the clinicians and infrastructure needed and to effectively deliver care in the community. The Committee believes that the London Health Commission's call for an increase in the proportion of expenditure on primary care in London for the next five years is a sensible one. The key consideration must be how to make better use of available resources to ensure that primary care receives the level of funding it needs. However, this re-distribution must be carefully considered, given the context of limited resources.

3.14 The Better Care Fund, due to come on-stream in the next financial year, is a shift in the right direction. Its underlying principles and aspirations are commendable, although some doubts have been expressed surrounding the lack of new money. This single, pooled budget for health and social care services presents an opportunity to build on the progress already made towards developing integrated care models. The Fund should help develop closer working relationships locally, built around a joint ownership of an agreed plan, between local authority health and wellbeing boards and clinical commissioning groups (CCGs). A joint plan should help address the increased demands on healthcare as the population ages and the number of people with long-term conditions rises. In London, the latter account for more than 50 per cent of all GP appointments, 65 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.

The Better Care Fund
The £3.8 billion Better Care Fund (BCF), formerly the Integration Transformation Fund, was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The BCF creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. It is a critical part of the NHS two-year operational plans and the five-year strategic plans as well as local government planning.

3.15 Funding for the Better Care Fund will be sourced jointly from existing CCG allocations, and NHS money transferred to social care budgets. For most CCGs, investing in the Better Care Fund will involve redeployment of their resources. This could place additional pressures on providers already faced with the challenge of how to maintain and improve quality of care while

achieving financial balance. This is a discussion yet to play out fully in the lead up to implementation.

3.16 While it is acknowledged that the concept of a pooled fund has helped galvanise helpful conversations between local councils and NHS partners, serious concerns have been expressed about its long-term viability and whether it provides sufficient funding to address the cost of the service changes needed to reduce hospital admissions.[34] National guidance is clear that bringing the Fund online will entail a substantial shift of activity and resource from hospitals to the community, and should result in a 15 per cent reduction in hospital emergency admissions. Therecent National Audit Office report also raises concerns that planning for the BCF is based on *"optimism rather than evidence"*.[35]

Shared funding streams

3.17 There is strong evidence that there are financial savings to be realised from better use of out-of-hospital care, including GP care. Benefits can include reduced A&E usage and length of in-hospital stay, and savings through avoided admissions, or re-admissions to hospital.[36] The RCGP estimates that the cost per patient, for an entire year through general practice, is equivalent to the cost of only ten per cent of one day's stay in hospital.

3.18 But clinicians and managers are of the view that, as long as the funding streams for hospital and community care are handled separately, and the incentives for the preferred outcomes remain misaligned, neither system will be able to function properly. Practical experience has shown that getting the resources to follow the patients (particularly out of the acute care setting to the hospital) is difficult, and the amount of cash transfer is, in reality, minimal. The current tariff system is a key barrier as it does not incentivise Trusts to consider treatment settings other than traditional in-patient care.

Recommendation 4

The increasing demands on NHS services, including primary care, necessitate a whole-system review so that services and financial flows can be integrated. Changes to one part of the NHS system will inevitably have an impact elsewhere and could lead to unintended consequences. We recommend that NHS England (London), in its review of general practice, incorporates analysis of the impact that changes to the wider primary and community care infrastructures could have on general practice service provision.

A multi-faceted approach to improving general practice

3.19 Any attempts to address the intense pressures faced by general practice in London will require a multi-faceted approach to: manage the increasing demand on services; effectively operate within current financial constraints; and tackle the wider infrastructure challenges raised previously.

3.20 The Government's recruitment drive for GPs must gain impetus nationally, but particularly in London. We cannot get away from the fact that increasing capacity in general practice, to cope with the challenges it faces, will require the recruitment and skilling-up of more personnel. Similar recruitment drives will be needed at London-level for community nurses and other essential primary care staff. The Commission's findings point to a *"ticking time bomb"* in respect of London's primary care workforce, noting that a large proportion (of GPs, midwives, and community nurses) are due to retire. Twice as many London GPs are aged 60 or over, than elsewhere in England – 15 per cent versus 8 per cent.

3.21 We spoke earlier of, and recognise the need to further explore, the London Health Commission's call for £1 billion capital investment in GP premises. We also recognise the need for increased revenue investment as a proportion of total NHS spend in London. Equally important is an holistic approach to NHS estate planning.

3.22 Of the 1240 GP premises across London, over 160 of them are in either a *"poor"*, *"very poor"* or *"terrible"*[37] state and in need of significant refurbishment, or a complete rebuild. Over half will require renovation to bring them to an acceptable standard. Around 500 premises do not meet disability access requirements, and need adjustment. The London Health Commission estimates that around 60 per cent of the primary care estate is not fit for purpose.

3.23 Closing the gap in strategic capital planning and links to service planning, also highlighted in the Commission's report, will be essential. It says, *"The capital regime and estates planning have long languished in the 'too difficult' category. Fundamental reform has not taken place and, as a result, patients and their care have suffered, with services frequently being delivered in buildings and facilities which would shame any other city with global ambitions to offer its citizens the best quality of life and care of anywhere in the world".*

3.24 In addition to improving existing GP premises, it will also be necessary to look at whether new GP surgeries need to be opened, and in which areas, to meet

demand. In particular, the NHS needs to consider playing a more active role in London's planning system, to ensure that new GP surgeries, and other primary care facilities are provided, whenever new housing developments are proposed.

3.25 The phasing out of MPIG[38] may remove the incentive of opening a practice in more deprived areas. In some cases it may render the practice economically unsupportable. Changes to the funding scheme must be monitored to ensure that, if necessary, funding is equitably distributed to support and encourage practices in deprived areas.

3.26 The NHS should also work closely with London Boroughs to ensure that health facilities benefit from the community infrastructure levy,[39] and section 106 funding."

3.27 As the largest land owner in London, the Mayor can, through better planning, play a major role in the crisis in general practice premises. Precedents have been set, with both the Metropolitan Police Estate, and the London Fire Brigade. The Metropolitan Police now has an estate strategy setting out a proposed overhaul, and reduction in running costs of the estate. The Fire Brigade has reviewed its estate, and used the information from the review to prioritise property improvements. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Recommendation 5

Alongside the need to develop and increase the primary care workforce, improving existing GP premises, and investing in new ones will be essential to enable the increase in capacity needed, to cope with the demographic and service challenges faced by general practice. As the largest land owner in London, the Mayor can, through better planning, play a major role in relieving the crisis in general practice premises. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Appendix 1 – Trust performance against waiting target

Table 1 **Number of weeks out of the last 52 (to November 2014) in which 95 per cent under four-hour waiting target was missed by London Trusts with Type 1 A&E departments** *(excluding North West London Hospitals NHS Trust and London North West Healthcare NHS Trust)*

London NHS Trust with Type 1 A&E department	Number of weeks of last 52 reported	Number of weeks of last 52 in which the target was missed	Total patients dealt with within four hours over last year
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	52	52	85.5%
BARTS HEALTH NHS TRUST	52	34	94.3%
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	52	7	97.0%
CROYDON HEALTH SERVICES NHS TRUST	52	23	95.0%
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	52	8	96.2%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	52	3	96.5%
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	52	11	95.8%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	52	15	95.2%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	52	52	89.2%
KINGSTON HOSPITAL NHS FOUNDATION TRUST	52	15	95.5%
LEWISHAM AND GREENWICH NHS TRUST	52	51	89.1%

NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	52	23	95.1%
ROYAL FREE LONDON NHS FOUNDATION TRUST	52	10	95.7%
ST GEORGE'S HEALTHCARE NHS TRUST	52	30	94.4%
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	52	20	95.4%
THE WHITTINGTON HOSPITAL NHS TRUST	52	17	95.5%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	52	25	94.7%

Source: NHS England, Weekly SitReps

Table 2 Number of weeks out of the last 52 (to November 2014) in which 95 per cent under four-hour waiting target was missed by London Trusts with Type 1 A&E departments *(showing North West London Hospitals NHS Trust and London North West Healthcare NHS Trust only)*

London NHS Trust with Type 1 A&E department	Number of weeks of last 52 reported	Number of weeks of last 52 in which the target was missed	Total patients dealt with within four hours over last year
NORTH WEST LONDON HOSPITALS NHS TRUST	43	43	84.0%
LONDON NORTH WEST HEALTHCARE NHS TRUST	9	9	88.6%

Source: NHS England, Weekly SitReps

Appendix 2 – Recommendations

Recommendation 1

We urge NHS England (London), in partnership with Health Education England, to commission work to evaluate the reasons for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession, and encouraged to remain. We recommend that money be set aside for this from the proposed London Transformation Fund, recommended by the London Health Commission, to fund investment in strategic change to improve care.

Recommendation 2

NHS England (London) should conduct a wholesale review of its Information Technology Strategy in the capital, and explore how it might provide general practice with the digital capability it needs, to improve patient access and care. We recommend that the review include an evaluation of the impact of technology, on demand for GP appointments.

Recommendation 3

NHS England (London) should commission and facilitate general practice to explore and embrace alternative ways of working, to ensure inclusive patient access that meets the need of London's diverse population. These can include the adoption of alternate service models, and better use of technology, where appropriate.

Recommendation 4

The increasing demands on NHS services, including primary care, necessitate a whole-system review so that services and financial flows can be integrated. Changes to one part of the NHS system will inevitably have an impact elsewhere and could lead to unintended consequences. We recommend that NHS England (London), in its review of general practice, incorporates analysis of the impact changes to the wider primary and community care infrastructures could have, on general practice service provision.

Recommendation 5

Alongside the need to develop and increase the primary care workforce, improving existing GP premises, and investing in new ones will be essential to

enable the increase in capacity needed, to cope with the demographic and service challenges faced by general practice. As the largest land owner in London, the Mayor can, through better planning, play a major role in relieving the crisis in general practice premises. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Appendix 3 – Endnotes

[1] British Journal of General Practice (Committee report, Risks to A&E services this winter, November 2013, p6)
[2] The Government has set an operational standard of 95 per cent for patients being seen and discharged within four hours and uses this target to help ensure patients are treated quickly. This operational standard is designed to deliver patients' rights under the NHS Constitution.
[3] For example, Chelsea & Westminster Hospital NHS Foundation Trust consistently met the target to November 2013, but in the current year missed it on 7 out of the 52 weeks; Kings College Hospital NHS Foundation Trust has consistently missed the target during the current year, but previously missed it 32 out of 52 weeks. Lewisham & Greenwich NHS Trust missed the target 51 out of 52 weeks, but previously 26 out of 52 weeks; St George's Healthcare NHS Trust missed the target 30 out of 52 weeks to November 2014, but previously missed it 25 out of 52 weeks.
[4] Department of Health announcement on 14 November 2014
[5] Press release dated 10 September 2013. The Trusts are Barking, Havering & Redbridge University Hospitals Trusts £7,000,000; Barnet & Chase Farm Hospitals NHS Trusts £5,120,000; London Barts Health NHS Trust £12,800,000; Croydon Health Services NHS Trust £4,500,000; Ealing Hospital NHS Trust £2,900,000; North Middlesex University Hospital Trust £3,800,000; North West London Hospitals Trust £6,400,000; South London Healthcare NHS Trust £7,700,000; Whittington Health NHS Trust £2,960,000 and West Middlesex University Hospital NHS Trust £2,300,000.
[6] Department of Health announcement on 14 November 2014
[7] The Care Quality Commission monitoring system uses 38 different indicators to determine the perceived risk of each practice in England. Each practice receives a risk rating from one to six, with one being the greatest perceived risk and six the lowest.
[8] Whole System Demonstrator Programme: Headline Findings, The Department of Health, December 2011
[9] Bupa satisfaction survey 2013 Reasons cited include: convenience and an opportunity to be with their loved ones at some of the more emotionally distressing times of their lives.
[10] Transforming Primary Care in London: General Practice a call to action, NHS England London, November 2013
[11] North West London, Greenwich, Kingston, WELC care collaborative (Waltham Forest, East London and City)
[12] Two Integrated Care Pilots were established in North West London. The first, established in July 2011, to cover the boroughs of Westminster, Kensington & Chelsea, Hammersmith & Fulham and Hounslow; the second, to cover the boroughs of Brent, Ealing, Harrow and Hillingdon, was mobilised from summer 2012.
[13] RCGP data requoted by Dr Chaand Nagpaul at the Committee meeting on 8 July 2014 (p2 Transcript)
[14] Drs Michelle Drage, Chief Executive, Londonwide Local Medical Committees, and Clare Gerada RCGP, 6 February meeting (p3&4 Transcript)
[15] Transcript of 8 July meeting, p2
[16] GLA Intelligence analysis of 2011 Census data; 2013
[17] From 910,000 in 2011 to 1.5 million in 2035; Population Projection Round 2013; GLA Intelligence.
[18] Census 2011; Office for National Statistics.

[19] No patient left behind: how can we ensure world class primary care for black and ethnic minority people? Department of Health, May 2008.
[20] RGCP releases dated July 2013 and February 2015.
[21] Pulse Today, online medical journal article, July 2014
[22] Pulse Today online medical journal article. Figures correct at February 2013
[23] See articles: Pulse Today February 2013, and August 2014; Guardian May 2013, and October 2013
[24] Pulse Today, August 2014
[25] From 555 in 2000 to 6962 full time equivalents in 2010
[26] Pulse Today, February 2013
[27] Pulse Today article, May 2014
[28] GP Patient survey
[29] Based on 2011 data, single-handed GP practices make up 19.9 per cent of all practices in London, compared with 13.8 per cent nationally. General Practice in London: Supporting improvements in Quality, The Kings Fund, 2012
[30] Transcript of Health Committee meeting, dated 25 November 2013
[31] Transcript of Health Committee meeting dated 22 January 2013
[32] Transcript of the Health Committee, dated 6 February 2014
[33] NHS England (London), Transforming primary care in London
[34] The Better Care Fund: will the plans work? The Kings Fund, November 2014
[35] The National Audit Office published its highly critical report – *Planning for the Better Care Fund* – in November 2014
[36] Turning a vision into reality: a practical guide to moving care out of hospital BUPA, November 2011
[37] Categorisation as per the London Health Commission report, see the supporting technical pack, *Unlocking the value of NHS estates in London*, October 2014.
[38] The Minimum Practice Income Guarantee (MPIG) was introduced as a measure to protect the previous income levels of general practice and smooth the transition between the old and the new contracts, following the national contract changes in 2004. The MPIG has been in payment for 10 years.
[39] The community infrastructure levy is a levy that local authorities in England and Wales can choose to charge on new developments in their area. It is designed to be fairer, faster and more transparent than the previous system of agreeing planning obligations between local councils and developers under section 106 of the Town and Country Planning Act 1990.

