Healthcare for London

NHS London

Delivering Healthcare for London: An Integrated Strategic Plan 2010-2015

FIRST STAGE REPORT

January 2010

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1. Introduction

Healthcare for London: A Framework for Action was published in July 2007. Led by Professor Lord Ara Darzi it made a compelling case for change in health and healthcare services across London. What made these proposals so powerful was that they drew directly on evidence put forward by clinical working groups.

The key recommendations in *A Framework for Action* focused on improving quality and productivity by: improving health, creating better access to care closer to home, and improving quality and safety by centralising specialist hospital services where necessary.

Following publication of the report, London's 31 Primary Care Trusts (PCTs) consulted the public on the proposals. From this came the decision in May 2008[1] by the Joint Committee of PCTs (JCPCT) to implement the report's recommendations. Since then, efforts have focused on delivering some specific proposals, to get the change programme under way and build confidence that Healthcare for London could and would be implemented. The focus included improvements to stroke, trauma and diabetes services and the creation of polyclinics.

By early 2009, new models of care for stroke and trauma had been developed and consulted on.[2] In July 2009, the JCPCT agreed to establish eight hyper acute stroke units with associated networks and four trauma networks.[3] Hospitals will start to deliver new services from April 2010 with all facilities open by summer 2011. These changes are expected to save around 500 lives per year and reduce long-term disability for thousands.[4] The first seven polyclinics (where much of the care for those with long term conditions will in future be provided) were established by April 2009. Best practice commissioning guidance for diabetes has also been developed[5] and PCTs have begun implementation of local plans.

Whilst quality improvements in some care pathways are now being realised, the focus on specific recommendations has achieved incremental progress rather than full delivery of *A Framework for Action*. The truly transformational changes in services and outcomes envisaged in the report are still some way off.

To give fresh energy to Lord Darzi's vision NHS London – the Strategic Health Authority (SHA) – hosted an NHS leadership event in April 2009. The challenge posed to commissioners of services in London's PCTs and to NHS London itself was how to accelerate the delivery of Healthcare for London.

It was agreed to produce an Integrated Strategic Plan – setting out the three to five year implementation path. This document is a First Stage Report of that Integrated Strategic Plan, including priorities for delivery in 2010/11. It is the culmination of work by commissioners and NHS London, drawing on the strategic plans from PCTs and their six sectors (geographically based commissioning bodies acting on behalf of the PCTs).

This First Stage Report also sets out how London intends to respond to the Department of Health's "Quality, Innovation, Productivity and Prevention" agenda: the need to ensure that the NHS provides better quality services in the most productive and cost effective way possible, making best use of the potential of innovation and targeted investment in prevention. It also explains how Healthcare for London will be implemented within the current financial context – which has tightened considerably since 2007 – taking account of the detailed affordability analysis, which has been undertaken as part of the development of the plan.

2. The case for change in 2010

The Healthcare for London vision is built on a compelling case for change with a clear set of reasons for improvement: current services are highly variable in their quality and they do not maximise London's potential to be world class.

- *Poor health*: 69 per cent of people over the age of 60 have one or more long term condition, with this age group predicted to be the fastest growing in London over the next 20 years. London has seen improvements in mortality rates from the big killer diseases, but it is now lagging behind other areas of the country for early deaths due to heart disease and stroke.[6]
- *An NHS not meeting Londoners' expectations:* 37 per cent of Londoners are unhappy with the time it takes to get a GP appointment, and 46 per cent think that A&E waiting times need to improve.[7]
- *Unacceptable inequalities in health and healthcare:* for example, male life expectancy ranges from an average of 71 years in Tottenham Green ward in Haringey, to 88 years in Queen's Gate ward in Kensington and Chelsea,[8] a difference of 17 years of life.
- *Over-reliance on the hospital as the answer*: a recent study of unscheduled care concluded that 87 per cent of children and young people attending A&E services could be better treated in primary and community care.[9] In some areas, patients are better looked after in the community; one example is people with conditions like chronic pulmonary disease, who have more effective rehabilitation out of hospital.[10] Only a quarter of patients attending A&E in London require admission. Every A&E attendance costs the NHS £75.[11]
- *A need for more specialised care*: in the first quarter of 2009/10, only 58 per cent of stroke patients in London were spending at least 90 per cent of their time in hospital in a dedicated stroke unit (the national standard for improving outcomes for patients). Centres of excellence save lives and reduce disability.[12]
- *A need for London to remain at the cutting edge of medicine:* as a world city, London has the opportunity to keep up with dedicated medical research centres in Canada, the US and Sweden, thus allowing innovative treatments to quickly become available to London and the wider NHS.

3. Affording the best

The Healthcare for London vision – to improve radically the quality of health and health services in London – requires change to the whole system. London faces significant pressures from increasing demand for healthcare with a growing and ageing population,

changing patterns of disease and health,[i] innovations in medical technology and public demand. While the population is expected to grow by approximately one per cent per year, taken together, these factors mean that demand for services is expected to rise by four per cent per annum to 2015.

Although the overall London health economy is currently in surplus, NHS London's analysis of the future affordability of the capital's healthcare shows a very different picture. A combination of activity and cost growth will outstrip funding growth by 2011/12. As a result, the system will be in deficit by the end of that financial year. By 2016/17[ii] the NHS in London will face a funding shortfall of between £3.8 billion[iii] and £5.1 billion[iv] per year on a recurrent basis. Ensuring that London's health services remain affordable necessitates major changes for commissioners and providers. Commissioners will benefit from paying hospitals less (deflation of the national tariff), but still face a forecasted shortfall of between £1.4 billion and £2.7 billion, or eight to 15 per cent. Hospitals will face the challenge of saving £2.4 billion,[13] implying a three to four per cent productivity gain each year, significantly greater than what is currently achieved.

Currently, there is wide variation between organisations. The overall surplus masks a number of financially failing providers and challenged PCTs (for example, South London Healthcare NHS Trust, faces cumulative debts of £196 million). Commissioners have come together to create the Challenged Trust Board and an associated fund of £373 million to tackle the issue of legacy debt.[14] The NHS has experienced ten years of consistent and unprecedented growth in funding that, from 2011/12, will come to an end. Unless the pattern of services is changed quickly and the problems of excess hospital capacity are addressed, overall financial stability of the NHS in London will be threatened.

London has a higher number of hospital beds than the national average (3.7 versus 2.8 per 1,000 population)[15] and the current configuration of hospital services is not making best use of taxpayers' money. London's workforce is 30 per cent less productive than the rest of the country[16] and over 15 per cent of London's NHS estate (worth between £1 billion and £2 billion) is either unoccupied or underutilised.

The analysis suggests that the current model for delivering healthcare in London is not affordable. Alongside the ambition to provide better quality, five interventions for commissioners have been identified as having the greatest impact on addressing the £1.4 billion to £2.7 billion affordability gap projected by 2016/17:

1. £800 million to £2 billion can be achieved through reducing the unit cost of those services delivered in the community, including: the elimination of unnecessary service overlaps (for example out of hours, extended hours, urgent care, walk-in

[i] For instance, the number of people with diabetes is expected to rise by 200,000 between 2005 and 2025 (PBS Diabetes Model Phase 3).
[ii] NHS London's analysis of future affordability covers the next two spending review periods – 2011/12 to 2013/14 and 2014/15 to 2016/17.
[iii] 2.3 per cent per annum funding growth in the next spending review period (2011/12 to 2013/14), followed by 0.5 per cent in the one thereafter (2014/15 to 2016/17).
[iv] 0.75 per cent funding growth per annum from 2011/12.

centres and A&E services); staff spending more of their time with patients; changing the staff mix; and changing how patients get in contact with and receive services, such as through greater use of the internet and email.

2. £400 million to £500 million can be achieved through providing more care in the community and less in hospitals, leading to more appropriate and proactive care at a reduced unit cost.[v]
3. £300 million to £450 million can be achieved through stopping clinical interventions that have little or no benefit to those receiving them, for example some joint replacements and some outpatient follow-ups.[vi]
4. £20 million to £200 million can be achieved through proactive care for people with long term conditions, helping them to look after themselves, reducing the need for hospital admissions.[vii]
5. Approximately £60 million can be achieved through targeted investment in prevention to reduce the risk of ill-health and demand for healthcare services and improving rates of screening to detect ill-health at an earlier stage.[viii]

Key actions have also been identified for improving productivity in healthcare providers as they seek to deliver services at a reduced unit price. These are listed in Table 1 (page 8).

