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[A note on engagement and evidence](#)

The Commission has heard from thousands of Londoners and many expert witnesses during evidence sessions and a London-wide programme of engagement events, which have been central to this report. It is no exaggeration to say it would not have happened without them. The Commission has therefore used quotations from these contributors throughout the report to highlight particularly relevant points.

The Commission has also undertaken a significant amount of work to explore, develop and create its recommendations. The evidence base and detailed exploration of data which sits behind each of these is all available on the Commission's website at www.londonhealthcommission.org.uk/supportingdocuments



A letter to the Mayor of London



Dear Mayor,

A year ago, I was honoured to be asked by you to chair the London Health Commission.

You rightly observed that London's Mayor must be concerned with Londoners' health – and that the Mayor and GLA could be champions for better health in the capital. You had the courage to ask for an independent commission – focused on what the evidence shows is the best way forward. On behalf of all of us who have been involved: thank you.

Today, I am delighted to present my report to you: it reflects the creativity and wisdom of London's extraordinary people – a report bursting with ideas and proposals from the public and from renowned experts. Its message is simple: ours can be the healthiest major global city. By working together, we can achieve better health for all Londoners.

London is the world's preeminent city: a centre of commerce and enterprise; a cultural, economic and political powerhouse surpassed by none and equal to any. We have tremendous assets – energetic and enterprising people, successful businesses, a strong public sector, good infrastructure and more parks and green spaces than any other capital city.

Many Londoners lead healthy lives – eating well, exercising often, and enjoying fulfilling jobs and social lives. Yet that is not true for all of us. Londoners' waistlines are expanding, since we eat too much and exercise too little. More than a million Londoners still smoke, and there is significant harm from problem drinking. Too many children get off to too poor a start in life. It's reflected in life expectancy, which ranges widely from one part of the city to another.

We can do better: the healthiest choice isn't always easy and isn't always obvious. Every day, we make hundreds of choices that affect our health – how we get to and from school or work, what we choose to eat, how we spend our free time. The goal is to make each of those millions of individual decisions that little bit easier. Because in that difference is everything: making small changes individually will make a huge difference collectively.

For many, better health comes through good care, especially from London's GPs. We should be proud of our NHS and our social care. But we should not be complacent. Many improvements can be made to raise the quality and efficiency of services. At times, the challenges can seem too great to meet, too difficult and too stubborn, too deeply rooted and too perennial. But I am convinced Londoners can rise to any challenge.

All Londoners want to lead healthy lives. That means that all of us need to work together to improve health – schools, employers, charities and voluntary groups, local and regional government, transport, the NHS and above all Londoners themselves. We can each choose to invest in our own health and we can help each other to choose better health.

The ideas and proposals in this report have been developed for London. Yet they could just as easily apply to other big cities in the UK – London should be a leader, not an exception. It is my hope that this report can catalyse wider discussion and joint action between cities and the health and care sector. I passionately believe that Britain's local and city governments can become the defining locus for better health.

Let us Londoners look forward to the blossoming of better health across our capital city, in our homes and in our hospitals, in our schools and our workplaces, in our parks and our playgrounds. We have the shared ambition: better health for London. Now is the time to act.

Professor the Lord Darzi of Denham

PC KBE FRS

Chair, the London Health Commission



A letter to Londoners

Our city, our health

This report is about better health for London – our mental health and our physical health, each as much as the other. It rests on the foundational belief that this city – its people, its institutions, and its political, economic and cultural leaders – have an obligation to help and support one another to achieve better health.

We start from a simple premise: that a truly great global city is a healthy city. London aspires to be the world's healthiest major global city. That means a city that helps its people to make healthier choices; it means a city that focuses on improving the health of the most vulnerable; it means providing consistently excellent care for people when they need it; and it means a city that enables its health enterprise to prosper and to flourish to the benefit of all its citizens.

London's obesity emergency

More than 3.8 million Londoners are obese or overweight. Our city has too many people who eat too much and exercise too little. We should feel deeply ashamed that London has the highest rate of childhood obesity of any major global city. Obese children become obese adults – facing a lifetime of poorer health and quality of life. London's obesity emergency is a national disgrace.

