

The People's Inquiry: One Year On

Evidence presented by Dr Onkar Sahota (OS)

Thursday 11 December

Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:

Dr, thank you so much for coming, I'm very conscious you have organised your affairs to get here and see us this morning and I am very grateful. Our purpose really is to reflect on our report which we published I can't believe it's a year ago where we made a number of recommendations and it's to take view of things really to see whether or not the situation's improved, stayed the same, got worse, if we've had any impact and to gather more evidence for a supplementary report that we will be publishing I think early in the new year.

OS:

I am a member of the Greater London Assembly, representing Ealing and Hillingdon. I am the Labour spokesman on health and also give advice on health to the GLA. The remit I was given was to give an overview of health in London from the GLA point of view. But that's the irony. There is no one in London taking an overall view of health care across London. Our health committee does its best to bring issues and failures to the forum where we can suggest solutions, but it has no powers to enforce anything.

London is a unique health reality. London has some of the finest hospitals in the world which provide cutting edge treatment across a number of different fields. London also faces a complicated and diverse set of challenges. The population is rising at twice the rate as the rest of the United Kingdom. By 2020 the population of London will be 9 million. 40 per cent of the population come from 90 different minority ethnic groups. They speak hundreds of different languages. The average age is 34. 16 per cent of doctors are over the age of 60.

The city has also some of the starkest health inequalities in Britain. The difference in life expectancy between some wards across the capital can be as much as 17 years. There is a crisis in London, across London. A crisis in care and a crisis in leadership. Some things are getting better: more specialisation has reduced mortality in key areas. Research is amongst the best in the world.

But ambulance response is in free fall. In October Barnet, Haringey, Waltham Forest, Ealing, Enfield and Barking & Dagenham all had a 50% chance of getting an ambulance to the most serious and life-threatening accidents in the target of 8 minutes. A&E times are getting worse, attendances are up and A&Es have closed. Queen Mary's Sidcup, South-East London, closed in October 2013. Chase Farm in North London closed in December 2013. Hammersmith in West London, September 2014. Central Middlesex also in September 2014. King George Hospital A&E in Ilford is due to close in 2015.

North-West London is facing A&E chaos, with the worst waiting times in the country. There is now an internal inquiry going on in London North-West looking at the implications of implementing further the *Shaping a Healthier Future* plan. It can only tell us what we all know and we have all campaigned against: the closure of four major A&E units is going ahead without proper contingency

plans. We don't know what the future of Charing Cross and Ealing Hospitals are at the moment. But all avenues point to reduction in care for patients.

In London it's harder to see a GP and it's harder to be a GP also. People can't get appointments. National survey data has shown that from 2011 it has become increasingly difficult to contact your local GP and get an appointment. In 2014 the NHS National General Practice Survey found that in London 27% of people found it not easy or not easy at all to get an appointment with their GPs. GPs can't find partners, trainee doctors don't want to be GPs. This has led to an increasing number of GPs who are salaried in London. I am told it is something like 55% of GPs in London are now salaried.

PT:

Do you know how fast that's risen and in what way?

OS:

I don't know the recent data but I certainly know that about 10-15 years ago we were about 10%. This has risen rapidly.

Patients' experience of cancer care in London is the worst in the country. Mental health services in London are under-resourced and cannot cope – a subject we are looking into at the London Assembly at this very moment. Throughout all this there is a complete lack of strategic leadership or accountability across the capital. Since the Health and Social Care Act of 2012, London's NHS and public health has been fragmented.

Lord Darzi has completed a review of the health situation in London, the London Health Commission. It's a wonderful document. He makes a whole raft of recommendations. The one thing that caught the public eye was smoking in Trafalgar Square and Parliament Square, but there were 61 other recommendations which didn't get to see the light from the press but think are very powerful arguments of what should happen in London.