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Chinese

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Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Bengali

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Greek

Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں
درکار ہو تو، براہ کرم نمبر پر فون کریں
یا مذکورہ بالا ڈاک کے پتے یا ای میل
پتے پر ہم سے رابطہ کریں۔

Turkish

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Arabic

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فرجاء الاتصال برقم الهاتف أو الاتصال على
العنوان البريدي العادي أو عنوان البريد
الإلكتروني أعلاه.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં જોઈતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો અથવા ઉપર આપેલ ટપાલ અથવા ઈ-મેઈલ સરનામા પર અમારો સંપર્ક કરો.

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Subject: Access to Health Services for Deaf People	
Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 24 June 2015**
This report will be considered in public	

1. Summary

1.1 This paper sets out for noting the committee's report on access to health services for deaf people.

2. Recommendation

2.1 **That the Committee notes its report *Access to health services for deaf people*, as agreed by the Chair under delegated authority, in consultation with the Deputy Chair.**

3. Background

3.1 At its meeting on 6 March 2014, the Committee agreed to recommend to the GLA Oversight Committee that Andrew Boff AM be appointed as a rapporteur to carry out a review of access to health services for d/Deaf people. The GLA Oversight Committee agreed the appointment on 12 March 2014, and his continued appointment was agreed at the Annual Meeting of the Assembly on 14 May 2014.

3.2 The Committee had also agreed to delegate authority to the Chair to agree the terms of reference and the scope of the review, in consultation with the Deputy Chair. The full proposal for the review, including the terms of reference, scope and methodology was considered by the Committee at its meeting on 4 June 2014. It included the following terms of reference:

To review access to health services for d/Deaf people to:

- Identify key elements of an accessible health service model for d/Deaf people;
- Explore the challenges health service providers face in improving access for d/Deaf people, and how they might be overcome;
- Explore what levers the Mayor could employ to promote and support improved access to health services for d/Deaf people; and
- Recommend practical changes that can be made towards making health service provision more accessible to d/Deaf people.

3.3 The rapporteur held meetings with stakeholders, hosted seminars and undertook site visits in order to gather evidence for the report. The report was launched at City Hall on 9 June 2015 along with representatives from the British Deaf Association and Action on Hearing Loss.

4. Issues for Consideration

4.1 In March 2015, the Committee delegated authority to the Chair, in consultation with the Deputy Chair, to agree the Committee's report on access to health services for deaf people. Following the Chair's agreement, in June 2015, the Committee published its report.

4.2 Officers confirm that the report and its recommendations fall within the terms of reference.

4.3 The full report is attached for Members and officers only, but can be found on the London Assembly website at: www.london.gov.uk/mayor-assembly/london-assembly/publications/access-to-health-services-for-deaf-people.

4.4 The report made the following recommendations:

Recommendation 1
Data on hearing disability should be routinely collected and compiled. We recommend that NHS England London take lead responsibility for this, and that it explore with key stakeholders, such as the British Deaf Association, Action on Hearing Loss, and the National Deaf Children's Society, how this might best be done.

Recommendation 2
The earlier work on prevalence data by Adrian Davis et al (1995) should be updated at the earliest opportunity, and is a task that could reasonably be undertaken or sponsored by the Knowledge and Intelligence arm of Public Health England.

Recommendation 3
The NHS England London Clinical Senate Patient and Public Voice Group should lead on initial work to develop an Equality and Diversity Monitoring template that will allow health service providers to gather more specific information on hearing impairments.

Recommendation 4
Local Clinical Commissioning Groups should consider jointly commissioning communication support services to deaf patients to improve the level and standard of these services, achieve economies of scale and stimulate a more competitive market.

Recommendation 5
We recommend a universal minimum standard for BSL interpreting support provided in healthcare settings. Work to determine the appropriate standard to be applied should be led by NHS England working in partnership with the National Registers for Communication Professionals working with Deaf and Deafblind People and other key deaf support organisation such as the British Deaf Association and Signature.

Recommendation 6
NHS England must commission a review of advocacy services for deaf people. As part of this, NHS England must establish whether local authorities are fulfilling their responsibility to commission advocacy services under the Health and Social Care Act 2012.

Recommendation 7
We recommend that London GPs and NHS Trusts review the accessibility of information on their complaints process for deaf patients, with a view to providing a direct link on the home page of their websites. They should also provide alternative formats of this information, which should include an 'easy read' format.

Recommendation 8
When local Clinical Commissioning Groups commission communication support services for deaf patients – either jointly (as per recommendation 4) or individually – they should ensure those services include appropriate means of supporting deaf people through whatever complaints processes they need to navigate. NHS England London should provide guidance on what those 'appropriate means' might involve.

Recommendation 9
NHS England London should work with London GPs and hospitals to develop a universal standard for access to health services for deaf people, and draw up a plan to share the good practice that is already happening across London.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 There are no direct financial implications arising from this report.

List of appendices to this report:
Appendix 1 – *Access to health services for deaf people*

Local Government (Access to Information) Act 1985	
List of Background Papers: Member's Delegated Authority Form 585	
Contact Officer:	Steve Wright, Scrutiny Team Manager
Telephone:	020 7983 4390
Email:	scrutiny@london.gov.uk

LONDONASSEMBLY

Health Committee

Access to health services for deaf people

June 2015

Health Committee Members

Onkar Sahota (Chair)	Labour
Andrew Boff (Deputy Chair and Rapporteur)	Conservative
Kit Malthouse MP	Conservative
Murad Qureshi	Labour
Valerie Shawcross CBE	Labour

Role of the Health Committee

The Health Committee is tasked with reviewing health and wellbeing across London, including progress against the Mayor's Health Inequalities Strategy. The Committee will consider the Mayor's role as Chair of the new pan-London Health Board and the impact that recent health reforms are having on the capital, notably NHS reconfiguration and the decision to devolve public health responsibilities to local authorities.

The GLA Oversight Committee approved the appointment of Andrew Boff as the Rapporteur for the Health Committee in March 2014. The following terms of reference for the Rapporteurship were agreed by the Health Committee in June 2014:

To review access to health services for D/deaf and hard of hearing people to:

- Identify key elements of an accessible health service model for D/deaf and hard of hearing people;
- Explore the challenges health service providers face in improving access for D/deaf and hard of hearing people, and how they might be overcome;
- Explore what levers the Mayor could employ to promote and support improved access to health services for D/deaf and hard of hearing people; and,
- Recommend practical changes that can be made towards making health service provision more accessible to D/deaf and hard of hearing people.

Contact

Lisa Lam, External Relations Officer
Lisa.Lam@london.gov.uk
020 7983 4067

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Foreword

It is a shocking fact that deaf people are more likely to suffer ill health than other people, simply because it is harder for them to use the health services that many of us take for granted. Deaf people are twice as likely to have high blood pressure, four times more likely to develop diabetes and generally have a reduced life expectancy. This is unacceptable and has to change.

I certainly take for granted the fact that I will be able to communicate easily with health service staff – booking an appointment through a receptionist, discussing treatment options with my GP, or understanding a diagnosis from a hospital consultant.

But this is not the experience for many deaf people, and it can be so frustrating and difficult that some simply don't use our health service. Those who do use it often have a much poorer experience than others might.

It is so disappointing that the situation doesn't seem to have improved in the last twenty years. Even the passing of the Equality Act 2010, which should protect deaf people from discrimination and require service providers to make reasonable, proactive adjustments, has not made a significant difference to the experience of deaf people.

An important first step would be to collect better data on the number of deaf people in London. It is incredible that estimates for London's deaf population range as widely as 25,000 to one million. How can communication support services be commissioned to meet the needs of London's deaf population if we do not understand the scale and nature of that demand?

