

# A FRAMEWORK FOR ACTION

London has 57% of HIV cases

One in four drug users live in London

60% of Londoners want improvements to waiting times

2 in 3 Londoners dissatisfied with running of the NHS

One Londoner dies every hour from a smoking-related illness

suicide is the most common cause of death for men under 35

4,000 Londoners die due to obesity each year

One million Londoners have mental health problems





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Second edition



## FOREWORD

By Professor Sir Ara Darzi<sup>1</sup>

London is one of the greatest cities in the world. Inhabited for over two thousand years, it has a rich historical and architectural heritage. It is a city renowned for its vibrant artistic and creative output, as well as for being a hub of innovation and invention. It is a financial powerhouse, rivalled only by New York.

This greatness is the achievement of London's wonderfully diverse inhabitants. London is a cultural melting pot, its inhabitants drawn from every corner of the globe.

These people, and this city, deserve the very best. The inhabitants of a world-class city should not have to settle for anything less than world-class healthcare.

However, we know at present that whilst there is excellence in healthcare in London, that excellence is not uniform. There are stark inequalities in health outcomes and the quality and safety of patient care is not as good as it could, and should, be.

The need for improvement was recognised by NHS London, the Strategic Health Authority for the capital, and I was asked by them in 2006 to carry out a review of London's healthcare. As a surgeon who has spent all my working life in London, I was delighted to accept that request.

This *Framework for Action* sets out my findings from the review. It details how I believe London's healthcare needs to change over the next ten years. I think these evidence-based proposals offer a compelling vision for the future.

Yet at the moment these proposals are only words – implementing them will be a major challenge. I am well aware that this review follows in a long line of reports into the



healthcare of London.<sup>2</sup> Many sceptics may wonder why this *Framework* should fare any better than previous reports, reports which have only ever been partly implemented.

I hope and believe that this *Framework for Action* will not just sit on a bookshelf gathering dust. Let me give you six reasons why I think this review will bear fruit. First, clinicians across London have been involved in the review's work and there is a considerable clinical consensus behind this report's proposals. Second, we have based the *Framework* on what Londoners have



told us they want, so I believe we will have the public's support for the proposed changes. Third, because my proposals are to improve the quality and safety of the care patients receive, I hope politicians of all parties will support them. Fourth, NHS London exists as a pan-London body to drive forward strategic changes in healthcare and is ideally placed to take forward the review's recommendations. Fifth, we have looked beyond the vision and identified the key enablers that will turn this vision into a reality. One key lever will be the commissioning regime. Another will be continuing our engagement with the Greater London Authority, the Mayor, London boroughs and other partners to deliver change on the ground. Sixth and finally, as a practising surgeon I'm going to be around in London to champion these proposals and help make them happen.

Before I let readers venture into the main section of the report I want to acknowledge that without the contribution of several individuals and organisations this *Framework* would not have been published. The sheer number of contributors means that I have not been exhaustive and I apologise to any whom I have neglected to thank here.

Imperial College, St Mary's Hospital and the Royal Marsden have been gracious in allowing me the time to conduct this review. The Presidents of the Royal Colleges gave of their expertise to help me develop my ideas. The King's Fund kindly allowed us to use their rooms for the myriad of meetings and events that the review inevitably entailed.

The members of the six clinical working groups contributed a considerable amount of their time and expertise especially Cathy Warwick, Maggie Barker, Tom Coffey, Martyn Wake and Sir Cyril Chantler who, along with me, each chaired a group. The chief executives of London's mental health trusts kindly helped me develop robust proposals in their particular area.

NHS London provided a lot of support that enabled me to carry out my review, especially Sue Dutch, Gary Dakin and Catherine Martin who managed the many consultation events and Ruth Carnall, Bill Gillespie, Steve Gladwin and Hannah Rich for their full support of this review. Working for NHS London, Nicholaus Henke, Penny Dash, Ben Richardson, Chris Llewellyn, Eoin Leydon and their colleagues identified national and international good practice, as well as carrying out much of the analytical work underpinning my proposals. Michael Soljak, John Hamm and Trudi Kemp helped a great deal on our projections for future needs and our analytical modelling. Sue Atkinson carried out a preliminary health inequalities assessment on the proposals.

Finally I would like to thank the review team here at Imperial College, including Peter Howitt, Omer Aziz, Erik Mayer, James Kinross, Rachel Davies, Deborah Crewe, Penny Humphries, Helen Cullen and Beth Jantz for their dedication and effort.



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  - 2 See for instance *Report of the Inquiry Into London's Health Service, Medical Education and Research* (Tomlinson Report) 1992, *London Healthcare 2010*. *King's Fund Commission on the Future of London's Acute Services*, June 1992, *Transforming Health in London*, King's Fund, 1997 and (Turnberg Report) 1998

## Summary

### Introduction

**1.** London is a world-class city and Londoners deserve a world-class healthcare system. But, though there are many areas of real excellence in London, of which we should be proud, world-class care is not currently what every Londoner can expect. There are stark inequalities in health outcomes across London, and the quality and safety of patient care is not always as good as it could, and should, be.

**2.** This report makes recommendations for change. It is based on a thorough, practitioner-led process, and rooted in evidence – gathered from a wide range of people and organisations from the world of healthcare and from the NHS's partners in local government and beyond, from thorough reviews of the literature and data, and from the use of a range of analytical modelling techniques. It also reflects a major exercise to hear what Londoners say they want from their healthcare system. It sets out a compelling ten-year vision for healthcare in London.

### The case for change

**3.** Healthcare in London needs to change. There are many excellent reports considering how healthcare must change in the future, both in general and in particular specialties. This report focuses on the specific challenges for London.

- We need to improve Londoners' health.** London's health services need to be able to tackle some health challenges that are specific to London – notably high rates of HIV, substance misuse, mental health problems, and high rates of childhood obesity. They also need to be able to meet the needs of our wonderfully diverse and highly mobile population. The NHS must be accessible to all.
- The NHS is not meeting Londoners' expectations.** There is much public support for the work done by the NHS. But not all expectations are being met. Twenty-seven per cent of Londoners are dissatisfied with the running of the NHS compared with eighteen per cent nationally. Londoners are also less satisfied than people nationally with their GP services. Though the NHS has improved considerably over the last twenty years, it has not kept pace with rising expectations. The NHS in London will have to work harder to meet the expectations of Londoners and respond to their concerns.
- London is one city, but there are big inequalities in health and healthcare.** Equity of care is a founding principle of the NHS, but healthcare in London is not equitable, either in terms of mental and physical health outcomes, or in terms of the funding and quality of services offered. London-wide data mask significant disparities. For example, Westminster and Canning Town are separated by just eight stops on the Jubilee Line, and by a seven-year disparity in life expectancy. And there is significant variation in GP distribution, with overall fewer GPs per head in some of the areas where health need is greatest.
- The hospital is not always the answer.** As set out in the White Paper, *Our health, our care, our say*, most people are best cared for by community services. This is what Londoners have told us they want and medical advances make it more possible now than ever. But 97 per cent of London outpatient appointments still take place in hospital. And, dissatisfied with the availability of GP services out of





working hours, Londoners are instead using A&E departments for urgent care.

- **We need to provide more specialised care.** Whilst most people can be cared for by community services, the most seriously ill need more specialised care. For instance, a detailed review of stroke services has found that dedicated, high-quality, specialist stroke units save lives. In order to ensure sufficient volumes of work to maintain specialist staff expertise, to support high-tech facilities, and to allow comprehensive consultant presence, specialised services need to be centralised in fewer hospitals catering for large populations. Yet London has one of the smallest average catchment populations per hospital in the country.
- **London should be at the cutting edge of medicine.** Many great medical breakthroughs have occurred in London, which remains the leading centre for health research in the UK. But the UK as a whole risks lagging behind its

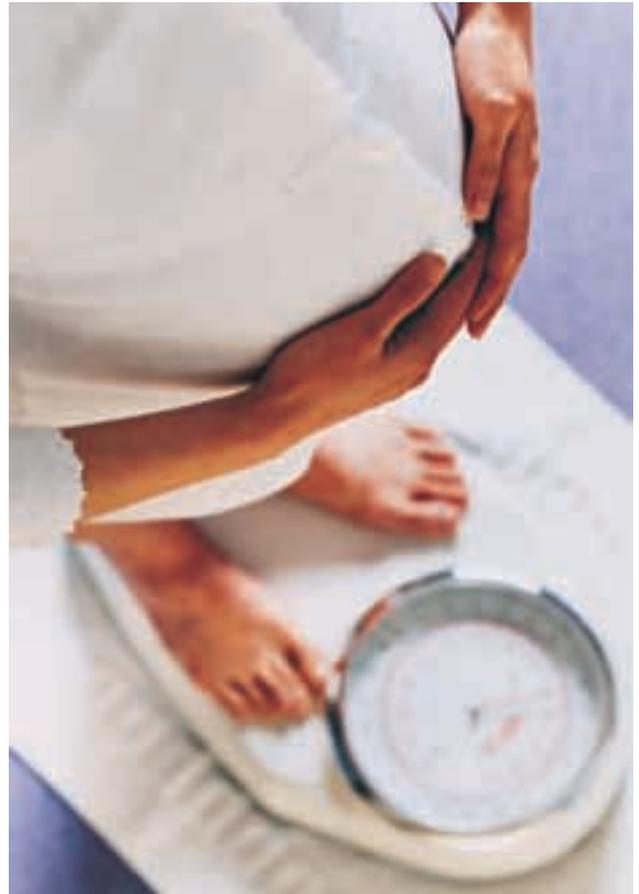
international competitors. London needs to explore the model of Academic Health Science Centres being followed by other large cities if it wants to be at the cutting-edge of research and clinical excellence.

- **We are not using our workforce and buildings effectively.** The NHS's staff are its greatest asset but their abilities are not always fully used. Productivity levels in London are lower than elsewhere in England – for example, doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts. Staff are also not employed in ways that make it easy for them to move between hospital and community settings. The NHS estate is a huge and hugely under-utilised resource.
- **We need to make the best use of taxpayers' money.** Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if

it did not make best use of the money it has. Money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere. Over the last five years, there has been unprecedented national growth in funding but this growth will slow down from April 2008. The only way for future healthcare provision to be sustainable is changing to ensure care is provided in the most cost-effective way.

### Future health needs

- 4.** We want to build an NHS for London that meets not only today's challenges (outlined above) but also the challenges of the future.
- 5.** Probably the biggest challenge for the NHS over the next ten to twenty years will come from London's growing and ageing population. Population projections suggest an increase in London's population from 7.6 million in 2006 to 8.2 million in 2016. These increases are being driven not by migration into London (which is balanced by migration out of the capital) but by a birth rate that exceeds the death rate.
- 6.** London's population is also becoming older. The fastest-growing sections of the population are the 40-64 age group and the over-85s, both of which have higher health needs than younger age groups.
- 7.** A population that is both bigger and older will have a significantly greater need for healthcare. This need will not be spread evenly throughout London, but will be concentrated where the greatest population growth is predicted – mainly along the Thames Gateway on the eastern side of London.
- 8.** Any vision for the future of London's NHS also needs to take into account the likelihood of technological changes and of ever-rising patient expectations. Although some new technology can save the NHS money, the overall trend is that new technologies increase



the demand for healthcare by making new interventions and procedures possible. At the same time, a new generation will expect NHS services to fit with their lifestyles, not the other way around. People will demand the very best care as a right, not a privilege, and the NHS will have to respond.

**9.** It is clear that demand for NHS services is only going to grow. Our detailed modelling makes it clear that continuing with the old ways of doing things will not only be ineffective, it is also likely to be unaffordable. Any proposals for change need to show that they take into account our best predictions of what the future will bring.

### Five principles for change

**10.** During the course of this review we discussed healthcare in London with a huge



range of people. Some common themes quickly began to emerge. Whether it was a meeting of a clinical working group or a public deliberative event, five principles for the provision of future healthcare came through again and again.

**11.** This report's recommendations are based on these five principles.

- **Services focused on individual needs and choices.** Provision should, wherever possible, be tailored to the particular needs of each individual. Patients should feel in control of their care and be able to make informed choices.
- **Localise where possible, centralise where necessary.** Routine healthcare should take place as close to home as possible. More complex care should be centralised to ensure it is carried out by the most skilled professionals with the most cutting-edge equipment.
- **Truly integrated care and partnership working, maximising the contribution of the entire workforce.** Better communication and co-operation is needed – between the community and the hospital, between urgent and planned care, between health and social care – to stop people from falling through the gaps. Care should be multidisciplinary, bringing together the valuable contributions of practitioners from different disciplines. The NHS should be committed to working in partnership with other organisations, including local government and the voluntary and private sectors.
- **Prevention is better than cure.** Health improvement, including proactive care for people with long-term conditions, should be embedded in everything the NHS does. Close working with local authority partners is needed to help people stay mentally and physically healthy.
- **A focus on health inequalities and diversity.** As discussed above, the most deprived areas of London, with the greatest health needs, need better access to high-

quality healthcare. The whole thrust of this report is to tackle health inequalities by improving services across London, giving everybody access to the best possible care. Healthcare should be intelligently commissioned to tackle health inequalities. Preventative and outreach work should focus on the most deprived populations and new facilities should be located in the areas of greatest need. Improvements also need to take into account London's rich ethnic and cultural diversity. We are advocating that patients have more information to make choices about their care and this should be accessible to all.

**12.** The proposals in this report have undergone a preliminary inequalities impact review. A full inequalities impact assessment will be undertaken post-publication as part of the discussion period. The preliminary review indicated that the way in which the *Framework* is implemented will be the most important factor in reducing inequalities.

### Improved care from cradle to grave

**13.** This review commissioned six clinical working groups to look at six patient pathways – maternity and newborn care, staying healthy, acute care, planned care, long-term conditions and end-of-life care - and make recommendations for change. In addition, the chief executives of London's mental health trusts helped develop robust proposals in their particular area. Taken together, these seven groups make proposals for improving care from cradle to grave.

**14.** The main report contains a great deal of material setting out the thinking and recommendations of each group. This summary cannot do justice to the huge amount of work that went into each group's proposals. What it does do is set out, under the five principles outlined above, each group's key proposals (though of course most recommendations address more than one principle).

### Universal services focused on individual needs

- Women's social and medical needs should be assessed at an early stage, and then reassessed during their pregnancy, with their care based on these assessments (maternity and newborn working group).
- As many women as possible should receive continuity of care throughout the antenatal, labour and postnatal periods (maternity and newborn working group).
- Women should be offered a genuine and informed choice of home birth, birth in a midwifery unit or birth in an obstetric unit (maternity and newborn working group).
- All women should be given one-to-one midwifery care in established labour (maternity and newborn working group).
- Mental health service users should be put in control and their recovery and social inclusion should be supported (mental health working group).
- Access to GPs for routine appointments should be improved (planned care working group).
- People with long-term conditions should be at the centre of a web of care (long-term conditions working group).
- People should have an end-of-life care plan, including preferences on place of death, and this should be registered electronically (end-of-life working group).

### Localise where possible, centralise where necessary

- Antenatal care should be provided in local, one-stop settings, and postnatal care should be provided in local, one-stop settings as well as at home (maternity and newborn working group).
- There should be a significant increase in the number of midwifery units, with each

obstetric unit having an associated midwifery unit, either co-located or stand-alone depending on local circumstances (maternity and newborn working group).

- Obstetric units should have at least 98 hours a week consultant presence (maternity and newborn working group).
- More use should be made of "talking" therapies in the community complemented by a strategy for developing inpatient care (mental health working group).
- There should be centralisation and networks for major trauma, heart attack and stroke (acute care working group).
- Dispatch and retrieval protocols for London Ambulance Service need to be aligned with centralisation (acute care working group).
- Routine diagnostics and outpatients should be shifted out of large hospitals (planned care working group).
- Increased use should be made of the day case setting for many procedures (planned care working group).
- Rehabilitation should be done at home wherever possible (planned care working group).
- More specialised inpatient care should be centralised into large hospitals (planned care working group).
- Specialist providers should offer care on other hospital sites (planned care working group).
- There should be greater investment to support people to die at home (end-of-life working group).

### Truly integrated care, maximising the contribution of the entire workforce

- Maternity networks – involving maternity commissioners and all providers – should be formally established across London and be linked with neonatal networks (maternity and newborn working group).



- There should be a clear pathway for care, so that mental health service users and partner organisations know what to expect and how to be involved (mental health working group).
- Community mental health teams should have a more focused remit (mental health working group).
- There should be a single point of contact (by telephone) for urgent care (acute care working group).
- London care bundles for intensive care and hospital-acquired infections should be developed (planned care working group).
- Integration of services should be improved (both between GP practices and hospital specialists and between health and social care) for people with long-term conditions (long-term conditions working group).
- London-wide best practice care pathways should be developed for different long-term conditions – for example, diabetes, chronic obstructive pulmonary disease, coronary heart disease and asthma (long-term conditions working group).
- End-of-life service providers should be commissioned to co-ordinate end-of-life care (end-of-life working group).

### Prevention is better than cure

- Promoting health and wellbeing means the NHS working more energetically with other public services and organisations (staying healthy working group).
- More should be invested in proven health improvement programmes and initiatives (staying healthy working group).
- There should be a pan-London campaign for activity and healthy eating linked to the 2012 Olympic and Paralympic Games (staying healthy working group).
- All health organisations and their staff should be incentivised to take every opportunity to promote physical and mental health (staying

healthy working group).

- There should be a greater focus on health protection, with improved sexual health, tuberculosis and childhood immunisation services (staying healthy working group).
- The NHS should play a greater role in improving the physical and mental health and wellbeing of its employees (staying healthy working group).
- Early intervention services need to be improved (mental health working group).
- There should be more pro-active community care to reduce emergency admissions and lengths of stay (long-term conditions working group).

### A focus on health inequalities and diversity

- Mental health services should be developed for those at risk – offenders, asylum seekers and refugees and the black and minority ethnic population (mental health working group).
- Access should be significantly improved through urgent care centres with doctors on-site. Urgent care centres in hospitals should be open 24/7, the hours of those in community settings will depend on local need (acute care working group).
- Long-term conditions should be prevented where possible by outreach and tailored



advice to the most deprived (long-term conditions working group).

- All organisations should meet existing good practice guidelines – for example, gold standards framework (end-of-life working group).

### Models of healthcare provision

**15.** This review's focus has been on services, not institutions and buildings. That is why the process was built around looking at what form future care should take in seven different clinical areas. But it is clear that at present London does not have the infrastructure and facilities to provide the ideal care outlined by our clinical working groups. New models of provision will be needed in order to deliver the kind of high-quality care Londoners need and deserve.

**16.** There are two particularly stark needs. First, we need to provide a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital. In London, primary care is mainly provided in GP practices, the majority of which have just one or two GPs. Practices are often in cramped, converted residential spaces with little opportunity to expand and provide a greater range of services. Secondary care by contrast is offered by the 32 acute trusts and ten mental health trusts. Most hospitals are large, with thousands of employees and hundreds of beds each.

**17.** Second, we need to develop hospitals that are more specialist, delivering excellent outcomes in complex cases. Although many of our district general hospitals try to provide a wide range of specialist care, there are simply not the volumes of patients with complex needs to make this either viable or as safe as possible for patients. We need fewer, more advanced and more specialised hospitals to provide the most complex care, some linking directly into universities to foster research and development.

**18.** These two needs lead us to propose seven models of provision for the future:

- more healthcare should be provided at **home**
- new facilities – **polyclinics** – should be developed that can offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals
- **local hospitals** should provide the majority of inpatient care
- most high-throughput surgery should be provided in **elective centres**
- some hospitals should be designated as **major acute hospitals**, handling the most complex treatments
- existing **specialist hospitals** should be valued and other hospitals should be encouraged to specialise
- **Academic Health Science Centres** should be developed in London to be centres of clinical and research excellence.

**19.** Each model is fully described in the main part of this report. This summary restricts itself to describing in more detail the way a polyclinic – which will be at the heart of delivering the improved services – might work.

#### *Polyclinic*

**20.** If London is to gain the improved services we envisage, then large, high-quality community facilities are needed, providing a much wider range of services than is currently provided by most GP practices. Following the testing of various names for these facilities with Londoners, we are provisionally labelling them polyclinics.

**21.** We propose that the polyclinic will be where most routine healthcare needs are met. Londoners will view their local polyclinics as their main stop for health and wellbeing support. GP practices will be based at polyclinics, but the





range of services available will far exceed that of most existing GP practices.

**22.** In terms of the clinical working groups' recommendations, polyclinics will offer access to antenatal and postnatal care, healthy living information and services, community mental health services, community care, social care and specialist advice all in one place. They will provide the infrastructure (such as diagnostics and consulting rooms for outpatients) to allow a shift of services out of hospital settings. They will be where the majority of urgent care centres will be located. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions.

**23.** The scale of the polyclinics will allow them to improve accessibility by offering extended opening hours across a wide range of services. Scale should also make it more possible to provide the expertise necessary to improve accessibility for some disadvantaged groups, and

to implement much more sophisticated telephone booking systems.

**24.** We are aware that this proposal may be challenged as de-personalising GP care. Many patients are understandably keen to maintain a relationship with their own GP. However there is no reason why larger polyclinics should not be able to provide exactly this kind of personalised care. For instance, whilst a patient attending the urgent care centre at their local polyclinic at 10pm may not necessarily see their regular GP, there is no reason why they shouldn't be able to book to see their GP within a bigger practice just as they do now.

**25.** We believe these new models of healthcare provision will provide better, more tailored healthcare closer to home for most people, whilst also delivering excellent specialised care in centralised major hospitals for those who need it. They will provide truly integrated care, bridging the current divides between primary and secondary care, between those working within

different disciplines, and between healthcare and social care. They will provide a greater focus on prevention. And they will deliver more, better quality, more accessible healthcare to all Londoners but in particular to those who have traditionally been less well-served by their NHS.

**26.** Our detailed feasibility modelling suggests that our proposed new model would, in the most likely growth scenario for demand in health services, save the NHS £1.4 billion each year. So these changes are necessary not just to improve services, but also to make future activity affordable. An NHS with a strong emphasis on prevention and early intervention saves lives and saves money.

### From vision to reality

**27.** A huge amount of energy and enthusiasm has gone into this report. People across London who really care about improving the NHS in the capital have contributed their time and knowledge to this review. The challenge will be to carry that energy and enthusiasm forward into implementation.

**28.** It is unfortunately the case that previous strategic frameworks have been at best only partly implemented. Both opposition to change, and a lack of understanding of how to bring change about, have stopped the momentum. People working in the NHS have believed that their organisations will be changed by powers above them, rather than by them themselves.

**29.** I am determined that things should be different this time. This report identifies the main drivers for change and improvement that will ensure the vision in this *Framework* becomes a reality, and demonstrates the part that everyone in the NHS can play.

- **Commissioning.** Commissioning is potentially a very powerful lever for driving change. We need the right commissioning skills and structure, and we need to commission in partnership with others.



- **Partnerships to improve health.** The NHS has often made the mistake of thinking it can change healthcare outcomes on its own. It cannot. The NHS must work with its partners – the London boroughs, the Greater London Authority and the Mayor's Office, the voluntary and private sectors, and the higher education sector – to implement this *Framework*.
- **Public support.** For change to succeed both the public and politicians need to believe that it is in the public's interest. The clinical case for change needs to be clearly made. And there needs to be up-front investment to help put new services in place quickly and win public support for change.
- **Clinical leadership.** The whole approach of this review has been to develop clinical support for our proposals. But it is easy to support principles for London, harder to support change in the hospital or locale where you work. Many clinicians understandably fear that change will affect their job satisfaction, their autonomy, their clinical reputation. To confront and assuage these fears, NHS London needs to identify clinical champions to make the case for change.



- **Training and the workforce.** Clinical leadership is important but so too is the development of the workforce more broadly. New models will call for new roles and new skills. NHS London needs a single workforce strategy to help align recruitment and training with changing needs.
- **Patient choice and information.** The choices that patients make about their healthcare will increasingly drive change and improvement. The better the information, the more those choices can drive improvement. Information for choice needs to be developed in priority areas such as GP and maternity services.
- **Funding flows.** Commissioning can only drive change if it has a direct impact on the income of healthcare providers. Funding flows need to be used to incentivise the best practice contained in this report. At its simplest, this means commissioners defining the best, safest practice for a patient pathway and then ensuring that this and only this is the practice they pay for.
- **Better use of our estates.** The NHS in London has a huge and under-utilised estate. We need a comprehensive estates strategy to support this *Framework*, including exploring how surplus or underused estate can be used to finance new developments.

**30.** These are the drivers for change. I have also identified four short-term activities that I think will be necessary to show that the NHS in London is serious about this *Framework* – the development of five to ten polyclinics by April 2009, the urgent London-wide re-configuration of both stroke and trauma services, and rapid work to further improve the skills and capacity of our already-remarkable London Ambulance Service.

**31.** And finally, one of the main themes of this report is the importance of reducing health inequalities by giving everyone access to the best

possible care. Whether this *Framework* succeeds in this goal will depend on how it is implemented. So I will be expecting both local and strategic implementation to make systematic use of health inequalities impact assessments to ensure improvements are helping those who are currently the least well-served by the NHS.

**32.** I feel passionately about London, and I feel passionately that Londoners deserve world-class healthcare. From here on in, taking things forward will be the collective responsibility of the NHS in London, together with its partners. Specifically, NHS London, the strategic health authority for London, will need to co-ordinate the task of turning the vision into the reality of improving healthcare for London. I hope that all those who have a stake in creating a world-class healthcare system for London will keep working with them to make the vision a reality.



## Introduction

**1.** This brief introduction summarises the inputs to the Healthcare for London Review and then sets out how the report is structured.

### Methodology of the review

**2.** This report is the culmination of a major exercise to hear the views of Londoners, clinicians, public sector partners and other key stakeholders on the future of healthcare in London. Since the review started in earnest in December 2006 many different groups have contributed.

**3.** Londoners have been able to have their say. An Ipsos MORI phone survey of 7,000 Londoners obtained high quality quantitative data on the public's perception of the capital's healthcare. This was supplemented by two deliberative events, each involving a hundred Londoners.<sup>1</sup> These were run by Opinion Leader Research to allow deeper discussions on our future vision. Both the survey results and a report on the deliberative events are available electronically.<sup>2</sup>

**4.** If we want to achieve change, clinical buy-in is crucial. So as part of this review, clinical working groups were established to make recommendations on the future provision of services. The groups' membership was drawn from clinical innovators across London. The groups' recommendations informed the content of "improved care from cradle to grave" in particular. Full versions of the groups' work are being published electronically, to complement this report. Supplementing the clinical working groups was a full-day clinical conference with international speakers highlighting good practice around the globe.

**5.** Although the review's focus has been on healthcare, we recognise that health services do not operate in isolation – the NHS is dependent



on other public services and will need to work in partnership with them to deliver this report's recommendations. So we have been keen to involve key NHS partners, holding a deliberative event for voluntary sector organisations, whilst both London Councils and the Greater London Authority have been engaged in the review.

**6.** As the review has developed, a host of leading figures in the world of healthcare and beyond have had the chance to contribute their thoughts.

**7.** We also received over 70 written consultation submissions, which provided valuable detail and





suggestions for improvement. A full list of the organisations that made submissions is being made available electronically.

**8.** A wide range of approaches has been employed to ensure that the best available evidence has been brought to bear to inform the report's conclusions. We have drawn on evidence from literature searches and that highlighted by clinical experts. We believe this report is evidenced-based and have made every effort to use references where appropriate.

**9.** We have also used a range of modelling techniques to investigate and validate our proposals, particularly in modelling future demand for healthcare and feasibility testing our proposals. A technical paper setting out this modelling work is being made available electronically.

### Framework for Action's story

**10.** This report can be read as stand-alone segments, but is intended to tell a coherent story.

**11.** The first chapter, "the case for change", sets out why healthcare in London needs to change. It examines eight reasons why the status quo is unacceptable.

**12.** The second chapter, "future demands on healthcare", then looks forward to how London's healthcare needs will change over the next ten years, driven by demographic changes and technological developments.

**13.** The third, and largest, chapter, "improved care from cradle to grave", initially sets out common principles for future healthcare services. It then focuses on seven specific clinical areas, setting out our key recommendations for how services need to change in order to provide the best quality of care.

**14.** The fourth, "future models of healthcare provision", acknowledges that at present we do not have the infrastructure and facilities to provide the ideal care outlined. It sets out future

models for how care should be organised.

**15.** The final chapter, "turning the vision into reality", begins to consider some of the drivers (such as improving commissioning) that will make the report's recommendations a reality, and sets out the next steps.

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- 1 Follow-up deliberative events in May and June 2007, involving some of the 200 original participants, allowed us to test emerging proposals.
  - 2 [www.healthcareforlondon.nhs.uk](http://www.healthcareforlondon.nhs.uk)





## The case for change<sup>1</sup>

### Introduction

**1.** This chapter seeks to make a compelling case for why healthcare in London has to change. There are many excellent reports that consider how healthcare must develop in the future, both generally and in particular specialties.<sup>2</sup> We do not seek to repeat those, but focus instead on the specific challenges to improving healthcare in London.

### Ongoing change

**2.** Why does healthcare in London need to change? After all, there have been considerable achievements in the last few years, most notably in reducing waiting lists and increasing survival rates for the big killers of cancer and coronary heart disease. These improvements were made possible by the record increases in healthcare funding, the development of National Service Frameworks detailing how to improve the quality of care and the vision set out in *The NHS Plan*.<sup>3</sup> But none of these improvements could have been made without the dedication and support of NHS staff in London.

**3.** However, there has been a lack of focus on the specific challenges facing healthcare in London. The changes envisaged in London-specific strategic documents, most notably *Health Service in London - A Strategic Review*,<sup>4</sup> the 1998 report by Lord Turnberg, have not fully occurred.

**4.** Much of the Turnberg report continues to be relevant, with its emphasis on the rationalisation of major hospital services on the one hand, supported by the development of high-quality community care on the other. Of its major recommendations, only the suggestion that London does not need to reduce its acute

inpatient beds has been proved obsolete by healthcare developments.<sup>5</sup>

**5.** Competing priorities have meant that some of the most significant elements of the Turnberg report have never been implemented. In addition, the five previous Strategic Health Authorities (SHAs) that were established in 2002 were simply not configured to lead the pan-London improvements envisaged. And whilst individual clinicians and managers have made improvements to services, this has often been on a piecemeal basis.

**6.** London's healthcare must improve now. There are eight reasons why the time is right for NHS London to lead a co-ordinated programme of change across London.

### Reason one – the need to improve Londoners' health

**7.** NHS London's key aim is to improve the health of all the capital's inhabitants. "Improving health" means focusing on London's specific mental and physical health challenges and tackling the lifestyle factors that put people at risk.

**8.** In some health indicators London performs well. For instance, although it is a big killer, coronary heart disease mortality rates are lower in London than in other parts of England.<sup>6</sup> However, London faces specific health challenges such as HIV, substance abuse and mental health.

**9.** London has 57 per cent of England's cases of HIV. As many as 27 per cent of those infected with HIV may be undiagnosed, which would mean 8,600 Londoners are not receiving treatment. One in four adult drug users live in London. One million Londoners have had mental health problems.<sup>7</sup> Suicide is the most common cause of death for





men under 35 years old, and London is not on track to meet its target of a twenty per cent reduction in suicide rates by 2010.

**10.** Londoners also need more help to adopt healthy lifestyles. Twenty-two per cent of Londoners smoke. As a result, one Londoner dies every hour from a smoking-related disease and smoking costs the NHS in London over £100 million a year.

**11.** London has higher rates of childhood obesity than the rest of England. Every year in London, obesity accounts for 4,000 deaths. London is far away from the “fully engaged” scenario envisaged by Sir Derek Wanless, where everything is done to prevent ill health.<sup>8</sup>

**12.** The second half of the key aim – “for all the capital’s inhabitants” – means recognising that London’s health services have to meet the needs of the capital’s wonderfully diverse population. There are 300 different languages spoken and 90 different ethnic groups in the capital, but the NHS must be accessible to all Londoners.

**13.** London also needs an NHS that can cope with

a population that is highly transient. In some parts of London there is a turnover of twenty to 40 per cent of patients a year on GP lists, which presents a challenge in achieving continuity of care. People who move frequently are less likely to receive preventative care such as immunisation and screening. Those who are new to an area also do not know how to access local services.<sup>9</sup> For instance, recent immigrants tend to use A&E because they are unaware of alternatives.

**14.** In addition, as well as Londoners moving around within London, there are people coming into London. The NHS must provide services for the estimated one million daily commuters to London and the more than thirteen million tourists who visit every year. The need to cater for such a highly mobile and diverse population is one of the biggest challenges for the NHS in London.

#### Reason two – the NHS is not meeting Londoners’ expectations

**15.** There is much public support for the work done by the NHS. However, not all Londoners’ expectations are being met. Twenty-seven per cent are dissatisfied with the running of the NHS compared with eighteen per cent nationally,<sup>10</sup> and nearly 50 per cent of those who attended the two deliberative events held as part of this review could not describe themselves as satisfied with London’s health services.<sup>11</sup>

**16.** An Ipsos MORI survey of over 7,000 Londoners conducted in autumn 2006 revealed that, despite recent reductions, further improvement in waiting times for operations, appointments and in

Top four priorities for improvement from the Ipsos MORI survey	Percentage of respondents saying a lot/fair amount of improvement needed
Waiting times for with hospital consultants	62
Cleanliness of hospitals	62
Time spent waiting in A&E Departments	61
Waiting times for non-emergency operations	58

*“A couple of years back people were waiting for operations for a ridiculous length of time. The drive to reduce waiting times has really been effective and marks a massive improvement.”*

**Voluntary Sector Event Participant**

accident and emergency (A&E) departments is a priority for people.<sup>12</sup>

**17.** Also prominent as an issue needing attention is hospital cleanliness. Some of those surveyed cited cleanliness as a factor that would affect their choice of hospital.

**18.** The survey also highlighted that those who felt they had choice in their healthcare were much more positive about the care they received. Thus 80 per cent of those who said they have at least a fair amount of choice felt their local NHS was providing them with a good service, compared with 54 per cent of those who said they have little or no choice.

**19.** The survey found Londoners gave their GP services a lower net satisfaction rating than people nationally. This corroborates the findings of the London “listening event” conducted as part of the *Your health, your care, your say* consultation, where people spoke of difficulty booking GP appointments in advance or being seen outside normal nine-to-five working hours. They could also rarely speak to GPs directly by phone and tended to only get reactive, rather than proactive, care.<sup>13</sup>

**20.** Given these findings, it is no surprise that over 90 per cent of the Londoners at the two deliberative events felt that the NHS needs to improve.<sup>14</sup>

**21.** Calls for improvement are only likely to grow. Part of the NHS’s challenge in London is to meet rising expectations. A British Social Attitudes Report found that whilst 55 per cent of people were satisfied with the NHS in 1983, just 40 per cent were satisfied in 2003. Those who were dissatisfied with the NHS had increased from 25 per cent to 41 per cent over the same period.<sup>15</sup>

**22.** The NHS has improved considerably in the last twenty years, with the introduction of new treatments such as minimally invasive surgery and far better survival rates, but it has still not

kept pace with rising expectations. As Jon Appleby concludes, “Over the last twenty years people have come to have higher expectations of their healthcare and so, even though many things have improved, people are less satisfied than they were.”<sup>16</sup> The NHS in London therefore has to work hard to meet Londoners’ expectations and respond to their concerns.

### Reason three – one city, but big inequalities in health and healthcare

**23.** Equity of care is a founding principle of the NHS, but the evidence suggests that Londoners are not experiencing equity either in terms of their mental and physical health outcomes or in terms of the services they receive. Such inequity is not always visible, with London-wide data masking significant disparities.

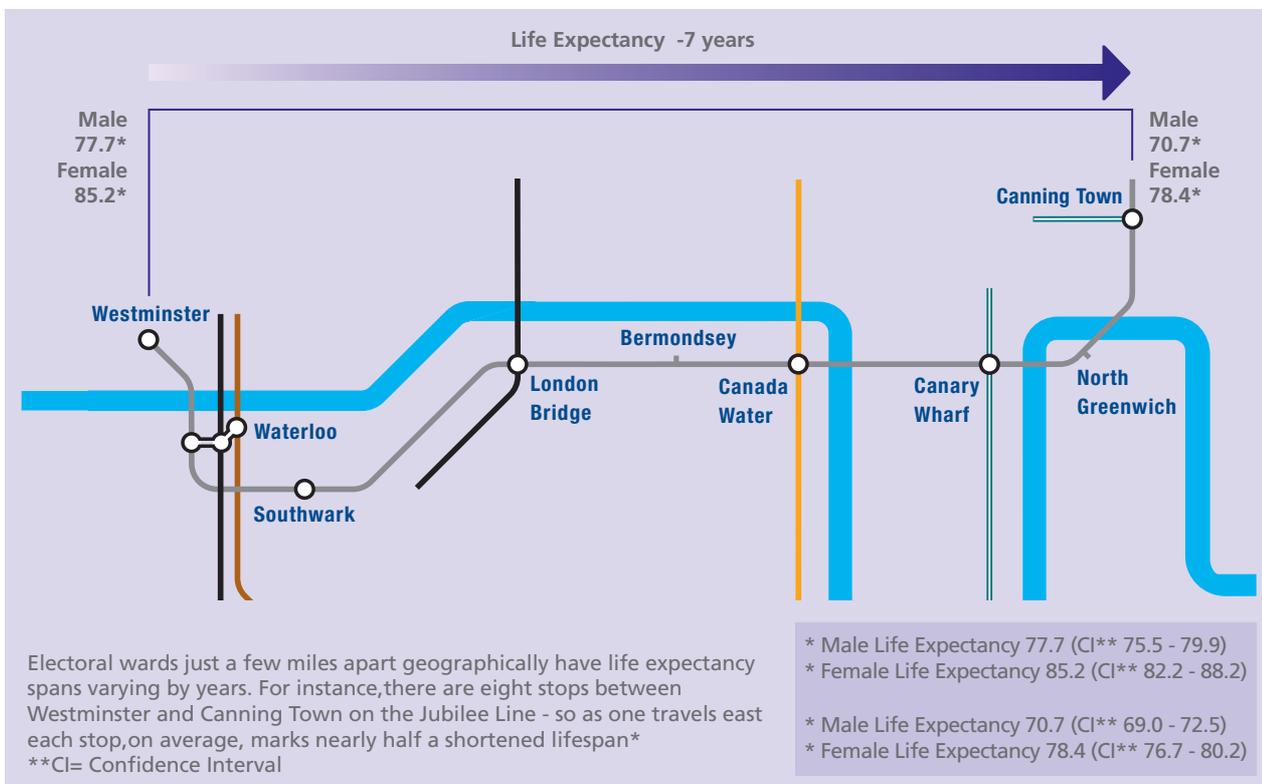
**24.** For instance, whilst overall life expectancy in London is similar to national levels there are very significant differences within London. Just eight stops on the Jubilee line takes you from Westminster to Canning Town where life expectancy is seven years lower.

**25.** This discrepancy means that raising life expectancy for the bottom half of London





### Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost



\* Source: Analysis by London Health Observatory using Office for National Statistics data

boroughs to the current London average would save 1,300 lives every year.<sup>17</sup>

#### 26. Other examples of health inequality include:

- the infant mortality rate in Haringey (8.1 per 1,000 births) is three times that of Richmond (2.7 per 1,000 births)
- Hammersmith and Fulham has twice the proportion of smokers of Harrow (34.5 per cent compared with 17.5 per cent)
- two thirds of children in Kensington and Chelsea consume three or more portions of fruit and vegetables a day, compared with one third in Barking and Dagenham<sup>18</sup>
- there are twice as many binge drinkers in Wandsworth (21.1 per cent) as in Newham (9.3 per cent)
- the teenage conception rate for Lambeth at

98 per 1,000 females aged fifteen to seventeen is almost four times that of Richmond (24 per 1,000)

- mental health inpatients are more than twice as likely to come from the twenty per cent most deprived London electoral wards as from the twenty per cent least deprived.<sup>19</sup>

**27.** At the same time as there are big inequalities in outcomes, there is great disparity in health inputs, such as funding per person. Looking at the funding for the five old strategic health authority areas it is noticeable that whilst North East London contains several deprived boroughs with some of the lowest life expectancies in England, in 2004/05 the average expenditure per weighted head of population was £1,090, compared with the North West London figure of £1,311.<sup>20</sup>

## There is significant variation in GP distribution



Source: The Information Centre - General & Personal Medical Services: 1995-2005

**28.** An inverse relationship also exists between health need and GP distribution. There are overall fewer GPs per head of weighted population in the east and north of London (where health need is greatest), compared with the south and west.

**29.** Of course, it is not simply the numbers of GPs that matters, but also the quality of care. The Quality and Outcomes Framework (QOF) measures the quality of care provided by GP practices. For coronary heart disease, the PCTs with the highest average QOF scores amongst their practices are those in the south and west of London.<sup>21</sup> This means a patient with coronary heart disease in Richmond is likely to get better care than one in Newham.