This report is backed up by the NHS 5-year Forward View. Central to both is the need to shift expensive hospital care focused on doctors and consultants to a more patient-oriented services, with many procedures in the community and primary care. This is a long-term issue. Put simply, prevention is better than cure. These services are designed to be whole-person services, which are not just to be medical but including social care altogether, so that we can take a whole-person treatment. For the GLA and for those of us on the Health Committee it is the Mayor who has the responsibility for tackling health inequalities and yet there is no functional body or force to drive that change.

Lord Darzi has recommended that we re-work public health care in London with Public Health England and the GLA health team to create a new body called to record healthcare across London under a Health Commissioner. Inequalities are not restricted to boroughs or trust areas: obesity doesn't look for lines on the map. Heart disease, diabetes and liver disease don't look for the lines on the map. Mental health evidence doesn't look for the lines on the map.

These complex and multi-faceted problems require complex and multi-faceted solutions. Most looming health problems need to be dealt in London in a coordinated and strategic way as there is a huge vacuum in strategic leadership in London: that's what the King's Fund have also referred to and Lord Darzi has referred to that also. So there is no one across London looking at what is happening across London and that's one of the big challenges.

RL:

Thank you very much. Perhaps if I can start, then I am sure my colleagues will have questions for you. One of our recommendations which Lord Darzi copied was that we noted the lack of strategic oversight across London, the lack of a strategic interlocutor. We stopped short of recommending a Health Commissioner. We were sort of told that the Mayor wanted to take responsibility for health in London. It's no secret that he is on record as saying he would like to do that.

What's your group's view? Given there is clearly politics involved here and you may not wish the present Mayor to have control of anything more than he does. But just looking at the role of the Mayor, putting politics to one side, do you think the Mayor is the right person to have this strategic overview of healthcare in London? Or should it be perhaps an organisation that's outwith politics. I'm giving you a bad example, like for example the Monetary Committee of the Bank of England or the Independent Review bodies. How would you see that rolling out if you had the opportunity to press a button and say this is what we are going to do tomorrow? What would you do?

OS:

I think there is a consensus of opinion, Roy, that this should be with the London Assembly. That the Mayor is accountable to the people of London. The mayor wanted more authority, more powers and he wasn't given that by the Secretary of State in the reforms. He feels hard done by. He is charged with reducing health inequalities, but he doesn't have the mechanism of delivering it.

I think whether you call them a Health Commissioner or you want to call him the Deputy Mayor for Health that there will be this consensus of opinion across all political groups that there should be some coordinating force across London, with over-sight. The Mayor does have a Health Intelligence Unit, but it doesn't have all the resources that it needs.

RL:

Can I just ask you there. On the question of the budget, at the moment local government is hosting public health in London with non-ring-fenced cash. The first dowry, they came with a dowry, is no longer ring fenced next year. So the money for your proposal would come from what would otherwise have been spent by the local authorities. Would you leave the local authorities having any public health involvement? Would you see them as subsidiary? Or would you just lift the whole job and do it on London-wide basis?

OS:

I think it would work with the Health Commissioner or the Deputy Mayor coordinating. There are also the London councils. This body would be responsible for making sure things are coordinated rather than being dictating to the local authorities.

RL:

So you would leave public health staff that have been transferred? Leave them there? Leave the local government funds alone but just have an overarching strategic public health presence?

OS:

Absolutely. Make sure they are coordinated. Make sure things are happening across London in a systematic way from the point of view of commissioning. Air quality issues. Commissioning things like sexual health. Dealing with mental health services. Making sure that someone in London is taking responsibility for what is happening.

PT:

Could they order them to? What if you had some Tory council who says 'sexual health, that's not for us much'?

OS:

I think that the Mayor has the political power to do that. Absolutely.

RL:

So when you say the Mayor, I'm sorry to press you but we want be thinking in terms of making recommendations. Just to take up Polly's point. What we are looking at here is giving the Mayor a statutory responsibility?

OS:

And the mechanisms.

