better services
better value
for South West London

NHS

Better services, better value

The case for change for health services in south west London

October 2011

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About this paper

This document presents the local 'case for change', and as such it offers a concise overview of the key factors which are driving change in South West London. Many of the challenges presented here are not unique to this area, and several are being felt across the UK at a national level. Wherever possible we have grounded the arguments in local evidence, taking on board the concerns and aspirations of colleagues and local people, and drawing on our knowledge of what local people want and need from their health service.

This paper presents the issues under four sections:

1. **Rising demand for healthcare: more people, needing more care in the future**
   Here we show how changes to the make-up of the South West London population and lifestyle trends are likely to lead to more people needing care in the future. We also explore how people's health can vary according to where they live, how wealthy they are, and their ethnic background – these differences need to be tackled.

2. **Needing to do more with less: the reality of financial pressures**
   This section highlights the financial constraints and demands being placed on the local health economy, as well as the opportunities for creating more efficient processes that also benefit patients and their carers.

3. **Achieving the highest possible standards of care, and meeting patients' expectations**
   Improving the quality of healthcare on offer to patients must be at the heart of any future changes: here we show where quality is not as good as it should be and where we must do better to provide local people with safe, effective, easily accessible and patient-centred services.

4. **Responding to changes in staffing arrangements and shortages of skilled health professionals**
   A number of important changes are happening to the way the workforce is organised. There are also national skills shortages in some areas of practice, which affect how many healthcare settings can be safely staffed.

A huge amount of data and evidence has been examined by five Clinical Working Groups set up to lead the review. The detailed findings from their in-depth evidence reviews are not presented here, and will be published separately in the coming months. These documents will also reveal their thinking on possible ways forward and options for responding to the challenges set out in this paper.

Introduction

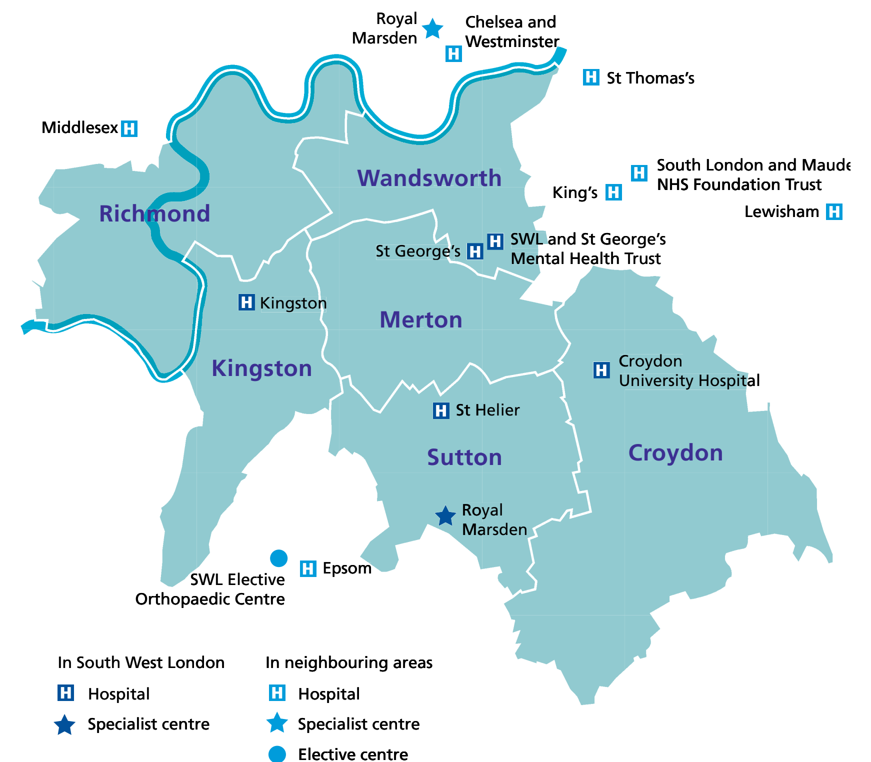
This Case for Change presents the key pressures facing the health system in South West London, now and in the future. It explains why it may not be feasible to 'keep on doing what we've always done' to meet the health needs of residents across the London boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

The *Better Services Better Value* review has been set up to look at ways to drive up the quality of patient care and health services in south west London, and to make sure the local NHS spends its money as effectively as possible. We want patients to experience a seamless service between different parts of the system, to ensure that we get things right first time more often and that services are genuinely integrated. The review is being led by local doctors, nurses and other health professionals, and asks two key questions:

1 How can we improve services for patients?

2 How can we be more efficient and get better value for money for local people?

What area is covered by South West London?



There are 1.4 million people living in south west London,[1] and the NHS spends £2.3 billion a year here on GP services, other primary care, community services, mental health and hospitals – that's equal to £6 million every day.[2] Clearly, there's a lot at stake. And we need to get this right.

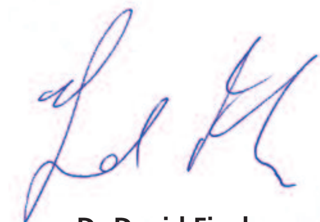
In this document, we provide an appraisal of some of the known strengths and weaknesses in our existing healthcare system. It also presents an evidence-based picture of where pressures will be felt in the future, unless action is taken now. We present a frank picture of where standards of care are falling short, and where the safety of patients may be at risk. At times this may make for uncomfortable reading. However we feel it's necessary to be as open as possible in 'telling it as it is' so that local people, health professionals and other stakeholders understand *why* change is necessary. We must achieve this shared understanding, so a wide range of people can work with us to shape viable solutions that are of real benefit to patients.