4. Higher quality care by 2015

The Healthcare for London vision responds to the case for change and the affordability challenge. In developing this vision, five guiding principles for change came through again and again in working with clinicians and in public deliberative events. These five principles have now been adopted. They are:

- Services focused on individuals' needs and choices: genuinely responsive services that give people more control over their health and healthcare.
- Localise where possible, centralise where necessary: healthcare should be provided in, or as close to, people's homes as possible, but some specialist care needs to be centralised in fewer locations to ensure better clinical outcomes.
- Truly integrated care and partnership working, maximising the contribution of the entire workforce: better team working within and across organisations.
- Prevention is better than cure: health improvement should be part of all the NHS' work.
- A focus on health inequalities and diversity: resources are targeted in the most deprived areas.

[v] London wide planning assumption to change the delivery model of 55 per cent of current outpatient appointments and 60 per cent of current A&E attendances.
[vi] Planning assumption that this could be as much as 7 per cent current elective activity, 30 per cent outpatient appointments, 10 to 15 per cent diagnostics.
[vii] Across London the planning assumption is to prevent 40 per cent of long-term conditions related episodes in non-elective medicine.
[viii] Across London the planning assumption is that 10 per cent of emergency medicine costs can be prevented through early detection.

Specific recommendations have been developed to improve quality across eight care pathways. These were developed by clinical working groups, and subsequently informed by emerging clinical best practice and further work by commissioners. Plans to prevent ill-health and to improve the quality of care and services across each of the pathways by 2015 are summarised here:

Maternity and newborn care

- All women will be assessed using risk stratification tools and placed on the appropriate pathway.
- An integrated programme of women's health, sex education and contraception will be delivered through polysystems and schools, with targeted interventions for hard-to-reach groups to reduce health inequalities.
- All women will receive a full health and social care needs assessment by 12 weeks and six days of pregnancy, with targeted support for women at higher risk of complication.
- Women will have a real choice of where and how to give birth with appropriate support, including one-to-one midwifery care in established labour.
- Obstetric units will operate with at least 98 hours a week consultant presence.
- Targeted support programmes will increase the number of women breastfeeding to six months, delivering associated health benefits to mother and child.
- Ante and postnatal care will be delivered in the community, with women enjoying continuity of care throughout the antenatal, labour and postnatal periods from one named midwife.

Staying healthy

- Systematic identification of those at highest risk of developing vascular disease (heart disease, stroke, diabetes and kidney disease) and support to manage that risk (either through treatment or lifestyle changes) including full roll-out of NHS Health Checks for those aged 40-74.
- PCTs focusing on smoking cessation; initiatives include social marketing programmes to target older men, expansion of the provision of services in community settings and workplaces and expansion of stop smoking services for pregnant women, with the aim of a six per cent reduction in smoking prevalence at four weeks.
- Increase uptake rates for childhood immunisation through incentives and performance management.
- Maximise screening uptake through improved community outreach, close monitoring of performance and stronger commissioning (including incentives for providers for performance).
- A London-wide campaign for physical activity and healthy eating linked to the 2012 Olympic Games: towards and beyond the Chief Medical Officer's recommended level of 30 minutes activity at least five days a week and to lift 150,000 people out of inactivity by 2012.[17]
- Implement the London NHS sexual health framework, focusing on HIV prevention, chlamydia screening and teenage pregnancy.[18]

Children and young people

- 40 per cent of paediatric outpatients will be decommissioned from acute providers and provided by community based paediatric teams.[19]
- 24 hour paediatric assessment units in place at every A&E department, staffed by specialist paediatric staff.
- Sector-wide specialist non-inpatient services for treatment of, for example, autism, drugs and alcohol and severe disruptive behaviour problems, implemented through polysystems.
- Creation of two networks of specialist tertiary care.
- All NHS staff who work with children will be trained in core competencies in child health and caring for children.

Mental health

- A social marketing programme based on the national work to raise awareness of mental health issues in London.
- Crisis resolution teams in every borough, to achieve improved early intervention services for at-risk and vulnerable groups.
- Psychological therapy services, such as cognitive behavioural therapy and psychological counselling, will be delivered through polysystems as the improving access to psychological therapies (IAPT) programme is implemented by every PCT.
- Community mental health teams established across London, working to agreed protocols and with a clear remit.
- Systematically improved care for patients with mental health issues who are admitted to general hospitals for physical reasons, with agreed protocols for the detection of, for example, depression or dementia.
- Memory assessment services will be available for everyone with dementia.
- Tailored services developed for those most at risk – offenders, asylum seekers and refugees, and the black and minority ethnic population, with a focus on depression, schizophrenia, and post-traumatic stress disorder.

Acute care

- Primary care-led urgent care centres co-located with every A&E department and in every polyclinic will treat 60 per cent of A&E admissions, making best use of primary care skills and providing timely access to diagnostic services.
- A single point of contact (by telephone) for urgent care with specialist advice by telephone provided by “hear and treat” (urgent care over the phone), or through an urgent care centre.
- Paramedics trained to provide more at-the-scene treatment with agreed protocols to ensure correct streaming of patients to either an urgent care centre, A&E or appropriate specialist facility.
- A senior clinical opinion will be available 24 hours a day, seven days a week in all A&E departments, followed by timely provision of definitive treatment.
- Centralised major trauma, heart attack, stroke and vascular surgery networks, with major trauma services available on four sites and hyper acute stroke services on eight from summer 2011.
- All surgical teams carrying out larger volumes of work resulting in improved outcomes.
- Avoidance of unnecessary deaths of patients related to venous thromboembolism and avoidable renal injury.

Planned care

- Outpatient appointments, routine diagnostics and minor procedures moved into polysystems to bring care closer to home.
- Transparent information on GP performance, for example on access, in the public domain to stimulate performance improvement.
- Agreed referral and pathway protocols to ensure follow up appointments are pertinent and in the appropriate setting.
- Separation of planned care from emergency care to reduce the risk of cancellations as well as infection rates.
- Increased use of day case settings for many procedures.
- Centralised planned specialist care to improve clinical outcomes, whilst delivering specialist planned care locally where possible.
- Agreement of a rehabilitation care pathway for patients before admission, with rehabilitation undertaken at home whenever possible.
- Improved joint commissioning of health and social care to support early discharge from hospital where possible.

Long term conditions – focusing on coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and diabetes

- Proactive case management by including 100 per cent of people with a long term condition on a disease registry, with an agreed personalised care plan.
- Reduced A&E visits, emergency admissions and length of stay through the development of integrated multi-disciplinary teams, including primary and community care, specialists and social care.
- Development of care pathway guidance for CHD and COPD, along the model developed for diabetes.[20]
- Standardised assessment of patients who arrive at hospital to minimise the need for admission.
- Immediate contact with the primary and community team in the event of a hospital stay, to facilitate discharge home.
- Increased use of e-health technologies that support home monitoring and better use of diagnostics and care management in the community

End of life

- All patients nearing the end of their life will have an electronic care plan, including preferences on place of death.
- All carers will have an assessment of their needs, carried out in partnership with local authorities.
- 75 per cent of all predictable deaths will occur in patients' preferred setting.
- End of life service providers will be commissioned to coordinate end of life care across London.
- Medications prescribed in advance for pain control, restlessness and agitation; clear protocols in place for dedicated support to administer pain relief or other medication, or to discontinue unnecessary drugs or interventions.

Quality and productivity metrics, to be published on London's Quality Observatory website[18], are being identified for each pathway. They will be used to monitor improvement and encourage changes in how services are delivered. These metrics will form the basis of London's Commissioning for Quality and Innovation (CQUIN) priorities for 2010/11 onwards, the London requirements to be included in Quality Accounts[19] and quality metrics to be included where appropriate in contracts. The current draft of these metrics is at Annex A, and they are set to be finalised by March 2010. They are drawn from the national library of metrics or have been proposed by commissioners, and will need further work to ensure validity.

5. The productivity challenge

Securing a higher quality, productive and sustainable health economy for London necessitates not only radical changes in care pathways, but also in how services are provided. Transforming care pathways will create efficiencies, but a profound change is also needed in how NHS providers deliver services. Over the next five years, providers need to make roughly 35 per cent productivity improvements: this challenge will require them to make productivity improvements across all areas of their business, as well as radically reconfiguring their estates. NHS London will work with the NHS Institute for Innovation and Improvement and NHS providers to identify opportunities so that organisations can best prepare for and respond to the productivity challenge. The London affordability analysis indentified five areas of opportunity for acute and non-acute (primary and community) providers (see Table 1).

