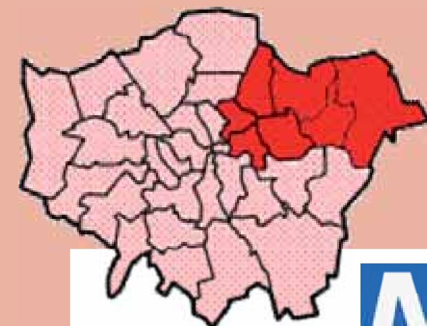
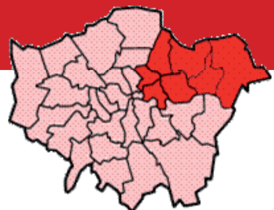
Making Healthcare for London Happen in North East London

The Case for Change
February 2009



NHS
North East London



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Making Healthcare for London happen in North East London

In July 2007, NHS London published Healthcare for London: *A Framework for Action*[1] written by Professor Lord Darzi. This document was a result of patient, public, staff and partner organisation engagement. The purpose was to determine how to deliver healthcare that is better, safer, more accessible and helps people stay healthier.

A Framework for Action led to the pan London consultation Healthcare for London: *Consulting the Capital*, commencing in late 2007. This consultation asked Londoners for their view on which health services could be really improved over the next ten years and how this should be delivered. The response from the public was that they wanted real change and to have responsive, safe, accessible and high quality healthcare.

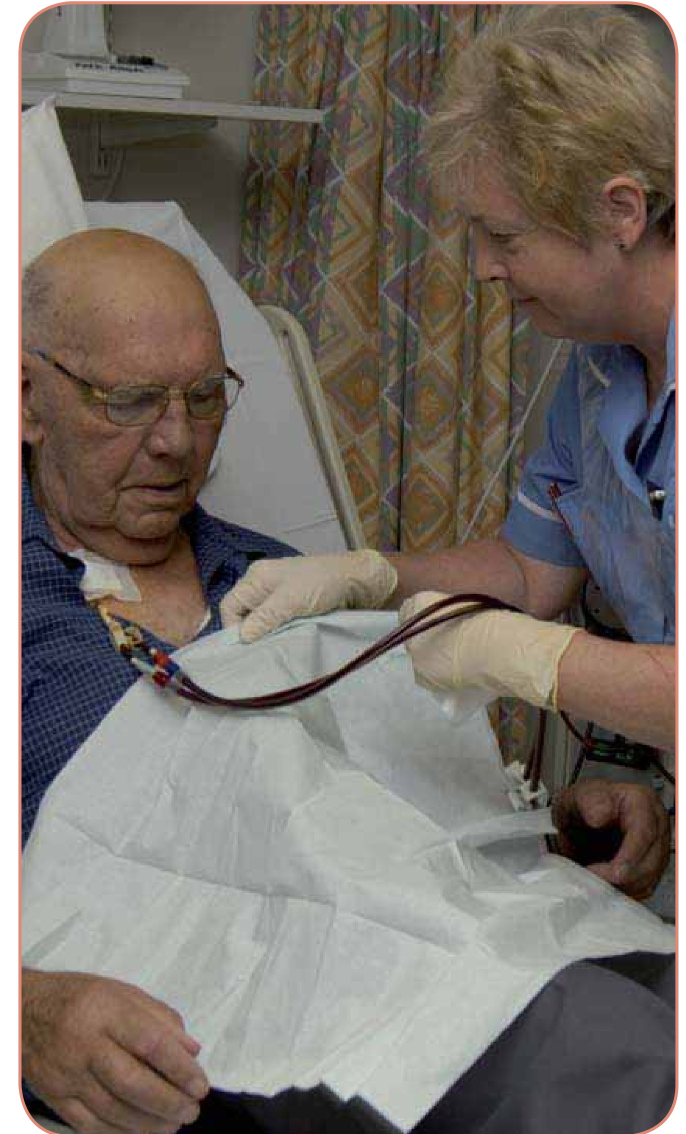
The Healthcare for London change programme is now gathering momentum and a pan London consultation commenced on 30 January 2009 to ask the public their views on stroke and major trauma provision in the capital.[2] The consultation runs until 8 May 2009.

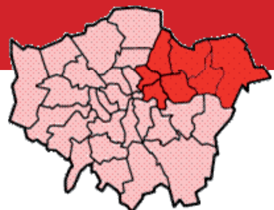
The challenge to North East London (NEL) is how to implement the Healthcare for London vision in our sector of London. We have taken an active role in the *Consulting the Capital* consultation, listened to what our communities are requesting from their healthcare providers and are now actively working on the stroke and trauma consultation. However this is only one element to providing high quality, accessible and safe healthcare. We now need to look at how we implement the whole programme of change across North East London.

Driven by Quality

As leaders of health care services, we are committed to the effective implementation of Healthcare for London (HfL) in North East London (NEL). This will require significant change to how and where services are provided to ensure equitable and sustainable delivery of high quality clinical services, effective use of resources (particularly our staff) and increasingly better health outcomes for the people of NEL.

North East London will continue to be a place of continued growth with more people living in our boroughs. Communities are likely to be much more ethnically and culturally diverse and will continue to add to the vibrancy of living and working in North East London.





Our central objective is to improve the health and wellbeing of our community, proactively investing in their health and responding to healthcare needs. This strategic review will develop a pattern of services to deliver the vision of HfL within a sustainable financial framework. Our prime objective is to improve quality, demonstrating best practice and affordability in all that we do. To do this we will provide care in facilities and locations that improve accessibility and the overall experience of health care. We will continue to work with our providers to improve productivity and efficiencies in our services. Our facilities will be more than just fit for purpose, but will genuinely meet user needs and expectations. We aspire for NEL services to be recognised as being amongst the best - high performing providers who deliver good health outcomes, are innovative, efficient and provide a positive user experience.