The local NHS will not be dealing with these challenges alone. Going forward, local authorities are going to play a critical role in improving public health, and giving communities a greater say in the services needed to provide care for local people.

We've started work to look at possible ways forward, but there's still a long way to go:

- Clinical Working Groups – made up of doctors, nurses and other health professionals – have been set up to look at possible reforms in five service areas: urgent and emergency care, planned care and 'end of life' care, long-term conditions, children's health services and maternity services.
- We've run events over the summer, to talk to local people and stakeholders about some of the challenges facing the health service, and to understand their top priorities for organising care in the future.
- Between September and December 2011, we will have attended over 100 meetings with local voluntary and community sector organisations, NHS clinicians, local authorities, Local Involvement Networks (LINks) and others to discuss *Better Services Better Value*.

No decisions have been made yet. So there's every opportunity for you to have your voice heard on these important issues. Below we explain where to go to get involved, and have your say. There's every reason to engage in the *Better Services Better Value* review. This isn't just about fixing problems and managing future risk, the review presents a chance to create a health system which we can all be proud of, with quality at its core. We now have a great opportunity to reshape services in the interests of providing not just average care, but the very best for the people of south west London.



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How do I get involved?

NHS South West London is extremely keen to hear your views on the challenges and ideas set out in this paper, as well as your responses to the options being developed by the Clinical Working Groups.

Please go to www.southwestlondon.nhs.uk or email us at betterservices@swlondon.nhs.uk if you would like:

- to comment on any of the issues presented here
- further information, or more detail about the evidence presented here
- an update on the *Better Services Better Value* review
- to know about other ways to get your voice heard on these important issues.

All comments and submissions will be recorded and considered by the clinicians leading the *Better Services Better Value* review.

Doctors, nurses and other healthcare professionals leading the review are committed to a process of continuous public and stakeholder engagement over the coming months. See 'Next steps' on page 23 of this document to find out more about ways to have your say.

1 Rising demand for healthcare: more people, needing more care in the future

Changes in the population

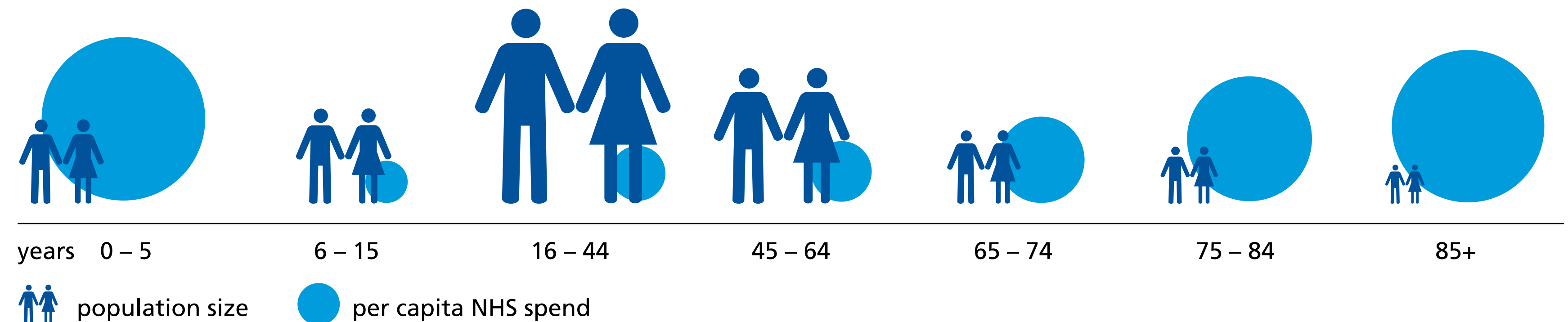
Our population in south west London is growing. People are living longer and the population is ageing. The latest projections suggest the number of people aged over 85 will increase by two thirds by 2029[3]. This is an important trend because we know that older people generally have more health problems, and need to use health services more than younger adults.

There will also be more births. As more women of child bearing age move to South West London, it's expected that the number of births will rise by more than 10% over the next five years[4].

As a result of these trends, the overall population of south west London will grow by 3.4% between 2011 and 2021. And some boroughs, such as Croydon, will see even higher growth levels, for example 4.5% in Croydon and 6.8% in Wandsworth[5].

The size, and nature, of this population growth is going to put pressure on NHS resources. The chart below shows how the NHS spends more of its money on the very young and the very old, as understandably, these age groups need more care.

Distribution of population age group and NHS per capita spend[6]



Looking ahead, this means there will be more older people, new mothers and children for the NHS to care for.

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More people living with long-term health conditions

It's expected that many more people will be living with long-term medical conditions in the future. By this we mean health problems that are present for over a year or more, such as diabetes, heart disease, respiratory problems, asthma and epilepsy. People often have more than one of these conditions, especially as they get older.

What's driving this trend? There are well known links between unhealthy lifestyles and the rise in many of these diseases. Although local professionals and volunteers continue to work hard with their communities to help people live healthy lifestyles, some problems still remain, and some are getting worse. For example,

- Being obese[7] raises the risk of developing diabetes, coronary heart disease, stroke and osteoarthritis. Although obesity rates among adults in south west London are generally below the England average,[8] more than 15% of adults are obese in south west London. Perhaps even more worryingly, in Croydon just over a fifth of all 10–11 year olds are obese.[9]
- It's estimated that roughly one in five people smoke,[10] and in the most deprived areas this may be as high as two in five (41%).[11] Smoking (and other forms of tobacco consumption) are the UK's single greatest cause of preventable illness and early death, with around 107,000 people dying in 2007 from smoking-related diseases[12].
- Alcohol and drug misuse pose significant threats to health, particularly among young people. London-wide studies have shown that when questioned nearly one in five residents admit to binge drinking in the previous week.[13]

Thanks to early diagnosis and improved treatments, fewer people are dying early from diseases like cancer, heart disease and strokes. Consequently, three out of every five people aged over 60 in England suffer from a long-term condition, and as the population ages, this proportion is likely to rise.[14]

Unhealthy lifestyles, coupled with longer life expectancy, mean more people are living with conditions like obesity, diabetes, respiratory problems, cancer and heart disease. This trend is set to continue.

