Healthcare for South West London

NHS

DRAFT – WORK IN PROGRESS

Healthcare in south west London: a case for change

Document Revision History

Revision date	Author	Change Summary	Version*
05/01/2010	N Millane	1st draft creation	0.1
06/01/2010	N Millane	Revisions	0.2
07/01/2010	D Neame	Edited	0.3
08/01/2010	N Millane	Revisions	0.4
11/01/2010	N Millane	Revisions	0.5
15/01/2010	D Neame	Edited	0.6

* Version 0.1, 0.2 etc - Draft
Version 1.0 - Final Issue 1
Version 1.1, 1.2 etc - Draft amendments to Final Issue 1
Version 2.0, 3.0 etc - Final Issue 2, 3 etc

Approvals
This document requires the following approvals before finalisation.

Name and Position/Group	Date Approved	Version
Programme Directors		
Clinical Strategy Group		
Sector Chief Executive		

Contents

We want your comments and views
Clinicians across south west London are looking at how we can improve healthcare services for local people. We welcome your views and feedback on this case for change and proposed initiatives for improvement. Please email comments to: healthcare@swlondon.nhs.uk

Transforming health services in south west London

People in south west London can be proud of their local NHS services. Primary care trusts are investing in more community services and supporting people to stay healthy. We have a committed workforce and many examples of innovative hospital services.

We know however that healthcare services are not as good as they could, and should, be. We need to achieve better patient outcomes, reduce health inequalities and improve patient satisfaction.

We must also ensure that healthcare services are sustainable. Transforming healthcare services has become an increasing priority with the challenge of the economic climate. We must look at new ways of delivering services to make best use of our resources. Much closer co-ordination and communication between NHS organisations will be needed in future, with the NHS working in networks to deliver care. We need to build strong and productive relationships with the community, including all partners in the public sector and the voluntary sector.

Clinicians are leading ambitious plans to change the NHS in south west London. Around 100 doctors and health professionals from across the area, working with patients, staff and members of the public, have looked at how we can best deliver better healthcare, and their ideas for improving services are described in this document. We believe these proposals will enable staff to deliver higher-quality care that better meets the needs of local people. By working together we can, and will, make a difference to the lives of everyone in south west London.

Sian Bates,
Sector Chair, NHS South West London

Ann Radmore
Sector Chief Executive, NHS South West London

A programme led by clinicians

Our health services compare well against national comparisons in many aspects of care, and there are beacons of excellent practice.

Nonetheless, the evidence is clear that many patients are not receiving the quality of care they deserve. There are big differences in the health of the residents of south west London – there is a 12-year difference between best and worst life expectancy across the area. People in south west London are also less satisfied with healthcare services than in other parts of England. And far more people could avoid attending A&E with the right support in the community. We need to provide more accessible services of the highest quality and deliver better care for everyone, especially mothers, newborn babies and children.

Clinicians representing all NHS organisations in south west London have looked at how we can provide the best quality care for our population. The recommendations in this document build on the many improvements staff have made in recent years. But there is still a long way to go. We are clear that services must change. The NHS will need to make bold decisions to enable future healthcare services to become truly world class. We believe more services should be provided in the community or as close to home as possible, whilst more specialised care should be available in real centres of expertise. Providing care in the most appropriate settings will be better for patients and more efficient, ensuring that services are sustainable in years to come.

We look forward to providing clinical leadership to the NHS in south west London, working with our colleagues, patients and the public to develop services that meet the needs of the whole community.

Mr Gavin Marsh, Dr Howard Freeman, Dr Martyn Wake
Joint Clinical Directors, Healthcare for South West London

Introduction

World class healthcare for a world class city; that was the ambition of *Healthcare for London: A Framework for Action*[1], published in July 2007 and followed by wider public consultation[2]. The Healthcare for London programme is now delivering on its promise to create significant improvements in the quality of healthcare services in the capital.

South west London residents are largely fortunate – overall they are wealthier and healthier than most people in London and England[3], and the sector has fewer areas of deprivation than other parts of the capital or the UK[4]. Residents live longer than the England average and they have good access[5] to relatively high quality healthcare.

But there is plenty of room for improvement and we cannot continue to provide care in the same way we have done in the past. Residents and visitors have different health needs; technology and our understanding of health have enabled us to develop new treatments; and our workforce is becoming more highly specialised. Our services need to change. We need to build on improvements in recent years and ensure services make best use of our limited resources.

Clinicians have examined the case for change and identified a vision for improving healthcare services in south west London, with a focus on:

- staying healthy
- maternity and newborn care
- children's services
- urgent, unscheduled and emergency care
- planned care
- mental health
- long term conditions
- end of life care.

This document describes those challenges and opportunities facing the NHS in south west London over the next seven years, and the proposed initiatives for improvement, building on local plans for high quality services.

Working with clinicians, patients and the public, we will look at developing a number of options for delivering better primary, hospital and community care; ensuring services are of excellent quality, financially viable and sustainable in the future.

The NHS in south west London will consider the following guiding principles when looking at how healthcare services should be delivered in future:

- Services should be of the highest quality and delivered cost effectively.

---

[1] Healthcare for London: *A Framework for Action* www.healthcareforlondon.nhs.uk

[2] Healthcare for London: *Consulting the Capital*, commenced November 2007

[3] Annual Survey of Hours and Earnings, Office for National Statistics

[4] Deprivation date from the Association of Public Health Observatories' website

[5] Department of Health Primary Care Toolkit, HCAI Data Capture System, July 2008; Care Quality Commission, Department of Health dataset QMAE; Neighbourhood Statistics, Emergency Department Survey 2008

- Care should be delivered by the right clinician in the right place at the right time.
- Centralise specialist acute care as much as possible and localise care closer to home.
- Services should be provided equitably and consistently across the sector.
- We need to attract, train and retain the highest quality workforce.
- Better integration of community, social, primary and secondary care is required.
- The sector should have a strong collaborative approach to provide expert support to all patients.

What is Healthcare for South West London?

NHS organisations in south west London are working together to consider how we can best deliver healthcare services for people in south west London. This includes:

- NHS Croydon
- NHS Kingston
- NHS Richmond
- NHS Wandsworth
- NHS Sutton and Merton
- Epsom & St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Trust
- Mayday Healthcare NHS Trust
- St George's Healthcare NHS Trust
- The Royal Marsden NHS Foundation Trust.

We are also working closely with mental health trusts in south west London and with hospital trusts in other areas that provide patient care for our residents.

Our vision

Our shared vision is to maximise the health of our population, increase life expectancy, and improve the quality of life for everyone in south west London.

Who is involved?

We are working with clinicians, community groups, patients and the public. All staff in the NHS in south west London have been asked to contribute their ideas.

Clinically-led change
Around 100 clinicians are leading the transformation of healthcare services, with representation from all primary care trust (PCTs), hospitals and foundation trusts in south west London. Five clinical working groups have reviewed the case for change and identify options for improving services.

Clinical working group members represent a broad range of professions and specialities, with representation from GPs, nurses, doctors, midwives and allied health professions.

Voice of patients and the public
A Patient and Public Advisory Group is working with clinical working groups to help identify ways we can improve healthcare services in south west London. Members represent all Local Involvement Networks (LINks) in boroughs within and bordering south west London, as well as hospital patient forums.

Balancing finances

Our priority is to improve the quality of care for people in south west London. However we also need to ensure that services are sustainable in future years. There is increasing demand for NHS services and costs of drugs, treatments and technology will rise. While the NHS has had unprecedented levels of growth in recent years, it's unlikely we will receive a lot of extra funding.

If no changes are made we estimate that by 2016/17 the NHS in south west London could be spending around £300 million more that its predicted budget.

Substantial savings can be made from better healthcare. Preventing people from becoming ill is more cost effective than providing care to people who are already ill. In a good health system, fewer people become ill, patients need fewer treatments and drugs; they get better quicker and stay in hospital for less time; and they are treated right first time. We need to take action now to balance our finances. For instance, smoking costs the NHS in London £100 million per year so there could be substantial savings in stopping people smoking.

Clinical evidence shows that specialist teams deliver higher quality care and are more efficient than those providing a range of services. Separating emergency and planned care teams could deliver 25% savings – over £30million in south west London – just in the operating theatre. There would also be savings and improved patient experience from less readmissions and reduced lengths of stay. Savings could then be invested in improving current services and future care for the expected increase in activity.

Profile of south west London

South west London has a resident population of more than 1.34 million people living in six boroughs. Our GP registered population is 1.5 million – 17.6% of the total population of London [6]. Whilst residents tend to be wealthier, younger and live longer than many other places in England, these averages hide big differences in life expectancy and deprivation.

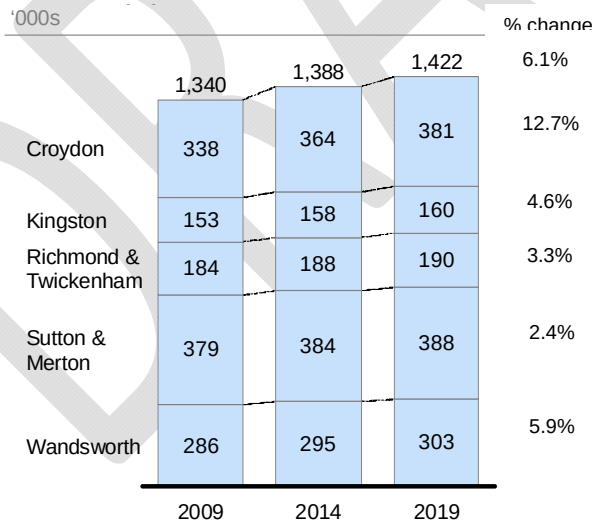
Population

South west London's population is growing and becoming older. This means there will be a significantly greater need for healthcare in future.

The population of south west London will grow by 6.1% over the next ten years (varying between 2.4% in Sutton and Merton and 12.7% in Croydon) [Exhibit 1]. The growth rate for most age groups is expected to be slower than the London average (5.3%); however there will be a 9% increase in people aged 65 - 84 living in south west London compared with a 7.7% rise for London as a whole. The mortality rate is expected to decrease across the sector, with Richmond and Wandsworth seeing the greatest decline[7].

Croydon has over 335,000 residents – the largest population of any borough in London[8] – and a GP registered population of 371,448. The borough also has a highly transient population, including high numbers of refugees and asylum seekers with specific health and social care needs.

Exhibit 1: South west London population growth



1 Population growth assuming GLA low scenario

[6] The GP registered population exceeds the 2009 resident population estimate of 1.34 million by more than 176,000 people (13%). This higher GP registered population needs to be factored into financial planning assumptions because it represents those people who receive healthcare in south west London.