A review of acute services can only be effective if it is linked to primary and community care activities. All NEL PCTs, as commissioners of services, have recently updated Primary and Community Care Strategies within their Commissioning Strategic Plans. These strategies outline the investment that the PCTs have allocated to strengthen primary and community care. Together with this general review commissioners will need to ensure alignment between the Acute Care Strategies and those for primary and community care across the NEL health economy; this will ensure effective working between primary and acute services.

The NEL acute provider review will be guided by experts and will be prepared in collaboration with local authorities, key partners and stakeholders. We anticipate that clinical models will be available by the end of April for further development with community and patient user groups. The clinical models will also be open to validation and scrutiny by external clinicians.

The next five years will be an exciting time for us in North East London as we move towards 2012 and the significant changes that holding the Olympics are going to bring for East London. We have recently embarked upon the consultation of changes to Trauma services and the designation of Hyper Acute Stroke Units (HASUs) in NEL. Continued dialogue with partners and service users over the coming months will help to articulate the challenges faced by the NHS in NEL and how we collectively move towards implementation of the future models of healthcare provision as outlined in Healthcare for London: *A Framework for action.*

Acute and PCT Chief Executives
North East London Health Economy
24 February 2009

Clinically Led

We were very pleased to have been appointed to the position of Joint Clinical Directors for the North East London Acute review and we have entered into this venture with a shared vision. We believe that by working together with clinical colleagues across the whole of North East London, we can improve outcomes and experiences of patients.

We are both experienced in change management and hold senior medical management positions in the area. While recognising the challenges facing the sector, we have confidence in the ability of our colleagues to implement change. We are particularly grateful to our NEL Medical Director, Chief Executive and Professional Executive Committee Chair colleagues from all NEL health commissioners and providers.

It is important to acknowledge from the start the hard work that NEL staff put into healthcare. It is often the system that hinders the delivery of excellence and we are committed to addressing such problems across organisational boundaries.

We propose to set about this in a methodical and logical manner. We will not favour any one organisation over another, and share the aim of seeing local beacons of good practice being

shared across the whole sector to benefit all. The overriding issue of Quality (Safety, Effectiveness and Patient Experience) will be enhanced by five guiding principles. They are:

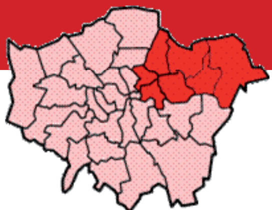
- Preventing chronic ill health
- Improving care of long-term conditions
- Delivering care in the most appropriate setting - mostly not a hospital
- Identifying - and addressing - inequity and inefficiency in health services
- Recognising and valuing the finite nature of human and financial resources - to deliver sustainable healthcare

The major service areas we will consider, determined through clinician engagement with NEL professionals, are:

- Urgent surgery
- Urgent medicine
- Children's services
- Maternity and newborn services
- Specialist services
- Planned care

We will each lead three work-streams, and guided by experts in these services gathered from across NEL, we will develop the best clinical models to be put forward to our partners across healthcare in NEL. These clinical pathways will inform settings of care which will form the basis of our work going forward.

Dr John Coakley MD FRCP
Dr Michael Gill FRCP
Joint Clinical Directors



Addressing Need

North East London needs to provide high quality services to a population that will grow to 1.80 million by 2021, with growth most marked in the boroughs of Tower Hamlets and Newham. These boroughs are projected to see 62% of the overall population growth projected for NEL over the coming decade. This is due to the higher than UK national average birth rate, new entrants to the UK settling in NEL and the investment in housing and social regeneration stimulated, in part, by the development of the Thames Gateway and Olympic Games which will be hosted in London in 2012.

The three inner NEL boroughs, together with Waltham Forest, are amongst London's youngest, most diverse and most deprived communities with a significantly higher proportion of 0-24 year olds living within these boroughs than the UK average. Havering is anticipating an extra 17,500 aged 65 and over (88% in the 85+ age group by 2026) which has implications for the PCT as older people are generally higher users of health services.

North East London is an area of marked contrasts with a rich cultural and ethnic diversity. The continued growth in Black and Minority Ethnic (BME) residents over the past five years is the result of a number of factors including birth rates and the significant regeneration taking place. Many younger families arrive or move from other parts of London to NEL because of the increased opportunities in terms of employment and affordable housing.