These trends have important implications for both the amount of healthcare needed in the future, and the type of care that will be most appropriate.

- We know that people with long-term health conditions are the most intensive users of health services. Across the UK, they make up 31% of the population but account for 52% of GP appointments and 65% of planned hospital appointments.[15]
- We know that local partnerships involving councils, schools, the voluntary sector, health and others need to continue to work hard to help people and local communities change behaviours and lead healthier lifestyles. Therefore it makes sense to invest our efforts and resources in prevention to help prevent people from developing long-term conditions in the first place.

- Also key to this is empowering patients and their carers to understand and manage their long term conditions better. In the future many older people who also have long-term conditions will need better organised care, closer to home, to help them self-manage their conditions and live as independently as possible. This is especially important, given that social trends – such as in the increase in single-person households, and people living further from their extended family – may mean many people won't receive the support they need from family members and loved ones.
- Having said that, around six million people in the UK – one in eight of the adult population – currently cares for a relative or loved one.[16] The number of carers in the UK is projected to increase to around 9 million by 2037.[17] It is important that carers are treated as partners in caring for people with long term conditions and that their needs are taken into account when planning and delivering health and social care services. Key to making this work is: making sure health and social care services are joined up; thinking about the role carers can play in helping those they care for to stay out of hospital and return home from hospital more easily; and helping carers support those they care for to be as independent as possible.[18]

Now, more than ever, it will be critical for the NHS to work with its partners in the community to support prevention, and to provide joined-up and coordinated care for patients and their carers.

Addressing health inequalities and tackling the underlying causes of ill-health

It's crucial that, now and in the future, people who live in south west London receive top quality healthcare and are able to live healthy lives no matter how much money they have or what their background is. Like most areas of London, the south west of the capital is a real mix, with very wealthy people living side-by-side with very poor households. Wandsworth and Croydon have the highest levels of deprivation: some areas in these boroughs are amongst the 10% of places with the highest levels of childhood deprivation in the country.[19]

How healthy people are varies just as widely. For example there is a 12 year difference in life expectancy between men in the ward with the lowest average life expectancy and men in the ward with the highest average life expectancy.[20]

There is a wealth of evidence that demonstrates a strong link between poverty and health: the poorer you are, the more unhealthy you are likely to be. This is caused by many things, including differences in living conditions, diet, levels of smoking and drinking, access to sport and leisure, social and support networks as well as barriers to accessing healthcare (such as language and literacy barriers). The recent national Strategic Review of Health Inequalities in England[21] emphasised how important access to good education and employment opportunities are for health as well.

Some **ethnic groups** tend to have poorer health outcomes than others. Work by the London Health Observatory suggests that Bangladeshi, Black African and Black Caribbean ethnic groups have

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significantly higher mortality rates than the overall population of the capital.[22] This can be explained by a complex interaction of lifestyle and other risk factors. For example evidence suggests that Pakistani men are significantly more likely to suffer coronary heart disease or stroke than the general population. Health outcomes for London's black and minority ethnic groups can partly be explained by other associated factors, such as the fact that employment rates are much lower for certain ethnic groups than White residents.[23]

In south west London, just as elsewhere, the link between affluence and health holds firm. Worryingly, these differences have a large impact on **children and young people**. Figures show that whilst child deaths from accidental injury have fallen, serious inequalities remain. For example rates of serious injury for child pedestrians are four times higher in the most deprived areas than the least deprived areas.[24]

'In Kingston we wanted to ensure that our immunisation rates were as good as we could get them, although we already perform well. We decided to start offering opportunistic immunisations for 'harder to reach' families, and those who had fallen behind with their immunisations. We started this during a 'stay and play' session in one of the Children's Centres in Norbiton. We can check if the child's immunisation record is out of date and if it is, we explain the benefits of immunisation to parents and with permission we do the injection then and there. There's no need for mum to make an appointment.'
Andrea Bennett, lead nurse for health visiting, Kingston borough

As everyone knows, obesity is a major health problem. The obesity rate in children in school reception year (ages 4–5 years) and in school year 6 (ages 10–11 years) is almost twice as high in the most deprived boroughs in the region compared with the most affluent areas.[25] The infant mortality rate is higher in the most deprived areas compared with the least deprived areas.[26]

There are many things that can be done to help tackle the challenges described here, and health inequalities are not inevitable. The Staying Healthy Strategy for South West London[27] shows there are a number of activities which are being targeted at the most disadvantaged communities to help make sure everyone has an equal chance to live a healthy life, including breast feeding support, programmes to help people stop smoking and initiatives to get people more physically active. Another example from Kingston (above) shows how practical solutions can be found.

Inequalities in health persist and need to be tackled. Given how significant the differences in health outcomes are in South West London, it will be vital to address the causes of this inequality as we move forward.

2 Needing to do more with less: the reality of financial pressures

In the last chapter we saw how in the future there will be more older people, new mothers and children living in South West London, and how more people are likely to be living with long term health conditions. This additional demand for care carries with it an additional cost which, when added to the other financial pressures described in this chapter, means that changes will need to be made with impact on finances in mind.

