Summary

Introduction

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

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

The case for change

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

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

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

- **We need to provide more specialised care.** Whilst most people can be cared for by community services, the most seriously ill need more specialised care. For instance, a detailed review of stroke services has found that dedicated, high-quality, specialist stroke units save lives. In order to ensure sufficient volumes of work to maintain specialist staff expertise, to support high-tech facilities, and to allow comprehensive consultant presence, specialised services need to be centralised in fewer hospitals catering for large populations. Yet London has one of the smallest average catchment populations per hospital in the country.
- **London should be at the cutting edge of medicine**. Many great medical breakthroughs have occurred in London, which remains the leading centre for health research in the UK. But the UK as a whole risks lagging behind its international competitors. London needs to explore the model of Academic Health Science Centres being followed by other large cities if it wants to be at the cutting-edge of research and clinical excellence.
- **We are not using our workforce and buildings effectively.** The NHS's staff are its greatest asset but their abilities are not always fully used. Productivity levels in London are lower than elsewhere in England – for example, doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts. Staff are also not employed in ways that make it easy for them to move between hospital and community settings. The NHS estate is a huge and hugely under-utilised resource.
- **We need to make the best use of taxpayers' money.** Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if

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

Future health needs

4. We want to build an NHS for London that meets not only today's challenges (outlined above) but also the challenges of the future.

5. Probably the biggest challenge for the NHS over the next ten to twenty years will come from London's growing and ageing population. Population projections suggest an increase in London's population from 7.6 million in 2006 to 8.2 million in 2016. These increases are being driven not by migration into London (which is balanced by migration out of the capital) but by a birth rate that exceeds the death rate.

6. London's population is also becoming older. The fastest-growing sections of the population are the 40-64 age group and the over-85s, both of which have higher health needs than younger age groups.

7. A population that is both bigger and older will have a significantly greater need for healthcare. This need will not be spread evenly throughout London, but will be concentrated where the greatest population growth is predicted – mainly along the Thames Gateway on the eastern side of London.

8. Any vision for the future of London's NHS also needs to take into account the likelihood of technological changes and of ever-rising patient expectations. Although some new technology can save the NHS money, the overall trend is that new technologies increase the demand for healthcare by making new interventions and procedures possible. At the same time, a new generation will expect NHS services to fit with their lifestyles, not the other way around. People will demand the very best care as a right, not a privilege, and the NHS will have to respond.

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

Five principles for change

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

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

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

- **Services focused on individual needs and choices**. Provision should, wherever possible, be tailored to the particular needs of each individual. Patients should feel in control of their care and be able to make informed choices.
- **Localise where possible, centralise where necessary.** Routine healthcare should take place as close to home as possible. More complex care should be centralised to ensure it is carried out by the most skilled professionals with the most cutting-edge equipment.
- **Truly integrated care and partnership working, maximising the contribution of the entire workforce.** Better communication and co-operation is needed – between the community and the hospital, between urgent and planned care, between health and social care – to stop people from falling through the gaps. Care should be multidisciplinary, bringing together the valuable contributions of practitioners from different disciplines. The NHS should be committed to working in partnership with other organisations, including local government and the voluntary and private sectors.
- **Prevention is better than cure.** Health improvement, including proactive care for people with long-term conditions, should be embedded in everything the NHS does. Close working with local authority partners is needed to help people stay mentally and physically healthy.
- **A focus on health inequalities and diversity.** As discussed above, the most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare. The whole thrust of this report is to tackle health inequalities by improving services across London, giving everybody access to the best possible care. Healthcare should be intelligently commissioned to tackle health inequalities. Preventative and outreach work should focus on the most deprived populations and new facilities should be located in the areas of greatest need. Improvements also need to take into account London's rich ethnic and cultural diversity. We are advocating that patients have more information to make choices about their care and this should be accessible to all.

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

Improved care from cradle to grave

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

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

Universal services focused on individual needs

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

Localise where possible, centralise where necessary

- Antenatal care should be provided in local, one-stop settings, and postnatal care should be provided in local, one-stop settings as well as at home (maternity and newborn working group).
- There should be a significant increase in the number of midwifery units, with each obstetric unit having an associated midwifery unit, either co-located or stand-alone depending on local circumstances (maternity and newborn working group).
- Obstetric units should have at least 98 hours a week consultant presence (maternity and newborn working group).
- More use should be made of "talking" therapies in the community complemented by a strategy for developing inpatient care (mental health working group).
- There should be centralisation and networks for major trauma, heart attack and stroke (acute care working group).
- Dispatch and retrieval protocols for London Ambulance Service need to be aligned with centralisation (acute care working group).
- Routine diagnostics and outpatients should be shifted out of large hospitals (planned care working group).
- Increased use should be made of the day case setting for many procedures (planned care working group).
- Rehabilitation should be done at home wherever possible (planned care working group).
- More specialised inpatient care should be centralised into large hospitals (planned care working group).
- Specialist providers should offer care on other hospital sites (planned care working group).
- There should be greater investment to support people to die at home (end-of-life working group).

