Healthcare for London consultation document

Title:
Healthcare for London: consulting the capital

30 Nov 2007

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1 Achieving excellence

London is one of the greatest cities in the world. We believe Londoners deserve the very best healthcare system in the world and we want to develop a service that meets your needs and expectations. We welcome your views on the proposals set out in this document.

We know that some healthcare services in parts of London compare well with the rest of the country and some services are world-class. But there are great variations in quality of care.

We also know that setting our sights on providing the best healthcare in the country is not enough. There are many countries in the world that have better survival rates and healthier populations than the UK – this is the gold standard to which we should aim and which Londoners deserve.

This booklet is published on behalf of the 31 Primary Care Trusts (PCTs) in London and Surrey PCT. PCTs buy and provide healthcare for over eight million people living or working in, or visiting, London. We spend over £11 billion a year on services such as hospitals, community nurses, GPs, mental health services, opticians, pharmacists and dentists. So it is important we know what healthcare you need and that we do everything possible to keep you healthy and get the very best health services for you.

Healthcare in London will only be improved by working in partnership with others. We would like to thank Lord Darzi, the doctors, health professionals, colleagues in partner organisations and NHS staff throughout London who contributed to *A Framework for Action*, and in particular the many Londoners who took part in discussions, events and the opinion survey (available at www.healthcareforlondon.nhs.uk).

We believe the way services are provided, and the services we offer, need to change. We hope that after reading this document, you will too. We look forward to reading your comments.

Name, Chair, *Xxxxx Primary Care Trust*
Name, Chair, *Yyyyy Primary Care Trust*
Name, Chair, *Zzzzz Primary Care Trust*
(All London's 31 PCTs plus Surrey)
30 November 2007

2 About this booklet

This booklet outlines ways in which health services in London could be improved over the next ten years and asks for your views.

The proposals are based on ideas in **Healthcare for London: *A Framework for Action***, written by Professor Lord Darzi and published on 11 July 2007 by NHS London. The proposals focus on services from a patient's point of view. They look at what needs to change to make services safer and more accessible. And they look at what needs to be done to make Londoners healthier.

> Lord Darzi is an internationally respected surgeon. He is the Paul Hamlyn Chair of Surgery at the Royal Marsden Hospitals NHS Foundation Trust and Chair of Surgery at Imperial College, London. In writing his report he drew on medical and social research, surveys and meetings with patients, the public and NHS staff. Seven working groups with front-line professionals and representatives from partner organisations also provided valuable assistance and guidance. Lord Darzi became a Minister in the Government's health team in summer 2007

The booklet does not repeat every recommendation and option considered in A *Framework for Action*, the technical paper and the clinical working group reviews. Nor does this booklet list the 250 pieces of information listed in the full report. If you would like more background information to help you comment, please visit our website www.healthcareforlondon.nhs.uk or call 0800 XXXXXXX or write to us at Freepost, Consulting the Capital.

We welcome your views on how healthcare in London could be organised and delivered over the next ten years. You will find a number of questions in this booklet that will help us develop our ideas. However, you do not have to answer any of them. If you prefer to make comments on other ideas then please do so, your views will be equally valid.

This consultation is ***not*** about any individual hospital or service. If proposals to change a service are put forward in the future they will be subject to a separate discussion, consultation and scrutiny.

There is a questionnaire at the end of this booklet or you can use the form on our website www.healthcareforlondon.nhs.uk

The deadline for responding to this consultation is 7 March 2008.

Background

This document aims to inform you about our understanding of healthcare in London and explain how we think services need to improve. We then ask for your views so that we can improve our plans.

When partner organisations, working groups and members of the public came up with ideas, they were asked to think:

- Will it improve quality of care and safety?
- Will it improve access?
- Will it tackle health inequalities and help people to stay healthy?

Where we are doing well…

There has been a big growth in funding the NHS over the past five years. The NHS in London now spends £11.4 billion a year on healthcare, up from £6.6 billion in 2002. The NHS now spends more per person than most developed countries.

Staff across London are working hard to improve care for everyone. GPs offer their patients more services than ever before and nurses and therapists are taking on more roles in the community, in GP practices and in hospitals.

Because of the effort made by staff throughout the NHS, waiting times for operations have fallen dramatically, new methods, new technology and treatments are saving many more lives. Investment in new and existing community-based centres and hospitals has made many buildings more pleasant, more economical to run, cleaner and easier for staff to deliver better standards of care.

…and not so well

Despite this, London's NHS is not performing as well as it could do. Whilst some services in London are the best in the country, many do not compare well. And we see many news reports showing the UK is falling behind other countries in the quality of care we give to patients, the access to care and the cleanliness of our hospitals.

The NHS in London is not providing easily accessible high-quality urgent care* for most of the population, nor the best quality specialist care for the small number of people who need it.

*** In this booklet 'urgent care' means care that is needed immediately or within the next day or two.**

Where we are…

London is very different to other parts of the country. It has a very diverse community and big differences in health and care. It has greater challenges than the rest of the country on issues such as mental and sexual health but it also has some centres of excellence that are the best in the world. Demands on services and the costs of new technologies, drugs and techniques are all increasing so we must make the best use of the finances available.

A Framework for Action examines new evidence and ideas, but it also looks at recent national and local patient and public surveys. We know that people would like to have improved out-of-hours access for urgent care. We know that people would like more money spent on preventative care and a more joined-up approach to end-of-life care. So some parts of this document should feel very familiar – many patients and members of the public have contributed to them.

…and where we are going

Following the consultation all your comments will be summarised by Ipsos Mori, our independent analysts. Ipsos Mori will comment on whether the consultation was carried out correctly and publish a report that fully and fairly reflects the views made in the consultation. This report will be made available to consulting PCTs to help them plan future services and we will publish it on www.healthcareforlondon.nhs.uk

In May 2008 a committee of PCTs will consider the report and take it into account, will all other relevant information, before making decisions on the issues being consulted upon.

Each PCT (or group of PCTs) will then develop detailed proposals on services – starting with those that are in most urgent need of improvement. These proposals will be subject to proper discussion, scrutiny and consultation with patients, the public, staff, and anyone with an interest in healthcare in London.

In parts of London some PCTs are consulting, or preparing to consult, on specific service changes. We have tried to avoid holding consultations at the same time. However we believe it is reasonable to consult in some cases where there is a pressing need.

3 A summary of the proposals

Five principles emerged from Lord Darzi's discussions with patients, public, staff and partner organisations.

Principle 1. Services should be focused on individual needs and choices

Patients should feel in control of their care and be able to make informed choices.

What does that mean for me?

People should be able to have simple tests in local facilities rather than having to go to hospital for simple tests and they should be able to see a doctor for routine appointments in the evenings and at weekends.

Women should have one-to-one care during established labour and be offered better information and greater choice of where they have their baby.

People who are nearing the end of their life should have an end-of-life care plan and be able to choose the place where they die.

Principle 2. Services should be localised where possible and centralised where necessary

Routine healthcare should take place as close to home as possible. The most complex care should be centralised to ensure it is carried out by the most skilled professionals with the most modern equipment.

What does that mean for me?

We want to make better use of the high levels of skill and experience of GPs, midwives, therapists and other healthcare staff working in the community. We will need to provide larger community healthcare teams, more equipment (for instance for tests), larger facilities in which to house the greater range of services and we want to see more hospital specialists providing clinics in the community.

When facilities aren't available in the community, local hospitals would provide all but the most complex services.

When very specialist care is needed, for instance for people suffering a stroke or a major injury – they should be taken to one of a small number of specialist hospitals. This already happens for people suffering a heart attack.

Principle 3.There should be joined-up care and partnership working, maximising the contribution of the entire workforce

Better communication and co-operation is needed between community services and hospitals, between different teams working in the same buildings and between the NHS and local government and voluntary organisations.

What does that mean for me?

If we better co-ordinate care for people with long-term conditions such as diabetes, heart disease, mental health problems, asthma and bronchitis they will be able to manage their condition more effectively and avoid unnecessary emergency admissions to hospital.

Every doctor-led maternity unit should have a partner midwife unit. For those women who need more complex maternity care we must make sure that senior staff are available on the ward for far more hours a week.

Principle 4. Prevention is better than cure

Because staying healthy is not just about NHS services we should work better with local government, the Greater London Authority and voluntary organisations to help people stay mentally and physically healthy.

What does that mean for me?

Childhood immunisation is safe and cost-effective but it needs to be seen as a high priority amongst staff concerned with the care of children.

Helping people stop smoking, providing services to reduce the number of unwanted pregnancies and making sure all health professionals advise people on how to live healthier lives will all improve the health of the community.

We know that if we diagnose and treat those suffering from mental health problems earlier this will lead to better results.

Principle 5. There must be a focus on reducing health inequalities

The most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare. Improvements also need to take into account London's ethnic and cultural diversity.

What does that mean for me?

Mental health problems are greatest in the most deprived areas of London and the very differing mental health needs of refugees, offenders and the black and minority ethnic community need to be met.

Some of the most deprived areas of London also have the fewest GPs, the highest infant death rates and the shortest life expectancy. We need to consider how we can address these issues in everything that we do.

4 Why London's healthcare needs to change

The NHS has made major improvements over the last 20 years in a period when science and medicine have developed in ways that could not have been foreseen.

Since the 1950s groundbreaking discoveries have included DNA, the link between smoking and cancer, beta-blockers, advances in transplantation, keyhole surgery and the pre-birth screen for Down's syndrome. All these developments have revolutionised the way healthcare services are provided to patients.

Over the next ten to 20 years we expect further major breakthroughs, for instance in:

- molecular genetics as scientists find more genes affecting conditions such as cystic fibrosis and heart disease
- bioengineering to produce artificial body parts and organs which could replace transplantation within 30 years
- keyhole surgery. Half of all operations could be performed using keyhole surgery, reducing the time patients spend recovering in hospital and cutting the risk of infection.

But today our NHS in London is not performing as well as it could be and should be. Millions of Londoners have illnesses which are not life-threatening but need quick and convenient treatment. A much smaller number suffer from more serious illness, such as stroke or heart attack, or have a major injury. The NHS is not serving either of these groups as well as it could.

We need to use our workforce in better, more flexible ways. The European Working Time Directive is helping to ensure that doctors are less likely to be tired when treating patients – by requiring them to work fewer hours. But that means increasing demands as more staff are needed to provide cover.

We believe there are eight main reasons why change is needed.

Reason One – the need to improve Londoners' health
London faces health challenges that are specific to the capital, for instance high rates of HIV/AIDS, substance misuse, mental health problems and childhood obesity. Every year in London obesity kills 4,000 people. One Londoner dies every hour from a smoking-related disease.

We also need to recognise the needs of a diverse population, speaking 300 different languages, and a population that swells by one million commuters every working day.

Reason Two – the NHS is not meeting Londoners' expectations
Twenty seven per cent of Londoners are dissatisfied with the running of the NHS, compared to 18 per cent nationally. Over 90 per cent of people who attended Healthcare for London events felt the NHS needs to improve.

People are not satisfied with access to GP services outside normal working hours. And around 60 per cent of 7,000 Londoners questioned in a poll said improvement was needed in cleanliness in hospitals, and in waiting times to see consultants in A&E and for routine operations.

Reason Three – one city, but big inequalities in health and healthcare
There are very big differences in the quality of life in different parts of the city and even in different parts of the same borough.

For instance:

- There are far fewer GPs per head of population in some areas, for instance Tower Hamlets and Newham where health need is greatest
- The infant death rate in Haringey is three times that of Richmond
- The teenage pregnancy rate in Lambeth is almost four times that of some other areas
- The 20 per cent of most deprived electoral wards have more than twice as many mental health inpatients as the 20 per cent least deprived.

Reason Four – the hospital is not always the answer
Londoners have told us they want more care to take place nearer their homes. The vast majority of patients do not need hospital care, but we have a long way to go to make alternatives a reality. Minor surgery and tests often do not need to be done in hospitals and people with long-term conditions like diabetes can be supported to stay at home.

Patients with long-term conditions such as bronchitis benefit from rehabilitation in the community, care from their GP and specialist nurses and therapists who can reduce the need for them to go into hospital.

We believe many people go to A&E departments because they are dissatisfied with the availability of GP and community services outside working hours. This is far from ideal. Patients are seen by junior doctors in hospitals rather than GPs, who are better skilled at treating minor illness and injury.

Polyclinics

Polyclinics are large, high-quality community facilities providing a wide range of services than is currently offered, reducing the need to visit hospitals and other services. The location and design of each polyclinic would need to meet the needs of each local community but the idea is flexible enough to suit the different needs of communities across London. The benefits are:

- moving a wide range of services out of hospitals and closer to homes (some of these services could be provided by hospital staff working in the polyclinics)
- providing a one-stop-shop to access GP services, clinical specialists, community services, urgent care, healthy living classes and other health professionals
- extended hours. Polyclinics based at hospitals would be open 24 hours a day, those in the community would meet the needs of their neighbourhood.