### Reason four - the hospital is not always the answer

**30.** The *Our health, our care, our say* White Paper presents a convincing argument that most people are best cared for by community services.<sup>22</sup> A review of the available evidence for shifting care into the community by the University of Birmingham's Health Services Management Centre has found positive evidence for this model.<sup>23</sup> To cite just two examples: one study demonstrates that people with chronic obstructive pulmonary disease greatly benefit from community pulmonary rehabilitation and another shows that specialised, dedicated heart failure nurses in





the community can improve health outcomes for patients with heart failure and reduce emergency admissions to hospital.<sup>24</sup>

**31.** Medical advances mean that more care can be provided locally than ever before. For instance, modern surgery allows more procedures to be safely delivered as day cases, outside of major hospital settings. More outpatient appointments can take place in the community. In the US this has meant that whereas in 1981, 90 per cent of outpatient appointments were in hospital, in 2003 the figure was 50 per cent with the other half being provided in physician offices (equivalent to GP practices) and "polyclinics".<sup>25</sup>

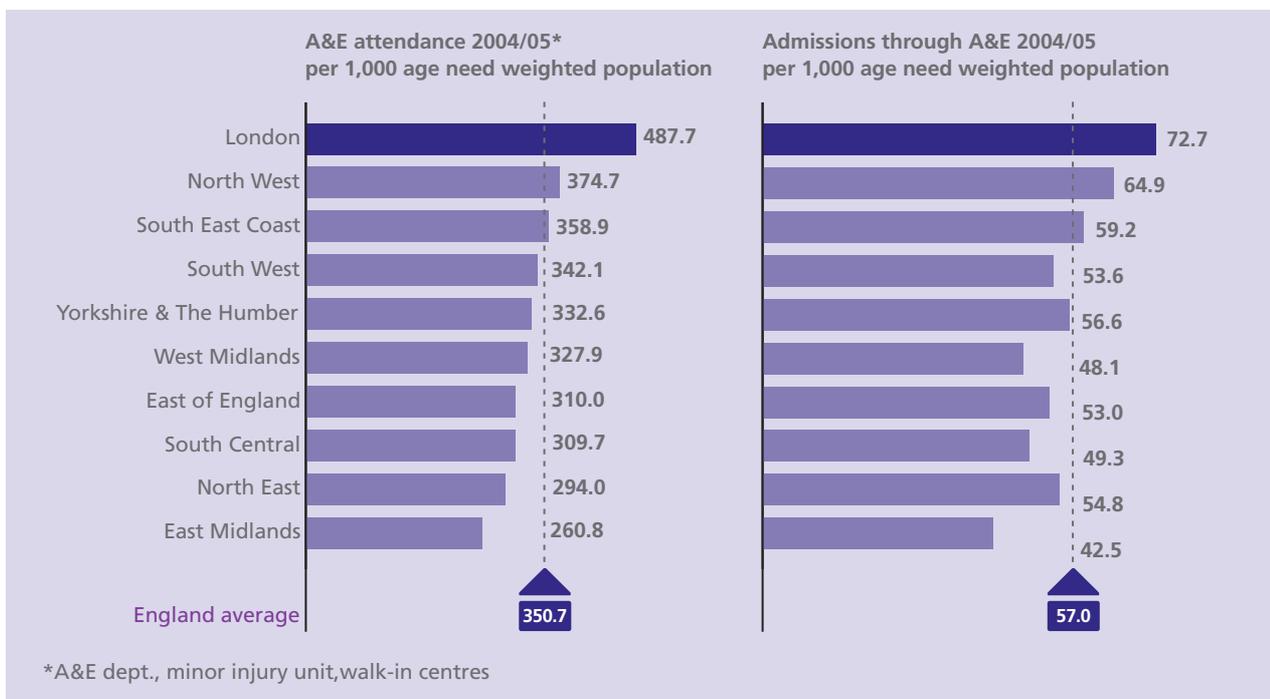
**32.** By comparison, in London 97 per cent of outpatient appointments take place in hospital. So, whilst the vast majority of patients do not need hospital care, London has a long way to go to make this a reality.

**33.** Yet at the moment, community services are not providing a satisfactory alternative to hospital. This is particularly apparent for urgent care. Londoners are dissatisfied with the availability of GP services outside normal working hours – it is the *only* aspect of services provided by GPs with which there is net dissatisfaction.<sup>26</sup>

**34.** As a result, Londoners are using A&E departments for urgent care instead. In another example, many patients are admitted to hospital because no alternative care – such as specialist nursing care for acute exacerbations of a long-term condition – is available. Therefore it is little surprise that London has by far and away the highest rates of both A&E attendances and A&E admissions in the country.

**35.** Improvements in community services clearly need to happen, but this is made more challenging because of the existing configuration of services. GP practices in London are smaller

**In London, A&E attendances and admissions through A&E are the highest in the UK**



Source: DH Hospital Activity Statistics 04/05, HES 04/05, team analysis

*"There's a lot of differences between GPs even where I live locally, there's no consistency, some are very good, some are very bad."*

**Public Event Participant**

than average for the rest of England – 54 per cent of GP practices in London have only one or two GPs, compared with 40 per cent nationally.

**36.** It is harder for small practices to provide additional services in their practices such as physiotherapy or diagnostics (from ultrasounds to even basic blood tests). Yet many cannot expand because of their buildings. A British Medical Association (BMA) survey found that almost 60 per cent of London GP practices felt their premises were not suitable for their present needs and this rose to 75 per cent when asked about their future needs.<sup>27</sup>

**37.** Professional attitudes also act as a barrier to providing more community services. For historical reasons there has been a sharp divide in the UK between GPs who work in the community and consultants who work in hospitals. Thus 65 per cent of doctors in the UK report problems due to care not being coordinated across sites/providers compared with 22 per cent in Germany and 39 per cent in Australia.<sup>28</sup> These barriers need to be overcome because most patients do not need hospital care and can be better cared for more locally.

### Reason five - the need for more specialised care

**38.** Whilst most people can be cared for by community services, the most seriously ill need more specialised care. For instance, a detailed review of stroke services has found that dedicated, high quality, specialist stroke units saved lives.<sup>29</sup>

**39.** As well as dedicated stroke units, the best stroke care means rapid access to a CT scan to determine the cause of the stroke, immediate treatment with clot-busting drugs (if appropriate to the type of stroke) and physiotherapy within a few days of the stroke. Delivering this high quality care requires specialist multidisciplinary teams and high quality equipment all available 24 hours a day, 7 days a week.

**40.** However, in 2004, out of the 30 hospitals in London providing stroke services, only four treated over 90 per cent of stroke patients in a dedicated unit. In addition, thrombolysis (the use of clot-busting drugs) needs to occur within three hours of the onset of a stroke to be effective, and a CT scan is required before thrombolysis can occur.<sup>30</sup> Yet in only seven hospitals were 90 per cent of patients getting a scan within 24 hours, which is less than ideal.<sup>31</sup>

**41.** This was in 2004 and performance could have been expected to improve. Worryingly however, the situation has got worse, so that in 2006 only three hospitals met the 90 per cent benchmark for care in a dedicated stroke unit and none reached the benchmark for CT scans within 24 hours.<sup>32</sup>

**42.** Stroke care provides a salient lesson in how uncontrolled growth in service provision, without giving proper consideration to the infrastructure and workforce needed to provide those services, can be dangerous for patients. What is needed is the planned development of specialist care. Achieving this requires the centralisation of more specialised services in fewer hospitals. There are three main reasons for this:

- first, specialist doctors, along with their specialised teams, need to see a large enough volume and variety of cases of a specific condition to hone their skills and develop and sustain expertise. There is evidence that specialist units performing larger numbers of cases achieve better results, particularly in more complex work.<sup>33</sup> A good example is provided by the Texas Heart Institute which performs 10,600 heart operations a year (compared with the average US healthcare provider which does 137). Patient survival rates for the Texas Heart Institute a year after surgery are 92 per cent compared with a US average of 82 per cent and a typical procedure costs \$27,000 compared with a US average of





\$48,000. Another example where volume and specialisation is related to clinical excellence is Memorial Sloan-Kettering Cancer Center. Such concentration of care, with large numbers of patients, also creates centres of excellence that make it easier to train future specialist staff.

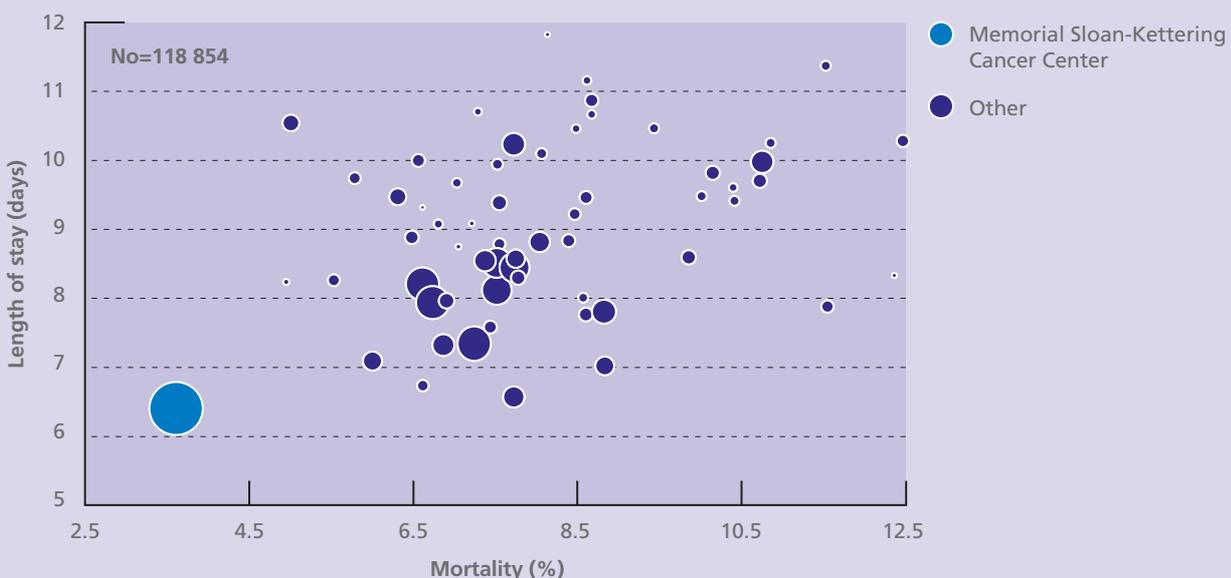
- second, technology advances are driving more centralisation of specialist services. The most complex cases require a range of diagnostic equipment – Magnetic Resonance Imaging (MRI) scanners, gamma cameras and even new methods such as Positron Emission Tomography (PET) scanners which can detect illness at a much earlier stage – all to be available in one place. To do this means locating high-tech equipment in centres of expertise where trained staff can utilise it, and where there are enough cases to justify the technology's cost.

- third, better working practices mean that staff are becoming centralised on fewer sites. Experienced staff are needed to manage the care of patients in hospital. The recent Healthcare Commission report into maternal deaths at Northwick Park Hospital recommended that there be increased consultant presence on the maternity unit.<sup>34</sup>

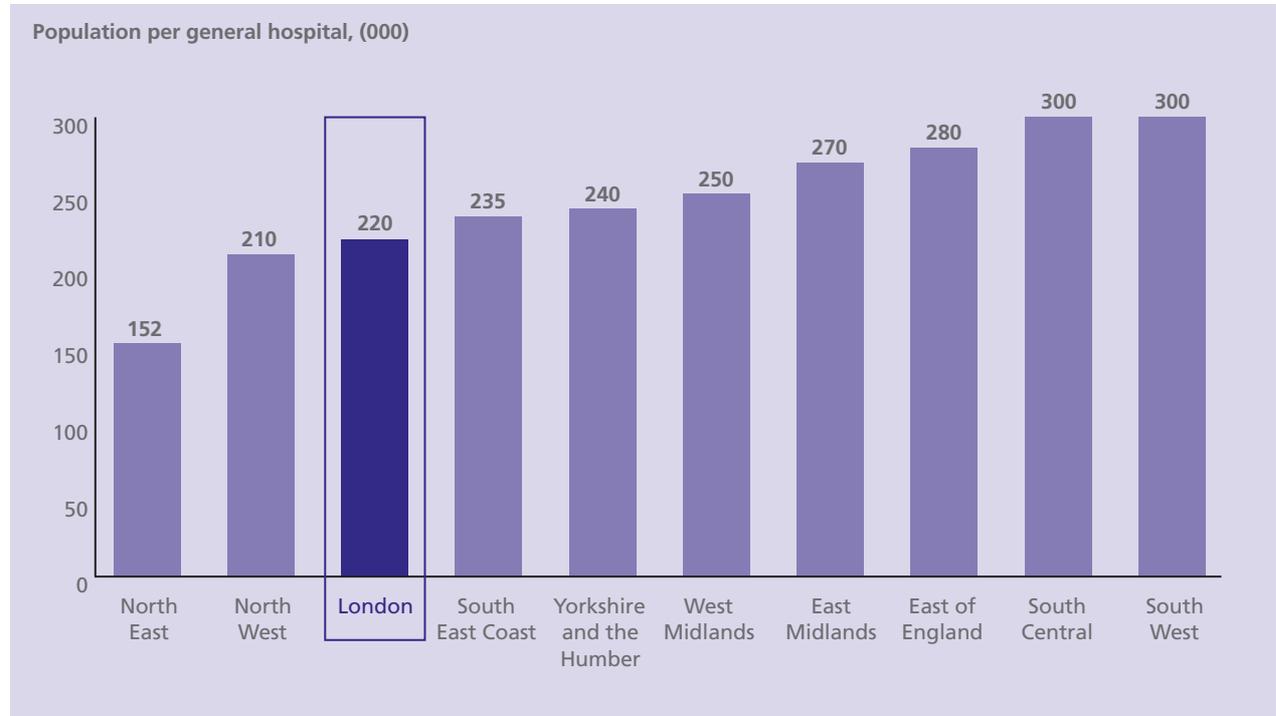
In addition, the European Working Time Directive (EWTD) is helping to ensure doctors are less likely to be tired when treating patients, by requiring them to work fewer hours. However, this does mean that more doctors are needed to maintain a 24 hours a day, seven days a week, service. To achieve greater consultant presence in hospital and to comply with the EWTD will require the reorganisation of services. It will be harder for small hospitals to employ enough consultants to provide continuous cover for acute services.

### Specialisation can lead to lower cost and better outcomes: cancer example

Risk-adjusted mortality from cancer against length of stay for institutions in New York State.  
The size of the circle indicates the number of patients treated



### London has a relatively high number of general hospitals despite high population density



Source: Hospital reconfiguration, IPPR Briefing, September 2006

**43.** In order to ensure sufficient volumes of work to maintain specialist staff expertise, to foster high-tech facilities, and to allow comprehensive consultant care, specialist services will need to cater for larger populations. Yet despite having the highest population density in England, London has one of the smallest average catchment populations per hospital in the country.

**44.** This means that hospitals in London are not able to take advantage of the latest advances in medical care, as specialist staff and facilities are spread across too many sites.

#### Reason six – London should be at the cutting edge of medicine

**45.** London is the leading centre for health research in the UK. Fifty per cent of the UK's biomedical research is carried out in the capital and 30 per cent of healthcare students are educated there.<sup>35</sup> However, the UK as a whole

risks lagging behind its international competitors. The UK now spends half as much on research as a proportion of GDP compared with the United States.<sup>36</sup> At the same time, the number of commercial drug trials taking place in India and Russia is growing exponentially, whilst trial numbers in the UK remain fairly static.<sup>37</sup>

**46.** Changes to the way funding is allocated under the government's new research and development strategy *Best Research for Best Health* are also likely to mean that the share of research funding that London receives will decrease.<sup>38</sup>

**47.** Many of the great medical breakthroughs have occurred in London. Alexander Fleming discovered penicillin at St Mary's Hospital and John Snow identified cholera as a water-borne disease in Soho. More recently, one of the earliest MRI scanners was built in the Hammersmith Hospital under the supervision of the Nobel Laureate Sir Godfrey Hounsfield.





The timeline below summarises a few of the key breakthroughs.

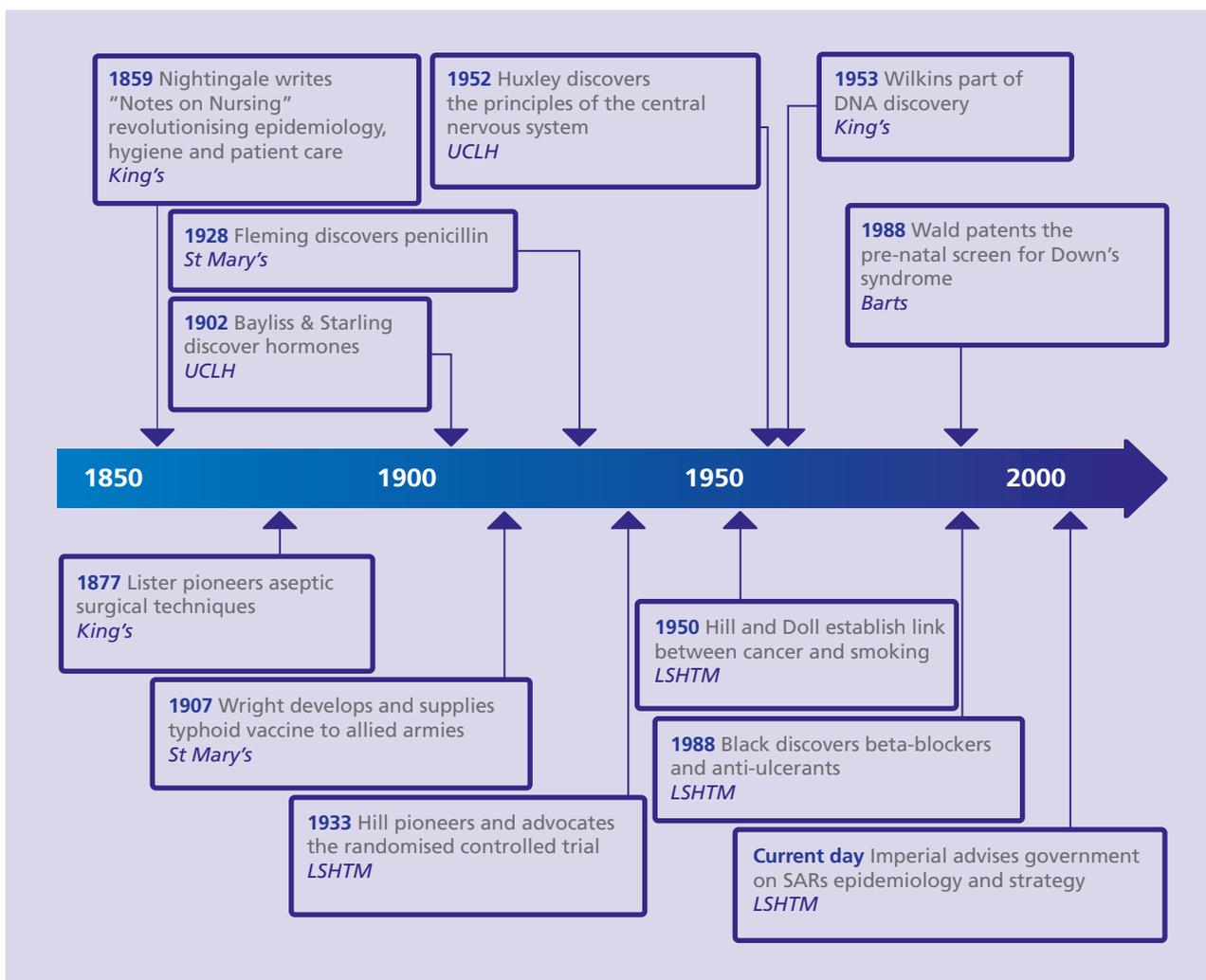
**48.** London’s future record in health research must match this distinguished past – because excellent health research will mean that London’s patients can benefit from the latest scientific breakthroughs in treatment.

**49.** To make this happen will require closer co-operation between hospitals and universities in London. A new form of university/hospital partnership is needed to maintain the UK’s

academic institutions at the forefront of the global marketplace where they compete for grants, recognition and staff.

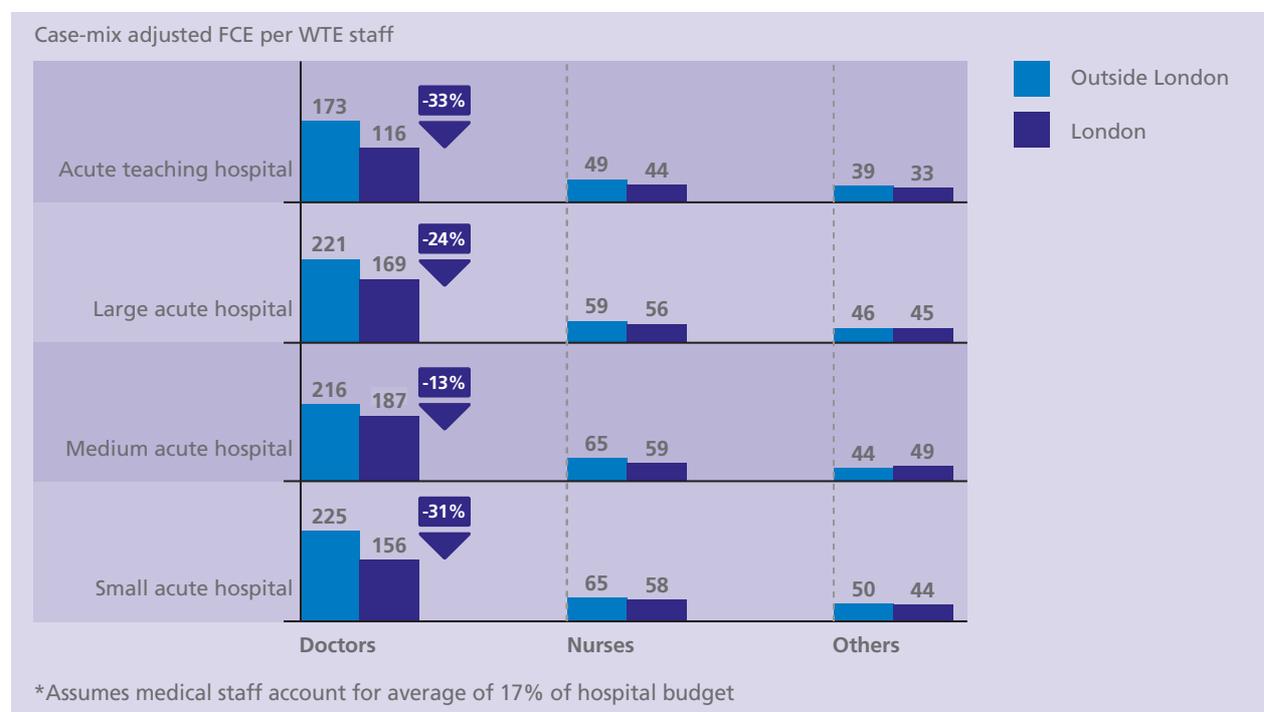
**50.** Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Science Centres (AHSCs), combining world-class research with leading-edge clinical services and education and training. For instance, Toronto has Sunnybrook Health Science Centre and Boston has Massachusetts General Hospital.<sup>39</sup>

**London contributions to medical innovation**



\* Source: London University submissions and websites

## Labour productivity is lower in London



Sources: Department of Health; HES data; team analysis

**51.** AHSCs help to ensure that research breakthroughs lead to direct clinical benefits for patients. In 2005, the top sixteen ranked hospitals in the US were all AHSCs.<sup>40</sup> Clearly AHSCs are a model of healthcare organisation London needs to explore if the capital wants to be at the cutting-edge of research and clinical excellence.

### Reason seven – not using our workforce and buildings effectively

**52.** The NHS's staff are its greatest asset, but their abilities are not always fully utilised. For instance, doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts in comparable hospitals elsewhere in England.<sup>41</sup> Nurses also see relatively fewer patients.

**53.** Meanwhile, the NHS has never employed staff in a way that helps them to move easily between hospital and community settings, as

they will have to in future. There needs to be more support for staff to work flexibly to deliver the best care and not tie them to one institution. And whilst we have come a long way on improving the quality of care (eg through improvements in clinical governance and the work of the Healthcare Commission) there must still be a greater emphasis on developing a culture that monitors and promotes improvements in the quality of the care that staff deliver.

**54.** The NHS's buildings also need to be used more effectively. The NHS in London has a huge property portfolio of nearly 100 hospitals as well as hundreds of other sites for mental health and community provision. This equates to a total of four to five million square metres of facilities and this estate costs at least £0.7 billion (around seven per cent of the total healthcare spend in London) simply to service.<sup>42</sup>





**55.** However, many of these facilities are under-utilised. The Bolingbroke Hospital in Wandsworth uses less than 50 per cent of its estate. Other sites are not fully utilised outside of the traditional working week.

**56.** Not only is our healthcare estate being used ineffectively, it is also ageing. Recent investment has led to the opening of impressive new healthcare facilities such as the Brent Emergency Care and Diagnostic Centre at Park Royal. Yet much more needs to be done. Backlog maintenance – the figure used to determine how much investment is needed to bring hospital buildings up to an acceptable standard – for just the acute hospitals in London is over £800 million. Barnet and Chase Farm Hospitals NHS Trust has backlog maintenance of £44 million whilst for Hillingdon Hospital NHS Trust it is over £55 million.

**57.** Ageing facilities cause a multitude of problems such as being more difficult to access, not being designed with the latest medical techniques in mind and being harder to keep clean, leading to more difficulties in the prevention of infections such as MRSA.

### Reason eight - making the best use of taxpayers' money

**58.** Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if it did not make the best use of the money it has. Money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere. And the money spent by the NHS in London is very considerable – £10.1 billion in 2005/06.

**59.** Over the last five years there has been unprecedented national growth in funding which has seen the NHS reach and then exceed the OECD average for spend per capita on healthcare.<sup>43</sup> In 2008, the UK will spend nine per cent of its GDP on healthcare, a greater proportion than Japan.

**60.** However, this growth will slow down from April 2008. In addition, an adjustment to the funding allocation will see most London PCTs getting significantly lower rates of increase to their funding than in the past whilst rising costs of staff, drugs and technology, and increasing expectations, will continue to exert pressure.<sup>44</sup> The only way for future healthcare provision to be sustainable is changing to ensure care is provided in the most cost-effective way.

**61.** One of the major ways to achieve good value care would be to ensure people are not staying in hospital longer than they need to. For instance, in 2004/05 if all London hospitals had achieved the English average for lengths of stay this would have saved 800,000 bed days or over £200 million.<sup>45</sup>

**62.** Across London, achieving the average length of stay would free up over 2,000 beds. This could be done by measures such as reducing the number of patients admitted the day before their operation.

### Conclusion

**63.** These eight reasons for change provide a clear rationale as to why we cannot persist with the status quo in London. They are the reason why this *Framework for Action* is necessary, so that Londoners get the best possible healthcare. The eight reasons are all healthcare-focused, as that was the remit of the review. However, our proposals will emphasise that change can only be achieved by the NHS working with its partners, such as local authorities.

- 1 This extended version of the Case for Change builds on the version that was published on 9 March with additional data, examples and illustrations. It does not significantly alter any of the reasons for change.
- 2 On general healthcare developments see, Farrington-Douglas J, *The Future Hospital: The progressive case for change*, IPPR January 2007. On particular specialties see the recent reports of the National Clinical Directors eg Boyle R, *Mending Hearts and Brains*, Department of Health, December 2006

*"The majority of staff are caring, respectful, friendly and professional. They make you feel at ease and make you confident that you're being looked after correctly and appropriately."*

**Public Event Participant**



- 3 *The NHS Plan*, Department of Health, 2000
- 4 *Health Service in London – A Strategic Review* (Turnberg Report), 1998
- 5 See for instance the NHS Confederation, *Why we need fewer hospital beds*, May 2006
- 6 *National Centre for Health Outcomes Development Indicators*
- 7 These and subsequent statistics in reason one taken from London Healthcare Observatory, *Health and Healthcare in London – Key Facts*, September 2006, <http://www.healthcareforlondon.nhs.uk>
- 8 Wanless D, *Securing our Future Health: Taking a long-term view* (The Wanless Report), April 2002
- 9 *Population Mobility and Service Provision: A report for London Councils*, LSE, London, February 2007
- 10 Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007
- 11 *Healthcare for London - A Framework for Action: Findings from two deliberative public events*, Opinion Leader Research March 21st 2007
- 12 Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007. The subsequent percentages are all from this survey
- 13 Report from London user group, *Your health, your care, your say*, 2005
- 14 *Healthcare for London: Findings from deliberative events*, OLR, March 2007
- 15 Appebly and Rosette in British Social Attitudes Report, NatCen
- 16 Appebly and Rosette in British Social Attitudes Report, NatCen
- 17 *The London Health Inequalities Forecast*, London Health Observatory, November 2006.
- 18 All taken from the *National Centre for Health Outcomes Development Indicators*
- 19 Dr Foster, *Availability of Mental Health Services in London*, April 2005
- 20 Weighted means adjusted to take account of health need based on age, health status etc. SHA data is based on PCT spend.
- 21 Quality, Prevalence and Indicator Database held by the Prescribing Support Unit in the Health and Social Care Information Centre
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- 23 University of Birmingham Health Services Management Centre, *Making the Shift: Key Success Factors*, July 2006
- 24 Man et al., Community Pulmonary Rehabilitation after hospitalisation for acute exacerbations of COPD, *BMJ* 2004; 329: 1209 and Blue et al., Randomised controlled trial of specialist nurse intervention in heart failure, *BMJ* September 2001; 323: 715-718
- 25 American Hospital Statistics; CSFB; AHA Trendwatch Chartbook; CMS, Office of the Actuary
- 26 Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007. A greater percentage of people said they were dissatisfied than the proportion of people who said they were satisfied with the availability of GP services outside normal working hours.
- 27 BMA Health Policy and Economic Research Unit, *Survey of GP practice premises*, London 2006
- 28 *International Health Policy Survey of Primary Care Physicians*, Commonwealth Fund, 2006
- 29 Intercollegiate Working Party for Stroke, *The National Clinical Guidelines for Stroke*, 2004 (2nd Edition) Royal College of Physicians, London
- 30 Thrombolysis is only suitable for patients with an ischemic stroke, not those with an haemorrhagic stroke and a CT scan can determine the type of stroke
- 31 *National Sentinel Stroke Audit* 2004
- 32 *National Sentinel Stroke Audit* 2006
- 33 Soljak M, Volumes of Procedures and Outcomes of Treatment, *BMJ* 2002; 325: 787-8 and Killeen SD, O'Sullivan MJ, Coffey JC, Kirwan WO, Redmond HP, Provider volume and outcomes for oncological procedures, *Br J Surg* 2005; 92(4): 389-402.
- 34 Healthcare Commission, *Investigation into Maternal Deaths at Northwick Park Hospital*, August 2006.
- 35 London Higher, *Leading Health*, [www.londonhigher.ac.uk](http://www.londonhigher.ac.uk)
- 36 HM Treasury (UK). NIH and US Government (US)
- 37 Pharma projects trend analysis 2005
- 38 *Best Research for Best Health*, Department of Health, January 2006 and Lewis M, *Analysis of Funding of R&D in London*, NHS London (NWL), January 2007
- 39 Sunnybrook is partnered with the University of Toronto and Massachusetts General is partnered with Harvard
- 40 US News & World Report Best US Hospital 2005 Ranking. The ranking is constructed from some subjective factors such as peer reputation, but also objective factors such as standardised mortality rates.
- 41 Analysis of Department of Health HES statistics
- 42 NW London SHA, *Pan London Estates Strategy*, June 2006
- 43 OECD Health Data 2005
- 44 London PCTs are "above target" ie they are receiving slightly larger budgets than the PCT funding allocation formula suggests they should
- 45 *London Health Observatory, Health and Healthcare in London – Key Facts*



## Future demands on healthcare

**1.** “The case for change” demonstrated that simply to meet Londoners’ *current* healthcare needs, the NHS in London must improve. However, as this report seeks to set out a vision for the next ten years, we cannot afford to base it solely on the here and now – we also need to consider how the demands placed on the NHS from Londoners will change and grow in the future. Otherwise there is a danger that we will create an NHS to meet the challenges of the past, but not of the future.

**2.** What factors affect the need for healthcare? Undoubtedly the major determinants relate to the population of London. Most obviously, population size is important – other things being equal, a larger population will have greater health needs. However, a host of other issues, from the population’s age, composition and ethnicity through to population characteristics such as deprivation and lifestyle, will affect a given population’s healthcare needs. This chapter also recognises that there are some issues beyond pure population trends – most notably technology changes and public expectations – that are likely to impact on the demand for healthcare.

### Demographic growth

**3.** London’s population is going to grow over the next ten to twenty years. Population projections from the Greater London Authority suggest an increase from 7.6 million in 2006 to 8.2 million in 2016, with a further increase to 8.7 million by 2026.<sup>1</sup> These 1.1 million extra people will all need healthcare provision.

**4.** This growth will not be uniform across the capital. As the map on page 30 shows, the population increase will mainly be along the Thames Gateway on the eastern side of London.



**5.** The considerable disparity in growth rates, from 40 per cent in Tower Hamlets to three per cent in Bexley, means that there will have to be differential expansion in health services in different parts of the capital. Clearly, additional healthcare capacity will need to be targeted at the areas experiencing the greatest population growth.

**6.** It might be assumed that population growth is driven by migration into London. Certainly there is considerable migration into London, especially from abroad. London’s overseas-born population is growing at the rate of 100,000 per annum.<sup>2</sup> However, the impact of migration into London is balanced by migration out from London to other regions of the UK, such as the South East.

**7.** Instead of migration, the primary factor behind London’s population growth is that London has a



Both of these groups have higher health needs than the 15-39 age group, which, whilst it will remain the biggest group in London, is growing more slowly.

**11.** For instance the average over-85 year-old makes almost three times as many visits to the GP or practice nurse and is fourteen times more likely to be admitted to hospital for medical reasons than the average 15-39 year old. There is even a marked difference between the healthcare needs of the 40-64 age group and the 15-39 age group, with almost treble and double the number of hospital admissions for medicine and surgery respectively.<sup>6</sup>

**12.** One of the reasons for the greater needs amongst the older age groups is that the prevalence of long-term conditions (LTCs) – diseases such as chronic obstructive pulmonary disease (COPD) that often can only be ameliorated, not cured – increase with age. More than 70 per cent of those over 75 have one or more LTCs compared with twenty per cent of the 16-44 age group.<sup>7</sup>

**Disease prevalence**

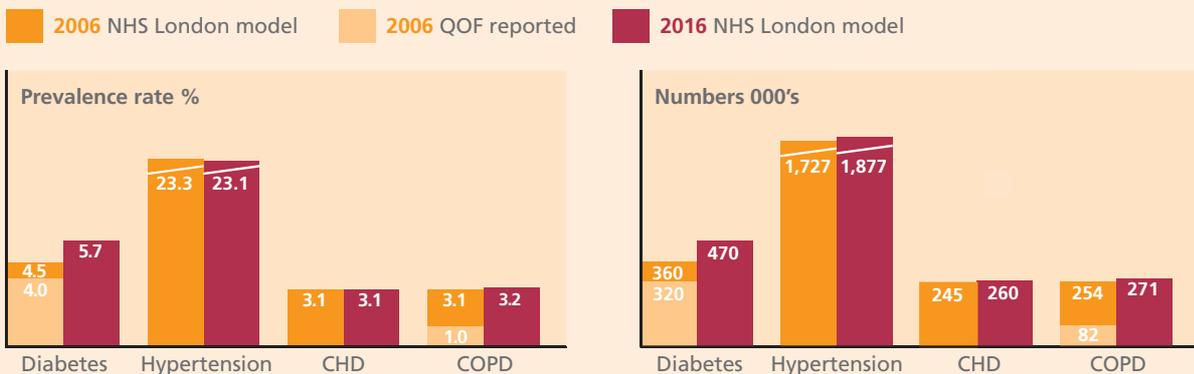
**13.** It is the growing and ageing population that

will have the biggest impact on the numbers of cases of common LTCs and diseases, though other factors are also relevant (see below). In London, as part of this review, estimates of both expected absolute numbers and expected prevalence (ie, cases per 1,000 individuals in the population) were calculated for COPD, coronary heart disease (CHD), diabetes and hypertension.<sup>8</sup>

**14.** As can be seen, the absolute number of cases is growing for all conditions, due to London’s population growth. For CHD, hypertension and COPD this population growth is the major factor in increasing numbers of cases – the prevalence rate, or percentage of the population suffering from CHD and hypertension, remains static, whilst the rate for COPD increases only slightly (an increase in prevalence due to an ageing population is offset by declining rates of smoking).

**15.** However, diabetes shows a significant increase in prevalence rate as well as an absolute increase in numbers of cases. This is due to increases in both type II diabetes and type I diabetes, which recent research has shown to be on the rise.<sup>9</sup>

**Numbers suffering from long-term conditions will rise in the next 10 years**



\* Estimates of current prevalence are higher than the detected prevalence in the disease registers kept by GP practices as part of the Quality and Outcomes Framework, as we know that many people remain undiagnosed

Sources: NHS London Public Health/LHO, QOF, team analysis

**16.** These predictions used extrapolations of current trends in declines in smoking and obesity. If we could influence these trends to a positive degree we would expect to see reduced prevalence – of COPD, CHD and hypertension in relation to smoking, and of diabetes in relation to obesity.

**17.** Other, non-age-related diseases in London are also increasing. For instance, in London the tuberculosis (TB) rate increased from 32 per 100,000 population in 1999 to 48 per 100,000 in 2005. This trend is set to continue, due to migration into London from TB prevalent areas (70 per cent of newly-diagnosed cases in the UK are amongst people born abroad), co-infection with HIV and the development of more drug-resistant strains of TB.

**18.** Sexually transmitted infections (STIs) are also growing sharply, particularly chlamydia and syphilis. In the case of chlamydia, these rises are partly due to the new testing kit introduced in 1999/2000 leading to better diagnosis.<sup>10</sup>

**19.** These rates are expected to continue, reflecting changing lifestyles (sixteen to nineteen year olds with multiple sexual partners are responsible for much of the rise in chlamydia rates) and the implementation of the national chlamydia screening programme, which will result in more previously undiagnosed cases being diagnosed and treated. Sexual health services will need to be able to meet this growing demand. A multi-faceted approach is needed involving better education, better information and better access to services, including community-based services that are accessible to young people.

**20.** The prevalence of HIV is also expected to increase, reflecting immigration from areas with a high prevalence of HIV, continued exposure to HIV infection amongst some men who have sex with men, and the impact of new technology on life expectancy for those who contract HIV. The

success of HIV testing take-up campaigns, which will lead to diagnosis and treatment of more previously undiagnosed cases, will also impact upon the life expectancy of those living with HIV.<sup>11</sup>

### Ethnicity

**21.** Sixteen out of the twenty most ethnically-diverse local authorities in England are in London. The 2001 Census recorded that more than two million Londoners were from non-white ethnic minority groups, 29 per cent of the capital's population.

**22.** Both the absolute number and the proportion of non-white ethnic minority Londoners will continue to grow – the GLA population projections estimate that by 2016 over three million residents (37 per cent of all Londoners) will be from non-white ethnic groups.

**23.** Healthcare provision needs to respond to this growth. Certain ethnic minority groups experience a higher incidence of certain diseases – for example, the Asian population has a higher-than-average incidence of type II diabetes, coronary heart disease and tuberculosis, whilst the Afro-Caribbean population has a higher-than-average incidence of mental health problems.<sup>12</sup> White ethnic minority Londoners may also have specific health problems requiring a focus – for instance, Londoners of an Irish origin have a high rate of coronary heart disease, linked to their comparatively high smoking rate. Healthcare services will need to be accessible and acceptable (eg culturally appropriate) to all.

### Public health trends

**24.** The mental and physical health of the population has very broad social, economic and environmental determinants. Policy change – and collective and sustained effort from the NHS, local government, national government and the voluntary and community sector – in relation to education, housing, income and employment, transport, environment, social



## General socio-economic, cultural and environmental conditions



Source: Dahlgren and Whitehead, 1991

cohesion and so on, will have a significant impact on future public health trends. The Mayor's forthcoming health inequalities strategy will focus on these wider determinants of health.

**25.** We also know that people's lifestyles – how much they drink, what they eat, whether they smoke, etc – affect their healthcare needs, so we need to consider whether the lifestyle of Londoners is likely to be more or less healthy in future.

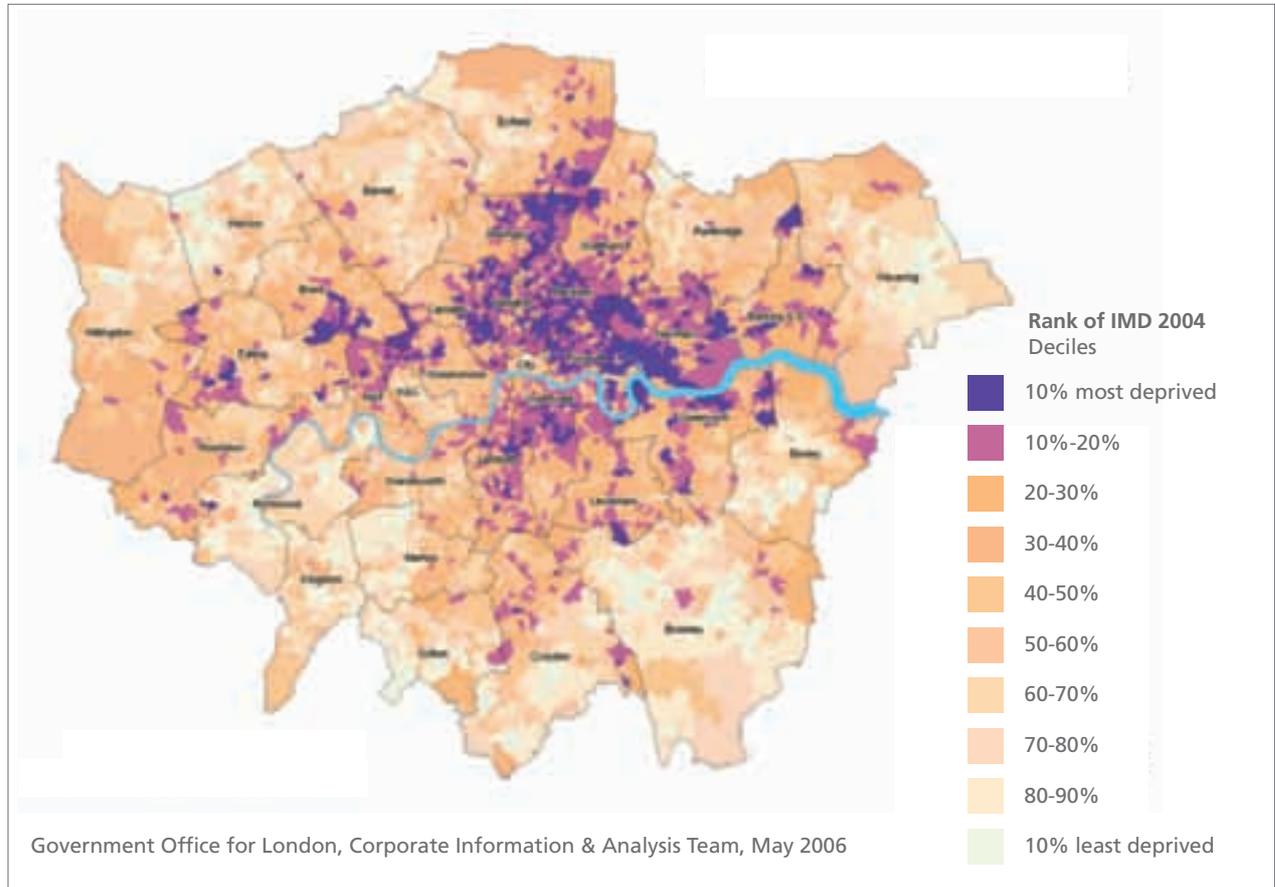
**26.** Due to public health efforts over the last twenty years, smoking prevalence is on a long-term downward trend, a trend that is steeper in London than in the rest of England. So, whilst smoking is still a significant killer, its effects are set to reduce. The decline in smoking is likely to be accelerated by the smoking ban in public

places, which came into effect on 1 July 2007. In Ireland there was a nine per cent reduction in the sales of tobacco products in the year following the ban, half of which has been attributed to the ban itself.<sup>13</sup>

**27.** In terms of obesity, there is good and bad news. Childhood obesity seems to be a particular problem in London. In 2003, London had the highest proportion of obese boys (21 per cent of two to fifteen year olds) of any region in England and this is forecast to rise to 29 per cent by 2010.