Truly integrated care, maximising the contribution of the entire workforce

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

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

Prevention is better than cure

- Promoting health and wellbeing means the NHS working more energetically with other public services and organisations (staying healthy working group).
- More should be invested in proven health improvement programmes and initiatives (staying healthy working group).
- There should be a pan-London campaign for activity and healthy eating linked to the 2012 Olympic and Paralympic Games (staying healthy working group).
- All health organisations and their staff should be incentivised to take every opportunity to promote physical and mental health (staying healthy working group).
- There should be a greater focus on health protection, with improved sexual health, tuberculosis and childhood immunisation services (staying healthy working group).
- The NHS should play a greater role in improving the physical and mental health and wellbeing of its employees (staying healthy working group).
- Early intervention services need to be improved (mental health working group).
- There should be more pro-active community care to reduce emergency admissions and lengths of stay (long-term conditions working group).

A focus on health inequalities and diversity

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

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

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

Models of healthcare provision

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

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

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

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

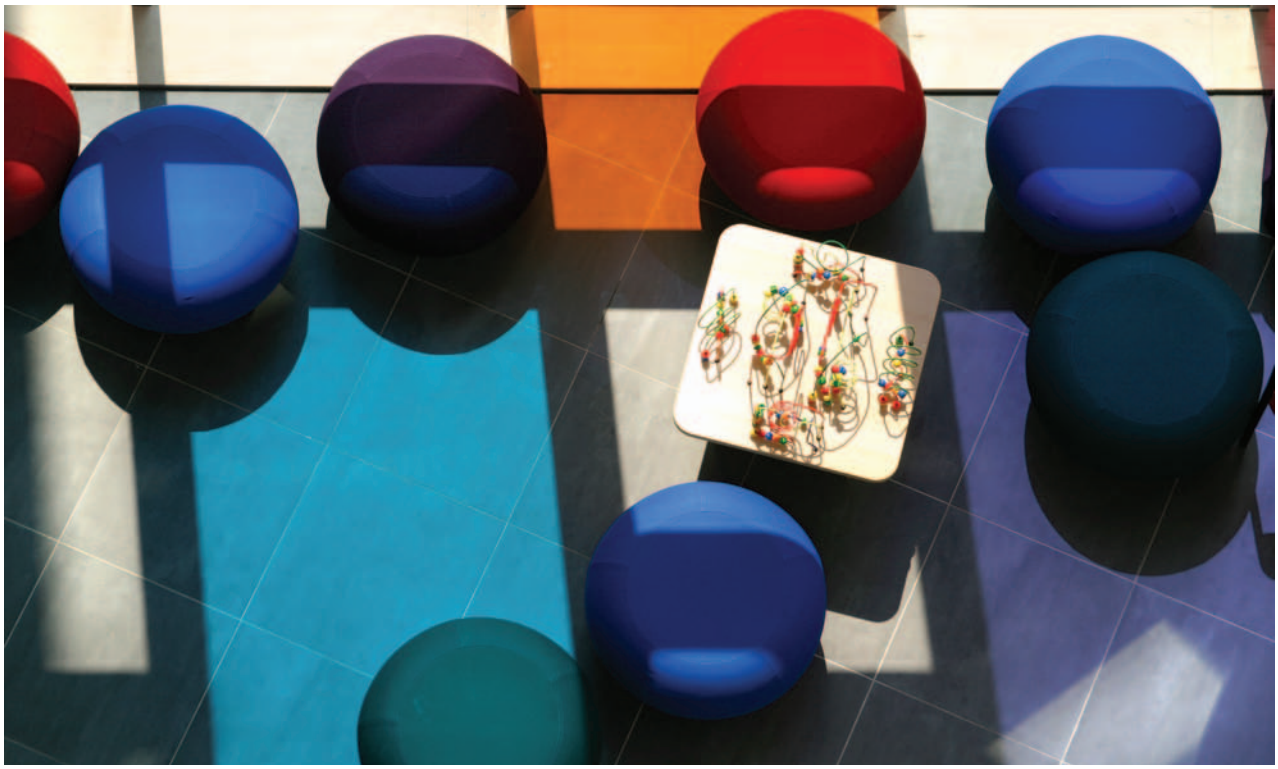
- more healthcare should be provided at **home**
- new facilities – **polyclinics** – should be developed that can offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals
- **local hospitals** should provide the majority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

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

Polyclinic

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

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



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

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

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

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

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

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

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

From vision to reality

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

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

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

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

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

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

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

31. And finally, one of the main themes of this report is the importance of reducing health inequalities by giving everyone access to the best possible care. Whether this *Framework* succeeds in this goal will depend on how it is implemented. So I will be expecting both local and strategic implementation to make systematic use of health inequalities impact assessments to ensure improvements are helping those who are currently the least well-served by the NHS.

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