[7] NCPC, May 2008, quoted in Richmond & Twickenham PCT End of Life Review, April 2008

[8] GLA 2007 Round Population Projections – low, quoted in South West London Collaborative Commissioning Initiatives Plan 2008-2012, Nov 2008

There are more people aged 25-34 in south west London than the England average, and fewer children and young adults aged 5-24. However, this picture is not uniform across boroughs – Richmond and Kingston has a higher proportion of people aged over 75 than the London average, whilst Croydon and Sutton both have an above average population of children under the age of 16[9]. Wandsworth has a higher proportion of young adults and a lower proportion of older people.

A comparison of the population profile for south west London and London is provided in the table below.

Exhibit 2: Population age profile

Age group	SWL population estimate	London population estimate
0-19	23.9%	24.5%
20-64	64.4%	64.2%
65-84	10%	9.7%
85 and over	1.7%	1.6%

Births

Birth rates` vary across south west London. Merton, Richmond and Sutton have similar rates to the London and England averages, Croydon has a higher rate, and both Kingston and Wandsworth have lower rates. Future planning for maternity and children's services will need to be able to accommodate a range of predicted birth rates.

In 2007, 21,200 babies were born to mothers living in south west London, a 21% rise since 2001. Some of these babies were born at hospitals outside of the area. Similarly some mothers delivering at hospitals in south west London reside in other areas.

Ethnicity

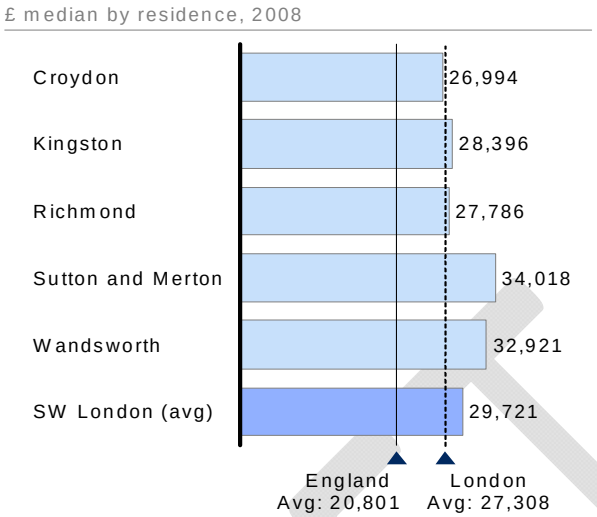
The black and minority ethnic population comprises 24% of the total population in south west London, which is less than the London figure of 35%. Black people are the largest ethnic minority group in Croydon while Asian people are the largest ethnic minority group in all other boroughs. Different ethnic groups experience a range of different health problems. For example, people from south Asian communities have higher risk of coronary heart disease and diabetes; people from an African or Caribbean background have higher risk of stroke; while people from a white British background have higher risk of breast and skin cancer.

Deprivation

Overall, residents have above average earnings and lower levels of deprivation, but south west London is not one of the most affluent areas in England. Annual income in Croydon is lower than the London average [Exhibit 3].

[9] GLA 2007 Round Population Projections – low, quoted in South West London Collaborative Commissioning Initiatives Plan 2008-2012, Nov 2008

Exhibit 3: Gross annual income in south west London



SOURCE: Annual Survey of Hours and Earnings, Office for National Statistics

A broad range of social, economic and environmental factors influence the population's mental and physical health. For instance, deprivation is linked to health need and life expectancy.

The Index of Multiple Deprivation (IMD) can be used to rank boroughs by degree of deprivation, and the table below lists the positions of the south west London boroughs. Croydon and Wandsworth are among the most deprived half of boroughs nationally.

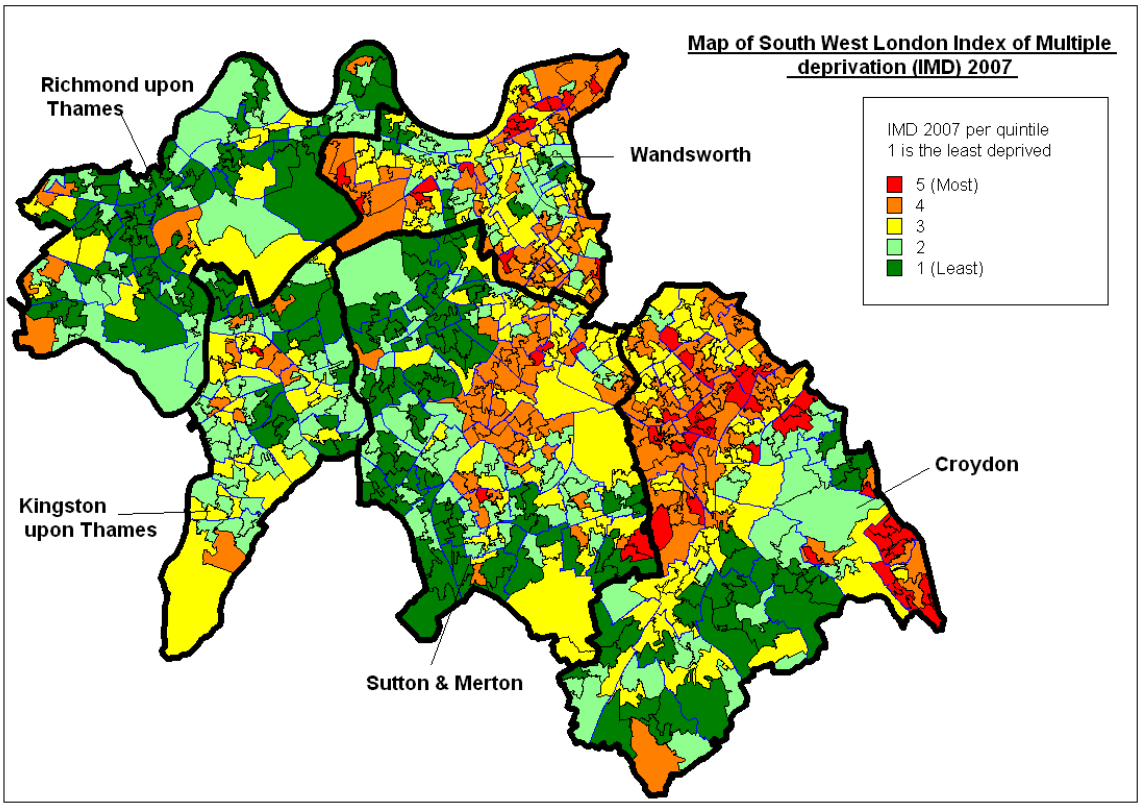
Borough	Overall IMD 2007*
Croydon	125
Wandsworth	144
Merton	222
Sutton	234
Kingston	245
Richmond	309

* 1 is most deprived borough in England and 354 is the least deprived

There are pockets of populations with very high socio-economic status in all six boroughs alongside areas of severe deprivation; with Wandsworth and Croydon having the highest proportion of deprived areas. In these wards over a quarter of children live in poverty/deprived areas[10].

[10] Association of Public Health Observatories, Community Health Profiles

Exhibit 4: Map of 2007 Index of Multiple Deprivation



Life expectancy

On average, residents in south west London live one year longer than London residents – the average life expectancy for women in south west London is 83 years, and 79 years for men[11]. However life expectancy varies between boroughs – life expectancy for men is 76.9 years in Wandsworth and 80 years in Richmond. The majority of wards with the lowest life expectancy are in Croydon and Wandsworth.

There is more significant variation within boroughs. For instance there is a seven-year difference in life expectancy between the least deprived and most deprived wards in Wandsworth alone. Across south west London there is a 12 year gap in male life expectancy and a 10 year gap in female life expectancy between wards.

The maps below show life expectancy for males and females across wards by deciles. The ten per cent of wards with lowest life expectancy in south west London are highlighted in dark red.

[11] London Health Observatory Public Health Performance Report, 2008/09 Q4

Exhibit 5: South west London life expectancy for females by ward

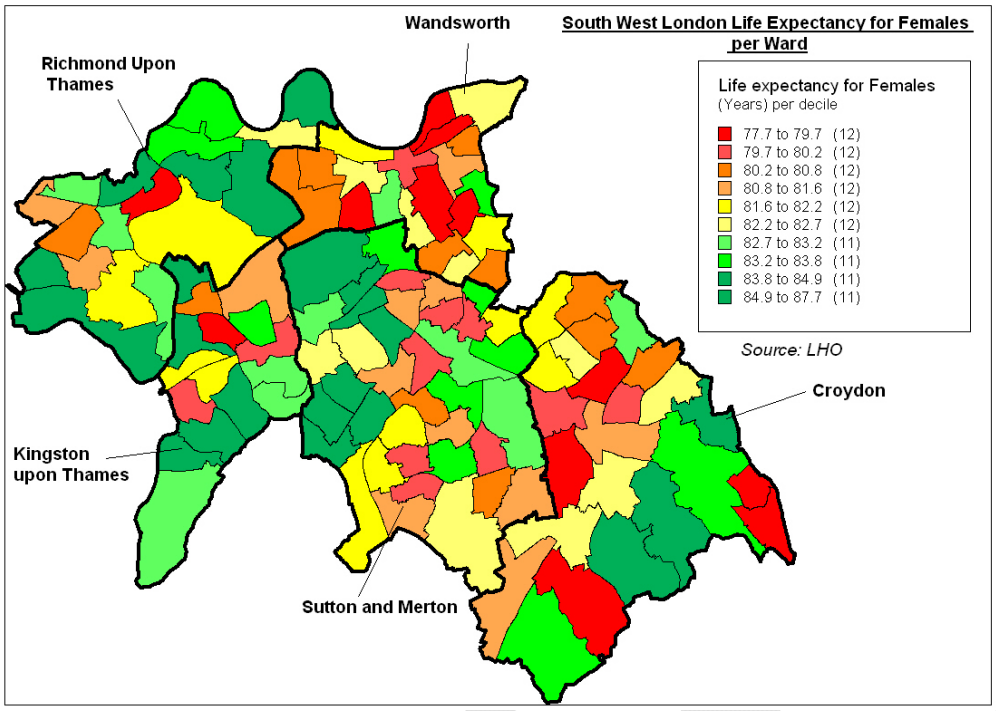
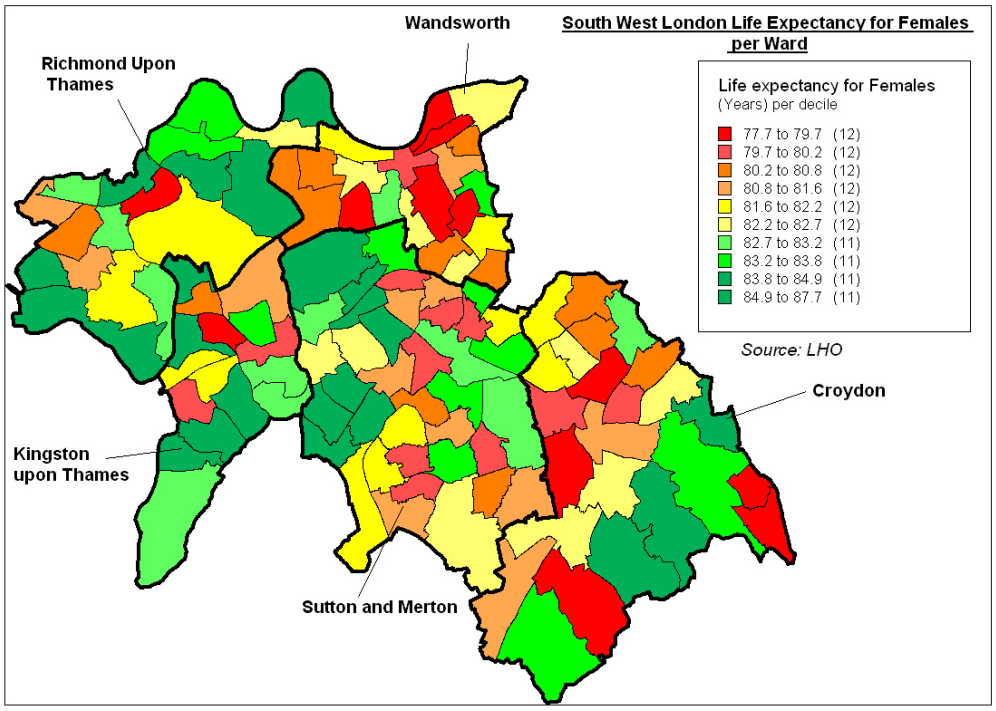