**28.** By contrast, levels of adult obesity in London for both men, at eighteen per cent, and women, at twenty per cent, are lower than the average for England (22 per cent and 23 per cent respectively)

## Index of multiple deprivation 2004



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and forecasts suggest the national trend of increasing adult obesity may not be as marked in London as elsewhere. A specific London survey based on the Health Survey for England is being conducted which may help in understanding these trends.<sup>14</sup> However, tackling obesity is likely to remain a priority and there is still clear scope for continuing measures in this area.

**29.** We know that deprivation is linked to health need. For instance, women and men in the least wealthy twenty per cent of the population are respectively 50 and 30 per cent more likely to suffer from coronary heart disease than their counterparts in the most affluent twenty per cent.<sup>15</sup>

**30.** We also know that there are areas of real

deprivation across London, as shown by this map, with eleven of London's 32 boroughs classified as spearhead areas.<sup>16</sup>

**31.** Barking and Dagenham, for example, a spearhead area containing several electoral wards that are in the ten per cent most deprived in the country, also has the highest rate of obesity of all London boroughs and the lowest levels of consumption of fruit and vegetables.<sup>17</sup> Unsurprisingly, it has a premature mortality rate from cardio-vascular disease that is significantly worse than the England average, and one of the worst in London.

**32.** From a public health point of view, the challenge will be to ensure that, as the population





of London grows and changes, the public health needs of those in the most deprived areas of London are being met. Barking and Dagenham, for example, is predicted to be the fourth-fastest growing borough in London, with its population expected to increase by 23 per cent by 2020. However its socio-economic demographic is likely to change. Much of the growth will be fuelled by the Thames Gateway development and the 2012 Olympic and Paralympic Games and the expectation is that every opportunity will be taken to improve health in this part of London through improving the quality of the local environment.

**33.** The spearhead boroughs have a clear target to help improve the life expectancy of their populations compared with the average for the country. If they achieve this, they will diminish one of the major health inequalities in the capital. Whilst closing the gap becomes increasingly difficult as life expectancy increases amongst the better off, some boroughs are on track to succeed. This is being achieved by targeting to reduce premature deaths through heart disease, cancer and stroke.

### Beyond demographics

**34.** Demographic factors are very important in determining future health demands but they are not the only drivers of increased healthcare activity. Looking beyond demographics, technology and growing public expectations of healthcare are two further factors in the demand for future healthcare that merit consideration.

#### *Technology*

**35.** In the next ten to twenty years there are likely to be considerable technological

### Case study – Tower Hamlets PCT is on track to meet the life expectancy target

Very strong partnership arrangements with the local authority and voluntary organisations have had an impact. They have focused on the main causes of the inequalities gap in Tower Hamlets and substantially improved primary care. Examples of innovative joint initiatives include:

- the Bangladeshi Stop Smoking Programme (delivering clinics in the Mosque) and others targeting hard-to-reach groups
- an award-winning community-based rehabilitation programme targeted at Bangladeshi patients
- the HAMLETS diabetes self-management programme and the Ocean Diabetes Project, a diabetes specialist nurse-led programme
- delivering the flu vaccination target by working closely with primary care
- the Tower Hamlets Health Trainers Programme commissioned through the voluntary sector
- producing 'Health Guides' to help people to access services
- cancer screening specialist advocacy project.

breakthroughs in medicine including:<sup>18</sup>

- advances in molecular genetics, with the progress of the Human Genome Project identifying genes causing monogenetic diseases such as cystic fibrosis and genetic susceptibility to polygenetic disorders such as coronary artery disease
- development of bioengineering to produce artificial body parts and organs, predicted to replace transplantation within 30 years
- further developments in minimally invasive surgery, forecast to account for half of all surgical interventions within ten to fifteen years, and in image-guided surgery, exploiting developments in magnetic resonance imaging
- use of robotics in surgery, increasing accuracy and consistency, and in rehabilitation.

**36.** Not all of this new technology will place an additional burden on the NHS. Some can actually save the NHS money. For instance, minimally-invasive surgical techniques are reducing patients' rehabilitation times after an operation, and hence their length of stay.<sup>19</sup>

**37.** However, the overall trend is that new technology increases the demand for healthcare



by making new interventions and procedures possible. A good example is angioplasty (also known as percutaneous coronary intervention or PCI), the use of a balloon catheter to open up blocked blood vessels in the heart. The number of angioplasties performed in England increased by 150 per cent between 1999/2000 and 2004/05.<sup>20</sup> There is potential for angioplasty rates to increase even further, as the UK has comparatively low cardiac catheterisation rates when compared with other countries.<sup>21</sup>

**38.** The greater use of angioplasty, with better outcomes for patients, is clearly a positive thing. Yet it does come at a price.<sup>22</sup> Technological breakthroughs are going to place greater demands on the NHS in London in future years.





### *Growing public demands*

**39.** Public attitudes are also going to influence the demands placed on the NHS. “The case for change” highlights how rising expectations mean that people are less satisfied with the NHS, despite improvements in its performance.

**40.** Nationally, the younger members of the population are the least satisfied with the NHS.<sup>23</sup> The picture is somewhat different in London. Ipsos MORI’s survey of Londoners found that the oldest age-group (the over-55s) and the youngest age-group (18-24) were the most positive about the NHS, both with 65 per cent satisfaction with the running of the NHS, compared with satisfaction rates of 55 per cent and 57 per cent amongst the 25-34 and 35-54 age groups, respectively. The under-25s were also the group most likely to believe their local NHS would improve.<sup>24</sup>

**41.** We can speculate, but the reasons for this discrepancy with the national picture are unclear. What we can be certain of, is that the demands placed on the NHS by the younger generation will grow. People will expect NHS services to fit with their lifestyles, not the other way round. People will demand the very best care as a right, not a privilege. The NHS will have to respond to these demands – but in return the NHS should be expecting people to take greater responsibility for their own health.

### **London’s current system cannot meet future demand**

**42.** We have carried out detailed modelling of future healthcare needs in order to test how far London’s current healthcare system will be able to meet Londoners’ future demand, and to test our own proposals and ensure they are as future-proofed as possible.

**43.** To do this we first broke down all NHS activity in 2005/06 into “service lines”.<sup>25</sup>

**44.** Using bottom-up data about the demand in 2005/06 for each service line from each different age group, together with Greater London

Authority population forecasts, we then modelled how needs for each service line will change under three possible scenarios. We called these scenarios *low growth* (primarily driven by population growth), *baseline* (based on population growth but also assuming that most

### Current healthcare activity by service line, 2005/06

Service Lines	Activity 000's (Spells/attendances)	Examples	
Elective medicine	Complex	40	PCI, hepato-biliary procedures
	Non complex	165	Neuropathies, sleep disorders, scoping, renal, haem
	Long-term conditions	6	Planned admission for asthma, diabetes
	Under 17s	16	
Non elective medicine	Complex	60	Acute MI, stroke
	Non complex	260	DVT, pneumonia, pulmonary embolus
	Long-term conditions	46	Emergency admissions for asthma, diabetes
	Under 17s	12	
Elective surgery	Complex	126	Major GI procedures, transplants, neurosurgery
	High throughput	344	Cataracts, arthroscopy, hernia
	Minor procedures	73	Vasectomy, skin lesions
	Under 17s	53	
Non elective surgery	Complex	39	Trauma, major GI procedures, burns
	Non complex	147	ENT, fractures
	Minor procedures	2	Minor skin procedures
	Under 17s	19	
Obstetrics	Deliveries	114	Normal delivery, assisted delivery, caesarian section
	Antenatal admissions	103	Antenatal admissions
Paediatrics*	Paediatrics	89	Cystic fibrosis, neoplasms, epilepsy
	Neonatology	107	Neonates with major/minor diagnoses
Outpatient		8,255	New and follow up outpatient consultations
A&E**	Major	1,436	Emergency admissions, trauma
	Standard	581	Fractures
	Minor	1,832	Minor illness and injury
Community care		8,197	Health visitors, podiatrists, district nurses etc.
Primary care	GP & Nurse consults	27,836	GP and Nurse consultations
	Direct access diagnostics***	933	CT, MRI, ultrasounds, radiographs, etc

\* HRGv3.5 Chapter P. Children assigned non-chapter P HRG are included in other service lines

\*\* Based on national HAS 05/06 returns, split by Major/standard/minor proportions derived from St George's Healthcare Trust Feb-Aug 2006

\*\*\* GP direct access diagnostics estimated as 16% of 5.8m total tests in London - proportion derived from representative sample SHA data

Source: Department of Health NHS London admitted patient care 2005/06, HAS 2005/06, St George's NHS Trust, Croydon and Brent PCT community care consultations, Q Research 2006, London Ambulance Service, GLA, Team analysis



historical growth rates in patient activity over and above demographics, which have consistently outstripped population growth over the last five years, will continue) and *high growth* (exceeding the rates of growth in the baseline scenario due to greater pace of technological change and higher patient expectations). All scenarios made the same assumptions about population growth (from GLA projections) and changing prevalence rates (see section above on changing prevalence of COPD, CHD, diabetes and hypertension).<sup>26</sup>

**45.** This analysis shows that the greatest growth will occur in A&E, primary/community care, and medical admissions. Even under the low-growth scenario, A&E activity will increase by 21 per cent over an eleven year period, primary/community care by 30 per cent and medical admissions by 22 per cent. Under the baseline scenario these figures are 67 per cent, 126 per cent and 47 per cent respectively. Under the high-growth scenario they are 85 per cent, 154 per cent and 63 per cent respectively.

**46.** We also made a series of assumptions about the resources that will be available to the NHS in London over the next ten years. London currently has a healthcare budget of £10.1 billion. To forecast future resource allocation, we assumed annual growth from 2005/6 to 2007/8 of 7.5 per cent in line with published Department of Health figures.<sup>27</sup>

**47.** We assumed that from 2007/8 to 2010/11 spend as a proportion of GDP will remain stable as the investment phase in the NHS comes to an end; and that from 2010/11 to 2016/17 budget growth will exceed GDP growth by 0.25 per cent, in response to pressures from increased patient expectations, improved access and so on. We also made an adjustment to take account of the fact that London is above “target” in its allocation.<sup>28</sup> Employing these assumptions, we estimate that the resources allocated to London to meet its healthcare needs will grow to £13.1 billion by 2016/17.

**48.** We have already discussed how the old ways of doing things cannot deliver what Londoners need, either now or in the future. The findings of our analysis are that continuing with the old ways of doing things will not only be ineffective, it will also be unaffordable under all but the low-growth scenario. Under this scenario, the current system would spend £11.6 billion to meet Londoners’ healthcare needs. Under the much more plausible baseline scenario, required spending (£14.5 billion) will outstrip PCT funding within a decade. This disparity will be even greater under the high-growth scenario, which would require a budget of £15.9 billion.

**49.** We will return to this modelling later, when we test the feasibility of our proposed changes to the way London’s healthcare is delivered. Further detail is being made available electronically.

## Conclusion

**50.** It is clear that future demand for healthcare in London is only going to grow. It is also clear that our current healthcare system is unlikely to be able to meet this demand. Any proposals for change that we make need to be based on our best predictions of what the future will bring.

- 
- 1 GLA 2006 Round Population Projections
  - 2 *Population Mobility and Service Provision: A report for London Councils*, LSE, February 2007
  - 3 Low estimate applies current fertility rate to GLA 2006 Round Population Projections. High estimate also assumes continuation of historical growth rate over what would be expected simply from demographic change.
  - 4 ONS Figures, 2005
  - 5 GLA 2006 Round Population Projections
  - 6 Hospital Episode Statistics Data 2005/06. GP and Nurse Consultations based on attendances per registered population for sample GP practices. Activity rate is per 1,000 population.
  - 7 *Chronic disease management: a compendium of information*, Department of Health, May 2004
  - 8 These estimates were made by utilising existing models published by the Association of Public Health Observatories (<http://www.apho.org.uk/apho/models.aspx>) and modified using London-specific demographic projections.

- 9 Research funded by Diabetes UK and announced at the Diabetes UK Annual Professional Conference
- 10 *Choosing Health: A briefing on sexual health in London*, LHO, HPA, June 2005
- 11 *A Complex Picture – HIV and other sexually transmitted infections in the United Kingdom*, HPA, 2006, [http://www.hpa.org.uk/publications/2006/hiv\\_sti\\_2006/contents.htm](http://www.hpa.org.uk/publications/2006/hiv_sti_2006/contents.htm)
- 12 GLA and London Health Observatory, *Review of the London Health Strategy high level Indicators 2004 Update*, GLA 2004
- 13 *Where there's smoke*, Citigroup Smith Barney, August 2004. Also see *Action on smoking and health, Impact of smoke-free legislation in Ireland*, web article <http://www.ash.org.uk/html/publicplaces/html/irelandimpact.html>
- 14 Forecasting obesity to 2010, NatCen, [http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT\\_ID=4138630&chk=XVZ/60](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4138630&chk=XVZ/60)
- 15 ONS, *Key Health Statistics from General Practice*, 2000
- 16 Spearhead areas are the 20% of local authorities with the biggest health and deprivation challenges. The eleven Spearhead boroughs in London are (from East to West): Barking and Dagenham, Greenwich, Newham, Lewisham, Tower Hamlets, Hackney, Haringey, Southwark, Islington, Lambeth and Hammersmith and Fulham.
- 17 NCHOD Indicators
- 18 Taken from a submission by the Royal National Orthopaedic Hospital
- 19 For more information see Darzi A, *From Saws and Scapels to Lasers and Robots – Advances in Surgery*, Department of Health, March 2007
- 20 Stocktake of cardiac care (South East), DH 2005
- 21 OECD Health Data 2005
- 22 Each angioplasty costs the NHS at least £3,752.
- 23 Guardian ICM Poll October 2006
- 24 Ipsos Mori, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007
- 25 Department of Health, NHS London admitted patient care



- 2005/06, HES 2005/06, St George's NHS Trust, Croydon and Brent PCT community care consultations, QResearch 2006, London Ambulance Service, GLA, team analysis.
- 26 In line with the Wanless Report and subsequent reviews, this Framework gives prominent focus to the importance of public health and prevention. It is thus reasonable to expect that implementing its proposals would itself have an impact on prevalence rates. However, it has not been possible to take this into account and our projections are accordingly based on extrapolations from current trends.
- 27 All figures are at 2005/06 prices, adjusted for an assumed monetary inflation of 2.5 per cent per year over the period.
- 28 This means that PCTs in London received more money than they should according to the PCT allocation formula. PCT allocations are adjusted gradually over time so this gap between actual funding and their "target" funding will disappear.



## Improved care from cradle to grave

1. Healthcare in London must change. “The case for change” demonstrated that it must improve because current care is not good enough, and “future demands on healthcare” showed why it must change if it is to meet future health needs.
2. Before this chapter goes on to consider specific proposals for improved services, it sets out some guiding principles for change that emerged during the course of the review. Whether it was a meeting of a clinical group or a public deliberative event, five common principles for the provision of future healthcare came through again and again.
3. These principles are what underlie both the working groups’ proposals (set out in detail below), and the proposals for future models of healthcare provision that are detailed in the following chapter.

### The five common principles

- 1 Services focused on individual needs and choices
- 2 Localise where possible, centralise where necessary
- 3 Truly integrated care and partnership working, maximising the contribution of the entire workforce
- 4 Prevention is better than cure
- 5 A focus on health inequalities and diversity

**4. Services focused on individual needs and choices.** Provision should, wherever possible, be tailored to the particular needs of each individual. This is especially important for people with ongoing health needs, such as those with long-



term conditions, and for those at the end of life. To help ensure this, patients should feel in control of their care and be able to make informed choices to suit their personal needs.

**5. Localise where possible, centralise where necessary.** On the one hand, routine healthcare should be as close to people’s homes as possible. For example, many outpatient appointments should happen in local settings, instead of in hospital. Londoners want this – 52 per cent of survey respondents said closeness to home would be a factor affecting their choice of provider when referred on by their GP.<sup>1</sup>

**6.** On the other hand, some healthcare provision needs to be centralised to ensure that more complex care is carried out by the most skilled health professionals with the most cutting-edge equipment. For example, interventional stroke care should not be provided at every local hospital.

**7. Truly integrated care and partnership working, maximising the contribution of the entire workforce.**

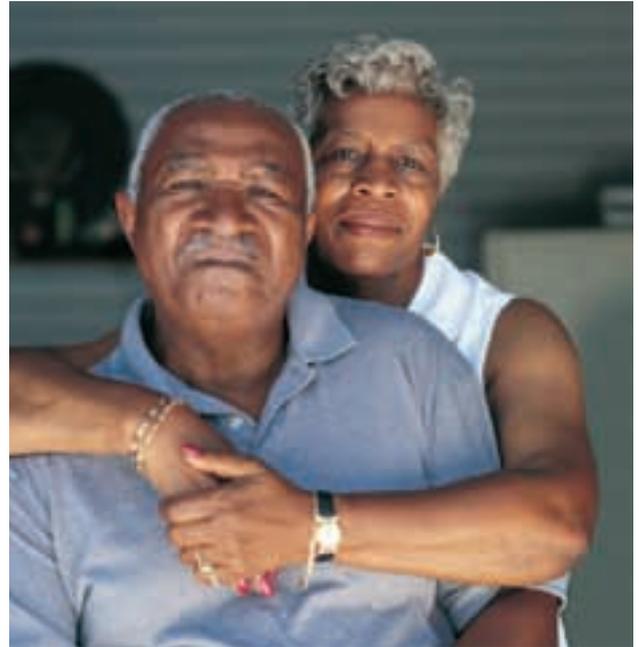
There needs to be better integration of care and partnership working at every level to prevent people falling into the gaps between services and organisations. Close co-operation and information-sharing is needed between services in the community and in the hospital, between urgent and planned care services and between health and social care. The electronic record will help, but this needs to be supplemented by better communication and co-operative ways of working.

**8.** Whether across different services and organisations or not, care should be multidisciplinary, bringing together the valuable contributions of practitioners from different disciplines, GPs, nurses, midwives, pharmacists, allied health professionals and others. For instance, a patient admitted for complex vascular surgery should be under the joint care of the vascular surgeon, cardiologist, anaesthetist and specialist nurses whilst in hospital and this hospital team will then need to ensure a smooth transfer of responsibility to GPs, community health nurses and social care staff post-discharge.

**9.** To provide integrated care, the NHS needs to work jointly with social care, education and other services. It must be committed to partnership working with other organisations, including local authorities and the voluntary and private sectors.

**10. Prevention is better than cure.** Health improvement should be embedded in everything that the NHS does and there should be close working with local authority and other partners to help people stay mentally and physically healthy. Secondary prevention (ie preventing an existing condition from deteriorating) is needed as well, with proactive care for people with long-term conditions to prevent emergency admissions.

**11. A focus on health inequalities and diversity.** As discussed in “the case for change”,



we know that the most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare. The whole thrust of this report is to tackle this inequality by improving services across London, giving everybody access to the best possible care. In the future, healthcare should be intelligently commissioned to tackle health inequalities. So preventative and outreach work should focus on the most deprived populations. New facilities should be located in areas of greatest need.

**12.** Improvements to healthcare services in London also need to take into account London’s rich ethnic and cultural diversity. New services must be accessible and acceptable (eg culturally appropriate) to all. We are recommending that patients have more information available to them to make choices about care and this should be accessible to all Londoners.

**13.** The Mayor of London’s health inequalities strategy, which is currently under development, will focus on the wider determinants of health – including income and employment, transport, education, environment and so on. The focus of this *Framework* is more specifically on health services



and the impact they can have on health outcomes and inequalities. We expect the two strategies, and their implementation, to be complementary.

**14.** The proposals in this *Framework* have undergone a preliminary inequalities impact review, which considered the potential impact of the proposals on twenty vulnerable and excluded groups.<sup>2</sup> A full inequalities impact assessment will be undertaken post-publication as part of the discussion period to ensure that the proposals are going to meet the needs of the most deprived. The preliminary review indicated that the way in which the *Framework* is implemented will be the most important factor in reducing inequalities.

**15.** We propose that as this report is implemented locally there is systematic use of health inequalities impact assessments to ensure improvements are helping the most disadvantaged. We also propose that a health inequalities indicator is included as one of the key metrics to measure the success of the strategy's implementation.

### Specifics of improving care

**16.** Having established some common principles for improving healthcare services, the rest of this chapter sets out the *Framework for Action's* detailed proposals in seven areas:

- maternity and newborn care
- staying healthy
- mental health
- acute care (urgent and emergency care)
- planned care
- long-term conditions
- end-of-life care.

**17.** Six of these areas were the subject of a clinical working group.<sup>3</sup> Mental health was also considered to need a specific focus and the chief executives of London's mental health trusts were involved in drawing up key proposals.

**18.** The key recommendations in each clinical area are summarised in a box at the start of each section.

## Maternity and newborn care

### Key proposals

- Women's social and medical needs should be assessed at an early stage, and then reassessed during their pregnancy, with their care based on these assessments.
- Antenatal care should be provided in local, one-stop settings, and postnatal care should be provided in local, one-stop settings as well as at home.
- As many women as possible should receive continuity of care throughout the antenatal, labour and postnatal periods.
- Women should be offered a genuine and informed choice of home birth, birth in a midwifery unit or birth in an obstetric unit.
- There should be a significant increase in the number of midwifery units, with each obstetrics unit having an associated midwifery unit, either co-located or stand-alone depending on local circumstances.
- Obstetrics units should have at least 98 hours a week consultant presence.
- All women should receive one-to-one midwifery care in established labour.
- Maternity networks – involving maternity commissioners and all providers – should be formally established across London and be linked with neonatal networks.

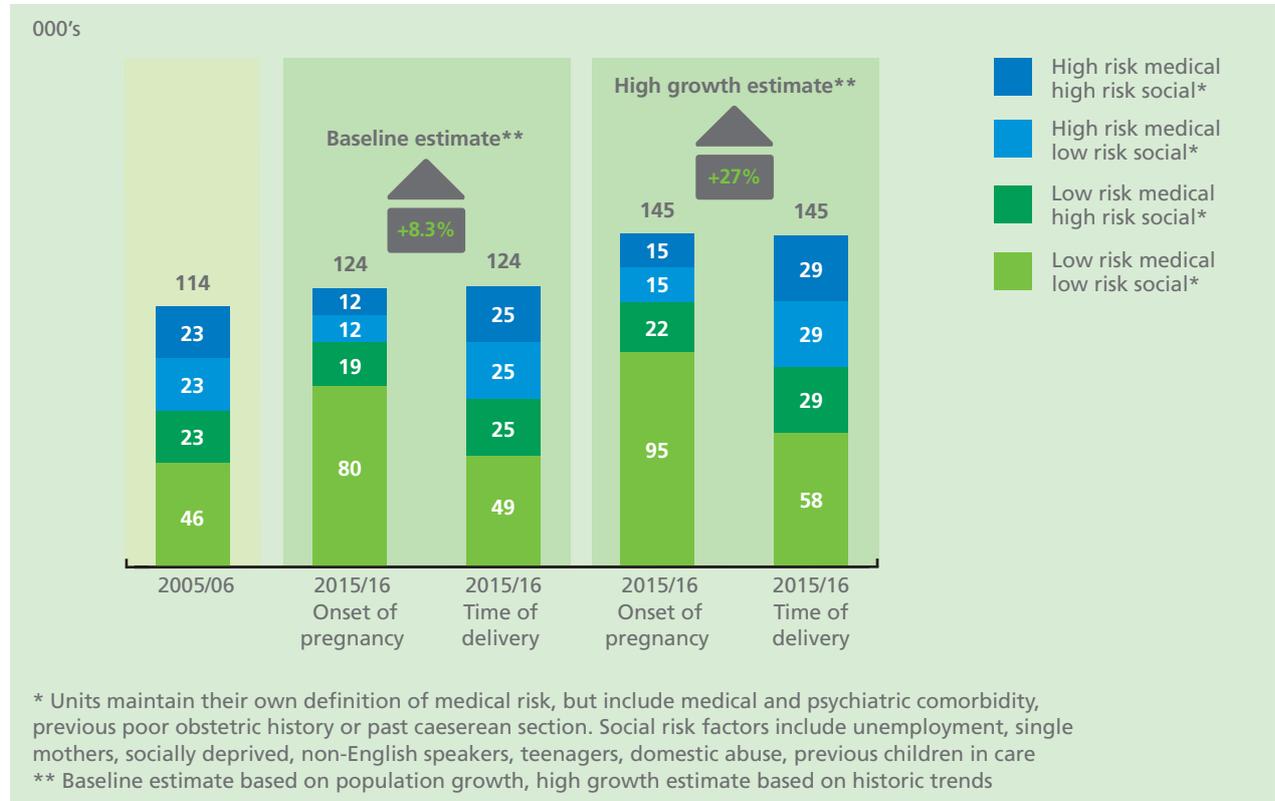
### The drivers for change

**19.** Maternity services in London are going to experience more demand due to the growth in the number of births that was highlighted in the previous chapter. This diagram shows predicted

*"I'm pleased to see this programme is aware of problems such as inequalities in healthcare provision in different areas. You sometimes wonder whether that really is taken into account."*

**Voluntary Sector Event Participant**

## Demand for obstetric services is projected to increase



Source: London Maternity Review Progress Report, February 2007; projections based on GLA population growth

increases in births and also stratifies them based on the level of medical and social risk.

**20.** Alongside the challenge of growing demand, is that of offering more choice to pregnant women – choice over where they receive their antenatal care and where they give birth. Women also value continuity and quality of care, so expectant mothers should be offered continuity of care from conception through to postnatal care, and all women should have one-to-one midwifery care during established labour. In advocating choice and continuity, we are supporting the proposals for English maternity services set out recently by the Department of Health in *Maternity Matters*<sup>4</sup> and seeking to show how they could be implemented in London.

**21.** The following sections describe our vision for how these needs – for more services, more choice, and improved quality and continuity of care – should be met for London.

### The vision for the future

#### *Pre-conception care*

**22.** GP practices should have responsibility for providing pro-active pre-conception care tailored to individual women's needs, and this responsibility should be reflected in GP contracts.

**23.** For example, women with diabetes, or taking anti-epileptic medicine, should receive information about the risks associated with pregnancy. More generally, GPs should communicate the importance of healthy living (diet, exercise, stopping smoking) for conception



and pregnancy, and commission services to support women to adopt healthy lifestyles.

### *Antenatal care*

**24.** Antenatal care should be provided locally and in a one-stop setting (eg with ultrasound and phlebotomy on site) wherever possible. This could be in a children's centre or a polyclinic (see "future models of healthcare provision").

**25.** Women should be able to choose a midwife or group of midwives and book directly with them without having to be referred first by their GP. As far as possible, each group of midwives should offer continuity of care from one named midwife antenatally and postnatally. If available, that named midwife should also provide support during established labour. Where it is not possible to provide such continuity of care for all women, priority should be given to those most likely to benefit, ie those with greater social and medical complexity.

**26.** We envisage that in the future midwife groups across London will differentiate themselves. Particular groups would, for example, specialise in home births, offer births at certain hospitals, be focused on women with particular social needs, or provide antenatal care within the community close to a woman's home or place of work. Women should have access to information about each midwifery group in order to make an informed choice.

**27.** As part of the booking process, a midwife should carry out an early needs assessment on the expectant mother, with the resultant needs-profile informing their subsequent antenatal care. Women with high medical needs, for example, would need additional obstetric antenatal care. Women with high social needs (for example women with mental health problems or misusing alcohol or other substances) would need active help to engage them with relevant services and co-ordinated care across multiple agencies.

Further needs assessments will be required during the course of the pregnancy, as a woman's circumstances can change during that time.

**28.** Good antenatal care will include ensuring women are put in touch with other expectant mothers from their local community, enabling them to develop local support networks.

### *Labour and birth*

**29.** Women should be offered a genuine and informed choice between a home birth, birth in a midwifery unit, and birth in an obstetric unit.

**30.** Giving women choice over where they give birth, and information about the options, allows them to opt for a less medicalised delivery. The recent National Institute for Health and Clinical Excellence (NICE) review of the clinical evidence for different birth locations found that women who had a planned birth at home or in a midwifery unit were more likely to have a spontaneous vaginal birth, had a reduced likelihood of caesarean section, and were more likely to have an intact perineum, compared with those who had a planned birth in an obstetric unit.<sup>5</sup> NICE also found some evidence of small differences in infant perinatal mortality rates (ie death around the time of birth) in different types of birth location, though it assessed this evidence as "uncertain" and "not strong".

**31.** To inform choice, women should have access to high-quality information about the risks and benefits of giving birth in different locations, including services available (eg types of pain relief), quality of care (including episiotomy rates, where a surgical incision is made to ease delivery, infection rates and caesarean section rates) and transfer rates.

**32.** Women should receive one-to-one midwifery care during established labour and birth. One-to-one care during labour has been shown to significantly improve outcomes.<sup>6</sup> However a recent survey found that 56 per cent of women were left without one-to-one care at some stage

*"I remember in the old days, you had a personal relationship with your midwife. I'm sure that new mothers nowadays would want to have that kind of support. I'm pleased to see that it is in here again."*

**Public Event Participant**

in their labour.<sup>7</sup> Achieving this standard will require significant change in the way midwives work, as well as continued efforts to attract and retain midwives.

**33.** To provide the best possible care for those women giving birth in an obstetric unit, there needs to be a high level of consultant presence. Evidence suggests that consultant obstetricians are less likely than junior doctors to opt for caesarean sections.<sup>8</sup> There is also evidence to suggest that increased consultant presence is linked to a reduction in foetal distress which can lead to neonatal mortality and disability.<sup>9</sup>

**34.** Obstetric units should have a consultant presence for at least 98 hours a week.<sup>10</sup> This will require fewer obstetric units than now in order to ensure there is an adequate workforce, that staff gain sufficient experience and that the units are affordable.



### Postnatal care

**35.** Postnatal care should be provided within local one-stop settings in the community as well as at home. This could be in the form of drop-in clinics which have been found to work well in East London, and could make use of the facilities at children's centres. A key aim would be to

improve outcomes such as breastfeeding, focusing particularly on women from disadvantaged groups.<sup>11</sup> Postnatal care should be linked with easy access to mental health care for those women who suffer from postnatal depression. Midwives should work with social care staff to ensure those women assessed as having high social needs during pregnancy have all the support they need as new mothers.

### Neonatal care

**36.** Services should be equipped and staff trained to provide immediate life support and stabilisation prior to transfer where necessary. All professionals involved in birth should be competent in basic neonatal life support skills. Prolonged care for seriously ill babies will require a neonatal intensive care unit (NICU). The Department of Health expert working group on neonatal care envisaged one level III NICU per 15,000 to 25,000 births.<sup>12</sup> These units would provide the most intensive care.

**37.** Most obstetric units without a level III NICU would have a level II NICU, capable of providing short-term intensive care and longer-term high dependency care. Level II units will normally need to coexist with paediatric units and some staff will work both in neonatal and paediatric services.

**38.** Some London obstetric units may have a level I NICU, providing special care. Crucial to the success of this approach will be the further development and strengthening of neonatal networks.

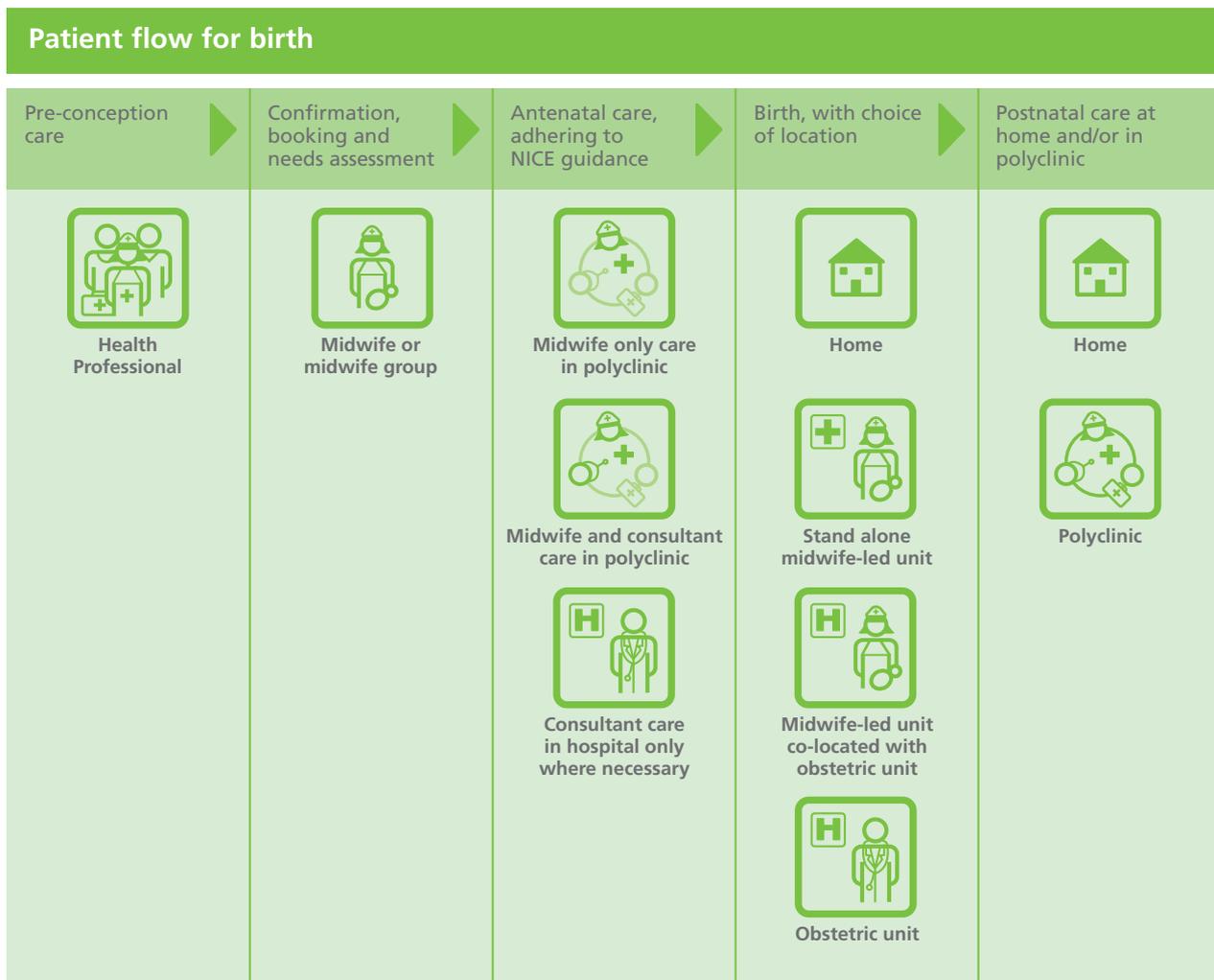
### Vision summary

**39.** The diagram, *patient flow from birth*, on page 47, summarises how a woman would move through the stages of care and the choices available to her.

### Achieving the vision

**40.** To achieve this pattern of care will require more effective use of midwives and the development of a new and sustainable model of service provision.





### Maximising midwife efficiency

**41.** To achieve one-to-one care during labour will require significant changes in ways of working. The changes we are proposing include:

- more use of one-stop community facilities for the provision of antenatal and postnatal care. Midwives currently spend valuable clinical time travelling between GP practices, women's homes and/or hospitals. Instead, most antenatal and some postnatal care should be provided in larger clinics in the community.
- making greater use of maternity support workers (MSWs). MSWs, given appropriate training, could take on several tasks currently

performed by midwives (eg collection of information, routine urinalysis, routine blood pressure monitoring) freeing up midwife time.

- eliminating discrepancies in productivity. There is debate over whether deliveries attributed to bank and agency staff should be included in figures for midwife productivity. However, whichever figures are used, there are huge discrepancies in the number of babies delivered per midwife in hospitals across London. If bank and agency staff are excluded the deliveries per midwife per year range from 36 to 19. If bank and agency staff are included, deliveries per midwife per year range from 42 to 23.<sup>13</sup>

### Case study – Albany midwifery group

The Albany midwifery group operates in Peckham, South East London, and is made up of six midwives, sub-contracted by King's College Hospital. The midwives offer one-to-one care during pregnancy and labour, delivering either at home (46 per cent of births in 2006) or in hospital (54 per cent in 2006). Antenatal care and some postnatal care is provided in the local leisure centre. The group, which takes all women, not just those deemed low risk, achieves high rates of breastfeeding (78.8 per cent exclusively breastfeeding at 28 days) and low intervention rates. The midwives each work nine months of the year and take three months off, and cover each other's holiday, sick and training leave. They achieve a workload of 36 deliveries per midwife per year. The group is supported by a named obstetrician and a named neonatologist at King's College Hospital.



**42.** There are already examples in London (see above) of how the maternity workforce can provide personalised and high-quality care despite carrying out a relatively high number of deliveries.

**43.** There is clearly scope to improve the provision of one-to-one care with the current maternity workforce, but only if there are significant changes in ways of working. However, new ways of working will be only part of the answer and current efforts to attract midwives back into the profession and to retain existing midwives will need to continue.

#### *New service provision model*

**44.** At present 97 per cent of births in London occur in obstetric or co-located midwifery units in hospitals. We do not know exactly how this 97 per cent is split between obstetric units and the eleven co-located midwifery units across London. Around two per cent of births in London take place at home, a percentage inflated by the home birth rate out of King's College Hospital which was nearly seven per cent in 2005/06. Another 0.5 per cent of births take place in

London's two stand-alone midwifery units.

**45.** The small number of midwifery units, and the lack of resources and priority given to home births, means that at present the only option for most women is to give birth in an obstetric unit. If women in London are to have a genuine choice over their place of birth then services need to change.

**46.** Home birth should be positively promoted as a real option and there should be adequate numbers of appropriately-trained and confident midwives to support this. An expectation of 1,500 home births per sector would mean that six per cent of London's births would take place at home. We believe this is achievable – whilst nationally the home birth rate is two to three per cent, this hides significant variations with, for example, a rate of 11.7 per cent in South Devon.

**47.** For the choice of a midwifery unit to be a reality, there must be an increase in the number of midwifery units in London. To achieve this we are advocating that all obstetric units should have an associated midwifery unit.



**48.** This associated unit may be co-located or it may be a stand-alone facility. We expect the pattern of provision to be decided locally, based on patients' choices, the working preferences of maternity staff and the viability of the different approaches.

**49.** To support this growth in midwife-led care, there must be clear and agreed standards for transfer of women from home or midwifery units in case of complications. For example, the London Ambulance Service response times for different situations should be clarified and there should be agreed "triggers" that result in transfer to an obstetric unit. Prompt transfers are vital – the Royal College of Obstetricians and Gynaecologists recommends that such transfers should ideally take fifteen to twenty minutes.<sup>14</sup>

**50.** Whilst we are advocating more midwifery units and more home births, there will need to be fewer obstetric units than at present in order to provide the best levels of care, with an increased consultant presence.

**51.** Underpinning this organisation of care will need to be the development of broader maternity networks – linked to existing perinatal and neonatal networks – for the five sectors of London, to develop expertise, share good practice and effectively organise more specialist care.

**52.** We envisage that in the future maternity services might become more differentiated between community-based services on the one hand, and hospital-based services on the other. Community-based services could be commissioned from, developed with and led by midwives, who would be professionally accountable for the quality and safety of the services provided. They would encompass home births and births in midwifery-led units, whether co-located in hospitals or stand-alone. Hospital-based services would remain obstetrics-led with significant midwife involvement, and obstetricians would remain professionally accountable for quality and safety.