Table 1: Acute and non-acute productivity opportunities

Acute	Non-acute
1. Reducing excess bed days, case-mix adjusted average length of stay and increasing day case rates to best in class (the savings realised here are captured in 2 and 5).	1. Increasing the amount of time GPs and nurses spend with patients, saving in the region of £600 million. GPs typically spend 18.5 hours of their contracted 37.5 hours per week on direct patient facing care. The plan is to move to 25 hours per week (achieved in Tower Hamlets), a 35 per cent increase.
2. Moving workforce productivity to best in class could save up to £1.5 billion. For example, the Productive Ward[20] initiative has seen increases of up to 40 per cent in the amount of time nurses spend on direct patient care.	2. Adjusting the skill mix with greater use of nurse practitioners, saving up to £290 million. To increase from a current rate of 33 per cent of appointments attended by a nurse or nurse practitioner to 50 per cent.
3. Reducing drug costs to best in class through a combination of reductions in branded drug prices, addressing variability in prescribing and increased generic prescribing, saving up to £505 million.	3. Moving to best in class appointment length, and patients accessing care though greater use of new channels of communication (such as telephone appointments and consultations via email), could save approximately £570 million.
4. Reducing 'do not attend' rates to release appointments for other patients or allowing a reduction in the number	4. More efficient use of space in primary and community care could yield savings of up to £40 million.

Acute	Non-acute
of appointments, saving approximately £71 million. 5. Reducing clinical (for example, pathology) and non-clinical back office costs and rationalising overheads, saving up to £1 billion.	5. Saving up to £210 million by reducing drug costs to best in class via a combination of reductions in branded drug prices, addressing variability in prescribing and increasing generic prescribing.

6. New style services: the key to improved healthcare

To deliver high quality care and productivity together is only possible by changing the shape of London's health services. Today London has poor quality primary care services. It is the worst performing region in all but three of the 19 clinical indicators in the 2008/09 QOF scores.[21] The 2008 GP patient survey identified that although more patients were able to get an appointment within 48 hours than in 2006/07, at 83 per cent London still lags behind all other regions.[ix] Practices remain small (54 per cent of GP practices in London have only one or two GPs, compared to 40 per cent nationally[22]). This combined with poor facilities, makes it difficult to offer extended opening hours and a broader range of services, including diagnostics and effective support of patients with long term conditions. In London there are large numbers of hospitals, with some high quality, specialist centres, but others that do not meet minimum clinical best practice, for example for some aspects of cancer care.[23] This results in an over-reliance on A&E services for urgent care and poorer outcomes for some specialist care.

Creating world class care for London means delivering a step change in the capacity of primary and community care services. It means creating polysystems – a network of care involving all health professionals and services across a given population and maximising partnerships with social care and other public services. For hospitals this means moving from a district general hospital model to one that recognises the need to specialise to secure the best clinical outcomes. It means centralising some specialist activity into major acute and specialist hospitals, moving some planned care to elective centres and developing high quality local hospitals.

To make the care pathway recommendations achievable and to assist providers in increasing productivity, six settings of care are being implemented:

[ix] Every PCT in London has been asked to develop an action plan detailing how it would improve performance in the five key access indicators. These plans were reviewed against metrics developed by NHS London and where necessary feedback to improve plans given. NHS London is now monitoring progress against these plans as part of its performance management function.

Home: care at home will focus on increasing the number of women supported to give birth at home, increasing self care and the number of people managing their long term conditions from home and for more people to be able to choose to die at home.

Polysystem: a primary care-led approach to healthcare, designed to localise care wherever possible. Each polysystem will have a polyclinic as its "hub", but also with a proportion of care delivered at home, in linked GP "spoke" practices and/or locations in the community. Polyclinics will improve accessibility and quality by offering extended opening hours across a wide range of services, including health promotion, urgent care, diagnostics, community services, minor procedures, outpatients and the case management of patients with long term conditions and provide a link to social care services.

Local hospital: will deliver a range of non-complex inpatient and outpatient services, including 24 hours a day, seven days a week A&E, acute medical and surgical admissions, maternity care, bed-based rehabilitation and diagnostics, networked with specialist and major acute hospitals as well as with polysystems.

Elective centre: will focus on providing planned, routine, high-throughput elective surgical procedures, allowing for more planned operations to be done as day cases. Separating elective surgery improves productivity and quality of care, as operations do not have to be moved or cancelled to make way for emergency cases and infection rates are reduced.

Major acute hospital: will focus on emergency care for patients suffering the most critical conditions requiring immediate specialist care. They will require sufficient volumes of activity to ensure critical mass to enable clinicians to maintain and develop specialist skills and sustain 24 hours a day, seven days a week rotas. Based upon the recommendations from clinical working groups, and the views of patients and the public expressed in consultation, commissioners will:

- over time, seek to concentrate major trauma, hyper acute stroke, heart attack centres and complex vascular surgery onto major acute sites to secure the optimal clinical model; and
- decommission non-major acute providers currently undertaking some procedures (for example complex vascular surgery) that, on quality and safety grounds, should now only take place in major acute settings.

Specialist hospital: will focus on a single area of care and deliver the most complex treatment within that specialty or group of associated specialities. Concentrating specialist activity onto fewer sites helps specialist hospitals achieve a critical mass of activity, ensuring that specialist skills of clinicians and facilities can be used most effectively. To maximise the capabilities of specialist hospitals and ensure that they stay at the cutting edge of medicine and research, the expectation is that they will all be linked to one of London's three Academic Health Science Centres (AHSCs).

Implementation plans
Establishing the Healthcare for London settings of care is being led by PCTs. They are working in cooperation with providers and using competition where appropriate. London's PCTs have developed plans for 102 polyclinics (see Map 1), the vast majority of which are expected to be fully operational by the end of 2013. Ten polyclinics are currently open, although these are yet to meet the full quality and productivity specification:

- Alexandra Avenue, Harrow
- Barkantine, Tower Hamlets
- Beckenham Beacon, Bromley
- Charing Cross Hospital, Hammersmith & Fulham
- Gracefield Gardens, Lambeth
- Hammersmith Hospital, Hammersmith & Fulham
- Heart of Hounslow, Hounslow
- Hornsey Central, Haringey
- Loxford, Redbridge
- Oliver Road, Waltham Forest

NHS London is working with all PCTs to help them finalise their plans, including those few PCTs where the precise location of some of their polyclinics remains unknown. PCTs are continuing to engage with their local populations to inform and improve their plans, in line with national policy and guidance.[24] In some cases, formal consultation on a PCT's plan may be needed.

Where acute hospital services need to be changed to implement the Healthcare for London settings of care, London's six sectors have developed options for how the new settings apply to sites in each sector. Following consultation on *The Shape of Things to Come* – proposals for improving stroke and trauma services in London – London's PCTs agreed to designate four major trauma centres with associated networks and eight hyper-acute stroke units, linking to 24 stroke and transient ischaemic attack units. This has enabled sectors to signal the locations of their major acute hospitals. In north west London, St Mary's Hospital has been designated as a major trauma centre and Charing Cross Hospital has been designated as a hyper-acute stroke unit. Commissioners are working with Imperial College Healthcare NHS Trust on a plan to co-locate both services on the St Mary's site, subject to public consultation.

NHS London is working with the sectors in finalising their proposals, so that these move forward as quickly as possible. In most circumstances, this will include formal consultation on the proposals in line with national policy and guidance. Consultations are not expected to commence before autumn 2010. However, some changes consistent with the new settings of care have already been agreed following the *Barnet, Enfield and Haringey Clinical Strategy* and the *A Picture of Health for South East London* consultations. In south east London, a new organisation – South London Healthcare – has been formed by a merger of three NHS trusts. All the NHS organisations in these parts of London are focused on implementing the agreed changes.