Exhibit 6: South west London life expectancy for males by ward



The case for change

Investment in NHS services has substantially improved services over recent years, including:

- primary healthcare: local people have better access to GPs at evenings and weekends, more community nurses and mental health therapies. We have also strengthened the ability of PCTs to commission high-quality services through creating a sector acute commissioning unit which will share specialist knowledge and skills, take advantage of economies of scale and ensure all services perform to the highest standards. PCTs have also established arms-length organisations to provide primary care services. This will drive up quality by introducing more competitiveness to provide services and allowing better scrutiny of services provided.

- hospitals: have reduced waiting times in A&E and for a wide range of treatments; we have transformed services for people having a heart attack, and are doing the same for people who have a stroke or trauma.

Yet there are still huge variations in life expectancy and mortality rates across south west London .And demand on healthcare services will increase in future with more people, more babies and potentially more disease unless we do something to prevent illnesses often brought by lifestyle choices such as eating, drinking and smoking too much.

As well as improving the efficiency and sustainability of healthcare services, we need to actively drive up the quality of care in hospitals to save lives and improve the quality of life for people in south west London [Exhibit 7].

Exhibit 7: Hospital performance[12]

	Overall quality mark	Use of resources	Children's services	Maternity services
Epsom and St Helier	Good	Fair	Fair	Weak
Kingston	Fair	Good	Good	Weak
Mayday	Good	Good	Fair	Weak
St George's	Fair	Fair	Fair	Weak

Performance against other trusts in England: ■ worse ■ about the same ■ better

In developing this case for change, clinicians focused on key areas where they believe we need to improve healthcare services. Discussions focused on what should be done across the sector – leaving PCTs to concentrate on improvements at a local level, particularly improvements to primary care services and health prevention initiatives.

12 Source: Care Quality Commission review 2008/09; Review of children's services 2007/08; Review of maternity services 2007/08

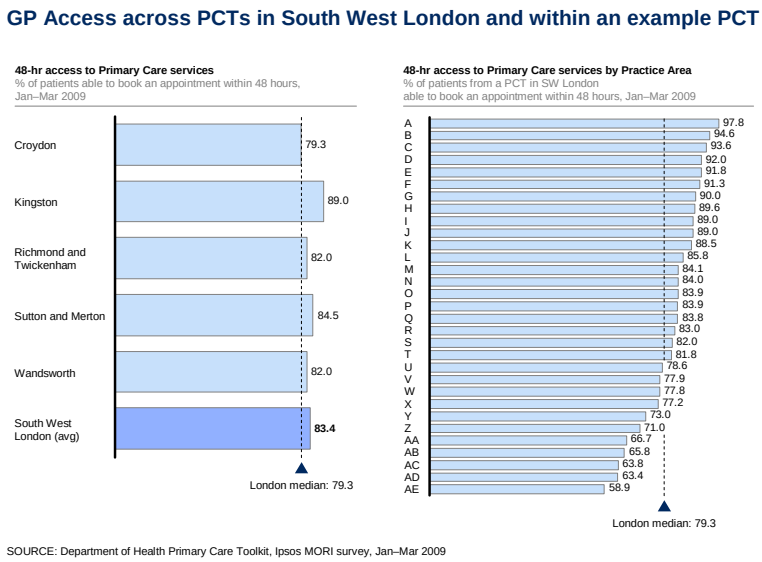
Staying healthy

Context

The need for an increasing focus on keeping people healthy has been highlighted in a number of reports in recent years[13]. In south west London, two-thirds of respondents to *Consulting the Capital* agreed that prevention was better than cure.

Overall, residents in south west London are fairly healthy. Yet the NHS – in south west London and more generally in London – is not meeting the needs of local people. For instance, there are large differences in the availability of GP appointments within 48 hours across practices[14] [Exhibit 8] and residents are less satisfied with surgery waiting times and out-of-hours provision than the England average[15]. More than 80% of respondents to *Consulting the Capital* in South West London thought it would be useful if GP surgeries were open for appointments in the evenings and at weekends.

Exhibit 8: GP access across PCTs in south west London and within an example PCT



SOURCE: Department of Health Primary Care Toolkit, Ipsos MORI survey, Jan–Mar 2009

There are examples of investment, innovation and excellent practice within the sector. NHS Sutton and Merton has developed and commissioned an older people's assessment and rehabilitation service (OPARS) in partnership with the Sutton local authority which is fully integrated with Cheam Priory Day Centre, a local voluntary organisation. This provides a more seamless service to patients. NHS Wandsworth has developed a primary care alcohol service that offers advice and short-term interventions to those not requiring secondary care. NHS Kingston has invested in a local voluntary sector group helping refugees to navigate the health service. At one event for over 150 people interpreters translated sessions into Arabic, Korean, Tamil, Farsi, Kurdish and Punjabi. And the PCT has encouraged black and minority ethnic residents (who are at higher risk of obesity and heart disease) and young asylum seekers on a low income to become more active and independent through a *Bike for Health* project.

13 The Wanless Report, the Choosing Health white paper, the Our health, our care, our say white paper, and Healthcare for London: A Framework for Action

14 Ipsos MORI survey, Jan–Mar 2009

15 Department of Health Primary Care Toolkit, Ipsos MORI survey, Jan–Mar 2009

Lifestyle issues

- **Obesity**
  Obesity is a risk factor for a range of diseases including diabetes, coronary heart disease (CHD), stroke and osteoarthritis. People living in south west London tend to eat more healthily than other parts of London and England, but fewer people exercise regularly in Croydon, Sutton and Kingston. While adult obesity rates are below the England average[16], the number of obese children and adults is still far too high, especially in Croydon and Sutton where close to 20% of adults are obese[17].

- **Smoking**
  Smoking is the leading cause of health inequality and is highly associated with deprivation; prevalence reaches 50% in the most deprived areas. One in two smokers will die from diseases such as CHD, stroke and various types of cancer. Many smokers will suffer from chronic diseases, increasing pressure on health services.

  Although the percentage of smokers in south west London is less than the London average[18] (with the exception of Sutton and Wandsworth) the rate of adults quitting smoking is below average too.

  Local smoking cessation services show a wide variation in the percentage of people who successfully quit. In Croydon, the rate of successful quitters is less than half the London and England average, while people using cessation services in Richmond and Kingston are more likely to quit.

- **Alcohol**
  Alcohol abuse causes a range of health problems including liver disease, CHD, mental health conditions, as well as accidents. A&E admissions and deaths from alcohol-related conditions are highest in Wandsworth and are rising in Richmond and Kingston.

- **Substance misuse**
  Substance misuse is lower in south west London than in London as a whole. However, the recorded rates of drug misuse in Croydon and Wandsworth have more than doubled in the past three years. In addition, admissions of people with drug-related mental health and behavioural disorders is higher in the area than the London average.

16 Association of Public Health Observatories; Government Office for London Indicator Profile 2007; PCT Health Profiles 2009; Care Quality Commission 2009

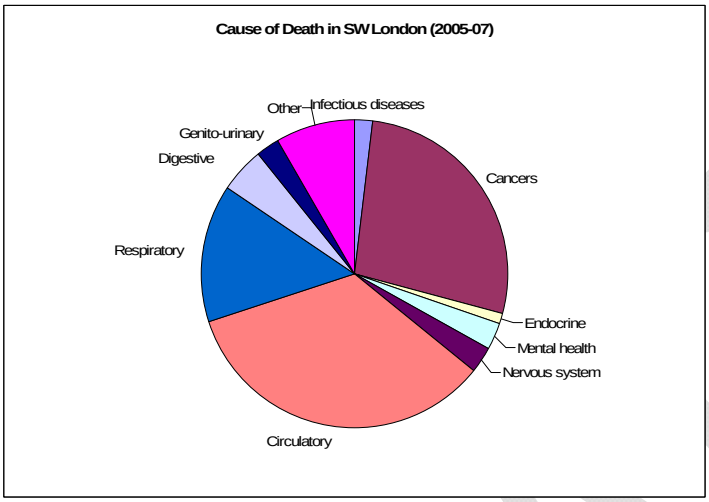
17 Association of Public Health Observatories, National Child Measurement Programme 2007/08

18 Association of Public Health Observatories, Community Health Profiles

Major killers

Cancer and CHD are the biggest killers in south west London [exhibit 9], though deaths in people under 75 years of age have significantly declined over the past three years (2006-2009).

Exhibit 9: Causes of death in south west London (2006/07)



- **Cardiovascular disease**

  Cardiovascular mortality rates in south west London are lower than in all other London sectors[19]. However there is significant variation in, and between, boroughs and deaths from heart disease and stroke in under 75s are still higher than the England average in Wandsworth, Croydon and Sutton[20].

  Coronary heart disease (CHD)
  CHD is responsible for 14% of all deaths across south west London – lower than the London and England averages of 15.6% and 15.9% respectively. However, the proportion of people identified with CHD is significantly lower than the estimated prevalence, though is likely to improve with the rollout of the vascular checks programme.

  Stroke
  Stroke is responsible for 8.4% of all deaths in south west London, which is slightly higher than the London average of 8.2% but lower than the England average of 9.3%. Local prevalence of stroke is considerably less than expected prevalence. The introduction of new stroke services across London and improvements to rehabilitation services will improve outcomes for people who have a stroke in south west London.