## Staying healthy

### Key proposals

- Promoting health and wellbeing means the NHS working more energetically with other public services and organisations.
  - More should be invested in proven health improvement programmes and initiatives.
  - There should be a pan-London campaign for activity and healthy eating linked to the 2012 Olympic and Paralympic Games.
  - All healthcare organisations and their staff should be incentivised to take every opportunity to promote physical and mental health.
  - There should be a greater focus on health protection, with improved sexual health, tuberculosis and childhood immunisation services.
  - The NHS should play a greater role in improving the physical and mental health and wellbeing of its employees.
- 53.** In recent years the need for the NHS to focus on keeping the population healthy has been highlighted many times, most notably in the Wanless Report, the *Choosing Health* White Paper and the *Our health, our care, our say* White Paper.<sup>15</sup>
- 54.** Yet despite these exhortations, the NHS has not given keeping people healthy the priority it deserves. Nor has it done all it could to address London's entrenched health inequalities through influencing the social, environmental and economic root causes of inequality, or through ensuring equitable access to health promotion and prevention services. This has to change and we have several proposals for how this can be done.

## The importance of partnerships for improving health

**55.** We need to acknowledge that staying mentally and physically healthy is not solely, or even primarily, about healthcare services. Social, economic, environmental and lifestyle factors are at the root of much ill health and these are issues over which the NHS has little direct control.

**56.** So the NHS must work with local authorities and other partners to help Londoners stay both physically and mentally healthy. There are formal mechanisms already in place to achieve this. For instance, local authorities have a responsibility to develop Sustainable Community Strategies (setting out a vision for the economic, social and environmental wellbeing of each area).<sup>16</sup> The means to put these strategies into action are Local Area Agreements (LAAs), public service priorities agreed by local authorities and their partners, including PCTs.<sup>17</sup> LAAs are an important means to foster committed partnerships to improve health and wellbeing. As the report *Health, work and wellbeing – caring for our future* recognises, the Department of Work and Pensions and the Health and Safety Executive also have key roles in to play in keeping working-age people healthy.<sup>18</sup>

**57.** More broadly, the NHS should also act as a champion for healthy lifestyles when working with partners. So for instance, PCTs could work with local authorities to discourage car use, and improve facilities for walking and cycling.

**58.** The NHS must take advantage of the opportunities for involvement provided by new developments. For instance, the Thames Gateway development offers a chance for PCTs and local authorities to develop new housing areas with a design that encourages a healthy lifestyle. In addition, the large-scale redevelopment of a deprived area of the East End, as part of the preparation for the 2012 Games, will offer the ideal opportunity to create high-quality community health facilities.<sup>19</sup>

**59.** At a more local level, we need to ensure that practice-based commissioners are considering the wider health agenda and forging local partnerships in the community with schools, employers, leisure centres and housing organisations.

**60.** Wherever possible, the NHS should maximise the potential for synergy and joint working that exists where policy proposals for health and wellbeing are aligned across services. In children's services for example, PCTs and local authorities share a joint agenda and priorities. The government's publications *Every Child Matters* and *Our health, our care, our say* are both seeking to encourage better, integrated, child and family-centred services.<sup>20</sup> Both are seeking to shift care to new community-based services in schools, in children's centres, and at home.

## Matching rhetoric with money

**61.** Germany and the Netherlands spend more than three times as much per capita on prevention and health promotion as the UK spends, devoting a far higher proportion of their healthcare budget to the prevention of ill-health.<sup>21</sup>

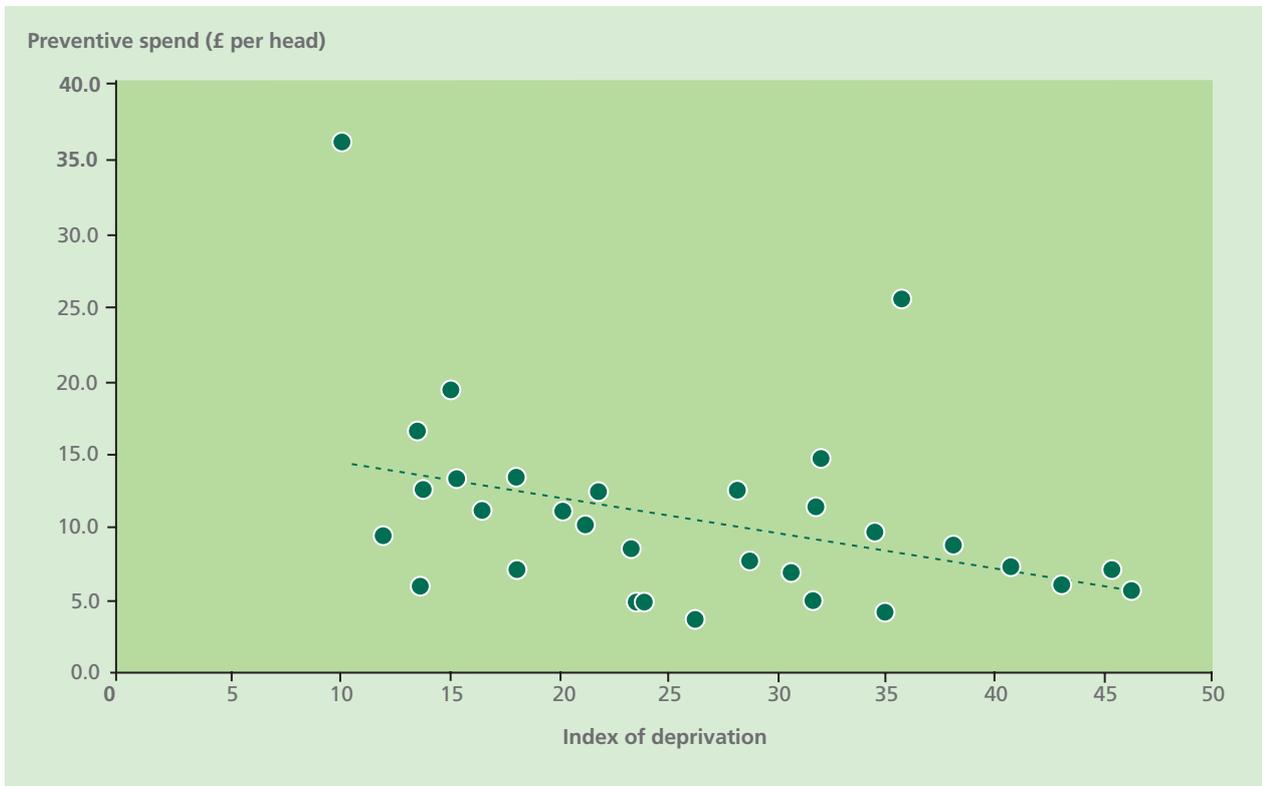
**62.** In London, this relatively low overall spend is compounded by the fact that there is an inverse relationship between the spending on prevention by PCTs and the needs of their population, as demonstrated in the graph on page 51.

**63.** Spending on prevention needs to increase across London, but particularly in the most deprived areas. We propose this is achieved by:

- shifting expenditure from acute hospital care into prevention as advocated by the *Our health, our care, our say* White Paper<sup>22</sup> as part of the PCTs' planning process.
- developing a London-wide menu of evidence-based preventative interventions (eg drawing on NICE guidance on obesity and *Annex B – Investing in Prevention* of the Department of Health's *Commissioning Framework for Health*



### There is an inverse relationship between preventive spend by PCT and deprivation



Source: PCT Programme Budget Spend 2005/06, NCHOD indicators

and Wellbeing)<sup>23</sup> to help commissioners make informed decisions.

- using programme-budgeting techniques to analyse both which aspects of care money is being spent on, and where it is having the biggest impact on outcomes.
- using the London public health research community to evaluate interventions and to develop further commissioning tools to analyse inequalities, model trends and measure the impact of interventions so that outcomes can be monitored to assure return on investment.

#### Local leadership for staying healthy

**64.** Strong public health leadership needs to be followed through with clear responsibility for health improvement at a very local level, for

example through a community healthcare professional. This should be supported with better local information, setting physical and mental health alongside, for example, employment, education and housing, to give a clearer picture of community health needs and to inform how local services are designed, commissioned and delivered.

**65.** Health improvement initiatives need to reach people who are not “ill” or “patients.” To achieve this, health improvement services should be delivered through a much broader range of practitioners (pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, health visitors, etc) working in a variety of settings (school, leisure, workplace, prison, etc).

*“The best thing is preventive measures. Anything that can help prevent an illness is money well spent now, and saved in the long run.”*

**Public Event Participant**

**66.** For instance, community pharmacies should be used extensively for health improvement as they serve many customers who do not use other traditional healthcare facilities – it is estimated that 1.2 million Londoners visit one every day. City and Hackney PCT, for example, commissioned community pharmacists to give influenza vaccinations.<sup>24</sup> Dentists and opticians, who, like pharmacists, see people who are not “ill,” should also be used by PCTs to drive the health improvement agenda.

### A pan-London perspective

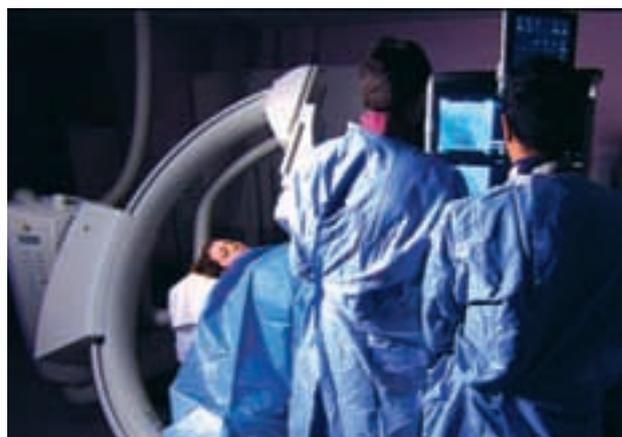
**67.** Whilst much health improvement should be driven locally at a community level, there is a place for pan-London campaigns, for example, linked to the 2012 Games.

**68.** The 2012 Games have the potential to generate a surge of sporting and other physical activity across London, bringing great benefit to health.<sup>25</sup> This was recognised in the *Our health, our care, our say* White Paper, which called for a Fitter Britain initiative.<sup>26</sup> London, as the host city of the 2012 Games, should lead that initiative, focussing on healthy food and physical activity in the run-up to 2012. This city-wide campaign should include social marketing approaches and incentives schemes, whilst making use of a wide array of media.

**69.** In addition, there should be pan-London commissioning and provision of some health promotion and prevention services. This already happens to some extent for HIV, but there should be a focus on other diseases and/or population groups. For instance, services for homeless people could benefit from a pan-London perspective.

### Health improvement as an integral element of all healthcare services

**70.** Health improvement should be an integral element of all healthcare. Prevention and health promotion should be actively built into all patient care. This would mean interventions could occur throughout a patient’s period of treatment.



- **Post-diagnosis.** A patient who is diagnosed with tuberculosis may be having their condition aggravated through living in poor quality housing or being homeless. To tackle this a GP could arrange hostel accommodation and then work with the hostel workers to encourage the patient to take their medication.
- **Pre-operation.** Before an operation, smokers should receive smoking cessation advice and support. Stopping smoking improves surgical outcomes and reduces the average length of stay post-operation<sup>27</sup> – a Danish study found that patients who gave up smoking six to eight weeks before their operation reduced their length of stay by two days, or over fifteen per cent.<sup>28</sup> This reduction in length of stay provides a powerful incentive for NHS Trusts (who will be receiving a set tariff for the operation regardless of length of stay) to work with commissioners to ensure there are appropriate stop-smoking services available to their pre-operative patients.
- **Post-discharge.** After a patient is discharged from hospital the follow-up helps them take the necessary steps to prevent a recurrence or worsening of their condition. For instance, patients who have had a transient ischaemic attack (in effect a short-term stroke) should be prescribed aspirin to reduce their chances of having a full-scale stroke and they could be



assessed to see whether they need a carotid endarterectomy (an operation which improves the flow of blood through the carotid arteries, which supply the brain).

- **At any stage in care.** Holistic care for older people should include the early identification and treatment of the common problems of aging, for example, problems with hearing, vision, teeth and feet.

**71.** These are just four examples of how health improvement should be part of routine NHS care. All health professionals should be thinking about issues of diet, exercise, alcohol consumption and smoking in their interactions with patients.

**72.** To support this there needs to be a major focus on education, training and development to help all clinicians provide health improvement interventions. For instance, health improvement should be included in the undergraduate or pre-registration curriculum for all health professionals. There could also be new roles, such as lifestyle practitioners and GPs with a special interest in health improvement. At the same time, a requirement to undertake health improvement interventions should be part of contracts and NHS staff performance management.

**73.** As new models of care develop, we need to ensure that traditional public health programmes, such as cancer and child health screening are continuously reviewed and remodelled to take full advantage of service improvements to enhance the quality of these programmes and to maintain clinical governance through changes.

### Health protection

**74.** London must maintain a firm focus on health protection – communicable disease and infection control, resilience and emergency preparedness. This means that, working with local partners, and crucially with the Health

Protection Agency, we need to continue to ensure that there are robust arrangements in place as new models of healthcare delivery are implemented. Particular health challenges in London are high levels of sexually transmitted diseases and tuberculosis (TB).

### Sexual health

**75.** There should be a focus on redesigning services, for both prevention and treatment, to tackle the rising rates of sexually transmitted infections,<sup>29</sup> based on:

- increasing the use of contraception.
- providing services around sexual healthcare pathways, including services for contraception and abortion, particularly for young people
- improved sexually transmitted infection and genito-urinary medicine (GUM) services, addressing chlamydia screening and HIV/AIDS.
- improving service access, for example, through seven-day-a-week access to GUM through London-wide rotation of opening times, and greater use of outreach services for at-risk populations, such as sex workers and young people.
- increasing the availability and accessibility of information on sexual health and sexual health services. Messages need to be tailored and taken out to young people and at-risk groups. Information should be supplied in multiple locations such as community pharmacies, health centres, schools (PCTs should be supporting sexual health programmes in their local schools) and further education institutions. There also needs to be more imaginative ways of giving information, for example, on-line through the use of internet sites that are popular with young people.

### Tuberculosis

**76.** There is a need to come up with innovative new ways of finding people with TB and treating

*“The idea of looking into other things while you’re there [polyclinic] is good; visiting the doctor would be a bit more holistic.”*

**Public Event Participant**

them.<sup>30</sup> This includes developing appropriate accommodation for complex patients to ensure that they complete their treatment, because incomplete treatment can result in drug-resistant TB developing, requiring longer treatment, with more drugs, at much greater cost to the NHS and disadvantage to the patient. Existing services should develop to:

- provide more rapid diagnosis
- assess each newly-diagnosed patient in terms of risk of not completing treatment and/or suffering from drug-resistant TB
- design services on the basis of this assessed risk, including the provision of supported housing and outreach to ensure completion of treatment
- provide the specialist expertise required by some patients, eg those with co-morbidities such as HIV or substance misuse, or with particular language or cultural needs
- provide effective tracing of people who have come into contact with TB sufferers.

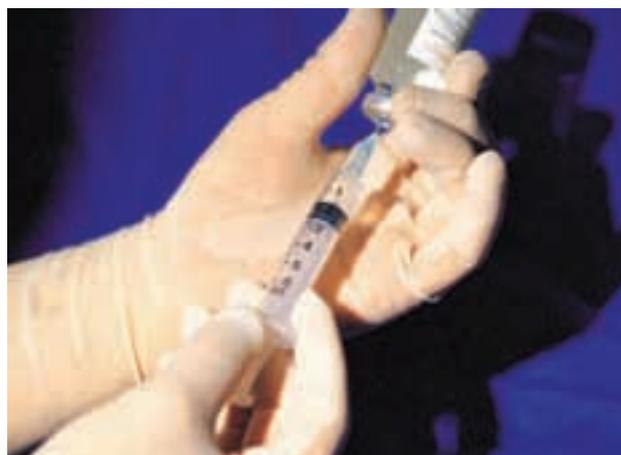
### Immunisation

**77.** Childhood immunisation is one of the safest, most cost-effective and evidence-based of all health interventions, yet it has not been given the priority it deserves.

**78.** As a result, in the final quarter of 2006 only 73 per cent of London's two year-olds had received a measles, mumps and rubella (MMR) vaccination compared with an England average of 85 per cent. Within PCTs across London the figure ranged from 91 per cent to just 49 per cent.<sup>31</sup>

**79.** London's highly mobile population means it can be difficult to track which children have been immunised, although the electronic patient record should help in the future.

**80.** Solutions to low uptake of immunisation require a multifaceted approach tailored to the particular population. Crucially, immunisation



needs to be seen as a high priority amongst all staff concerned with the care of children. We propose that:

- each organisation involved in immunisation has a named lead
- healthcare workers should ask about immunisation status when they have contact with patients
- there should be opportunistic immunisation of children in all settings, including acute healthcare, at primary and secondary school entry, in children's centre facilities and extended schools
- all staff should be trained in giving accurate information on vaccines
- there should be adequate numbers and types of staff trained in giving vaccination
- there should be public health oversight on a London-wide basis to coordinate and facilitate the programme.

### The NHS as a healthy employer

**81.** The NHS must exercise corporate social responsibility to achieve health gain and sustainability through the raft of areas where it has social, economic and environmental impact. Most pertinently here, if the NHS is expecting the broader public to live healthy lives it ought to help and support its staff to do so. Private



sector companies such as Unilever and BT have paid far more attention to the health and wellbeing needs of their staff.

**82.** There is great potential to improve population health and to reduce health inequalities through improving the health of NHS staff, especially since the healthcare workforce includes low paid workers and people from disadvantaged groups, ethnic minorities, and communities at greatest risk of ill health. Healthier, happier NHS staff would be good for patients. Other sectors have demonstrated a clear link between a healthy workforce and productivity.<sup>32</sup>

**83.** A greater focus on the physical and mental health and wellbeing of staff could be achieved by:

- making use of the existing tool-kit for trusts that helps them to devise green and active travel plans for their staff. Funding has been secured from Transport for London to support this.<sup>33</sup>
- clearly demonstrating the financial benefits to trusts of helping staff to be healthy, in terms of reduced absences from sickness and greater productivity whilst at work. For instance, it is estimated that reducing staff sickness by two per cent would save the average acute trust £0.5 million, mostly through reducing their use of agency staff.
- learning from models of good practice. For example, a “well at work” programme to test the effectiveness of health-promoting interventions in the workplace, led by the British Heart Foundation, is currently being piloted across the country, including within the NHS in Newham, where the objectives are to help people to become more active and eat more healthily, and to promote smoking cessation.<sup>34</sup>
- setting an example of taking immunisation seriously by ensuring front-line staff receive an influenza immunisation each year.
- ensuring there is procurement of healthy food, not just for patients, but easily available for staff and visitors.

## Mental health

### Key proposals

- Early intervention services need to be improved.
- There should be a clear pathway for care, so that service users and partner organisations know what to expect and how to be involved.
- Service users should be put in control and their recovery and social inclusion should be supported.
- More use should be made of “talking” therapies in the community, complemented by a strategy for developing inpatient care.
- Services should be developed for those most at risk – offenders, asylum seekers and refugees and the black and minority ethnic population.
- Community mental health teams should have a more focused remit.

**84.** London has a knowledge-driven economy. Industries of the mind such as finance, media, academia and government provide employment for many of the capital’s inhabitants. London depends on the mental abilities of its population. And yet, as “the case for change” highlighted, Londoners suffer from a high prevalence of mental illness, with eighteen per cent of Londoners suffering from a common mental health problem, compared with sixteen per cent nationally.<sup>35</sup>

**85.** London also has a high proportion of the most seriously mentally ill – 23 per cent of mental health inpatients have a psychotic diagnosis (compared with fourteen per cent nationally) and these patients have the greatest needs. This creates a more volatile, disturbed environment on mental health wards. In addition, the need to focus resources on those

with the most severe illness can mean Londoners with moderate problems are less likely to be able to access services than in other parts of the country.

**86.** London's high prevalence of mental illness costs the capital £5 billion per year, when the cost of services, lost earnings and benefits are all taken into account.<sup>36</sup> In addition, as with so many healthcare problems, the prevalence of mental illness is highest in the more deprived parts of London. Social, economic and psychological factors have significant impacts on the incidence, duration and recovery from mental illness and on service use. Issues such as housing shortages, drug use and contact with the criminal justice system are all critical factors and they are particular problems in London. For example, some 400,000 of London's children are living in extremely poor housing.<sup>37</sup>

**87.** Mental health problems are touched on in the other clinical areas in this chapter (for instance postnatal depression). However, mental health is such a significant issue for London, necessitating links between health, social care, housing and other statutory and voluntary services, that mental health requires a dedicated focus.<sup>38</sup> The following proposals seek to provide that focus by building on and developing the existing policy direction for mental health set out in the National Service Framework.<sup>39</sup>

### Early intervention

**88.** Young people with mental health problems risk losing out on education and training, which in turn increases the risks of mental health problems later in life. Early intervention teams, which aim to identify and work effectively with young people (the fourteen to twenty-five age group) with emerging psychotic disorders and their families, have been shown to lead to improved outcomes, reduced inpatient bed days and fewer admissions involving the police.<sup>40</sup> However, the implementation of effective early

intervention services is currently patchy across London.<sup>41</sup> London now needs to act quickly and decisively to put in place excellent early intervention services.

**89.** Improving early intervention more generally will require greater integration of Child and Adolescent Mental Health Services (CAMHS) with education and health services. Community mental health nurses should work in close partnership with schools to identify those at risk, provide quick targeted intervention and help promote mental health and wellbeing in the wider school population. CAMHS services should be co-located with other health services where possible, to enable an integrated approach to family health and social care, improving access and promoting inclusion.

**90.** Further efforts should be made to reduce stigma and fear of services by a communication campaign to encourage earlier contact with mental health services. For communities where it is culturally less acceptable to seek help, special measures need to be taken to improve access. At the Tavistock and Portman NHS Foundation Trust, for example, a Bangladeshi/Sylehti speaking service has been set up to improve access for Bangladeshi families.

**91.** Whilst mental health amongst children and young people should be the first priority, early intervention should be developed more broadly to identify, treat and support people with mental health conditions in later life, particularly Alzheimer's disease and other forms of dementia.

### A clear pathway, not a maze

**92.** When mental illness is identified, the next step of treatment should be clear. However, a recent London Assembly report described accessing mental health services as being like navigating a maze.<sup>42</sup> This needs to be addressed, with a transparent London-wide approach to care. The development of clear care pathways would enable service users and staff to know





what is expected of different services and service users at each point in their care, and would facilitate patient choice.

**93.** Care pathways should be developed in partnership with local authorities and non-statutory providers, and should include a single coherent system to enable non-mental health professionals (such as police officers) to refer people for mental health assessment and help in an emergency.

**94.** Care pathways should clarify specialist mental health providers' role in supporting GPs to manage the care of people with less severe mental health problems, for example, in prescribing therapies and/or medication.

### **People in control, supported by a range of services to promote recovery and inclusion**

**95.** People with mental health problems need more choice over their healthcare.<sup>43</sup> A London Assembly survey found that only 50 per cent of respondents felt they had a choice over the service or treatment they received.<sup>44</sup>

**96.** To support recovery, there needs to be wider implementation of direct payments. This would give mental health service users more choice and control over their lives and enable them to decide on the social and wellbeing services that they need.

**97.** People will also have more control over their lives if they have access to opportunities more broadly. Lack of employment, poor housing and social isolation are worse for people with mental health problems. By the same token, improved social and economic standing, such as being in employment, improves mental health outcomes. For instance, around 40 per cent of claimants are on incapacity benefit because of mental health problems; the vast majority of these want to work.<sup>45</sup> It is also important that people with mental health problems are able to access physical health services.

**98.** Mental health services must therefore help people lead full lives as part of their local community, by focussing on more than just their mental health needs. This will require strong partnership working between mental health providers, physical health providers, social care and a range of other organisations, especially housing and employment resources, local businesses and faith communities. It will also require a fresh approach to commissioning, providing clear leadership and co-ordination.<sup>46</sup>

### **Local treatment for the many, specialist inpatient care for the few**

**99.** Mental health services have led the way in localising care in the NHS. Twenty years ago, mental health care was provided in very large inpatient institutions offering only limited outpatient services. Now, services are based on the premise that mental health care is best delivered to people in their own homes, with medical and other care staff working in multidisciplinary teams in community settings.

### Inpatient psychiatric activity has fallen over time as treatment has moved towards community-based care



Source: Hospital Episode Statistics (HES), The Information Centre for health & social care; Analysed by LHO

**100.** As a result there have been significant reductions in mental health admissions and consequent decreases in mental health inpatient beds over the last few years.

**101.** Ninety per cent of people with mental health problems already receive their care in local community settings.<sup>47</sup> However, too often care is focused on anti-depressant drugs, with 31 million prescriptions being written by UK doctors for anti-depressant drugs in 2006.<sup>48</sup> A survey found that 93 per cent of GPs had prescribed anti-depressant drugs because of the lack of perceived alternatives.<sup>49</sup>

**102.** Alternatives to medication need to be further developed in London. Cognitive behavioural therapy (CBT) and other "talking therapies" have been recommended by the National Institute for Health and Clinical Excellence (NICE) and should be used extensively, but waits in London are long. To tackle this, a strategic approach to training and supervision is required and more graduate mental health

#### Case study – community therapies in Newham

Newham is a national pilot site in the Department of Health's programme to improve access to therapies. Newham's Psychological Treatment Centre provides both CBT (including computerised, group and individual) forms and employment support to help service-users return to work. The centre has taken over 700 referrals since it opened and has been able to attract large numbers of black and minority ethnic users. Satisfaction with the service is high and early results show improvements in over 40 per cent of attendees.

workers should be employed to deliver "talking therapies" and support people to use computerised programmes. NHS London should also consider a performance measure of incremental increases in the percentage of GP referrals for "talking therapies" that begin



treatment within eighteen weeks.

**103.** Other therapies should be explored and evaluated such as bibliotherapy (therapy through reading) and the greater use of exercise. The mental health charity MIND has recently called for greater use of ecotherapy such as countryside walks.<sup>50</sup>

**104.** Whilst a strong focus must be on improving community services, London also needs to develop a vision for specialist inpatient mental health care. This will involve:

- greater clarity about the purpose of inpatient care, for example, as an elective time-limited treatment to support and monitor the introduction of new medication
- consideration of whether inpatient facilities are needed in each borough in the longer-term as inpatient admissions continue to decrease
- giving urgent attention to improving the quality of inpatient care, from the environment through to the therapeutic milieu
- fostering centres of excellence and specialisation amongst London's ten mental health trusts.

### Helping those most at risk

**105.** London's uniquely diverse population presents particular challenges for mental health. Minority ethnic communities, migrant communities including asylum seekers, high rates of offending, substance misuse and homelessness, all contribute to create a population with vastly differing risks and needs, attitudes to accessing care and patterns of service use.

**106.** For example, a large-scale study of first episode psychosis found that diagnoses of psychosis in people from African-Caribbean communities were five or more times greater than among white British people.<sup>51</sup> People from African-Caribbean communities were also more likely to be referred to mental health services via

the criminal justice system rather than by GPs, to be perceived as a risk to others, and were less likely to seek help.

**107.** Mental health services must respond to the specific needs of minority groups. Targeted use of assertive outreach and early intervention teams and community development workers is needed. In addition, mental health services need to work more closely with primary care, local authorities and, in particular, the black voluntary sector, to help break down barriers between mental health services and minority ethnic communities.

**108.** At the end of 2005, there were 6,551 people in London's prisons: however, the high turnover in London's prisons means that they are managing between eight to ten times their daily populations over the course of a year.<sup>52</sup> It has been estimated that up to 90 per cent of prisoners suffer from at least one mental health disorder, and the rate of severe mental illness is up to twenty times greater than in the general population.<sup>53</sup>

**109.** London's mental health services need to work in partnership with London's prisons to develop a pan-London strategy for delivering more effective mental health services to offenders. As part of this strategy, community forensic mental health teams could be piloted to work with offenders on their release from prison.

### Making effective use of the mental health workforce

**110.** In recent years, mental health teams have become more specialised with the development of early intervention teams and crisis resolution teams. By contrast, generic community mental health teams (CMHTs) often have a wide remit but without a clear focus or function. The role and function of CMHTs should be reconsidered. CMHTs could become more specialised, for example in providing assessment, recovery co-ordination, or therapies.

## Acute care

### Key proposals

- Access should be significantly improved through urgent care centres with doctors on-site. Urgent care centres in hospitals should be open 24/7, the hours of those in community settings will depend on local need.
- There should be a single point of contact (by telephone) for urgent care.
- There should be centralisation and networks for major trauma, heart attack and stroke.
- Dispatch and retrieval protocols for London Ambulance Service (LAS) need to be aligned with centralisation.



**111.** Annually, millions of Londoners have non-life-threatening short-term illnesses or health problems for which they need prompt and convenient treatment. The NHS needs to provide accessible care that meets their needs. A much smaller number suffer from serious illness (such as a stroke or heart attack) or have a major

injury. For instance, over 6,000 Londoners had a stroke in 2005/06.<sup>54</sup> These patients need highly-skilled specialist care to give them the best chance of survival and recovery.

**112.** However, as we saw in “the case for change”, there is evidence that the NHS in London is providing neither accessible urgent care to the bulk of the population, nor the best quality specialist emergency care to the small numbers who need it.

**113.** Many people are attending A&E who could be better cared for elsewhere. The provision of care for people with minor illness and injury in A&E departments is not ideal – patients may be seen by junior doctors rather than GPs (although the latter are better skilled and experienced in dealing with minor illness and injury and with people with long-term conditions), people sometimes have to wait several hours to be seen and A&E departments are often a significant distance from people’s homes and work places.

**114.** Care for the most seriously ill is simply not good enough – more could be done to ensure people get the best possible care.

### Beyond A&E for urgent care needs

**115.** Urgent care is the range of responses provided to people who require – or perceive the need for – urgent advice, care, treatment or diagnosis. People using services and their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care and an appropriate and prompt response to that need.

**116.** We propose improving the two ways by which Londoners can access urgent care – over the phone or face-to-face.

#### *“Hear and treat” – urgent care by phone*

**117.** At present, when Londoners need urgent care they can ring three different organisations – the London Ambulance Service, NHS Direct or the local GP out-of-hours (OOH) provider.



Respectively, these organisations take 1.2 million, 0.9 million and 1.5 million calls annually. The evidence suggests that Londoners do not always know which organisation is most appropriate to call. As many as 70 per cent of NHS Direct’s calls are left unresolved or passed on to another service, whilst it is estimated that 40 per cent of those the ambulance service conveys to hospital could have been cared for in the community.<sup>55</sup>

**118.** To reduce this confusion and potential duplication we propose an integrated “hear and treat” model is put into operation across London.

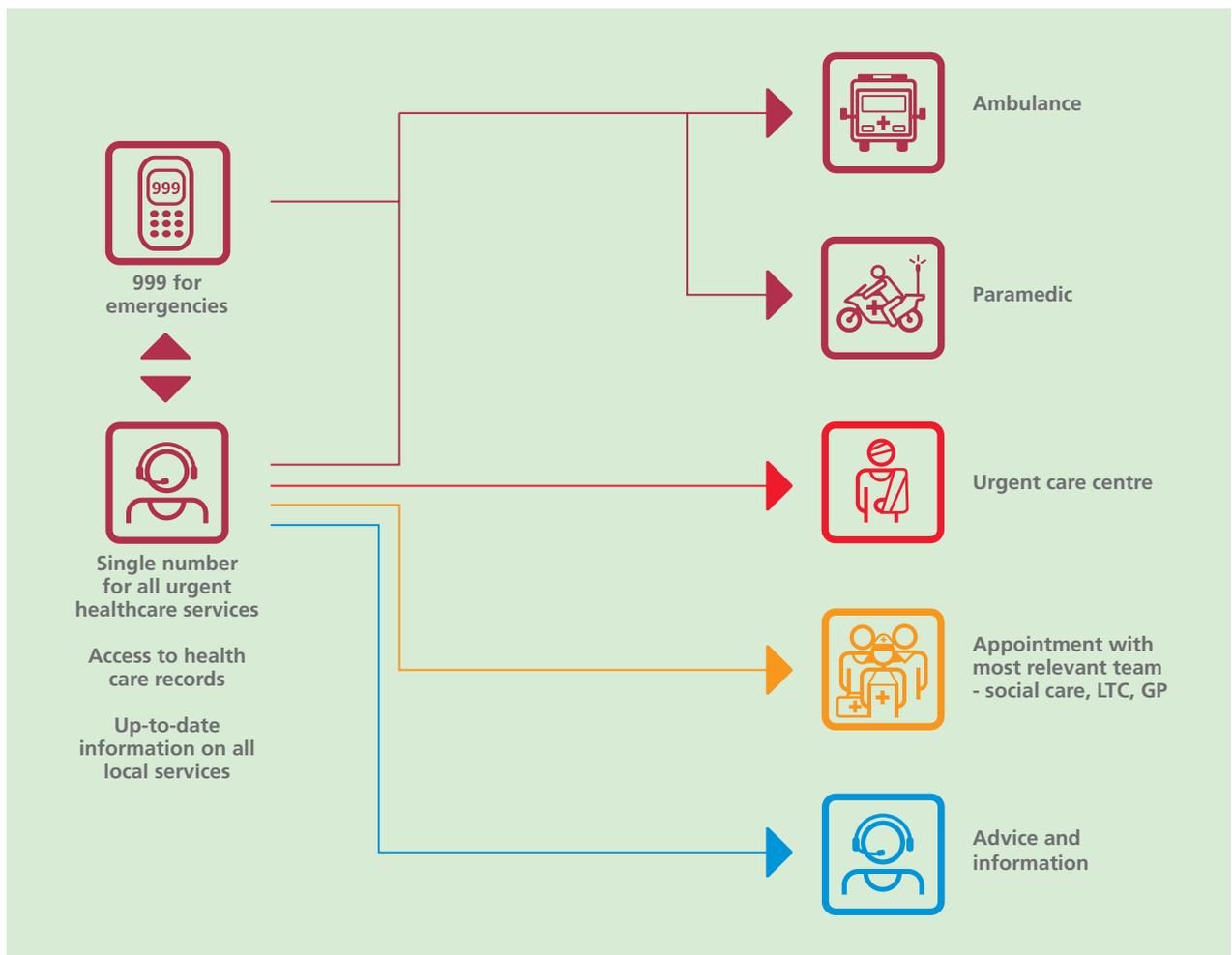
**119.** This would mean that as well as 999 for

emergencies, people accessing urgent care would have a well-known number they can ring at any time (the possibility of a single number for London needs to be considered). They would then access a virtual call-centre hub, bringing together the call-handling operations of existing organisations.

**120.** The diagram below illustrates how it would work.

**121.** Call-handlers should have access to high-quality real-time information and advice, tailored to the location of the caller. Staff answering calls would assess and determine the most appropriate course of action, from self-care advice through to transfer to emergency services

**‘Hear and Treat’ – urgent care by phone**



and ambulance response. Calls could be passed on to the local urgent care centre (see below) so that the caller can speak directly to clinicians, mental health teams, social care, etc as required. Where clinical advice is given it should be provided by experienced staff and quality must be auditable.

**122.** Callers who need face-to-face urgent care should be directed to their local urgent care centre or a nearby pharmacy or have an appointment booked with their GP or other healthcare professional (eg nurse or mental health worker) for the next day. There should be a high completion-rate with callers clear as to what they should do next.

**123.** A well-known urgent care number should reduce the number of non-emergency 999 calls, but 999 call-handlers should be able to transfer people to the “hear and treat” system for non-emergency advice and care.<sup>56</sup>

#### *Urgent care centres – urgent care face-to-face*

**124.** GPs will continue to provide much face-to-face urgent care through their regular appointment system, as Londoners should be able to get an appointment within 48 hours. However, we recognise that sometimes people may feel they cannot wait that long or they need urgent care when their GP practice is not open.

**125.** Only 27 per cent of Londoners are very satisfied or fairly satisfied with the availability of “outside working hours” care.<sup>57</sup> This dissatisfaction may be one of the reasons why so many people who could be better cared for elsewhere are attending A&E instead.

**126.** To fill this gap in service provision, and to significantly improve both the accessibility and the availability of urgent care, we propose to develop urgent care centres, both as the front-end of hospitals with A&E departments and in community settings.

**127.** Urgent care centres should provide multidisciplinary care using GPs (some of whom could have a special interest in urgent care/emergency medicine), nurses, emergency care practitioners, mental health crisis resolution teams and urgent social care workers (depending on the availability of staff and local needs). Given the high proportion of attendances for urgent care related to substance and alcohol abuse,<sup>58</sup> urgent care centres should also have professionals skilled in helping patients with these problems.

**128.** Twenty-four hour urgent care centres will be part of all hospital A&E departments. Patients will be able to self-present at the urgent care centre where they will be seen by an experienced emergency department nurse or GP, who can determine the most appropriate treatment. All patients brought by ambulance as part of a serious emergency response (a “category A call”) will go directly into A&E.

**129.** We do not wish to be overly-prescriptive about the opening times of urgent care centres not attached to a hospital. We are clear that urgent care centres will have much more extended hours than GP practices and they will be open in the evenings and during the weekends, but whether this is sixteen hours, seven days a week, eighteen hours, six days a week or so on, should be determined based on local need.

**130.** Clearly a balance will need to be struck between the desire to have highly-accessible alternatives to A&E and the costs of much-extended opening hours. For instance the urgent care centre at Edgware found that it did not see sufficient patients between midnight and 8am to justify being open. Instead, patients attending in that time period can now see NHS Direct staff who are on site overnight.

**131.** Urgent care centres will have a doctor on-site when they are open. Urgent care centres will also have diagnostic equipment on-site including



x-ray, ultrasound, ECG, echocardiogram, spirometry and blood testing.

**132.** Urgent care centres will be able to provide some basic pathology services at the point of care. For more complex pathology, they should be networked with a hospital pathology laboratory providing haematology, clinical biochemistry, and medical microbiology/virology tests.<sup>59</sup>

**133.** Some existing services would be subsumed into urgent care centres. For instance GP OOH would become part of services provided by the urgent care centre. Depending on local needs, walk-in centres and minor injury units could also be integrated with, or developed into, urgent care centres.

**134.** In addition, ambulance stations/staff should be co-located at these urgent care centres wherever feasible. Emergency care practitioners and paramedics could use the urgent care centre as a base for travelling out to provide “see and treat” services to urgent care callers.

**135.** Patients should be made aware of their nearest urgent care centre through local publicity and should know that, after telephoning, this is their first point of call for urgent care needs.

### Specialist care for the most seriously ill and injured

**136.** When an ambulance arrives at the scene of a heart attack, the ambulance staff are able to carry out an ECG, which they can then interpret to see whether the heart attack victim needs primary angioplasty (insertion of a balloon catheter) to remove a blood clot in their heart. If they do need angioplasty they are taken to one of nine hospitals across London that are equipped and able to do the procedure at all times.

**137.** This model of excellent centralised care for heart attacks should be replicated for people suffering severe trauma and stroke in London.

### Trauma

**138.** A trauma system should be put into operation within London, integrating hospital and pre-hospital care to identify and deliver patients to a specialised place of care quickly and safely. This should have big benefits for patients – the establishment of a trauma system in Quebec resulted in mortality dropping from 52 per cent to nineteen per cent due to treatment in specialist centres and direct transport from the scene to these centres.<sup>60</sup> The need for change has been evident for some time – the 2000 Royal College of Surgeons Report advocated the development of a systematic approach to trauma but this has never been put into practice.<sup>61</sup>

**139.** At the heart of this system would be the trauma centres. There is an existing multi-speciality trauma service at the Royal London Hospital that currently manages over 950 trauma patients per year. The Royal London’s outcomes are impressive – in 2006 they had a 28 per cent reduction in mortality in the most severely-injured patients when compared with the national average.<sup>62</sup>

**140.** Bypass protocols will need to be in place so that the most seriously ill would be taken direct to trauma centres by ambulance, instead of the closest hospital. This is not dangerous – evidence from Scotland shows that longer pre-hospital travel times do not increase mortality or length of stay.<sup>63</sup> It is better to take longer to get to the right hospital – direct transfer to a trauma centre, as opposed to transfer into one from another hospital, reduces mortality and lengths of stay.<sup>64</sup>

**141.** We provisionally suggest there should be another two trauma centres to complement the Royal London. This figure is derived from the Royal College of Surgeons’ recommendation that trauma centres should serve between one and three million people depending on population density. London’s trauma centres would operate at the upper end of that range, given the city’s

*“Timely intervention by the right people counts, not how quickly you can get inside the doors of your local A&E.”*

**Public Event Participant**

high population density. Emergency resilience and mutual aid requirements will need to be built into trauma centre planning.

### Stroke

**142.** In the past, the only good care for stroke was rehabilitative treatment. However technological advances have made interventional treatment for some stroke patients possible, if done soon after a stroke's onset. Speed is of the essence, as the sooner treatment is started, the more brain function is retained.

**143.** Suspected stroke patients should be initially assessed by ambulance staff using the FAST (face, arm, speech test) criteria and it should be determined whether the onset of their symptoms was within the treatment window of three hours.<sup>65</sup>

**144.** If that is the case, stroke patients should be taken direct to a hospital providing CT scans and interventional treatment. The stroke team at the hospital should take the patient directly to the CT scanner, so that they can be scanned as soon as the equipment is free. All patients should have a CT scan before being admitted to a stroke unit.