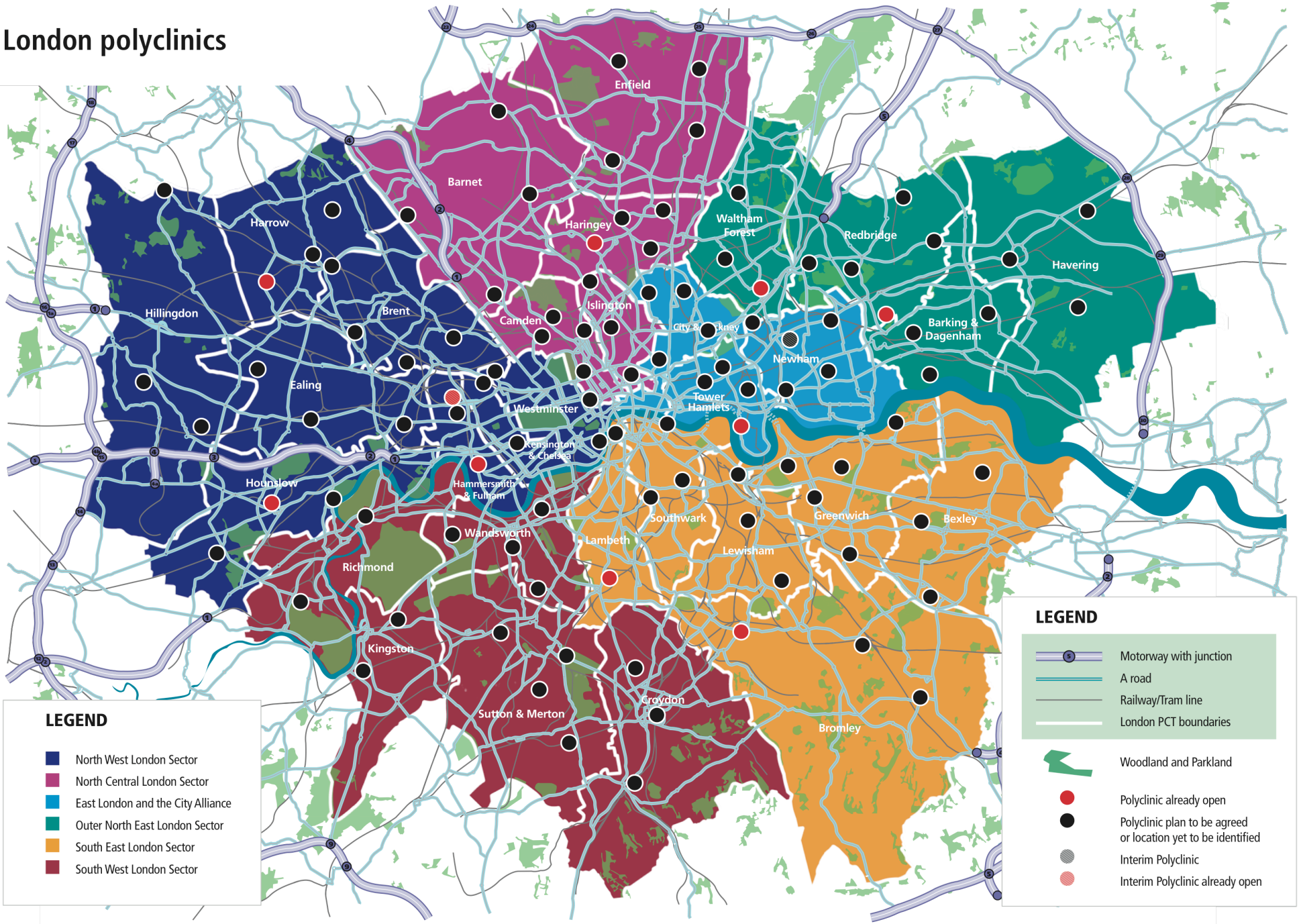
In north east London, the two sectors (Outer North East London and East London and the City) have been working together and began formal consultation in November 2009 on proposals to designate Queen's Hospital in Romford and the Royal London Hospital in Whitechapel as major acute hospitals. The King George Hospital site in Ilford would be transformed into a polyclinic with 24 hour a day, seven days a week access to urgent care along with an elective centre.[25] Further consultation to confirm the precise future of the sectors' local hospitals may be needed, but this would not commence before autumn 2010.

Map 2 shows the current acute hospital landscape in London, including the sites designated as major trauma centres and/or hyper acute stroke units.

While commissioners are leading the changes, NHS London is supporting NHS trusts and PCT provider organisations in delivering the new care settings. A range of potential transactions that secure clinical and financial sustainability for providers, including options for vertical integration and a small number of community foundation trusts, are all being considered.

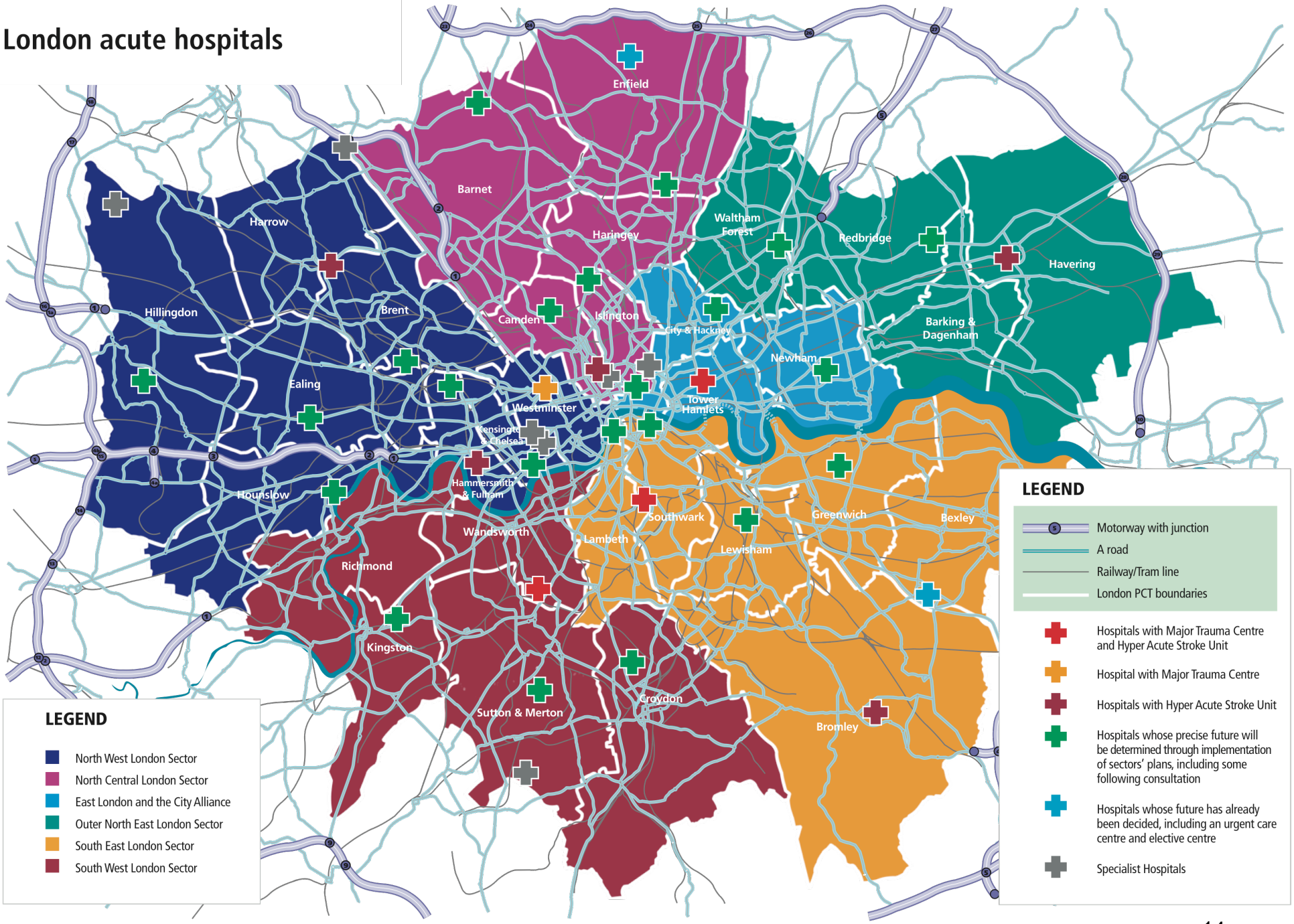
MAP 1

London polyclinics



MAP 2

London acute hospitals



7. Making it happen

To transform health and health services successfully, the right support and infrastructure needs to be in place. In recognition of this, NHS London, building on the original work in *A Framework for Action*, has developed ten enabling strategies to support implementation of the Healthcare for London vision. These are focused on:

- Strengthened clinical and managerial *leadership* to drive a step change in performance.
- *Strengthened commissioning* to ensure high quality and productive services, based on population needs.
- The development of *providers and business models* which secure clinically and financially sustainable organisations capable of responding to the Healthcare for London vision.
- The transparent use and publication of routinely collected *information* on clinical process and outcomes, patient experience and productivity to provide clinicians with a way to measure the quality of themselves relative to their peers, and the public to make choices.
- *Incentives* to support dramatic improvement in quality and productivity.
- Faster dissemination of *innovation* to address particular implementation challenges.
- A *workforce* delivery model which supports greater workforce mobility across care settings, including changed roles, skills and contractual arrangements.
- Better management and utilisation of *estates* to support the establishment of the new models of healthcare provision.
- *IT* systems which support delivery of integrated care including the patient care record and patient booking.
- Better *communications* to engage the public and other key stakeholders so as to create an understanding of the need for change.

Each enabling strategy has a detailed implementation plan and specific actions to deliver on from 2010-2015. The roll-out of the enabling strategies will be sequenced so that they provide the best possible opportunities for improved care and productivity. Some work is already under way, for example, with NHS London funding workforce directors for each sector to lead the development and implementation of workforce plans.

8. Priorities for 2010/11

The scale of the task to deliver Healthcare for London and the resources required to support this are considerable. This section summarises the priorities for implementation in year one (2010/11), of the developing Integrated Strategic Plan.

A set of priority actions for 2010/11 has been developed drawing on the care pathway recommendations, opportunities for improving productivity and the proposed settings of care. These have been developed by assessing which deliverables offer the greatest quality and productivity improvement, together with the best sequencing of implementation (i.e. some recommendations need to be delivered to allow the implementation of others).