19 London Health Observatory Public Health Performance Report, 2008/09 Q4
20 Association of Public Health Observatories, Community Health Profiles

- **Cancer**

  Cancer prevention and screening
  While the quality of the screening undertaken is high, no PCT meets the 80% national target to screen all eligible women for cervical cancer. Wandsworth screens only 71.5% of eligible women.

  Breast screening rates only just exceed the national target of 70%, although they are below the England average of 77%. Wandsworth has a lower breast screening rate of 64% (the same rate as the London average).

Infectious diseases

- **Influenza**
  In 2008/09 all PCTs achieved the national target of 70% for seasonal flu vaccine for over 65s with the exception of Croydon (68.7%), although uptake was below the London average (72.5%) in all PCTs except Richmond. People aged under 65 in at-risk groups are also offered the vaccine, but only Kingston, Croydon and Richmond exceeded the London average of 46%. Increasing the immunisation rate in south west London will reduce hospital attendances, especially during the pressured winter months.

- **Tuberculosis (TB)**
  South west London's incidence rate of TB of 25.4 per 100,000 people is higher than the England average (15.5) but less than the London average of 44.3. Wandsworth has high incidence of TB and changes to screening at Wandsworth Prison is likely to identify a significant number of additional cases from 2010.

Sexual health

- **Sexually transmitted infections (STIs)**
  There was an increase in most major STIs from 2007 to 2008 in south west London; this contrasts with London as a whole where there has been no increase in STIs and a decrease in syphilis, gonorrhoea and chlamydia. For example, while chlamydia has decreased in London by 3%, south west London has seen a 17% increase.

  While there are fewer new HIV/AIDS cases than the London average, people in south west London are diagnosed later. The number of new HIV and AIDS diagnoses in the sector was 340, making up 10.1% of new diagnoses in London.

- **Screening**
  Fewer young people (aged 15 – 24) are screened for chlamydia in south west London; in 2008/09 only Kingston and Wandsworth exceeded the London average of 18% and the national average of 17% (Croydon met this average). As at June 2009, screening rates in the area were lower than both the London and England averages.

Key initiatives for improvement:

- NHS health checks should be offered to everyone aged 40-74 to help prevent heart disease, stroke, diabetes and kidney disease.
- Increasing awareness of cancer risk factors and better performance of cancer screening will be essential to prevent and identify cancers early. Working with providers, we need to identify why people are not attending screening services and adapt services to achieve higher

coverage. Close monitoring of the outcomes of treatment interventions will help to assure cost effectiveness and to guide future commissioning decisions.

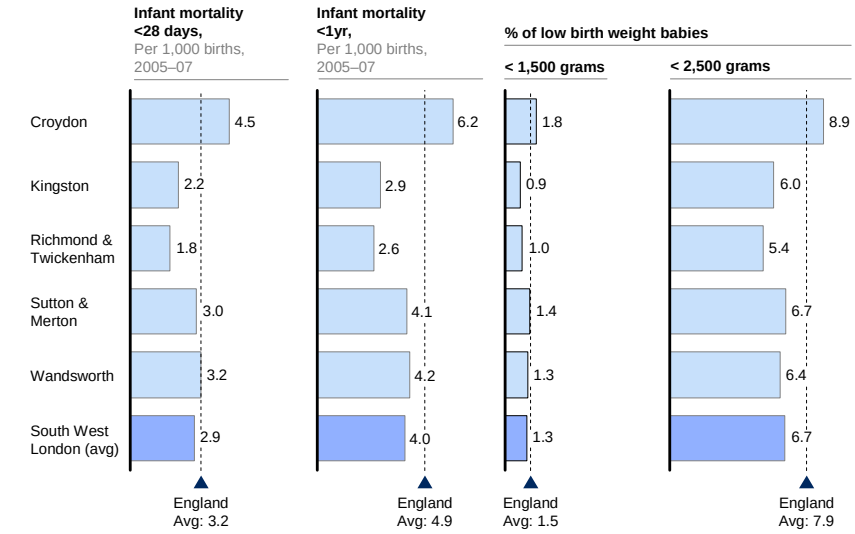
- We need to identify and share best practice within and between PCTs for health promotion campaigns, including smoking, alcohol, diet and exercise, and work with local authorities and health partners on healthy living.
- Ensure all stroke and cardiac patients have access to high quality rehabilitation services in the community.
- Improve sexual health promotion and the uptake of chlamydia screening through health promotion initiatives, and increase the availability of long-acting reversible contraception
- Invest in interventions to tackle childhood and adult obesity to reduce future demand on health services.
- Identify why some people in risk groups are not being vaccinated and target them appropriately, and use alternative providers to boost uptake of immunisations.
- Prioritise mental health promotion and invest in computerised cognitive behaviour therapy. More partnership working will be essential, particularly with drug and alcohol action teams. And services for people with dual diagnosis should be reviewed to reduce hospital admissions.
- Deliver sustainability by reducing the carbon footprint.

Maternity and newborn

Context

Overall, pregnant women in south west London are fairly healthy. More mothers in south west London breastfeed and fewer pregnant women smoke compared with the England average[21]. Infant mortality and low birth weight rates are below the England average, except in Croydon[22] [Exhibit 10].

Exhibit 10: Clinical indicators of infant health



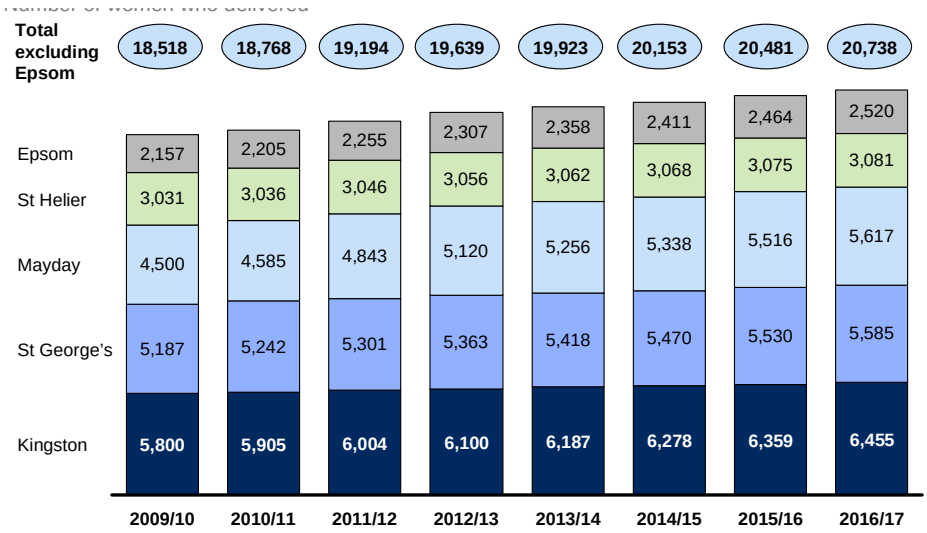
SOURCE: Compendium of Clinical and Health Indicators/Clinical and Health Outcomes Knowledge Base, Dec 2008; National Centre for Health Outcomes Development indicators 2006, quoted in SWL Collaborative Commissioning Initiatives Plan 2008-2012, Nov 2008;

However, there are challenges in providing maternity and newborn services to the population in south west London. The increasing age of women giving birth and high rates of immigration into the sector are factors which change the types of services needed. The number of women delivering in south west London hospitals is expected to increase by 12% to 21,000 births by 2016 [Exhibit 11].

21 Community Health Profiles 2009; PCT Health Profiles 2009; Care Quality Commission 2009; Vital Signs data released by Care Quality Commission on Aug 28, 2009

22 Compendium of Clinical and Health Indicators/Clinical and Health Outcomes Knowledge Base, Dec 2008

Exhibit 11: The number of women delivering in south west London hospitals



SOURCE: Data provided by Trusts, ONS; team analysis

The number of women delivering at Epsom Hospital is expected to increase from 2,157 births in 2009/10 to 2,520 births in 2016/17.

South west London has higher rates of emergency caesareans, episiotomies and perineal trauma than other parts of England, and consultant presence on labour wards in south west London is well below the 168 hours presence recommended for larger units. At the moment none of the maternity units are providing 98 hour consultant presence in a week, let alone the round the clock presence recommended for units delivering more than 5,000 births[23]. We also have difficulty recruiting and retaining midwives in some of our hospitals and do not always provide patients with the midwife care they desire and need. These challenges are not going to disappear as the number of births is predicted to rise.

There have been improvements to maternity services in the sector, for instance in Richmond the proportion of women who have their needs assessed by the 12th week of their pregnancy has increased from 50% to 80%. Kingston Hospital achieves a 95% success rate. However the sector's medium-sized obstetric (doctor)-led units do not always provide high quality care for women and babies. The 2007 Care Quality Commission review rated all four south west London trusts as 'weak', the lowest rating possible[24]. The review highlighted the need to improve training of staff and appropriate involvement of obstetricians in antenatal and baby care after discharge. The review also called for improvements in commissioning of maternity services, in particular monitoring quality and improving services. While significant steps forward have been made since the Care Quality Commission review, the sector will look collectively at the further improvements that can be made.

In *Consulting the Capital*, respondents in south west London felt that (from a list of alternatives) the most important factors for maternity provision were:

- Giving birth in a midwife-led unit with a doctor-led unit on the same site (51%). There are currently three in the sector, at Kingston, St George's and Mayday.

[23] The Future Role of the Consultant, Royal College of Obstetrics and Gynaecology, December 2005

[24] HCC review of maternity services, 2007

- Having a senior doctor present on the unit where you give birth (47%).
- Time taken to travel to the place where you give birth (41%).

Two in five respondents in South West London wanted the choice of having a home birth.

Key initiatives for improvement:

- Every woman should be offered high-quality care as well as a genuine and informed choice of how and where they have their baby.
- Better access to antenatal and postnatal care in the community should be provided (we could reduce antenatal admissions to hospital by 50%), along with health promotion services for pregnant women:
    - Social risk should determine the level of additional support required
    - Medical risk should determine the recommended location of birth, and whether a birth is midwife or obstetric-led.
- Maternity care should be midwife-coordinated, with extra care by an obstetric team if women are assessed as 'high-risk' or they choose obstetric-led care, e.g. an epidural.
- We should aspire to 24/7 consultant labour ward presence and providing 1:1 midwife care (for all women in established labour) in all birth settings.
- The highest level of intensive care is required at every obstetrics unit.
- Co-located midwifery-led units could deal with 20-30% of births.
- If an obstetric unit has more than 7,000 births, an additional standalone midwife-led unit should be considered.