Within the ethnically and culturally diverse communities living

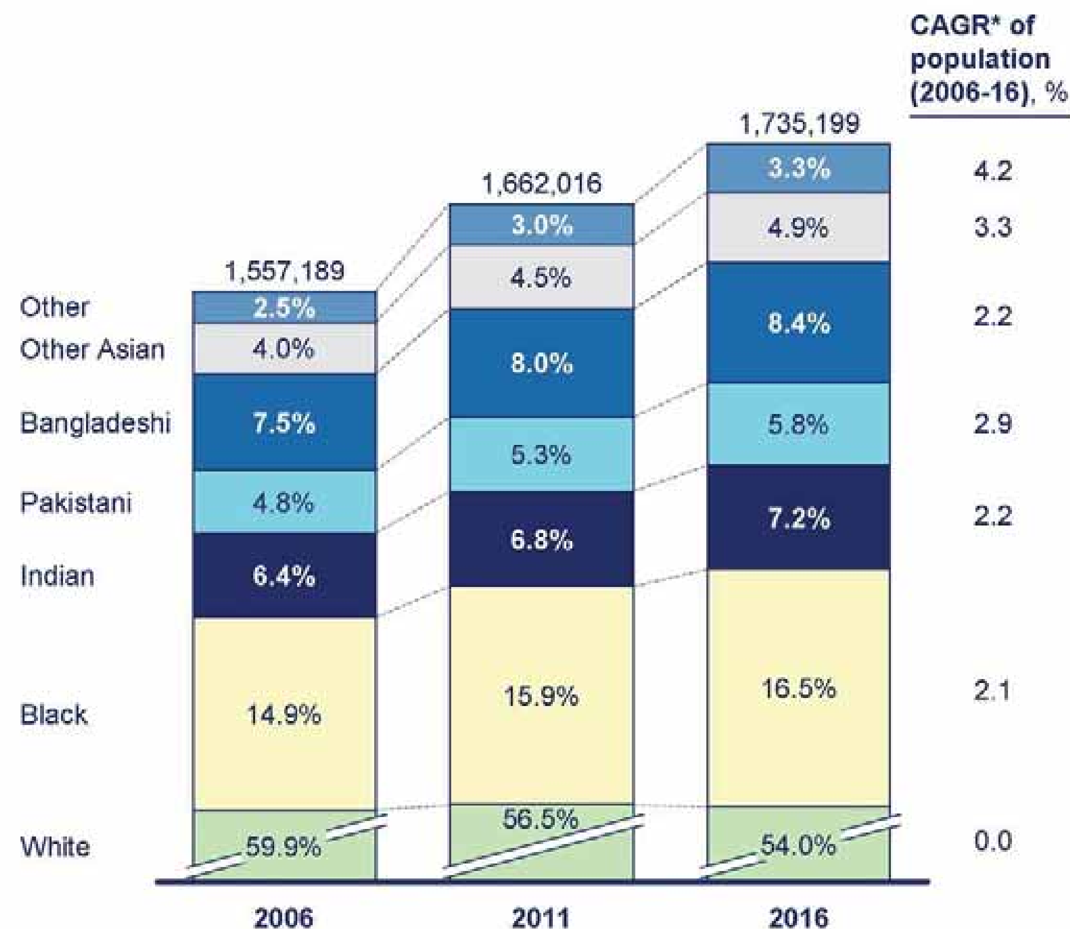


Figure 1: Changes to the ethnic mix of the residential population in NE London 2006 – 2016
Source: GLA 2007 Round Ethnic Group Projections, low growth scenario
*Compound Annual Growth Rate

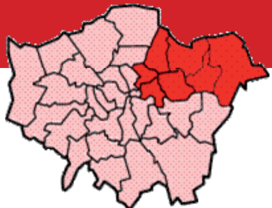
in NEL there are many examples of innovation and development. However there are also areas of considerable deprivation, unemployment, tangible health inequality and as a result, reduced life expectancy. There is a high incidence of Long Term Conditions such as Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Cardio Vascular Disease and there are a significant number of people living in the community with a mental illness or conditions such as Tuberculosis or HIV.

Cancer and Heart Disease are the major causes of premature death rates across NEL with a continued need to address hypertension and diabetes which remain the main long term conditions leading to a reduced life expectancy, with a growth in the incidence of COPD predicted in some PCTs. A focus upon the needs of the elderly is needed in ONEL, where greater investment in partnership working is anticipated.

It is recognised that people living in deprived communities experience worse health than those living in less deprived communities and several of the most deprived communities in the UK are located in NEL. Inequalities in health not only exist across geographical areas, but also between genders, ethnic communities, social and economic groups.

Life expectancy at birth in NEL still remains lower than the rest of London and England with greatest variation in male life expectancy, with Redbridge and Havering having greater life expectancy for males than the other NEL Boroughs, whereas Newham has the lowest life expectancy for women in London.

Tackling health inequalities in NE London is a challenge but there is scope in addressing some of them through significant improvement in quality and effectiveness of the health care services we provide. However this will require a step change in making such services available and accessible to those who need them most and also in removing the barriers that hinder healthy life style.



North East London: The Case for Change

The NHS organisations in NEL have all committed to work together to realise a set of common ambitions for healthcare in NEL, namely to:

- Improve the health of the whole population;
- Improve service quality as measured by access, quality standards, safety and patient experience;
- Meet all key national targets;
- Put clinicians in the driving seat for change;
- Ensure ongoing financial sustainability.

To this end the NEL health economy have developed the following case for change in order to develop high quality care for all and to reduce inequalities in our sector.

Introduction

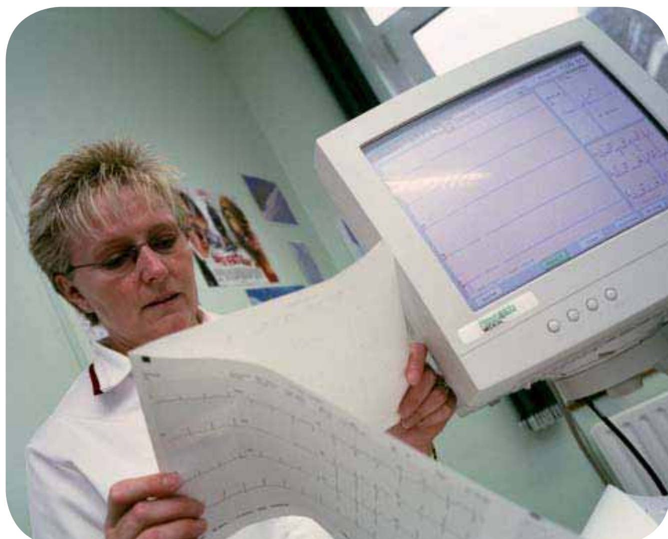
Healthcare for London is an ambitious ten year plan to improve the quality of health and provision of healthcare in London. The agenda is challenging but we are committed to improving services in North East London. We have tried to develop a common starting point and, working in partnership across the sector, will now focus on how we get positive change to happen.

NEL is home to a diverse, growing and often transient population. While there are areas of relative affluence, we generally provide services to some of the most deprived communities in the UK.
Meeting the healthcare needs of the people of NEL presents particular challenges. There have been improvements over the last few years, and there are areas of excellence. But health and health outcomes are highly variable. NEL has some of the worst health indicators in the country and many healthcare needs are not currently being met. While this presents significant challenges to those trying to provide services, particularly healthcare, it also suggests continuing provision in the same way is not the answer.
Accordingly, those of us responsible for the management of health services together with clinical leaders have worked together to present a case for changing the way we deliver healthcare across NEL. Whilst we are guided by national and London-wide approaches, we have tried to focus in particular on local needs and challenges. It is based on analysis of information and initial engagement with clinicians, and has been developed in close consultation with a group of clinical leads from NHS organisations in NEL.