Achieving higher quality
In 2010/11 the focus will be on realising the benefits of the work completed to date (stroke, trauma, diabetes and shortly cardiovascular and cancer) and on the staying healthy, acute, long term conditions and planned care pathways, with four specific priorities in mind:

1. Putting prevention into practice.
2. Improving London's response to urgent care in the community.
3. Prevention, early identification and better management of those with long term conditions.
4. Moving planned care closer to home.

Recommendations from the care pathway work which will need to be delivered to meet these aims are outlined in Table 2.

Table 2: Care pathway recommendations

Staying healthy	• Systematic identification of those at risk of vascular disease (stroke, heart disease, kidney disease, diabetes) and support to manage that risk, primarily through full roll-out of NHS Health Checks for those aged 40-74, improving exercise levels and healthy weight programmes. • Smoking cessation - a reduction in smoking prevalence at 4 weeks. Two areas of focus are: stop smoking campaigns targeted on manual socioeconomic groups and tobacco control strategies. • Implement the London NHS sexual health framework, focusing on HIV prevention, chlamydia screening and teenage pregnancy. • Increase uptake rates for childhood immunisations through incentives and performance management. • Maximise screening uptake through improved community outreach, close monitoring of performance and stronger commissioning (including incentives for providers for performance).
Acute	• Provision of 12 hours a day, seven day a week urgent care service at every polyclinic, with timely access to diagnostic services (whilst consolidating the commissioning of out of hours services, extended hours, walk-in centres, minor injuries units and NHS Direct). • Primary care led and contracted urgent care services at every A&E department, as part of a local polysystem, with 24 hour access to senior clinicians.

	• More treatment at the scene by appropriately trained ambulance staff. • Implementation of agreed changes to stroke and trauma services and the forthcoming model of care for cardiovascular.
Long term conditions	• Adoption of evidence based screening programmes that consider the whole care pathway, and proactive management of at risk populations using health checks. • 100 per cent of diagnosed patients on a disease registry with a personalised care plan. • 24 hour service to proactively care for patients with single point of contact and responsibility. • Self-care and home monitoring of conditions. • Immediate contact with the primary / community team in the event of a hospital stay to allow rapid discharge back into the community.
Planned care	• Create transparency on GP performance, for example on access, to stimulate improved performance. • Develop polysystems to accommodate transformation of outpatient appointments, diagnostics (including results) and minor procedures in out of hospital settings. • Develop and implement systems and protocols to reduce length of stay, for example through a planned discharge date. • Create step-down capacity to facilitate effective discharge and rehabilitation. • Implementation of the forthcoming model of care for cancer.

A focus on productivity

To deliver cash releasing productivity improvements successfully year on year over the next five years, London's providers will need to focus productivity work in 2010/11 on building the systems and capacity to do so. Simultaneously, there is a need to adopt best practice on key indicators. Priorities for 2010/11 are:

Acute providers:

- Gaining a full understanding of their cost base and cost drivers, for example, by use of service line reporting and the NHS London productivity tool.
- Fully engaging clinicians so that they lead on the productivity agenda, for example, by implementing service line management.
- Reducing length of stay and reducing excess bed days towards the level of the current best (top 25 per cent) in the country.
- Moving towards best practice use of buildings and facilities.
- Reducing clinical and non-clinical back office costs starting with implementing the recommendations of the Carter report on pathology.[26]

Non-acute providers:

- Introducing systems to understand fully the cost of treatments, including the adoption of the polyclinic commissioning and financial model in all polysystems, which should be reflected in contracts.
- Using primary care performance indicators to move towards best practice in use of staff, making sure there is an appropriate mix and increasing time spent with patients. A balanced scorecard will be developed across London that looks at the performance of individual GPs, polysystems, PCTs, sectors and London as a whole.

Introducing new settings for care

Having established what can most quickly can be done to improve quality and productivity the next priority is to facilitate delivery by focusing on the settings for care:

- *Polysystems:* the focus in 2010/11 will be on ensuring there are 30 polysystems established, meeting the full specification in terms of services and delivering the full cost savings as set out in the affordability study. Having used 2010/11 to understand how to deliver polysystems to their full specification, commissioners will plan for a rapid increase in the roll-out of polysystems in 2011/12.

- *Hospital care settings*: the focus in 2010/11 will be on implementing the changes to stroke and trauma, and those shortly to be agreed for cardiovascular services and cancer. This needs to ensure that improved quality and financial benefits are assured thereby laying the firm foundations for London's major acute hospitals. Mechanisms to reduce double running costs and to release capacity in the acute sector, to be utilised in 2011/12 onwards will also be developed.

Enabling delivery

Successful delivery of the proposed actions for 2010/11 depends on overcoming some key barriers using the solutions developed by the enabling work programmes. These solutions are:

- *Strengthening commissioning.* To support delivery, there is a need to strengthen the current commissioning arrangements in London, to ensure capabilities are in the right place; that governance and accountabilities are streamlined and clear at London, sector and borough level; and that the 30 per cent reduction in management costs can be delivered.

- *Creating business models to support the development of polysystems.* To deliver polysystems, a set of business models need to be created that allow primary care clinicians to employ secondary care professionals and deliver polysystems, and allow acute providers to employ GPs and provide primary care services, thus allowing commissioners to easily contract for the service model.

- *Introducing new payment mechanisms to drive productivity and support new models of care delivery.* In 2010/11 work will focus on 'unbundling' the tariff[x], piloting capitation budgets[xi], and rolling out a transparent, activity-based costing system for community health services to support improvements in productivity.

- *Transparent information to support change.* Quality metrics are being developed to support implementation of each of the care pathways. These will be part of the routinely collected clinical information used to support clinicians in improving quality and productivity. It will also be delivered through CQUIN, quality accounts and contracts. Outcome data will be proactively published by providers for key aspects of care so that commissioners and patients are informed about the quality of care at each trust.

- *Training the polysystem workforce*. The workforce needs to be in the right place with the right skills to deliver polysystems.

- *Putting in place integrated IT systems which support implementation of Healthcare for London*. To deliver polysystems that operate to their maximum potential, electronic patient records must be able to be shared between care settings, and safely share information with social care services, linked to disease registries. It must also be possible to provide diagnostics in the polysystem setting and exchange diagnostics between care settings.

- *Ensuring that the existing estate is used productively and assets recycled to fund new developments*. For 2010/11 investment in polysystems will be prioritised where there is easy and affordable access to sites and there is a financially and clinically viable business case. Alongside this a new capital and estates regime needs to be created to encourage more productive use of estate and to develop sector based estate funds.

- *Developing an approach to decommissioning.* Implementing Healthcare for London means a considerable shift in activity from acute to polysystem settings. Unless any surplus capacity can be exited quickly, there will be significant double running costs. Developing proposals for service change, consulting stakeholders on those proposals and implementing agreed

[x] The current hospital tariff structure means that a trust receives a single payment for the whole hospital stay. This needs to be broken down, 'unbundled', so that care takes place and is paid for in the right setting. This would underpin the development of polysystems by ensuring that payments follow the shift in services and the NHS doesn't pay twice.

[xi] Moving to a system of capitation budgets for integrated care will incentivise budget holders to provide cost effective services, focus on proactive management of patients with long term conditions, and invest in prevention.

service changes takes too long and is expensive. A speedier approach to reconfiguring services needs to be developed, where necessary in partnership with the Department of Health and the Cooperation and Competition Panel.

9. Ensuring delivery of 2010/11 priorities

To ensure the delivery of the 2010/11 priorities, roles and accountabilities of organisations throughout the system need to be clear.

The leadership group of the NHS in London, the London NHS Policy Group (LNPG), which is comprised of the chief executives and chairs of NHS London and the sectors, will take overall responsibility for oversight of progress on implementation of the Integrated Strategic Plan (ISP). The membership of the LNPG will be expanded to include all those responsible for leading implementation of the ISP.

Sectors will take lead responsibility for implementation of care pathways and care settings in their areas, ensuring strategic coherence. Commissioners will drive change in providers, via contracts and performance management, where appropriate support and performance management will also be provided by NHS London. The ten enabling strategies will be delivered by NHS London and Commissioning Support for London.

Detailed roles and responsibilities will be produced by March 2010, to ensure clarity and reduce duplications. Delivery will be supported by aligning resources and levers behind the priorities, as illustrated in Table 3.