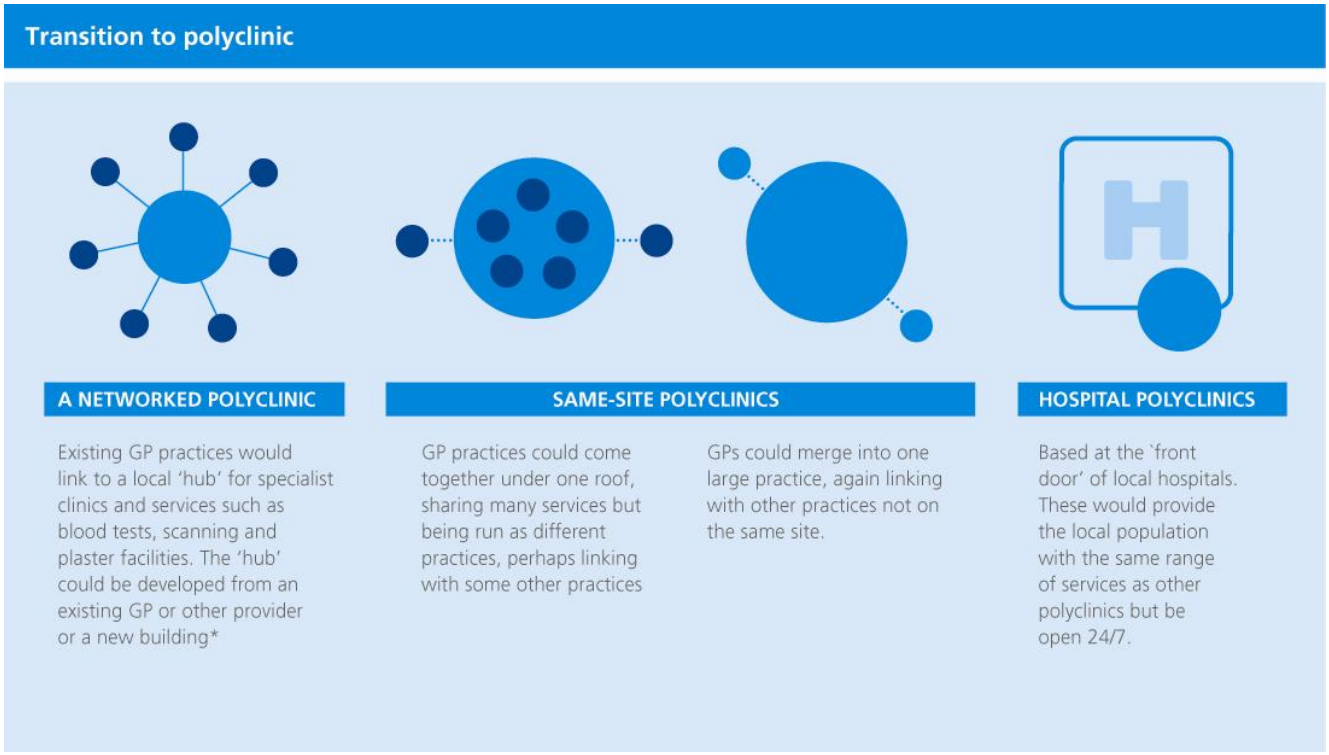
Take in merged diagram from below.

Isle of Dogs networked polyclinic

Four GP practices serving 31,000 people on the Isle of Dogs in Tower Hamlets are working together in a network to bring more services out of hospital and closer to local people.

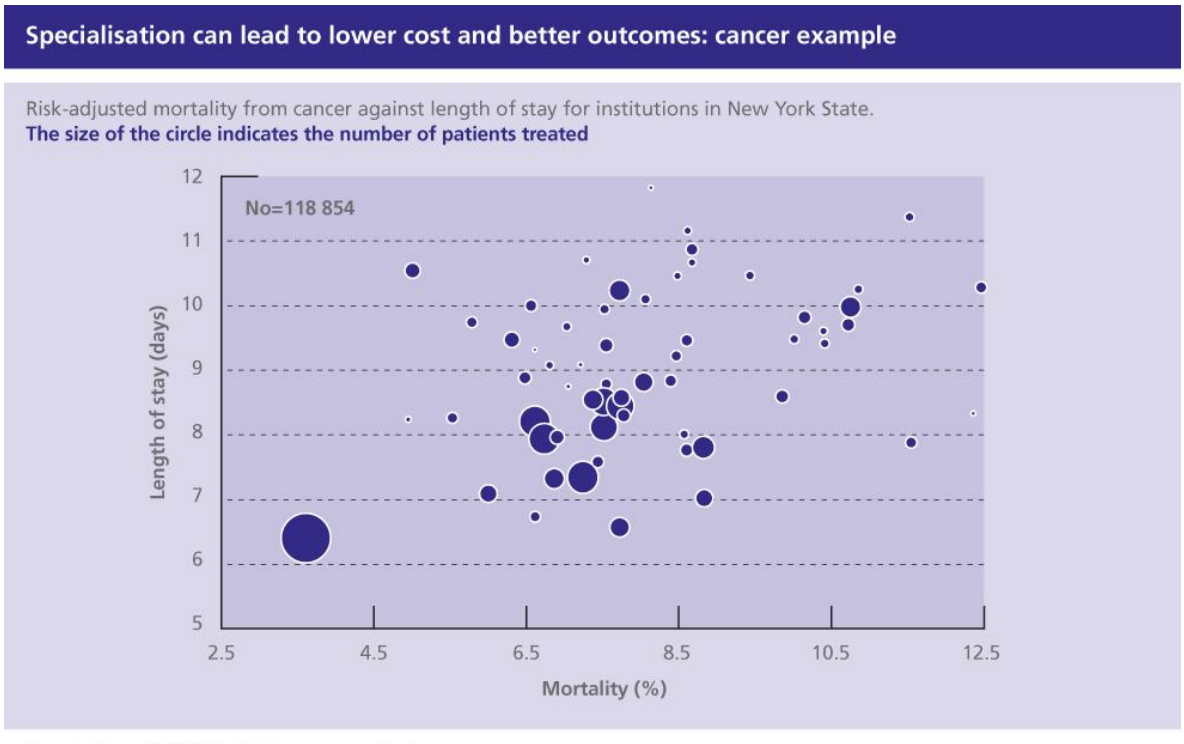
One of the practices offers minor surgery – which is provided to patients of all the local practices. The network also includes pharmacists and practice nurses. In December one of the practices moves into a new £12 million centre which will bring community dental care and consultant outpatient clinics into the local network. Other services will soon be part of the network.

Local GP Dr Mike Fitchett said: ”Working together to pool expertise and to provide more services is common sense and the patients love it – they are able to get appointments quicker and closer to home”.



Reason Five – the need for more specialised care

The most seriously ill patients need specialist care. We need to develop, and take advantage of, exciting clinical and technical advancements. And we need to concentrate specialist equipment and expert staff in centres with enough patients being treated by each specialty to ensure the service provides the best quality of care.



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Reason Six – London should be at the cutting edge of medicine
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 here.

However, the UK is lagging behind its international competitors in medical research. The UK now spends half as much on research as a proportion of its economy as the US.

To enable patients to benefit from the latest scientific breakthroughs, closer cooperation between hospitals and universities in London is needed. One option is a new form of university / hospital partnership. For instance, Hammersmith Hospitals and St Mary's Hospital have recently joined with Imperial College, London to create the UK's first Academic Health Science Centre.

Reason Seven – not using our staff and buildings effectively
The NHS's staff are its greatest asset, but their abilities are not always fully used. There needs to be more support for staff to work flexibly to deliver the best care.

The NHS occupies a large number of buildings in London – almost 100 hospitals, 500 mental health facilities, 900 other sites and over 1,500 GP practices. Servicing these buildings costs the NHS £700 million a year. Many buildings are old and difficult to clean and work to bring them up to date would cost £800 million.

Reason Eight – making the best use of taxpayers' money
Although some trusts are still overspent, in 2005/06 the NHS in London made a surplus of over £90million. This money can be used to improve healthcare in the city. Over the next few years PCTs will continue to receive growth in their budgets above inflation. But any money spent inefficiently on one aspect of healthcare is money that could be used to save lives elsewhere. And the money spent by the NHS in London is very considerable - £10.1 billion in 2005/06, or £27.7 million a day.

London's growing and ageing population and the rising cost of drugs, and treatments will challenge the NHS. Demand for services is only going to grow. Our 'most likely' forecast, comparing the cost of services with funding in 10 years time, shows that if we carry on without making any changes we will not be able to afford the services we need.

5 How we could provide care: the journey through life

Here we look at how health services perform in London, from the perspective of the patient. The detailed reports that support these chapters, from each of the seven working groups set up by Lord Darzi, can be found at www.healthcareforlondon.nhs.uk. Background information regarding the children's section can be found within each of the working group reports.

5.1 Staying healthy

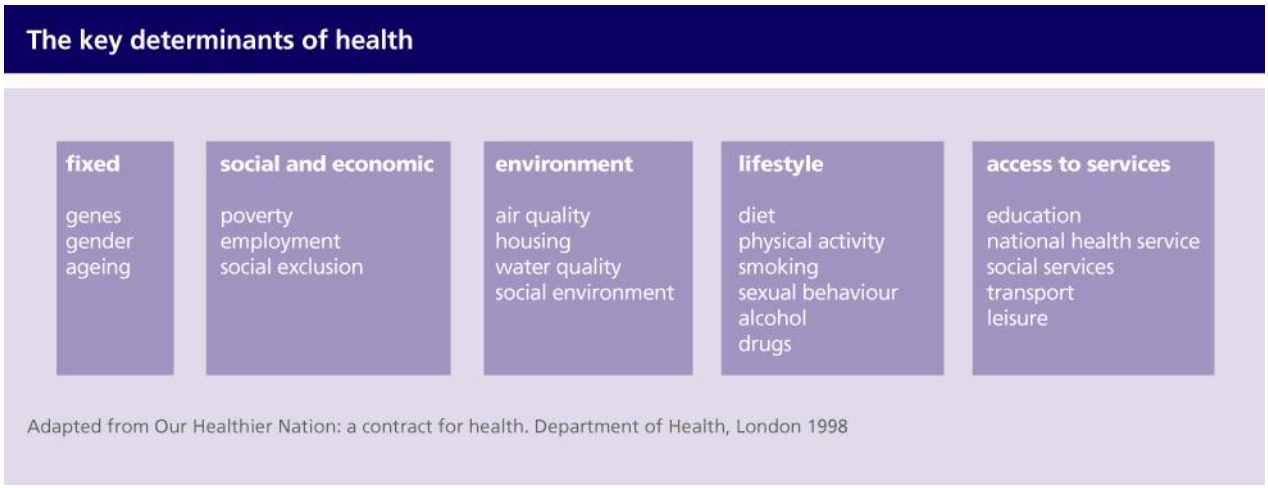
"Prevention is definitely better than cure, but we tend to spend much more of the NHS budget on hospital care – treating the illness – than preventing it in the first place. Finding ways to help people stay healthy will reduce the strain on all the services described on the following pages, from mental health and children's services to maternity services and the management of long-term conditions."
Dr Maggie Barker, Deputy Regional Director of Public Health, London and Working Group Chair, Healthcare for London.

Dr Barker has held posts at Great Ormond Street Hospital for Children and Camden and Islington Health Authority, and has advised the Department of Health on a range of task forces. She holds honorary senior lectureships at the Department of Epidemiology and Public Health, University College London and the Centre for Paediatric Epidemiology ad Biostatistics, Institute of Child Health. (picture)

A snapshot

Staying mentally and physically healthy is not solely, or even primarily, about healthcare services. Social, economic, environmental and lifestyle factors are the cause of much ill health and these are issues over which the NHS has little direct control. For instance 184,000 homes in London are judged to be unfit to live in and 41 per cent of children live in households that are below the poverty line.

Sexual health is not good in the capital. Large numbers of unwanted (often teenage) pregnancies end in termination. The capital also has very high levels of sexually transmitted disease, again particularly amongst young people.



What are we recommending?

Partnership with local authorities and others is the most important factor in helping people stay healthy. For instance we need to make sure that people with a manageable disease do not have to give up work, that new housing encourages a healthy lifestyle and that people are encouraged to walk and cycle.

We wish to work with the Mayor of London to achieve the priorities he sets out in *Reducing health inequalities – issues for London and priorities for action*. You can view this at www.london.gov.uk/mayor/health/strategy

MRSA and Clostridium difficile

Good hygiene practices, education and training to promote clinical skill will help reduce the number of cases of healthcare associated infections. Many of the proposals in this document also help to reduce infections. For instance:

- Moving care out of hospitals and into the community and people's homes
- Separating emergency and booked operations and different specialisms

We need to help carers in the valuable role they play, and ensure they are supported.

More money needs to be spent on health prevention, particularly in the most deprived areas of London. This could be done by:

- Shifting the balance of expenditure from hospitals to prevention as recommended by *Our health, our care, our say* *www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/index.htm*

- Analysing where money is having the greatest impact on preventing ill-health and concentrating our efforts in these areas.

Prevention of ill health and health promotion should be a part of all patient care. For instance, smokers could be encouraged to stop before they have an operation. This would prevent between 2,500 and 5,300 complications a year after operations. Avoiding having to put these problems right would save the NHS in London between £1.5 million and £4 million per year.

Health improvement should be part of the course for all students training to become a health professional. And it should be an important part of professional development. This would help and encourage them to become more involved in improving the health of their patients. For instance older people with the common problems of ageing – poor hearing, eyesight, teeth and feet – could be given good advice on these issues whichever health professional they visited.

Health improvement initiatives also need to reach people who are not ill. So they should be delivered:

- by more people, for instance, pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, health visitors
- working in more places, for instance, in schools, leisure facilities, in the workplace or in prisons.

London has 57 per cent of England's cases of HIV and the highest rates in the country for new diagnosis of chlamydia, gonorrhoea and syphilis. We believe we need to tackle the rising rates of sexually transmitted infections by:

- increasing the use of condoms
- improving information about healthy living and the services available
- improving access to services (for instance longer opening hours)
- improving the services themselves.

Whilst most health improvement programmes should be focused on local issues, there is a place for pan-London campaigns. For example, linked to the 2012 Games, London should lead an initiative focused on healthy eating and physical activity. And if the NHS expects the public to live healthy lives it should help and support its staff to do so.

Health protection

We believe London health organisations need to continue to work with other partners to maintain a firm focus on health protection – for instance improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.

Questions for you…

Question 1a

Looking at the list below, which of the following changes, if any, would you like to make in the future to improve your health? Please choose up to 3.

Improve your diet

Increase your level of exercise

Lose weight

Give up smoking

Reduce your alcohol intake

None of these

Other

Question 1b

How could the NHS in London best help you to make these changes?

Question 2

Do you agree or disagree with the following statement… “I would welcome advice on staying healthy when I come into contact with healthcare professionals (for example, advice on losing weight or stopping smoking)”.

Strongly agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree

Question 3

Please tell us any other comments you might have on the proposals in this section.

