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Healthcare for London
A Framework for Action

The Case for Change

Introduction

1 This report makes a compelling case for why healthcare in London has to change. There are many excellent reports which consider how healthcare must develop in the future, both generally and in particular specialties.[1] This document does not seek to repeat those, but focuses instead on the specific challenges to improving healthcare in London. It is the first stage of a review being conducted by Professor Sir Ara Darzi on behalf of NHS London and will be followed by a *Framework for Action*, detailing the necessary response to these challenges.

[1] On general healthcare developments see, J Farrington-Douglas, *The Future Hospital: The progressive case for change*, IPPR January 2007. On particular specialties see the recent reports of the National Clinical Directors e.g. Professor Roger Boyle, *Mending Hearts and Brains*, DH, December 2006

Ongoing Change:

2 Why does healthcare in London need to change? After all, there have been considerable achievements in the last few years, most notably in reducing waiting lists and increasing survival rates for the big killers of cancer and coronary heart disease. These improvements were made possible by record increases in healthcare funding and the vision set out in *The NHS Plan*.[2] However, strategic documents setting out necessary changes specifically for London have been relatively neglected, most notably *Health Service in London – A Strategic Review*, the 1998 report by Lord Turnberg.[3]

3 Much of the Turnberg report continues to be relevant, with its emphasis on the rationalisation of major hospital services on the one hand, supported by the development of high quality community care on the other. Of its major recommendations only the suggestion that London does not need to reduce its acute inpatient beds has been proved obsolete by healthcare developments.[4] However, competing priorities meant that some of the most significant elements of the Turnberg report have never been implemented. In addition, the five previous Strategic Health Authorities (SHAs) that were established were simply not configured to lead the pan-London improvements envisaged. And whilst individual clinicians and managers have made improvements to services, this has often been on a piecemeal basis. There now needs to be a co-ordinated programme of change across London for eight reasons.

[2] *The NHS Plan*, Department of Health, 2000
[3] *Health Services in London – A Strategic Review* (Turnberg Report), 1998
[4] NHS Confederation, *Why we need fewer hospital beds*, May 2006

Reason 1

The need to improve Londoners' health

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

5 In some health indicators London performs well. For instance, although it is a big killer, coronary heart disease mortality rates are lower in London than other parts of England.[5] However, London faces specific health challenges such as HIV, drug abuse and mental health. London has 57 per cent of England's cases of HIV. One in four adult drug users live in London. One million Londoners have had mental health problems.[6]

6 Londoners also need more help to adopt healthy lifestyles. Smoking is more prevalent in London than nationally. One Londoner dies every hour from a smoking related disease and smoking costs the NHS in London over £100 million a year.

7 London has higher rates of childhood obesity than the rest of England. Every year in London, obesity accounts for 4,000 deaths. London is far away from the "fully engaged" scenario envisaged by Sir Derek Wanless, where everything is done to prevent ill health.[7]

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

[5] *National Centre for Health Outcomes Development Indicators*
[6] This and subsequent statistics in Reason 1 taken from London Healthcare Observatory, *Health and Healthcare in London – Key Facts*, September 2006, http://.healthcareforlondon.nhs.uk
[7] Sir Derek Wanless, Securing our Future Health: Taking a long-term view (The Wanless Report), April 2002

Reason 2

The NHS is not meeting Londoners' expectations

9 There is much public support for the work done by the NHS. However, not all Londoners' expectations are being met. 27 per cent are dissatisfied with the running of the NHS compared to 18 per cent nationally.[8]

10 A MORI survey of over 7,000 Londoners revealed that, despite recent reductions, further improvement in waiting times for operations, appointments and in accident and emergency (A&E) departments is a priority for people.[9]

11 62 per cent of those surveyed listed cleanliness of hospitals as an issue needing attention and some cited cleanliness as a factor that would affect their choice of hospital.