Children's services

Children and young people

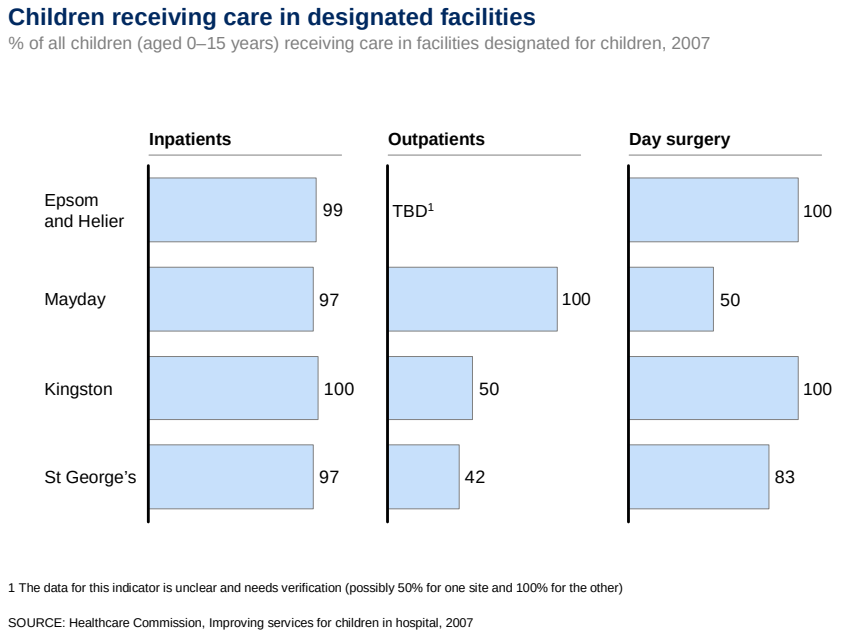
Context

In south west London, 16-19% of the population is aged 0-15[25]. The variation in deprivation across south west London complicates the delivery of appropriate care of all children and contributes to large differences in outcomes. For example, the infant mortality rate is three times higher[26] in the most deprived areas compared with the least deprived areas.

Children's A&E attendances in south west London are expected to grow significantly over the next ten years. A large number of these children could be cared for in primary care settings. However, lack of readily accessible primary care services can encourage presentation to A&E, which may in turn lead to inappropriate admission to hospital.

Currently not all children receive care in facilities designed for children – evidence suggests that dedicated children's facilities results in better outcomes. In some hospitals only 42-50% of outpatient services for children are provided in dedicated facilities[27] [Exhibit 12].

Exhibit 12: Children receiving care in designated facilities



1 The data for this indicator is unclear and needs verification (possibly 50% for one site and 100% for the other)

SOURCE: Healthcare Commission, Improving services for children in hospital, 2007

Children's hospital services in south west London at three hospitals were rated 'fair' and one hospital was rated 'good' in the 2007 Care Quality Commission review[28]. Children's outpatient services were rated 'weak' at two hospitals and 'fair' at the other two[29] [Exhibit 13].

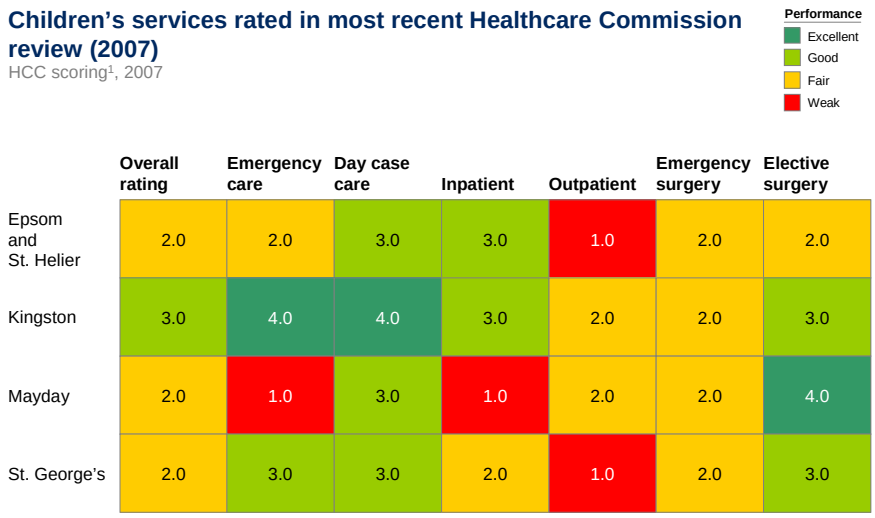
25 GLA PLP low 2007, quoted in South West London Collaborative Commissioning Initiatives Plan 2008-2012, Nov 2008

26 London Health Observatory Public Health Performance Report, 2008/09 Q4; Association of Public Health Observatories 2009 data from website

27 Healthcare Commission, Improving services for children in hospital, 2007

28 Kingston scored 'Good' overall. The scoring is 1-4 in the order of weak, fair, good, and excellent.

Exhibit 13: Care Quality Commission 2007 ratings of children's services



1 The scoring is 1–4 in the order of Weak, Fair, Good, and Excellent Performing. The ratings are given based on comparison with other organisations

SOURCE: Healthcare Commission, Improving services for children in hospital, 2007

The quality of children's elective surgery varies across the sector, and all four trusts were rated 'fair' for provision of emergency surgery. Currently specialist services are provided in too many sites, which can result in surgeons and anaesthetists not seeing enough cases to retain their expertise and training. In addition there are problems in recruiting paediatric (children's) clinical specialists. Children's services within A&E and inpatient units are currently stretched as a result of workforce constraints. The introduction of the European Working Time Directive (EWTD) will exacerbate this.

Services for children out of hospital are not as good as they should be, and the working arrangements between children's and newborn baby services could be improved. More than two thirds of urgent children's admissions are for less than one day. Many of these admissions, and the average length of hospital stay, could be avoided or reduced by providing more care in the home and in the community.

More planned care can be provided outside of hospital particularly for children with disabilities and long term conditions. There is currently limited integration between hospitals and community services – often services are not accessible when children most need them, and the NHS is poor at actively promoting self care.

Safer, higher quality children's services are important to the public. Providing more specialist children's care in fewer hospitals – even though this could be further from their home – was supported by over half of respondents to *Consulting the Capital.*

Health needs of children and young people

Infant mortality

The death rate of children under one year of age is lower in south west London than the London and England averages. In Croydon however, infant mortality is 29% higher than the London average and this issue is a priority for the PCT.

[29] Healthcare Commission, Improving services for children in hospital, 2007

Immunisation
South west London immunises more children at age two than the London average (77%), although rates are below the England average (86%). Increasing immunisation rates is a priority for the NHS in south west London and better information on the characteristics of the families whose children do not complete their immunisation schedule is needed to inform service models.

Obesity
Rates of childhood obesity vary across the sector – Kingston and Richmond have the lowest rates in London, whilst Wandsworth has the seventh highest rate in London and the eighth highest rate nationally (year six data). Tackling this issue will be vital, particularly in preventing obesity in adulthood.

Teenage pregnancy
Teenage pregnancy rates in south west London have been consistently lower than both the London and England averages, although rates for Wandsworth and Croydon are higher. Reducing teenage pregnancy rates is important as children of teenage mothers are at greater risk of experiencing poverty and are more likely to become teenage parents themselves, repeating a cycle of deprivation and poor health outcomes. Each borough has a teenage pregnancy action plan which detail actions for each PCT.

Alcohol
Alcohol-related hospital admissions of people under 18 is higher in the area than London as a whole, although significantly lower than the England average. However, alcohol-related admissions in Kingston and Sutton are higher than the England average.

Key initiatives for improvement:

- Children and young people should receive appropriate high quality care that is integrated and coordinated around their needs, and those of their family.
- We should work towards designated carers and facilities for children that are separate from adult services, both in community and hospital settings. Care should be provided in a safe environment, appropriate to the patient, and delivered by staff that have the right set of skills and experience.
- Over 60% of all current hospital outpatient appointments could be delivered in the community.
- Children's services within A&E and inpatient units are currently stretched.
- More than two thirds of urgent children's admissions are for less than one day. Many of these admissions could be avoided by providing more care in the community.
- Every A&E should have a children's A&E including a Paediatric Assessment Unit (PAU). Introducing PAUs and better discharge protocols will lead to a requirement for less inpatient beds. All PAUs require:
    - the presence of a specialist in intubating children
    - 16 hour consultant presence.

Urgent, unscheduled and emergency care

Context

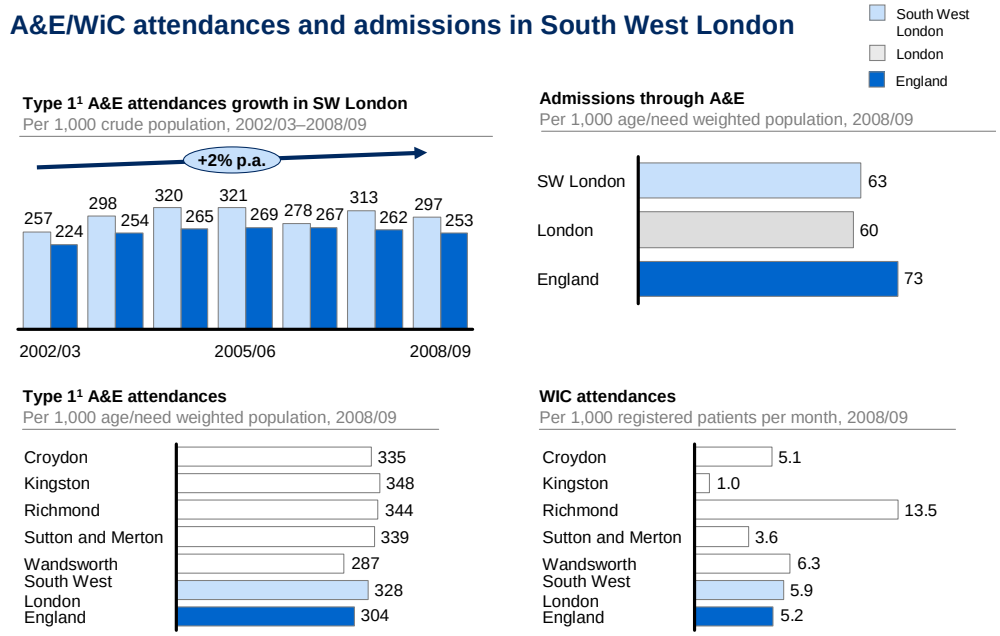
Urgent care comprises a range of responses provided to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. Across south west London, there are a variety of urgent care services offered, including walk-in-centres, minor injury units, GP out-of-hours services and A&Es. Difficulty in accessing urgent care provided by GPs, particularly out of hours services, and confusion in navigating different access points can result in patients defaulting to A&E.