5.2 Maternity and newborn care

"The challenge for the NHS is to meet the growing demand for maternity services and offer more choice to pregnant women. The small number of midwifery units and the lack of resources and priority given to home births means that at present the only realistic option for most women is an obstetric (doctor-led) unit."
Professor Cathy Warwick, General Manager of Women and Children's Services and Director of Midwifery, King's College Hospital NHS Foundation Trust and Working Group Chair, Healthcare for London..

Professor Warwick trained as a nurse and midwife. She is Visiting Professor of Midwifery at King's College and has advised on the development of midwifery services in Northern Ireland, South Africa and Hong Kong (Picture)

A snapshot

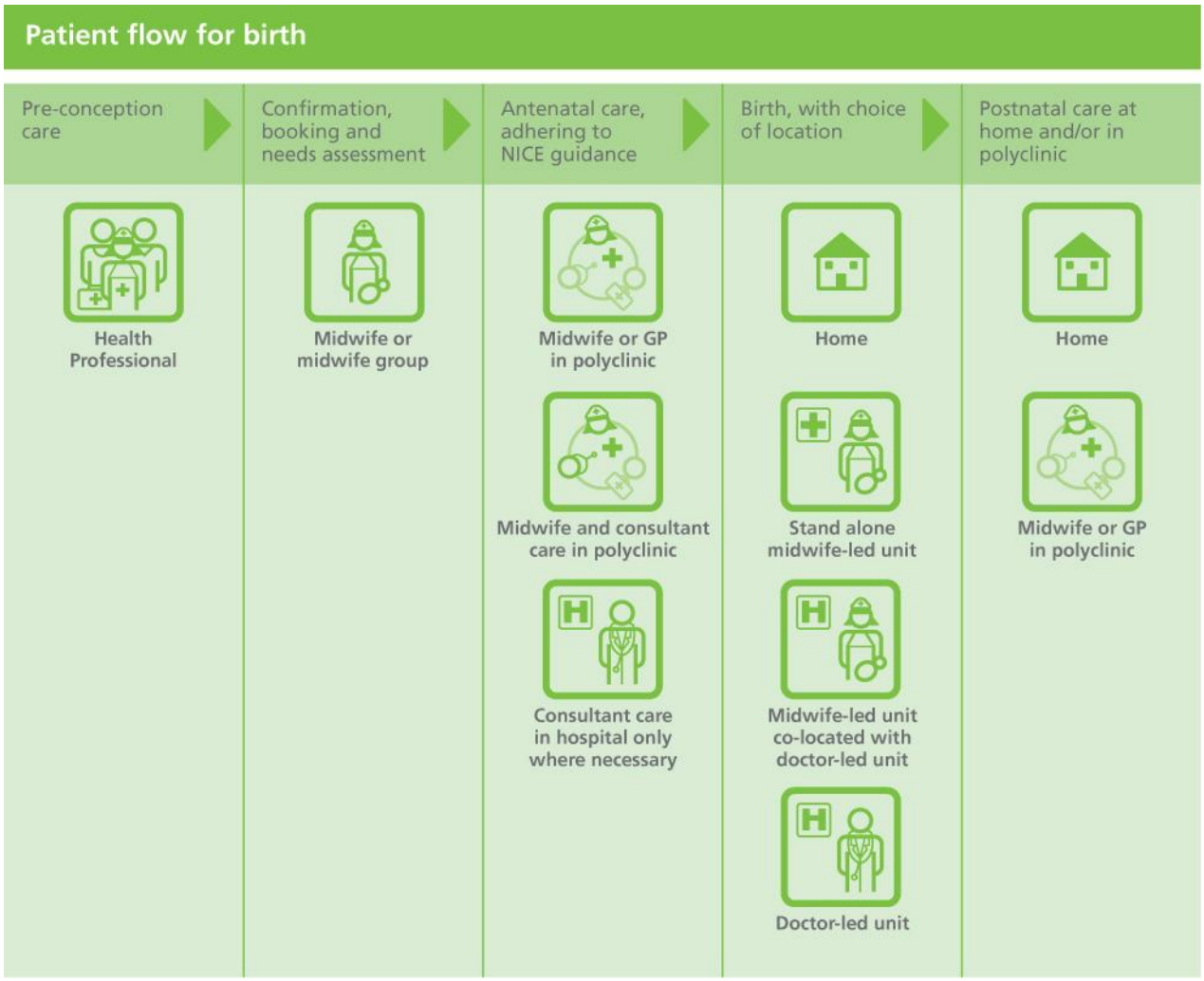
In 2006/07 there were over 120,000 births in London and that figure is expected to rise to between 124,000 and 145,000 by 2015/16.
At the moment 97 per cent of births in London take place in obstetric (doctor-led) units or the midwifery units found in about a third of hospitals. Around two per cent of births take place at home and 0.5 per cent in London's two stand-alone midwifery units.

A recent national study showed that 56 per cent of women were left alone for periods during their labour whilst women consistently say one-to-one care is the most important thing for them.

What are we recommending?

Expectant mothers should be offered:

- an early assessment by a midwife to ensure their care is right for them, and further assessments during the course of the pregnancy
- care before birth provided at local one-stop centres
- choice of where they give birth – for instance at home, in a midwifery unit or in a doctor-led unit
- care with the same team from conception until after the birth
- one-to-one midwifery care during established labour
- care following birth in local, one-stop centres as well as at home.



Services and information needs to be provided to enable mothers to give birth at home if they wish.

High quality doctor-led care requires senior doctors to be on the labour ward, not just to manage issues when they are there, but to train others and to put in place good systems for when they are not available. Evidence suggests that senior doctors are less likely than junior doctors to recommend caesarean births and their presence results in less distress for unborn babies. This distress can result in the disability or even death of a baby.

At the moment a senior doctor should be present on the ward for 40 hours per week. However, the Royal College of Obstetricians and Gynaecologists suggest units delivering over 4, 000 babies a year should have a senior doctor present for 98 hours a week. We think this level of

senior doctor presence would mean mothers could be assured of an excellent service.

Staff who are experienced in dealing with difficult births are able to provide the best quality care for women who do have complications. To ensure units have experienced staff and are affordable, we think we will need slightly fewer maternity units in London than we do now. We cannot be firm about how many fewer at this stage because this will require detailed examination of specific services.

To balance this change there should be more midwife-led units and more support for home births. All doctor-led units should have a partner midwifery unit at the hospital or in the community.

Care following birth should be provided at home and in local one-stop settings such as drop-in clinics, which can provide a range of support to parents. Mental health care for those women who suffer from postnatal depression, and social workers should also offer support.

All professionals involved in birth should be competent in basic newborn (neonatal) life support skills.

Prolonged care for seriously ill babies will require a neonatal intensive care unit (NICU).

Questions for you…

Question 4

We are trying to balance a number of different factors when planning proposals on maternity care in London, please can you rank in order (with 1 being the most important) the following factors:

- Choice of a home birth
- Choice of birth in a midwife-led unit attached to a doctor-led unit
- Choice of birth in a midwife-led unit in the community
- Choice of birth in a doctor-led unit
- Time taken to place of birth
- Time a senior doctor is on the labour ward

Please explain your reasons

Question 5

To be able to give high quality care, we need to balance the time that midwives can spend with mothers after the birth of their baby, with the time taken to travel to women's homes. Which of these options would you prefer?

a) as now, midwives seeing women at home after the birth of their baby

b) most women travelling to a GP or health centre for care following the birth of their baby, and midwives having more time to spend with them. (There would be home visits available to women when necessary)

Question 6

Please tell us any other comments you might have about the proposals in this section.

Albany Midwifery Group

The group operates in Peckham and is made up of six midwives. 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. Care before birth and some care after birth is provided in the local leisure centre. The group take all women, not just those who are low risk, and achieves high rates of breastfeeding. The midwives work nine months of the year and cover each other's holiday, sick and training leave. They achieve a workload of 36 deliveries per midwife per year (the best in London). The group is supported by an obstetrician and neonatologist at King's College London.

5.3 Children and young people

Children's services were discussed by all the *Framework for Action* working groups. However, during recent talks with interested groups it has become clear that it would be better to consider children's services separately. So, we have put all the information in the original report into this new section and have set up a new working group to re-examine the health issues specific to children. To find out more about this work visit www.healthcareforlondon.nhs.uk

A snapshot

A recent UNICEF report, ranked the UK 18th out of 21 countries for the well-being of children – below Hungary, Portugal, Poland, and the Czech Republic. England has high levels of infant deaths and poor survival rates for cancer.

England has some of the worst rates in Europe for incidence of childhood obesity and London has higher rates than the rest of the country. England also has high levels of type one diabetes. We need to help children, and their parents, understand how to live a healthy life.

Immunisation has in the past virtually eliminated major diseases such as polio. However, in the final quarter of 2006 only 73 per cent of London's two-year-olds had received an MMR (measles, mumps and rubella) vaccination, compared with an England average of 85 per cent. In some parts of London the average is only 49 per cent. Yet these diseases can cause serious disability and kill those affected. Last year the number of cases of measles was the highest number ever recorded and this year looks set to follow that trend. This year a third of all cases of measles in the UK have been in London.

Often, children attending A&E for a minor illness may be getting treatment from a junior doctor rather than the ideal - an experienced GP. However, parents take their children to A&E because they see it as providing a solution to all healthcare problems. And, of course, it is always open.

Evidence shows that more children survive and they recover more quickly and better in hospitals where specialist care is provided to large numbers of children. Compared with smaller units, 28 per cent fewer

babies die in children's heart surgery units that perform over 100 operations a year. And 33 per cent fewer babies die if they are operated on by surgeons who do more than 75 operations a year.

A US study found that the rate of wrongly diagnosing appendicitis in hospitals with the most child patients was half that in the hospitals with the least.

What are we recommending for the future?

Childhood immunisation is one of the safest, most cost-effective evidence-based health interventions, yet many parents do not immunise their children. Immunisation needs to be seen as a high priority amongst all staff concerned with the care of children. For instance, healthcare workers should ask parents whether their children have been immunised and staff should be trained in giving accurate information on vaccines. There should be London-wide co-ordination of effort and each organisation involved in immunisation should name a person in charge.

We are recommending localising more services where possible, for instance at home or in community facilities, and centralising services when necessary.

The majority of urgent care for children should continue to be provided by GPs. But when specialist care, or care needing an overnight stay is needed, the child and the parents should be transferred or directed to a hospital with specialist child care. The Royal College of Paediatricians and Child Health have said: "the current children's healthcare workforce cannot safely sustain the number of existing inpatient and acute children's services". We are recommending specialist urgent care for children is concentrated on fewer sites. We cannot be firm about the number of sites at this stage as this will involve detailed examination of specific sites and services.

Hospitals without inpatient facilities for children should have clinicians with advanced skills as well as a children's assessment unit which can review children in A&E and provide day-time care.

Unfortunately, some children are born with, or develop, a life-limiting or life-threatening illness. For these children we propose arranging new providers to coordinate meeting the health needs of each child and ensuring that there is partnership working with providers of social, education and other services. Because of the complexity of co-ordinating

these services and the relatively small numbers of children involved we propose that there should be pan-London commissioning of care.

Questions for you…

Question 7

What, if anything, could we do to encourage more parents to immunise their children?

Question 8

The majority of care for children, including urgent care, will be provided locally. We are proposing that specialist care for children will be concentrated in hospitals with specialist child care. This may mean that they are further away from your home. Do you agree or disagree with this proposal?

Strongly agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree

Please explain your reasons

Question 9

Please tell us any other comments you might have about the proposals in this section.

5.4 Mental health

"England's mental health services are amongst the best in the world. But services in London are under severe pressure due to higher levels of mental illness than the rest of the country. As with many other healthcare problems, the levels of mental illness are highest in the more deprived parts of London, a situation that needs to be urgently addressed."
Stephen Firn, Chief Executive, Oxleas NHS Foundation Trust, Working Group Co-Chair.

Mr Firn joined the NHS 26 years ago as a Health Care Assistant. He trained as a Mental Health Nurse and worked with adults and elderly people. He has since worked as a lecturer and researcher and held advisory roles at the Royal College of Nursing and the Department of Health.) - picture in tint box

Following discussions with interested groups over the past few months it is clear that there are advantages in establishing a new mental health working group with greater clinical representation to take forward the work of the original group which supported Lord Darzi, and to report back to PCTs. To find out more about this work visit www.healthcareforlondon.nhs.uk

A snapshot

Eighteen per cent of Londoners suffer from a common mental health problem. Mental illness is estimated to cost the capital £5 billion a year, when the cost of services, lost earnings and benefits are taken into account.

Twenty three per cent of inpatients (people needing an overnight stay) have the most serious mental illness compared with 14 per cent nationally. Higher rates of the most serious mental illness create a more volatile, disturbed environment on mental health wards. But the need to focus resources on the most severely ill can mean people with moderate illness are less likely to be able to access services than those in other parts of the country.

Twenty five years ago care was provided in very large mental hospitals offering only limited outpatient services. Now it is accepted that mental health care is best delivered to people in their own homes, with medical and other staff working in multidisciplinary teams in the local community. This has resulted in big reductions in admissions to hospitals and

currently 90 per cent of people with mental health problems receive their care in a community setting.

However, too often care is focused on anti-depressant drugs. Ninety three per cent of GPs have said they have prescribed anti-depressants because they don't believe there are good alternatives.

London's diverse population has vastly differing needs, attitudes to accessing care and patterns of service use. And high rates of offending, substance misuse and homelessness all present particular challenges.

For instance:

- diagnosis of serious mental illness in people from African-Caribbean communities is five times greater than among white British people. People from these communities are also less likely to seek help than others
- up to 90 per cent of prisoners are estimated to be suffering from at least one mental health disorder.

What are we recommending for the future?

The following proposals aim to develop existing mental health services:

- Young people between 14 and 25 with emerging mental health problems need to be able to get help quickly. We know this improves care, reduces time in hospital and leads to fewer admissions to hospital involving the police.

- Further efforts should be made to reduce the fear of services, with special measures taken in communities where it is culturally less acceptable to seek help.

- Clearer pathways should be developed so that patients, carers, GPs and those who come into contact with people with mental health problems, such as police officers, know how to contact services and what they can expect from them.