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

13 The survey found Londoners gave their GP services a lower net satisfaction rating than people nationally. This corroborates the findings of the London "listening event" conducted as part of the *Your health, your care, your say* consultation, where people spoke of difficulty booking GP appointments in advance or being seen outside normal 9-5 working hours. They could also rarely speak to GPs directly by phone and tended to only get reactive, rather than proactive, care.[10]

[8] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006
[9] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006. The subsequent percentages are all from this survey.
[10] Report from London user group, *Your health, your care, your say*, 2005

Reason 3

One city, but big inequalities in care

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

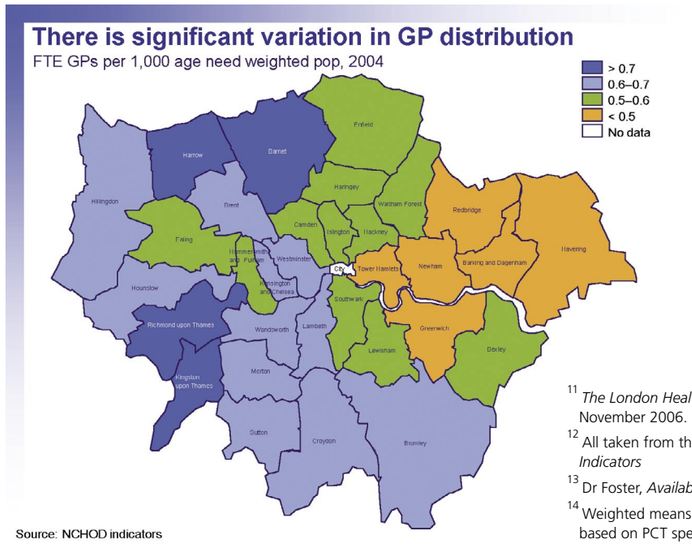
15 For instance, whilst overall life expectancy in London is similar to national levels, there are very significant differences within London. Just eight stops on the Jubilee line takes you from Westminster to Canning Town where life expectancy is seven years lower. This discrepancy means that raising life expectancy for the bottom half of London boroughs to the current London average would save 1,300 lives every year.[11]

16 Other examples of health inequality include:

- The infant mortality rate in Haringey (8.1 per 1000 births) is three times that of Richmond (2.7 per 1000 births).
- Hammersmith and Fulham has twice the proportion of smokers of Harrow (34.5 per cent compared to 17.5 per cent).
- Two thirds of children in Kensington and Chelsea consume three or more portions of fruit and vegetables a day, compared with one third in Barking and Dagenham.[12]
- Mental health inpatients are more than twice as likely to come from the 20% most deprived London electoral wards than the 20% least deprived.[13]

17 At the same time as there are big inequalities in outcomes, there is great disparity in health inputs, such as funding per person. Looking at the funding for the five old SHA areas it is noticeable that whilst North East London contains several deprived boroughs with some of the lowest life expectancies in England, in 2004/05 the average expenditure per weighted head of population was £1090, compared with the North West London figure of £1311.[14]

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



Source: NCHOD indicators

[11] *The London Health Inequalities Forecast*, London Health Observatory, November 2006.

[12] All taken from the *National Centre for Health Outcomes Development Indicators*

[13] Dr Foster, *Availability of Mental Health Services in London*, April 2005

[14] Weighted means adjusted to take account of health need. SHA data is based on PCT spend

Reason 4

The hospital is not always the answer

19 Medical advances mean that more care can be provided locally than ever before. For instance, modern surgery allows more procedures to be safely delivered as day cases, outside of major hospital settings. More outpatient appointments can take place in the community. In the US this has meant that whereas in 1981 90 per cent of outpatient appointments were in hospital, in 2003 the figure was 50 per cent with the other half being provided in physician offices (equivalent to GP practices) and polyclinics.[15] These developments mean that the vast majority of patients do not need hospital care.

20 The *Our health, our care, our say* White Paper presents a convincing argument that most people are best cared for by community services.[16] This is corroborated by medical studies such as one that demonstrates that people with chronic obstructive pulmonary disease greatly benefit from community pulmonary rehabilitation and one that shows that specialised, dedicated heart failure nurses in the community can improve health outcomes for patients with heart failure and reduce emergency admissions to hospital.[17]

21 Yet at the moment, community services are not providing a satisfactory alternative to hospital. Local urgent care is not good enough. Londoners are dissatisfied with the availability of GP services outside normal working hours.[18] They are using A&E departments for urgent care, and as a result London has proportionately almost twice as many A&E attendances as the East Midlands.[19]

22 In another example, many patients (especially older people) are admitted to hospital because no alternative is available. Lack of an alternative to admission seems particularly bad in London, which proportionately has over 50 per cent more admissions through A&E than the West Midlands.