South west London residents use urgent care services more frequently than other areas of England[30], therefore the pressures on these services are more immediate [Exhibit 14]. Up to 60% of patients with minor conditions could be treated in an urgent care centre (at an A&E or a community setting) by a primary care clinician such as a GP. Forty percent of current attendances will continue to need treatment in A&E, while 2% of attendances could be avoided.

Overreliance on A&E in the sector impacts on patient satisfaction. Patients in south west London report lower satisfaction with the quality of care, provision of information, building of relationships and comfort of facilities. In addition, patients being treated in A&E do not always have access to community support services, such as 24 hour liaison psychiatry. Social services can also be difficult to access out of hours.

Recognising that A&E isn't the most appropriate place for many patients – who don't have an accident or an emergency – but do need urgent or primary care; NHS Richmond's introduction of a walk-in centre has slowed the growth in attendances at A&E. And, despite the high number of A&E attendances in south west London, there are fewer emergency admissions than the England average – perhaps because of higher admission thresholds or because there is better support for people in the community, reducing the need for an admission.

Exhibit 14: A&E and walk-in centre attendances and admissions



1 Attendances to A&E departments excluding Minor Injury Units and Walk in Centres

SOURCE: Office of National Statistics; Hospital Episode Statistics, 2008/09, Reused with the permission of The Health and Social Care Information Centre; DH Primary Care Toolkit, Ipsos MORI survey, Jan–Mar 2009

30 Office of National Statistics; Hospital Episode Statistics, 2008/09, Reused with the permission of The Health and Social Care Information Centre

Whilst some performance indicators show services are better than the England average,[31] for example urgent surgery readmission and mortality rates, there are services that could be improved.

Concentrating specialist staff and equipment in fewer hospitals would result in better clinical outcomes as clinical teams develop and maintain their expertise. This would also help address recruitment shortages and as the challenges of compliance with the EWTD. Two thirds of respondents to *Consulting the Capital* in south west London agreed that more specialised care should be provided for patients suffering a major trauma, stroke or requiring complex emergency surgery.

By working together in networks, hospitals could ensure services are available in the sector round the clock, not just during the day. Work by Healthcare for London in partnership with local hospitals and PCTs on stroke and major trauma services showed that the quality and safety of services could be substantially improved by commissioning for quality and redesigning care pathways.

There are also problems with the way we diagnose and treat conditions. We need to streamline pathways of care to aid prompt and accurate diagnosis of conditions and recovery.

Key initiatives for improvement:

- Urgent care should be provided in a range of different settings, from hospital to the community, to ensure access to services where the need is greatest.
- All facilities should have the capability to stabilise and transfer patients safely, with clear transfer protocols and improved networking arrangements.
- The staffing needs for particular settings should be dictated by the competencies needed in that setting, rather than particular specialisations.
- Many more patients having urgent surgery could be managed as day cases. This would benefit the majority of patients who prefer shorter hospital stays.
- A&Es:
    - An average of eight patients a night are operated on in the sector. At the moment, hospitals need to reopen their theatre if urgent surgery is required. Urgent surgery at night should be avoided to the greatest extent possible and could be consolidated.
    - Registrars must have rapid access to experienced surgical and anaesthetic opinions at all times.
    - All A&Es should be consultant-led with 24/7 consultant presence and an extra 12/7 consultant in a major acute hospital. The decision to operate should be made at consultant level.
    - Currently A&Es are dealing with Anything and Everything. Nearly 60% of A&E activity could be provided in Urgent Care Centres (UCCs) which are more appropriate and often closer to people's homes.
    - Too many people are being admitted to wards unnecessarily or are waiting too long for care after their urgent needs have been dealt with.
    - Every A&E should have an Acute Assessment Unit (AAU).
    - All AAUs should have 16/7 consultant presence, and be covered by the A&E consultant for the remaining time.

[31] Hospital Episode Statistics, Copyright © 2008, Reused with the permission of The Health and Social Care Information Centre. All rights reserved; Dr. Foster

Planned care

Context

Planned care includes all booked appointments with primary and community care, diagnostics, outpatient, day care services and surgery. In south west London, planned care accounts for two-thirds of NHS spend on services.

Some of the most highly regarded planned care sites in London are based in the sector – for example, The Royal Marsden NHS Foundation Trust – which, in conjunction with Kingston Hospital has established a satellite unit on the Kingston site to deliver acute cancer treatment closer to patients' homes. Also, the South West London Elective Orthopaedic Centre achieves low infection rates and high patient satisfaction levels by separating out emergency and planned surgical work. Across the sector, the Care Quality Commission has judged hospitals' management of diagnostics as better than the England average[32] and elective surgery readmission rates for most sites are also lower than in most parts of England[33]. But we could still do better.

For instance, separating planned care from emergency care improves the quality and safety of services, utilises staff and resources more efficiently and patients like it. Fewer procedures would be cancelled because of emergencies in other parts of the hospital taking priority; and the length of time patients stay in hospital can be reduced. In the 2007/08 Care Quality Commission survey, only Kingston achieved the target for surgery occurring as scheduled.

Patients value improved clinical practices that enable them to stay in hospital for as short a time as possible – but many delays are due to poor administrative practice. This is neither cost efficient or safe – a study of MRSA rates in UK acute trusts estimated that of the 27% fall in MRSA rates between 2001/02 and 2006/07, somewhere between 11% and 19% is attributable to the overall fall in the time patients spend in hospital.

People in some areas of south west London are waiting too long for elective surgery and are less likely to be treated within 18 weeks from referral to treatment than patients in other parts of England. The demand for elective surgery is likely to increase in future years.

There is also the potential to improve care by either specialising different units within current acute settings for high volume specialties (e.g. gastroenterology, urology) or developing stand-alone centres such as the South West London Elective Orthopaedic Centre. This means patients are treated by teams that are more experienced in their particular condition.

There are also unacceptable variations in quality and performance across the sector. For example, as highlighted in 'Staying healthy' the percentage of patients able to book a primary care appointment within 48 hours can vary from 59% to 98% in different practices within one PCT[34] and rates of hospital-acquired infections can vary up to seven-fold from one trust to another[35] [Exhibit 15].

---

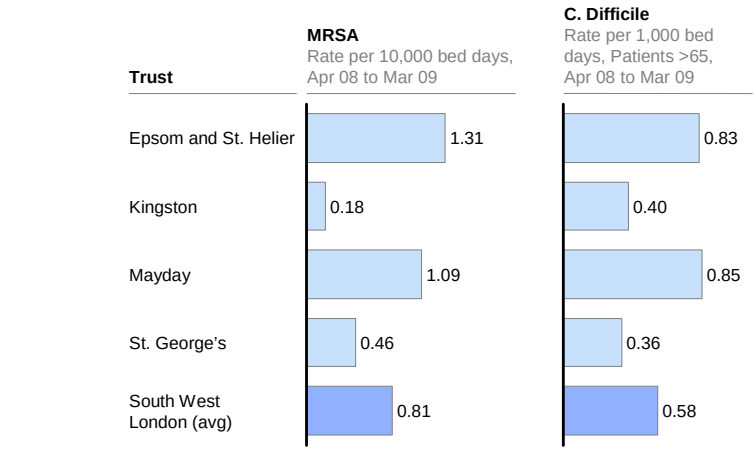
32 Care Quality Commission 2005/06 acute hospital portfolio review of medicines management

33 Hospital Episode Statistics, Copyright © 2008, Reused with the permission of The Health and Social Care Information Centre. All rights reserved

34 Ipsos MORI survey, Jan–Mar 2009

35 NHS Health Policy Unit, 2009

Exhibit 15: Performance on hospital infections



SOURCE: NHS Health Policy Unit, 2009

Poor communication between clinicians and other healthcare professionals, patients and their families at different times of a patient's illness and recovery means that often a patient will see the 'wrong' professional. For instance a doctor's appointment will be booked for removal of stitches that could easily be done by a nurse – this can lead to inefficient use of resources and poor quality care.

We also know that 42% of south west London respondents to *Consulting the Capital* said they wanted more outpatient care, minor procedures and tests provided in the community, for instance in polysystems. Only 16% of respondents wanted the NHS to continue to provide services in the same way as now, with most hospitals providing most services. Far too many diagnostics and procedures occur in hospitals when they could be provided in the community – reducing the need for patients to travel, reducing the chances of infection and potentially reducing the time taken to diagnose and treat a condition.

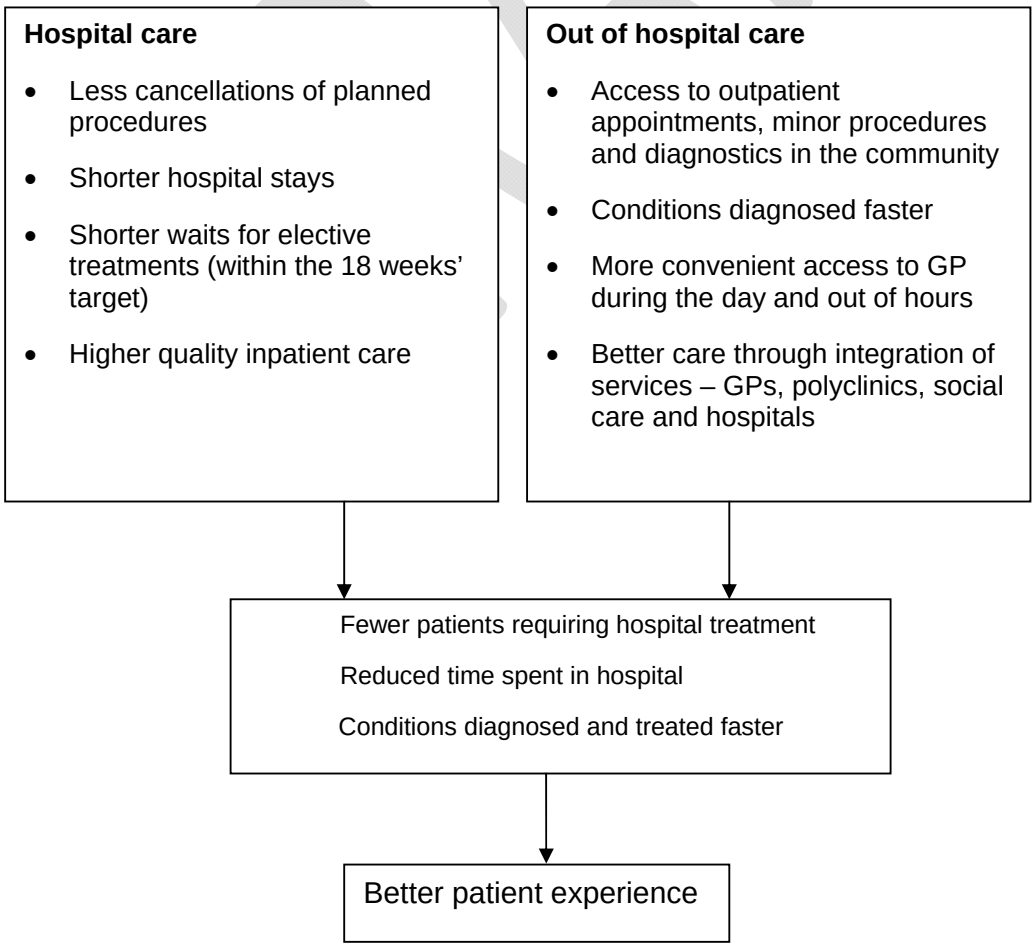
Key initiatives for improvement:

- Planned care (including beds, theatres and staff) should be separated from non-elective care. This will result in improved quality, efficiency and patient satisfaction.
- Whenever possible, diagnosis and the development of a treatment plan should take place in a single visit.
- Consolidation of inpatient planned surgical care would improve quality.
- Single specialty elective centres are possible, but multi-specialist centres would allow for greater economies of scale and better care, e.g. clinicians who could support patients with co-morbidities.
- Sixty-nine percent of elective surgery could be performed as day-case activity. There are no significant advantages to centralising day-case activity.
- Diagnostics:

- All tests should be carried out in a single patient visit to a setting of care. Reporting of results may occur subsequently.
- Consultant pathologists will need to provide infection control services for all settings of care.
- The level of support provided to primary care should be increased.
- Diagnostics output should be interpretable, consistent and be quality assured.
- A shift in setting of care for diagnostics should not increase the overall time a patient waits.