- Cognitive behaviour therapy and other `talking therapies' could be used extensively, but waits for these services in many parts of London are long. More graduate mental health workers could be employed to deliver talking therapies. Other therapies should also be explored, including exercise, reading and walking.

A London Assembly survey found that only 50 per cent of mental health service users felt they had a choice over the service or treatment they received. People could be given more control over their lives by:

- Greater use of direct payments to patients so that service users have more choice and control over their lives.

- Better access to opportunities such as housing and employment. Around 40 per cent of benefit claimants are on incapacity benefit because of mental health problems, but the vast majority of these people want to work.

- Mental health services working in partnership with local organisations including physical health providers, social care, housing and employment agencies, local businesses and faith communities to help people lead full lives as part of their local community.

Mental health services must meet the needs of minority groups. In some cases assertive outreach (a system where community professionals go out to the homes of patients who are reluctant to come in to be seen) should be used. Health services, local authorities, community development workers and, in particular, the black voluntary sector need to work together to break down barriers between mental health services and minority ethnic communities.

Mental health services also need to work with London's prisons, to develop a pan-London strategy for delivering more effective mental health services to offenders.

In recent years a range of specialist mental health teams have developed. But more generalist community mental health teams (CMHTs) need a clearer focus, perhaps on providing assessment, co-ordinating support, recovery or therapies.

Whilst community services are improved, London needs to develop a vision for specialist inpatient mental health care, involving:

- discussion of whether, as admissions decrease, inpatient beds are needed in every borough

- improving the quality of inpatient care, from the environment where treatments are given, to the quality and range of treatments

- encouraging centres of specialisation amongst London's ten mental health trusts.

A question for you…

Question 10

More detailed work is being carried out on mental health issues and this will be published in summer 2008. In the meantime, we welcome your views on the recommendations shown in this section.

5.5 Acute care

"Each year millions of Londoners have short-term illnesses or health problems that are not life-threatening, such as a chest or bladder infection, but for which they need quick and convenient treatment. A much smaller number suffer from serious illness, such as a stroke or heart attack, or have a major injury. These patients need highly skilled specialist care to give them the best chance of recovery. The NHS in London is providing neither accessible, high-quality urgent care for the bulk of the population, nor the best quality specialist care for the small number of people who need it."
Dr Chris Streather, Renal Physician, Director of Strategy and Medical Director at St George's and member of the Adult Care Working Group, Healthcare for London.

Dr Streather was a National Kidney Research Fund Training Fellow at King's College and has a particular interest in cardiovascular risk in renal disease. (picture in tint box)

A snapshot

Most people with an urgent care need will ring their GP practice for an appointment. But people can also call a number of other organisations – for instance the London Ambulance Service, NHS Direct, emergency dental services or their local GP's out-of-hours provider. People are often unclear as to which number to ring.

- Almost three million people attended A&E services in 2005/06.
- Many of these people attend A&E with a minor injury or illness.
- 40 per cent of those taken to hospital by ambulance could be treated and cared for in the community.

Often, someone attending A&E for a minor illness may be getting treatment from a junior doctor rather than the ideal - an experienced GP. However, people go to A&E because they see it as providing a solution to all healthcare problems. And, of course, it is open all day, every day.

At the other end of the scale, the services for more complex, specialist care are simply not good enough. Hospitals do not have the specialist staff, equipment, or number of patients needed to ensure care of the highest quality can be provided 24 hours a day, seven days a week.

Stroke care – speed is of the essence

In 2005/06 over 6,000 Londoners suffered a stroke (a 'brain attack' similar to a heart attack).

Best care for a stroke patient means:

- rapid assessment by ambulance staff
- access to a CT scan (a sophisticated x-ray) to determine the cause of the stroke
- early treatment using clot-busting drugs if the scan shows it is appropriate. The scan is essential as the drugs could worsen some patients' condition

Patients who receive this treatment within 90 minutes of the attack are twice as likely to survive or have less disability than those that don't.

Not every hospital can provide the specialist multidisciplinary teams and the equipment to deliver this level and speed of care all the time. At the moment many people are not even having the initial scan within 24 hours. In 2006 no trust in London gave at least 90 per cent of stroke patients a scan within the less-than-ideal benchmark of 24 hours.

We recommend that approximately seven hospitals should be centres of excellence providing 24/7 care supported by full neuroscience expertise. Other hospitals could provide treatment during the day and rehabilitation services close to people's homes. To decide on the best location of these specialist units we think a London-wide stroke strategy is needed.

What are we recommending for the future?

When people need – or think they need – urgent care they should expect consistent and thorough assessment 24 hours a day, seven days a week.

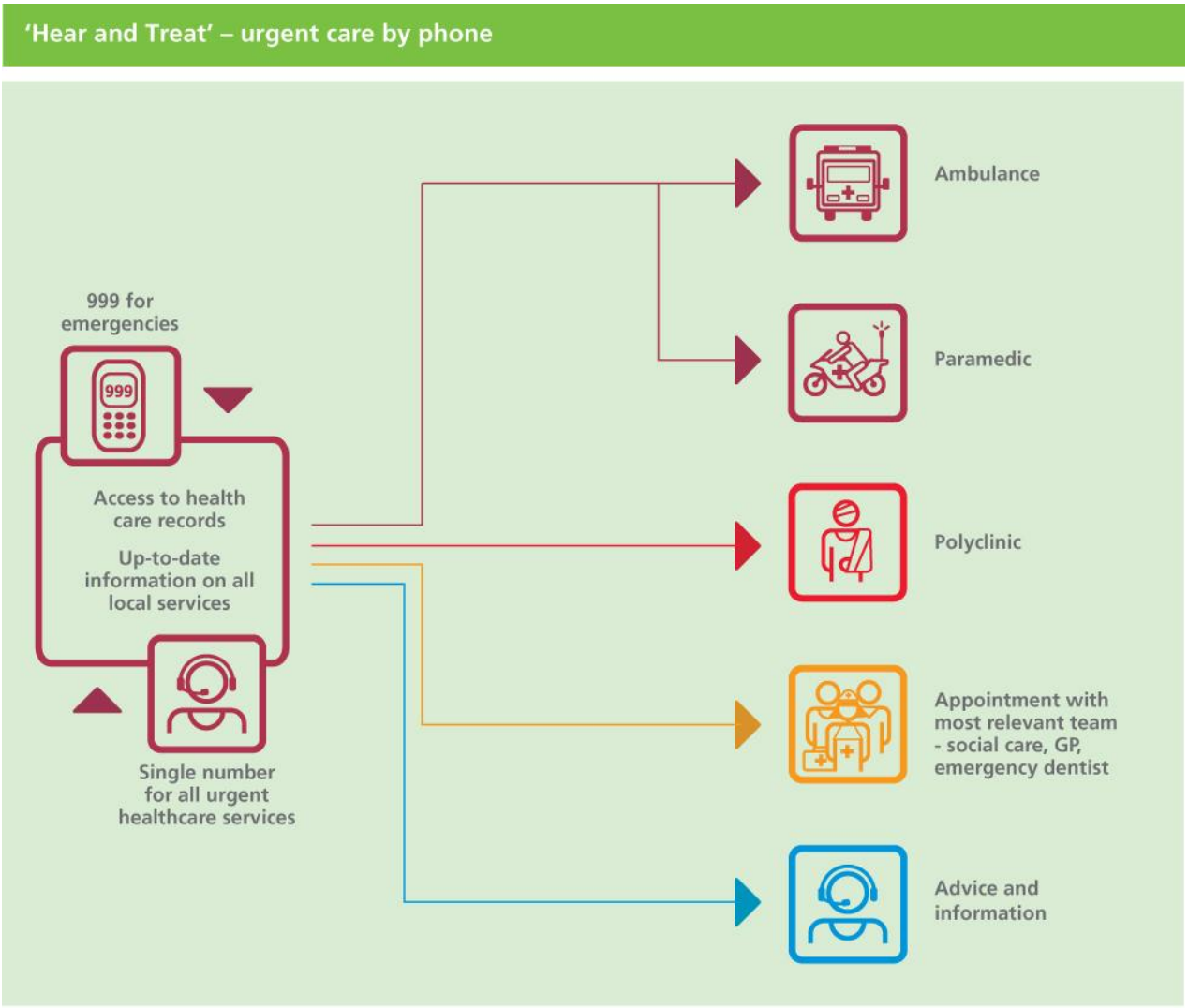
Telephone advice

To reduce the confusion of different numbers to call for urgent care advice on the telephone we think there should be two points of contact.

The existing 999 number for emergencies and a new service which could, for instance:

- provide advice. Call-handlers would have access to real-time information and advice, tailored to the address of the caller
- book an appointment with the caller's GP or other healthcare professional such as a nurse or a mental health worker
- transfer callers to a polyclinic, so they could speak to a healthcare professional
- give directions to a polyclinic close to their home or workplace, a nearby pharmacy, or a hospital
- transfer callers to emergency services.

Call-handlers would be able to respond quickly to callers' needs rather than the caller having to find their way through the system. This is shown below.



Face-to-face care

GPs will continue to provide most face-to-face urgent care for patients through the well respected appointments system. Those people whose need is more pressing should have the choice of:

- attending a hub or same-site polyclinic in the community. Polyclinics would be open for extended hours and could house GPs, nurses, emergency care practitioners, mental health crisis resolution teams and social care workers. Staff would be able to help patients with substance or alcohol problems and have access to testing equipment including x-ray, ultrasound, heart checks and blood tests

- attending a polyclinic attached to an A&E. These would have similar facilities to a community-based centre and be open all day, every day

- admission to the nearest local hospital A&E or major acute hospital's A&E – these would be open all day, every day. Most ambulance admissions will be to the nearest hospital as we recognise that for many conditions such as severe asthma attacks, heart failure and choking, speed of treatment is the most important issue

- admission to the nearest hospital with specialist facilities.

Ambulance staff could take 999 patients to any of these places, depending on what is right for their needs.

Currently, when ambulance staff arrive at a patient suffering a suspected heart attack, they use a 12-lead electro-cardiogram to see if this is the problem. If it is, they can take the patient directly to one of nine specialist centres in London. This means the patient can benefit from a technique known as angioplasty, where a balloon is inserted and inflated into the blocked artery. It is too early to provide figures on the impact on survival rates in London, but research from America has shown that 92% of patients receiving angioplasty are alive after a year compared with 84% of patients receiving the previous gold standard treatment.

This same model should be replicated for patients with:

- major trauma (severe injury)

- stroke (see case study)
- complex emergency surgery needs.

At present there is one severe injury centre in London, at the Royal London Hospital in Whitechapel. In 2006 it recorded 28 per cent fewer deaths in the most severely injured patients compared to the national average.

We believe there should be a few more severe injury centres to complement the one at the Royal London. This is based on the recommendations of the Royal College of Surgeons that these centres should serve between one and three million people. These severe injury centres would not replace A&E departments at other hospitals, which would still provide the majority of emergency care.

The evidence for stroke and complex emergency surgery is just as convincing.

With arrangements in place to take patients needing complex emergency surgery, or who have suffered a severe injury or stroke, straight to specialist centres instead of the nearest hospital, many more lives could be saved and many more patients could avoid disability. For these conditions it is better to get to the right hospital with the right team of specialists than go to the nearest hospital. Rehabilitation would take place either at home or in the patient's local hospital.

Questions for you…

Question 11

To treat your urgent care needs by telephone, what facilities would you like a telephone service to have? (Please choose all that apply)

A. Provide medical advice

B. Book an appointment with GP

C. Book an appointment with another healthcare professional

D. Transfer callers to emergency services

E. Transfer callers to a healthcare professional

F. Give directions to a polyclinic, pharmacy or hospital

G. Other (please specify)

H. I would not use a telephone service for the treatment of urgent care needs

Question 12

We propose developing some hospitals to provide more specialised care to treat urgent care needs of the following conditions. These might be further from your home than your local hospital:

- Trauma (severe injury) - approximately 3 hospitals in total
- Stroke - approximately 7 hospitals
- Complex emergency surgery needs – (more work needs to be done to look at how many hospitals might provide this work)

Do you agree or disagree with the proposals to create more specialised centres for the treatment of…?

a) Trauma (severe injury)

Strongly agree / Tend to agree / Neither agree nor disagree / Tend to disagree / Strongly disagree

b) Stroke

Strongly agree / Tend to agree / Neither agree nor disagree / Tend to disagree / Strongly disagree

c) Complex emergency surgery needs

Strongly agree / Tend to agree / Neither agree nor disagree / Tend to disagree / Strongly disagree

Please explain your reasons

Question 13

If you agree that there should be specialist centres for the treatment of trauma, stroke and complex surgery, do you agree or disagree that ambulance staff should be given the power to take seriously ill and injured patients directly to these specialist centres, even if there is another hospital nearby?

Strongly agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree

Please explain your reasons

Question 14

Please tell us any other comments you might have on the proposals in this section.

5.6 Planned care

"Each year in London there are over eight million appointments that don't need patients to stay overnight. GPs and nurses could carry out a lot of these appointments closer to people's homes. When specialist outpatient care is needed this should happen as locally as possible, with hospital consultants and other clinicians coming to local clinics, avoiding the need for patients to travel to specialist hospitals."
Dr Martyn Wake, GP and Joint Medical Director, Sutton and Merton Primary Care Trust. Working Group Chair, Healthcare for London.

Dr Wake has worked in South West London for 25 years. He is involved in developing extended primary care particularly in the management of diabetes, cardiovascular and respiratory disease. His practice was one of the first to adopt "lean" methodology to ensure that patient appointments were available on the day of booking and that all patients are seen within 24 hours of requesting an appointment. (picture)

A snapshot

Access to diagnostic tests in hospitals, in particular Magnetic Resonance Imaging (MRI), ultrasound and Computerised Tomography (CT) scans, is slow compared to other parts of the country. The bottleneck is putting lives at risk. Over 70 per cent of tests are performed on outpatients who have to travel to hospital just for a test.

In 2005/06, 800,000 Londoners had planned surgery or medical treatment needing an overnight stay. These people deserve the best possible care, but the way existing services are provided and organised is not meeting their needs.