Obesity impairs lives. It raises the risk of serious physical health conditions such as diabetes, heart disease, stroke and cancer. It drains energy during the day and causes sleeplessness at night. It affects our mental health too – our sense of self-esteem and happiness – and can stop us from leading the lives that we want and fulfilling our dreams for ourselves and our families.

Now is the time to act. Personal responsibility remains central – but the healthy choice is too often the hardest choice, and too many people know too little about what a good and varied diet should be. It is hard to eat healthily. 'Bad' food tastes good. Highly processed food is cheap, plentiful and tempting. Questioning the moral character of people who are obese is as useless as it is self-defeating. Londoners urgently need help.

Helping Londoners to better nutrition

All of us need help to make better choices with our food and drink. Good nutrition is the foundation of good health.

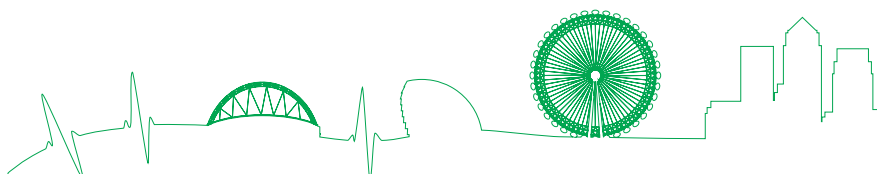
We need to help our children make healthy choices. All London councils should follow the lead of Waltham Forest, Barking and Dagenham, and Tower Hamlets by refusing permission for fast food outlets to open within 400 metres of schools. The Mayor should include this guidance in his London Plan.

We also need to help ourselves to make better choices. Concerted action is necessary by London councils to use licensing arrangements to require all chain restaurants and food outlets to include nutritional labelling on all menus.

More information alone will not be sufficient to break our sugar habit. Accordingly, I have explored the case for a sugar tax for London. Regrettably, a sugar tax for London alone is impractical. Nonetheless, as the Chair of the London Health Commission, as a doctor, and as a father, I give my full and unequivocal support to calls for the introduction of a national sugar tax.

Getting London walking

Being active is good for us: it helps our physical health, our mental health and our wellbeing. Whilst a sedentary lifestyle has become the default for most of us, the good news is that some simple steps can make a huge difference.



There is compelling evidence that there are huge health benefits from taking around 10,000 steps a day – better fitness, lower cardiovascular risk and better mental health too. For the average Londoner, this would represent an extra two miles walking each day. And London is a great city in which to walk.

Getting London walking requires joint action from employers, the Mayor, local councils and Transport for London. It requires better information and labelling on infrastructure and in the streets, and campaigns to encourage active travel.

Yet encouraging walking can only be the first step: Londoners should also be given positive incentives to walk. Workplace-based campaigns in Australia, Japan and the US, as well as in the UK, have raised average steps per day from 4,000 to 10,000.

It is in employers' interests to act since each year London employers lose £1.1 billion due to stress, anxiety or depression. However, employers do not incur direct costs from their employees' health conditions since the vast majority of Londoners receive their healthcare through the NHS. This means businesses have less incentive to invest in employees' health than in other countries such as Germany or the US.

So, if we want to get London employers on board with helping to promote health, we need to act to make it easier for them to do so. The public sector should enable, rather than make, investment in employee health.

Transport for London should establish a scheme, paid for by employers, to incentivise walking the last mile to work and the first mile home. Employees tapping in or out with their Oyster or contactless card at least one mile from their registered place of work would collect points and be eligible for employer-financed transport rewards.

Our city, our air: cleaner London

As Londoners take to the streets, parks and open places to walk more, they will likely notice the quality of the city's air. London's air quality is the poorest in the UK and amongst the poorest in Europe. All our lives are poorer for it.

Alarmingly, London's air quality is killing Londoners at a terrible rate. As a doctor, I was shocked to discover that every year, 4,200 Londoners die as a direct result of air pollution – that's 7% of all deaths that occur in the capital.