**145.** The CT scan will reveal if thrombolysis (the use of clot-busting drugs) is appropriate – thrombolysis can be used on ischaemic stroke patients but harms people with a haemorrhagic stroke. The aim should be that if a patient is suitable for thrombolysis they should receive it within one hour of the onset of stroke (although thrombolysis is effective within three hours of the onset of a stroke its impact diminishes within that time). The impact of thrombolysis is such that patients who receive thrombolytic treatment within 90 minutes of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months compared with a control group.<sup>66</sup>

**146.** Supporting this interventional care should be excellent quality rehabilitation. The importance of rehabilitation should not be forgotten in the desire

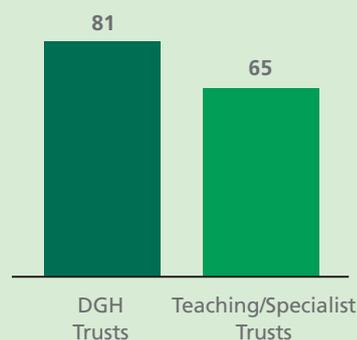
### International case study – Ontario

Ontario introduced a stroke strategy in 2000. In 2000, 3.2 per cent of patients with ischaemic strokes had thrombolysis. By 2005, this had risen to 31.7 per cent.<sup>67</sup> Mortality and readmission rates fell over a similar time period. Ontario's stroke strategy is recognised as an example of international best practice – other areas of Canada are seeking to implement their own version.

to increase interventional treatment. Particularly important is rapid access to a swallow screen (an assessment to test whether a patient is having difficulty swallowing) and prompt assessment and treatment by both physiotherapists and speech and language therapists in the days following a stroke. Secondary prevention and education for patients and carers should also be part of the rehabilitative process.

### Average standardised mortality ratio for stroke in DGH versus Teaching/Specialist Hospital Trusts

2003 - 2005



Source: Hospital reported HSMR scores

**147.** It is not possible for every hospital in London to have the specialist multidisciplinary



teams and high-quality equipment required to deliver this level and speed of care 24 hours a day, seven days a week. We know that in London the larger, more specialist hospitals have better outcomes for stroke patients as shown in the graph on page 64.<sup>68</sup> Based on the work of Buchan,<sup>69</sup> we propose that approximately seven hyper-acute sites in London should be centres of excellence in interventional stroke care, providing CT scans 24/7 supported by full neuroscience expertise. Other sites would provide CT scans and interventional treatment during the day.

**148.** To determine the exact location and configuration of services as well as the workforce implications (for instance work is being done to develop competencies for nurses working in hyper-acute stroke sites) we propose that a London stroke strategy should be developed.

**149.** The London stroke strategy should build on international best practice, such as that pioneered in Ontario and it should also take into account the proposals of the stroke strategy for England, being developed by Roger Boyle, the National Clinical Director for Heart Disease and Stroke, and published this month.<sup>70</sup>

### Emergency surgery

**150.** As well as care for stroke and trauma, we also propose centralisation of emergency surgery. Carrying out larger volumes of emergency surgery improves outcomes.<sup>71</sup> This, when coupled with the need to comply with the European Working Time Directive (EWTD), means that emergency surgery should not be provided at every hospital with an A&E department.

**151.** For hospitals taking emergency medical admissions, but with no 24 hour emergency surgery department, we believe there are three options:

- emergency surgery is provided during the day at local hospitals but not at night. At night, cover is provided by non-resident surgeons.
- emergency surgery is provided during the day

at local hospitals. At night, cover is provided by surgeons from the nearest major hospital providing 24/7 emergency surgery.

- groups of local hospitals work together to provide emergency surgery, perhaps on a rotation basis between sites.

**152.** This should ensure that a surgical opinion will be available at all A&Es within a reasonable time-frame following admission. In addition, all A&Es should have senior medical decision-makers on duty 24 hours a day who would be able to resuscitate, intubate and ventilate patients who require immediate surgical care allowing their rapid transfer to hospitals with emergency surgery on site. Clear protocols will also need to be put in place to support the care and transfer of patients between sites as necessary.

### Acute care for children<sup>72</sup>

**153.** We expect the majority of urgent care for children to be provided in urgent care centres. To support this, urgent care centres will need to have staff with additional training in caring for children, for example, GPs with a special interest in paediatrics. In addition, all staff will need to have the basic skills necessary for providing safe care to children. Urgent care centres, especially those attached to a hospital, should have suitable facilities for children, such as play areas.

**154.** For inpatient care, there are concerns about the viability of having paediatric units in all hospitals. The Royal College of Paediatrics and Child Health said in their submission to the Healthcare for London Review that “the current children’s healthcare workforce cannot safely sustain the number of existing inpatient and acute children’s services.”<sup>73</sup> Only 75 per cent of current acute paediatric units will be staffed with EWTD-compliant rotas in 2009.

**155.** There is also evidence that where larger numbers of children are treated, then paediatric acute care has better outcomes. For instance a

*“I would love to be able to take my children somewhere local and less intimidating than A&E.”*

**Public Event Participant**

US study found that the rate of misdiagnosis for appendicitis in the hospitals with the most paediatric patients was half of that in the hospitals with the least.<sup>74</sup>

**156.** We therefore propose that paediatric acute inpatient care is concentrated on fewer sites in London. Hospitals without paediatric acute inpatient care should have emergency clinicians with advanced paediatric skills (including the ability to provide advanced paediatric life support), as well as a paediatric assessment unit able to review children attending A&E and provide daytime care for children. There is good evidence that these units are effective.<sup>75</sup>

**157.** Where clinical opinion (eg triage by a paramedic, GP at an urgent care centre or clinical assessment by phone) deems that specialist paediatric care is needed, children and their parents will be transferred or directed straight to a hospital site with full specialist paediatric care. This approach should be underpinned by the fostering of managed local networks for acute care for children, linking together health professionals from the community and hospital as well as other services.<sup>76</sup>

### Enabling centralisation

**158.** To support the centralisation of care for the most seriously ill the following actions need to be taken:

- care should be commissioned on a network basis to ensure that all organisations know their role and any transfer and repatriation arrangements. NHS London could facilitate this by taking an overview role.
- as highlighted in the section on trauma, ambulance bypass protocols should be in place. To support this there will need to be investment to improve the capability of ambulance staff to make correct diagnoses. They could also be supported by doctors skilled in pre-hospital assessment.
- even with bypass protocols in place,



centralisation of care is likely to require more transfers of patients between hospitals. Transport of the critically-ill by critical care experts improves outcomes, when compared with non-expert transfer.<sup>77</sup> Experts in critical care transport are also

able to offer good advice and support to all hospitals, even when transport is not deemed necessary. We recommend NHS London works with the London Ambulance Service to develop a dedicated critical care transport service across London (considering the existing Children's Acute Transport Service as a potential model) to allow the moving of the critically-ill to where they can receive the best care.

- to prevent those hospitals offering specialist acute care from becoming too full, patients who have been treated and stabilised at specialist centres should be repatriated to their local hospital for inpatient rehabilitation as soon as possible. This will ensure they can receive dedicated rehabilitative treatment. Continuity of care could be continued by having network arrangements, for example, with a stroke physician at a hyper-acute centre having oversight of patients rehabilitating at other hospital sites.
- funding flows need to be examined to support the centralisation of specialist care. At present there can be perverse incentives, with hospitals who are taking more complex patients not getting full re-imburement due to their emergency admissions increasing beyond their threshold limit.<sup>78</sup> In addition, the tariff needs to be unbundled to match a model of care where intervention is provided at one hospital, but rehabilitation at another.



## Planned care

### Key proposals

- Access to GPs for routine appointments should be improved.
- Routine diagnostics and outpatients should be shifted out of large hospitals.
- Increased use should be made of the day case setting for many procedures.
- Rehabilitation should be done at home wherever possible.
- More specialised inpatient care should be centralised into large hospitals.
- Specialist providers should offer care on other hospital sites.
- London care bundles for intensive care and hospital-acquired infections should be developed.

**159.** In 2005/06 almost 600,000 Londoners had planned (also known as elective) surgery, whilst over 200,000 saw specialist doctors for elective medical problems.<sup>79</sup> These thousands of people deserve the best possible care, but the way existing services are provided and organised in London is not achieving that goal.

### Access to GPs

**160.** We have already discussed (“future demands on healthcare” and section on acute care above) the extent of Londoners’ dissatisfaction with the availability of “outside working hours” care from their GPs.<sup>80</sup> People want not only access to urgent

care, but also the opportunity to see their doctor for routine appointments at a time that suits them. We recommend that people should be able to access their GPs for routine appointments (not just urgent care) outside of normal working hours, including on Saturdays, and at either end of the standard nine-to-five working day.

### Outpatient care

**161.** There are over eight million outpatient appointments in London each year. Not all of this outpatient care is necessary – there is good evidence that GPs and nurses could carry out a lot of the outpatient follow-up appointments currently happening in hospital.<sup>81</sup> For instance, a study comparing the outcomes of patients post-operatively demonstrated that frequency of follow up had no effect on outcome of care.<sup>82</sup> In a London example, Croydon GPs are successfully taking on the follow-up of patients with prostate cancer where the disease is stable. So we propose that commissioners should be taking action to reduce outpatient follow-ups that have no clinical benefit.

**162.** Where specialist outpatient care is needed, we propose that this should happen as locally as possible, avoiding the need for patients to travel to specialist hospitals wherever feasible. This will require clinicians to provide outpatient clinics in the community, with careful management to ensure they are seeing sufficient volumes of patients.

### Diagnostics

**163.** Slow access to diagnostics is a major barrier to rapid planned care and the reduction of waiting times. The work to achieve a national waiting times target of eighteen weeks by 2008

Type of diagnostic	London 13+ weeks waiters	West Midlands 13+ weeks waiters
MRI	2,354	203
Non-obstetric ultrasound	4,225	78
CT	523	7

has identified that diagnostics are a potential bottleneck. National data shows that London has long waiting times for some diagnostics compared with other strategic health authority (SHA) areas. The table on page 67 shows that far more tests are taking over thirteen weeks to occur in London than in the West Midlands.<sup>83</sup>

**164.** London does of course have a larger population than the West Midlands (7.4 million and 5.3 million respectively), but clearly this alone does not account for such large differences in the speed of access to diagnostics.

**165.** To tackle these waits we propose that diagnostics should be available in the community, ideally on the same site as GPs, so that patients do not have to be referred on. GPs should have direct access to these local diagnostics, using standardised London-wide pro formas. The pro formas would provide referral guidelines as to when and which diagnostics should be used.

**166.** The advantages of such an approach in reduced time and cost are considerable. For instance, one trial in the UK found that direct access sigmoidoscopy clinics reduced the NHS and patient's combined costs by £105 compared with a standard outpatient appointment (a sigmoidoscopy is a non-invasive examination of the large intestine).<sup>84</sup>

**167.** Improving diagnostics is not simply about imaging – to enhance the clinical and cost-effectiveness of pathology services we propose that NHS London learns from the recommendations of the Carter Review<sup>85</sup> and the subsequent pilot sites that were established, three of which are in London.<sup>86</sup>

#### More operations as day cases

**168.** Advances in surgical techniques have meant that more and more surgical procedures can be done as day cases.<sup>87</sup> Day case surgery tends to use

#### Day case procedures are more cost effective than inpatient procedures



less invasive techniques that mean patients are not forced to spend days in hospital recovering. Unsurprisingly this is popular with patients. As long ago as 1991 an Audit Commission report found that patients were positive about receiving day surgery.<sup>88</sup> In addition, day cases, by negating the need for inpatient stays in hospital, are much more cost effective for the NHS.

**169.** The NHS has known for some while that it needs to increase day case rates. Back in 2004 this was identified by the NHS Modernisation Agency as one of its *10 High Impact Changes*.<sup>89</sup> London has a particular challenge here, as in 2004/05 its day case rate was 7.1 per cent less than expected, the worst performance of any SHA area.

**170.** Looking at what this means for individual surgical specialities, London has day surgery rates of just 38 per cent for gynaecological surgery and 37 per cent for breast cancer. The British Association of Day Surgeons recommends that the day case rates for these specialties should be 76 per cent and 63 per cent respectively.

**171.** To improve day case rates will require better facilities. There are not enough units in London specifically designed for short-stay and day case procedures, resulting in lower productivity and high costs.

**172.** However, this is only part of the solution as some new units (such as that at Greenwich) have been built, but are not being fully utilised. Commissioners need to be more pro-active in demanding that providers offer the best quality, most efficient care.

### Rehabilitation at home

**173.** We propose that rehabilitation following a procedure or hospital admission should take place as close to a patient's home as possible. In some cases this will be in their local hospital. In many instances, however, it will actually be in a patient's own home, especially given the planned increase in day case surgery.

**174.** Home-based rehabilitation is effective – a Cochrane review found that early supported discharge plus home-based rehabilitation for stroke patients delivered good quality care whilst reducing average length of stay by eight days.<sup>90</sup> Significantly, recovery at home is also what most patients prefer.<sup>91</sup>

### Case study – MediHome and the Royal National Orthopaedic Hospital (RNOH) NHS Trust

A trial partnership between MediHome and RNOH has allowed more patients to recover from orthopaedic surgery at home. Since November 2006, MediHome have been using multidisciplinary teams of nurses, physiotherapists, occupational therapists and health care assistants to care for RNOH patients at home. Doctors at RNOH are able to monitor their patient's progress using MediHome's own electronic patient record system. Patient satisfaction is high and the scheme is proving cost effective. Sheila Puckett, Director of Service Improvement at RNOH "hopes that a long-term partnership will develop between us and MediHome. MediHome support enables us to improve our service provision to our patients as well as improving the trust's financial position."

**175.** However, to achieve such home-based rehabilitation, will require greater use of social care. For many discharged patients in London, social care support will be crucial – London has more one-person households than other parts of England, with 37 per cent of London pensioners living on their own, compared with 33 per cent nationally.<sup>92</sup>

**176.** PCTs should work with local authorities to ensure the necessary support by health and social care to ensure rapid discharge from hospital is achieved. Such support should focus not simply on maintenance but on "re-enablement", helping people return to a full and independent life

wherever possible.<sup>93</sup> Particular focus should be given to tackling issues around the availability of community equipment, as we know access to appropriate beds and hoists is restricted. In addition, resources freed up from more day cases may need to be re-invested into social care support.

**177.** As well as the absence of social care support, a second factor limiting the ability to discharge patients for rehabilitation at home is the need for physiological monitoring. Outside the hospital setting, such monitoring has traditionally been labour-intensive and difficult to administer to large populations. However, new and evolving wireless monitoring and tele-medicine based systems offer the ability to continuously monitor patients in their home environment. These systems may also be used to give feedback to the patient, helping them to play a more active part in their rehabilitation.

### The safest, highest quality, specialist care

**178.** There is a growing body of evidence that hospitals providing high volumes of complex care have the best outcomes. Some of this evidence was considered in “the case for change”. In addition, a recent meta-analysis in the British Journal of Surgery has found that there is a positive relationship between volumes of specialist surgery and three key outcome indicators (mortality rates, reduced lengths of stay and complication rates).<sup>94</sup>

**179.** For the most complex treatment, the safest care is centralised care. That is the primary reason why specialist planned care should be provided at centres of excellence. Secondary factors behind centralisation are changes to working practices including the European Working Time Directive (EWTD) and the increase of sub-specialisation amongst clinicians.

**180.** Cancer care offers a good example of how current decentralised services are simply not of a good enough standard. The NICE Improving Outcomes Guidance (IOG) sets standards for high-quality cancer care. The IOG level one measures are defined as “fundamental to the delivery of a

satisfactory service” and compliance should be 100 per cent. However, of the five London cancer networks, the best performing network only reports 78 per cent compliance, with the worst network achieving 59 per cent compliance.

**181.** Compliance is hampered by care not being sufficiently centralised. Some of the IOGs require that centres perform a certain number of each type of procedure (so that surgeons and their teams are performing enough operations to maintain their skills) and this is not yet happening fully in London.

**182.** Centralisation of care would also be a move supported by cancer patients. A survey of service-users by the West London Cancer Network’s User Partnership found that a majority of them preferred large specialist centres for cancer to more general local provision.<sup>95</sup>

**183.** So we propose that in London, complex care should be provided in a smaller number of specialist centres with world-class outcomes. This concentration of cases should achieve a critical mass of expertise and skills, improving patient safety and the quality of care.

**184.** This could be achieved in London through a hub-and-spoke model, with large, high-performing hospitals forming the centre of a network. Modern technology means that patients would not always have to go to the “hub” for specialised care. For instance, a diagnostic test could be undertaken locally and then reviewed by a specialist at the “hub.” They could give their opinion remotely, all without the patient actually having to journey to the specialised hospital. If and when patients did have to be admitted to the “hub” for care they would be looked after by a specialist multidisciplinary team.

**185.** In some cases the “hub” might be responsible for the provision of specialist care on the sites of other hospitals. This happens internationally – The Hospital for Sick Children in Toronto provides the paediatric services at all of Toronto’s hospitals. This model is also beginning to be used in London. For



instance, the Royal Marsden provides cancer services at Kingston Hospital, whilst Great Ormond Street Hospital delivers paediatric care at North Middlesex Hospital. This pattern, of specialist centres offering their expertise at local hospitals, should increase.

**186.** We are clear that for the best care, more hospitals need to become specialist in particular aspects of healthcare. The days of the district general hospital seeking to provide all services to a high enough standard are over. The numbers of specialist hospitals in the US have doubled in the last twenty years and we expect to see a similar trend in England.<sup>96</sup>

### Planned care for children

**187.** Planned care for children, will, like that for adults, be localised where possible and centralised where necessary. So paediatricians should move outpatient consultations to the community. Less-complex treatment should be provided at home, in children's centres or other community settings.

**188.** More-complex planned paediatric care should be centralised into fewer centres, as already happens in many European countries. There is good evidence for this – for paediatric cardiac surgery, units that perform over 100 procedures a year have a mortality rate 28 per

cent less than smaller units, whilst surgeons who perform more than 75 procedures a year have a mortality rate 33 per cent less than their colleagues who treat fewer patients.<sup>97</sup>

**189.** We therefore advocate that specialist children's surgery should be done in larger centres. Just as with adult care, this allows for the concentration of specialist staff, which should provide better care and is also necessary to comply with the European Working Time Directive.

### Good practice

**190.** We propose that two areas of focus for planned care in London should be eliminating hospital-acquired infections as far as possible, and improving the use of intensive care. In the public's mind, hospital infections and cleanliness are inextricably linked. Cleanliness was the second highest priority for improvement in the Ipsos MORI survey. Cleanliness's links to hospital infections was raised as an issue at the OLR deliberative event, with one participant saying, "It just doesn't seem like they're trying to do anything about MRSA. There's not the drive to keep things clean that there used to be. We need minimum standards and penalties if they're not met."<sup>98</sup>

**191.** For intensive care, London needs to ensure it is putting international good practice into action (see box).

### International case study – reducing intensive care use

A long-running study in Melbourne, Australia has seen the average length of stay in intensive care and the mortality rates for patients with major abdominal surgery fall dramatically. In 1985, the average length of stay was fifteen days and in 1999, it was just three, whilst mortality had fallen from nineteen per cent to 0.5 per cent over the same time period. This was achieved by improvements in pre-operative assessment, peri-operative care and post-operative support.<sup>99</sup>

When integrating the Melbourne model of treatment into a care package with other evidence-based interventions (such as early feeding/topping up of fluids) quality of care is further improved and length of stay reduced. Seven randomised trials have shown simple use of cheap ultrasound technology to reduce length of stay consistently by two to three days in elective intra-abdominal surgery. The evidence-base is clear here and changes should be rapidly implemented across London.

**192.** One way of disseminating good practice in both these areas would be the introduction of NHS London endorsed “care bundles,” which identify all the different elements of care that are needed for tackling a particular procedure or condition. For instance, North West London Hospitals have developed a care bundle for tackling the clostridium difficile infection. We propose that approved care bundles for dealing with hospital-acquired infections and intensive care are developed and disseminated across London.



## Long-term conditions (LTCs)

### Key proposals

- LTCs should be prevented where possible by outreach and tailored advice to the most deprived.
- People with LTCs should be at the centre of a web of care.
- There should be more pro-active community care to reduce emergency admissions and lengths of stay.
- Integration of services should be improved (both between GP practices and hospital specialists and between health and social care).
- London-wide best practice care pathways should be developed for different LTCs (eg diabetes, COPD, CHD and asthma).

**193.** People with LTCs are the biggest users of healthcare. For instance, patients with an LTC account for 80 per cent of all GP consultations.<sup>100</sup>

**194.** “Future demands on healthcare” highlighted that the incidence of LTCs will grow in future and that the burden of LTCs is not equal across London. For instance, diabetes is most prevalent in PCT areas that are deprived and/or areas which have high BME populations.

Improving LTC care will therefore be a step in reducing health inequalities across London.

**195.** The map on page 73 shows how some London PCTs have higher than expected rates of admissions for ambulatory-care-sensitive conditions, suggesting there is scope for improved LTC care in London.<sup>101</sup>

**196.** The needs of people with LTCs have been recognised in recent national policy.<sup>102</sup> Our proposals support the thrust of this national policy and seek to put it into practice.

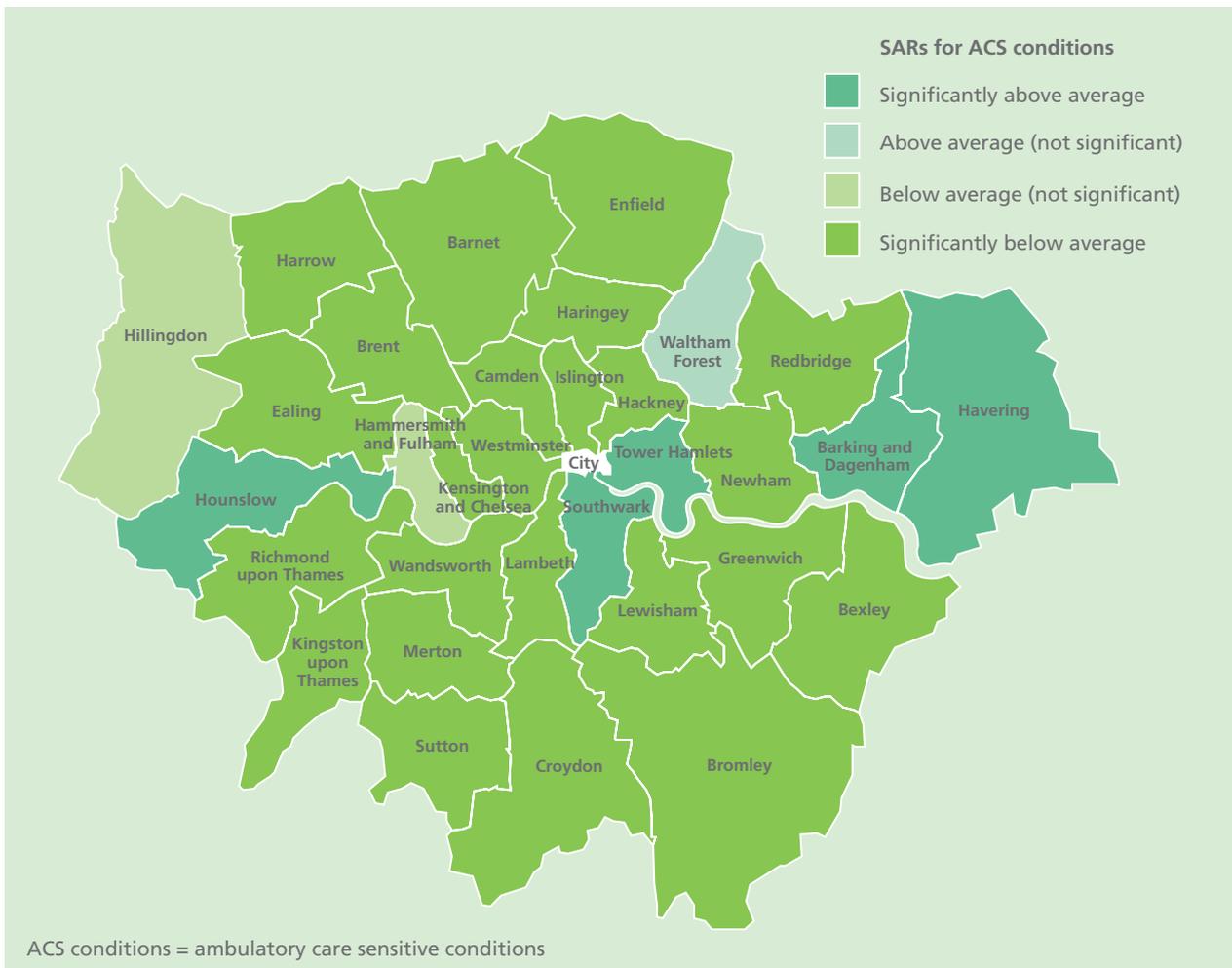
### Preventative care

**197.** Every effort must be made to prevent LTCs where possible. There are clear links between lifestyle behaviours and the incidence of some LTCs. For instance smoking increases the likelihood of developing cancer, and obesity the chances of suffering from type II diabetes.

**198.** To do this, community healthcare staff (ie GPs, practice nurses, case managers, pharmacists), should work with public health colleagues to seek out people at high risk of smoking and obesity (eg through deprivation indices). They should then provide tailored advice and support to help people to improve their diet, take more exercise and stop smoking. This is likely to require effort to reach out, recall and follow people up who may be reluctant to access services or keep up with



## 2006 standardised admission ratios for ACS conditions by PCT



Source: Dr Foster. NB Imperial College has an academic relationship with Dr Foster.

the programmes. Any programmes (eg smoking cessation) must be appropriate to the different ethnic groups served. This could be achieved by each PCT implementing a Locally Enhanced Service to target smoking cessation and obesity-management at the most deprived.

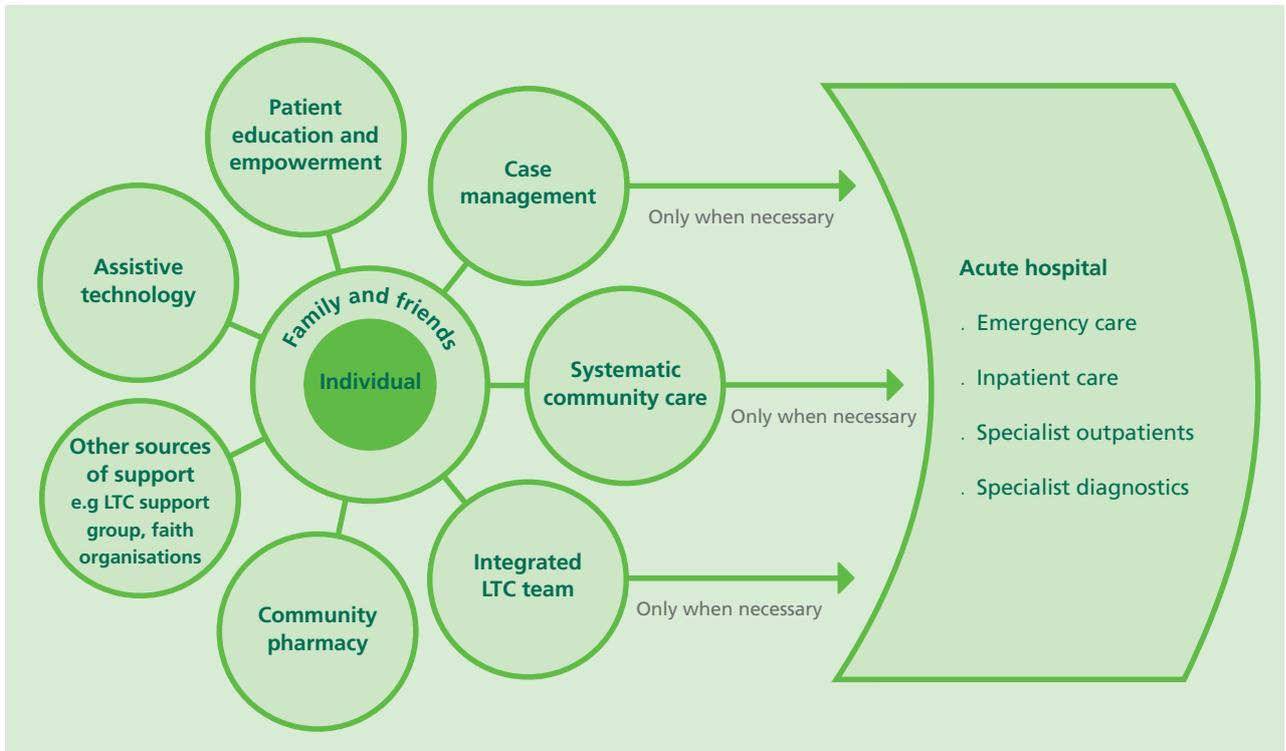
### Diagnosis

**199.** Many people with LTCs remain undiagnosed or under-diagnosed. For instance, it is estimated that up to 33 per cent of people with diabetes<sup>103</sup> may be undiagnosed and up to 41 per cent of people with COPD.<sup>104</sup>

**200.** In the planned care section we proposed that GPs could have pro forma-driven direct access to diagnostics. This should help to improve diagnosis of LTCs. For instance, direct access spirometry has been found to improve diagnosis of COPD and hence the treatment of previously undiagnosed patients.<sup>105</sup>

**201.** However, access to diagnostics alone will not be enough. There will need to be outreach to at-risk groups to identify cases of ill health, as these groups may not access healthcare of their own volition. Social care staff are in contact with

### Proposals will create a web of care with the individual at the centre



many of these at-risk groups, so GPs and practice nurses should work with them to develop effective case-finding approaches.<sup>106</sup>

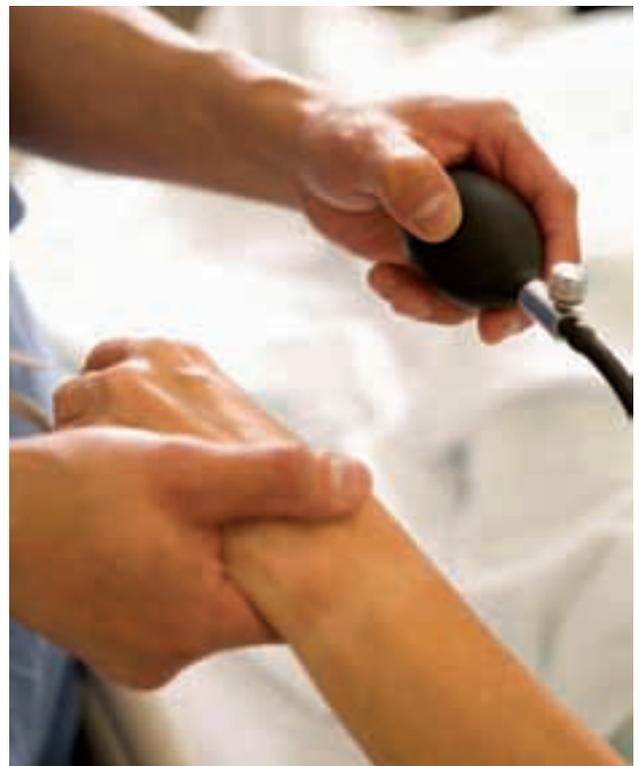
#### Care for people with LTCs

**202.** Once a diagnosis has been made, then a person with a LTC should be able to access the full range of support for their condition. We characterise this as a web of care.

**203.** The individual with the LTC should be in control of their own care. They should be at the centre of the web of care, making informed decisions about the support they can access. The different forms of support form strands of the web, which we consider in turn.

#### *Patient education and empowerment*

**204.** The patient needs to be personally responsible for their own health and to be the





### Case study – diabetes education for non-English speakers

In Newham, the NHS Service Delivery and Organisation Research and Development programme have funded the pioneering use of bilingual health advocates (BHAs) who provide diabetes education in the community for patients who do not speak English. BHAs are community workers who are offered six months of accredited training and then provide group education, with input from health professionals as required, for patients with diabetes (though this model could be rolled over to other LTCs, if successful). This is being compared with standard health professional-led education and clinical, biochemical, wellbeing and organisational impact is being measured.<sup>110</sup>

expert in the management of their condition. This requires them to have the information about their condition and the strategy for managing it, supported by, and developed in partnership with, clinicians.

**205.** We endorse the many national initiatives in this area, such as the expert patient programme and information prescriptions. The expert patient programme is led by trained volunteers who have an LTC themselves and aims to give participants the knowledge they need to become experts in their own condition. Research and monitoring confirm that the courses reduce health service usage by supporting people to manage their condition better and improve their quality of life.<sup>107</sup>

**206.** Information prescriptions were announced in the *Our health, our care, our say* White Paper, as a way of directing people to all the latest information and advice on their condition. Information prescriptions are currently being piloted in twenty sites across England including three in London.<sup>108</sup>

**207.** Any patient education and empowerment methods in London need to take account of language and cultural issues. An example of this is taking place in Newham (see box).

#### *Systematic community care to reduce emergency admissions*

**208.** There is clear evidence that interventions in the community can reduce emergency admission rates and lengths of stay, leading to improved care for people with LTCs. For instance, interventions by specialist nurses have been found to reduce emergency admissions for people with asthma and COPD. Heart failure patients benefit from specialist nurse care with reduced emergency admissions and length of stay.<sup>111</sup>

**209.** The Department of Health's *Disease Management Information Toolkit* can help PCTs and other users quantify the expected benefits of improving LTC care in this way.<sup>112</sup>

**210.** At present, patients with diabetes, asthma and congestive heart failure should have one annual review appointment with their GP and two appointments with a nurse. Whilst this is satisfactory for patients with a mild LTC, it is not for those with greater needs.



**211.** There needs to be much greater use of systematic appointments with community healthcare professionals to reduce emergency care needs. The table below indicates what that would mean for a patient with one of those three LTCs, depending on how severe their condition was.

	Mild	Moderate	Severe
GP	1	2	4
Practice Nurse	2	0	0
Specialist Nurse/GPwSI	0	4	8

**212.** What does that mean across London? The table below shows the additional and total number of appointments that will be required (by definition the existing column for GP appointments shows the number of patients in London diagnosed with that condition).

		Existing	Additional	Future Totals
GP	Congestive heart failure	111,548	163,000	254,000
	Asthma	390,000	285,000	657,000
	Diabetes	292,000	391,000	683,000
Total			839,000	
Specialist Nurse/GPwSI	Congestive heart failure	151,000	326,000	477,000
	Asthma	288,000	570,000	858,000
	Diabetes	390,000	781,000	1,171,000
Total			1,677,000	

**213.** Over 800,000 more GP appointments would require approximately 175 more GPs, and over 1.6 million nurse appointments would require around 350 specialist nurses across London. This increase would be offset by a reduction in urgent care appointments due to better planning and management of LTCs in the community and a reduction in emergency admissions to hospital.

**214.** Clearly, considerable investment will be needed to put in place the necessary systematic care for these three conditions. This approach will need to be monitored and evaluated to ensure that the expected benefits in reducing emergency admissions are achieved.

### Integrated LTC team

**215.** A recent report into diabetes care has stressed the need for care to be integrated.<sup>113</sup> Yet too often in the NHS, care is not effectively integrated between the community and the

hospital. In one London PCT, a single patient attended A&E 250 times with minor issues (eg the need for a new inhaler) without their GP practice ever being aware of this.

**216.** Kaiser Permanente and other health management organisations have shown the benefit of integrated care. To achieve this integration, without organisational change, we recommend the designation of a consultant/nurse



specialist and community lead (GP, pharmacist, etc) for each major long-term condition in each PCT area. They would be clinically accountable for driving closer working between staff in hospital and staff in the community.

**217.** The consultant/nurse specialist would be contracted with the PCT and have a population responsibility based on practice populations. As part of the contract, the specialist would provide training to those practices and specialist advice to all practitioners by mobile phone, e-mail and letter, webcam, etc.<sup>114</sup> This would require the identification of sessions in the community when a consultant's job plan is drawn up.

**218.** Many people with LTCs have on-going social care needs and better integration of care is also needed between health and social care. There are many good suggestions for how this should be achieved as part of the *Our health, our care, our say* White Paper, including the development of individual health and social care plans and the establishment of joint health and social care teams.<sup>115</sup> This should be built on by requiring PCTs to work with local authorities to develop joint action plans for the management of long-term disease.

**219.** Social care staff can play a key role in supporting people with LTCs, coaching them in good practice in on-going disease management, such as the maintenance of a good diet and the taking of sufficient exercise.

#### *Assistive technology*

**220.** The *Our health, our care, our say* White Paper highlighted the potential of assistive technology as part of an integrated care approach for people with LTCs.<sup>116</sup> Assistive technology includes telehealth monitoring devices that allow patients to test their blood glucose levels at home and telecare sensors that monitor a vulnerable person's movements around their home.

**221.** The White Paper promised to establish whole-system demonstration sites to investigate the potential for assistive technology and Newham is one of the three successful applicants.

#### *Community pharmacies*

**222.** Community pharmacies should in the future be playing an active role in supporting people with LTCs.<sup>117</sup> For instance, recent national guidance highlights the vital role community pharmacists can play in helping people self-care.<sup>118</sup>

**223.** In particular, community pharmacies can support people with LTCs to take their prescribed medication correctly, as problems with medicines may be the cause of as many as fifteen per cent of hospital admissions.<sup>119</sup> For example, Hillingdon have instigated a Community Pharmacy Medication Management Service for people with diabetes requiring medication. Users of the service have a consultation with a pharmacist to review their medication at least six times a year.

#### *Case management*

**224.** For people with the most complex needs, a case manager can usefully co-ordinate the provision of the support services they need. There is clear evidence that patients value this co-ordinating role, as case management improves patient satisfaction.<sup>120</sup> Case management can also reduce the use of hospital services – the Castlefields Health Centre in Runcorn, Cheshire found that targeted case management of high-risk older people resulted in a fifteen per cent reduction in admissions and a 31 per cent reduction in length of stay.<sup>121</sup>

**225.** Case management on its own is not a magic bullet – the evaluation of the Evercare pilots found that total hospital admissions were not affected by its implementation.<sup>122</sup> This possibly reflects the fact that the Evercare model achieves better case-finding and more treatment, as well as indicating

*“My local pharmacist is unbelievably good. He was willing to talk to me for a good fifteen minutes and provided some really useful advice before getting my prescription ready quickly and thoroughly explaining what I should do if I didn't see any improvement within the next few days.”*

**Public Event Participant**

that case management needs to be combined with improvements to care, such as nursing support at home, to be fully effective.

### Putting the web of care in place – care pathways

**226.** We propose the development of London-wide care pathways for long-term conditions that would specify the supporting spokes each person could access. These care pathways would be accessible to all clinicians and to people with LTCs. Patient access to the guidelines would allow patient-led audit of care – they would know if their care was not up to the standard they should be receiving.

**227.** Guidelines would need to include details on:

- which diagnostics should be accessed and when
- self-care options and support, including education and skills training for patients
- sources of information and advice
- when specialist input is required
- interventions required as part of an annual review
- management of a crisis
- particular care requirements for children and young people with an LTC.<sup>123</sup>

**228.** Development of these care pathways should begin in 2007/08 with COPD, asthma, diabetes and rheumatoid arthritis. NHS London should appoint a group of experts to develop these pathways, including clinicians, patients, local authority and voluntary sector representatives. Existing work should be used wherever possible, such as the pathways developed as part of the *Map of Medicine*.<sup>124</sup>

**229.** These care pathways should be used to inform service level agreements (SLAs), with the financial incentives behind the SLAs aligning to ensure the care pathway is followed.

### Children with LTCs

**230.** In the 2001, census 57,286 children in London were recorded as having a limiting long-term illness.<sup>125</sup> That is 4.4 per cent of the under-fifteen population. Hospital Episode Statistics data shows that the four LTCs for children that result in the highest number of hospital admissions are sickle cell and thalassaemia, asthma, epilepsy and diabetes.<sup>126</sup>

**231.** Care for these children needs to follow the same principles as outlined above for adults, but should also reflect the specific needs of children. So they will have extra strands to their web of care, such as their school and children's centres. They are also likely to need more specialist care from paediatricians.

### End-of-life care

#### Key proposals

- End-of-life service providers should be commissioned to co-ordinate end-of-life care.
- People should have an end-of-life care plan, including preferences on place of death, and this should be registered electronically.
- All organisations should meet existing best practice guidelines (eg gold standards framework).
- There should be greater investment to support people to die at home.

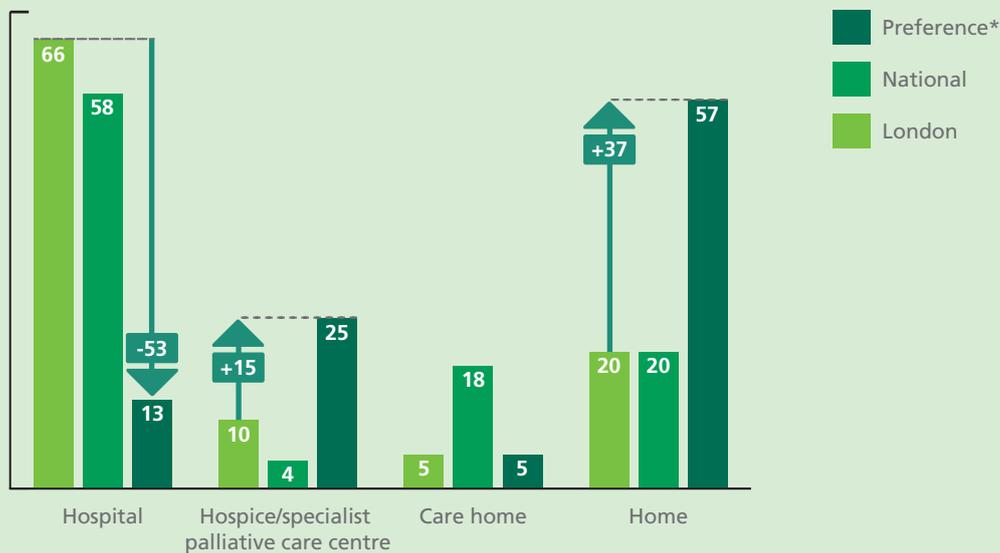
**232.** There were 52,991 deaths in London in 2005.<sup>127</sup> That is 0.7 per cent of the population. Some, particularly amongst the young, will have been sudden, unexpected deaths. But many of these people would have been intensively supported by the NHS in their last few months and weeks.