When specialist care is needed it is not good enough. Cancer care is a good example. The National Institute for Health and Clinical Excellence (NICE) sets standards for high quality cancer care. Level one standard is essential to the delivery of a satisfactory service, but none of the five London cancer networks achieve this level.

What are we recommending for the future?

We think people should be able to access their GPs for routine appointments on Saturdays and at either end of the 9am – 5pm working day.

GPs should have access to test facilities in the community to reduce waiting times and save patients unnecessary trips to hospitals. Hospitals should keep their test facilities, providing services for the hospital and local patients.

More surgery should be carried out as day cases, allowing patients to go home the same day. Patients prefer it, it is more cost-effective and it reduces the risk of catching an infection. In 2005, London was the worst performing region in England, performing far fewer operations as day cases than expected.

After an operation patients need help to recover return to good health. This is called rehabilitation and it should take place as close to the patient's home as possible – it is effective and it is also what patients want. In some cases rehabilitation will be in a patient's local hospital, and in many cases in their home. However 37 per cent of pensioners in London live alone so we will need to work closely with social care agencies to help people return to a full and independent life.

Evidence shows that hospitals providing lots of complex care have the best outcomes for patients. Even if money was no object and it was possible to equip and staff specialist centres in every hospital it would be better to transport patients to teams that regularly perform the procedure.

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 all patients, to a high enough standard, are over.

We recognise that there will be times when specialist care means more travel for a patient. We will need to work hard to ensure patients only come to the hospital when necessary. For instance tests could be done close to a patient's home and reviewed by a specialist at the hospital who could give an opinion remotely – without the patient having to visit. Or the specialist hospital might provide care at other hospitals.

Questions for you…

Question 15

How useful, if at all, would you find it for GP surgeries to be open for routine appointments in the evenings and at weekends?

Very useful

Fairly useful
Not very useful
Not at all useful

Question 16

Please tell us any other comments you might have on the proposals in this section.

Telemedicine

Every two minutes, someone in the UK has a heart attack and early death from heart disease is higher in London than England as a whole.

New techniques and technology can be used to detect changes in the heart rhythm or other problems of patients, before they start feeling unwell.

Patients can either monitor themselves at home or go to a local GP surgery. Data can then be sent electronically to a specialist team, constantly available and trained in reading the results. The team look at the data and advise the patient, nurse or GP on the best course of action.

The results are impressive. Patients using this type of telemedicine, who used to regularly attend hospital because they felt chest sensations or were worried, now rarely have to do so because they feel confident in the tests.

Of course this peace of mind and avoidance of unnecessary trips to a hospital also saves money.

5.7 Long-term conditions

“Patients with long-term conditions are the biggest users of healthcare. Good management of diabetes, arthritis, heart failure, asthma, obesity, lung disease and some cancers can mean patients lead a full and active life in the community without the need for hospitalisation and emergency care. People with long-term conditions should be in control of their care, making informed decisions about the care they can access.”
Dr Tom Coffey, GP and Professional Executive Committee Chair, Wandsworth Primary Care Trust. Working Group Chair

Dr Coffey has been a GP partner in south-west London for ten years. He is chair of the Tooting Healthy Living Centre and medical advisor to Tooting Walk-in Centre, Clinical Assistant in A&E at Charing Cross Hospital and a Tutor at St George’s Medical School. (picture in tint box)

A snapshot

The number of people with long-term conditions is likely to grow. There are clear links between lifestyle and the incidence of some long-term conditions. For instance smoking increases the likelihood of cancer, and obesity increases the chances of suffering from type II diabetes.

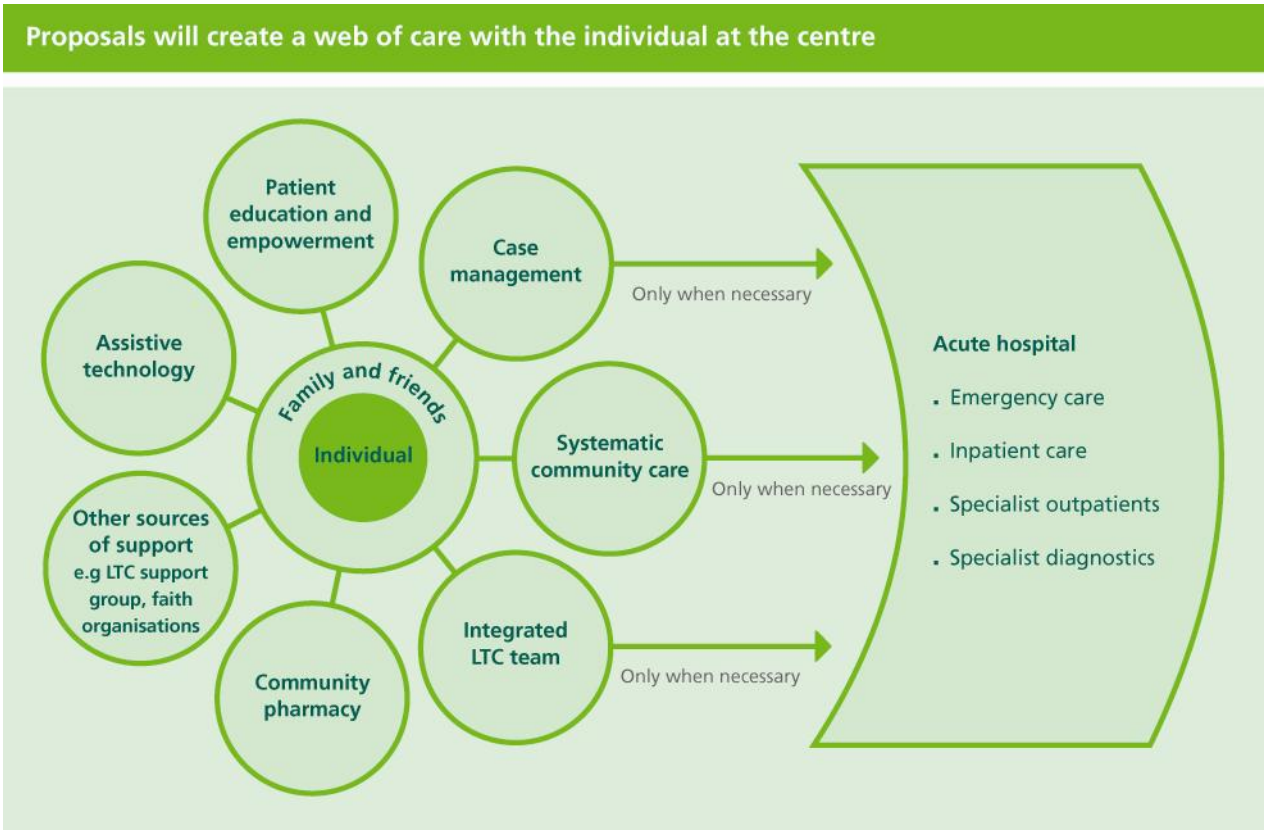
Many people with long-term conditions have yet to be diagnosed. It is estimated that up to a third of people with diabetes may be undiagnosed, putting them at risk of blindness and amputation. Forty per cent of people with lung disease are undiagnosed and only a third of people with dementia are ever formally diagnosed, denying them access to drugs that could improve their lives.

What are we recommending for the future?

Every effort should be made to prevent long-term conditions by promoting healthy living.

GPs, practice nurses and social care staff should be supported to develop effective ways of diagnosis and of finding undiagnosed people who do not present themselves to the healthcare system. Encouraging hospital consultants to work in the community will encourage healthcare teams to take advantage of their specialist skills.

People with long-term conditions should be able to access the full range of support for their condition so that they can manage it more effectively, with professional help.



Individual patients should be making informed decisions about the support they need. There are many good examples of this type of work, for instance:

- the expert patient programme which is a course giving people the confidence, skills and knowledge to manage their condition better and be more in control of their lives
- information prescriptions, which signpost people to further information and advice.

London-wide guidelines and standards should be developed so that patients know if their care is up to the standard they should expect and much greater use is needed of regular appointments with community healthcare professionals and specialist nurses working in the community.

All these recommendations will keep people healthier, reduce the need for hospital care and unnecessary emergency admissions. However it will require considerable investment to support patients in this way, rather than the hospital-based care we are all used to.

Community pharmacies can support people with long-term conditions too, by helping them with their medicine. Problems with taking medicine are estimated to cause as many as 15 per cent of hospital admissions.

Questions for you…

Question 17

Thinking about how the NHS in London is balancing the resources it spends on long-term conditions, (e.g. asthma, diabetes), do you think:

a) a greater proportion of future spend should go to supporting people with long-term conditions by investing more in GPs, specialist nurses and other health professionals

b) the current balance of investment between hospitals and community support for people with long-term conditions is about right

c) a greater proportion of spend should go to supporting people with long-term conditions through investing in hospital care

Please explain your reasons.

Question 18

Please tell us any other comments you might have on the proposals in this section.

Partnerships putting patients first

Many patients, after they have been diagnosed with a terminal illness, have the chance to talk with their GP or their nurse about where they want to die. Most people decide that they would prefer to be at home when the end comes. But sometimes it is very hard for a family to just let that happen, and often they will call an ambulance.

In the past the ambulance crew arrived and, with no knowledge that the patient has decided they would like to die at home, they followed their training and did all they could to save the patient's life, and then took them into hospital. Although they were doing their best, the person often died in hospital, against their previously expressed wishes and without their family around them.

The ambulance service is trying to address this. When someone knows they are dying, they can agree that their GP sends a letter to the ambulance service asking for their details to be registered. It means that if an ambulance is called to them, the staff will know that they are going to a patient who has expressed their wishes about where they want to die. If death can't be avoided, the ambulance crew can provide pain relief and support to the patient and their family, and ensure that the patient's wishes are respected.

The same principle could apply to patients who are not dying, but living with long term conditions. For instance, Chronic Obstructive Pulmonary Disease (COPD) is a long-term condition of the lungs which means patients often suffer from breathlessness and low oxygen levels in their blood. Ambulance crews will often take patients to A&E unnecessarily because they don't know the patient has COPD and would be expected to have lower than 'normal' oxygen levels.

If ambulance staff know that the patient they are going to has COPD then they can provide enough oxygen to bring the patient up to normal and then contact the right person (the district nurse, community matron or GP for example) sure in the knowledge that they will get a follow-up call.

5.8 End-of-life care

"People at the end of life often need support and care from a number of different services, but there is no consistent approach to organising this complex care. Too often services react slowly to patient's needs that could easily have been predicted. Better planning is needed to ensure help arrives at the right time to provide comfort and services that the patient has chosen."
Cyril Chantler, Chair of Great Ormond Street Hospital for Children and the King's Fund. End-of-Life Working Group Chair, Healthcare for London.

Sir Cyril has been Dean of the Guy's, King's College and St Thomas' Hospitals' Medical and Dental School, where he was the Children Nationwide Medical Research Fund Professor of Paediatric Nephrology until his retirement in 2000. He has also held posts as Principal of the United Medical and Dental School of Guy's and St Thomas's Hospitals, President of the British Association of Medical Managers and was also a Member of the General Medical Council , where he was Chairman of the Standards Committee.

A snapshot

Almost 53,000 people died in London in 2005. Care for people in their last weeks and months often involves intensive support by the NHS.

In an ICM poll, 77 per cent of people who had experienced the death of a loved one in the last five years were fairly or very happy with the care given. However 54 per cent of all complaints about hospitals received by the Healthcare Commission are about end-of-life care.

And whilst across the country 57 per cent of people express a preference to die at home, in London just 20 per cent do so.

Best practice techniques in end-of-life care that are used by over 90 per cent of GP practices in some parts of the country are used by fewer than 25 per cent of GP practices in London, nor are they being used by all hospitals.

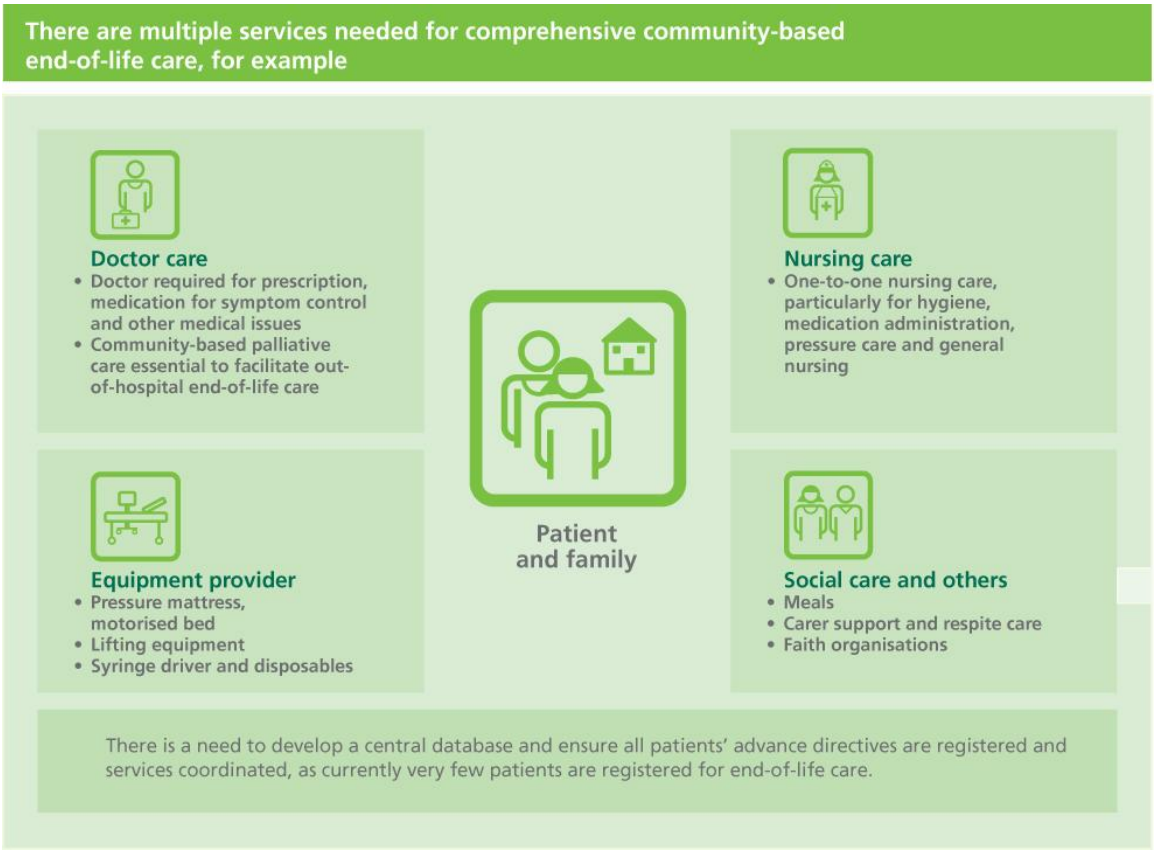
What are we recommending for the future?