- Polysystems:
  - Minimum provision of services at hubs should be standardised.
  - Minimum services for a hub are GP services, unscheduled care and diagnostics. While not all outpatient activity needs to be delivered in a hub, co-locating fracture clinics with x-rays facilities would be a significant benefit.
  - Services should be offered from 8am to 8pm, seven days a week initially. Urgent care services collocated with hospitals should be open 24 hours.
  - A significant proportion of outpatient care currently delivered in an acute setting could be shifted closer to home in polysystem hubs.

Exhibit 16: Patient benefits of improving planned care services



Mental health

Context

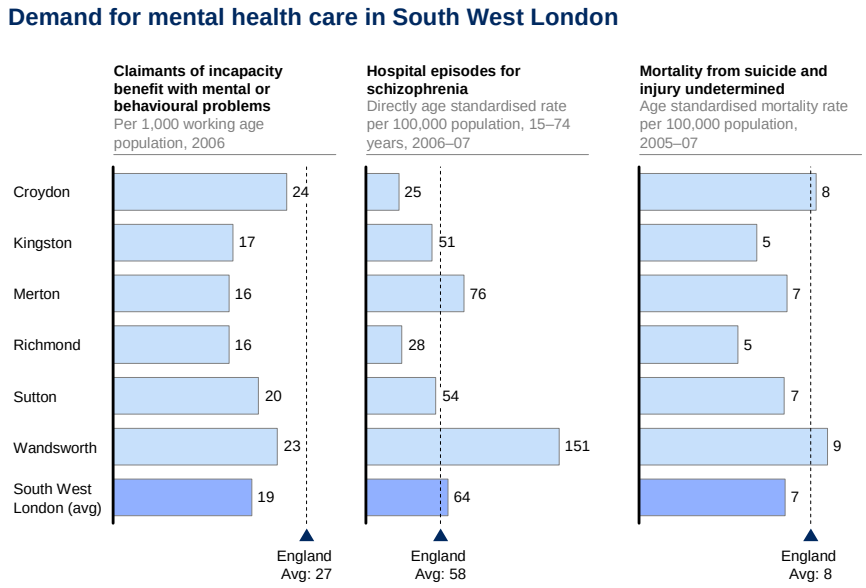
In common with the rest of London, the sector's economy depends on residents' mental wellbeing. At any time, one in six people of working age have a mental health problem. Mental health problems vary from mild and transient disorders to illnesses that are lifelong and have a profound effect on all aspects of a patient's life.

Poor mental health is a less significant problem in south west London than in other parts of London and England. The only borough where mental health need is higher than the national average is Wandsworth[36].

The recorded prevalence of psychotic illness in south west London is similar to London and England whilst the average prevalence of depression is lower. South west London has fewer claimants of incapacity benefit with mental or behavioural problems and lower mortality rates from suicide than other parts of England[37] [Exhibit 17].

However, the number of people with neurotic disorders is considerable, affecting 175,000 people across south west London. And given the increase in the number of older people in south west London, the number of people with dementia will increase in future years.

Exhibit 17: Demand for mental health care



SOURCE: London Health Observatory calculations based on Hospital Episode Statistics, 2005-07

Many factors (such as unemployment, poverty, major life events and physical illnesses) can influence the likelihood of developing mental illness. People with mental health problems (particularly if severe and long standing) often suffer poor physical health and reduced life expectancy. And the majority of new cases of depression in older adults are caused by poor physical health.

---

36 Mental Health Needs Index 2000

37 London Health Observatory calculations based on Hospital Episode Statistics, 2005-07. Note: a shortage of incapacity benefit claimants may not reflect fewer patients – it may be that these patients have more difficulty in accessing their entitlements – which may, in turn, be having a further negative impact on their health and wellbeing.

Diagnosis of serious mental illness in people from black African-Caribbean communities is significantly greater than among white British people. People from these communities are also less likely to seek help than others.

Poor diagnosis and management of mental health conditions in children and young people, and limited transition between children's and adult care services, exacerbates mental health problems in adulthood.

Treatments and outcomes for mental health patients have improved recently with most PCTs having invested in new models of care which include crisis resolution, early intervention teams and talking therapies teams[38]. By focusing investment in these areas, NHS Wandsworth has reduced deaths from suicide or undetermined injury by a quarter in the past three years (2006 - 2009).

But despite this increased investment there is still a shortage of crisis resolution teams and provision varies in each borough. Consequently the sector relies too heavily on hospital admissions for treating mental health patients, as seen by above average admission rates and longer length of stays compared with the England average[39]. Conversely the rate of emergency readmissions to hospitals (for mental health conditions within 28 days) is lower than the England average[40].

Mental health care continues to be delivered in a fragmented fashion, functioning separately from acute, primary and community care. For example, care pathways often address mental illnesses and substance abuse separately rather than treating patients who exhibit both problems with an integrated package of care. Closer working between health and social services and better information is essential for people with dementia and their carers.

We also know that too many patients with psychological un-met need who do not need medical interventions are inappropriately referred to hospitals. And neither out of hours services or psychological support for people with long term conditions are as good as they should be. This results in avoidable admissions.

Patients in south west London are also less satisfied with acute mental health services, in particular the quality of estates and clinical care. National benchmarking shows that St George's Mental Health Trust has low levels of inpatient adult mental health nursing staff per acute bed and, at the same time, a high bed occupancy rate. This means fewer staff providing services for more patients than elsewhere in the country. Stretched resources may impact negatively on inpatient experience.

Key initiatives for improvement:

- Treatment of mental health consumes a third of all GP time. We need to increase the support available to GPs.
- We should develop shared care protocols between primary and secondary care.
- We should move to providing single-sex wards for all mental health inpatient facilities and explore providing wards focusing on speciality/level of condition rather on a geographical area. This may lead to some patients having to travel further.
- We must provide more interventions earlier in the care pathway to avoid problems becoming more serious e.g. increase the levels of early expert assessment and primary care liaison.

38 The Service Mapping 2006/07 by Mental Health Strategies

39 Hospital Episode Statistics, Copyright © 2008, Reused with the permission of The Health and Social Care Information Centre. All rights reserved

40 Ibid

- We could further shift care from inpatient to community.
- Ensure we grasp the opportunities offered by polyclinics to provide better access and responsive treatments in a more suitable environment than current services.

Long term conditions

Context

Preventing long term conditions is preferable to managing the conditions when they emerge. Smoking kills one Londoner every hour[41] and obesity – which can be addressed through better diet and more physical activity – is becoming an increasing problem[42]. Preventing and treating long term conditions appropriately will improve residents' quality of life, allow them to be productive for longer, and avoid them being a drain on the health service.

People with long term conditions are the most intensive users of health services. They account for 80% of all GP consultations[43] and make up the majority of the 14.1% of patients who are admitted to hospital four or more times a year. This group is responsible for 36.5% of hospital bed days[44]. In addition the prevalence of most long term conditions is predicted to rise rapidly over the next 10 years across the sector, especially Chronic Obstructive Pulmonary Disease (COPD), asthma, and diabetes. And, whilst the prevalence of long term conditions usually increases with age, conditions such as diabetes are increasing among younger people.

Ironically, the incidence of people with a long term condition is partially growing as a consequence of improvements in the health and care system. As patients' long term conditions are better managed, they live longer and the prevalence of the long term condition increases.

In south west London, the prevalence of CHD, COPD, stroke, diabetes, asthma and other long term conditions is lower than the England average, but is often higher than the London average[45].

The reported prevalence rates for some long term conditions are lower than expected and this raises concerns that our healthcare services may not be adequately identifying people with long term conditions. In Wandsworth, for example, it is estimated that up to one-third of people with diabetes may be undiagnosed. In addition, south west London performs below the England average on all diabetes prevention metrics.

There have however been significant improvements in the way in which we identify and treat the most prevalent long term conditions in recent years. Developments such as Quality and Outcomes Framework (QOF) disease registers have meant that many more people have been identified as having a long term condition and so more proactive treatment has started earlier. These improvements have resulted in better outcomes – for example, emergency admissions in south west London for COPD and heart failure are lower than the England average[46] [Exhibit 18], though the admission rates for asthma and diabetes in Croydon and Kingston are higher than the England average[47].