**233.** Some will have received excellent care.



## Patients do not die in their preferred setting

Location of death, %



\* Values have been scaled up to allocate 5% not accounted for in originally reported data, 2% on hospital, 1% on each of other three groups

Source: England, Wales and Scotland (2000); Telephone survey; Priorities and preferences for end of life care in England, Wales and Scotland (2003) Telephone Survey NCHPCS/Cicely Saunders Foundation; National statistics 2003, London Health Observatory 2005

In an ICM poll of the general public, 77 per cent of people who had experienced the death of a loved one in the last five years were fairly or very satisfied with the care given.<sup>128</sup>

**234.** Others will not have received such good treatment. For instance, 54 per cent of all complaints about hospitals received by the Healthcare Commission are about end-of-life care.<sup>129</sup> We also know that communication can be poor between healthcare services, patients and their families.

**235.** People are also not able to die in their preferred location, as shown by the graph above.

**236.** In addition, best practice techniques for end-of-life care, such as the Liverpool Care Pathway and the Gold Standard Framework, are only used sporadically across London.<sup>130</sup> For

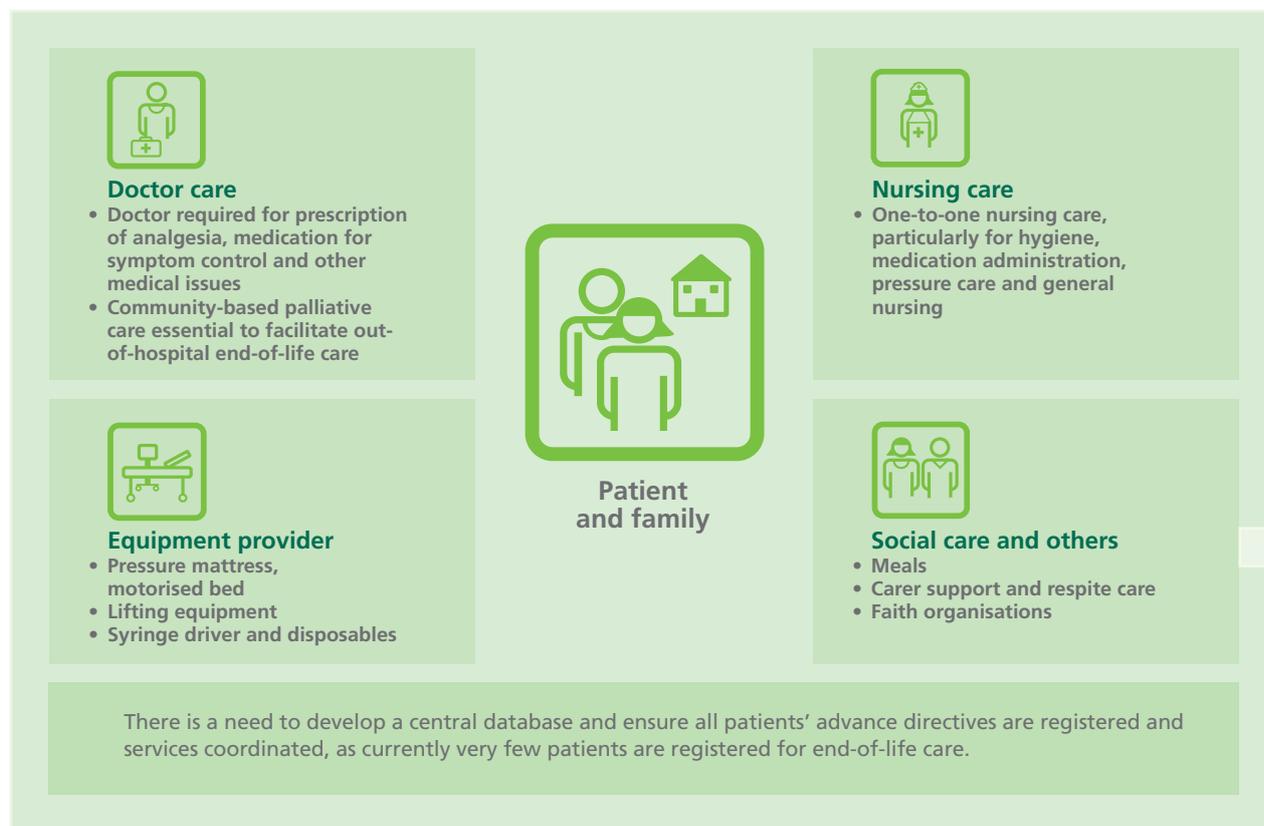
example, over 90 per cent of GP practices have adopted one or more tools in the old strategic health authority (SHA) areas of Cumbria & Lancashire and Cheshire & Merseyside. By comparison, less than 25 per cent of GP practices in London are using one of the tools. The tools are not being used by all acute trusts in London and even those that are using them may not be using them on all wards.

### Complexity of end-of-life care

**237.** People at the end of life often require support and care from a number of different services as illustrated in the diagram on page 80.

**238.** Currently, across London, there is no consistent approach to organising this complex array of care. We propose that such a co-ordinating role needs to be commissioned by the NHS in London.

## There are multiple services required for comprehensive community-based end-of-life care



### End-of-life service providers

**239.** We propose the commissioning of end-of-life service providers (ELSPs) to co-ordinate care for the thousands of Londoners who die each year. These ELSPs would ensure an integrated service for those in their care.

**240.** They are likely to provide some services themselves. They would also be able to use service level agreements with other providers, such as GP practices, specialist palliative care teams, local authorities, the voluntary sector, and acute care providers. In addition they could provide resources for individuals to use themselves.

**241.** The exact requirements for each ELSP should be set as part of the commissioning process. However, as a minimum they should:

- maintain an end-of-life register
- develop personalised plans for the end-of-life care of each person on the register
- have a clear contact point for each person and their family/carer.

### End-of-life register

**242.** Patients with an advanced progressive illness who are identified as nearing the end of their life should be offered the opportunity to be included on an end-of-life register. Placement on the register would bring with it a commitment on behalf of the ELSP to a systematic assessment of needs and the co-ordination of appropriate services. It could also bring other entitlements to a wide range of services from free parking to dedicated support services.



**243.** The process of systematically identifying those who should be on this register would entail applying a range of ‘triggers’ for different conditions, designed to identify those with a high potential of death from the disease in the following months. These triggers will need to be developed as part of the implementation of this model of care.

**244.** Entry onto the register would not mean that curative treatment would stop. We need to adopt a more sophisticated approach to end-of-life care that does not draw a dividing line between curative and palliative care. Kaiser Permanente has outlined such an approach diagrammatically (see below).

**Personalised end-of-life care plans**

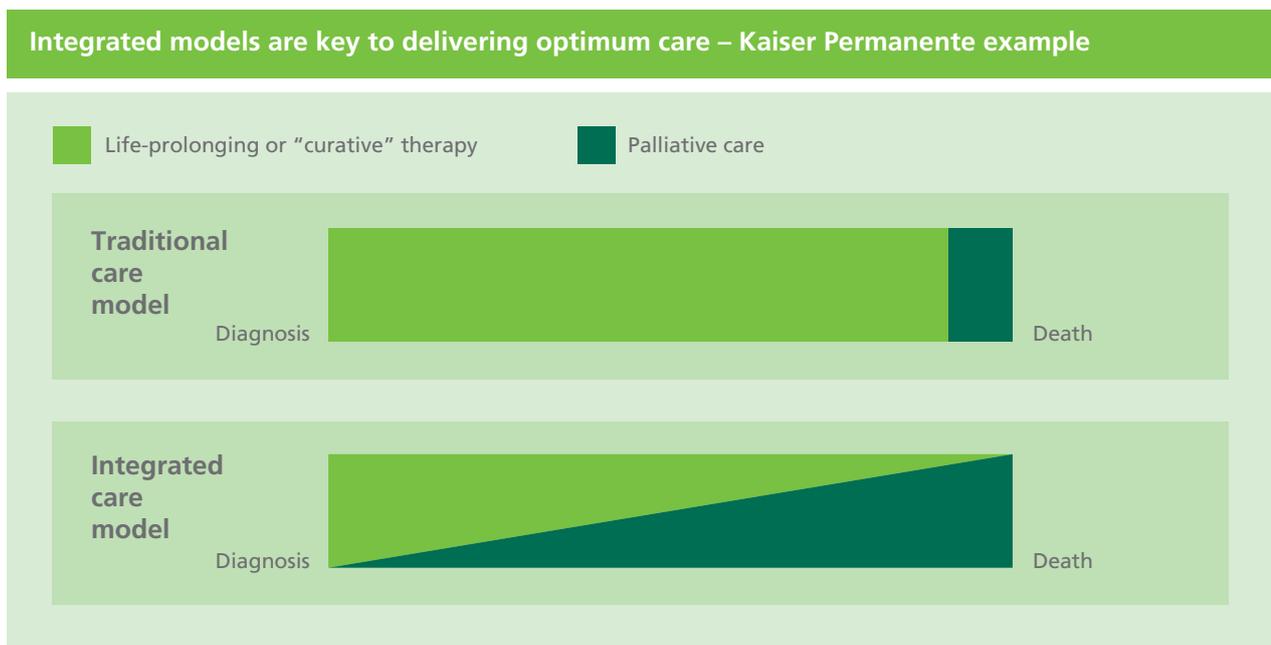
**245.** When a person is placed on the end-of-life register they will have the opportunity to develop a personalised end-of-life care plan with a health professional. This should refresh and build on the existing health and social care plan that the *Our health, our care, our say* White Paper envisaged that all people with an LTC would have.<sup>131</sup>

**246.** As part of this personalised care plan, people will have the opportunity to discuss their preferences for end-of-life care (eg their preferred location of death) with appropriately-skilled health professionals. To inform their preferences, patients need to be given access to comprehensive, locally-tailored information about what services and support are available locally for individuals and their carers, as well as access to advocacy, potentially provided by local voluntary sector providers. As a patient’s preferences may well change over time, they need to be able to refresh and change their preferences in consultation with health professionals.

**247.** In the short-term, care plans might need to be hand-held and paper-based. However, as soon as possible they should be held as part of the electronic health record and accessible to patients via electronic forms or on HealthSpace.<sup>132</sup>

**A clear contact point**

**248.** The ELSP should also ensure that all patients on the end-of-life register and their carers have a single point of contact for



*“In this model [of end-of-life care], liaison seems to be much more thorough resulting in time and surely cost savings.”*

**Public Event Participant**

accessing care. We are not proposing to be prescriptive as to how this is done, but it could be via a named responsible healthcare professional, or it could be through telephone access to a multidisciplinary team.

### Making this model of end-of-life care work

**249.** To make this proposed model of end-of-life care work the ELSP will need to be accountable through their contract with the NHS for maintaining end-of-life care registers, developing care plans, and ensuring appropriate care is provided. We envisage that voluntary, public and private sector organisations could all be ELSPs.

**250.** We propose that commissioning of ELSPs should not be done at a PCT level, but at a “sector” level (areas coterminous with the five old London SHAs). This would mean each sector would be commissioning end-of-life care for a population of around 10,000 per annum. We believe that there are good arguments for locating this commissioning of adult end-of-life care at the sector level. Commissioning for this number of patients would allow for the development of expertise in commissioning and economies of scale in provision. It may also enable patients to exercise choice within their area between two or more ELSPs.

**251.** To ensure the most disadvantaged and complex cases are not neglected, ELSPs would be contracted to provide care for the whole of a geographic location. So all end-of-life patients would be covered irrespective of place of care, place of dying, cause of death (including dementia), co-morbidities or socio-demographic factors.

**252.** Competencies need to be developed for the sensitive role of end-of-life care planner and recorder of preferences. ELSPs will need to assess clinical professionals against the competences necessary to undertake the eliciting and recording of preferences and the necessary care planning activities.



**253.** ELSPs would need to quality assure the service offered by the providers they contract with. To do this they could set requirements, for example, in terms of using the best practice tools.

**254.** We recognise that an end-of-life care strategy for England is being developed by Mike Richards, the National Clinical Director for Cancer, and the Department of Health. The implementation of these proposals will need to take account of the key recommendations in that strategy when it is published.

### Palliative care for children

**255.** The same principles for palliative care for adults (ie at home wherever possible, well co-ordinated) should apply to children’s palliative care. However, children’s palliative care is even more complex – palliative care for children can be much longer-term and is often focused on ameliorating the pain of severe disabilities, rather than the end of life. Palliative care for children also has an additional partner – education – that needs to be fully involved.

**256.** The recent national review of palliative care found that “services are generally commissioned at PCT level, but our evidence indicates that the numbers requiring services at PCT level are generally too low to support sustainable services.”<sup>133</sup> Because of the complexity and numbers involved, we propose that there should be pan-London specialised commissioning of children’s palliative care.



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## Future models of healthcare provision

1. This review's focus is on services, not institutions and buildings. That is why the review process was built around looking at what form future care should take in seven different clinical areas. However, we need to examine how this vision of future care relates to current healthcare organisations.
2. It is worth restating at this point the five guiding principles that underlie both our working group recommendations and our thinking about future models of healthcare provision.

### The five common principles

- 1 Services focused on individual needs and choices
- 2 Localise where possible, centralise where necessary
- 3 Truly integrated care and partnership working, maximising the contribution of the entire workforce
- 4 Prevention is better than cure
- 5 A focus on health inequalities and diversity

### Current provision must change

3. In London, there is currently a stark divide between primary and secondary care, both in terms of location and scale. Primary care is mainly provided by GP practices, and in London the majority of practices have just one or two GPs.
4. Practices are often located in cramped, converted residential spaces. This can cause difficulties for patients. A British Medical Association (BMA) survey of UK GP practices found that 35.7 per cent of practices could not be adapted to meet all the disabled access requirements of the Disability Discrimination Act, and there is no reason to believe that this is not

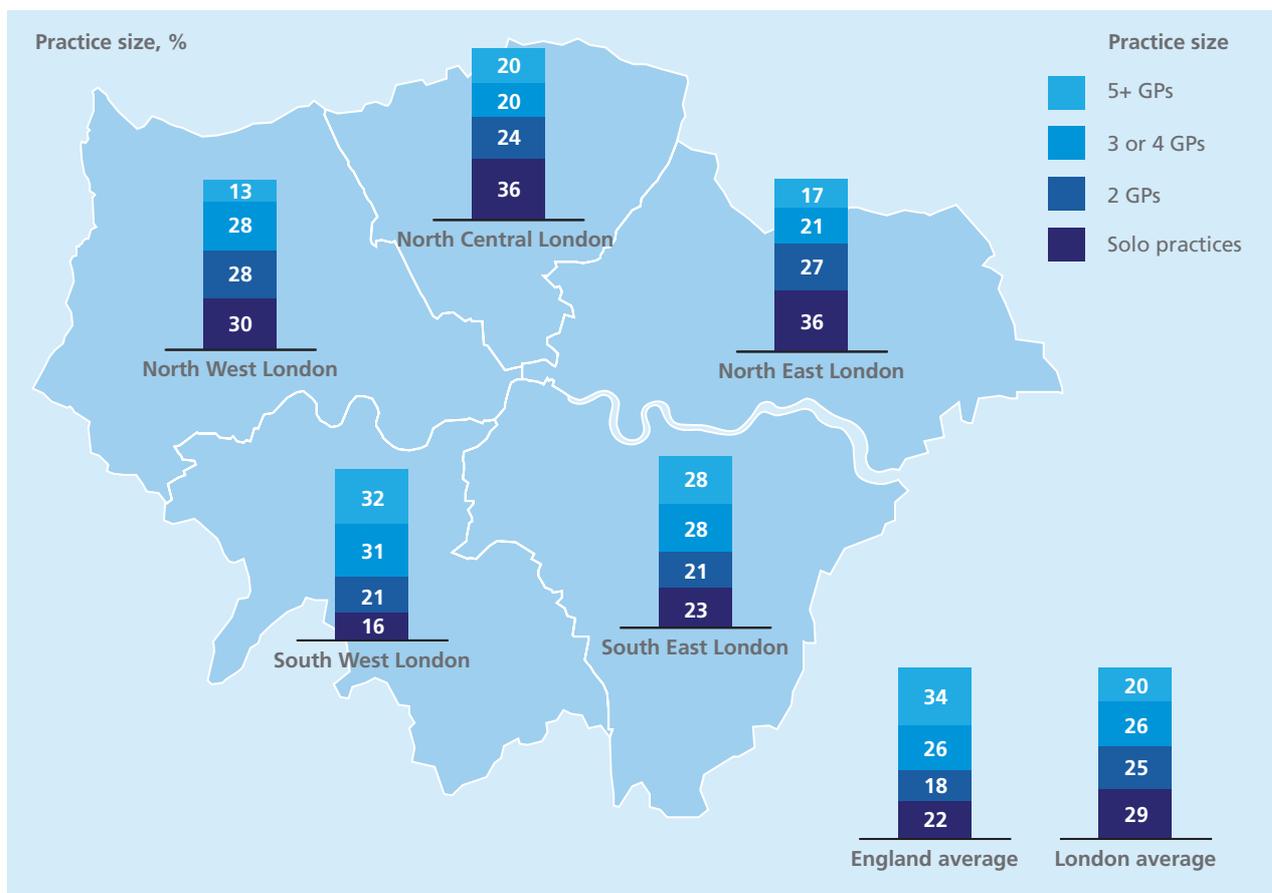
representative of London practices.<sup>1</sup> It also prevents practices providing the extended services envisaged in the previous chapter.

5. By contrast, secondary care is offered by the 32 acute trusts and ten mental health trusts in London, some of which operate on multiple sites. Most hospitals are large, with thousands of employees and several hundred beds each. Many seek to provide a wide range of specialist care. Hospitals are spread over a sizeable and poorly designed estate that it is not necessarily used efficiently.
6. There is thus a chasm in provision for those Londoners who cannot have all their care needs met by a small GP practice, but do not require the services of a large hospital. We need to bridge this gap between primary and secondary care – we have deliberately not used those terms in our description of future services as we are seeking to break down the traditional primary/secondary care divide.
7. We also cannot have all 32 acute trusts in London seeking to provide the most specialised kinds of care. There are simply not the volumes of patients with complex needs to make this either viable or as safe as possible for patients.<sup>2</sup> We need fewer, more advanced and more specialised hospitals to provide the most complex care, some linking directly into universities to foster research and development. There is a need for strong commissioning to ensure that specialist care develops in a co-ordinated way.
8. These two needs, first to provide a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital, and second to develop fewer, more advanced and more specialised hospitals, with excellent outcomes, lead us to propose seven

## Key proposals

- More healthcare should be provided at home.
- New facilities – polyclinics – should be developed that can offer a far greater range of services (eg extended urgent care, healthy living services, community mental health services and social care) than can be offered by GP practices, whilst being more accessible and less medicalised than hospitals.
- Local hospitals should provide the majority of inpatient care.
- Most high-throughput surgery should be provided in elective centres.
- Some hospitals should be designated as major acute sites, handling the most complex treatments.
- Existing specialist hospitals should be valued and other hospitals should be encouraged to specialise.
- Academic Health Science Centres should be developed in London to be centres of clinical and research excellence.

## London has more small GP practices than nationally



models of provision, where the majority of future healthcare will happen:

- home
- polyclinic (the future base for most GP services, community care, diagnostic services and outpatient activity)
- local hospital
- elective centre
- major acute hospital
- specialist hospital
- Academic Health Science Centre.

9. This chapter will now consider each of these models in detail. To help bring the models to life it uses some illustrations of what care will be like

for patients in the future, as opposed to the care they receive now.

10. When considering the proposed models it is important to be aware that they can inter-link, so that for example a local hospital could share the same site and infrastructure as an elective centre and/or a polyclinic, with the polyclinic acting as the “front-door” to the hospital. A summary of the proposals is below.

### Home

11. This review has identified that far more healthcare can take place in the home. In particular, both the beginning of life (with more home births) and the end of life (with home being the place where most people say they wish to die) will

## What should be available at home

### Activities



Rehabilitation



Ongoing care for long-term conditions and support for self care



Specialist care  
e.g. chemotherapy



Step-up care to prevent admissions



Step-down care to support discharge from hospital



Support for home birth



End-of-life care

### Infrastructure

- Equipment to support home care will need to be provided
- Community staff are based in the polyclinic
- Links to major acute hospital for specialist care

### Patients and staff

- Community nurses including district nurses, health visitors, specialist nurses from hospitals
- Community therapists
- Midwives for home births
- Social care services
- Emergency care practitioners

increasingly take place in people's homes. People will also spend less time in hospital and more at home recovering from acute illnesses and surgery.

**12.** An increase in the provision of healthcare at home will help to tackle health inequalities by addressing the needs of vulnerable groups – for example, people with physical disabilities, or older people with long-term conditions.

**14.** The following is an example of what an increase in healthcare at home will mean for patients.

**15.** NHS staff will be going into people's homes to help keep people out of hospital. Providing more care at home will have transport implications for NHS and social care staff, who will need to be able to travel quickly and (where travelling by car) park easily.

### End-of-life – James has advanced prostate cancer which has spread to his bones. James wants to die at home close to his wife and family

#### Current

James has been feeling increasingly unwell over the last few days. He has seen his GP who has ordered some blood tests. The blood test results are called through to the GP practice on Friday at 5 pm as they are highly abnormal. The receptionist calls the on-call GP at 6pm.

The on-call GP rings James at home and tells him he needs to go to A&E. James talks to his GP about the treatment and decides that he wants it, so his GP orders an ambulance to take him.

At A&E the doctors repeat the blood tests, admit him to the hospital and begin treatment.

Treatment continues for two days but James doesn't get better and dies in hospital on the third day.

#### Future

The abnormal blood test results are phoned through to the GP practice. The receptionist sees that James is being cared for by the end-of-life team and calls the coordinator who is available 24/7. The care co-ordinator arranges for James's palliative care nurse to visit him at home that evening.

The palliative care nurse explains to James and his wife that his blood test results show his kidneys are not working. James understands and decides to stay at home without active treatment. The nurse checks his pain medication and makes sure he is comfortable.

The nurse visits James twice a day for the next three days. On the third day he dies peacefully at home with his family.

**13.** To provide more care at home the NHS will need to work closely with social care to ensure there is enough support for people, especially for older people who live on their own. The need for increasing support from social care and the associated costs of this should be considered as part of NHS commissioning, with NHS resources being used, where appropriate, to commission social care.

#### Polyclinic

**16.** If London is to gain the improved services envisaged in the previous chapter, then large, high-quality community facilities are needed, providing a much wider range of services than is currently offered by most GP practices. Following the testing of various names for these facilities with Londoners,<sup>3</sup> we are provisionally labeling them polyclinics.





**17.** In terms of the recommendations in “improved care from cradle to grave”, they will be the ideal location for antenatal and postnatal care by midwives, linked to other care such as mental health, wellbeing services and social care. They will provide healthy living information and services. They will be the location for community mental health care such as cognitive behavioural therapy, and the base for those providing home-based mental health care. The majority of urgent care centres will be based in polyclinics. Polyclinics will be able to provide the consulting rooms and diagnostics that will be crucial to shifting much planned care into community settings. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions.

**18.** We propose that the polyclinic will be the place where most routine healthcare needs are met, and the place from which further navigation through the healthcare system is provided.

Londoners will view their local polyclinics as their main stop for health and wellbeing support. GP practices will be based at polyclinics, but the range of services – from pharmacy and social care to staying healthy services and dentistry, from outpatient appointments and diagnostics to mental health services and antenatal care – will far exceed that of most existing GP practices.

**19.** The scale of the polyclinic will allow it to improve accessibility by offering extended opening hours across a wide range of services. Scale should also make it more possible to provide the expertise needed to improve accessibility for groups of people such as those with learning disabilities, the mentally ill, or those with language or cultural barriers. The clinics’ scale will also allow them to implement much more sophisticated telephone booking systems. The inadequacy of current GP telephone booking systems was a major area of concern for Londoners at the two public events.<sup>4</sup>

*“We should all be able to go to centres [polyclinics] like this to ensure we get quick, joined up care.”*  
**Public Event Participant**

## What a polyclinic should provide

Activities	Hours open per day	
 General practice services	12	<b>Infrastructure</b> <ul style="list-style-type: none"> <li>• Consulting rooms</li> <li>• Procedure rooms</li> <li>• Urgent care centre</li> <li>• Dedicated child-friendly facilities</li> <li>• X-ray, ultrasound and other diagnostics</li> <li>• Base for other services such as district nurses</li> <li>• Healthy living/information centre</li> <li>• Pharmacy, optician, dentist</li> <li>• On-site translation services where necessary</li> <li>• Co-located local authority services in some e.g. social services</li> <li>• Co-located leisure facilities in some, e.g. swimming pool</li> </ul>
 Community services	12	
 Most outpatient appointments (including antenatal/postnatal care)	12	
 Minor procedures	12	
 Urgent care	12-24	
 Diagnostics – point-of-care pathology and radiology	18-24	
 Interactive health information services including healthy living classes	18-24	
 Proactive management of long-term conditions	12	
 Pharmacy	18-24	
 Other health professionals, e.g. optician, dentist	12	
		<b>Patients and staff</b> <ul style="list-style-type: none"> <li>• Open 18-24/7</li> <li>• Serve population of approximately 50,000</li> <li>• Staff would typically include: <ul style="list-style-type: none"> <li>- Approx 25 FTE GP's</li> <li>- Consultant specialists</li> <li>- Nurses</li> <li>- Dentists, opticians, therapists</li> <li>- Emergency care practitioners</li> <li>- Mental health workers</li> <li>- Midwives, health visitors</li> <li>- Social workers</li> </ul> </li> </ul>

### *The transition to the polyclinic*

**20.** London has some healthcare facilities that come close to our vision of a polyclinic. For instance, the Heart of Hounslow Centre for Health has GP services, outpatient care, physiotherapy, dentistry, podiatry, social care

outreach, mental health services for children and a gym to help in rehabilitation. All these services take place in a purpose-built facility that covers six floors. However, the centre does not provide urgent care and only has a limited range of diagnostics. So we have to look abroad to see a full example of a polyclinic.





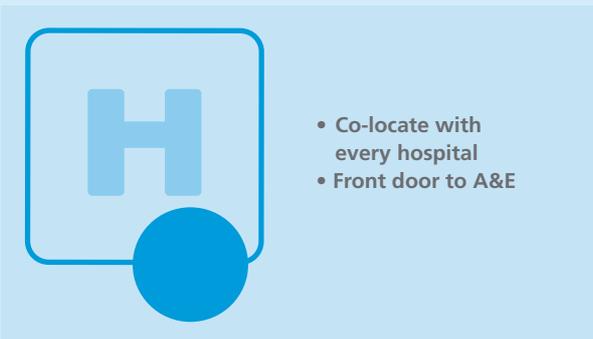
**International case study – Polikum in Berlin**

Polikum, in Berlin, provides over 250,000 outpatient contacts a year. It has 45 doctors, a mixture of GPs and specialists, as well as nurses, physiotherapists and other health professionals. On-site it has access to x-ray, ultrasound, echocardiography and spirometry. Nine further sites are planned by 2009.

**21.** As London does not currently have polyclinics, we recognise it will take time to develop them. Initially, we may see some federated polyclinics emerge where several GP practices refer patients on to use a common community facility. Other polyclinics may develop with multiple GP practices on one site, with all practices having access to the wider range of services. Over time, the co-located GP practices may perceive benefits of economies of scale in merging together to form one large practice.

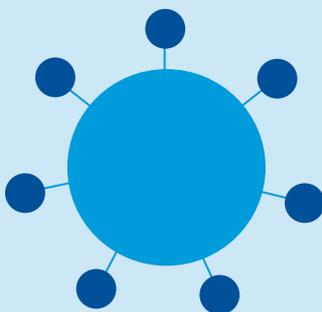
**Transition to polyclinic**

**Two locations for polyclinic**

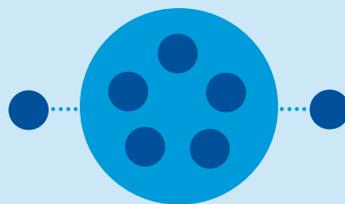


Patients choose where to attend

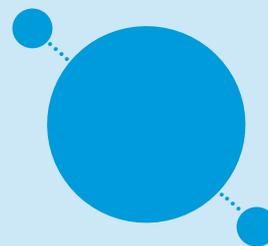
**Polyclinics and GP services – three options for organisation**



- Federated model, providing common services to existing practices.



- Co-located model with multiple practices co-located to share services. Possibly some satellite practices.



- Merger model, multiple practices combine into one large practice. Possibly with satellite services.

GPs choose how to organise

*“Polyclinics would be ideal for speeding up treatments. We’d really like to see this happen, we urgently need a faster healthcare service.”*

**Public Event Participant**

**22.** Over time, we expect polyclinics will become the site of *most* GP care. However, we do not expect that all GP practices will become part of a polyclinic. Some GP practices will remain separate from the polyclinic, but could be networked with it so that their patients will be able to use the extended facilities.

**23.** The transition will not be simple or without challenge from independent contractors. We are aware that GPs in particular may have concerns over the transition, given that the traditional models of ownership, control and succession planning for their practices will need to be modified at least in part if the polyclinics are to be successfully implemented. The new model would however bring significant benefits to GPs, including:

- the ability to offer improved access to primary

care through a range of supporting professionals, whilst retaining control over access

- more control over a wider range of supporting facilities (eg diagnostics), with these facilities on site
- the ability to prevent wasteful multiple access points developing (eg out of hours, A&E)
- the ability to make links more easily with social care, housing, benefits advice and so on
- access to better support systems including administration, business support, HR, IT and planning
- a managed end to cramped, expensive-to-maintain and inappropriate premises, and to concerns over Disability Discrimination Act requirements.

### Long-term conditions – Kishore is 45 and overweight with type II diabetes

#### Current

Kishore was diagnosed with diabetes two years ago. He only went to see his GP then as his wife had been nagging him for three years. He had probably had diabetes for years. He is now under the care of the hospital but frequently misses specialist appointments as he is too busy at work to take time out to go to his hospital appointments. He also does little exercise.

Kishore also fails to keep appointments at the hospital for eye and kidney checks. He cannot walk upstairs due to shortness of breath and gets pains in his legs if he walks too far. He often gets more breathless and ends up being admitted to hospital as an emergency.

Kishore has severe diabetes and has not been able to control his weight and now suffers from impotence.

#### Future

Kishore was diagnosed with diabetes five years ago at a routine health check. He was called up for the check automatically and sent weekly reminders until he booked an appointment for 10am on a Saturday morning. Since then, he has been under the care of a diabetic nurse who makes sure she sees him every month, at a time convenient to him, and checks his diet, exercise and treatment.

Kishore is prescribed vouchers for an exercise class at the polyclinic and gets his kidney and eye checks at the polyclinic. Blood tests show his diabetes is controlled adequately. Kishore attends the healthy living centre of his polyclinic for diet and weight-loss advice.

Kishore successfully loses some weight and has no complications of his diabetes. He now enjoys exercising at the local recreation centre thanks to free vouchers from his polyclinic.





### Long-term conditions – Coral, seven years old, was born with cerebral palsy and suffers from recurrent pneumonia due to problems swallowing

#### Current

Coral is usually cared for by her mother. She needs on-going care. She attends the local community hospital where she sees a community paediatrician and therapists. If she needs medical treatment she has to go to see her GP in the practice.

Coral frequently gets chest infections. Sometimes her GP sees and treats her but often her GP is not available and her mother takes her to A&E. The doctors there don't have access to her medical records so don't know what treatment she is receiving either from her GP or from the community staff.

Coral is often admitted to hospital for antibiotic treatment. When discharged a letter is sent to her GP but it can take a few weeks to get there. This means that when Coral goes to see her GP or the community therapist, they often don't know what treatment she has received in the hospital.

#### Future

Coral is cared for by her mother and the team of community paediatricians at the local polyclinic. She receives ongoing physiotherapy at the polyclinic.

Coral is seen regularly by the community paediatricians. Community nurses based at the polyclinic visit at home as needed. If she needs to see her GP, he is in the same centre and the staff can easily discuss Coral's needs.

If Coral gets sick, her mother takes her to the urgent care centre where she doesn't need an appointment. X-rays can be done on-site. If her infection is caught early, she can be treated with tablets, although if the emergency doctor thinks Coral needs admission to hospital, she can be sent to the major acute hospital where she will be seen by a paediatrician 24/7. Her electronic record is always accessible at the hospital too.

**24.** We are also aware that this proposal may be challenged as de-personalising GP and other primary care provided by nurses, opticians, dentists and so on. Many patients are understandably keen to maintain a relationship with their regular GP or primary care practitioner. However, there is no reason why larger polyclinics should not be able to provide exactly this kind of personalised care.

**25.** For instance, whilst a patient attending the urgent care centre at their local polyclinic at 10pm may not necessarily see their regular GP, there is no reason why they shouldn't be able to book to see their regular GP within a bigger practice just as they do now. After all, care can be organised in large hospitals with hundreds of

consultants so that patients see "their" doctor. Finally, a patient with a long-term condition (LTC) could see the same doctor or nurse for all the LTC appointments recommended in "improved care from cradle to grave".

**26.** People are also likely to be concerned about the travel implications of giving up their local GP practice for a larger (but potentially further away) polyclinic. High-level modelling, based on average population densities at a borough level, indicates that the vast majority of Londoners would be within one to two kilometres of a polyclinic serving a population of 50,000. Public transport links and current and projected patterns of population distribution will be important in choosing polyclinic sites.

### Healthcare in other local settings

**27.** Whilst we anticipate that most local healthcare will be provided in the home and in the polyclinic, care will also be available in other community locations. For instance, some health services for young children will also be provided in children's centres (although we feel the potential to co-locate children's centres and polyclinics should be explored). And whilst polyclinics will have pharmacies on-site, most Londoners will also be using their local high-street pharmacies for medication and self-care support.

**28.** In addition, polyclinics will be providing a lot of outreach care to their local populations. For instance, polyclinics should take charge of health provision for local residential homes. Polyclinics can therefore act as a base for bringing healthcare to

where people need it. They will also, wherever possible, combine that with social care provision.

**29.** Providing a wide range of services and facilities on one site or on linked sites would be a positive benefit to disadvantaged people who have complex needs beyond healthcare. Developing polyclinics alongside other amenities, including leisure facilities and libraries and other public and voluntary services, would increase the benefits of this model to people from disadvantaged groups and help to reduce health inequalities.

### Local hospital

**30.** Local hospitals will provide non-complex inpatient and day case care to Londoners. They will be able to offer care for all but the most severe emergency cases, with a 24/7 urgent care centre acting as a "front door" to the A&E

## Acute care – Andrew has a bad cough, a high fever and feels very unwell

### Current

Andrew calls his GP at 6.30 pm. He is advised to call NHS Direct. He calls, and is advised a nurse will call him back. The nurse calls after half an hour and suggests he speak to a GP. He decides to go to A&E instead.

Andrew waits at A&E to be seen and then has an x-ray which confirms pneumonia.

Andrew is admitted for treatment from A&E for IV antibiotics for two days, then remains in hospital for another day waiting to see the consultant to discharge him.

Andrew recovers and goes home. He has to return to hospital twice – once for an x-ray and once for a follow-up outpatient appointment.

### Future

Andrew's local polyclinic has a 24/7 urgent care centre. He attends there without an appointment, is seen promptly and gets a chest x-ray on-site. The doctor diagnoses pneumonia and thinks Andrew needs admission to the local hospital.

Andrew's electronic medical record is accessible to the doctors at the local hospital so that the x-ray and blood test results are available and don't need to be repeated. He goes straight to a bed on the ward as they have been expecting his arrival.

Andrew has an uncomplicated two-day stay in hospital and is discharged home.

Andrew sees his GP at the polyclinic and a repeat x-ray on-site confirms the pneumonia has resolved and there are no other abnormalities of the lung.



## What a local hospital should provide

### Activities

Hours open per day

	Inpatient bed-based community rehabilitation with full range of community services	12
	A&E Acute non-complex medicine Emergency non-complex surgery	24 24 12
	Urgent care	24
	Outpatient services requiring hospital infrastructure	12
	HDU for non-ventilated patients, facility for intubation and transfer of patients	24
	Regular attendees, e.g. renal dialysis	12
	Paediatric assessment unit	18
	Obstetric unit with a MLU and level 1/2 NICU (in some local hospitals)	24
	Diagnostics including CT	24**

\*Pathology satellite laboratories provide rapid test results needed by A&Es and other local hospital services. Key staff will include consultant haematologists

\*\*Core Services only

### Infrastructure

- Consulting rooms for outpatient services
- Procedure rooms
- Theatres
- HDU (but not ITU)
- Rehabilitation and intermediate care
- Acute admissions unit
- Inpatient beds
- Pathology satellite laboratory\*
- Diagnostic imaging including CT scanning

### Patients and staff

- Open 24/7
- Serve a population of around 200,000-250,000
- Have a similar staff composition to current district general hospitals

department. They should also become expert centres for inpatient rehabilitation.

**31.** This report has already outlined the need to centralise specialist services so they are provided on fewer hospital sites in order that patients receive the safest, highest-quality care. Therefore, local hospitals will not be providing the most complex hospital care.

**32.** Local hospitals will be able to provide most inpatient emergency care:

### Networks of care

**33.** Local hospitals will operate in a network of care with a major acute hospital. Patients needing specialised care will be transferred from the local hospital to the major acute hospital.

We recommend that a clinical working group should work with the London Ambulance Service to design and agree clear, pan-London transfer protocols.

**34.** Local hospitals might also carry out some more complex activity in the day-time, such as emergency surgery, but if emergency surgery is needed at night, the patient will be taken to the major acute hospital.

**35.** A paediatric assessment unit will operate to assess children presenting through the A&E's urgent care centre. Children needing inpatient care will be transferred to a major acute hospital.

**36.** Patients will be repatriated to their local hospital for inpatient rehabilitation following more specialised care being provided at the major acute hospital. We anticipate that local hospitals should become standard setters in rehabilitative care through effective use of their medical, nursing and therapist workforce.

**37.** Our vision of the future local hospital is quite different from the current district general hospital model. But London does already have an example of how we envisage the future local hospital, in the Brent Emergency Care and Diagnostic Centre (BECaD) at the Central Middlesex Hospital. BECaD has 10,000 emergency admissions a year. It has critical care facilities, expert consulting services and a children's centre, as well as social care staff on-site. It is linked into major centres for more complex services such as St Mary's Hospital for cardiac care and Northwick Park Hospital for emergency surgery.

#### *Intensive care in a local hospital*

**38.** We anticipate that most local hospitals will not treat large enough numbers of critically ill patients to require a fully staffed intensive care unit. This will be because the patients most likely to require intensive care –

the most seriously ill needing the most specialist care – will be directly admitted (for an elective procedure) or taken by ambulance (for a non-elective procedure) to major acute or specialist hospitals.

**39.** However, as a minimum, the local hospital will be able to provide level 2 critical care with high dependency beds to support the local hospital's urgent care work. Patients in the local hospital's care who deteriorate and need level 3 critical care will receive it as quickly as possible. They should be stabilised by an acute physician, and transferred by a dedicated critical care transport service, as proposed in the previous chapter.

**40.** Beyond this minimum service, some local hospitals may be able to provide a greater level of intensive care through the use of telemedicine. The American company Visicu has developed a telemedicine approach to intensive care. Such an approach should be piloted in London.

#### **International case study – Visicu in the USA**

Visicu is a company founded by intensive care doctors to improve the quality of intensive care. It is responsible for eight per cent of the intensive care beds in the USA. It has developed a pioneering approach called eICU, which allows an intensive care doctor and intensive care nurses based at a central site to oversee patient care at remote sites that cannot sustain a full intensive care team. The eICU uses monitoring devices and two-way video to ensure patients are receiving the best care. This approach is new, but evidence of its efficacy is already emerging – Visicu's first remote-site reported a decrease in hospital mortality of 27 per cent and a reduction in ICU length of stay of seventeen per cent.<sup>5</sup>





### Elective centre

**41.** Elective centres will focus on particular types of high-throughput surgical procedures such as knee replacements, arthroscopies and cataract operations. This work will be separated out from emergency surgery to achieve better clinical outcomes and productivity. Elective centres will be crucial to achieving the recommendations of the planned care clinical working group, such as increasing day cases and reducing waiting times. Critical care support will be required in the stand-alone elective treatment centres.



length of stay is less than five days, because at its inception PCTs worked with local authorities to develop community support to facilitate discharge from SWLEOC.

**43.** However, as was suggested in “improved care from cradle to grave”, more elective centres

### What an elective centre should provide

Activities	Hours open per day	
 High throughput elective surgery, some centres may sub-specialise	12	<b>Infrastructure</b> <ul style="list-style-type: none"> <li>• Inpatient beds</li> <li>• Consulting rooms</li> <li>• Theatres</li> <li>• Day case unit</li> <li>• Diagnostics including MRI</li> <li>• Paediatric wing</li> </ul>
 Simple day case medical interventions (such as endoscopy)	12	
 Outpatient consultations	12	
 Pre-admission clinic and facility for pre-op workups	12	
 Diagnostics	12	
		<b>Patients and staff</b> <ul style="list-style-type: none"> <li>• Open 24/7, although surgery only during the day</li> <li>• Staff composition and numbers to be determined</li> </ul>

**42.** Elective centres are already being used successfully in London, for example, the South West London Elective Orthopaedic Centre (SWLEOC). SWLEOC is an NHS treatment centre located on the Epsom General Hospital site in Surrey. The centre was officially opened in March 2004 and provides hip, knee and shoulder replacement surgery for a catchment area of 1.5 million people. It performs nearly 3,000 joint replacements a year. Its average

are needed and they need to be used more effectively. Developing more elective centres will build on the national programme of establishing Treatment Centres that began in 2002.<sup>6</sup> As in the example of SWLEOC, close working with local authorities to ensure appropriate community support following discharge will be crucial to their success.

### Planned care – Agnes needs a knee replacement, she is 72 and lives alone in a terraced house

#### Current

Agnes has a pain in her left knee and is finding it difficult to climb her stairs.