We believe that all organisations involved in end-of-life care need to meet existing best practice guidelines.

There should be new end-of-life service providers (ELSPs) coordinating care for patients. Patients with an advanced progressive illness who are identified as nearing the end of their life should be offered the opportunity

to have their needs assessed and to identify their preferred place of death. The end-of-life service provider would then be responsible for arranging a package of care.

Voluntary, charitable, public and private sector organisations could all be ELSPs, contracted to provide care for a group of PCTs. ELSPs will need to cover quite a large area so that they can become expert in buying services and take advantage of economies of scale.



Questions for you…

Question 19

Do you think that new end-of-life service providers responsible for co-ordinating end-of-life care will result in better or worse care for patients than the current arrangement?

Much better / A little bit better / No change / A little bit worse / Much worse

Please explain your reasons.

Question 20

Please tell us any other comments you might have on the proposals in this section.

6 Where we could provide care

This consultation document has concentrated on the way care is provided to patients and how that care can be improved. This section looks at the organisations and places that provide care and makes recommendations for a new approach. This would be based on evidence of best practice, clinical effectiveness and the needs and wishes of Londoners.

Please note that the analytical work that underpins this section can be found in the technical paper at www.healthcareforlondon.nhs.uk or by requesting the printed version from 0800 XXXXXXXXX

6.1 A snapshot

A national survey by the British Medical Association (BMA) found that 75 per cent of GP practices felt their premises were not suitable for future needs and over a third of practices cannot be adapted to meet all the disabled access requirements of the Disability Discrimination Act – we expect this reflects the picture in London. This limits the ability of the NHS to provide services such as physiotherapy and basic blood tests closer to people's homes.

Many hospitals, both acute and mental health units, operate on multiple sites, spread over a large and poorly designed set of buildings that are not used effectively.

The 32 hospital trusts in London cannot all try to provide every kind of specialised care, each treating only a small number of patients.

6.2 Our recommendations

There are two key needs. First to provide a new kind of community-based care at a level that falls between the current GP practice and traditional hospitals, and second to develop fewer, more advanced and more specialised hospitals.

This leads us to describe six places where the majority of future healthcare will take place:

- Home

- Polyclinic or GP practice linked to a polyclinic
- Local hospital
- Elective centre
- Major acute hospital
- Specialist hospital.

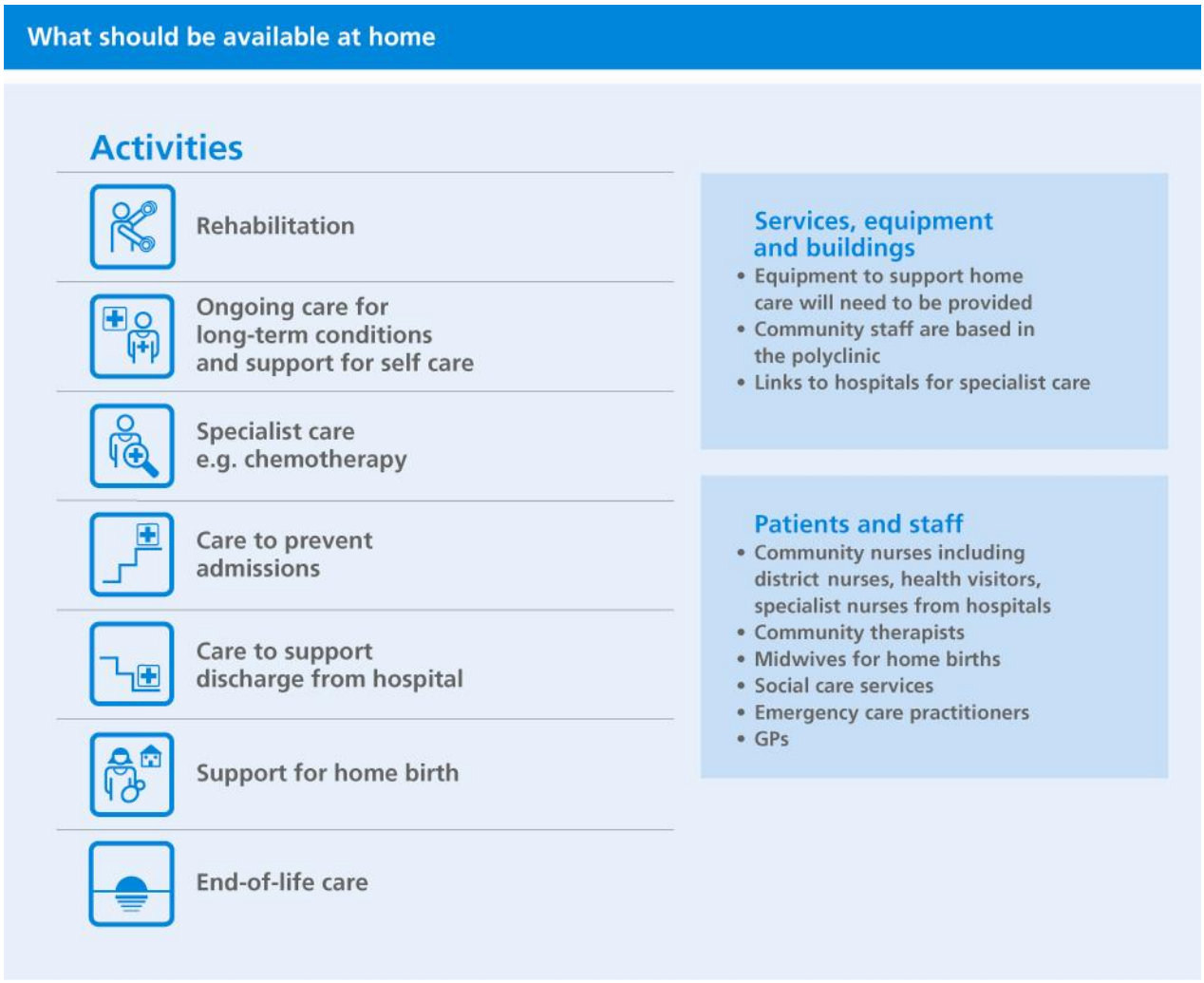
The following diagrams show the health activities that could be provided at each of those locations – they do not describe exactly what will be delivered in each location – these will depend on local needs and circumstances.

Some services may be on the same site, for instance there would always be a polyclinic on the same site as a local hospital, and an elective centre could share the same site as a local or major acute hospital.

The proposals set out where we could provide safe and expert services in the most convenient place for the patient.

Home

We believe more services should be provided in people's homes or in more local settings. We want to make better use of the high levels of skill and experience of GPs and other healthcare staff – for instance community matrons, therapists and ambulance staff – working in the community. Providing more care closer to people's homes will need larger community healthcare teams, more hospital specialists providing clinics in the community, more equipment (for instance to do tests) and buildings large enough to house the greater range of services.



Polyclinic

For more information on Polyclinics please see page xxx.

Polyclinics exist in other cities in the world and there are plenty of examples of large health centres and GP practices in London that are well on the way to becoming polyclinics. Polyclinics could help GPs offer more extended opening hours and services. Each Polyclinic would house or network about 25 GPs.

The networked model could be suitable in parts of London where the population is relatively spread out. The same-site model would be more suitable where the population is concentrated and existing GP practices are too small or there are not enough doctors.

Every hospital A&E would have a polyclinic as its `front entrance' so that patients who did not need to go to A&E or be admitted to a bed could receive care there.

We are recommending the development of 10 pilot polyclinics but in ten years there could be 150 across London.

Many patients are keen to retain a relationship with 'their' doctor and we are keen to ensure this happens – the family doctor relationship can be maintained in a polyclinic. But if an urgent appointment with a doctor is needed the proposed extended opening hours of polyclinics would make this easier. And if patients wanted to see a GP whilst their own doctor was unavailable, attend before-birth classes or use other health facilities, this would be possible too.

Services that would be under-used and uneconomic for one GP practice would be fully-used in bigger settings. For instance, staff could be available to meet the needs of people with learning disabilities, the mentally ill or those with language or cultural barriers.

We recognise that some people will be concerned about having to travel further to see their GP. Of course in a networked model there would be no additional distance for patients to travel. However high-level modelling suggests that, even if all GPs in an area wanted to relocate to the same building, the vast majority of Londoners would be within one or two kilometres of a polyclinic. And of course, because polyclinics would have far more services provided over extended hours, the need to attend a hospital would be reduced.

What a polyclinic should provide

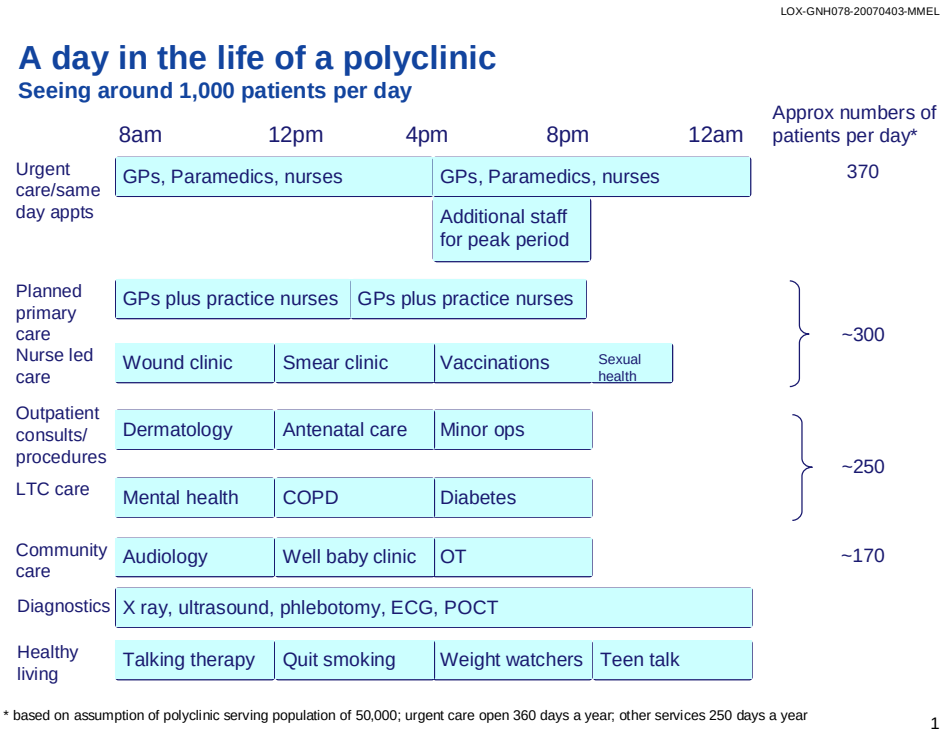
Activities	Hours open per day
General practice services	12
Community services	12
Most outpatient appointments (including antenatal/postnatal care)	12
Minor procedures	12
Urgent care	12-24
Tests	18-24
Interactive health information services including healthy living classes	18-24
Proactive management of long-term conditions	12
Pharmacy	18-24
Other health professionals, e.g. optician, dentist	12

Services, equipment and buildings

- Consulting rooms
- Procedure rooms
- Dedicated child-friendly facilities
- X-ray, ultrasound and other tests
- Base for other services such as district nurses, radiology
- Healthy living/information centre
- On-site translation services where necessary
- Co-located local authority services in some e.g. social services
- Co-located leisure facilities in some, e.g. swimming pool
- Co-located ambulance

Patients and staff

- Open 18-24/7
- Serve population of approximately 50,000
- Staff would typically include:
  - Approx 25 GP's (in a networked polyclinic some GP's would be based in the 'hub' and some in linked general practices)
  - Consultant specialists
  - Nurses
  - Dentists, opticians, therapists
  - Emergency care practitioners
  - Mental health workers
  - Midwives, health visitors
  - Social workers
  - Ambulance staff



Questions for you…

Question 21

Do you agree or disagree that all or almost all GP practices in London should be part of a polyclinic, either networked or same-site (see diagram)?

Strongly agree / Tend to agree / Neither agree nor disagree / Tend to disagree / Strongly disagree

Please explain your reasons

Question 22

The proposed polyclinics will have a number of features. Which are the three most important features for your local polyclinic to have…?

- GP services
- Social services
- Leisure services (for example a swimming pool)
- Outpatient appointments (including antenatal/postnatal care)
- Minor procedures
- Urgent care
- Tests – blood tests, scans, radiology
- Healthy living classes
- Proactive management of long-term conditions
- Pharmacy
- Optician
- Dentist

Local hospital

Local hospitals would include a 24/7 polyclinic as their ‘front door’. Most would also have a doctor-led maternity unit, outpatient services such as kidney dialysis and rehabilitation facilities for patients whose complex condition had required a visit to a major acute hospital. A 24/7 A&E department would treat people with urgent needs such as choking, diabetic complications, heart failure, asthma attacks and fractures – but not complex surgery.