Table 3: Levers and resources 2010/11

Implementation resources	• Using the innovation funding available in 2010/11, to set challenges based upon the identified priorities (NHS London) • Aligning the £3.5m of strategic fund resources available behind the identified priorities (NHS London) • Ensuring that CSL resource is aligned to supporting the delivery of the priority actions (commissioners) • NHS London will work with the NHS Institute for Innovation and Improvement to develop a suite of existing and new products to support implementation of Healthcare for London (NHS London)

Hospital provider levers	• Prioritising identification of acute and planned care pathway CQUIN indicators for 2010/11, including patient experience metrics (commissioners) • Setting a clear position, through the Challenged Trust Board, that funding support will only be approved for trusts which demonstrate compliance with plans to implement the acute, long term conditions and planned care pathways, and the activity and service shifts to create polysystems (commissioners) • Setting clear guidelines for Foundation Trust applications during 2010/11 that applicants must demonstrate compliance with plans to implement the Healthcare for London care pathways as well as the activity and service shifts proposed to create polysystems (NHS London) • Focusing Health Innovation and Education Cluster (HIEC) funding for 2010/11 on the priority care pathways (NHS London) • Academic Health Science Centres (AHSCs) to prioritise work to drive development of best practice on prioritised pathways (NHS London) • Linking any further access to research and development funding to trusts driving delivery of the prioritised care pathways (NHS London) • Enhanced appraisal of medical staff to include focus on London quality priorities and improved productivity (also relevant to polysystems) (NHS London) • Aligning Multi Professional Education and Training (MPET) funding to the Healthcare for London priorities (NHS London)
Polysystem levers	• Prioritising identification of long term conditions CQUIN indicators for 2010/11 (commissioners) • Putting in place processes to fast track polysystem capital business cases, and prioritise capital where necessary (NHS London) • Where appropriate putting in place Local Enhanced Service agreements to drive implementation of the long term conditions and acute care pathways (commissioners) • Putting in place procedures to fast track Practice Based Commissioning business cases for long term conditions and acute care pathways for the 30 polysystems (commissioners) • Devolving significant resources to the 30 polysystems to drive delivery, for example finance and information support (commissioners) • Creating a bespoke leadership programme for 2010/11 for the clinicians leading the polysystems (to ensure successful implementation of the full polysystem specification, but also to create a set of primary care change agents) (NHS London)

Conclusion

This First Stage Report of the Integrated Strategic Plan sets out the key areas of focus for the NHS in London for 2010/11 and the next five years, as it works together to deliver Healthcare for London. Progress has been made, but the journey ahead remains challenging. Leadership, drive and commitment will be called for at all levels of the NHS if services are to be truly transformed for all in the long-term.

The Healthcare for London vision is clear, not only on the rewards of change, but on the areas that must be changed. That is why the priorities for 2010/11 are the four areas that will move the NHS in London most quickly towards a tipping point in this transformation, and are the quickest wins in improving quality of care and productivity. By delivering Healthcare for London, rights for patients enshrined in the NHS Constitution, such as the rights to choice and access to high quality care, will be met consistently across the capital.

Maternity and newborn care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11

Annex A: Monitoring progress – proposed care pathway metrics

	Pre-conception	Ante-natal non-delivery	Birth	Postnatal & neonatal care
Current	Percentage mothers smoking at delivery (7.4%)	Assessment of health and social care needs, risks and choices by a midwife or maternity professional completed by 12 weeks of pregnancy	Low birth weight babies % (7.7%)	Breastfeeding rates at 6-8 weeks (57%)
	Teenage conception rate (47.0 / 1000 females)		Caesarean section rates (23.7%)	
			Average length of stay (normal delivery (1.7), assisted delivery (2.6), C-section (3.7))	
			Deliveries per midwife (~35)	
Future	Percentage given advice or information about contraception	Ratio of antenatal admissions to birth events	Episiotomy rates	Health visitor productivity/utilisation
		Healthcare commission rating of care during pregnancy	Healthcare commission rating of labour and pregnancy	Midwife productivity/utilisation
		Adherence to NICE protocols	Apgar scores at 1 min/10 min	Healthcare commission rating of care after birth
		Midwife productivity/utilisation	Perinatal mortality	

Source: London data – pack (various sources)

Staying healthy pathway

(XX) – London average performance

Key data metric | Priority for 2010/11

	Changing Health behaviours	Improving protection and prevention	Managing disease burden
Current	% obese (adults1 = 6.5% % obese children2 = 21.3%)	Uptake of immunisation, influenza over 65s (72.5%)	See management of LTC
	Smoking cessation success[3] (829.9) 4 week smoking quitters (99.7% against plan Q1 09/10)	Uptake of breast screening, 53-64 yrs (63.8%)	
		Uptake of cervical screening, 25-64 yrs (73.8%)	
	% women exclusively breastfeeding at 6-8 weeks (34.9%)	Uptake of bowel screening, 70-75 yrs	
		Prevalence of Chlamydia	
	% on 5 a day[4] (29.8%) % taking regular exercise[5] (20.2%)	NHS health check	
Future	Smoking prevalence Cost per quitter	Cost per immunisation/screen	
	% women exclusively breastfeeding at 3 months, 6 months	Uptake by segment	
	Success rates at changing health behaviours e.g. increase rates of 5 a day		

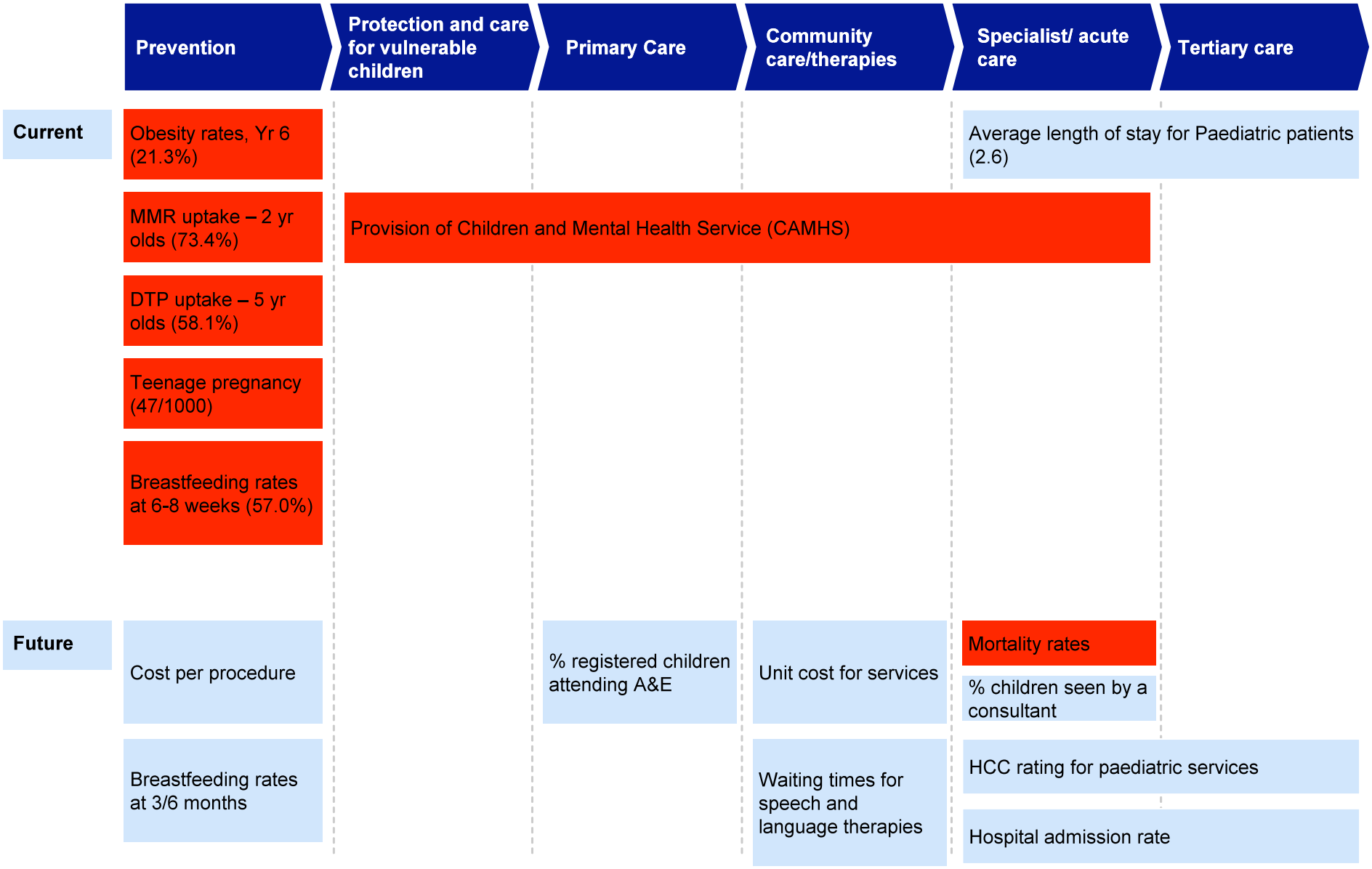
Source: London data-pack (various sources). Department of Health, September 2006