The national picture

Although the Government's pledge to protect the national health budget meant it fared well in comparison to some other areas of public spending, analysis suggests expenditure will be flat in real terms in the years up to 2015.[28] The 2010 Spending Review also committed the NHS to finding £20 billion in productivity improvements by 2015. This means the NHS is required to deliver efficiency savings of at least 4% a year – something which is unprecedented in its history.[29]

Across the country, finding savings will be a priority for the NHS and any reforms over the next few years must support it in meeting this challenge.

What does this mean for south west London?

These financial constraints and demands will present a real challenge in south west London, where it is expected that more people will need more care in the future.

There are other pressures on costs too. For example, the local health system continues to make use of the most effective and up-to-date technology and medicines to keep its local population healthy. That has revolutionised healthcare in the past, but new **drugs and cutting-edge equipment are expensive**. The case study below gives a great example of the benefits advances in technology can bring, and also the costs involved.

Radically changing the quality of care… at a cost
Mike Bailey

'Kidney stones are common, affecting 1% of the population. They can be very painful, can give rise to repeated infections and may lead to kidney damage and ultimately kidney failure.

When I started my career as a urologist, the treatment of kidney stones was to remove them via a major surgical procedure. This involved a cut through the skin and muscles over the kidney approximately 30 cms long, and an incision in the kidney itself to remove the stone. The incision was a painful one, and left the patient with an unsightly scar. The hospital stay was often two weeks or more.

Pioneering work by British surgeons led to the development of a technique to introduce a telescopic instrument through the

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skin on the back into the kidney, through which the stone could be broken up and removed. This technique allowed removal of the stone via a 1cm incision, with minimal pain afterwards, and a one or two day hospital stay.

The next development was the invention of the external shock wave lithotripter in the 1990s. The ingenious device focussed high energy shockwaves on the kidney stone, breaking it into powder which is then passed in the urine. This treatment can be carried out without an anaesthetic as a day case. The vast majority of kidney stones are now dealt with as day cases using a lithotripter.

The increasing patient comfort, decreased chances of death and reduced hospital stay is obviously great news for patients, but is very dependant on expensive technology. A shock wave lithotripter costs several hundred thousand pounds. An inevitable consequence of this is that, whilst open kidney surgery could be offered by every district hospital, and the key hole technique was available from major centres, lithotripsy is usually only offered by one centre in each geographical region of 1–2 million people.'

Mr Mike Bailey is a Consultant Urologist
at St George's Hospital

Meeting the standards as set out in national guidance on clinical quality and safety may present further cost pressures. For example, the Royal College of Obstetricians and Gynaecologists (RCOG) has released guidance which recommends much higher levels of senior doctor presence per week on maternity wards than is currently provided in South West London.30 Clearly, there are costs associated with recruiting and retaining more senior and expert professionals.

Primary Care Trusts are currently responsible for deciding how resources are spent on services to meet the health needs of the local population. And in the future Clinical Commissioning Groups are likely to play this role, with leadership from local GPs – we call these bodies 'commissioners'.

There's a pressing need to look at how the local health system can be financially sustainable in the future.

Ultimately, if no changes are made to the way resources are currently spent on health services, and demand for services goes up as predicted, then commissioners in **south west London could be spending up to £155 million more than their likely budgets by 2014/15.**[31]

On top of this, the organisations responsible for the front line delivery of healthcare also need to find efficiency savings.

It's estimated that South West London's four main hospitals – Croydon, Epsom and St Helier, St George's and Kingston – will need to reduce their costs by around £370 million by 2016/17. This is 24% less than their current costs.[32]

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Tackling inefficiencies and achieving more with less

Undeniably, there are some inefficient practices present within the current health system. For example, planned surgery appointments are often cancelled on the day because emergencies in other parts of the hospital take priority. In 2010/11,over 980 operations in South West London were cancelled on the day of the operation for non-clinical reasons such as this.[33] This is distressing for patients and carers, and it's also wasteful in terms of the resources needed to reschedule appointments.

There are also possible changes that could improve health outcomes for patients, and also happen to cost less. For example, advances in surgical techniques mean that many types of surgery that used to need long hospital stays are now performed more quickly and effectively as day cases. Examples include cataract surgery, hernia repair and gall bladder operations. It is estimated that about three out of four planned surgeries could be performed as day cases[34] – potentially this could be more convenient for patients, safer in reducing the chances of hospital associated infections, and also less costly.

Locally, we do need to find savings, but there's also an opportunity to explore solutions which could simultaneously drive down costs, and drive up the quality of care on offer.

3 Achieving the highest possible standards of care, and meeting patients' expectations

No matter how much pressure on resources there is, the principal goal of healthcare services in south west London remains the same: to achieve the highest possible standards of care.

In some cases this will mean identifying areas where the quality or safety of care isn't up to scratch, and taking necessary action to improve it. In other cases it means ensuring that good services get even better, or making sure that services are consistently good across the whole of south west London.

One of the biggest changes to the way healthcare services are provided is the growing importance of patient power. The age of 'doctor knows best' is over: twenty first century patients expect clear and up-to-date information to help make the choices about their care they feel are best for them, including access to the latest treatments and technology, and services that are available when and where they want them. First and foremost, patients expect to be treated with dignity and respect at all times.

Although there are pockets of excellence in south west London, we know that local health services are not always achieving the standards of care that clinical experts recommend and local people expect. We want to be honest about these shortfalls and risks, because we are committed to addressing them, and we believe we can address them, even in a challenging future context.