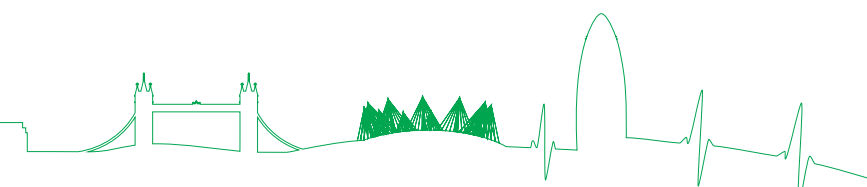
Acting to reduce emissions is expensive; but failing to act comes at a terrible cost in lives lost and quality of life degraded. Having examined the evidence, I am compelled to conclude that London's clinicians must also become London's environmentalists.

That is why I believe the Mayor's Air Quality Strategy should go further and faster. The Ultra Low Emission Zone (ULEZ) is urgently needed, as is the development of a public transport fleet capable of zero emission operation, including more low emission buses and new requirements to accelerate the uptake of zero emission capable taxis and private hire vehicles.

Our city, our air: smoke free London

Better air in London also means liberating our city from the scourge of tobacco. Each year, more and more Londoners are choosing to quit smoking, improving and lengthening their lives. We need to help more Londoners to do the same. After all, smoking is still the leading cause of avoidable deaths: every year, more than 8,000 Londoners die prematurely from tobacco-related diseases.

Hundreds of children take up smoking every week – two classrooms full a day – with advertising outlawed they do so inspired by the adults that they see. Once they start, they continue, since cigarettes are more powerfully addictive than narcotics. It's little surprise that in places where more adults smoke, more children begin smoking too.



Just as smokers' lungs are polluted, the lungs of our city – our parks and green spaces – are polluted by smoking. London should lead the way for Britain, and the Mayor should lead the way for London by acting to make our public spaces smoke free. Our parks and green spaces account for nearly 40% of the capital, the equivalent of 20,000 football pitches; imagine that space completely smoke free.

The Mayor should use his byelaw powers to make Trafalgar Square and Parliament Square smoke free. It would send a powerful message for the iconic centre of our city and the political heart of our country to become smoke free. What better way to show our city's ambition to be the healthiest major global city?

Local councils and the City of London Corporation should use their byelaw powers to make local parks smoke free. The Mayor should direct the Board of the Royal Parks – whom he appoints – to make all of the parks and open spaces that they manage smoke free.

A smoke free London will be better for us all; a better example for children; fewer opportunities for smokers to smoke; less litter; greener and more pleasant places for us to come together for better health.

In the review of the evidence, I was shocked to discover that nearly half of the cigarettes smoked in London are smoked by people with mental illnesses, contributing to alarmingly lower life expectancy for people with severe mental illness – some 10-15 years lower than the rest of the population.

Our mental health and care

More than a million Londoners will experience mental ill health this year. More than 100,000 of them will be children. Mental ill health is all around us. It is experienced by our family, it is experienced by our friends, it is experienced by our colleagues – and it's experienced by ourselves. On average, mental ill health affects thirteen people on the busy bus with us in the morning, more than a hundred people on the tube train on their way into work, three of the children in our child's school class, and ten of our fellow mums and dads.

We don't talk, think, or act enough on our mental health and wellbeing. Mental illness – and related life events like homelessness – are particularly high in London compared to the rest of Britain. Our city should be more caring, more compassionate, and more open about mental health.

Too often in our system, physical and mental health are unnecessarily separated, creating dire consequences for care. For example, in 2014, the life expectancy of a man who has experienced psychosis is 65 – 14 years less than the average, and the same as the typical life expectancy for a man in 1954. Similarly, too many people with long-term conditions do not have their mental health needs properly taken into account.

The Commission has discussed this challenge with the leaders of all the mental health trusts in London, who have committed to a set of shared ambitions for mental health care. They have set the goal to reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 10% within 10 years. They will lead an all-London, all-agency pledge to identify and treat psychosis in half of cases within two weeks and all cases within eight weeks of the first signs and symptoms.

For people who are under their care, London's mental health trusts pledge to work with commissioners to proactively offer access to smoking cessation, blood pressure monitoring and treatment, cancer screening and treatment, and effective weight management programmes.