We need to lobby for improved access, in a co-ordinated and systematic way, in order to place the needs of deaf people firmly on the agenda. We hope this report will help bring stakeholders together, so they can bring their collective pressure on local Health and Wellbeing Boards to take the needs of deaf people more seriously.

Issues with access are entirely avoidable and this report suggests some practical and workable solutions for healthcare professionals. I want to build on the growing momentum for change. The injustices deaf people have to

battle against when accessing the health service need to be urgently addressed.

Andrew Boff AM
Rapporteur for the Health Committee

Executive summary

Deaf people in London are more likely to suffer ill health than the rest of the population, largely because they face problems accessing health services that should be available to all. Basic interactions, like making an appointment, or getting advice from a doctor, are harder for those with hearing loss, and this is putting deaf people off making use of the health services they are entitled to. Despite the passing of the Equality Act 2010, health service providers have still not tackled the inequality in access that disadvantages deaf people in London.

We do not know how many people in London suffer from hearing loss; estimates range from approximately 25,000 to over one million. Without more accurate data, health commissioners and providers cannot understand the scale and variety of needs among London's deaf population. We therefore recommend that NHS England London should take the lead in collecting better data on hearing disability in London. As part of this, Public Health England should update the 20-year old research on hearing loss prevalence among the general population.

It is obvious that, for the deaf person, good quality communication is the key factor in determining how easily they can access their GP or hospital, and we highlight a number of areas for improvement:

- We recommend that local Clinical Commissioning Groups should work together – perhaps at a pan-London level – to commission the communication support services that deaf people need. We believe that, as well as improving the level and standard of these services, joint commissioning would reduce costs for the health service.
- We note that there are not enough British Sign Language (BSL) interpreters to ensure a consistent standard of service at health appointments, and we recommend that stakeholders agree a minimum BSL standard for support services in health settings.
- We conclude that all health staff need deaf awareness training appropriate to their role. It is important that staff receive this training periodically to ensure that they keep their knowledge and skills up-to-date.
- Building on the conclusions from our previous report, *Access to GP care*, we note that GPs and hospitals need to make better use of digital solutions to make it easier for deaf patients to access health services.

Deaf people may be put off complaining about the service they receive because of the complicated complaints process and the lack of advocacy support available. This means that health providers are not always aware of the problems that deaf people are encountering.

Throughout this report we will use deaf with a capital 'D', to identify individuals who are profoundly deaf, who were born deaf or became deaf at an early age, would describe themselves as culturally deaf, and whose first language is British Sign Language. We will identify individuals with mild hearing loss, through to severe loss with a small 'd', and will also use this when referring to the deaf population as a whole, including profoundly Deaf individuals.

1. Introduction

Ten million people in the UK have some form of hearing loss,[1] ranging from mild loss to being profoundly deaf.[2] These people face a range of barriers and problems in accessing the health service, with damaging effects on their health and wellbeing. Through this investigation, we hope to raise the profile of this important issue, generate momentum for change, and highlight some practical solutions that can be implemented.

The barriers to health services

1.1 Deaf people can be at a disadvantage in making full use of health services in London. They can find many basic aspects of access difficult, such as making an appointment, understanding how to take their medication, or receiving advice on options for treatment.[3] The rest of the population will take these and other interactions with health professionals for granted. Recent research into the experiences of Deaf people found that almost half found contact with their GP 'difficult' or 'very difficult', and a third thought it wasn't worth seeing their GP because communication was poor.[4] These findings and experiences are replicated among all people who experience hearing loss, and with the evidence we collected during this inquiry.[5]

1.2 Good communication is probably the singular most vital component of improved access but it continues to be a major barrier. Providers generally seem to lack awareness and understanding of the range of communication support deaf patients might need, the options available to address those needs, and how they might make services more accessible to the deaf user.[6]

"I have just visited a deaf friend in hospital. She couldn't understand what the doctors were saying and no communication support was available to her."

"My deaf daughter had to go for a pregnancy check up and the midwife didn't know anything about interpreters or how to get one, or even who would get one."

"I am a good lipreader, but I know people have difficulties understanding my voice, so I take a friend with me when I go to the GP… Only one of them has ever looked at me when they are answering my questions."

The consequences of poor access for deaf people

1.3 Poor access to health care has a negative impact on the health and wellbeing of deaf people. Recent research concluded that

> *"Deaf people's health is poorer than that of the general population, with probable under-diagnosis and under-treatment of chronic conditions, putting them at risk of preventable ill health."*[7]

The research also found that just under half of all the deaf people in the study sample were in a high risk group for serious illness, and that they had higher rates of obesity than the general population. Other research shows that high blood pressure is more common in Deaf people, and proportionately more cases go undetected, or are insufficiently treated. Deaf people are also twice as likely to have high blood pressure, four times more likely to develop diabetes, and generally have reduced life expectancy.[8] In short, deaf people are more likely to suffer ill health than the hearing population – primarily as a result of the entirely avoidable difficulty in accessing services.

Time for change

1.4 People with hearing loss have long campaigned for the same level of access to health services that hearing people receive. For some, accessing their local GP or hospital remains as much a challenge now as it did 20 years ago. The Equality Act 2010, which is the legal framework that should protect deaf people from discrimination, is not yet having the required effect. It requires service providers to make reasonable, proactive, adjustments to improve the accessibility of their services to people who are disabled. But previous research and the evidence we have heard suggest that adjustments made to accommodate people with hearing loss are reactive and being implemented in a piecemeal way.[9] As a result of this ongoing failure, deaf people increasingly have to enlist the media to highlight the challenges they face, or are taking their concerns all the way to the Parliamentary and Health Service Ombudsman (PHSO).[10]

After its Primary Care Trust withdrew funding for a British Sign Language interpreter in 2011, Mrs E's GP Practice decided it would no longer provide them for appointments. It offered Mrs E longer appointment times and said staff would communicate with her through written notes. Mrs E complained, and ultimately took her case to the PHSO, which decided in her favour. The Practice apologised, paid Mrs E £3,000, and put together an action plan to show how it will meet the needs of Mrs E and other patients with disabilities.

The role of the Mayor

1.5 By law, the Mayor must promote the reduction in health inequalities in London and publish a strategy which identifies health inequalities in the capital, priorities for reducing them, and the roles to be played by key partners.[11] Equitable access to high quality health and social care is one of five strategic objectives set out by the Mayor in the London Health Inequalities Strategy, published in April 2010.

The purpose of this investigation

1.6 We hope that this investigation, and this report, will help to raise the profile of the challenges deaf people face in accessing health services in London. Our review focuses specifically on access to GPs and local hospitals, but many of our findings are also relevant to other parts of the health system, such as dentists, pharmacists or other community-based providers.

1.7 We also hope that this work will provide practical and workable suggestions for improving access for deaf patients, and add to the momentum for change in the way London GPs and hospitals plan and provide services to accommodate their deaf patients.

2. The role of data in improving access

Accurate data on deaf people in London is urgently needed. The lack of this data makes it difficult for commissioners of health services, and those in the front line of delivery, to plan and provide services that meet the needs of deaf patients. Official data, last collated in 2010, underestimates the true number of deaf people in London, meaning that demand for relevant services is outstripping supply. NHS Equality and Diversity Monitoring forms can be adapted to help provide this data.

2.1 There is no widely accepted estimate for the number of deaf people in London. In a society awash with data, this is a shocking gap, and a clear weakness in the health system's ability to allocate its scarce resources properly. According to the latest official data, published in 2010, there are around 25,000 deaf people in London. Of this number, two thirds (about 17,000) are small 'd' deaf, and one third (8,000) are capital 'D' Deaf.[12] But other estimates (discussed further below) indicate that there may be more than one million people deaf people in London, including over 80,000 profoundly or severely Deaf people.