She goes to her GP who says she will have to go to hospital to get an x-ray. After waiting several weeks, Agnes visits the hospital for the x-ray, which shows she needs a replacement.

She has to return to hospital several weeks later for an appointment with a surgeon. She is booked in for a knee replacement, for which she will again have to come back to the hospital.

She comes in the day before the operation. The operation goes well, but Agnes has to spend ten days in hospital as there is no support available for her to go home. She receives physiotherapy which helps her get back on her feet, and is very grateful to finally get home.

#### Future

Agnes goes to see her GP at her local polyclinic. She can get her x-ray at the same time and then goes to see a consultant surgeon who books her in for an operation at a specialist elective centre in a few weeks time.

Agnes goes in on the morning of her operation. The replacement is successful and she recuperates for four nights at the elective centre.

Whilst she is in hospital her home is adapted (she is given a mattress that moves to help her get in and out of bed). After her brief hospital stay she is then able to go home, supported by a multidisciplinary social care and health team. Meals are prepared for her until she is able to make her own independently. A nurse monitors her recovery and a physiotherapist helps Agnes exercise her knee.



**Major acute hospital**

**44.** Major acute hospitals will provide more specialised health services to the highest clinical standards. They will treat sufficient volumes of patients to maintain the most specialised clinical skills and to achieve the best outcomes for patients.

**45.** The proposals for centralisation of care where necessary in the previous chapter, such as the development of trauma centres, and the provision of comprehensive 24/7 stroke care, will be realised at some of London’s major acute hospitals.

**What a major acute hospital should provide**

**Activities**

Hours open per day

	Emergency surgery (including complex)	24
	Complex elective surgery	12
	Non-complex elective surgery for patients with comorbidities	12
	Complex medicine (acute and elective)	24
	A&E taking most seriously ill	24
	Inpatient paediatrics including critical care	24
	Obstetric unit with associated MLU and level 2/3 NICU	24
	Some outpatient services	12
	Specialist diagnostics	24
	Some will be or form part of Academic Health Science Centres	

**Infrastructure**

- Interventional radiology suites
- Operating theatres
- Inpatient beds for adults and children (including critical cases)
- Full host of diagnostic facilities including specialist diagnostics
- A cardiac catheterisation lab
- ITU facilities

**Patients and staff**

- Open 24/7
- Serve a 0.5-1m population (200-250K for local hospital service offering) but may offer some specialist services for up to 5m population (e.g. Level 1 trauma, transplants)
- Staff composition will be similar to current major acute hospitals, but will reflect a greater focus on specialist activities

## Acute care – Harminder is cooking dinner for her grandchildren when she suddenly feels weak and cannot talk properly

### Current

Harminder's family call 999. Her paramedics use the FAST protocol and diagnose an acute stroke. She is taken to the local district general hospital.

Doctors suspect a stroke. She is admitted to a bed on the stroke unit.

A CT scan is ordered, but it doesn't take place until the next day.

On the next day, Harminder swallows some food and it goes into her lung.

Harminder develops aspiration pneumonia which needs treatment for another two weeks.

Harminder remains weak and she has severe difficulties with her speech and movement. After six weeks, she is discharged to a nursing home where they provide some physiotherapy and ensure that she takes her medication.



### Future

Harminder's family call 999. Paramedics assess her using the FAST protocol and, suspecting an acute stroke, she is taken to the nearest stroke centre, even though this is 20 minutes further away by ambulance than her local hospital.

Doctors confirm a stroke clinically, and arrange for an immediate CT scan. The scan shows a treatable ischaemic stroke so Harminder is treated with clot-busting drugs (thrombolysis) within an hour of her first symptoms.

Harminder is admitted to a dedicated stroke ward where there are specialist stroke nurses. She receives close pressure care, intense physiotherapy and speech therapy assessment early in her stay.

Harminder's symptoms resolve with minimal residual weakness and intact speech.

Harminder is discharged home to live independently. She receives intense follow-up from the team at the local polyclinic who check her cholesterol, organise an ultrasound to check for carotid narrowing which may have caused the stroke and ensure she is on the right tablets to prevent another stroke. She receives advice on lifestyle at the healthy living centre of the polyclinic and free vouchers for the exercise facilities next door to her polyclinic.

**46.** Major acute hospitals will sit at the centre of networks, providing the most complex care. Relatively few Londoners will need to be cared for in a major acute hospital.

#### *Location of major acute hospitals*

**47.** It is not the remit of this review to determine which of London's 32 acute Trusts are designated

as major acute hospitals. We propose that is done by NHS London and Primary Care Trusts (PCTs) in a clear and transparent process.

**48.** However, we suggest that three key criteria in designating major acute hospitals must be their current clinical outcomes, providing cover for both outer and inner London, and ensuring good transport links.



**49.** We know that clinical outcomes vary across London. The graph below shows how a small group of London hospitals (teaching hospitals in inner London)<sup>7</sup> have mortality rates well below the England average, whilst the other London hospitals have rates around the England average.

**50.** However, when this report talks about centralisation of care it does not mean that all specialist care should be provided in central London. Whilst many of the oldest and most prestigious hospitals, founded when London was much smaller than it is today, are located in central London, London's great post-war expansion means that much of London's population lives in suburban outer London. Clearly, some of the major acute hospitals will need to be located in outer London to provide comprehensive population coverage.

### Specialist hospital

**51.** London already has several specialist

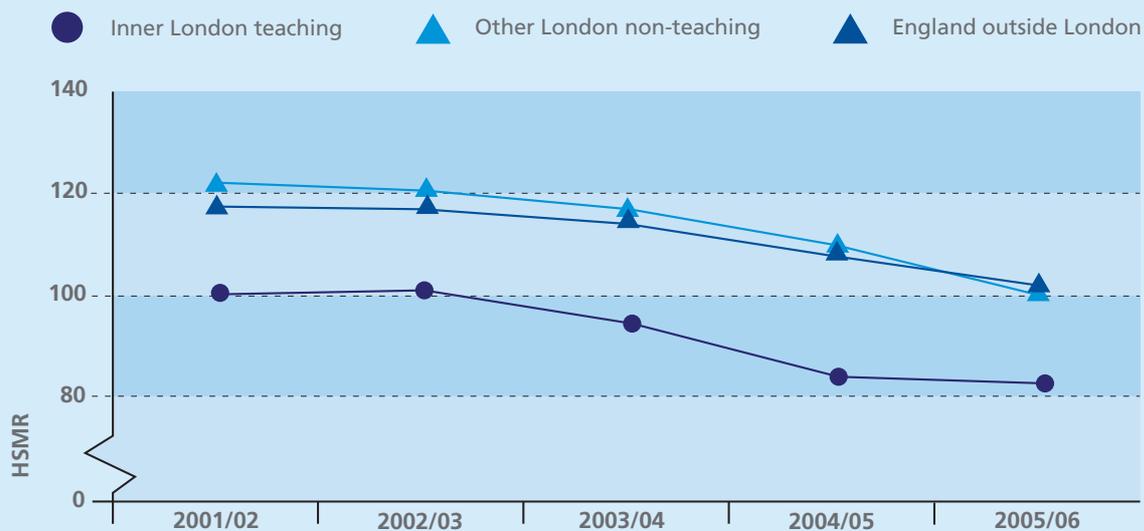
hospitals that excel in their own areas of care. These specialist hospitals are very much part of our future plans.

**52.** There are currently six specialist hospitals in London. We may see the development of more specialist hospitals – this is certainly what has happened in the US, where over the last twenty years the number of specialist hospitals has more than doubled.<sup>8</sup>

**53.** Such specialisation allows hospitals to concentrate on what they are good at. Memorial-Sloan Kettering Cancer Center is the world leader in cancer care because it is not distracted by needing to provide the whole gamut of services, such as an A&E department.<sup>9</sup>

**54.** Focusing specialist services in either specialist hospitals or in other specialist facilities would be of particular benefit to some vulnerable and disadvantaged groups who have higher rates of particular health problems such as sexually

### HMSRs (hospital standardised mortality ratios): London hospitals vs non-London hospitals (HSMR all England year 2005/06=100)



Included in this group are St Mary's, St George's, King's, Guy's and Thomas's, The Royal Free, UCL, Barts and the London, Chelsea and Westminster and Hammersmith Hospitals

Source: Hospital reported HSMR scores

## What a specialist hospital should provide

Activities	Hours open per day	
 Complex surgery	12-24	<b>Infrastructure</b> <ul style="list-style-type: none"> <li>• Specialty inpatient and outpatient services</li> <li>• Inpatient beds</li> <li>• Theatres</li> <li>• Procedure rooms</li> <li>• Consulting rooms</li> <li>• Specialty diagnostics</li> <li>• (For some) single speciality A&amp;E</li> </ul>
 Complex medicine	12-24	
 Related outpatient services	12	
 Specialist diagnostics e.g. CT/PET for cancer	12-24	<b>Patients and staff</b> <ul style="list-style-type: none"> <li>• Six specialist trusts currently exist (Moorfields Eye Hospital, Royal National Orthopaedic Hospital, Great Ormond Street, Royal Brompton, Royal Marsden, South London and the Maudsley), as well as a number of specialist hospitals which are part of major acute trusts</li> </ul>
 Some will be or form part of Academic Health Science Centres		

transmitted infections, HIV/AIDS, TB, substance and alcohol misuse, and mental health.

### Academic Health Science Centre

**55.** The need for London to remain at the cutting-edge of medicine was highlighted in “the case for change”. The concept of Academic Health Science Centres (AHSCs) was also introduced as a means of achieving this, by bringing together world-class research, teaching and patient care.

**56.** AHSCs are corporate entities with integrated governance and leadership structures that have assumed the role of strategically and operationally managing both healthcare and relevant academic resources. Their purpose is to exploit the potential for exemplary care and innovation through the

integration of the clinical, research and education functions. AHSCs are able to attract the best talent internationally by providing a high-quality clinical environment where research can be carried out.

**57.** There are many forms AHSCs can take. The Kantospital in Basle and the University of Basle have a jointly appointed research director who has budgetary and recruitment authority for research in both institutions. Leiden University Medical Centre is a single organisational entity with one board for the hospital and medical faculty.<sup>10</sup> AHSCs can cover a range of medical specialties or focus on a particular area of expertise.

**58.** However, “AHSC” is not a label that should be applied indiscriminately. We propose six criteria for determining if a university/hospital partnership is really an AHSC.



**59.** These criteria should be developed further (by NHS London, and potentially by the Department of Health, nationally) to assess if a university/hospital partnership is really an AHSC with a real intent to pursue an internationally-recognised and integrated clinical, teaching and research mission.

**60.** This would ensure that the AHSC label did not become a term like “university hospital” and “teaching hospital,” which are both used loosely and liberally.

**61.** The criteria suggest that London does not yet have any AHSCs. However, the capital does have three comprehensive and four specialist Biomedical Research Centres (BRCs).<sup>11</sup> The BRCs were selected following a rigorous review by international experts. They are centres of research excellence

- **Integrated Governance** – this could range from delegated authority through to full mergers.
- **Internationally-recognised excellence in research and clinical practice** (with the concurrent ability to be a leader within the UK).
- **Clear integrated funding streams for research and teaching.**
- **Integrated leadership and career paths.**
- **Joint programmes which combine research and clinical work.**
- **Commercial expertise** to market research developments and benefit the UK’s economy.

and BRC status conveys five years of guaranteed support for their research infrastructure.<sup>12</sup>

**62.** BRCs could develop into AHSCs. Indeed, Imperial College London, with St Mary’s and Hammersmith Hospital, is already proposing that it will become London’s first AHSC.

**63.** In managing the development of AHSCs, NHS London will have to seek to ensure that

research and clinical excellence is not diluted. They will also need to work closely with the Department of Health, as AHSCs will have both national and international importance.

**64.** How will the development of AHSCs benefit patients? The experience of the US shows that AHSCs provide excellent patient care. Thirteen out of the top fifteen hospitals for digestive disorders and rheumatology are AHSCs which focus on a range of clinical areas. Five of the top fifteen hospitals for cancer care are specialist cancer AHSCs.<sup>13</sup>

#### *Research across London*

**65.** The development of AHSCs does not, and must not, mean that all research is concentrated in major acute and specialist hospitals. We expect that both polyclinics and local hospitals will be linked with AHSCs or even be part of them:

- polyclinics’ much larger size than existing GP practices will make it easier to conduct large-scale population-based research and test new clinical approaches. We propose that some polyclinics should be designated as having a research element and that these would be linked with academic institutions.
- many local hospitals will be networked with AHSCs so that they can benefit from the latest research developments and AHSCs can co-ordinate research and trials within local hospitals.

**66.** Work should also continue to build the Global Medical Excellence Cluster (GMEC) in the South East of England. This is an initiative involving collaboration between leading biomedical universities (including Imperial College, University College and King’s College in London as well as Oxford and Cambridge universities), industry, and leading London hospitals. It is designed to make the most of the medical research being done in all of these organisations and enable them to work more effectively together.

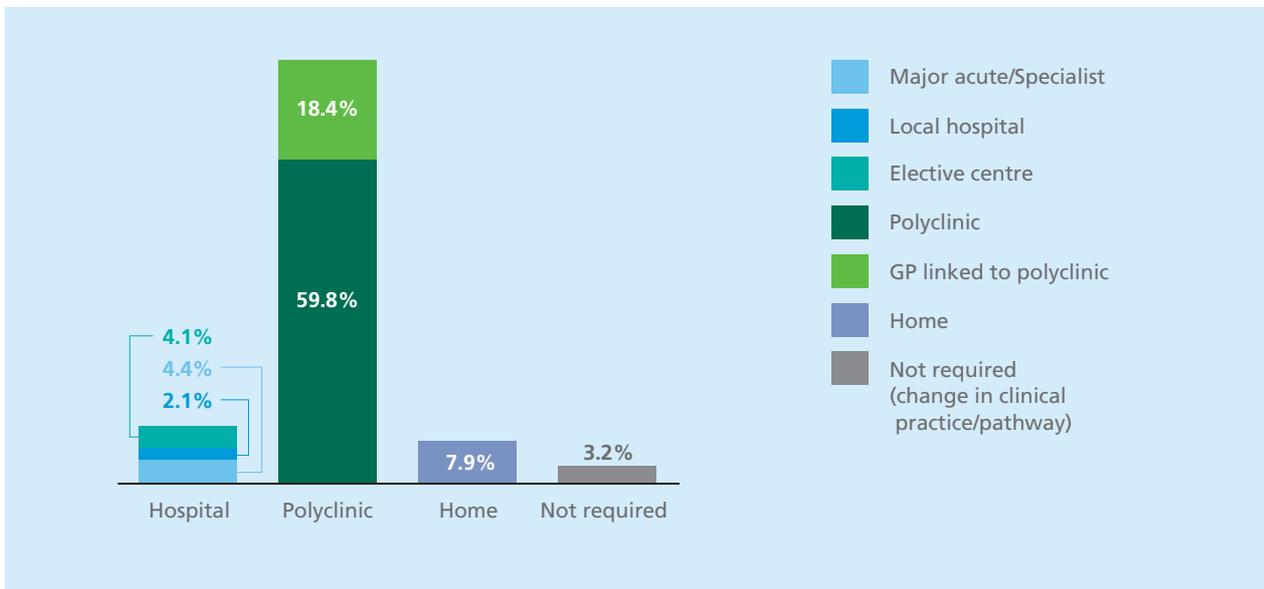
## Future models of healthcare provision

	Home	Polyclinic	Local hospital	Elective centre	Major acute hospital	Specialist hospital
Activities						
A&E/Acute non-complex medicine			●			
A&E taking most seriously ill					●	
Community services		●				
Complex surgery					●	●
Complex medicine (acute & elective)					●	●
Diagnostics		●	●	●	●	●
Emergency non-complex surgery			●			
Emergency surgery					●	
End-of-life care	●					
General practice services		●				
HDU for non-ventilated patients, facility for intubation and transfer of patients			●			
High throughput elective surgery, some centres may sub-specialise				●		
Home-based rehabilitation	●					
Inpatient bed-based community rehabilitation			●			
Inpatient paediatrics including critical care					●	
Interactive health information services including healthy living classes		●				
Minor procedures		●				
Non-complex elective surgery for patients with comorbidities					●	
Obstetric unit with associated MLU and level 1/2 NICU (in some hospitals)			●			
Obstetric unit with associated MLU and level 2/3 NICU					●	
Ongoing care for long-term conditions and support for self care	●					
Other health professionals, e.g. optician, dentist		●				
Outpatient services (consultations)				●		
Outpatient services (most appointments including antenatal/postnatal care)		●				
Outpatient services (related)						●
Outpatient services (requiring hospital infrastructure)			●			
Outpatient services (some)					●	
Paediatric assessment unit			●			
Part of Academic Health Science Centres (some)					●	●
Pharmacy		●				
Pre-admission clinic and facility for pre-op workups				●		
Proactive management of long-term conditions		●				
Regular attendees, e.g. renal dialysis			●			
Simple day case medical interventions (such as endoscopy)				●		
Specialist care e.g. chemotherapy	●					
Step-up care to prevent admissions	●					
Step-down care to support discharge from hospital	●					
Support for home birth	●					
Urgent care		●	●			





### Patient activity by setting under new model of delivery – 2016/17 baseline scenario



Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians

### Summary

**67.** The table on page 106 summarises the proposals for future models of healthcare set out above.

### The feasibility of these models

**68.** We have considered future models of healthcare provision right from people's own homes through to internationally-renowned AHSCs. But will these models of care meet Londoners' needs? We wanted to test this out and so we have done a detailed piece of feasibility modelling. This is available electronically but we have summarised the main findings here.

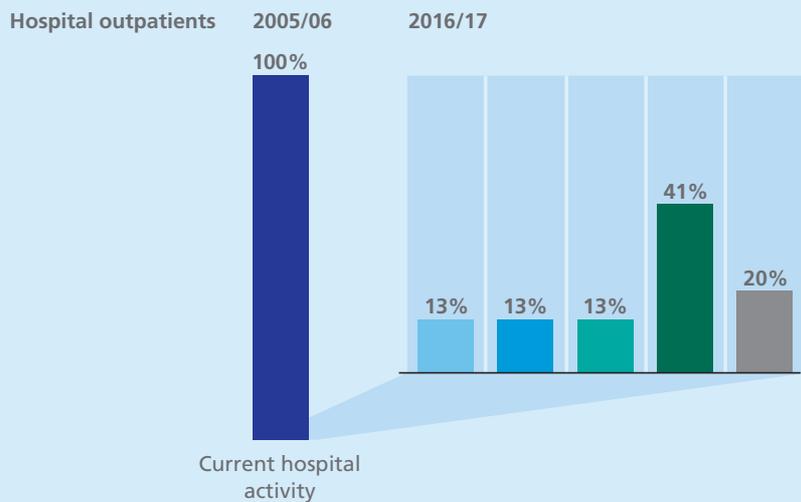
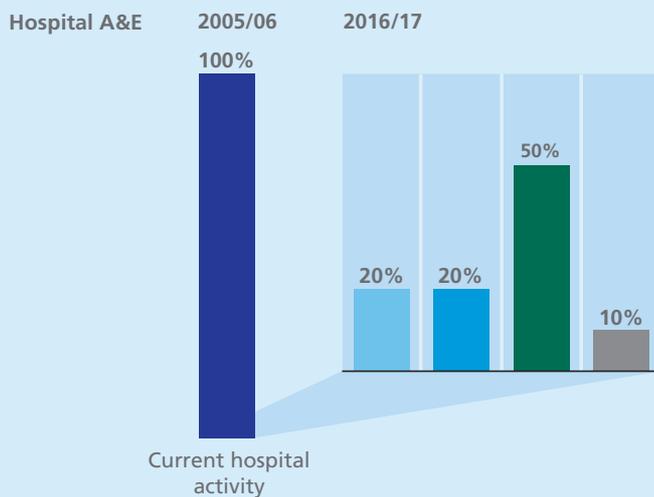
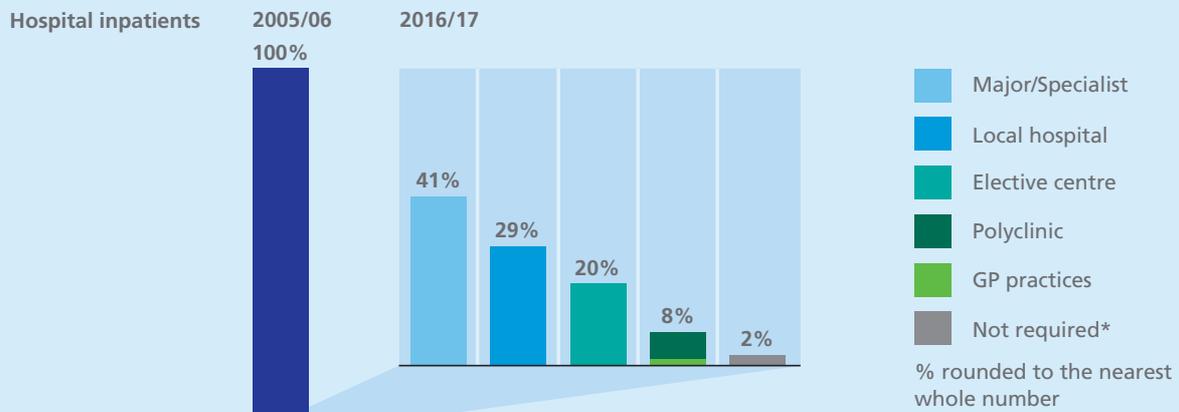
**69.** As explained in "future demands on healthcare" we have looked at how we expect future demand for healthcare services to change over time. This data has been used to generate predictions of expected activity in 2016/17 under three different growth scenarios – low growth, baseline growth, and high growth.

**70.** We have also forecast how we expect the new models of care to alter how services are provided. For each "service line" (such as complex elective medicine) we have looked at the top twenty Healthcare Resource Groups by volume (eg angioplasty – percutaneous coronary interventions – is the second most common complex medical procedure) and then looked to where we expect these to be provided in the future – polyclinic, local hospital, major acute hospital, etc.

**71.** Next, we applied the three forecasts of activity in 2016/17 to our expectations of where care will be provided in the future. This shows that if the *Framework for Action* is implemented the bulk of healthcare activity will take place in polyclinics. The graph above shows activity by setting for the baseline scenario.

**72.** The primary reason that most activity will be taking place in polyclinics is that the majority of GP and practice nurse consultations – which make up the bulk of overall NHS activity – will

Shifts in settings of hospital activity - comparison of 2005/06 with 2016/17 baseline scenario



\* Activity not required is the result of changes in care pathways or clinical practice consistent with best practice

Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians





take place there. But there will also be a significant shift of activity out of the hospital setting – in particular outpatient appointments and urgent care attendances which currently take place in hospital A&Es (see graphs on page 108).

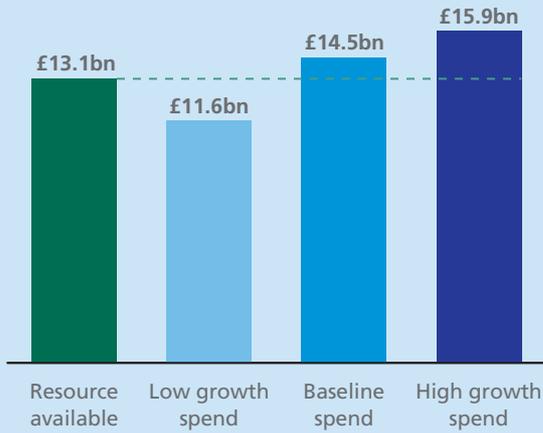
**73.** To determine the cost of all this activity we have used current Payment by Results tariff prices as the basis for spending on acute hospital activity and then made bottom-up calculations for the cost of primary and community care. This has been done for both the status quo provision of healthcare and for our proposed future models of care.

**74.** Is all this activity affordable? In “future models of healthcare provision” we explained our rationale for projecting that London’s PCT allocations will rise to £13.1 billion by 2016/17,

Cost of delivery models against projected commissioning resources available in 2016/17

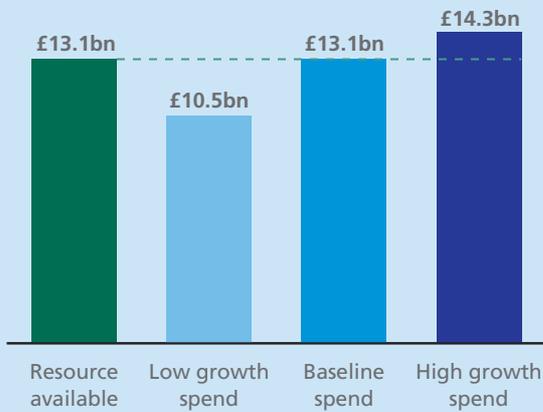
Delivery models

No change in delivery model



No step change in quality, safety and access in any of the scenarios. Two of the scenarios unaffordable.

Proposed delivery model



Step change in quality, safety and access in all scenarios. Low growth and baseline growth scenarios affordable. Over-run on resources available in high growth scenario.

Source: Outcomes of PCT allocation projections and activity and spend forecasts

Patient activity scenarios

Patient activity: spells/attendances (millions)

% Percentage increase against 2005/06 actual



2005/06 Actual



**2016/17 Low growth scenario**  
Growth in line with demographics and impact of changing prevalence rates for selected long-term conditions



**2016/17 Baseline scenario**  
Historical growth rates over and above demographics and changing prevalence rates except for A&E



**2016/17 High growth scenario**  
Growth rates higher than demographics, changing prevalence rates and historical due to improved access and pace of technological development

Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians





an average annual growth of 2.4 per cent over monetary inflation. Under the most likely scenario (baseline growth) the status quo would be unaffordable at £14.5 billion. However, under the models we are proposing, the activity expected in the future would just be affordable.

**75.** Why does the alternative model we propose save £1.4 billion? Partly it is because of the polyclinic being able to provide services more cheaply than hospitals can. Our bottom-up costing reveals that they can, for instance, provide A&E services more cheaply than under the existing tariff. It is also because we are expecting that some activity will no longer need to be done, for example, reducing unnecessary follow-up outpatient appointments.

### Conclusion

**76.** Our feasibility modelling suggests that our proposed new model of care is necessary not just to improve services for people, but in order for future activity to be affordable.

- 1 BMA Health Policy and Economic Research Unit, *Survey of GP practice premises*, May 2006
- 2 See "the case for change", reason five for more detail.
- 3 Various names were tested at the 22 May public event. We are not wedded to this one and a better alternative may emerge.
- 4 *Healthcare for London – A Framework for Action: Findings from two deliberative public events*, Opinion Leader Research, March 21st 2007
- 5 Breslow MJ, Rosenfeld BA, Doerfler M, Burke G, Yates G, Stone DJ, Tomaszewicz P, Hochman R, Plocher DW, Effect of a multiple-site intensive care unit telemedicine program on clinical and economic outcomes: an alternative paradigm for intensivist staffing, *Crit Care Med.* 2004 Jan; 32(1): 31-8
- 6 *Treatment Centres – Building Faster, Quality Care and Choice for NHS Patients*, Department of Health, January 2005
- 7 Included in this group are St Mary's, St George's, King's, Guy's and Thomas', The Royal Free, UCL, Barts and the London, Chelsea and Westminster and Hammersmith Hospitals
- 8 MedPac report to Congress; GAO; CMS; McKinsey analysis (From CDHP document authored by Linda Roach).
- 9 See video of Professor Sir Ara Darzi's visit to Memorial-Sloan Kettering, [http://www.london.nhs.uk/londonnhs-news.aspx?id\\_Content=7311](http://www.london.nhs.uk/londonnhs-news.aspx?id_Content=7311)
- 10 Ellis P, *Criteria for designation of Academic Health Science Centres in the UK*, May 2007
- 11 The three comprehensive BRCs are Imperial College London with St Mary's and Hammersmith Hospital, University College London with University College London Hospital and King's College London with Guy's & St Thomas' NHS Foundation Trust. The four specialist BRCs are University College London Institute for Child Health and Great Ormond Street Hospital for Children, University College London Institute of Ophthalmology and Moorfields Eye Hospital, Institute of Cancer Research and the Royal Marsden, Institute of Psychiatry and the South London and the Maudsley Mental Health Trust.
- 12 Announcement of Biomedical Research Centres, [http://www.nihr.ac.uk/programmes\\_biomedical\\_research\\_centres.aspx](http://www.nihr.ac.uk/programmes_biomedical_research_centres.aspx)
- 13 Both of these figures taken from the US News and World Report's Best US Hospitals 2005 Ranking.



## Turning the vision into reality: improving healthcare for London

**1.** A huge amount of energy and enthusiasm has gone into this report. People across London who really care about improving the NHS in the capital have contributed their time and knowledge to this review. The challenge will be to carry that energy and enthusiasm forward into implementation.

**2.** From here on in, taking things forward will be the collective responsibility of the NHS in London. NHS London, the strategic health authority for London, will need to co-ordinate the endeavour of turning this vision into the reality of better healthcare for Londoners.

**3.** In the coming months NHS London will be discussing and further developing the proposals in this report with key stakeholders. These discussions will facilitate refinements to the proposals and the development of detailed plans for how to turn them into reality.

**4.** However, this is not a task for NHS London alone. Everybody who works in the NHS, from hospital porter to chief executive, from GP receptionist to senior consultant, has a part to play in making change happen, enabling healthcare in London to be as good as it can possibly be.

**5.** It is unfortunately the case that previous strategic frameworks have been, at best, only partly implemented. Both opposition to change and a lack of understanding of how to bring change about have stopped the momentum. However, this time things will be different.

**6.** In the past, too many people working in the NHS have believed that NHS organisations will be changed by powers above them, and that change and improvement can somehow be left

to others. Yet in an organisation the size and complexity of the NHS in London, a top-down approach cannot succeed. The people who work in the NHS must actively be involved in developing these improvements themselves. Change must come from within.

**7.** In making change and improvement happen, the main drivers are:

- commissioning
- partnerships to improve health
- public support
- clinical leadership
- training and the workforce
- patient choice and information
- funding flows
- better use of our estates.



### Key proposals

- Commissioning needs to improve through strengthening Primary Care Trust (PCT) commissioning skills, development of London wide guidelines and standards and the effective involvement of clinicians and partners.
- The NHS must foster partnerships to improve health with local authorities, the voluntary and private sectors, and the higher education sector.
- There should be up-front investment to put new services in place quickly and get public support.
- NHS London should identify clinical champions to make the case for change.
- Training and education should be improved, with a particular focus on the London Ambulance Service, developing centres of excellence in non-medical education, ensuring staff have the skills to tackle inequalities and developing new roles.
- Information for choice should be developed in priority areas, such as maternity and GP services.
- Financial flows should be used to incentivise best practice.
- NHS London should develop a comprehensive estates strategy. Key aspects of the strategy will be how to make the best use of existing estates and how to develop sustainable new facilities.

### Commissioning

**8.** The NHS is now organised with a clearer distinction between those who commission healthcare for NHS patients and those who provide it. This provides commissioners with a very considerable amount of power to change and improve the NHS services that Londoners

receive, and potentially puts them in the driving seat of change.

**9.** The importance of good commissioning has been well rehearsed and does not need to be repeated here.<sup>1</sup> Nearly all of the expenditure on NHS care for Londoners is commissioned by the 31 PCTs. The success of this *Framework* depends upon their strength and capacity.

**10.** The significance of good commissioning in implementing this *Framework* is underlined by the way in which all seven of the working groups mentioned its importance, and emphasised how its improvement would have an impact on healthcare for Londoners.

**11.** What good commissioning looks like is also clear. In the Department of Health's *Commissioning Framework for Health and Wellbeing* it is described as:

*"The means to secure the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users which:*

- *deliver the best possible health and wellbeing outcomes, including promoting equality*
- *provide the best possible health and social care provision*
- *achieve this within the best use of available resources."*<sup>2</sup>

**12.** This *Framework* outlines both what "the best possible health and wellbeing outcomes" might be for London and what the "best possible health and social care provision" could look like.

**13.** It is the commissioner's task to buy services with these high standards of quality and access. By doing this, commissioning can be a powerful lever for change. For example, the *Our health, our care, our say* White Paper saw this potential





and called for PCTs to commission GP services with extended opening hours and weekend opening.<sup>3</sup> However, improvements in opening times are only happening slowly. In London, this is partly because good commissioning is not as widely spread as is necessary.

**14.** National policy is seeking to improve commissioning by increasing clinical input. Giving community clinicians more responsibility for local health spending, through practice-based commissioning, does have the potential to increase the quality and range of services offered in the community, such as clinics in GP practices. Its impact could be increased by the conglomeration of GP practices in polyclinics. However, at the moment, whilst most GP practices are involved in some form, practice-based commissioning is still in its infancy.

**15.** Therefore, the importance of PCTs as commissioners remains, both in supporting

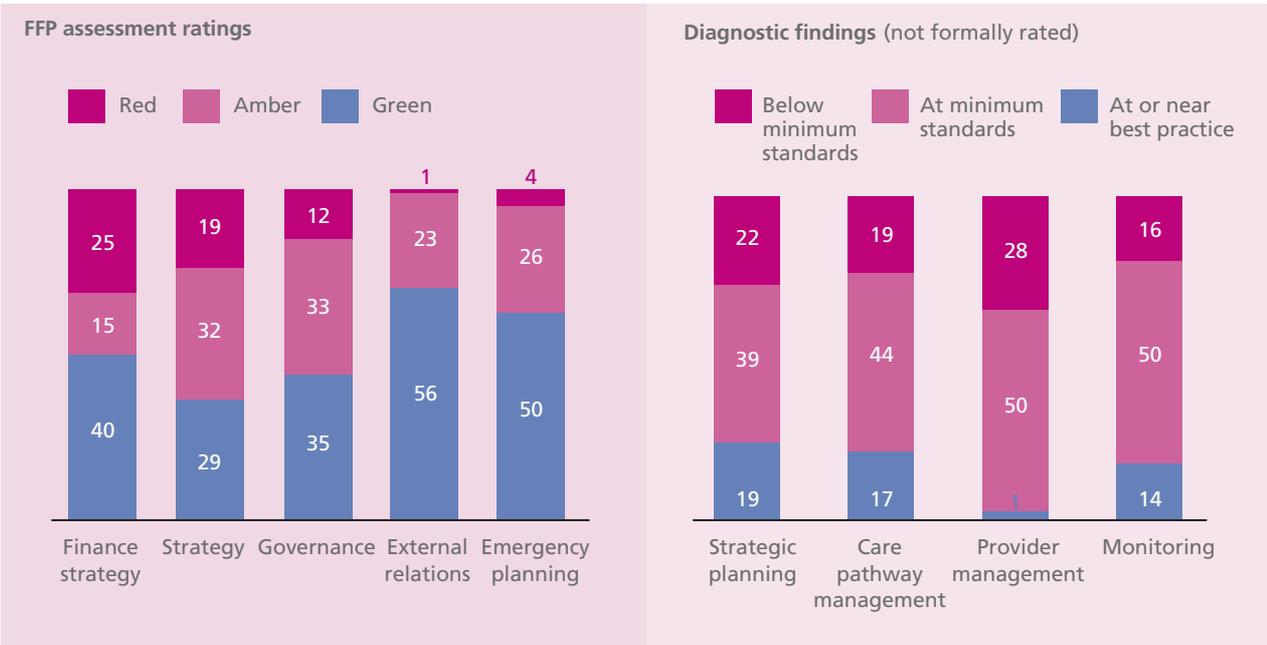
practice-based commissioners and in commissioning services outside the scope of practice-based commissioning. However, the Fitness for Purpose review of PCTs found several weaknesses in PCTs' commissioning abilities, especially their management of providers through methods such as contract appraisal and performance reviews.

**16.** If we are to achieve the improved health outcomes in this *Framework*, then NHS London needs to satisfy itself that an adequate commissioning regime is in place, in terms of both skills and structure, to deliver its proposals. What this means is set out below.

*A clear commissioning approach*

**17.** The NHS in London needs London-wide clarity about which services should be commissioned at each level (from pan-London commissioning to practice-based commissioning). Some healthcare is better purchased in a contract for several

**The Fitness for Purpose Programme shows PCTs lack core commissioning skills and capabilities, especially for provider management (100% = 80 PCTs)**



Source: The Fitness for Purpose Programme

million people, some in a contract for several thousand. As a general rule, the more highly-specialised the service, and the lower the numbers of people being treated, the higher the level at which it should be commissioned. So for example in mental health, eating disorders services should be commissioned at a supra-PCT level, but talking therapies should be commissioned locally.

**18.** To help inform the development of a clear commissioning approach we have made some specific recommendations on commissioning in this *Framework*, such as the commissioning of adult end-of-life services at a sector level and of children's end-of-life services at a pan-London level.

**19.** In areas such as high-volume planned care, practice-based commissioning has considerable potential to drive the changes envisaged in this *Framework* and PCTs should be supporting their practice-based commissioners to achieve this.

#### *London-wide guidelines and standards*

**20.** Commissioners could be greatly aided by some London-wide guidelines specifying what to commission. We have made two recommendations in areas where the greatest clarity is needed – health improvement and long-term conditions. For health improvement we have recommended the development of a list of proven interventions that should be commissioned. For long-term conditions we have proposed the development of specifications for London-wide care pathways, which would indicate the key services needed for optimum care in specific conditions.

**21.** For this *Framework* to be implemented it will also need the commissioners in London to agree on the standards to which each of the main sets of services (eg stroke care) should be commissioned. If commissioners can do this, they will be able to insist that they are commissioning to agreed standards of access and quality, and those providers who do not already meet those standards will have to

improve and meet them if they wish to keep providing the service. This will be one of the clearest enablers for this new *Framework*.

#### *Partnership working with other local commissioners*

**22.** The importance of integrating NHS commissioning arrangements with those of local authorities cannot be underestimated. If we want truly holistic public services meeting individuals' needs, then health, social care, education, leisure and transport cannot be commissioned in isolation from each other. The Department of Health's *Commissioning Framework for Health and Wellbeing* sets out some practical steps on how commissioners can work together to deliver better health and wellbeing outcomes for local populations and we urge commissioners to put this into practice across London.<sup>4</sup>

**23.** In encouraging co-operation between commissioners the focus has been at a PCT/London borough level. However, this co-operation should also happen at a pan-London level with NHS London, the Greater London Authority and the cross-city organisation of London councils.

#### *Developing the commissioning role*

**24.** The NHS in London needs to improve its commissioning skills, including through learning from local authorities (who have been successfully commissioning for cost and volume for many years) and instigating an NHS London training programme for commissioning. This programme should be not just for the NHS but should bring in other commissioners (such as commissioners of children's services) to foster relationships and share learning.

#### **Partnerships to improve health**

**25.** Health and healthcare are not the responsibility of the NHS alone. This *Framework* started by





recognising the importance of other organisations and institutions to improving Londoner's health and healthcare, and therefore working in partnership is a key driver for change and improvement.

**26.** The importance of joint working between the NHS and other public services was evident in all the clinical areas considered in this *Framework*. This applies not only to the obvious need for joint working with services, such as social care and education, but also to joint working to develop policies to improve mental and physical health and wellbeing. So the NHS must work with local government – the London boroughs, the Greater London Authority and the Mayor's Office.

**27.** Whilst some of the changes in this *Framework* will require structural change, some can be achieved more quickly through Local Area Agreements. For example, the creation of improved pathways that integrate the range of services that particular vulnerable groups need (eg benefits advice, housing, social care and health care for older people) could be achieved through joint commissioning with local authorities.

**28.** The NHS should also embrace working with the voluntary sector. The voluntary sector has a vast wealth of expertise through advocacy and championing of patients' needs. Yet the prevailing feeling at the voluntary sector event was that at present this expertise is not being drawn upon by the NHS.<sup>5</sup> The NHS needs to address this by fully involving the voluntary sector in taking this *Framework* forward.

**29.** At a local level, the voluntary sector can help in the planning of services and could also be a deliverer of more care. For instance, the role of end-of-life service providers (ELSPs) could be performed by voluntary sector organisations.

**30.** The private sector will also be a partner in making this *Framework* happen. They will be able to provide services important to several of the clinical areas, from exercise classes to mental health

inpatient facilities. They also have the experience of developing procurement relationships which provide best value for money.

**31.** The NHS has some very important partnerships with the higher education institutions of London. NHS London provides an important part of their research and teaching income and receives some vitally important services in return. We need to improve this partnership and seek ways in which it can be better used to implement this *Framework*.

**32.** The NHS in London needs to develop its ability to work in partnership - to be able to influence and respond to the pulse of the capital in order to drive change and improvement.

### Public support

**33.** For change to succeed, both the public and politicians need to be convinced that it will improve healthcare. Politicians, from MPs through to local council members, can be vocal opponents of changes to their local healthcare services. One way of tackling this is to clearly make the clinical case for change and highlight the costs, in terms of mortality and morbidity, of not making those changes.

**34.** However, the recent IPPR report into the politics of hospital change, found that MPs might oppose change for which they could see the clinical rationale, if they believed that such change would be unpopular with their constituents.<sup>6</sup> So clearly, persuading politicians alone is not enough.

**35.** Therefore, Londoners need to be convinced of why the proposals set out in this report are right. That is a challenge as many people remain very attached to the services that are provided at the moment. People can end up supporting the status quo because that's what they know best, and therefore defend the services provided by their local district general hospital, especially A&E and

*"The RNIB working with the DH to develop eye-care pathways shows you what can be achieved. This sort of thing we need more of."*

**Voluntary Sector Event Participant**

maternity services, without knowing that there are better ways of providing these services.