Improving clinical quality and safety where services are falling short

In many instances, clinical quality and safety is not good enough. Doing nothing in these cases is simply not an option, especially as things are only going to get more challenging in light of the financial and demographic pressures described in the previous chapters.

A full picture of where services are falling short will be presented by the five Clinical Working Groups when they publish their Clinical Reports in the coming months. These documents will also reveal their thinking on possible ways forward and options for responding to the challenges set out in this paper. Below we focus on a few illustrative examples.

Maternity services is one area where we would need to change to achieve some of the best practice standards described by the Royal Colleges to achieve safe care. The Healthcare Commission rated maternity services in South West London as 'weak' in 2007.[35] A lot of work has been done since then and there is evidence that improvement has been made but some key quality standards are still not being met. One of these is the amount of time that a senior doctor is present in the maternity units. For example three out of the four maternity units do not currently meet the Royal College of Obstetricians and Gynaecologists (RCOG) recommended senior doctor presence per week – see inset.[36] Although the majority of women have relatively few complications when giving birth, feedback from patients has consistently found that mothers also want a senior doctor (obstetrician) present on the unit when they give birth.

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The Royal College of Obstetricians and Gynaecologists recommends that there is a senior doctor present at all times day and night in maternity units with more than 5,000 births and that we should be working towards this standard in all but the smallest low risk units.

If we want to meet this recommendation, we will have to consider a reconfiguration of maternity units or work towards this aim in only the largest units.

To achieve the RCOG standard, as services are currently configured, we would need to provide over 200 more consultant hours per week across south west London and this would require many more doctors. The shortfall between the number of existing obstetricians and the numbers needed to provide sufficient coverage at all four maternity units in order to meet the RCOG guidance is so large that there may not be enough qualified obstetricians available quickly enough, regardless of the cost involved.

Recruitment and retention of midwives is also difficult. We need to ensure that there are enough midwives to provide one-to-one care for women in labour and to provide the type of antenatal and post natal care that is needed to achieve the best outcomes.

This is not a problem that will get any easier over time: projections suggest more women of childbearing age are moving to south west London, and the average age of women giving birth is going up, which tends to lead to a higher risk of complications. More mothers are obese than ever before, which also leads to higher risks, such as a condition called pre-eclampsia, which causes high blood pressure and other complications. All these factors may lead to higher risks of obstetric complications and require the availability of complex medical and midwifery care.

There are also concerns around standards of care in **children's health** services, where performance reviews have suggested that senior clinicians are not undertaking enough procedures to maintain their specialist skills.

A recent report from NHS London has raised some serious concerns about the quality of **emergency care** across the capital.[37] In London, data shows that a patient's chances of dying as a result of many emergency conditions is significantly higher if they go to hospital in an emergency at the weekend, as compared to a weekday. This difference is largely put down to a reduced level of service at the weekend, and fewer senior consultant doctors being on hand to care for patients at that time. This is critical, as senior doctors have an indispensable role to play in offering specialist emergency care and senior clinical decision making. There are also other unacceptable differences in the quality of emergency care offered, such as patchy access to diagnostic scans and modern surgical techniques (such as key hole surgery).

NHS South West London is not an exception to this. Local specialists believe that to meet the standards set by the College of Emergency Medicine, local A&Es would need a consultant on hand for a minimum of 16 hours a day. Unfortunately, current arrangements do not meet these standards.[38]

In London, around 520 lives could be saved if the rate of mortality for patients admitted at the weekend was the same as the mortality rate for those admitted during the week. Reduced consultant presence at weekends is associated with mortality.

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These are just a few examples of where the need to guarantee the highest clinical standards is prompting a radical rethink about how services are best delivered across the patch.

Building on the best: continuous improvement in quality

There's really strong evidence that the more specialised that doctors and other clinicians become, the more that outcomes for patients improve.[39] Specialist surgeons have better overall outcomes than generalist surgeons performing the same operation in 91% of cases. They also have lower death rates in 92% of cases, as well as shorter stays in hospital, and fewer complication rates in 82% of cases.[40]

Specialists become proficient by dealing with large volumes of similar complex cases, and if located in specialist centres and networks they can access the best equipment and develop their skills by working alongside other specialists.

There are some excellent specialist centres and networks already benefitting patients and carers in south west London, such as the South London Cardiac and Stroke Network. However, there may be other areas of clinical practice which would also benefit by being centralised in a few centres of excellence, such as emergency 'keyhole' surgery[41,42] and long-stay hospital beds for very sick children.[43]

Clearly there are important choices to be made here, as by specialising services in a few centres of excellence, some patients will have to travel further to receive care.

New advances in communication that help specialist teams work together with other professionals can also help patients recover and regain their independence more quickly. For example, patients who have had complex surgery often stay in hospital for up to ten days following their operation. To avoid a long hospital stay, and to increase the chances of successful recovery, in some hospitals the surgical team works closely with a home care team to help the patient get back home after just four days. This is achieved safely by the home care team sending electronic updates on the patient's condition back to the surgical team.[44]

Another area where there's the potential to improve care is by thinking about basing some other services nearer to where people live. Providing some care closer to home can be more convenient, and can also improve access to timely treatment, which in turn could help reduce unnecessary admissions to hospital.

Obviously there are some cases where care delivered outside of hospitals in community settings doesn't work. But there are many where it does, and we know from our recent engagement events with local patients and stakeholders that people are generally happy to receive care in a different location as long as they're convinced there's a genuine advantage in terms of the quality or accessibility of care.

There are many opportunities to improve access by providing services traditionally delivered in hospital in community settings that are closer to home, for example at GP surgeries, walk-in centres and even home visits.