Our physical health and care

Our NHS has been a friend to millions, sharing their joy and comforting them in their sorrow. The first generation to grow up with it has been the longest lived in the history of this country. Our NHS offers care that is amongst the best in the world, and the health and care system of the capital turns over some £22 billion every year – that's around £2,600 for every Londoner.



Yet these are challenging times for the NHS and for social care in London. More health and social care will be needed in the future, driven by the dual effects of people living longer and more children being born. Londoners are increasingly beset by long-term conditions like diabetes and heart disease. People are getting sicker sooner as a result of poor lifestyles. Indeed, long-term conditions account for most health and care spending.

The whole health and social care system is under intense financial pressure, with the squeeze being felt right across the capital. We need to make our money go further for the people of London. As technology revolutionises our lives – from shopping to banking to dating – the NHS has been falling behind. We need to make care more personal, organising care around Londoners and their needs, rather than the system and its rules.

Modern general practice for London

General practice is the bedrock of our NHS: Londoners really appreciate and value their GPs. On a typical day, London's GPs see 150,000 people. They are our first point of contact, and often, our only point of continuity.

GPs are best placed to help people to manage long-term conditions and to coordinate their care. Good GP care is essential to good health, and GPs remain highly regarded and well-appreciated by the public. That's why the rhetoric of government policy has again and again called for an enhanced and expanded role for general practice.

London's GPs are under unprecedented pressure. GPs face a rising workload, falling numbers, a poor working environment and more work-related stress, whilst spending is tumbling as a percentage of total expenditure on health. Today, it stands at less than 9% of the NHS budget.

Perhaps not surprisingly, GP services in London are not as good as they should be. Nearly two thirds of London practices perform worse than the England average in overall patient satisfaction. Access to general practice is variable, with 60% of practices in London performing worse than the England average, and the worst out-of-hours access score in the country.

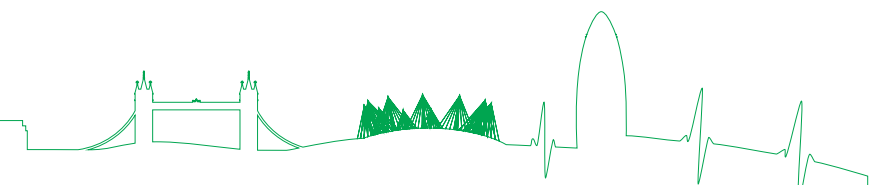
All of us should be ashamed at the state of many of London's GP practices: the condition of most practices is 'poor' or 'acceptable', and a staggering three-quarters of London's GP practices are in need of rebuild or repair. One third of practices are inaccessible for people in wheelchairs. This is the sign of chronic underinvestment from a capital expenditure system that has fundamentally failed.

That is why I am calling for the greatest investment in London's general practice since the NHS was founded in 1948. London needs a £1 billion programme over the next five years to rebuild or refurbish every GP practice in the capital. There must be local leadership from Clinical Commissioning Groups (CCGs) and councils in planning and designing new facilities, and closer integration with the rest of the health and care system.

That figure – £1 billion – sounds like a vast amount of money. Yet it represents just 4% of total capital spending in the NHS over the next five years, and 26% of anticipated capital spending in London. That still means 74% of the capital budget or some £2.8 billion will be invested in hospitals and other care facilities.

Modern, accessible, purpose-built or purpose-designed facilities will cost more to run, too. And so the capital investment must be met with a commitment to increase the proportion of total NHS expenditure dedicated to primary medical care rising for each of the next five years. This is how we should match words to action.

This investment must be joined with reform. There must be an end to professional isolation, with every GP practice joining and participating in a network of local practices. New, more stretching standards should be set and more tightly enforced. People should be able to access care more conveniently. And stubbornly poor care must be routed.



The financial challenge facing the NHS: big choices

All health systems aspire to convenient and timely high quality care delivered as cost-efficiently as possible. This report aims to improve the health of Londoners – one way of reducing the burden on the system.

In addition, it seeks to improve the quality and efficiency with which care is provided. The assessment of the measures in this report shows they will save and improve lives and make a positive economic impact. Yet even the measures proposed here cannot and will not close the yawning funding gap faced by the NHS and social care.

That's why I am calling for a better public debate on funding the NHS and social care.