No specific recommendations are made here as these will need further work. However, this document outlines a common starting point for all those working to improve the health of the people of NEL.

North East London Health Economy

The health economy of NEL includes Barking and Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest PCTs, the Homerton University Hospital NHS Foundation Trust, Newham University Hospital NHS Trust, Whipps Cross University Hospital NHS Trust, Barts and the Royal London NHS Trust (BLT), Barking, Havering and Redbridge University Hospitals NHS Trusts (BHRT), East London NHS Foundation Trust, North East London NHS Foundation Trust and the London Ambulance Service. There are also a number of independent providers and services provided by Primary Care Trusts.



This review is looking at the viable options for the acute hospitals. Mental Health services in NEL will be considered as part of the review focus where acute and mental health services interact. Our mental health services are a crucial service area to our community and as such we will work in partnership with our colleagues at all times throughout the review process.

We take our cue from *Healthcare for London*[3] and from the *Next Stage Review*,[4] with a clear challenge to commissioners to improve the quality of care. Together these documents set out challenging ambitions for healthcare in terms of clinical quality, patient satisfaction and sustainability.

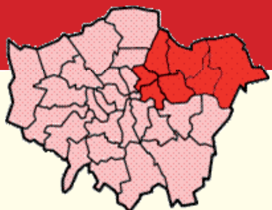
However, to meet national, London-wide and local aspirations we need our own case for change, focused on our own needs, and our own challenges. We believe there are four reasons why healthcare in NEL needs to change now.

The need to prevent ill health

Improving health means not only treating illness effectively, but also preventing ill health. This means focusing on the challenges and lifestyle factors that put people's health at risk and directing funding at interventions that make a difference.

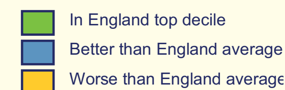
People living in NEL have relatively low life expectancy and relatively high rates of infant death compared to other areas of England.[5] In five NEL PCTs, life expectancy for men is in the bottom 25% in the country. Life expectancy for women is in the bottom 25% across the country in four NEL PCTs.[6] Premature death from heart disease and cancer are also relatively high, with five PCTs reporting levels of death from heart disease in the highest 25% of the country and four PCTs reporting the same for cancer deaths.[7] While we recognise that much of this is a reflection of the deprivation, the response of the health service must be aimed at improving these markers of ill health.

The health of the population has broad social, economic and environmental determinants and as such we are always likely to have big challenges compared with other parts of the capital and of the country. However, we believe that we can improve on the status quo and reduce variation within the sector.



NEL PCTs plan to increase expenditure on prevention and public health in the future. NEL spending on prevention is higher than in London as a whole and is predicted to increase significantly but spending in this area of healthcare has not kept pace with others. We recognise that this will not have an immediate effect.

Funding will be targeted on the areas of greatest need, and on public health programmes that have been shown to work – for example on interventions to reduce smoking, increase rates of child immunisation and the uptake of screening programmes. Improvements have already been seen in some areas[8] and we aim to build on this work across the sector.



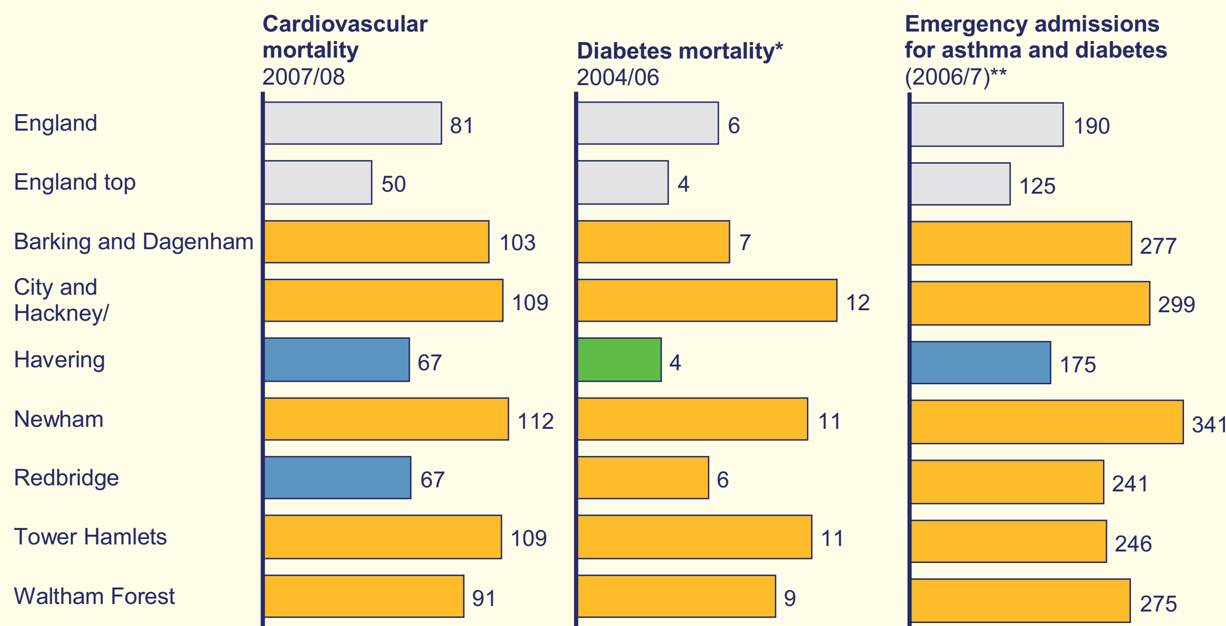


Figure 2: Health indicators
(Source: Healthcare Commission annual health check 2007/08, National Centre for Health Outcomes Development 2004/06)

The need to improve care for people with long-term conditions

We need to do more to help people manage their long-term conditions and avoid emergency admissions to hospital. This will mean improved quality of life and better health outcomes for those suffering from long-term conditions as well as more efficient use of healthcare resources.