For example:

- More outpatient appointments for children suffering from minor problems could be provided in community settings, rather than in hospital as they often are now.
- Community nursing teams, working with social care staff, could make sure older people, and people with long-term health conditions, can access urgent care at home.
- GP out-of-hours services and 24/7 community nursing teams could be more readily available to offer in-home support, so that people don't have to go to hospital when they are nearing the end of their life, if that is not their preferred location.

What's the latest thinking on the changing role of hospitals?

A recent report by the Kings Fund (Reconfiguring Hospital Services, 2011) explains how advances in medicine and surgery have led clinical staff and equipment to become more specialised. As skilled specialist staff are scarce and budgets are limited, services have been centralised onto fewer, larger sites, to make sure patients are cared for by staff with the necessary skills and equipment. In addition, there has been **less reliance on bed rest** as part of treatment. For example, most routine surgery is now day surgery, and 80% of all patients have stays of less than three days. Because of these trends, the **number of hospital beds in England has fallen by about 8% over the last five years.** Looking ahead, as medicine and surgery continues to become more specialised and as new techniques allow people to go home earlier or avoid going to hospital at all, it's likely the number of hospital beds will continue to go down.

Another report by the thinktank Reform (The Hospital Is Dead, Long Live The Hospital, 2011) also suggests that the role of hospitals needs to change. People with long term conditions need frequent, ongoing care to remain healthy, and hospitals are by far and away the most inefficient way of providing this kind of care. Yet despite this, because of the current way NHS finances are allocated, eight out of eleven hospital admissions (nationally) are for people with long term conditions. As the authors conclude: 'Given the increase in the numbers of people who will have a long term condition, the future of the NHS depends upon reducing the level of resources spent on each person with such a condition. This will need the development of **services which assist the patient to maintain good health,** rather than continuing to fund the emergency beds in hospitals that are the most expensive aspects of the NHS'.

We need to get better at using evidence to understand what approaches are known to help improve health outcomes for people. We should use this knowledge, alongside an awareness of what's possible within the resources available, to inform the future development of our local health services.

3

Ensuring a consistently good, joined-up and accessible service

Providing good services in one part of south west London is one thing, but the key is making sure that people can easily understand where's best to go, and access the same standard of services wherever they live, and at any time of day.

Access to services is not as easy as it should be, and this can mean patients can end up going to one place when somewhere else would be better suited. The NHS can be confusing and patients and carers do not always know where to go to access the care they need. A report by the Healthcare Commission noted that:[45]

> **Most people understand the role of their local GP and A&E department, but many are either less aware of, or less confident in using the range of new services designed as an alternative. Some people also report that it can also be difficult to navigate between services.**

Many patients find it difficult to access urgent care provided by GPs, particularly through out-of-hours services, and many are unsure where their nearest walk-in facility is located. Other than 999 for an emergency ambulance, there is no easily memorable telephone number for patients and the public to phone.[46]

Improving these channels of communication and making it crystal clear which options are available and which are best suited for different situations could be an important step in reducing the number of people going to A&E with minor illnesses.

Re-locating services to be in line with how patients tend to access care is another option for improvement. This has worked well in some other areas elsewhere in London. For example, the former Charing Cross Hospital A&E Department is now separated into an Emergency Department and an Urgent Care Centre. The latter is staffed by GPs and emergency nurse practitioners, and since it opened in September 2009 it has seen some 60% of both walk-in and ambulance patients.

> **'Of all the walk-in patients they only pass approximately 18% on to the emergency department, which means 82% are seen in the Urgent Care Centre. Emergency department consultants are available to give the nurse practitioners opinions on the trauma cases they see. When the GPs want a specialist opinion they refer the patient to the relevant specialist, just as they do in their own practice. The change has resulted in fewer short term admissions to hospital.'**
> Hugh Millington, Emergency Department Consultant and Urgent Care Lead, Charing Cross Hospital

In some instances care is not as joined up and **coordinated** as it should be. In many cases patients need different types of support, but in these circumstances the last thing anyone wants is to feel like they're being passed from pillar to post. The main challenge is connecting parts of the health and social care system so that people are supported to manage their own health problem better. At the moment there is often poor co-ordination between GPs, practice nurses, community services, social services and hospital staff. Less than half of London residents surveyed in 2010 (46%) felt that local NHS and social services were working well together to provide a joined up service.[47]

3

There are some unacceptable inconsistencies in how health services are delivered across the patch. According to patient surveys, access to GPs for urgent same-day appointments or out-of-hours services varies a lot. Recent engagement events with patient and stakeholders reinforced this finding: many participants say there is little consistency in appointment systems across surgeries. For example, some offer 'walk-in' sessions, extended hours and/or email communication, and others do not. This kind of variation is confusing, and it raises concerns among patients that the standards of care and clinical safety are also inconsistent.

This is an important opportunity to develop more accessible, coordinated and consistent healthcare.

4 Responding to changes in staffing arrangements and shortages of skilled health professionals

There are a number of pressures affecting the healthcare workforce, which are having a knock-on effect to the way services are organised. Some of these changes mean it's either unfeasible or unsafe to run medical units in the same way as we have done in the past.

For example, the introduction of the European Working Time Directive (EWTD) **has restricted the number of hours** junior doctors can work. Given that traditionally we've relied on junior doctors to provide a lot of front line medical cover, particularly out of hours, this is posing a real challenge. It has made it much harder and more expensive for smaller units to ensure that medical cover is available at all times of the day and night.[48] Since the application of the European Working Time Directive to junior doctors, there has been a 50% increase in the number of junior medical staff required to provide 24/7 care, and it's likely many units will have struggled to achieve this.[49]

Looking at the national picture, the Royal College of Paediatrics and Child Health have highlighted an **overall shortfall** in doctors across the UK because of these changes, and warn that as a consequence some paediatric units may have to close. Given that there is not an inexhaustible number of trained paediatric doctors and nurses, there is now a limit to how many units can be staffed safely.[50]

There are also likely to be shortages in trained health professionals in some other areas of practice. The number of doctors in training is expected to fall after growth in recent years and there are already shortages in some areas of nursing, for example, midwifery.