What a local hospital should provide

Activities	Hours open per day
Bed-based community rehabilitation with full range of community services	12
A&E	24
Acute non-complex medicine	24
Emergency non-complex surgery	12
Urgent care	24
Outpatient services	12
High Dependency Unit for non-ventilated patients, facility for intubation and transfer of patients	24
Regular attendees, e.g. renal dialysis	12
Children’s assessment unit	18
Doctor-led unit with a Midwife-led Unit and level 1/2 Neonatal Intensive Care Unit *(in some local hospitals)*	24
Tests	24**

Services, equipment and buildings

- Consulting rooms for outpatient services
- Procedure rooms
- Theatres
- High Dependency Unit (but not Intensive Care Unit)
- Rehabilitation and intermediate care
- Acute admissions unit
- Overnight beds
- Pathology satellite laboratory*
- Test imaging
- Open 24/7

Patients and staff

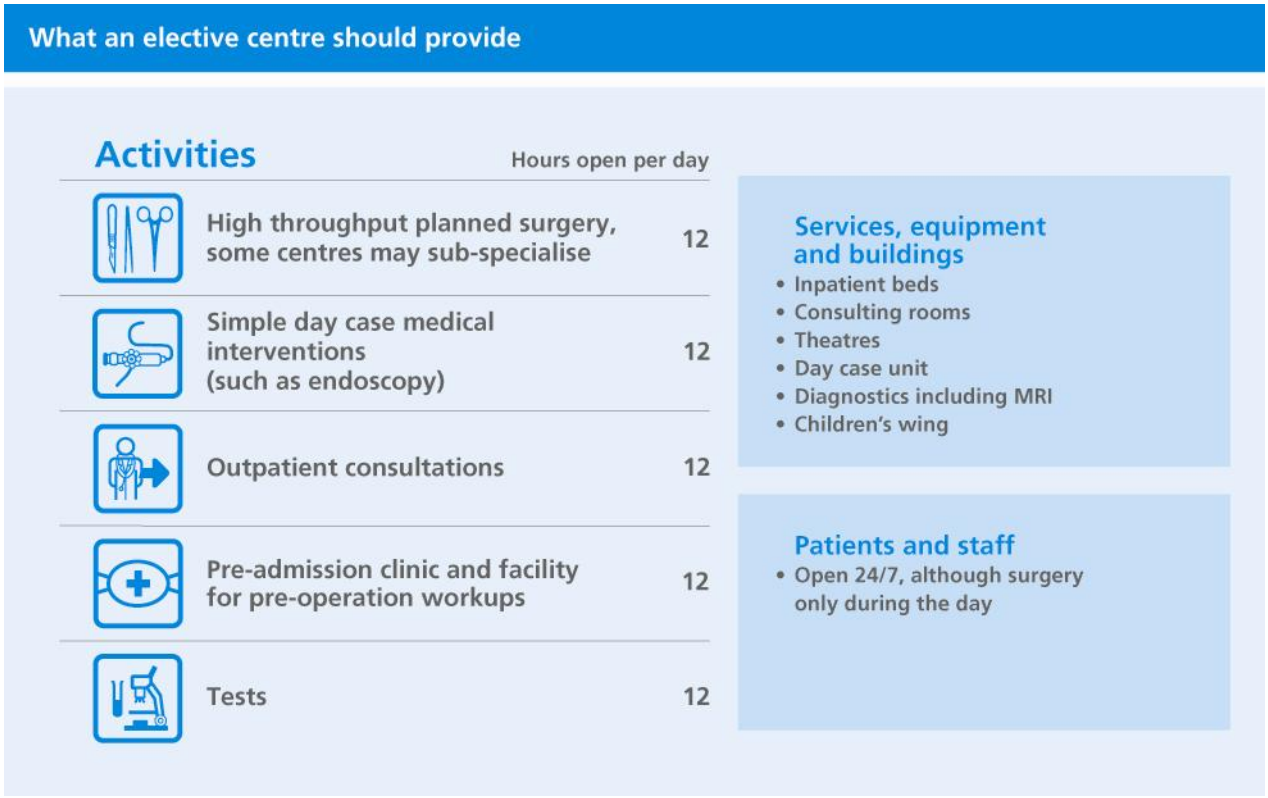
- Serve a population of around 200,000-250,000
- Have a similar staff composition to current district general hospitals

*Pathology satellite laboratories provide rapid test results needed by A&Es and other local hospital services.
**Core Services only

Elective centres

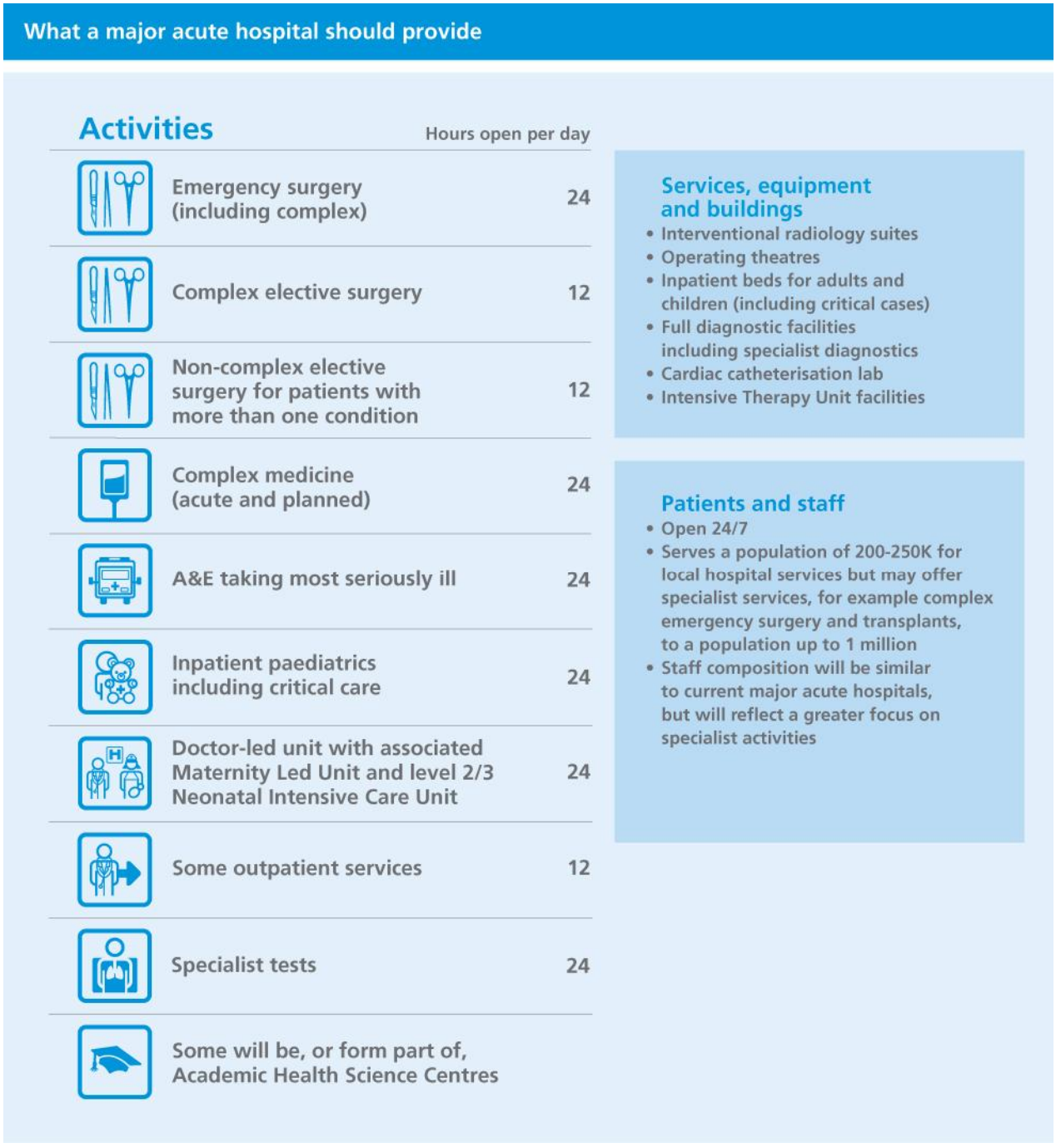
Elective centres would focus on particular types of high-throughput planned surgery such as knee and hip replacements and cataract operations. This work will be separated out from emergency surgery to achieve better results and productivity and reduce the risk of cancellations and cross-infection. Elective centres could be on a hospital site or separate.

Elective centres are already being used in London, for example the South West London Elective Orthopaedic Centre is an NHS treatment centre on the Epsom General Hospital site. It performs nearly 3,000 hip, knee and shoulder replacements a year.

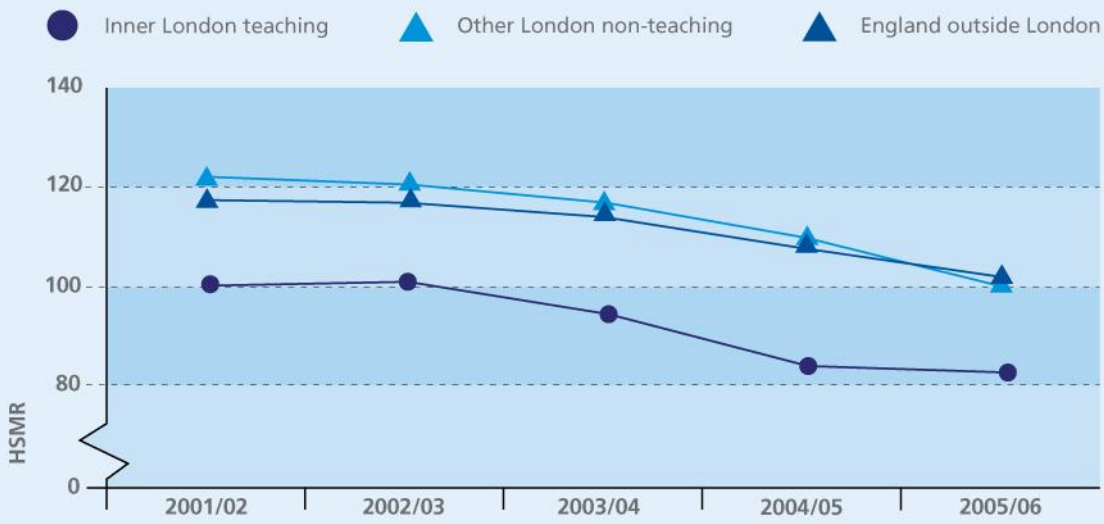


Major acute hospital

Major acute hospitals would provide all the services of a local hospital but also have teams in a range of specialties for the more complex work. They could treat sufficient numbers of patients to maintain their specialised skills, make best use of high technology equipment and deliver the best results for patients. In a serious emergency, the ambulance service would bring patients here rather than take them to their nearest hospital if it didn't have the most appropriate facilities.



HMSRs (hospital standardised mortality ratios): London hospitals vs non-London hospitals. More people are saved in larger teaching hospitals in London compared to other London and national hospitals

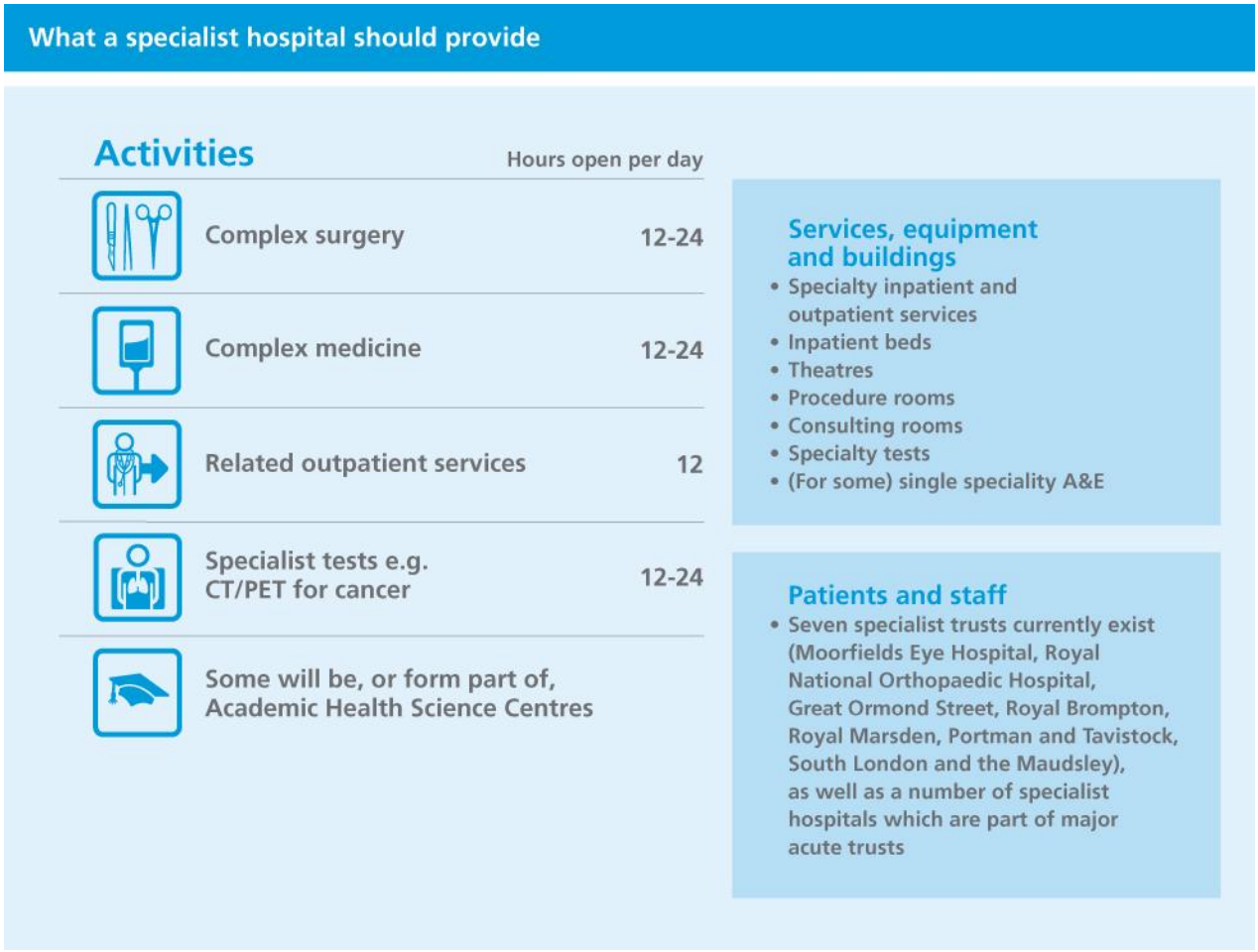


Included in this group are St Mary's, St George's, King's, Guy's and Thomas's, The Royal Free, UCL, Barts and the London, Chelsea and Westminster and Hammersmith Hospitals. (HSMR all England year 2005/06=100)