NEL performs well in some areas. For example, three of the seven PCTs (Tower Hamlets, City & Hackney and Newham) received an overall excellent rating from the Healthcare Commission for the treatment of heart failure, and the other PCTs received a good rating.[9]

However, patients with other long-term conditions do not receive the best possible care, and this affects health outcomes. A Healthcare Commission service review of diabetes services showed poor performance across all measures for all NEL PCTs, and emergency admission rates are higher than

average.[10] Mortality rates for diabetes are higher than the England average in all NEL PCTs except Havering and Redbridge.

Data for other long-term conditions shows a similar picture. Rates of death from heart disease are higher than the England average in all NEL PCTs except Havering and Redbridge. The level of emergency admissions for asthma in NEL overall in 2006/2007 was significantly higher than the average for England.

While we recognise that many of these indicators reflect the chronic disease burden within NEL, we need to change the way we deliver quality primary and community care. Access and quality need to be improved to encourage better case and self management.

Hospitals as we know them are not always the answer

There is considerable evidence, as set out in *Healthcare for London* and the White Paper *Our health, our care, our say*, that many people currently attending hospital could be cared for closer to home.[12] Health services provided in community settings, close to where people live, will need significant development (for example; accommodation and workforce), to ensure that high quality and accessible services are in place throughout

NEL.

Patients with minor illness and injury, or with long-term conditions, should be seen by the most appropriate professional with the right skills and experience. In many cases this might mean that they are treated by primary care practitioners. Continuity of care is made more difficult when care is accessed through A&E, which should therefore be reserved for the most serious conditions.

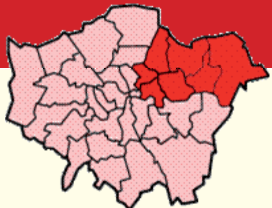
A&E should be reserved for the most serious conditions.

NEL has a high rate of A&E attendance. The level of A&E activity in NEL has increased year on year and levels are significantly higher than the UK average. This level of growth is not sustainable clinically or financially. At present A&E services are regularly overwhelmed, and basic targets are often not being met. Many of the conditions currently treated during A&E attendances could be dealt with elsewhere offering wider access to primary

40% of today's outpatient appointments could occur outside the hospital.

care. Alongside this there are a higher number of very sick patients with multiple co-morbidities where earlier intervention may prevent such deterioration. This may explain why admissions through A&E are also higher than elsewhere in the country but is unlikely to explain it all. Despite the introduction of urgent care centres and walk-in centres in recent years, A&E services in NEL are stretched.

Similarly, the traditional hospital setting is probably not the best place to deliver much of the current outpatient activity, particularly for people with long term conditions. Healthcare for London has estimated that 40% of today's outpatient appointments could take



place in a community setting.[13] More than half of gynaecological and dermatological procedures, for example, could be made more accessible, allowing greater convenience and choice for patients.[14] Moving some diagnostic services into the community setting would also mean that patients were tested quicker and closer to home.[15]

The movement of these kinds of services from hospital to the community is not always possible in NEL due to limited infrastructure and therefore public confidence in settings outside the hospital.

The quality of primary care is variable, at least as measured by Quality Outcomes Framework scores. NEL does however score above the average for London.[16] Some aspects of patient access to primary care in NEL are good. In Barking & Dagenham and Tower Hamlets over 90% of GP practices offer extended hours – over 40% more than the England average. Nonetheless, every NEL PCT has fewer than average GPs per head, with Barking & Dagenham having only 40 GPs per 100,000 population compared to an overall average of 60.[17] Historically NEL PCTs have had lower than average levels of access to a GP within 48 hours, although patient satisfaction with opening hours is around the London average overall.[18] The insufficient and varying levels of access in NEL cannot be easily be explained by deprivation, age or ethnic profile.

There are challenges in the quality and efficiency of hospital services

There are examples of excellent practice in the five acute trusts in NEL. 100% of urgent cancer patients at BLT and the Homerton are seen within 2 weeks and BHRT and the Homerton are among the top 10% of English trusts for low rates of *C. difficile*[19]., while Whipps Cross is better than the English average for MRSA.

The Healthcare Commission rates some hospital services, such as Homerton and Newham University's diagnostics services, as 'excellent'. Others, such as BHRT and Newham's admissions, are rated as 'weak'.[20]

Whilst some hospitals are performing above the England average on national targets and improvements have been seen in some areas of performance[21], some are still below the national average.

Readmission rates within 28 days are higher than average in four of seven PCTs for elective care and five PCTs for non-elective care.[22]

Average length of stay is significantly higher for certain conditions, such as stroke in under-69s, compared to the average for England in most areas of NEL.[23]

Patient satisfaction with treatment at the acute trusts is below the average for England, particularly in relation to experience of admission to hospital and the quality of the hospital environment.[24] While we recognise that there are problems (which the Healthcare Commission also acknowledges) in the interpretation of these results, we cannot

Patient satisfaction with treatment at acute trusts is below the England average.

permit the current levels of dissatisfaction to continue.