2.2 It is obvious that health service providers need accurate, granular and timely data to plan and deliver the services that deaf people need in London. It is equally obvious that this data is not available. We can safely say that, without this data, providers do not understand the scale and variety of needs among London's deaf population. Furthermore, because this data is absent, the services for deaf people do not receive an appropriate profile or share of funding and other resources. Deaf people are being systematically disadvantaged and, without an accurate picture of demand for services, we see little prospect of this inequality being removed.

2.3 We believe that the responsibility for improving the quality of the data and routinely compiling it sits squarely with NHS England London. An important first step will be to work with representative organisations, such as the British Deaf Association, Action on Hearing Loss, and the National Deaf Children's Society, to establish an approach that will address outstanding questions on methodology, criteria and frequency.

How to improve the data

2.4 Most of the stakeholders we spoke to felt that the work on hearing loss prevalence by Professor Adrian Davis and others[13] would be a good starting point in improving the data. This estimated the percentages of the population (by age band) with hearing loss, and with severe or profound Deafness. Despite being 20 years old, it is still routinely applied to census data and provides – according to Action on Hearing Loss, the BDA and others – a more realistic estimate of the deaf population. Applying the latest prevalence data to the 2013 Office for National Statistics (ONS) population estimates indicate there are one million people deaf people in London, of whom 82,500 are profoundly or severely Deaf. The Davis research was updated in 2007, but would benefit from being updated again – a task that could reasonably be undertaken or sponsored by the Knowledge and Intelligence arm of Public Health England at a national level.[14]

2.5 One part of the problem is that there is currently no single approach among public bodies on what identification criteria to apply, and no agreement among stakeholders about how to record deafness.[15] Some prefer to measure it in terms of the degree of hearing loss, while others favour measuring based on the range of communication requirements of deaf people. It may be that either one or a combination of the two will be needed. Either way, it is important that stakeholders agree on the criteria to use so that the data is as useful as possible.

2.6 There may be an argument for collecting detailed information on a regular, periodic, basis. The Office for National Statistics (ONS) collected data on British Sign Language (BSL) users for the first time in its 2011 census, and this certainly represents progress. However, the way the question was phrased has led some stakeholders to argue that it underestimated the real number of BSL users, with some fearing this could result in demand being underestimated, and funding cut.[16] This is further evidence of how important it is to collect data in the most methodologically sound way.

2.7 We do not claim to have devised a solution for this problem. But we hope that this investigation acts as a stimulus to encourage stakeholders to work together to find a workable and cost-effective way of generating the data that is needed. One option that should be examined further is making better use of NHS Equality and Diversity Monitoring forms. These forms should be updated and improved to provide more detailed information about hearing disability.

Equality and Diversity Monitoring

2.8 NHS Equality and Diversity Monitoring forms are not being used to their full potential, and opportunities to collate data on deaf patients are being missed. In recent years, there has been a real focus on capturing data on the range and scope of disabilities. Many forms now give options on the type of disability the individual may wish to record and in some cases, the opportunity to elaborate on that disability, if needed. The list of options vary, depending on the form, but even with an extended list, a deaf individual generally has the option only to identify themselves as either being Deaf or having a hearing impairment.

2.9 There is scope for equalities monitoring forms to gather more specific information on hearing disability, allowing the individual completing the form to identify whether they are profoundly Deaf, have severe, moderate or slight hearing loss, and whether they are a BSL user. The more developed and detailed the options are, the better the returned information will be. The NHS England London Clinical Senate Patient and Public Voice Group, working closely with key stakeholders, could lead on work to develop an Equality and Diversity Monitoring template that will provide this vital information.

Recommendation 1

Data on hearing disability should be routinely collected and compiled. We recommend that NHS England London take lead responsibility for this, and that it explore with key stakeholders, such as the British Deaf Association, Action on Hearing Loss, and the National Deaf Children's Society, how this might best be done.

Recommendation 2

The earlier work on prevalence data by Adrian Davis et al (1995) should be updated at the earliest opportunity, and is a task that could reasonably be undertaken or sponsored by the Knowledge and Intelligence arm of Public Health England.

Recommendation 3

The NHS England London Clinical Senate Patient and Public Voice Group should lead on initial work to develop an Equality and Diversity Monitoring template that will allow health service providers to gather more specific information on hearing impairments.

3. Developing consistency in access

A range of approaches should be taken to improve patient access and ensure better patient experience and engagement with health service providers. There is potential for local Clinical Commissioning Groups to jointly commission the communication support needed to improve the deaf patient's initial and ongoing access to services. Standard minimum levels are needed for deaf awareness training to professional staff and for BSL translating and interpreting support at health appointments. Health care providers need to make better use of technology to improve access for deaf patients.

3.1 For the deaf person, quality of communication is the key factor regarding the ease of access to their GP or local hospital. Good communication options need to be available right from the start of the process, but this is not always the case. We have identified a number of factors that inhibit good communication and therefore limit access to health services for deaf people.

Joint commissioning

3.2 The way that communication support to deaf patients in London is commissioned does not always work effectively, and is contributing to the variation in access to services. Commissioners – usually the local Clinical Commissioning Group (CCG) for communication support provided through GPs and hospitals – are able to focus on the needs of their local population.[17] But there is a strong argument in favour of more joint commissioning across CCGs or even at a pan-London level. We agree with the conclusions of the NHS England Action Plan on Hearing Loss, published earlier this year, which recognises the need for *"improving both the commissioning and integration of services"*, and we think this applies equally to services for the deaf population.[18]

3.3 A joint or, ideally, a pan-London approach would enable CCGs to provide a strategic response to planning and delivering services across a much wider geographical area, and for the benefit of much larger numbers of deaf people. Commissioners would be able to maximise the cost advantages that come from operating on a larger scale, and ultimately deliver improved outcomes for deaf people. A focal point that both service users and providers can revert to would help to address uncertainties that can arise locally about who is responsible for arranging or paying for the support. There are joint

commissioning models elsewhere in the country and internationally that could be applied to London.

Commissioned across two CCGs, Action on Hearing Loss (AOHL) has provided communication support to deaf patients in Merseyside since June 2013. The service provides BSL interpreters, deafblind interpreters, lipspeakers and notetakers for people with hearing loss who attend GP appointments in Liverpool, Sefton, Knowlsey, Halton and St Helens. AOHL ensure appropriately qualified professionals by sourcing them through the National Registers for Communication Professionals working with Deaf and Deafblind People (NRCPD).

Minimum standards for BSL interpreting support

3.4 There are simply not enough BSL interpreters to ensure a consistent standard of service at health appointments. There are fewer than one thousand BSL interpreters registered with the NRCPD in the UK.[19] A 2012 survey of BSL users found that two out of three Deaf patients who asked for an interpreter at a hospital appointment did not receive one.[20] Even among those who did have an interpreter, almost half were unhappy with the service they received. This may indicate that not all BSL interpreters at health appointments are appropriately qualified and registered.

3.5 One of the main reasons for the low numbers of BSL interpreters is the length of time and expense involved in becoming fully qualified. There are currently six levels of training to complete, which can take seven or eight years in total. Furthermore, because of reductions in local authority grants and community funding, students increasingly have to fund themselves or seek sponsorship, possibly from their employer.[21]

3.6 Stakeholders and health service providers do not always agree on what level of BSL qualification is needed to support deaf patients at appointments. One provider told us that they would use interpreters qualified to Level 4. The London Borough of Islington in-house interpreting service only uses Level 6 interpreters – the highest level of qualification. The BDA and other support organisations are clear that a Level 6 qualification in both the language and skill of interpreting is needed to provide an appropriate level of support.