23 Improvements in community services clearly need to happen, but this is made more challenging because of the existing configuration of services. GP practices in London are smaller than average for the rest of England – 54 per cent of GP practices in London have only one or two GPs, compared to 40 per cent nationally. This makes it harder for them to provide additional services in their practices such as basic blood tests and ultrasounds. Yet many cannot expand because of their buildings. A BMA survey found that almost 60 per cent of London GP practices felt their premises were not suitable for their present needs and this rose to 75% when asked about their future needs.[20]

24 Professional attitudes also act as a barrier to providing more community services. For historical reasons there has been a sharp divide in the UK between GPs who work in the community and consultants who work in hospitals – a separation which does not exist in other countries. Thus 65 per cent of doctors in the UK report problems due to care not being coordinated across sites/providers compared to 22 per cent in Germany and 39 per cent in Australia.[21] These barriers need to be overcome because most patients do not need hospital care and can be better cared for more locally.

[15] American Hospital Statistics; CSFB; AHA Trendwatch Chartbook; CMS, Office of the Actuary

[16] *Our health, our care, our say: a new direction for community services*, January 2006, Department of Health.

[17] Man et al., "Community Pulmonary Rehabilitation after hospitalisation for acute exacerbations of COPD," *BMJ* 2004:329;1209 and Blue et al., "Randomised controlled trial of specialist nurse intervention in heart failure," *BMJ*, Sep 2001;323:715-718

[18] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006

[19] This and subsequent figure from analysis of DH Hospital Activity Statistics 04/05

[20] BMA Health Policy and Economic Research Unit, *Survey of GP practice premises*, London 2006.

[21] *2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.*

Reason 5

The need for more specialised care

25 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 found that dedicated stroke units saved lives.[22]

26 Dedicated stroke units provide rapid access to a CT scan to determine the cause of the stroke, immediate treatment with clot busting drugs (if appropriate to the type of stroke) and physiotherapy within a few days of the stroke. Delivering this high quality care requires specialist multidisciplinary teams and high quality equipment all available 24 hours a day, 7 days a week.

27 However, out of the thirty hospitals in London providing stroke services, only four treated over 90 per cent of stroke patients in a dedicated unit, and, whilst patients should receive a CT scan within three hours, only in seven hospitals were 90 per cent of patients getting a scan within a less-than-ideal 24 hours.[23]

28 Stroke care provides a salient lesson in how uncontrolled growth in service provision without proper consideration to the infra-structure and workforce needed can be dangerous for patients. What is needed is the planned development of specialist care. Achieving this requires the rationalisation and centralisation of more specialised services in fewer hospitals. There are three main reasons for this:

- **First**, specialist doctors, along with their specialised teams, need to see a large enough volume and variety of cases of a specific condition to hone their skills and develop and sustain expertise. There is evidence that specialist units performing a large number of cases achieve better results, particularly in more complex work.[24] Such concentration of care, with large numbers of patients, also creates centres of excellence that make it easier to train future specialist staff.