The current structure and organisation of acute services may explain some of the variability in patient experience and standards of care received by patients in NEL. This structure can reduce productivity in our sector, for example, compared to the rest of the country, the average number of patients treated per practitioner per year in London is lower.[25] In addition, many healthcare providers struggle with high levels of unfilled vacancies compared to the London average for both medical and non-medical employees.[26] This then necessitates the spending of relatively large amounts on agency staff.[27]

Clinicians in NEL have identified particular challenges in six major service areas:

- Urgent surgery
- Urgent medicine
- Children's services
- Maternity and newborn services
- Specialist services
- Planned care

Urgent surgery

Urgent surgery is currently provided across all NEL hospitals. Urgent surgery is defined as surgery which cannot be planned (usually referred to as routine, elective or scheduled surgery), and has to be performed within a defined timescale. While some deliver high levels of service quality and efficiency in specific areas – for example, Newham's mortality rates of 2% are among the best in England – there are significant challenges, and different levels of quality and efficiency.[28]

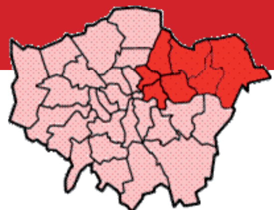
The average length of stay patients experience for the same condition varies by location.

The time taken to operate on specific conditions varies, with the Homerton treating 75% of cases of fractured neck of femur within 48 hours, which is far above the England average of 58%. The performance of three of the other four trusts is lower than the England average.[29]

The average length of stay patients experience for the same condition also varies depending on where in NEL they are treated. Patients recovering from an appendectomy could expect to stay on average 2.9 days to 3.7 days.[30]

Changes to the organisation of services could improve patient outcomes. For example, there is little clinical rationale for operating on urgent patients during the night and there is good evidence that doing so leads to worse clinical outcomes.[31] The National Confidential Enquiry into Peri-operative Deaths review recommended that all emergency surgical patients be assessed by a dedicated consultant on call and operated on the next day. Clinical opinion is that not all NEL trusts are achieving this.[32]

While urgent surgery at night should be minimised, it remains critical that patients have access to experienced consultants when necessary. Urgent surgeons and support services are not consistently available in certain key specialties in all hospitals out of hours. This requires a collaborative approach across all organisations to provide mutual support in the interests of patients. It is also true that some NEL trusts suffer from staffing shortages. There are emerging models for managing these issues and they should be explored further.



Urgent medicine

There is also wide variation in the quality, outcomes and efficiency of NEL's urgent medical services.

Examination of stroke treatment, which is one of *Healthcare for London's* key priorities, shows that all trusts in NEL have struggled to meet national targets for stroke care.[33] *Healthcare for London's* stroke strategy identifies the need for swift treatment of patients within a dedicated location. To align with this strategy stroke services in NEL will need to be modified. Healthcare for London and the 31 Primary Care Trusts in London, including NEL, are undertaking a public consultation on pan London stroke services from 30 January to 8 May 2009.[34]*

Length of stay for urgent medical patients differs according to place of treatment. These variations may be explicable but it is important to understand the variation and learn from best practice.

There seem to be variations in the quality of care patients receive and the critical care backup that exists, depending on where in NEL patients are treated. We must find ways to standardise care across the sector so that all receive the highest quality treatment. Clinicians have also identified a need to improve collaboration between hospital specialists in acute and emergency medicine and those working in primary care, to ensure patients receive efficient and consistently high quality care.

Children's Services

NEL has a high population of children and due to health inequalities we have a high number of sick children compared to other London sectors.[35] All five trusts received Healthcare Commission ratings of "good" or "fair" for paediatrics, and areas of excellence were highlighted at three trusts.

While the majority of routine and specialised children's services are provided within NEL, there is currently limited paediatric intensive care provision in our sector. While there will always be a need for children to be sent outside NEL, more comprehensive treatment for many critically ill children could be provided within NEL, closer to their homes and families. This would also reduce the burden on specialised children's emergency retrieval teams.

Current staffing levels and deployment of staff do not allow this. Providing such a service will require more paediatric surgeons, anaesthetists and nurses, providing 24 hours a day, 7 days a week cover. Community-based services for children, especially those with long-term conditions, will also need to improve, as will integration between different services. This will mean a close examination

of the distribution of funding and services between hospitals and community settings.

Maternity and newborn services

The birth rate in NEL is rising overall. At the same time, in all PCTs except Havering, there are higher than average numbers of low birth-weight babies.[36] This reflects variations in wealth, ethnicity and co-existing conditions such as diabetes and smoking. Levels of caesareans are higher than average, in many, but not all, cases due to complications of pregnancy, for all NEL trusts except BHRT. Rates of episiotomies at Whipps Cross are three times that of the top-performing 25% of trusts.[37] Maternity and ante-natal care in the area therefore faces considerable challenges either to explain or reduce (or both) such differences from expectation.

More comprehensive treatment for critically ill children could be provided closer to their homes and families.

A Healthcare Commission review of maternity services in 2007 identified weaknesses in NEL. The Healthcare Commission identified a need for PCTs to improve the monitoring of quality and make better plans to improve service delivery.[38] There are a number of local reviews already underway to address many of these issues, and there is some evidence that services are improving already.

Services need to respond to changes in the population and in patient need. There is an increased risk of complications during pregnancy and birth in NEL and greater need for assisted deliveries.[39] Reasons for this include higher levels of diabetes, higher than average levels of HIV and mental health challenges.[40] Increasing obesity levels add further to the risk of complications, and our diverse population presents significant social challenges. In addition, mothers are increasingly asking for more choice over how and where they give birth.[41]

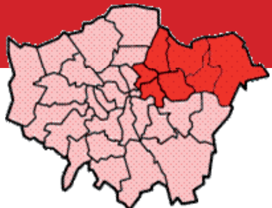
Best practice includes 1:1 midwife care for women giving birth.[42] Other evidence has highlighted the need for 98-hour consultant cover to ensure safe obstetric services.[43]

Current staffing levels and capabilities do not allow for the improvements that are needed in maternity services. While above-average numbers of staff have core maternity skills, staffing levels are low, particularly in BHRT and Newham, and both the Homerton and Newham were found by the Healthcare Commission to have low levels of appropriate involvement of different staff members in antenatal care.[44]

NEL, like some other areas of the country, has problems with recruitment and retention of midwives. Numbers of consultants do not currently allow the 98-hour cover recommended. We need to explore new service models to ensure that care is safe, that risks are managed and that mothers are given the best experience possible.