3.7 We agree with the stakeholders we have received evidence from that a minimum BSL interpreting standard needs to be applied to support provided in health settings. This would remove any doubt about what constitutes an

acceptable level of support, and provide a clear measure against which to benchmark the providers' obligation under the Equality Act 2010. We are not in a position to recommend a specific level of qualification. That work should be led by NHS England working in partnership with key stakeholders such as the NRCPD, the BDA and Signature.

Deaf awareness training

3.8 Deaf awareness training needs to be a key part of professional and support staff training in the health sector. Encouraging front line health staff to make simple changes can make huge improvements to the experiences of deaf patients. These changes can be as easy as asking reception staff to ensure that their face and mouth are clearly visible, for example by standing up from their desk.

3.9 Training obviously needs to be proportionate to specific roles and the frequency of contact with deaf service users. Stakeholders suggested that a short online training course might be sufficient for many staff. For those staff who would be in regular contact with deaf patients (such as those working in an audiology department) more intensive training lasting several days would be necessary. All training would need to be refreshed periodically to ensure that staff maintain their knowledge levels and ensure that they can provide deaf patients with the same level of service they do for other patients.

Maximising technology use

3.10 GPs and hospitals need to make better use of the range of digital solutions available to facilitate easier access for deaf patients. While this is an issue that affects the level of service for all patients, evidence suggests that the impact is more severe among deaf patients. For example, in 2014, just under half of Deaf BSL users could only make an appointment to see their GP by physically going in to the practice. Technological assistance for deaf patients does not have to be expensive. Online interpreting services, for example, can be accessed at approximately £2.50 per minute, and could be used to supplement the work of traditional BSL interpreters.

3.11 In our 2015 report, *Access to GP care*, we recommended that 'enabling digital capability' should be integral to the work of NHS England London to transform primary care in the capital.[22] We are therefore pleased to see some signs of progress, such as a rapid increase in capability for patients to book appointments with their GPs online, which is now up to 97 per cent in England (up from just 3 per cent in April 2014).[23]

Recommendation 4

Local Clinical Commissioning Groups should jointly commission communication support services to deaf patients to improve the level and standard of these services, achieve economies of scale and stimulate a more competitive market.

Recommendation 5

We recommend a universal minimum standard for British Sign Language interpreting support provided in healthcare settings. Work to determine the appropriate standard to be applied should be led by NHS England working in partnership with the National Registers for Communication Professionals working with Deaf and Deafblind People and other key deaf support organisation such as the British Deaf Association and Signature.

4. Making it easier to complain

Simplifying the complaints process will improve access. Poor access often goes undetected as individuals are put off by an over-complicated complaints system and the absence of any structured advocacy support to help navigate their way around it. Other than through equalities legislation, providers are not currently held to account for any failure to make their services easily accessible to deaf patients. Establishing accountability through the court process is difficult and costly.

4.1 Stakeholders have told us that deaf individuals are often reluctant to make a formal complaint when the service they have received is not up to standard. The process itself can be confusing and difficult, with information and guidance hard to find. In addition, the loss of community-based advocacy and advice, to help navigate an individual through the process and to help access the appropriate communication support, is also a big concern.

Navigating the complaints process

4.2 A formal complaint follows a two-stage process. At the first stage, a complaint can be made to the service provider (GP or hospital) or commissioner of those services (the local CCG or NHS England, respectively). The complainant can opt to ask someone else to submit the complaint on their behalf. If the complainant is unhappy with the outcome of their complaint at the first stage, there is the option to take it to the PHSO.

4.3 These seemingly simple steps, when unpacked from a practical perspective reveal a process that can be difficult and inconsistent. To start with, information on how to make a complaint is not generally well signposted. It can be difficult to find the relevant information on GP Practice, hospital and NHS England websites, which is often lying several clicks away from the homepage.[24]

4.4 The prospect of scrolling through several text-dense web pages in order to work out how to make a complaint can be a particularly daunting prospect for a deaf person. The London Borough of Islington's in-house Interpreting Service pointed out that many Deaf sign language users have restricted literacy in English. Web pages tend to be text-dense and are not offered in 'easy read format' or in an alternative communication format, such as BSL.

There is also a widely held assumption that BSL provides a literal translation of written or spoken English, which is not the case.

4.5 Formal complaints made to service providers are generally required to be submitted in writing. Guidance set out on the NHS England website gives three possible options, two of which involve a written submission – by post or by email.[25] The third option involves making a telephone call to NHS England's Customer Contact Centre.

4.6 The potential for a breakdown in official support mechanisms throughout the process can add to the stress of making a complaint. Take the example of a complaint about hospital services. In the hospital, Patient Advice and Liaison Services (PALS) work with and guide the complainant, typically offering advice and support where needed, and a liaison point between the individual and hospital personnel. But, as we were told, *"There is a lack of understanding, or when you arrive at a PALS team, they can't communicate with you."*[26]

Advocacy and advice

4.7 Our understanding is that deaf people are finding it increasingly difficult to access advocacy and advice services. Where services are available, they may not always suit the deaf person's specific advocacy needs or may be difficult to access because of the range of organisations one might need to navigate to identify the right service.[27]

4.8 Under the Health and Social Care Act 2012, responsibility for commissioning advocacy and advice support through the complaint process now rests with the local authority.[28] The NHS England Complaints Policy confirms that:

> *"Since April 2013, individual local authorities have a statutory duty to commission independent advocacy services to provide support for people making, or thinking of making, a complaint about their NHS care or treatment. Arrangements will vary between local authority areas."*[29]

The lack of advocacy support has also been raised as an issue for concern by stakeholders participating in other reviews by the London Assembly Health Committee, such as its review of mental health service provision in London for young people and Black Asian and Minority Ethnic Groups.

4.9 Reduced access to advocacy and advice support also presents challenges for those individuals who want to enforce the legal requirements of the Equality Act 2010. The legal process is lengthy and costly. The absence of advocacy representation is deterring deaf patients from pursuing this avenue.

4.10 The Act, stakeholders told us, is a valuable framework, but needs to be accompanied by guidance that clearly explains the requirement to make 'reasonable adjustments'.[30] The present lack of case law to provide some guidance makes it more difficult to hold providers to account.

Recommendation 6

NHS England must commission a review of advocacy services for deaf people. As part of this, NHS England must establish whether local authorities are fulfilling their responsibility to commission advocacy services under the Health and Social Care Act 2012.

Simplifying the complaints system

4.11 Poor signposting of the complaints process, coupled with the frustrations perpetuated by the challenge of navigating an often convoluted pathway, is resulting in deaf individuals either succumbing to barrier-fatigue and giving up, or escalating their concerns through the media and/or the PHSO. Deaf patients should not have to resort to this.

4.12 A consistent and simplified complaints process is needed. In the short term, there are some simple, low-cost steps that could be taken. The link to information on how to make a complaint needs to be brought forward to the home page of the GP or hospital website. Information also needs to be made available in an 'easy read' format.

4.13 The help that some deaf people need to navigate the complaints system is, by its nature, different from the help that other people require – and it is not always consistently available to them. As we have said in paragraph 3.3, we think that there are clear benefits from local CCGs joining together to commission support services for deaf people; this should also include services to help deaf people to make complaints. As well as trained and qualified support staff, this could include specialist online support in line with the wider agenda to make better use of technology to facilitate patient access.