1. Reported prevalence of BMI>30
2. Year 6 children who are obese
3. # of successful quitters per 100,000 popn aged 16 and over
4. Estimate of healthy eating, Neighbourhood stats (03-05)
5. Physically active adults (exercise >3 days per week), Sport EngaInd

Children and young people's care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11

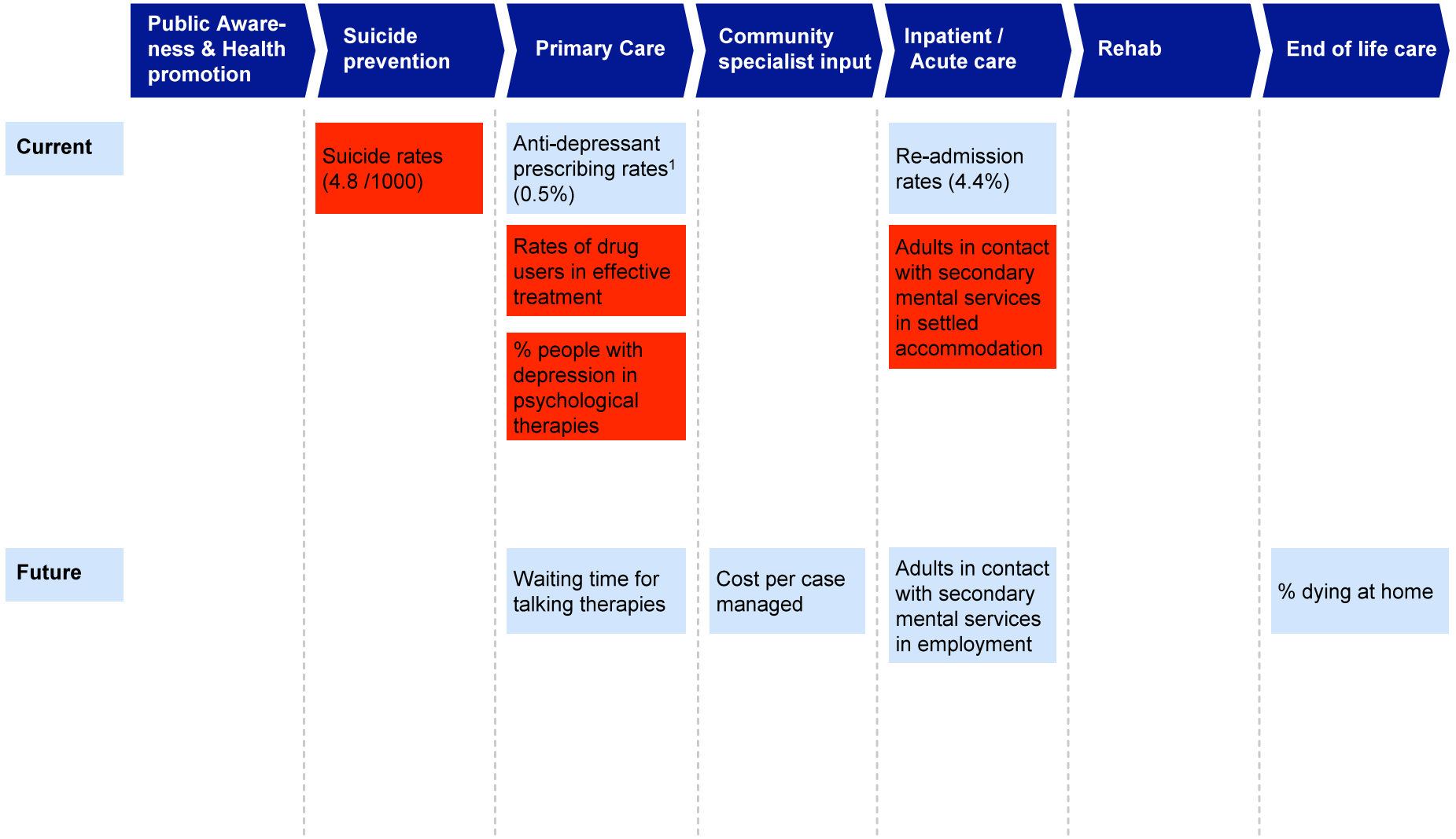


Source: London data – pack (various sources)

Mental health care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11



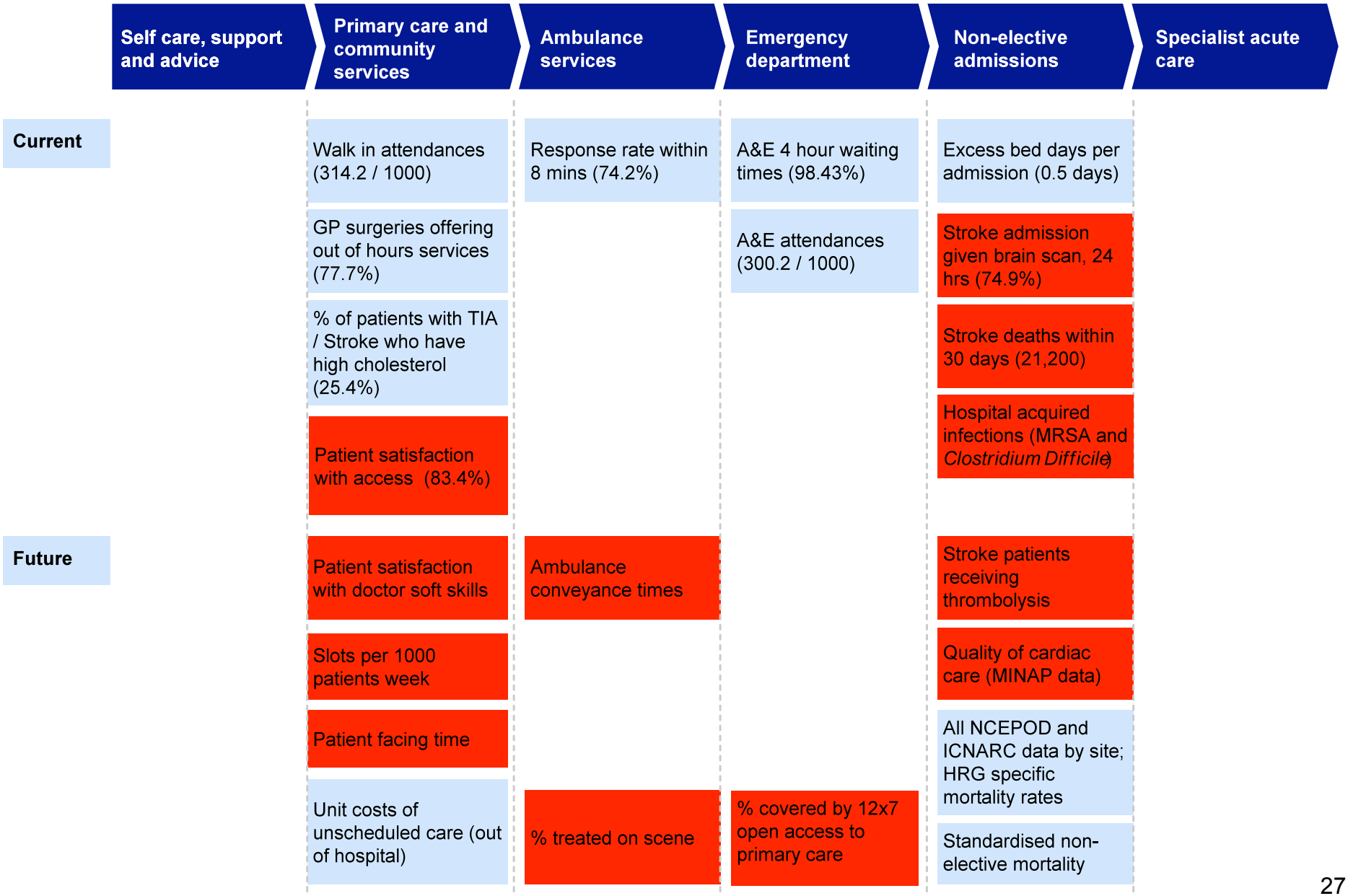
1. Ave daily quantity / specific therapeutic groups age, sex-related prescribing unit

Source: London data-pack (various sources)

Acute care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11



Source: London data-pack (various sources)
Weekly A&E/ambulance data packs YTD 03/01/10