Specialist services

Specialist services (those that are provided for rare conditions or require a concentration of a large number of people or equipment)



have improved in NEL over recent years. The introduction of multi-disciplinary teams has led to improved care for cancer patients, for example. Better access to diagnostic services has enabled earlier detection of tumours and earlier treatment of patients.

These changes have meant safer services, better compliance with treatment and greater efficiency. However, cancer survival rates are still below the EU average and mortality rates are average across the sector. Outcomes for breast cancer are close to the European average, but for lung and colon cancer we lag significantly behind. Some NEL PCTs perform significantly better than others.[45]

There is strong evidence that consolidating some specialist services, such as cancer, neurosurgery, vascular surgery and trauma, leads to better clinical outcomes.[46] However, some services are still spread across too many sites in NEL for this to be achieved.

It is important to ensure that centralisation of services does not lead to inequities of access across the NEL health economy.

Planned care

Planned care which is appropriate to need, and delivered in the most timely and accessible way, is crucial to the delivery of better health and health outcomes. Using planned care effectively for patients with long term conditions will be of great value to patients and will improve patient satisfaction levels. Planned care should never be postponed and currently in NEL this is not the reality. A review of planned care will, therefore run alongside the other five reviews.

Planned care is defined as care that is predictable in advance. It may cross many organisational boundaries. Examples would range from the provision of chronic dialysis services, through diabetic care to elective surgery. Some of the changes which emerge from other work streams might impact on planned care, and it is also clear that some aspects of planned care need to be improved irrespective of other work streams.

For many residents of NEL the delivery of this planned care, either in a community or traditional hospital setting is their main contact with health services. They are also the services which are often focused on promotion of health and healthy living, working with partners in primary care, local authorities and community groups.

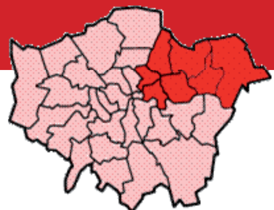
Within planned care we will establish the infrastructure that will allow Primary Care and Hospital specialists to work together across the new settings of care in the delivery of diagnostic, ambulatory, day and home treatment services, and to minimise waiting times within 18 weeks from referral to treatment.

The planned care work stream will maximise the quality and efficiency of services provided outside hospital including those provided by the Independent Sector, for example, commuter walk in centres, treatment centres and community diagnostics. It will also provide integrated health and social care services to support care outside hospital.

Londoners cite proximity to home as the top factor that would influence their choice of provider,[47] and today's diagnostics and outpatient services are predominantly based in the hospital setting. This is not always the most convenient setting for service users. Furthermore, it reduces the opportunity to break down barriers between primary and secondary care, and the opportunity to share information and skills. Poor access to diagnostics has also been highlighted as a key barrier to achieving a reduction in waiting times and there is the potential to improve access.

A review of planned care will therefore consider issues arising from other work streams and advise on likely impact. To give a hypothetical example, it would be important in any discussion on the centralisation of emergency and elective vascular surgery in one or two hospitals to consider the needs of diabetic patients across NEL for access to local vascular surgical services. This work stream will ensure that such factors are taken into account.

Planned care will look to concentrate the most complex planned surgery on fewer sites to ensure that the right infrastructure, equipment and expertise can be consistently available.



Conclusion

We need to act to change the way that healthcare is provided in NEL so that we can prevent ill health, improve the quality of services and ensure a sustainable healthcare system for the future.

The increasing population in NEL means that we simply are not in a position to meet the healthcare requirements in a sustainable manner in the long term. The demand on the healthcare system in NEL is going to increase and with this comes increased pressure to maintain high quality services. In order to provide consistency of healthcare services across our sector we need to ensure we can meet the demands of increased numbers, that our estate is appropriate for the service delivery and also to implement advances in healthcare technologies as they become available.

Only when we have consistent high quality care for all delivered by an appropriate infrastructure with highly skilled clinicians and partners will we be in a position to prevent ill health of the generations to come.

Glossary

BME	Black and Minority Ethnic
COPD	Chronic Obstructive Pulmonary Disease
HASUs	Hyperacute stroke units
HfL	Healthcare for London
INEL	Inner North East London
MD	Medical Director
MRSA	Methicillin Resistant Staphylococcus Aureus bacteria
NEL	North East London
NHS	National Health Service
ONEL	Outer North East London
PCT	Primary Care Trust
SRO	Senior Responsible Officer