There's no doubt that alternatives can be explored. For example skilled staff can be given more support from non-medical staff to free them up to concentrate on frontline clinical care. It may be safe for some procedures to be carried out by different kinds of skilled medical staff. However this may not always be enough.

The Care Navigator is just one example of a new professional role, focused on making care more joined-up and centred around the needs of the patient. The Care Navigator is not a doctor or a nurse, but they are based in the GP surgery and their main role is to help people find their way around all the different social care, health and wellbeing services available to them in their local area. They can be of particular benefit to people with a variety of long-term and complex needs (e.g. an older person who has been diagnosed with dementia). GPs can refer patients to a Care Navigator who will offer help and advice through phone contact, home visits and peer-support groups. This kind of role can work extremely well in ensuring patients are assessed by the right professionals to receive a tailored package of care.

In addition, many health professionals are going to be expected to **work in very different ways** in the future. It's widely acknowledged that joined up working across health and social care is often key to delivering more effective and efficient care. Clearly the workforce will play a huge role in achieving this goal. For example the way that care is organised for older people is likely to change significantly, with a much greater focus on helping people to maintain their independence and stay out of hospital where possible. In leading these new models of care, health professionals

are likely to need new skills and training, to be able to deliver care in different settings, and to be able to work much more flexibly and closely with local colleagues (eg, in social care). Learning new skills and improved ways of working will be a further demand on the local workforce.

In some areas shortages in available skilled staff will require changes to services. Also many health professionals will see their roles change as they try to provide more patient centred and joined-up care for patients.

Conclusion

This report has presented evidence about some of the most important pressures facing the health system in South West London, now and in the future. It should be clear from this evidence that it's unlikely to be feasible to 'keep on doing what we've always done' if we're to meet the health needs of residents across the region.

As we've seen, there are pressures caused by changes in society, for example with more older people and mothers with young children living in the South West in the future, and more people with long term conditions, and important issues we will need to tackle around health inequalities.

These changes cause challenges for health services because caring for more people with more complex needs costs more money. On top of this basic financial pressure, there are several others. The NHS needs to deliver efficiency savings at unprecedented levels, and there are other significant costs involved in using costly new drugs and technology in order to meet standards of care.

Within the broader context of financial pressures and increasing demand for services, we also need to make sure that all services are up to scratch. There are some areas where care is falling short, and we urgently need to make improvements. In other cases we need to make changes to ensure that good services get even better, or to enable access for good services to everyone, wherever they live in South West London.

Last but not least, we will need to respond to pressures affecting the healthcare workforce, which in some cases mean there's no choice but to look again at how services are organised.

These pressures are very real, and there are lots of different ways we and our local partners might respond to them. There are no easy answers, and patients and carers, members of the public, health professionals and stakeholders will have some difficult choices to make. Some questions that will need to be considered include:

- Is it right to set up specialist centres of clinical excellence to help drive up the quality of healthcare on offer, even if in some cases this means patients have to travel further?
- What steps can we take to make sure services for physical and mental health, in hospitals and in the community, work more closely together to benefit their patients?
- And how can we ensure that in meeting the different needs of particular groups of patients – older people, those with long term conditions, people from Black, Asian and minority ethnic communities, for example – one group doesn't fall behind at the expense of another?

In deciding how best to respond to these pressures and difficult choices the views of patients and other stakeholders are central. We've outlined below what will happen next to ensure these views are taken on board.

Next steps

Doctors, nurses and other healthcare professionals leading the review are committed to a process of continuous public and stakeholder engagement over the coming months. NHS South West London will also continue to work with its local partners – particularly local authorities – to help find solutions that meet the needs of all communities in the area.

Recent and upcoming activity includes:

- A report on the recent engagement events held over the summer to discuss the Better Services Better Value review was published on Thursday 8 September 2011 and can be found on our website at www.southwestlondon.nhs.uk
- Clinical Working Groups composed of local doctors and nurses will be using the feedback from the initial review to develop recommendations and options for further development and testing.
- Further planned engagement events with a range of representatives across the community of south west London include: a social media forum with mothers across South West London about maternity; several public meetings in each borough and focus groups at Croydon College and Kingston Learning Disability Parliament. Engagement with patients, carers and the public will also take place through meetings with Local Involvement Networks (LINks – soon to be HealthWatch) in every borough. Dedicated engagement events have also taken place with a wide group of local health professionals.
- The Clinical Working Groups will consider all of the feedback from the engagement programmes and events and will continue to develop their ideas, testing and considering them in further engagement events with the public.

For more information and for an up to date picture of how you can get involved, please visit www.southwestlondon.nhs.uk, or email betterservices@swlondon.nhs.uk, or telephone 020 3458 5747.