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

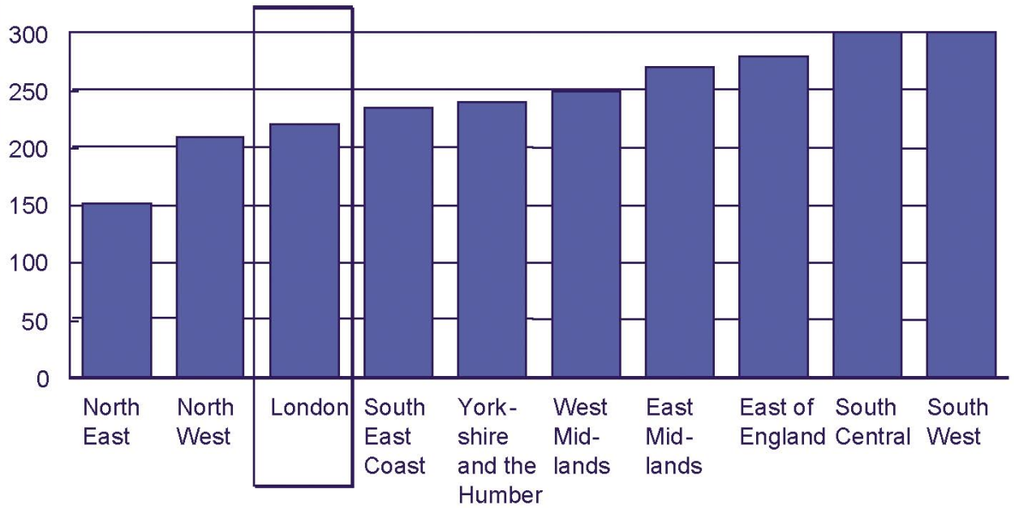
- **Third**, better working practices mean that staff are becoming centralised in fewer centres. Experienced staff are needed to manage the care of patients in hospital. The recent Healthcare Commission report into Northwick Park Hospital recommended that there be consultant presence on the maternity unit for 60 hours a week.[25] In addition, the European Working Time Directive (EWTD) is helping to ensure doctors are less likely to be tired when treating patients, by requiring them to work fewer hours. However, this does mean that more doctors are needed to maintain a 24 hours a day, 7 days a week, service. To achieve greater consultant presence in hospital and to comply with the EWTD will require the reorganisation of services. It will be harder for small hospitals to employ enough consultants to provide continuous cover for acute services.

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

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

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

Population per general hospital, 000



Source: Hospital reconfiguration, IPPR Briefing, September 2006

[22] Intercollegiate Working Party for Stroke, *The National Clinical Guidelines for Stroke*, 2004 (2nd Edition) Royal College of Physicians, London

[23] *National Sentinel Stroke Audit* 2004

[24] Michael Soljak, "Volumes of Procedures and Outcomes of Treatment,", *BMJ* 2002;325:787-8 and Killeen SD, O'Sullivan MJ, Coffey JC, Kirwan WO, Redmond HP "Provider volume and outcomes for oncological procedures," *Br J Surg* 2005; 92(4):389-402.

[25] Healthcare Commission, *Investigation into Maternal Deaths at Northwick Park Hospital*, August 2006.

Reason 6

London should be at the cutting edge of medicine

31 London is the leading centre for health research in the UK. 50 per cent of the UK's biomedical research is carried out in the capital and 30 per cent of healthcare students are educated there.[26] However, the UK as a whole risks lagging behind its international competitors. The UK now spends half as much on research as a proportion of GDP compared to the United States.[27] At the same time, the number of commercial drug trials taking place in India and Russia is growing exponentially, whilst the trial numbers in the UK remain fairly static.

32 Changes to the way funding is allocated under the government's new research and development strategy *Best Research for Best Health* are also likely to mean that the share of research funding that London receives will decrease.[28]

33 Responding to these developments requires closer co-operation between hospitals and universities in London. A new form of university/hospital partnership is needed to maintain the UK's academic institutions at the forefront of the global marketplace where they compete for grants, recognition and staff.

34 Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Sciences Centres (AHSCs), combining world-class research with leading edge clinical services and education and training. AHSCs help to ensure that research breakthroughs lead to direct clinical benefits for patients.

35 Cities such as Toronto and Boston already have AHSCs and London risks being left behind. AHSCs are a model of healthcare organisation London needs to explore – the recent announcement of three comprehensive and four specialist Biomedical Research Centres in London offers the first step in doing this.[29]

[26] London Higher, *Leading Health*, www.londonhigher.ac.uk

[27] HM Treasury (UK). NIH and US Government (US)

[28] *Best Research for Best Health*, DH, Jan 2006. Analysis of Funding of R&D in London, Dr Mark Lewis, Director of Clinical Governance and Research, NHS London (NWL) 15th January 2007

[29] Announcement of Biomedical Research Centres, http://www.nihr.ac.uk/programmes_biomedical_research_centres.aspx

Reason 7

Not using our workforce and buildings effectively

36 The NHS's staff are its greatest asset, but their abilities are not always fully utilised. For instance, productivity levels in London in terms of case mix adjusted Finished Consultant Episodes are noticeably lower than elsewhere in England. This means that doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts in comparable hospitals elsewhere in England. Nurses also see relatively fewer patients.[30]

37 Meanwhile, the NHS has never employed staff in a way that helps them to move easily between the hospital and community settings, as they will have to in future. There needs to be more support for staff to work flexibly to deliver the best care and not tie them to one institution. And there must be a greater emphasis on developing a culture that monitors and promotes improvements in the quality of the care that staff deliver.