RL:

And flowing from that responsibility the mechanisms to impose if required?

OS:

Yes.

SR:

Can I suggest to you that the Mayor already has executive power over many issues that relate to health inequalities? And he is exercising the powers, for instance his planning powers, to allow new housing developments with a minimal proportion of those units being social housing. He also is the person holding executive power over transport for London, and has allowed air quality to deteriorate in parts of the capital to such an extent it is really positively dangerous. A figure out the other day published the number of excess deaths caused by air pollution.

I think probably if you monitor his existing responsibilities you would be able to see that actually on health inequalities he has got a huge number of levers and he is not exercising them. So it's a bit rich, really, to ask for executive powers over health when he is not making full use of the means that he has got. So that's a point to put to you.

But I really wanted to ask you a separate question, which is in view of your role as Labour spokesman on the GLA for health, because I heard Ed Milliband recently say shifting from acute to primary is how we deliver health, the way in which we are going to solve the financial problem. In essence you've said the same, although you've slightly allied prevention and primary care and put them both in the same box. Perhaps they should be considered separately?

We've already had evidence this morning and there's been a lot published recently showing that it's not cheaper to reduce the proportion of hospital beds, or assume that primary care delivered services are going to come in and provide equivalent support but at a lower price. What's your thinking on that? Can you help Labour to a more intelligent position on it than believing that everything can be solved by integrating health and social care?

RL:

It's perhaps not our role to help Labour. But it would be interesting to have your observations.

OS:

First of all on the Mayor question I would entirely agree, I'm not here to defend the Mayor's record on it and I have criticised the Mayor's record on this repeatedly.

RL: But could you suggest why he hasn't used those levers? It seems to me that for present care, we have to think in context of the Mayor and not politics. But he is not backward in coming forward when he wants to do something. Setting aside politics, are there real reasons why more progress has not been made? Or is he just not bothered?

OS:

I think he also thinks that things aren't as bad as people are making out, though this other report says 4,000 deaths are attributable to poor air quality in London every year. So I think in some places his focus and attention hasn't been there. But when I ask him about other things like for example when we were looking at the impact of the closures in North-West London and I was to ask him what is the impact of this? He used to say 'I am informed by North-West London ...': he had no mechanism, he said, of 'interfering' or giving over-sight, or doing even analysis of what is happening across London.

RL:

Let's me just bring you back to these levers. Is the Assembly powerless really to make him use the levers?

OS:

The Assembly is there to hold him accountable for areas which are under his control. But if he says he's no control over them, he will say 'This is not my responsibility'. He has a responsibility for reducing inequalities in health, but he had very little mechanism for drafting conclusions over what's to be done. I think on air quality he's got a very poor record. I'm not defending that. I think the Mayor could have done more, you're absolutely right in terms of the planning regulations, in terms of air quality and in terms of buses to move from diesel to petrol or to dual engines in a quicker way. He could have done a lot of things differently. I accept that.

It must be accepted that prevention of illness is better than cure. I also think that in my own personal view that this thing about commissioning of vital services is wrong and I do believe in integrating the hospitals, primary care, social services into one unified budget, into one local economy. Stephen Dorrell when he was Chair of the Health Committee asked what are the transactional costs of commissioning and said it was something like 10-11% of budgets spent in negotiating contracts.

PT:

10-11% of the whole of the NHS budget?

OS:

10-11% of the whole NHS budget.

PT:

Stephen Dorrell got that?

OS:

He got it as an answer. So why doesn't the NHS accept that these are the patients who we need to treat, and the local economy works out whether for that treatment to refer the patient to a hospital or to a community or general practice? I do think that there should be integration and we should allow more GP-centred services to develop so they can integrate into the system rather than as independent contractors. That's my personal view.

RL:

You said earlier 55% are now salaried. Does it matter? I think you would say it is probably better?

OS:

If there was a more salaried service provided by the NHS themselves then you would put the doctors...