**36.** People's first reaction when thinking of where NHS money should be spent is their local hospital. Thus the Ipsos MORI survey found that when asked a one-off question as to where the NHS should invest its money, 58 per cent of Londoners would choose existing hospitals as opposed to investing in more local services and fewer, larger hospitals.<sup>7</sup>

**37.** Yet when the need for change is communicated clearly and when the evidence is presented, people can see the rationale for change. At the concluding event of the *Your health, your care, your say* consultation, 54 per cent of the thousand participants said they supported moving services closer to home even if this meant fewer services in hospital, compared with 29 per cent who opposed this proposal.<sup>8</sup>

**38.** There also needs to be up-front investment and some double-running to put new services in place first and get public support for change. Whilst this may be expensive in the short-term, if it can speed up the reorganisation process, it will help the NHS to move more quickly to high-quality, sustainable services. We recommend that the Strategic Health Authority (SHA) establishes a double-running or pump-priming fund, to help to establish new services that will gain support for change from the local population.

**39.** Another important means of gaining public support for change is to involve public and patient representative bodies in developing new and improved services at an early stage. Ensuring that the public and patients have a voice and a say over proposals will help local communities to feel they "own" suggested improvements.

### Clinical leadership

**40.** The whole approach of this review has been to develop clinical support for our proposals. I have led this process as a doctor myself. The focus has been on improving quality, access and

safety – the things that matter to clinicians as professionals – through evidence-based improvements. Through the clinical working groups, clinical experts and innovators have helped in the formulation of the recommendations. The proposals have also been tested with clinical leaders across London.

**41.** So we have the support of a range of London clinicians. Yet that alone is not enough. It is easier to support principles for London, harder to support change in the hospital or locale where you work. Many clinicians understandably fear change – fear how it will affect their job satisfaction, their autonomy and their clinical reputation.

**42.** Those fears need to be confronted and assuaged. To do this, as these proposals are implemented at a local level, clinical champions will need to be identified who can make the case to their peers and the public that change is necessary to improve the quality of services.

**43.** Committed staff will also be key to winning public support.<sup>9</sup> With 206,000 NHS staff in London, many Londoners have friends and relations in the NHS who will influence their views on changes to healthcare. Members of the public trust medical staff far more than they do NHS managers or politicians and their views carry great weight in determining the public's reaction to proposed changes in healthcare provision. For instance, survey results show over 90 per cent of the public trust doctors, whilst less than 25 per cent trust politicians.<sup>10</sup>

**44.** This means that medical champions will be crucial to driving change. The case for this *Framework* is a clinical one, and clinicians and other medical staff will need to continue to be involved in its implementation.

### Training and the workforce

**45.** Clinical leadership is important, but so is the development of the healthcare workforce in



London more broadly. Many of our recommendations are dependent on new ways of working and new roles in the workforce.

### Training requirements

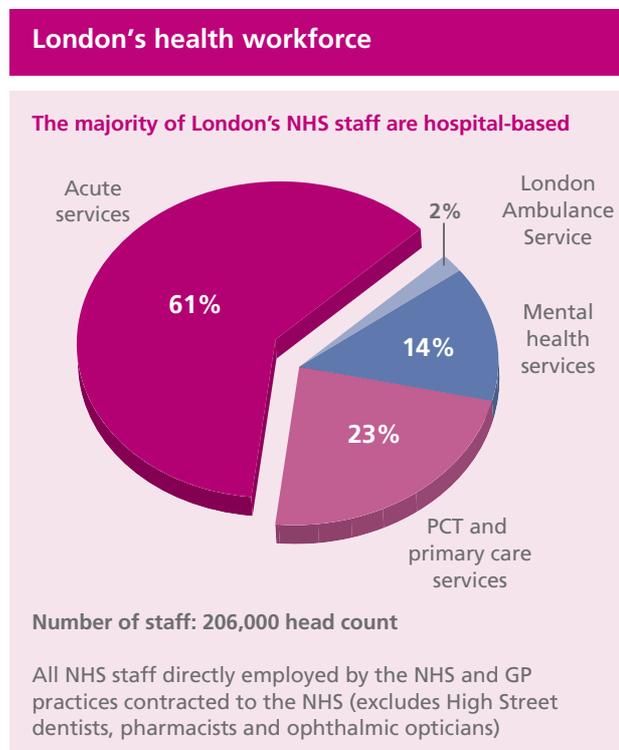
**46.** The NHS in London spends £1 billion annually training and developing its staff so they can provide the best quality care. Since we are recommending changes and improvements in healthcare, it is inevitable that this will require staff with different skills and capacities. This means that training will need to reflect how we want healthcare to be provided in the future. Yet too often the commissioning of education has not matched the commissioning of services. They need to be more closely aligned.

**47.** There are four specific training recommendations flowing from our wider proposals. First, data from NHS London shows that of all London's healthcare providers, the London Ambulance Service (LAS) receives the least funding for education. Given their growing role in diagnosing serious illness and injury and in providing more skilled staff who can treat patients without needing to convey them to hospital, we recommend that the LAS is given the significant investment it needs to improve the skills of its staff and develop robust clinical protocols to support its work.

**48.** Second, the Tomlinson Report established five medical schools in the capital, but did not consider the training of non-medical professions.<sup>11</sup> There are currently thirteen major providers of education and training for healthcare professionals in London. We propose that NHS London explores the option of developing centres of excellence to spearhead world-class education and training across the non-medical professions. Concentration of more advanced training and education in fewer places will allow for focus on leadership and a fostering of international excellence. Other providers should then concentrate on pre-registration

training and education to ensure a focus on teaching new staff to the highest standards.

**49.** Third, both clinicians and support staff need to ensure they remain up to date in their understanding of inequalities and specific needs of vulnerable groups. Because of the very complex picture of diversity and vulnerable and disadvantaged groups, a high level of cultural awareness and an understanding of inequalities are particularly important for staff working in London. To achieve this, continued attention



Source: Department of Health workforce census 2006

needs to be given to the commissioning of undergraduate nurse, allied health professionals and medical student education contracts, as well as other NHS staff induction and training.

**50.** Fourth, there is the potential for the development of many exciting new roles, such as GPs with a special interest in emergency medicine or paediatrics, end-of-life care co-

ordinators, and more specialised roles within a clinical mental health team. We will also need more of existing staff types, such as specialist long-term condition nurses and emergency care practitioners.

### *More staff in the community*

**51.** Our proposals will require the movement of staff out of major hospitals and into the community. The diagram on page 119 shows that the majority of NHS staff are currently hospital-based, which will need to change to support the proposals set out in this *Framework*. New ways of working will need to be described and communicated to staff.

**52.** Staff will need to be supported to make the shift, encouraging consultants to do more work in the community, to support the development of local services for patients. Training proposals by some professional bodies like the British Association of Urological Surgeons for training office urologists should also be replicated in more specialties such as orthopaedics and general surgery. We also recommend that London deaneries should adopt a training pathway for emergency non-trauma surgeons and emergency physicians whose role would be to support emergency activities within a local hospital setting. Such models exist in the US. Modernising Medical Careers (MMC) should be used to promote the development of community clinicians and increase the number of people training to become community consultants in both elective and emergency care. In addition, staff grades and associated specialists currently working in hospitals are already providing the services that we are saying will need to be provided by consultants in the community, and could find a shift to this new role an attractive career option.

**53.** Related to this is the potential for new models of employment. For instance, midwifery groups could be employed by a hospital, could

be social enterprise organisations or could be self-employed groups. Consultants may be employed by one organisation but contract on a sessional basis to provide care elsewhere. We must be clear that just because staff are contracted to one provider this does not mean that all their work is done for that one provider, on one site.

### *Tackling deprivation and promoting diversity as an employer*

**54.** The NHS is obviously a major employer in London. It therefore has an opportunity to use its recruitment policies to tackle inequalities. Applicants from local areas of deprivation and from communities with high levels of unemployment should be encouraged. The NHS needs to be a leader in enabling unemployed people – including those with physical or mental health problems or disabilities, or people from excluded groups, like refugees – to access work.

**55.** The NHS as an employer needs to reflect the cultural diversity of London. Throughout the delivery mechanisms of the health service there are people, like me, who were born abroad or come from families that were born abroad. However, the leadership of the NHS does not reflect that diversity and we should commit ourselves to action that ensures that this changes.

### *Workforce incentives*

**56.** There are relatively few performance incentives within the NHS. The clearest quality incentive is the innovative Quality and Outcomes Framework (QOF) for general practices, which rewards practices for achieving certain quality markers. However, arguably it is too easy to achieve high scores under the existing QOF – for instance all GP practices in London receive at least 92 per cent of the points available for asthma care – and this is partly because there is too much focus on clinical process rather than clinical quality.<sup>12</sup> In addition, QOF only applies to identified patients and the numbers of people with long-term conditions



recorded on QOF registers are often significantly less than the expected prevalence rates.

**57.** In terms of productivity incentives, Payment by Results provides a powerful incentive at an organisational level, as activity receives a tariff price. However, this incentive is not often felt at a team level, let alone by individual clinicians.

**58.** Individual incentives need to be found not only in relation to productivity but also to attract high-quality staff to work in the more deprived areas of London, and to maintain high-quality staff across all healthcare locations (polyclinic, local hospital, etc).

**59.** We propose that organisational and individual-level incentives – both financial and non-financial – need to be examined and strengthened. For example, transparent ranking of clinicians by their performance has potential to appeal to professional pride. A recent study of coronary artery surgery in the North West has found that the decline in mortality from 2.4 per cent in 1997/98 to 1.8 per cent in 2004/05 may in part be due to the publication of heart surgeons' performances.<sup>13</sup> Transparent and robust quality measurement tools can only improve the quality of healthcare.

**60.** Whilst existing outcome data is sometimes mistrusted by clinicians, there are more sophisticated outcome measures being developed all the time. For example, Copeland's Risk Adjusted Barometer – based on the widely-recognised POSSUM scoring system<sup>14</sup> – relies on locally-collected data (improving its accuracy) and incorporates a sophisticated analysis of a patient's presenting risk, together with an assessment of the complexity of the operation and any complications that arise during the operation. It can identify outcomes that are better than expected, as well as those that are worse, and thus can be used as an improvement tool as well as to assure clinicians and others of the standard of care being provided, and to measure productivity.<sup>15</sup>

**61.** In the US, annual productivity and performance reviews are conducted, with the top-performing staff rewarded and the worst-performing encouraged to leave. We do not believe this would fit with the culture of the NHS, but arguably there is a need to review the tenure of consultants on a regular basis, based on clinical performance, productivity rates and the needs of the local NHS.

#### *A workforce strategy*

**62.** To address these issues and others, we recommend that NHS London develops a single workforce strategy for London, something which has never been done before.

**63.** This strategy should seek to ensure the necessary workforce is in place to support this *Framework's* proposals. To achieve this will require an innovative and dynamic partnership between local organisations and the SHA to ensure that the NHS in London has the staff it needs, through the commissioning of training and the replacement of retiring staff.

#### **Patient choice and information**

**64.** The choices that patients make about their healthcare will increasingly drive change and improvement in the healthcare system. The better the information that Londoners have about their possible choices, the more those choices will drive improvement. From 2008 there will be free choice in the NHS, with Londoners able to choose any accredited provider for elective treatment. This is likely to improve satisfaction with the NHS in London, with the Ipsos MORI poll finding that those who felt they had more choice over their care were more satisfied.<sup>16</sup>

**65.** Choice is likely to have a significant impact on where patients go to have their treatment – in the London choice project, 67 per cent of eligible patients chose to go to another hospital for faster treatment and 97 per cent said they would recommend the scheme to others.<sup>17</sup>

London, with many healthcare providers only a short distance apart, is arguably where choice will have its biggest effect in England.

**66.** Choice will allow providers that are popular with patients to expand. For instance, University College Hospital and Guy's and St Thomas' Foundation Trusts are already attracting more expectant mothers to use their maternity services.

**67.** In theory, the one choice people have always had in the NHS is over which GP they register with. However, there are too many parts of London where that choice is not a reality because there are not enough GPs. Improving access to GP services is one of the main thrusts of this *Framework*. As more GPs services are provided within different models of community provision, so this will drive change and improvement.

**68.** So patient choice is set to drive the pattern of provision of planned care across London, although sophisticated commissioning is still needed to encourage the development of providers. To help make patient choice a powerful driver of improvement we must ensure that patients have the very best information to support that choice. To communicate this clearly to a wide range of different cultures will take constant attention.

#### *Information for choice*

**69.** Therefore, improved information for patients is also vitally important. There will always be an information imbalance between patients and skilled health staff who have had many years of training, but there is much that should be done to bridge the current chasm.

**70.** We want to encourage choice in healthcare, but for meaningful choices to be made information needs to be available on both the experience of patients over the whole patient pathway, and clinical outcomes. Our recommendation is that priority areas for the development of information for choice are

maternity (to support the recommendation of choice between obstetric units, midwife-led units and home births) and for GP practices, where there is a paucity of information to allow effective choices.

#### *Information for self-care*

**71.** Information for effective self-care is a vital plank of our proposals for better long-term conditions (LTC) services. Patients who have the information to manage their own care enjoy more independence and greater control over their lives.

#### *Information for patient assessment of services*

**72.** Patients need to know what they should expect from their services. The public events provided considerable support for the Department of Health's draft principles for what patients should expect from NHS services.<sup>18</sup> They could be a way of holding NHS organisations to account.

**73.** We need to build on the use of the Department of Health and Dr Foster website *NHS Choices*, which provides national information on all three of the areas outlined above.<sup>19</sup>

#### *Information within the services and IT as a driver for change*

**74.** London in the 21st century has a knowledge-driven economy. As a city, we recognise how important information is in keeping both our economy and our daily lives functioning effectively. The same is true for healthcare. However, in the NHS, information remains undervalued despite its potential to improve services.

**75.** The National Programme for IT (NPfIT – now known as Connecting for Health) was launched in 2002 to deliver an excellent IT infrastructure for the NHS. In London there has been good progress in some areas. The Picture Archiving





and Communication System (PACS) is now in place in 21 of London's acute trusts. The introduction of PACS at Charing Cross Hospital, in conjunction with voice recognition software, means that radiology tests are now available the same day (in September 2004, the results took seven days).

**76.** In addition, whilst development has proved difficult, the most significant element of the electronic record will be in place within three years. This will be vitally important in facilitating joint working between different NHS organisations and improving continuity of care for patients. This in turn will contribute to reducing health inequalities by facilitating the tracking of vulnerable patients to make sure that they are included in public health initiatives, for example immunisation.

**77.** London also has a potential advantage over other SHA areas as BT is the sole provider, working specifically on the London area. This means there is a good opportunity to develop the programme in London so that London has

the most advanced IT in the NHS.

**78.** Such further development will be needed to support implementation of the *Framework*. In particular there will need to be:

- integration of new polyclinics into the NPfIT programme
- improved capacity for image transfers to support dispersed diagnostics
- a fit-for-purpose booking system across all organisations (eg accessible through the urgent care number)
- consideration of how financial flows and performance tracking (both out of the scope of the current programme) can be supported by IT
- flexibility within the programme that allows alternative providers (such as voluntary organisations) access to the information system
- information flows along the care pathway, eg for maternity services
- IT support for staff who deliver care in people's own homes such as district nurses and midwives.

**79.** These initial thoughts on where development is required need much more detailed consideration and exploration. We recommend that a full information gap analysis is conducted to identify any new information technology requirements emerging from this strategy and then consideration is given to how to take these forward.

#### *Information for the NHS*

**80.** The NHS needs to make the best use of existing information through the tools it has available. Tools include the following:

- the *Map of Medicine*.<sup>20</sup> This could be used in developing London-wide care pathways for LTCs. This software was first developed at University College London and The Royal Free Hampstead NHS Trust in 2001 to help doctors share clinical protocols. It is being introduced as part of Connecting for Health and could

provide the basis for London-specific pathways.

- programme budgeting. There is a growing body of information available from the Department of Health's programme budgeting work which allows PCTs to see what they are spending and how effectively.<sup>21</sup>
- the National Knowledge Service.<sup>22</sup> The NHS's National Knowledge Service has launched a series of knowledge weeks, setting out the latest information and clinical evidence in particular medical disciplines. This will develop to include prescribing data.
- commissioning tools. Annex C of the *Commissioning Framework for Health and Wellbeing* has several useful resources and tools to help inform commissioning.<sup>23</sup>

**81.** To support the use of these tools, and to give a greater priority to the use of information within the NHS, we propose that London should develop an integrated NHS information service, bringing together the Library Service and the data from the London Health Observatory. Championing the greater use of knowledge should be a Chief Knowledge Officer for London.

### Funding flows

**82.** As we have seen, the NHS is now organised in such a way as to encourage commissioners to drive change in the health services that they buy for their local populations. This only has an effect upon the providers of health services if it can have a direct impact on their income. This means that the way in which money flows round the system is crucial. We need to use financial flows to incentivise the best practice that is contained in this report.

**83.** At its simplest, this involves commissioners defining the best, safest practice for a patient pathway and ensuring that this, and only this, is the practice that they pay for.

**84.** However, a range of different funding arrangements exist in the NHS in London, from capitation-based general practice through to

acute hospitals who receive most of their money from the activity-based re-imburement of Payment by Results. Some of our proposals will have an impact on Payment by Results. For instance, Payment by Results is a case-mix system, meaning it pays an average price for a procedure or diagnosis. So separating out complex and more routine care could leave the complex provider short-changed.

**85.** We are aware of, and support, the Department of Health's desire to develop Payment by Results further.<sup>24</sup> NHS London may want to engage in this development work as part of the implementation of this Framework, to work through the issues it presents. NHS London could work with the Department of Health to pilot new approaches to Payment by Results from April 2008.

### Better use of our estates

**86.** "The case for change" emphasised the vast amount of estate the NHS has in London. To show this estate visually we have plotted it on Google Earth.<sup>25</sup> The map on page 125 shows the numbers of each type of NHS facility.

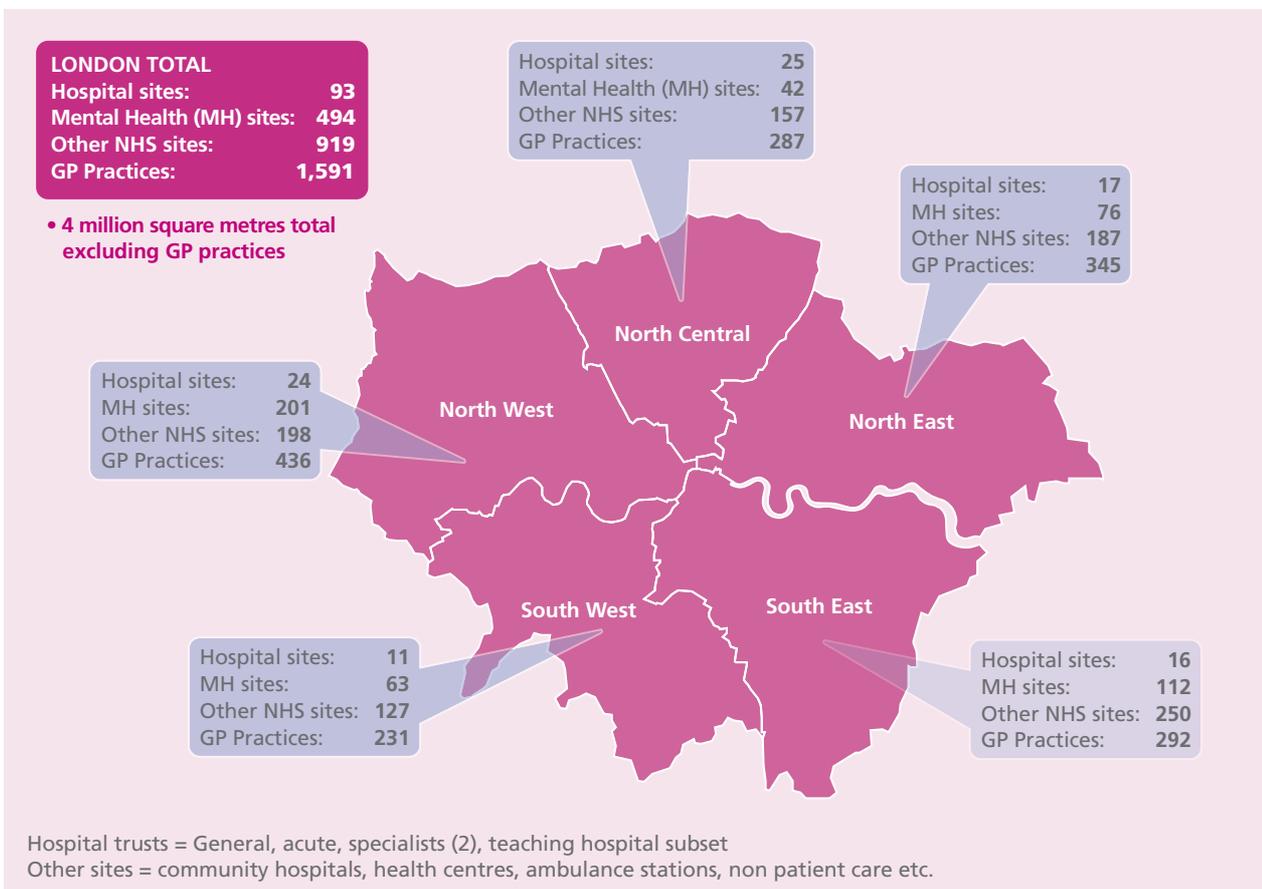
**87.** To make the most of this estate we recommend that NHS London develops a comprehensive strategy for estates. This would involve four steps:

- understand the NHS in London's current estates portfolio, its condition and its current utilisation
- determine what estate is needed for future services
- look at the potential for re-providing some services on better sites or rebuilding on existing sites
- determine which estate is needed and which may be available for non-NHS use.

**88.** This approach should help the NHS to maximise the value of its estates. There is some estate that is not being used at all, and changing patterns of provision (less inpatient, more



## Considerable capital is tied up in highly fragmented infrastructure



Source: Pan London Estate Review, NWL SHA June 2006

outpatient and home-based care) means that other estate may become redundant. We need to explore how that surplus or underused estate can be used to finance new developments.

**89.** In particular, we must ensure that all NHS organisations, including Foundation Trusts, are prevented from disposing of part of their estate without NHS London first considering whether that estate, and the surplus generated from it, would be suitable for the development of new facilities and services, for example, polyclinics.

### *Polyclinics*

**90.** One specific estates challenge will be the development of polyclinics. Suitable sites for

polyclinics will need to be found. To do this we advocate working with local authorities to find sites in areas of need that will be ideal for the health and wellbeing services the polyclinic will offer. Locating these with other services would be an advantage. One key criterion in choosing sites will be ensuring good 24/7 transport access and appropriate parking facilities in line with green/active travel plans.

**91.** We also suggest that existing LIFT scheme proposals are reviewed to ensure that they fit with our proposals for polyclinics. In addition, the potential to redevelop underutilised community hospitals, such as St Ann's and the Bolingbroke hospital, into polyclinics should be



considered. We also expect some proposals to come from entrepreneurial groups of GPs and other clinicians eager to develop the polyclinic model.

**92.** Aside from polyclinics created from the bottom-up by enthusiastic GPs, considerable thought is needed on how to encourage GPs to use them. Primary care contracting needs to be considered as a tool for recruiting GPs to be based in polyclinics. Issues around the ownership of existing premises also need to be resolved if there is to be a large-scale move of GPs into polyclinics.

#### *Sustainability*

**93.** As part of the NHS's corporate social responsibility, any new facilities built to implement the *Framework* must be sustainable and environmentally-friendly. We propose that new buildings should be designed to promote health, regenerate local communities (eg using firms that employ local trainees), and be suitable for increasingly hot and dry summers. In particular, new buildings should set standards of energy efficiency. The increased costs of doing this will need to be factored into the procurement process.

**94.** We also need to plot the way in which buildings will and could be used differently. For example if a patient pathway involves fewer but longer journeys we need to be aware of the impact this would have on the carbon footprint of the NHS in London. The NHS in London should continue to work with Transport for London on green/active travel plans, for both NHS staff and those accessing healthcare.

#### *Ownership models*

**95.** One particular consideration for the estate is ownership. Take the example of polyclinics. New polyclinics could be owned by the NHS and utilised by NHS staff and others. Or they could be owned by the independent sector – this could be a large GP practice providing some services and buying others in or it could be by a company interested in owning the asset but then letting it out to a service provider. Foundation Trusts may also be interested in owning and running polyclinics.

**96.** Clearly there is a diversity of models available and the most appropriate model will vary depending on the specific service needs.



Ownership issues could, however, be explored as part of the estates strategy.

### Next steps

**97.** Having outlined the drivers for change that could turn this *Framework* into a reality, I want to champion the immediate short-term activities that I think will be necessary to show that the NHS in London is serious about improving healthcare.

#### *Polyclinics*

**98.** It is important to provide some early examples of how polyclinics will work. In particular, their ability to deal with urgent care cases that would otherwise have gone to a full A&E department, will need to be proved to a public that may well be initially sceptical.

**99.** If this *Framework* is to be taken forward with speed it will be vital to build on existing developments and innovation in London. There are already some plans for large health clinics that could be easily adapted to this model. Similarly there are ongoing developments of some existing buildings into facilities that will come close to our model, providing they have the ability to scale up their approach. I also recognise that there are already some federations of GPs that are looking to work much more closely together to provide a wider range of services.

**100.** In the next few weeks and months, I hope that NHS London will encourage these existing developments to buy into the concept of polyclinics. It should be possible to have five to ten such clinics delivering services by April 2009.

#### *Improving stroke services*

**101.** In the next few years, if organised properly, medicine can make a very great difference to the morbidity and mortality of stroke sufferers. The *Framework* argues that this needs hospitals with specialist staff and equipment available 24/7, combined with a highly skilled ambulance service,

to ensure that stroke cases get the best treatment. This will need a London-wide reconfiguration of stroke services. This will not be easy, but, given the compelling case for change, it will need to be done with some urgency.

#### *Major trauma services*

**102.** The same is true for major trauma services. Medical science can now keep people who have suffered major trauma alive when a few years ago they would have died. We have one major trauma centre in London and instead of repeating the failed pattern of stroke care provision and pretending that we can develop 30 such centres, we need to plan where the other two major trauma centres should be.

#### *The London Ambulance Service*

**103.** The modern ambulance service is a remarkable medical service and London has one of the very best. It already moves people to the appropriate, rather than the nearest, emergency care centre, choosing, for example, to go past A&Es to get to the specialist centre where angioplasty can be safely carried out. Clinical judgements are made on the phone, when the patient has called the ambulance out, and in the ambulance going to the hospital. This *Framework* asks for a lot more clinical judgement from the London Ambulance Service, and if it is to be implemented, they will need further improvements to their skills and capacity.

#### *Tackling health inequalities*

**104.** One of the main themes of this report has been the importance of reducing health inequalities by giving everyone access to the best possible care. Whether this *Framework* succeeds in its goal of reducing inequalities will depend on how it is implemented – both locally, and at a strategic level. For example, I have identified the fact that there are fewer GPs per head of the population in parts of East London than in the rest of London. This inequality of access to healthcare must be tackled. Strategically, I believe that some of the early



polyclinics must be developed in the areas of greatest need with relatively few GPs per head.

**105.** Locally, each PCT area/borough will need a detailed understanding of the baseline position from which its health economy starts, with systematic use of health inequalities impact assessments to ensure improvements are helping the most disadvantaged. Progress on reducing inequalities will depend upon close working with local stakeholders and communities.

### Conclusion

**106.** In meeting people to discuss this *Framework*, there has been a lot of cynicism about the need for another report. Many people feel that there have been enough strategic reports already, and that the problem has been too little strategic action.

**107.** Whilst everyone recognises that implementing a ten-year strategy takes time, if people are to commit their energy and trust to this change then they will expect to see some outcomes fairly quickly. I believe that the feelings of loss that the public can have when a service changes can be overcome by ensuring that they see that they are being replaced by new, better services.

**108.** I would like to end by returning to my opening remarks. I feel passionately about London. London is a world-class city and those who live here should not have to settle for anything less than world-class healthcare. This *Framework* sets out a vision for the very best healthcare for London. It is now up to the NHS in London, and its partners, to make it a reality.





- 1 See for instance *Making commissioning effective in the reformed NHS in England*, Health Policy Forum, December 2006 and the Commissioning Framework, Department of Health, July 2006
- 2 *Commissioning Framework for Health and Wellbeing*, Department of Health, March 2007
- 3 *Our health, our care, our say*, Department of Health, January 2006, p.72
- 4 *Commissioning Framework for Health and Wellbeing*, Department of Health, March 2007
- 5 *Healthcare for London: Findings from an Event with Voluntary Sector Representatives*, OLR, March 2007
- 6 Farrington-Douglas J, Brooks R, *The Future Hospital: The politics of change*, IPPR, May 2007
- 7 Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007
- 8 *Our health, our care, our say*, Department of Health, January 2006, p.148
- 9 Farrington-Douglas J, Brooks R, *The Future Hospital: The politics of change*, IPPR, May 2007, p 37
- 10 Ipsos MORI Trust Survey, 2006 figures, <http://www.ipsos-mori.com/polls/2004/bma.shtml>
- 11 *Enquiry into London's Health Service, Medical Education and Research*, London, HMSO, 1992 (Tomlinson Report)
- 12 Taken from the *Quality, Prevalence and Indicator Database* held by the Prescribing Support Unit in the Health and Social Care Information Centre.
- 13 Bridgewater B, et al., Has the publication of cardiac surgery outcome data been associated with changes in practice in northwest England: an analysis of 25 730 patients undergoing CABG surgery under 30 surgeons over eight years, *Heart* 2007; 93: 744-748
- 14 Copeland GP, Jones D, Walters M, POSSUM: a scoring system for surgical audit, *Br J Surg*. 1991 Mar; 78(3): 355-360
- 15 Imperial College has an academic relationship with Elison Health Ltd, which owns Copeland's Risk Adjusted Barometer
- 16 Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007
- 17 London Patient Choice Project, *Patients' Experience of choosing where to undergo surgical treatment*, Picker Institute, 2005
- 18 *Consultation on the core principles for everyone providing care to NHS patients*, Department of Health, December 2006 and *Healthcare for London - A Framework for Action: Findings from two deliberative public events*, Opinion Leader Research, March 2007
- 19 <http://www.nhs.uk/Pages/index.html>
- 20 <http://www.mapofmedicine.com/>
- 21 <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/Programmebudgeting/index.htm>
- 22 <http://www.nks.nhs.uk/default.asp>
- 23 *Commissioning Framework for Health and Wellbeing*, Department of Health, March 2007
- 24 *Options for the Future of PbR 2008/09 to 2010/11*, Department of Health, March 2007
- 25 <http://earth.google.com/>

## Appendix 1

### Clinical working group membership

#### Pathway: maternity and newborn care

**Cathy Warwick**, General Manager of Women and Children's Services/Director of Midwifery, Visiting Professor of Midwifery, King's College Hospital NHS Foundation Trust (Working Group Chair)

**Sarah Brook**, Trustee, National Childbirth Trust Foundation Trust

**Jean Chapple**, Public Health Consultant, Westminster Primary Care Trust

**Jill Demilew**, Midwifery Advisor, Department of Health

**Adam Forman**, GP, Hackney

**Debbie Graham**, Lead Midwife, NHS London

**Frances Haste**, Consultant in Public Health, Newham Primary Care Trust

**Alison Herron**, Consultant Midwife, Barts and the London NHS Trust

**Michael Hird**, Consultant Neonatal Paediatrician, Barts and the London NHS Trust

**Anita Holdcroft**, Reader in Anaesthesia and Honorary Consultant Anaesthetist, Imperial College London / Chelsea and Westminster Hospital NHS Foundation Trust

**Claire Homeyard**, Consultant Midwife, Barking, Havering and Redbridge Hospitals

**Lynne Pacanowski**, Head of Midwifery, St Mary's NHS Trust

**Leonie Penna**, Consultant Obstetrician, King's College Hospital NHS Foundation Trust

**Jane Sandall**, Professor of Midwifery and Women's Health, King's College Hospital NHS Foundation Trust

**Andrew Shannen**, Professor of Obstetrics, Guy's and St Thomas' Hospital NHS Foundation Trust

**Austin Ugwumadu**, Consultant obstetrician, St Georges Healthcare NHS Trust

#### Pathway: staying healthy

**Maggie Barker**, Deputy Regional Director of Public Health, London (Working Group Chair)

**Sue Atkinson**, Visiting Professor of Public Health, University College London

**Carol Black**, National Director for Health and Work, Department of Work and Pensions

**Ian Basnett**, Director of Public Health, Tower Hamlets Primary Care Trust

**Alex Bax**, Senior Policy Advisor/Health, Greater London Authority

**June Crown**, Former President, Faculty of Public Health

**Tony Carson**, Community Pharmacy Advisor, Kensington and Chelsea Primary Care Trust

**Justin Gaffney**, Consultant Nurse, STI Control, St Mary's NHS Trust

**Jenny Gallagher**, Senior Lecturer and Honorary Consultant in Dental Public Health, Kings College London Dental Institute

**Trudi Kemp**, Clinical Director of Strategy, St George's Healthcare NHS Trust

**David Lloyd**, GP, Harrow

**Graham MacGregor**, Professor of Cardiovascular Medicine, St George's Healthcare NHS Trust

**Carol McCoskery**, Head of Nursing - Cardiothoracic SDU, Guy's & St Thomas' NHS Foundation Trust

**Hannah Miller**, Director of Social Services, London Borough of Croydon





**Mark Pakianathan**, Consultant in GU Medicine, St Georges Healthcare NHS Trust

**Angela Robinson**, Consultant GU Physician, Camden Primary Care Trust

**Deborah Turbitt**, Consultant in Communicable Disease Control, North East and North Central Health Protection Unit

**Rachel Tyndall**, Chief Executive, Islington Primary Care Trust

**Russell Viner**, Consultant in Adolescent Medicine & Endocrinology, University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Trust



### Pathway: mental health

**Simon Crawford**, Chief Executive, West London Mental Health NHS Trust (Working Group Co-Chair)

**Stuart Bell**, Chief Executive, South London and Maudsley NHS Foundation Trust (Working Group Co-Chair)

**Robert Dolan**, Chief Executive, East London and The City Mental Health NHS Trust

**Stephen Firn**, Chief Executive, Oxleas NHS Foundation Trust (Working Group Co-Chair)

**Peter Houghton**, Chief Executive, South West London and St Georges Mental Health NHS Trust

**Edana Minghella**, Management Consultant

**David Monk**, Development Consultant, London Mental Health Chief Executives Group

**Claire Murdoch**, Chief Executive, Central and North West London NHS Foundation Trust

**John Newbury-Helps**, Chief Executive, Barnet, Enfield and Haringey Mental Health NHS Trust

**Nicholas Temple**, Chief Executive, The Tavistock and Portman NHS Foundation Trust

**Wendy Wallace**, Chief Executive, Camden and Islington Mental Health and Social Care NHS Trust

**Judy Wilson**, Chief Executive, North East London Mental Health NHS Trust

**Melba Wilson**, Race Equality Director (Acting Chief Executive) London Development Centre

### Pathway: acute care

**Ara Darzi**, Professor of Surgery, Imperial College London (Working Group Chair)

**Steve Amiel**, GP, Camden

**Stuart Bell**, Chief Executive, South London and Maudsley NHS Foundation Trust

**Peter Bradley**, Chief Executive, London Ambulance Service

**Tom Coffey**, GP and PEC Chair, Wandsworth Primary Care Trust

**Elaine Cole**, Senior Lecturer Practitioner, Barts and the London NHS Trust

**Nigel Edwards**, Director of Policy, NHS Confederation

**Nancy Fontaine**, Consultant Nurse Emergency & Urgent Care, Whipps Cross University Hospital NHS Trust

**Charles Gutteridge**, Medical Director, Barts and the London NHS Trust

**David Hunt**, London Representative, British Orthopaedic Association

**Keith Ison**, Head of Medical Physics, Guy's and St Thomas' NHS Foundation Trust

**Fionna Moore**, Medical Director, London Ambulance Trust

**Graham Morgan**, Director of Strategy, North West London Hospitals NHS Trust

**Claire Perry**, Chief Executive, The Lewisham Hospital NHS Trust

**Julian Redhead**, Consultant in A & E Medicine, St Mary's NHS Trust and Chair of the London Emergency Medicine Consultants Group

**John Riordan**, Former Medical Director, North West London Hospitals NHS Trust

**Carl Shakespeare**, Consultant Cardiologist, Queen Elizabeth Hospital NHS Trust and South West London Cardiac Network

**Steve Shaw**, Consultant Anaesthetist, Royal Free Hampstead NHS Trust

**Chris Streater**, Medical Director, St Georges Healthcare NHS Trust

**Simon Williams**, Director of Community Housing, London Borough of Merton



### Pathway: planned care

**Martyn Wake**, GP and Joint Medical Director, Sutton and Merton Primary Care Trust (Working Group Chair)

**Charles Alessi**, GP and Medical Director, Kingston Primary Care Trust

**Dominic Blunt**, Consultant Radiologist, The Hammersmith Hospitals NHS Trust

**Shona Brown**, Director of Nursing, Whipps Cross University Hospital NHS Trust

**Nick Cheshire**, Professor of Vascular Surgery, Associate Medical Director, St Mary's NHS Trust

**Justin Cobb**, Professor of Orthopaedic Surgery, Imperial College, London

**Tim Crayford**, Director of Public Health, Croydon Primary Care Trust

**Chris Elliott**, GP, Sutton and Merton Primary Care Trust

**John Foran**, Consultant Cardiologist, Epsom & St Helier University Hospitals NHS Trust

**Martin Gore**, Professor of Cancer Medicine, The Royal Marsden NHS Foundation Trust

**Celia Ingham Clark**, Medical Director, Whittington Hospital NHS Trust

**Chris Jones**, Divisional Director for Acute Services, Epsom & St Helier University Hospitals NHS Trust

**Sheila McKenzie**, Consultant Paediatrician, Barts and the London NHS Trust

**Hugh Montgomery**, Senior Lecturer, Centre for Cardiovascular Genetics, University College London

**Jo Pritchard**, Joint Managing Director, Central Surrey Health

**Tim Richardson**, GP and Medical Director, Integrated Care Partnership, Epsom

**Elizabeth Robb**, Director of Nursing, North West London Hospitals NHS Trust

**Michael Sheaff**, Consultant Pathologist, Barts and the London NHS Trust

**Simon Williams**, Director of Community Housing, London Borough of Merton

### Pathway: long-term conditions

**Tom Coffey**, GP and PEC Chair, Wandsworth Primary Care Trust (Working Group Chair)

**Tracey Baldwin**, Chief Executive, Haringey Primary Care Trust

**Alan Cohen**, Senior Fellow, Sainsbury Centre for Mental Health





**David Elliman**, Consultant in Community Child Health, Islington Primary Care Trust and Great Ormond Street Hospital for Children NHS Trust

**Ursula Gallagher**, Director of Quality, Clinical Governance & Clinical Practice, Ealing Primary Care Trust

**Sandra Howard**, Head of Adult Social Care and Health, London Borough of Waltham Forest

**Stephen Jefferies**, GP and PEC Chair, Hammersmith and Fulham Primary Care Trust

**Kay Lewis**, Service Manager, Long-term Conditions, Enfield Primary Care Trust

**Martin Lindsay**, GP, Haringey

**Anne Mackie**, Senior Manager Health Improvement, NHS London

**Anita Macro**, Assistant Director Nursing, Adults and People with Long Term Conditions, Lambeth Primary Care Trust

**Stephen Nussey**, Clinical Director for Acute Medicine, St George's Healthcare NHS Trust

**Martyn Partridge**, Professor of Respiratory Medicine, Imperial College London

**Samantha Prigmore**, Respiratory Nurse Consultant, St George's Healthcare NHS Trust

**John Riordan**, Former Medical Director, North West London Hospitals NHS Trust

**David L. Scott**, Professor of Clinical Rheumatology, King's College London

**Debarjit Sen**, Consultant Rheumatologist, University College London Hospitals NHS Foundation Trust

**Shanti Vijayaraghavan**, Consultant Physician with special interest in Diabetes and Endocrinology, Newham Healthcare NHS Trust

**Wisla Wedzicha**, Professor of Respiratory Medicine, Royal Free & University College London Medical School

### Pathway: end-of-life care

**Cyril Chantler**, Chair, The King's Fund (Working Group Chair)

**Rachel Burman**, Honourary Senior Lecturer and Consultant in Palliative Care, Department of Palliative Care and Policy, King's College London

**Paul Cann**, Director of Policy, Help The Aged

**Steve Dewar**, Director of Funding and Development, The King's Fund

**Simon Fradd**, Director, Condordia Health

**Rob George**, Palliative Care Consultant, University College London Foundation NHS Trust/Meadow House Hospice

**Irene Higginson**, Professor of Palliative Care and Policy, Department of Palliative Care and Policy, King's College London

**Jan Holden**, Programme Lead End-of-Life Care, Westminster Primary Care Trust

**Tom Hughes-Hallett**, Chief Executive, Marie Curie Cancer Care

**Rob Larkman**, Chief Executive, Camden Primary Care Trust

**Maggie Owolade**, Area Manager, London Alzheimer's Society

**Keith Palmer**, Non-Executive Director, Guy's and St Thomas' Hospital NHS Foundation Trust

**Amanda Ramirez**, Director, Cancer Research UK, London Psychosocial Group

**Mike Richards**, National Cancer Director, Department of Health

**Vicky Robinson**, Nurse Consultant, St Christopher's Hospice

**Catherine Shipman**, Senior Research Fellow, Palliative Care and Policy, King's College London

**Susanna White**, Director of Housing and Community Services, London Borough of Hounslow

**Robert Freeman**, Department of Health (observer)



## Appendix 2

### Supporting material

The following supporting material is available at [www.healthcareforlondon.nhs.uk](http://www.healthcareforlondon.nhs.uk)

- Terms of reference
- Summary of organisations submitting evidence
- Summary of submissions
- Opinion Leader reports
- Working group reports
- Technical paper
- Ipsos MORI report

Further information on Healthcare for London can be found at: [www.healthcareforlondon.nhs.uk](http://www.healthcareforlondon.nhs.uk)

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