Recommendation 7

We recommend that London GPs and NHS Trusts review the accessibility of information on their complaints process for deaf patients, with a view to providing a direct link on the home page of their websites. They should also provide alternative formats of this information, which should include an 'easy read' format.

Recommendation 8

When local Clinical Commissioning Groups commission communication support services for deaf patients – either jointly (as per recommendation 4) or individually – they should ensure those services include appropriate means of supporting deaf people through whatever complaints processes they need to navigate. NHS England London should provide guidance on what those 'appropriate means' might involve.

5. Lobbying for change

A number of stakeholders are working hard to bring about change to improve access for deaf people. These efforts need to be coordinated more effectively to lobby local Health and Wellbeing Boards and NHS England London for service improvements.

5.1 There is a clear understanding and recognition among deaf health service users and support organisations that their lobbying for improved access has lacked the cohesion and momentum needed to place it firmly on the political agenda. Delegates who attended the seminar event hosted by the rapporteur as part of our investigation recognised that they need to be more cohesive and systematic in lobbying for their cause.[31]

5.2 The political profile on deaf access issues has, until recently, remained relatively low at both regional and national level despite the wealth of available research. But a change in pace is evident from the work being done through local Healthwatch, as it begins to prioritise and promote the need for improved access locally. Stakeholders need to work together to ensure that local Health and Wellbeing Boards take their concerns seriously and put the needs of deaf patients on their agendas.

5.3 Good practice is happening across London, such as the London Borough of Islington in-house interpreting service, and nationally, as seen from the joint commissioning model in place in Merseyside. But these examples of good practice tend not to be shared or applied more widely. A strategic overview and understanding of the support needs for deaf people, not just in accessing health services but for continuing treatment is needed. As the regional overseer of health service provision, it is now time for NHS England London to build on existing national work, such as the national Action Plan on Hearing Loss and development of an Accessible Information Standard. Specifically for London, NHS England should look at ways it might work with London GPs and hospitals to realise a universal standard for access to health services for deaf people, and develop a mechanism for sharing the good practice that is already happening across London.

Recommendation 9

NHS England London should work with London GPs and hospitals to develop a universal standard for access to health services for deaf people, and draw up a plan to share the good practice that is already happening across London.

Appendix 1 – Recommendations

1. Data on hearing disability should be routinely collected and compiled. We recommend that NHS England London take lead responsibility for this, and that it explore with key stakeholders, such as the British Deaf Association, Action on Hearing Loss, and the National Deaf Children's Society, how this might best be done.
2. The earlier work on prevalence data by Adrian Davis et al (1995) should be updated at the earliest opportunity, and is a task that could reasonably be undertaken or sponsored by the Knowledge and Intelligence arm of Public Health England.
3. The NHS England London Clinical Senate Patient and Public Voice Group should lead on initial work to develop an Equality and Diversity Monitoring template that will allow health service providers to gather more specific information on hearing impairments.
4. Local Clinical Commissioning Groups should consider jointly commissioning communication support services to deaf patients to improve the level and standard of these services, achieve economies of scale and stimulate a more competitive market.
5. We recommend a universal minimum standard for BSL interpreting support provided in healthcare settings. Work to determine the appropriate standard to be applied should be led by NHS England working in partnership with the National Registers for Communication Professionals working with Deaf and Deafblind People and other key deaf support organisation such as the British Deaf Association and Signature.
6. NHS England must commission a review of advocacy services for deaf people. As part of this, NHS England must establish whether local authorities are fulfilling their responsibility to commission advocacy services under the Health and Social Care Act 2012.
7. We recommend that London GPs and NHS Trusts review the accessibility of information on their complaints process for deaf patients, with a view to providing a direct link on the home page of their websites. They should also provide alternative formats of this information, which should include an 'easy read' format.
8. When local Clinical Commissioning Groups commission communication support services for deaf patients – either jointly (as per recommendation 4) or individually – they should ensure those services include appropriate

means of supporting deaf people through whatever complaints processes they need to navigate. NHS England London should provide guidance on what those ‘appropriate means’ might involve.

9. NHS England London should work with London GPs and hospitals to develop a universal standard for access to health services for deaf people, and draw up a plan to share the good practice that is already happening across London.

Appendix 2 – How the review was carried out

Stakeholder meetings

The rapporteur, Andrew Boff, met with the following stakeholders:

- **Dan Sumners**
  Senior Policy Officer, Signature
- **David Buxton**
  Chief Executive, British Deaf Association
- **Edward J Richards**
  Self-advocate with extensive experience of working with health service providers to reduce the communication barriers deaf people face.
- **Matthew James**
  Programme Lead, NHS England Advisory Group on improving experiences for deaf patients
- **Merfyn Williams**
  Self-advocate with extensive experience of working with health service providers to reduce the communication barriers deaf people face.
- **Paul Breckell**
  Chief Executive, Action on hearing loss
- **Professor Bencie Woll**
  Director, Deafness, Cognition and Language Research Centre, University College London
- **Steve Powell**
  Chief Executive, Signhealth

Andrew Boff also accepted an invitation to participate in the NHS England Advisory Group on improving experiences for deaf patients. An initial meeting took place in February 2015.

Site visits

Andrew Boff visited the following organisations, to understand how their services have helped improved access for deaf people, and what specific features might be replicated on a wider scale, to help provide an accessible service model of provision:

- London Borough of Islington Sign Language Interpreting Service

- Royal Free London NHS Foundation Trust

Written contributions

- Ealing Clinical Commissioning Group
- Guys and St. Thomas' NHS Foundation Trust
- Islington Clinical Commissioning Group
- Katy Judd, Consultant Nurse
- Healthwatch Ealing
- Healthwatch Islington
- Healthwatch Southwark
- London Borough of Islington
- Southwark Clinical Commissioning Group
- Tower Hamlets Clinical Commissioning Group
- Wandsworth Clinical Commissioning Group

City Hall Seminar

Andrew Boff hosted a half day seminar on 2 October 2014, to explore challenges faced by health service providers to provide an accessible service, and the levers open to the Mayor to promote and support improved access. The seminar was attended by 44 delegates, representing health care providers and service users.

Literature review

The Scrutiny Manager undertook a desk-based review of annual surveys published by Action on Hearing Loss, and other research and publications, including work by the British Deaf Association, Signhealth, and local Healthwatch organisations.

Appendix 3 – Defining deafness

Hearing loss is measured by finding the quietest sounds someone can hear by using tones with different frequencies, which are heard as different pitches. The level at which a person hears a tone is called the threshold. Thresholds are measured in units called dBHL – dB stands for 'decibels' and HL stands for 'hearing level'. Anyone with thresholds between 0 and 20 dBHL across all the frequencies is considered to have 'normal' hearing. The quietest sounds a profoundly deaf person can hear average 95 decibels or more.

Mild hearing loss – People with mild hearing loss can have some difficulty following speech, mainly in noisy situations. The quietest sounds they can hear average between 25 and 39 decibels.

Moderate hearing loss – People with moderate hearing loss may have difficulty following speech without hearing aids. The quietest sounds they can hear average between 40 and 69 decibels.

Severe hearing loss – People with severe hearing loss rely a lot on lip-reading, even with hearing aids. BSL may be their first or preferred language. The quietest sounds they can hear average between 70 and 94 decibels.

Profound deafness – British Sign Language may be the first or preferred language for people who are profoundly deaf, or they might communicate by lip-reading.

Everyday terms used to describe deafness

People who are deaf – People with all degrees of hearing loss.

People who are hard of hearing – People with mild to severe hearing loss and, who have lost their hearing gradually.