38 Our buildings also need to be used more effectively. The NHS in London has a huge property portfolio of nearly 100 hospitals as well as hundreds of other sites for mental health and community provision. This equates to a total of 4-5 million square metres of facilities and this estate costs at least £0.7 billion (around 7 per cent of the total healthcare spend in London) simply to service.[31]

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

40 Not only is our healthcare estate being used ineffectively, it is also ageing. Recent investment has led to the opening of impressive new healthcare facilities such as the Brent Emergency Care and Diagnostic Centre at Park Royal.

41 Yet much more needs to be done. Backlog maintenance – the figure used to determine how much investment is needed to bring hospital buildings up to an acceptable standard – for just the acute hospitals in London is over £800 million. Barnet and Chase Farm Hospitals NHS Trusts has backlog maintenance of £44 million whilst for The Hillingdon Hospital NHS Trust it is over £55 million.

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

[30] Analysis of DH HES statistics

[31] NW London SHA, *Pan London Estates Strategy,* June 2006.

Reason 8

Making the best use of taxpayer's money

43 Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if it did not make the best use of the money it has. Money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere.

44 The unprecedented national growth in NHS funding that has occurred over the last five years will slow down from April 2008. In addition, an adjustment to the funding allocation will see most London PCTs getting significantly lower rates of increase to their funding than in the past whilst rising costs of staff, drugs and technology, and increasing expectations, will continue to exert pressure. The only way for future healthcare provision to be sustainable is changing to ensure care is provided in the most cost-effective way.

45 One of the major ways to achieve good value care would be to ensure people are not staying in hospital longer than they need to. For instance, in 2004/05 if all London hospitals had achieved the English average for lengths of stay this would have saved 800,000 bed days or over £200 million.[32]

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

[32] London Health Observatory

Conclusion:

The Need to Lead Change

47 These eight reasons for change provide a clear rationale as to why we cannot persist with the status quo in London. This is a compelling case but we need to understand that people have become used to their health service as it actually is, not how it might be in order to save more lives. The public remain very attached to services provided by their local district general hospital, especially A&E and maternity services, and can fiercely oppose changes.

48 People's first reaction when thinking of where money should be spent is their local hospital. Thus the MORI survey found that when asked a one-off question as to where the NHS should invest its money, 58 per cent of Londoners would choose existing hospitals as opposed to investing in more local services and fewer, larger, hospitals.[33]

49 Yet when the need for change is communicated clearly and when the evidence is presented, people can see the rationale for change. At the concluding event of the *Your health, your care, your say* consultation, 54 per cent of the thousand participants said they supported moving services closer to home even if this meant fewer services in hospital, compared to 29 per cent who opposed this proposal.[34]

50 In the past, the NHS has often been poor in communicating the case for change. There has been little attempt to demonstrate the high quality community services that will be developed or these services lack visibility when compared to the much-loved local hospital building.

51 Commissioners at all levels, from GPs as practice based commissioners through to commissioners of highly specialised services, need to make the case for change coherently. To do this they need to form effective partnerships with their clinical colleagues and with the local authorities who provide the social care, leisure services and so much more that is crucial to supporting the health of Londoners. They need to draw on research and evidence to quantify the impacts of spending and work with the public to decide which health services should be bought to meet their needs. They need to lead change.

52 Often the leadership of change is hampered by a lack of information. This document is the first phase in tackling this paucity of information and it will be followed by *The Framework for Action*, setting out the principles that the NHS in London should follow in responding to the challenges it faces.

53 *The Framework for Action* will be informed by contributions from leading clinicians in London, the UK and the world. It will use the best available evidence. It will take into consideration the perspectives of London councils, the voluntary sector and others. Most importantly, it will draw on the views of Londoners.

54 *The Framework for Action* will appear shortly and it is not intended to delay current change until it is published. Where developments need to happen because of the eight reasons for change outlined here, they must proceed.

[33] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006
[34] *Our health, our care, our say*, p.148