Footnotes

1 GLA 2009 Round Population projections
2 The South West London Cluster Year One (2011/12) QIPP Plan, May 2011
3 GLA 2009 Round Population Projections
4 Local analysis carried out for Better Services Better Value Maternity Clinical Working Group
5 GLA 2009 Round Population Projections
6 The Office of Health Economics, The Economics of Health Care, October 2002
7 Body mass index (BMI), a measurement which compares weight and height, defines people as overweight (pre-obese) if their BMI is between 25 and 30 kg/m2, and obese when it is greater than 30 kg/m2.
8 Association of Public Health Observatories, borough health profiles, 2011. Please note: the England average is 24.2% adults, modelled estimate using Health Survey for England 2006-2008 (revised).
9 Staying Healthy Strategy for South West London, 2010-2016, 2010
10 Based estimates of current smoking, 2003-2005 by SWL PCT (Source: Household Survey for England (HSfE) 2006).
11 Mapped estimates of smoking prevalence in adults (16+) in the SWL sector, 2003-05 (Source: HSfE 2006; map by SWL Public Health Intelligence)
12 Peto,R. et al, Mortality from smoking in developed countries 1995, 2007. (2010).
13 Review of evidence for the Mayor's Health Inequalities Strategy, August 2009, GLA.
14 Ten things you need to know about long term conditions, Department of Health, 2008. See also Kings Fund http://www.kingsfund.org.uk/topics/longterm_conditions/index.html#background
15 Ten things you need to know about long term conditions, Department of Health, 2008. See also Kings Fund http://www.kingsfund.org.uk/topics/longterm_conditions/index.html#background
16 Carers UK, Facts About Carers, 2009.
17 Carers UK, Facts About Carers, 2009.
18 Commissioning for Carers, joint publication by 8 organisations, 2009
19 Income Deprivation Affecting Children Index (IDACI) 2007
20 Life expectancy at birth, 2005-2009, London Health Observatory, Analysed from ONS mortality data.
21 Fair Society Healthy Lives, Marmot Review, Executive Summary, Review of Health Inequalities in England, Post 2010.
22 London Health Observatory, Ethnicity and mortality in London Rhiannon Walters, Justine Fitzpatrick and Ed Klodawski, March 2009
23 All statements in this paragraph based on data from Review of evidence for the Mayor's Health Inequalities Strategy, August 2009, GLA.
24 P Edwards, J Green, K Lachowycz, C Grundy, I Roberts. Arch Dis Child 2008; 93:485–489.
25 South West London Staying Healthy Strategy, September 2010
26 Perinatal Mortality 2009, Feedback Report South West London Neonatal Network Centre for Maternal and Child Enquiries (CMACE)
27 Staying Healthy Strategy for South West London, 2010-2016, 2010
28 Where next for the NHS reforms? The case for integrated care, Kings Fund, 2011
29 Where next for the NHS reforms? The case for integrated care, Kings Fund, 2011
30 Safer Childbirth, RCOG 2007 and The Future Role of the Consultant: A Working Party Report. London: RCOG; 2005
31 NHS South West London financial modelling
32 NHS South West London financial modelling
33 Department of Health Quarterly Monitoring Cancelled Operations (elective only). April 2010–March 2011.
34 Analysis undertaken by South West London Planned Care Clinical Working Group
35 2007 was the date of the last Healthcare Commission review of maternity services in Kingston, St George's, Croydon University Hospital and St Helier hospitals. Much work has gone on to improve maternity services since then but there has not been another review to measure improvement.
36 Although it should be noted that Croydon is on course to meet this in the near future (Oct 11)
37 NHS London and London Health Programmes, Adult emergency services: Acute medicine and emergency general surgery, Case for Change Summary, September 2011
38 The College of Emergency Medicine, Emergency Medicines Consultant Workforce Recommendations, April 2010.
39 Hall B, Hsiao E, Majerck S, Hirbe M and Hamilton B. The Impact of Surgeon Specialization on Patient Mortality: Examination of a Continuous Herfindahl-Hirschman Index. Annals of Surgery, 2009
40 Chowdhury M, Dagash H and Pierro A, A systematic review of the impact of volume of surgery and specialization on patient outcome. British Journal of Surgery, 2007
41 By 'keyhole' surgery we mean surgery performed in an through small incisions, often associated with shorter length of stay and fewer complications
42 NHS London, Adult emergency services: acute medicine and emergency general surgery, NHS London, 2011
43 Profile of health and services in South West London, Report of the clinical working groups, July 2010
44 Saws and Scalpels to Lasers and Robots – Advances in Surgery: Clinical Case for Change, Reported by Sir Ara Darzi, National Advisor on Surgery
45 Not Just a Matter of Time (2008) Healthcare Commission.
46 Although this may be addressed in the near future through the NHS 111 telephone number, which is being introduced to provide a single point of access for all non-emergency NHS services.
47 A survey commissioned by NHS London from Ipsos MORI in 2010 on 'what Londoners think of their local NHS Services': data set available here: http://data.gov.uk/dataset/what-do-londoners-think-of-their-local-nhs-services-in-2010-survey
48 Kings Fund Briefing 2011, Reconfiguring Hospital Services
49 Kings Fund Briefing 2011, Reconfiguring Hospital Services
50 Royal College of Paediatrics and Child Health (2011). Facing the Future: A review of paediatric services. London: Royal College of Paediatrics and Child Health.

design: www.harperandcole.co.uk

Organisations are involved in *Better Services Better Value*

Clinicians from across health organisations in South West London are working together on the Better Services Better Value review. The organisations involved are:

- Croydon Health Services NHS Trust
- Epsom and St Helier University Hospitals Trust
- Kingston Hospital NHS Trust
- St George’s Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Royal Marsden NHS Foundation Trust
- Your Healthcare
- South London & Maudsley NHS Foundation Trust
- West Middlesex Hospital University NHS Trust
- South West London and St George's Mental Health NHS Trust
- The seven emerging GP consortia across South West London
- NHS South West London, including Croydon, Kingston, Merton, Sutton, Richmond and Wandsworth