1 Healthcare for London: www.healthcareforlondon.nhs.uk
2 Ibid
3 Healthcare for London: www.healthcareforlondon.nhs.uk
4 Next Stage Review final report, *High quality care for all*, June 2008: www.ournhs.nhs.uk
5 Office for National Statistics, Neighbourhood Statistics: www.neighbourhood.statistics.gov.uk and National Centre for Health Outcomes Development indicators. http://www.nchod.nhs.uk/ and http://www.ons.gov.uk
6 National Centre for Health Outcomes Development indicators, http://www.nchod.nhs.uk/ and http://www.ons.gov.uk
7 National Centre for Health Outcomes Development indicators, Ibid.
8 The Homerton won the award for 'Reducing Health Inequalities' from the Health Service Journal in 2008.
9 Healthcare Commission, Service review of heart failure 2008: http://2008ratings.healthcarecommission.org.uk/informationabouthealthcareservices/focusonnhsservices/othertopics.cfm. A scale of 1 to 4 is used, with 1 indicating that services are 'below minimum standards'.
10 National Centre for Health Outcomes Development 2004/06, Healthcare Commission annual health check 2007/2008: www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09.cfm
11 Healthcare Commission annual health check 2007/2008: www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09.cfm
12 Healthcare for London, *A Framework for Action*; July 2007: pp 10,12,118 and Department of Health, *Our health, our care, our say*; 2006.
13 Healthcare for London, *A Framework for Action*; July 2007: p 67
14 Department of Health 2002, Hospital Activity Statistics 2007/08: www.performance.doh.gov.uk/hospitalactivity/data_requests/index.htm plus NEL Programme Team Analysis
15 Data from Bedfordshire and Hertfordshire SHA, 2004
16 Quality and Outcomes Framework, April 2006 – March 2007, England
17 London Health Observatory Information Centre, 2007/08
18 Ibid
19 Hospital acquired infections data comes from HCAI Data Capture Systerm, July 2008; Data on two week wait comes from Department of Health Cancer waiting times database.
20 Healthcare Commission annual health check 2007/2008: www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09.cfm
21 Eg. BHRT has improved performance on the 4-hour target, from 88% in 2007/08 to 97% in Q2 of 2008/09: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_079085
22 Secondary Uses Service (SUS), 2006/07. This is a service hosted by Connecting for Health which providers information on comparative performance across NHS organisations.
23 Hospital Episode Statistics, 2006/07
24 Healthcare Commission, Patient satisfaction survey 2007: www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/nhsstaffandpatientsurveys/patientsurveys/hospitalcare/inpatientservices.cfm
25 HES data, Healthcare for London, page 26
26 The Information Centre, Vacancy Survey, 2008
27 Workforce for London: A Strategic Framework
28 Hospital Episode Statistics, 2006/07.Similar to NCHOD, this is an online database which containts data on activity hospitals perform in a given year.
29 Ibid.
30 Ibid.
31 Reference NCEPOD study
32 NCEPOD study www.ncepod.org.uk/2003wow.htm
33 Royal College of Physicians, National Sentinel Stroke Audit 2006
34 Healthcare for London, Consultation on stroke and major trauma January 2009: www.healthcareforlondon.nhs.uk/assets/Stroke-and-major-trauma-consultation/DetailedconsultdocFINALv1.0.pdf
* NEL has identified the location of Hyper Acute Stroke Units (HASUs) within the HfL Stroke and Trauma consultation but the location of stroke units without a HASU will be determined at the conclusion of the general review.
35 Based on data reported by London trusts in 2007/08
36 Secondary Uses Service, NHS Maternity Statistics, England, 2005-6, p. 39: www.ic.nhs.uk/webfiles/publications/maternity0506/NHSMaternityStatsEngland200506_fullpublication%20V3.pdf
37 Healthcare Commission, *Towards better births: A review of maternity services in England*, July 2008, http://www.healthcarecommission.org.uk/_db/_documents/Towards_better_births_200807221338.pdf
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39 Ibid.
40 Evidence from clinical leads group
41 Healthcare for London research
42 Department of Health, *Maternity Matters: choice, access and continuity of care in a safe service*, April 2007
43 Healthcare for London, p46, para 34
44 Healthcare Commission, *Towards better births: A review of maternity services in England*, July 2008, http://www.healthcarecommission.org.uk/_db/_documents/Towards_better_births_200807221338.pdf
45 Office for National Statistics. Cancers diagnosed 1997-99. Survival for 8 major causes and all causes combined for European adults diagnosed 1995-99; Results of Eurocare- 4 study, The Lancet Online (Aug 21, 2007)
46 Evidence based collected and reviewed under Healthcare for London. For example 9 M. Chowdhury et al., "A systematic review of the impact of volume of surgery and specialization on patient outcome," British Journal of Surgery, 2007; 94; 145-161
47 Ipsos Mori, London Residents' Attitudes to Local Health Services and Patient Choice, Jan 2007

Monday - Friday
9.00am - 5.00pm

55413

English	For free translation phone
Arabic	للترجمة المجانية الرجاء الاتصال هاتفيا.
Chinese	欲索取免費譯本，請致電。
French	Pour une traduction gratuite, téléphonez
Hindi	मुफ़्त अनुवाद के लिए फ़ोन कीजिए
Malayalam	സൗജന്യമായ തർജ്ജിമയ്ക്കായി ബന്ധപ്പെടുക
Somali	Turjubaan lacag la'aan ah ka soo wac telefoonka.
Portuguese	Para uma tradução grátis, telefone.
Bengali/Sylheti	বিনাখরচে অনুবাদের জন্য টেলিফোন করুন
Gujarati	મફત ભાષાંતર માટે ફોન કરો.
Punjabi	ਮੁੱਫ਼ਤ ਅਨੁਵਾਦ ਲਈ ਫ਼ੋਨ ਕਰੋ
Urdu	مفت ترجمے کے لئے ٹیلیفون کیجئے۔
Serbo-Croat	Za besplatne prevode pozovite
Spanish	Para obtener una traducción telefónica gratuita llame al:
Russian	Перевод – бесплатно. Звоните.
Albanian	Për një përkthim falas telefononi.
Tamil	இலவச மொழிபெயர்ப்புக்கு தொலைபேசி செய்யவும்.
Greek	Για δωρεάν μετάφραση, τηλεφωνήστε.
Turkish	Ücretsiz çeviri için telefon edin.
Vietnamese	Điện thoại để được thông dịch miễn phí.
Kurdish	بۆ وەرگێران (تەرجومەکردن) بە خۆڕایی، تەلەفۆن بکە.
Lithuanian	Del nemokamo vertimo skambinkinte
Polish	Po bezpłatne tłumaczenie prosimy dzwonić:

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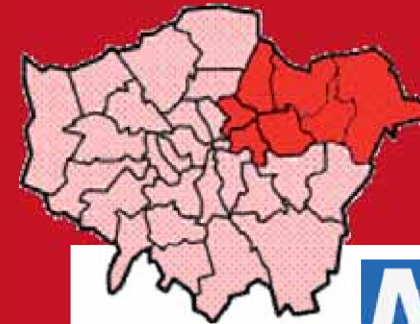

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