Planned care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11

	Self Assessment and Self Care	Primary and Community Care	Acute & Specialist Services	Rehabilitation and follow up
Current		% of patients seen within 18 weeks Admitted – 92.9% Non-admitted - 97.7%		Readmission rates (Standardised 28-day = 101.8)
		Number of diagnostic waits over 6 weeks (227)	Actual versus expected day case rates (-0.01%)	
		GP referrals into secondary care[2] (204.8)	1st to follow up ratio (2.2)	
		Patient satisfaction with access (83.4%)	Hospital acquired infections (MRSA and *Clostridium Difficile*)	
			Two week wait for breast symptom referrals	
Future		Outcomes for minor ops done in primary care	Post op infection rates	
			Day surgery rates	
		OP attendance rate	Actual versus expected interventions	
		% of patients admitted with planned discharge date	PROMs for frequent operations e.g. joint replacements	
			Actual versus expected length of stay (ALOS)	
			Clinical process and outcome measures e.g. use of venous prophylaxis prior to surgery	
			Wait times for second or subsequent radiotherapy cancer treatment	

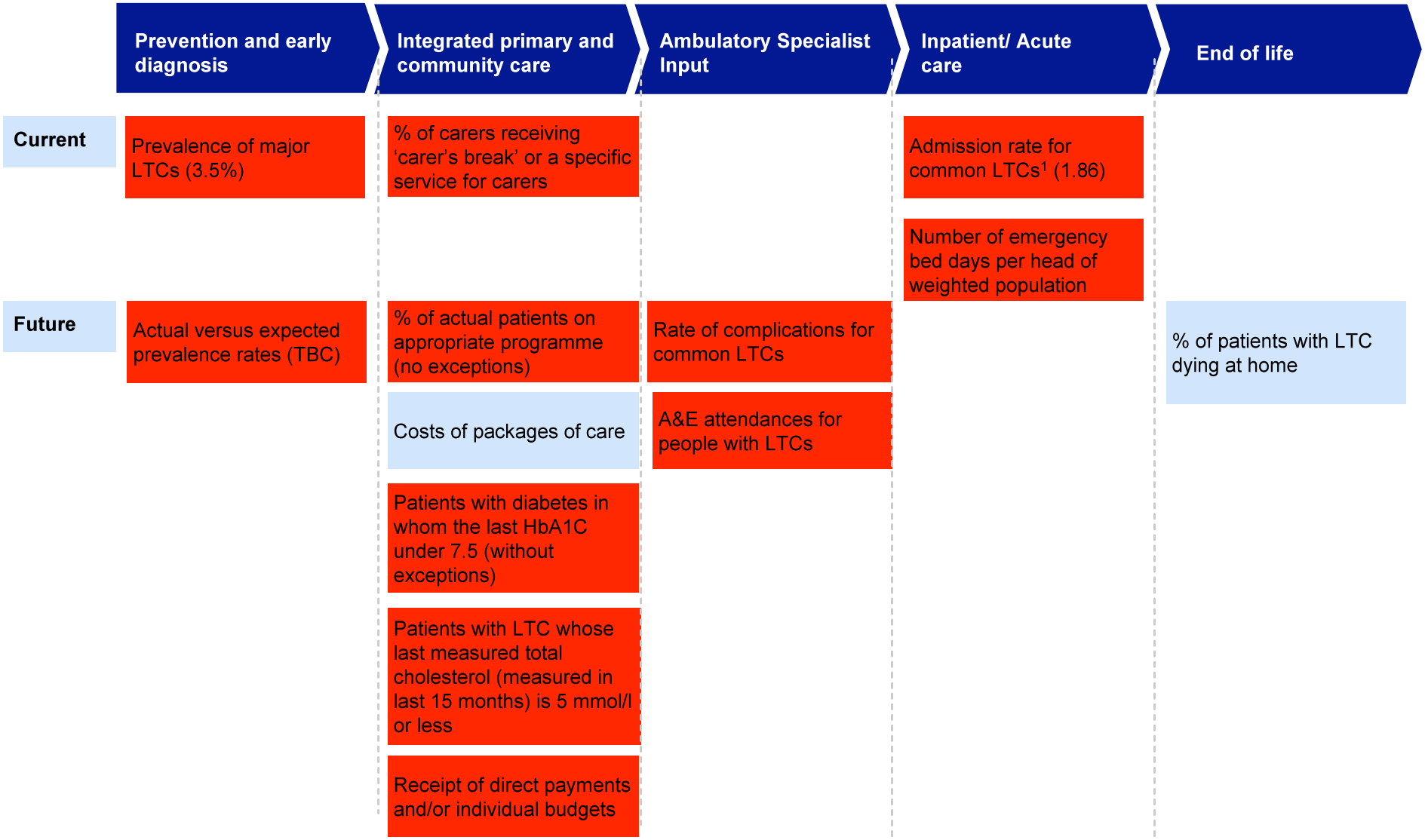
1. 18-weeks data pathways
2. # per 1000 weighted popn

Source: London data-pack evidence (various sources)

Long term conditions care pathway (numbers for diabetes)

(XX) – London average performance

Key data metric | Priority for 2010/11



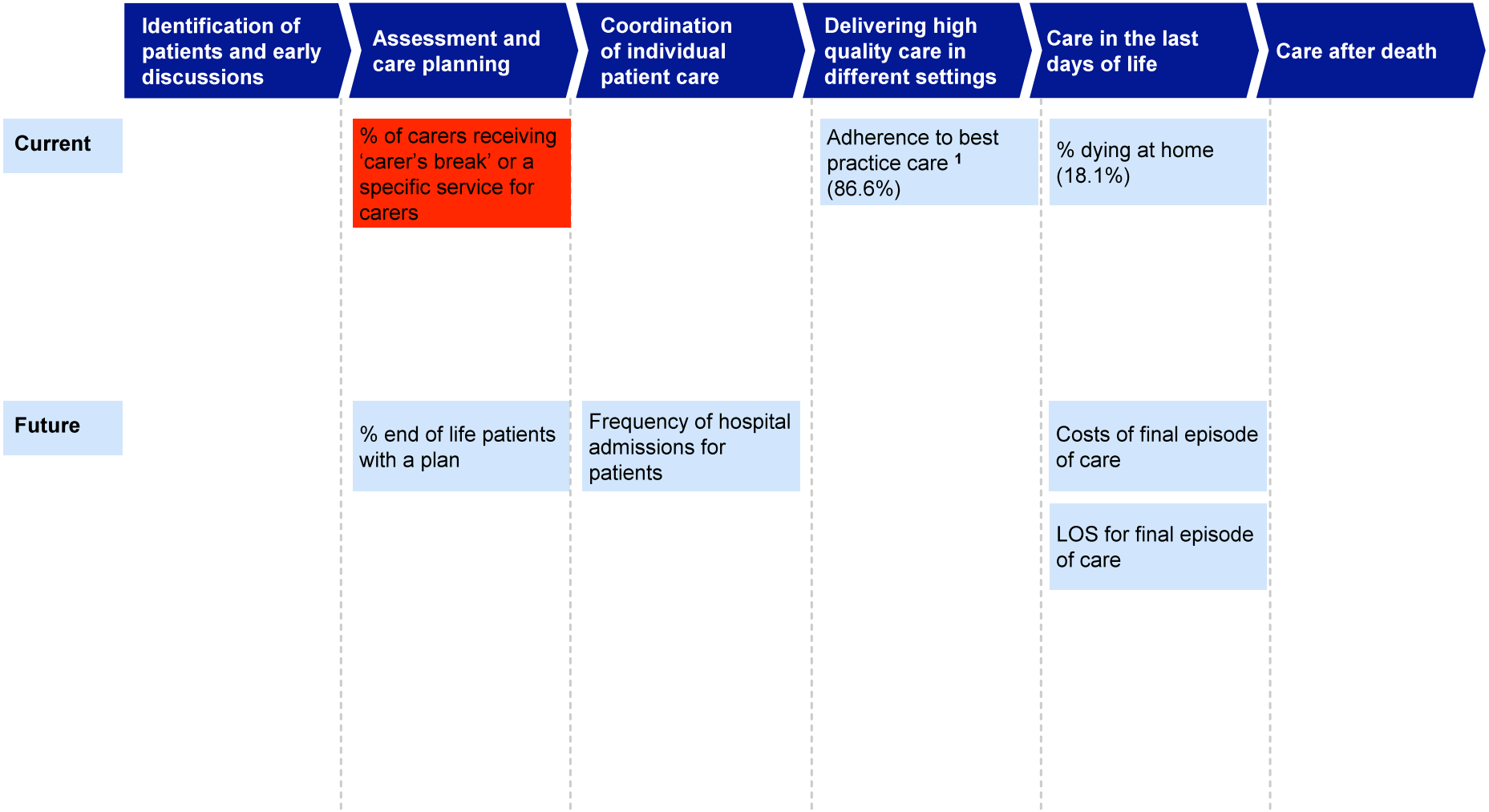
1. Admissions per 100 registered diabetes patients

Source: London data-pack evidence (various sources)

End of life care pathway

(XX) – London average performance

Key data metric | Priority for 2010/11



1. Proxy is % of GPs signed up to GSF

Source: End of Life Care Strategy Working Paper. Department of Health, September 2006

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