41 London Health Observatory

42 See analysis in *Securing Good Health for the Whole Population: Population Health Trends*, December 2003

43 *Chronic disease management: a compendium of information*, Department of Health, May 2004

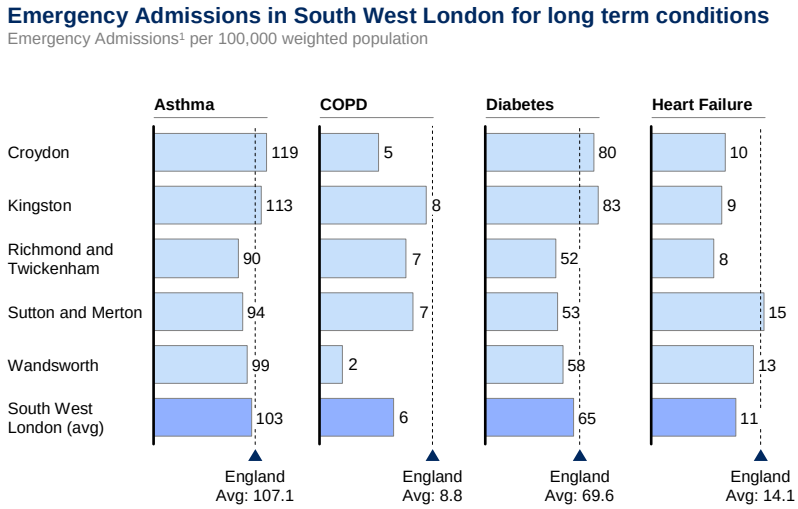
44 S. Williams et al., "Frequent Flyer" patients, *BMJ* 2005, 303

45 Quality and Outcomes Framework, Quality Management and Analysis System, Apr 07-Mar 08; Note: QOF data variation may indicate variations in local registers or in clinician behaviours in primary and secondary care

46 National Centre for Health Outcomes Development 2007/08

47 Hospital Episode Statistics, 2008/09

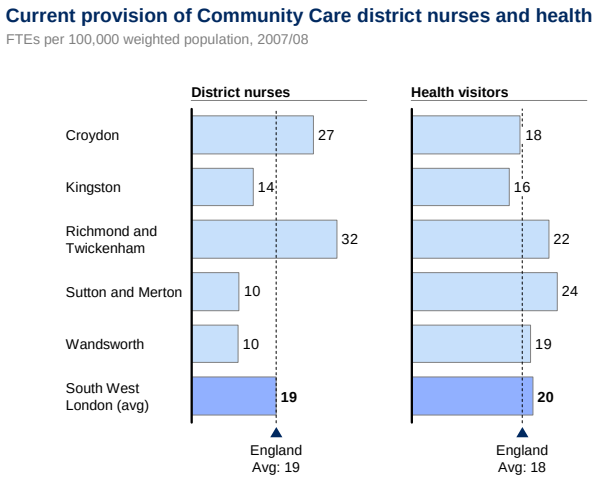
Exhibit 18: Emergency admissions of people with long term conditions



1 Definitions:
Diabetes: ICD-10 codes: E10 - E14, Asthma: ICD 10 codes: J45 - J46, Heart Failure: HRG3.5 codes: E18-19, COPD: ICD-10 codes: J40 - J44 & J47

For other conditions, such as atrial fibrillation the sector also has a good record of identifying relevant patients[48]. Further investments are likely to continue this positive trend. For instance, the number of district nurses and health visitors for the sector is at, or above, the England average[49], empowering patients to manage their conditions in the community. [Exhibit 19].

Exhibit 19: Provision of community care district nurses and health visitors



SOURCE: Information Centre and Department of Health

There are other areas of excellence and innovation in the sector. For example, there are well-recognised services to support people living with persistent pain at the Centre of Pain Education (COPE) in Sutton and the Woolfson Institute in Wimbledon. There have been successful initiatives in COPD management in Kingston and in Wandsworth, a significant rollout of education programmes for both staff and patients has transformed the shape and flexibility of diabetes services in primary care. Targeted work with patients who are frequently re-admitted to hospital has achieved a small decrease in numbers of patients over 65 attending St George's Hospital with respiratory, cardiac and endocrine conditions.

48 QOF (Apr 2007–Mar 2008), NHS Comparators (Apr 2007–Mar 2008)

49 Information Centre and Department of Health

However, much more can be done. Patients with long term conditions are not always supported to understand how best to navigate the health system and we don't always care for patients in the places that they prefer, such as settings closer to home (e.g. GPs and pharmacies). While the majority of long term condition care can take place in the community, 97% of outpatient appointments still take place in hospital[50]. There is often poor co-ordination between primary, social services and hospital staff. Additionally, there is significant variation in approaches to the treatment of long term conditions across the sector and clinicians see patients at different points in the pathway, rather than in an integrated way.

Health inequalities have a major impact on long term conditions. Those with lower incomes, living in deprived areas, are much more likely to suffer from long term conditions than their wealthier neighbours and are less likely to access care – this needs to change.

We know that two-thirds of respondents to *Consulting the Capital* in south west London want a greater proportion of the money currently spent on hospital care for people with long-term conditions to be spent on care in the community instead.

Key initiatives for improvement:

- The reported prevalence of long term conditions is lower than expected, suggesting people are living with undiagnosed conditions that could be treated. Treatment would improve the quality of life of patients and reduce emergency admissions. We need to implement new models of care in long term conditions to reduce emergency admissions, particularly focusing on COPD, diabetes and heart disease and failure.
- We need to improve diabetes management in primary care; more action is needed to reduce obesity and the impact of CHD on people with diabetes.
- PCTs need to increase the number of annual reviews to help asthma patients to better manage their condition; this could help to reduce emergency admissions.
- Integrated working across long term conditions specialist teams and clinicians is required to ensure a single plan and appropriate treatment – we need to focus on integrating mental health and social services.
- Booking should be by patient, not by condition. Wherever possible a patient should attend all their clinics and appointments on the same day.
- Specialist care should be available in hospitals, surgeries and community settings, seven days a week. Some services will need to be provided 24/7; in particular, rapid response teams could help prevent emergency admissions at the weekends and overnight.
- Proactive case management, including a care plan, should be in place.
- Step-up facilities should be provided as an alternative to hospital admission.

[50] University of Birmingham Health Services Management Centre, *Making the Shift: Key Success Factors,* 2006

End of life

Context

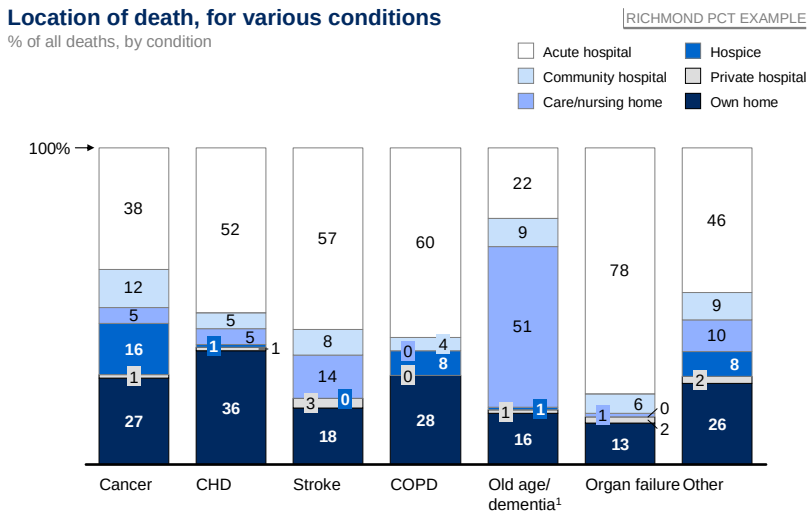
Everyone should have a dignified, controlled and peaceful end to their life in a location of their choice regardless of their age or cause of death. This should encompass pain and symptom management and provision of psychological, social, spiritual and practical support.

People at the end of their life often require support and care from a number of different services, including doctors, nurses, carers and family. Healthcare for London highlighted that 57% of Londoners prefer to die at home[51] and some studies suggest that many more people could choose to die at home than is currently the case. In one England trust up to one third of patients who died in hospital might have been able to die in their home[52]. But if services are not available in the community then patients will tend to be taken to A&E when they become ill and, once there, if support in the community cannot be arranged quickly, they will be admitted. Hospitals are often poorly configured to deliver good end of life care and patients do not always receive optimum symptom control.

More urgent access night nursing teams, more warden controlled accommodation, better access to urgent diagnostics and other initiatives would increase the number of people being able to choose to die at home.

In south west London less than 18% of people die at home, although this varies from 15% in Sutton to 19.6% in Richmond. However the sector is seeing a slow but steady increase in the percentage of people dying at home. We also see examples of good use of alternate care settings such as community hospitals, nursing homes and hospices. In Richmond over 70% of old age and dementia patients die in alternate care settings[53] [Exhibit 20] and the innovative service established at the Royal Marsden Hospital (Hospital2Home) ensures that people at the end of their life are enabled to die at home – but the picture is less good for patients with long term conditions.

Exhibit 20: Location of death by condition in Richmond



1 These include elderly patients with multiple co-morbidities and organ failure

SOURCE: End of Life Review at example PCT in South West London, April 2008

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

52 End of Life care in hospital, J Abel and A Rich, Journal of Palliative Medicine 2009; 00: 1-7

53 Selected PCT End of Life Review, April 2008

A great many people may be involved in providing end of life care: doctors, nurses, therapists, social workers, meals on wheels volunteers, equipment suppliers – and the list goes on. This can be confusing for people nearing the end of their life and we must get better at coordinating care and providing one point of contact, rather than expecting patients to deal with a complex set of arrangements provided by a number of different agencies. We must work with patients and their family and / or carers to discuss a care plan – providing a much more seamless service between curative and palliative care.

Key initiatives for improvement:

- End of life planning needs to span all conditions, not just cancer.
- 75% of all predictable deaths should occur in the patient's preferred setting. 57% of people would prefer to die at home – less than 18% do so.
- Education for carers, patients, healthcare professionals and institutions will be key in effecting change.
- Effective care and resources need to be available at any location 24/7.
- Resources must be shifted from the acute sector to the community.
- Better co-ordination and co-operation is needed (health and social services).
- A single end of life register should be held and maintained, and a system should be in place to ensure a patient's preferences are communicated with all healthcare professionals e.g ambulance, care home staff and social care.
- More information is needed to support individuals and their carers.
- GP out of hours services and rapid access community nursing, in particular 24/7 district nursing cover, is needed to prevent emergency admissions.
- Specialist palliative care staff should provide 24/7 telephone support to colleagues.
- Individuals in residential and nursing homes should be able to access the same care as those people dying in their own homes.

Conclusion

Healthcare services in south west London must change. We need to address local challenges facing the sector such as the rising prevalence of diseases and long-term conditions and the high demand on urgent care services. It is essential that we reduce the variation in performance and quality of services across the sector, particularly in areas of deprivation by identifying best practice and implementing clinically proven methods.

Transforming healthcare services has become an increasing priority with the challenge of the economic climate. We can't sustain the current healthcare system – we must look at new ways of delivering services, including providing more specialised care where appropriate and more care closer to home where possible.

Delivering this change will require much greater emphasis on partnership working – including the developments of networks. More integrated, seamless care across all care pathways will be vital in improving co-ordination and communication among NHS organisations and our health partners – including local authorities and voluntary organisations.

Clinicians in south west London are ready to rise to the challenge and are leading a programme to develop a health service which will meet the needs of this generation and generations to come. Working with a range of local NHS and social care organisations, and with the help of patients and the public, we will further investigate the issues that are preventing us from providing a world-class service. Later in the year, using this information, we will develop specific proposals to help prevent people becoming ill, to save lives and improve the quality of life for many thousands of people across south west London.