RL:

And you are going to make vertical integration model easier to achieve?

OS:

Absolutely.

RL:

And that's of course in the 5-year Forward View, one of the I think it's in the executive summary recommendations 8,9 and 10. One is multi-professional teams, not multi-disciplinary, multi-professional – that's a key issue. The next one is vertical integration. The third one is different treatment of out of hours. In that vertical integration model – everybody thinks the stumbling block will be the GPs who won't want to be vertically integrated.

OS:

Well, I put it to you that with 55% now salaried I don't see why they would not be integrated if the other choice was given for that. But the London hospitals are prevented from vertically integrating with primary care.

RL:

I think the final relationship was changed in 2013.

JL:

I just wanted to come back to a lot of the discussion has been about the GLA, the Mayor taking more responsibility for public health and I personally I can see a logic in that and obviously with various safeguards but it does seem to be there's a bigger question which you touched on briefly about North-West London and you asked the Mayor and he said 'all he has is the say-so of the various Commissioners' and he is happy to accept that. But do you think there should be a responsibility effectively making some kind of democratic control through the GLA on the actual service NHS services in London, as for example the Welsh Assembly has control over the NHS in Wales?

OS:

That's an excellent progression on what I'm saying, John, that is important. There has to be an independent review of what's happening, to make the services that are new to London deliver what they are meant to. The Mayor has an accountability directly to the public of London and that needs to happen.

RL:

Just let me just unpack that if I may, because it is quite critical to me what your thinking is on this. We've already taken you through the concept of you having over-sight and providing some sort of coordinating interlocutor role with local government on public health issues. If you were to take on the responsibility for the planning and coordination of healthcare in London, then you would need to have the budget.

OS:What I would argue is that you should be able to have an independent appraisal of what's happening. If the Mayor says 'I think I don't believe what you are saying to me' and it would be a very powerful force for people to re-think their steps again.

RL:

But it wouldn't give any power to the Mayor to say 'this is what I want'. It's probably not quite so binary as I'm presenting it but I guess what we're saying is 'do we want to give the Mayor of London responsibility for healthcare in London?'. In which case it would mean making the one London-wide allocation, a population-based capitated budget and say 'here you are, get on with it'.

OS:

I don't think the Mayor of London could handle that.

JL:

No but is this something which we should be progressing, this whole question of accountability and democratic accountability for what's done? Having somebody to hold to account. Would that be something we should aspire to?

OS:

I think this is something we should aspire to: having someone who does have the ability to look at what's happening across London, look at the impact and then say to people 'I am really concerned about that'. I don't think he is responsible for the delivery. In the police he's got operationally involved, he is chairman of the Police Board, in the Fire Service he is responsible. But I'm not recommending health is handled in the same way as that, or that he has to deliver the service – but he should be given a stake. I'm really concerned about what's going on in London. I've done an independent assessment for this and I believe in a voice on behalf of the people rather than simply saying 'I believe what you saying', to CCGs.

PT:

The problem with London is things are overlapped, things are all over the place, everybody is competing with each other. More and more people are losing money and worried about how they could get money off each other, and how to coordinate community services, and the local authorities with the health authorities: but you're not really asking for this all to be pooled together into one commission that's controlling London's health?

OS:

There are two things I'm asking for. One of these is that we need to have less of this commissioning stuff. The commissioning of services usually leads to fragmentation of services. That's one thing I'm saying. The NHS provides services. The more you contract out the more you commission services the more you can define services, the more you define services, people write contracts more to them, and that's leading to fragmentation as there are a plurality of providers. I think this idea that competition is going to improve healthcare is not a proven concept at all. What has been proven in healthcare right across the world has been looking at the good quality standards.

RL:

You said two things: less commissioning and...?

OS:

Less commissioning, and the second one is that the Mayor should have over-sight, he needs to have an independent ability to comment and coordinate function and bring heads together.