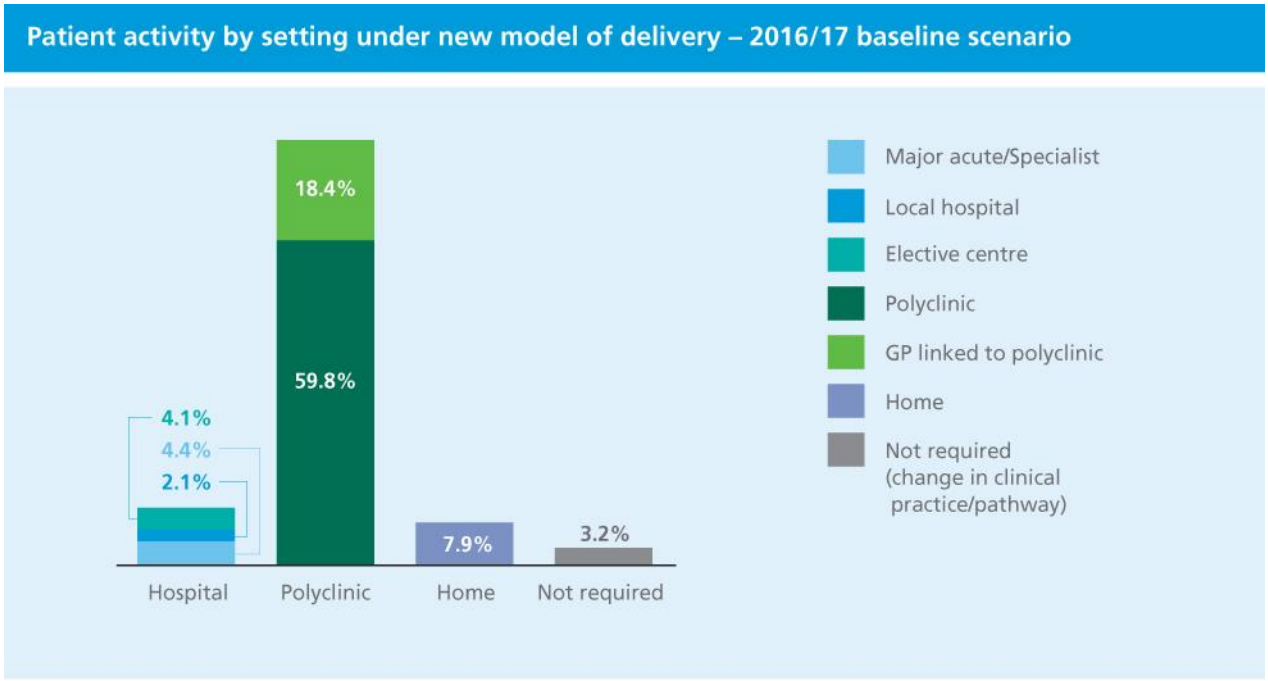
Source: Hospital reported HSMR scores

Specialist hospital

London currently has six specialist hospitals treating patients with conditions ranging from eye problems to cancer.



(Amend diagram below to show shift in patient activity by setting now and in 2016/17)



Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians

A question for you…

Question 23

Please tell us any other comments you might have on the proposals in this section.

7 The cost of new ways of caring

The work that supports this section can be found in the technical paper at www.healthcareforlondon.nhs.uk or by calling 0800 XXXXXXXXXX for a copy.

London's current £11.4 billion a year PCT healthcare budget has risen from £6.6 billion in 2002. We estimate that by 2016/17 it will have risen to £13.1 billion. So these proposals are not about healthcare 'cuts', they are aimed at providing the best healthcare system possible with the budget we have.

Three different forecasts of how demand for health services in London will change have been calculated: low growth, baseline growth (the most likely forecast) and high growth. Detailed modelling has been carried out to work out where, if these recommendations were implemented, different operations and procedures would be performed in ten years time.

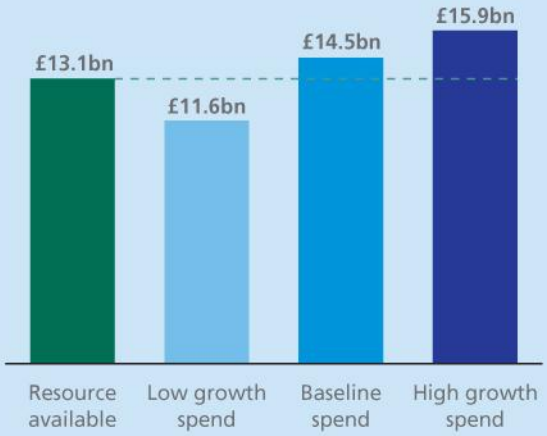
Our most likely forecast shows that providing services in the way that we do now will cost £14.5 billion – overspending the estimated budget by £1.4 billion. We also know that providing services the way we do now would mean the current weaknesses in quality and accessibility of care would not be tackled.

If we made the changes recommended in Healthcare for London (and we assume baseline growth again) the calculations predict that services will cost £13.1 billion – the same as the predicted budget. The £1.4 billion saving comes from some services being provided in polyclinics (where a large proportion of healthcare activity would take place) being cheaper. At the same time some activity would no longer be needed, for example, unnecessary follow-up outpatient appointments.

Cost of delivery models against projected commissioning resources available in 2016/17

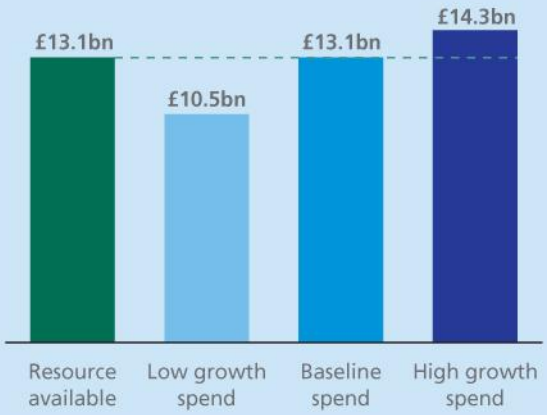
Delivery models

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

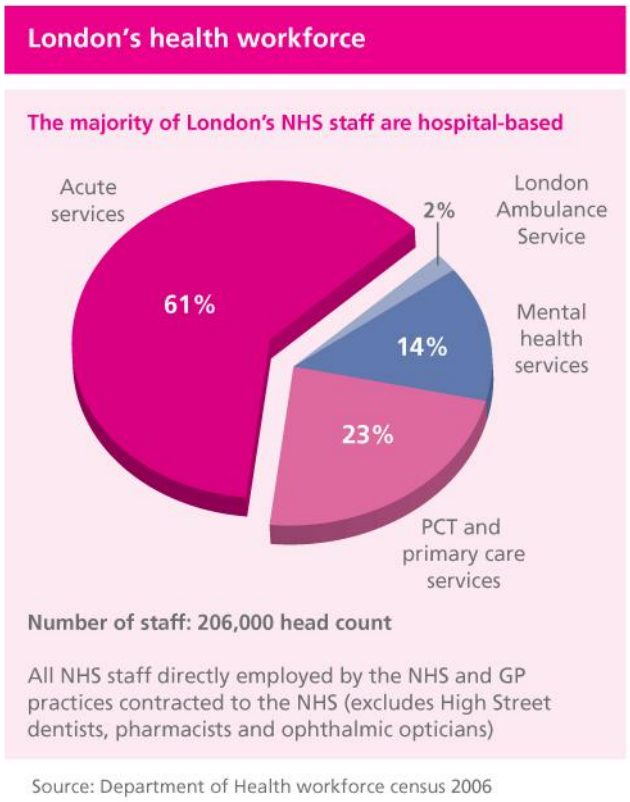
2016/17
High growth scenario
Growth rates higher than demographics, changing prevalence rates and historical due to improved access and pace of technological development

Source: Casemix analysis – output of the Analytical Working Group and interviews with clinicians

8 Turning the vision into reality

Making change happen in a service as complex as the NHS takes a lot of time and effort and there are some key issues to be got right if we are to succeed:

8.1 Workforce



Source: Department of Health workforce census 2006

We believe that NHS staff in London are truly inspirational. Working together they provide high quality healthcare 24 hours a day, 365 days of the year. They do so in an often challenging environment with professionalism, commitment and compassion. We need to support them in their efforts to improve services and keep Londoners healthy.

Introducing these proposals would mean big changes for NHS staff in London. We will require staff with different skills and capacities. We will need leaders from both clinical and non-clinical backgrounds. We will need to recruit and retain the right people at the right times. To do so we need to look at the number of staff required, the types of jobs available, how much travel will be needed and the types of teams that are created.

Our proposals also suggest moving staff out of some hospitals and into the community – and we recognise that staff will need to be supported to make this change.

The NHS is a major employer and we need to continue to encourage applicants from local areas of deprivation and ensure that the NHS reflects the cultural diversity of London.

All these ideas will require early, open and informed discussion with unions, staff, education and training providers and others. To address all these issues, NHS London will be developing a workforce strategy from which local workforce planning can happen.

8.2 Training

Training needs to be given a high priority and be linked to the workforce strategy. NHS London needs to explore how training and education can best be organised and provided to meet the future workforce needs of London and to support its role as a world-class centre for education and innovation.

Continued attention needs to be given to the contracts for training nurses, health professionals and medical students as well as other staff training, to ensure that NHS staff remain up-to-date in their understanding of inequalities and the needs of vulnerable groups.

There is the potential for developing exciting new roles, such as GPs with a special interest in emergency medicine or paediatrics, and we will need more staff in existing roles such as specialist long-term condition nurses. We will need to plan how we can train these people.

> Of all London's healthcare providers, the London Ambulance Service (LAS) receives the least funding for education. LAS staff have a growing role in diagnosing serious illness and injury and need resourcing to improve the skills of its staff and procedures.

8.3 Commissioning

PCTs buy, on behalf of the public, almost all health services. At the moment some PCTs do not have some of the skills needed to be able

to buy high quality, easy accessible services that result in the best possible health and well-being of residents.

To raise the standard of commissioning we need to develop London-wide guidelines, provide better training and involve more clinicians and other partners, for instance local authorities.

8.4 Partnerships

Turning the vision into a reality will need the involvement of everybody who works in the NHS. Everyone will need to be actively involved in developing improvements to ensure that healthcare in London is the best it can be.

The NHS will need to improve how it works in partnership with local authorities, the voluntary sector – which has a vast wealth of expertise – higher education, the private sector, health providers and other organisations.

8.5 Public support

For change to succeed both the public and politicians need to be convinced that it will improve healthcare. Many people remain attached to the services that are provided at the moment without being aware that there may be better ways of providing these services.

Clinicians must have a central role in explaining the clinical benefits of new ideas to the public.

8.6 Patient choice and information

From 2008, Londoners will be able to choose any approved provider of healthcare for planned treatment. This is likely to change where patients go to have their treatment, with providers that are popular with patients increasing their services to meet demand. Improved information is vital if people are to make informed choices. Patients need to know what they should expect from services and how to access information.

8.7 Information Technology

We will need good information technology to ensure staff can deliver high quality care wherever it is needed – for instance on the phone, in people's homes, in polyclinics and hospitals – and to deliver services faster and better.

Questions for you…

Question 24.

In the front of this booklet we described five principles. Now that you have seen how these principles will be applied throughout the proposals, please tell us whether you agree or disagree with each of these principles?

a. A focus on individual needs and choices
b. Localise where possible, centralise where necessary
c. Joined-up care and partnership working, maximising the contribution of the entire workforce
d. Prevention is better than cure
e. Reduce health inequalities

Strongly agree

Tend to agree

Neither agree nor disagree

Tend to disagree

Strongly disagree

Please explain your reasons

Question 25

Do you think there should be other principles?

Question 26

Please tell us any other comments you might have on how health services in London could be improved over the next ten years.

9 How to give us your comments

We believe that the people of London deserve the very best healthcare system in the world and we want to develop a healthcare service that meets the needs and expectations of all Londoners. We would welcome your views on our proposals.

Whatever your age, sex, ethnicity, sexuality, faith, job, or your current health, if you live or work in London this proposal affects you.

You can make your views known by contacting the independent consultants:

- Completing the comments form on the consultation website www.healthcareforlondon.nhs.uk
- Using the form opposite (CHECK) or writing a letter to: FREEPOST CONSULTING THE CAPITAL
- Freephone: 0800 XXXXX
- Email: XXXX
- Attending one of the consultation meetings. For details you can look at the website or phone 0800 XXXXX

All comments must be received by 7 March 2008

10 Consultation response form

(to be designed)

11 Inside back cover

The partner PCTs would like to thank all the staff and stakeholders who have generously assisted in the preparation of this document including:

- The members of the Joint Committee of PCTs (list names)
- The members of the Patient and Public Advisory Group (list names)

Complaints

If you have a complaint about this document or the consultation process you can contact Complaints, NHS London, …….

12 Other formats and languages (Back cover)

For a large print, Braille, CD or audio-tape version of this document, please contact Ipsos Mori at:

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13 Document Information

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14 Version History

Version	Date Updated	Updated By	Reason
0.1	24/08/07	J Street	First draft requiring input
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0.3	13/09/07	D Neame	Comments from J Robinson, D Mason etc. Feedback from JCPCT meet
0.4	18/09/07	J Street	Amends to current draft, mainly on style
0.5	28/09/07	D Neame	Comments from team and P Dash
0.6	12/10/07	D Neame	DN input and BG
0.7	14/10/07	D Neame	Comments from LCG, NHS London Exec and PCT Comms
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(12500 words)