People who are deafened – People who were born hearing and, became severely or profoundly deaf after learning to speak.

People who are deafblind – People who may have some hearing and vision or, could be totally deaf and totally blind.

The Deaf community – People whose first or preferred language is British Sign Language (BSL) and consider themselves part of the Deaf community. They may describe themselves as Deaf with a capital D to emphasise their Deaf identity.

Source: Action on Hearing Loss

Appendix 4 – Endnotes

[1] Action on Hearing Loss, Access All Areas, April 2012 http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/access-all-areas.aspx

[2] Hearing loss is measured by finding the quietest sounds someone can hear by using tones with different frequencies, which are heard as different pitches. The level at which a person hears a tone is called the threshold. Thresholds are measured in units called dBHL – dB stands for 'decibels' and HL stands for 'hearing level'. Anyone with thresholds between 0 and 20 dBHL across all the frequencies is considered to have 'normal' hearing. The quietest sounds a profoundly deaf person can hear average 95 decibels or more.

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Profound deafness **–** British Sign Language may be the first or preferred language for people who are profoundly deaf, or they might communicate by lip-reading.

[3] Signhealth, Sick of it, March 2014, http://www.signhealth.org.uk/health-information/sick-of-it-report/

[4] Forty-four per cent of Deaf patients found contact with their GP 'difficult' or 'very difficult' and 33 per cent could not easily arrange an appointment. Signhealth, Sick of it, March 2014

[5] London Assembly Health Committee, Access to health services seminar, 2 October 2014.

[6] Quotes taken from Signhealth, Why are you still missing me?, September 2009 www.signhealth.org.uk/v3/wp-content/uploads/2014/10/Why-Are-You-Still-Missing-Me.pdf

[7] The current health of the signing Deaf community in the UK compared with the general population: a cross-sectional study, BMJ, January 2015

[8] Signhealth, Sick of it, March 2014

[9] RNID, A Simple Cure, December 2004, www.signhealth.org.uk/health-information/sick-of-it-report/; Signhealth, Why are you still missing me? September 2009, www.signhealth.org.uk/v3/wp-content/uploads/2014/10/Why-Are-You-Still-Missing-Me.pdf; Action on Hearing Loss, Access All Areas, April 2012, www.signhealth.org.uk/v3/wp-content/uploads/2014/10/Why-Are-You-Still-Missing-Me.pdf

[10] For example, see www.ombudsman.org.uk/make-a-complaint/case-summaries/volume-2/health/deaf-patient-denied-access-to-bsl-interpreter-at-gp-practice

[11] Section 309, Greater London Authority Act 2007

[12] Health and Social Care Information Centre, People Registered as Deaf or Hard of Hearing - England, Year ending 31 March 2010, www.hscic.gov.uk/catalogue/PUB00594/peop-regi-deaf-hard-3103-2010-eng-anx.xls

[13] Professor Adrian Davis, Hearing in Adults, 1995

[14] A Davis et al, Health Technology Assessment: Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models, October 2007

[15] In a meeting with the BDA (29 May 2014), the rapporteur learned that data collation could be based on degrees of hearing loss which do not account for communication requirements, or solely on communication requirements. No universal agreement has been reached.

[16] British Deaf Association press release, March 2013

[17] Information on commissioning arrangements for communication support was requested from all London CCGs in December 2014. Responses were received from Ealing, Islington, Southwark, Tower Hamlets and Wandsworth.

[18] NHS England, Action Plan on Hearing Loss, March 2015, www.england.nhs.uk/2015/03/23/hearing-loss/

[19] As of 31 July 2014, there were 883 registered sign language interpreters plus 265 trainee sign language interpreters. NRCPD, Annual Report 2013-14, page 15.

[20] Conducted as part of the 'Our Health in Your Hands' campaign coordinated by AOHL and other organisations supporting deaf people.

[21] Oral submission, by Signature, 16 March 2015

[22] London Assembly Health Committee, Access to GP care, March 2015, page 20.

[23] NHS England, press release, 19 May 2015

[24] Examples include: University College London NHS Hospital Trust; The Whittington Hospital NHS Trust; Croydon Health Services NHS Trust;

[25] www.england.nhs.uk/contact-us/complaint/

[26] Oral submission, by Edward Richards and Merfyn Williams, 22 April 2014

[27] One example is the interim and subsequent arrangements put in place to support deaf people in Camden, following the closure of the support group Disability in Camden

[28] Health and Social Care Act 2012, section 185

[29] NHS England, Complaints Policy, March 2015, page 11.

[30] Action on Hearing Loss, stakeholder meeting dated 26 June 2014

[31] London Assembly Health Committee, Access to health services seminar, 2 October 2014.

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Email 与我们联系。

Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান, তাহলে দয়া করে ফো করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।

Greek

Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں
درکار ہو تو، براہ کرم نمبر پر فون کریں
یا مذکورہ بالا ڈاک کے پتے یا ای میل
پتے پر ہم سے رابطہ کریں۔

Turkish

Bu belgenin kendi dilinize çevrilmiş bir özetini okumak isterseniz, lütfen yukarıdaki telefon numarasını arayın, veya posta ya da e-posta adresi aracılığıyla bizimle temasa geçin.

Arabic

الحصول على ملخص لهذا المستند بلغتك،
فرجاء الاتصال برقم الهاتف أو الاتصال على
العنوان البريدي العادي أو عنوان البريد
الإلكتروني أعلاه.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં જોઈતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો અથવા ઉપર આપેલ ટપાલ અથવા ઈ-મેઈલ સરનામા પર અમારો સંપર્ક કરો.

Greater London Authority

City Hall
The Queen’s Walk
More London
London SE1 2AA

Enquiries 020 7983 4100
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Subject: Health Committee Work Programme

Report to: Health Committee

Report of: Executive Director of Secretariat | **Date: 24 June 2015**

This report will be considered in public

1. Summary

1.1 This report sets out proposals for the Health Committee Work Programme.

2. Recommendations

2.1 **That the Committee agrees its work programme.**

2.2 **That the Committee delegates authority to the Chair, in consultation with the Deputy Chair, to agree the topic, scope and terms of reference of the October meeting of the Committee.**

3. Background

3.1 The Committee receives a report monitoring the progress of its work programme at each meeting.

4. Issues for Consideration

4.1 The Committee's calendar of meetings for 2015/16 was agreed at the Assembly's Annual Meeting on 13 May 2015. The Committee is scheduled to meet on:

24 June 2015	9 December 2015
8 July 2015	3 February 2016
20 October 2015	2 March 2016

4.2 Initial priority areas identified by the Committee include:

- Tuberculosis (TB) in London;
- Accident and Emergency Care;
- End of Life Care;

- Maternity services; and
- Healthcare workforce recruitment and retention.

4.3 The scope, approaches and timings for the work in these areas will be determined as the work programme evolves, and the Committee will consider detailed scoping proposals for any new investigation undertaken in separate reports. Evidence may be gathered through formal committee meetings, informal briefings, site visits, rapporteur projects or a combination of approaches.

4.4 The table below sets out the proposed schedule for future meetings of the Committee and proposed topics to December 2015.

24 June 2015	Tuberculosis in London
8 July 2015	Tuberculosis in London
20 October 2015	Accident and Emergency Care
9 December 2015	End of Life Care

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 There are no financial implications arising from this report.

List of appendices to this report:
None.

Local Government (Access to Information) Act 1985
List of Background Papers: None.

Contact Officer: Lucy Brant, Assistant Scrutiny Manager
Telephone: 020 7983 5727
Email: scrutiny@london.gov.uk