RS:

Is there any reason why he couldn't have created a unit to support him on that?

OS:

Because he doesn't have the budgets to do it. He says he hasn't got the money to do it.

RL:

I'm not here to defend the Mayor, although if you look at the governance issues he can't spend taxpayers' money on things he's not responsible for, so that's just simple fiduciary duties as the Mayor. But we are very worried – and we made the point in our recommendations last time – that there is no strategic overview. The more you test that argument and say there needs to be a strategic overview, if he's not responsible for the money then he could be responsible I suppose for the strategy of healthcare in London.

That would mean that he would at the very least have to be a consultee of any change or what have you, but we want a bit more than that – we see that role perhaps, I'm not saying we do but I think it's for discussion, we see that role as a ring-master perhaps?

But he would have to have a statutory role wouldn't he, because if at the moment he says to a CCG 'I'm not happy with the way you are commissioning services' they can turn round and say 'well listen, you are a consultee but that's all, we're going to get on and do it because we've got to save £20 billion', or whatever it is.

It just seems to me that with Bernard Hogan-Howe we can get him in there, grill him, he's got his budget; but there isn't a Bernard Hogan-Howe for health services in London. There isn't an executive that you could hold to account.

OS:

That is a challenge, you can't. But on the other hand we do need this person, somebody who knocks people together, makes things happen in a coordinated way. Why is New York doing better than London? Why is Paris doing better than London? Because they have some coordination, some direction, that this is what we want to do.

RL:

So just to hurry you on because we're running out of time. Let's say for example, how many CCGs are there?

OS:

32.

RL

Just for example, if we said every CCG would have to have a representative on the Mayor's strategic overview health body? I know that gives you a 32-person committee which is an absolute nightmare. If there was some kind of structure like that which the Mayor chaired, where they agreed a plan? We're kind of getting into the bureaucracy.

OS:

Lord Darzi has suggested setting up a Board. I wouldn't want all 32 CCGs. I don't think the Mayor wants to be involved to the micro-level of management, but I certainly do think that public health is a big issue right across London. Certainly if he has concerns about CCG matters: he could raise concerns about them, but I don't think he would want to be involved at the micro-level in London. The other thing is I don't think the CCGs are representative, or accountable to the people of their area at all. They are unelected members.

RL:

One of our recommendations is that we beef up Health and Wellbeing Boards. Because we felt they weren't doing very much, we said give them more money, more power, more beef, more something or other, a steroid injection.

OS:

By combining health and social service budgets and local authority items on the same list, contributing to the balance of the CCGs, put it under elected members of the council, and take away unelected GPs who are leading this.

RL:

Just say that again.

OS:

Combine the social care budget of the area and healthcare budget in one single budget, put it under the command of elected politicians. Doctors can advise them, they can be the advisers rather than the drivers of the budget.

RL:

I think that's Labour policy, that's what Andy Burnham's trying to do.

OS:

It seems to me to be sensible because at least they are accountable to members of the community.

FW:

The narrative that the government is presenting is they've given the budget to commissioners. You're on a commission, saying 'give it to the politicians'.

OS:

There is that. The commissions are there to take the rap, all the things they are getting wrong because this government couldn't have the guts to stand up and say 'these are cuts' and are so terrible and so harsh. So we have GPs who have been given a budget, driven cut services, because the Health Secretary couldn't be bold enough to stand up and take the responsibility for it. I don't think people are interested. 95% of GPs don't even go to CCG meetings, they are too concerned on the coal-face driven services.

RL:

You are still a practising GP I think, aren't you?

OS:

Just about. A day and a half.

RL:

And how do you find that day and a half? A nice relaxing alternative to the hurly-burly of politics?

OS:

The happiest day of my life was when I went to medical school. The next happiest day of my life will be when I retire from the NHS, which I've got next!

RL:

On that happy note I think we will call it another time. Thank you enormously.