No matter who forms the next government, politicians who profess to be for the NHS must increase investment in the NHS. Over the long run, average healthcare expenditure grows at GDP + 2% in most developed countries. Politicians must explain how they will meet the challenge for the decades ahead, not just for next year's election.

This must be a debate about priorities. Will governments prioritise health over other areas of spending? Will the public prioritise more investment in health and care or lower taxes for individuals and businesses? Will quality of care be prioritised over access to care?

No investment without reform

I believe the NHS needs more investment and more reform: not one or the other but both. Investment without reform is irresponsible. Reform without investment is unachievable. Investment with reform is the only path forward.

To believe in the NHS is to believe in reform of the NHS. Evolving patient needs and advances in medical understanding and technology mean that high quality care is a constantly moving target. To stand still is to fall back.

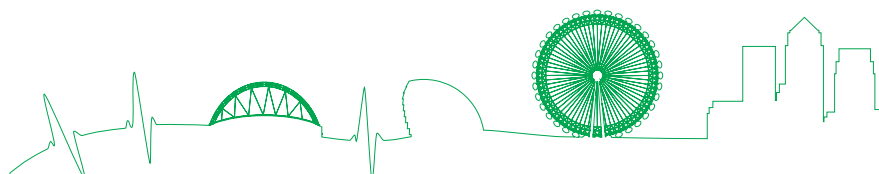
Too often care isn't up to scratch – poorer than it could or should be. Just as the NHS can be caring and compassionate, it can be cold and incomprehensible, faceless and frustrating. Care often does not treat us as individuals with different and complicated lives and needs.

The NHS was founded on the principle of universality: that access to healthcare should be based on need, not ability to pay. Yet universal access has for too long meant care that is too impersonal. Access to the care an individual needs, regardless of means, should not mean access to the same care regardless of his or her needs.

Some wants and needs are indeed universal. All Londoners want to see their GPs in modern, convenient spaces, and all Londoners want access when they need it to specialist care delivered in real centres of excellence. Today, care is organised so that generalist doctors work in GP practices, specialists work in hospital trusts, mental health professionals work in mental health trusts, and so on.

Yet different people want different things from their care, depending on their individual circumstances. Broadly, people in work want quick, convenient care; older people want continuity and a focus on their social needs; those with long-term conditions want well-coordinated, efficiently planned care: people with intensive needs want care that comes to them.

We believe that care should be more personal, planned around groups of people with broadly similar needs, rather than around groups of professionals with broadly similar skills. Rather than care provided around primary versus secondary, or mental versus physical, we should strive towards a system that holistically considers all aspects of care for a particular individual.



This understanding of the different needs of different groups is the foundation of the new approach proposed by this Commission. We propose a system in which care is provided for groups of similar individuals, in which people are treated as people, unique and complex, not as an ailment, condition, or piece of anatomy.

So, our maxim: start with Londoners, not London's NHS. Start with people and how best to meet *their* needs, *their* wants, and *their* expectations – not those of the system. Practically, it means more joint teams in the community, more joined up working, and more integration between health and social care. Complexity should be no barrier to quality.

The route to better care is through innovation. The Commission has proposed a new Institute for Digital Health that, working with Academic Health Science Networks, would support new frontiers in care quality. In-principle commitments to the Institute have been secured from five of the world's largest healthcare companies – Johnson & Johnson, Medtronic, Phillips, Novartis, and Merck – together worth over \$500 billion.

Leadership for change

This report sets out an ambitious agenda to improve the health and care of Londoners. There are bold changes proposed to promote a healthy city – to make London the healthiest major global city. This will take significant leadership from the Mayor, from local councillors and their officers, from the NHS and from many other parts of London's institutions and society.

London needs a champion for health who can encourage and support these important changes. That is why I propose that the Mayor appoints a London Health Commissioner reporting directly to him. The Commissioner's role should be to lead the better health agenda between local government, public health and the NHS, not to manage the health service or provide technical advice to the Mayor.

One of the great strengths of this Commission has been joint working between local government and the NHS. Now there is a need to strengthen strategic leadership for health in London by closer collaboration. Local councils, Clinical Commissioning Groups, Public Health England and NHS England should work together to meet this leadership challenge.

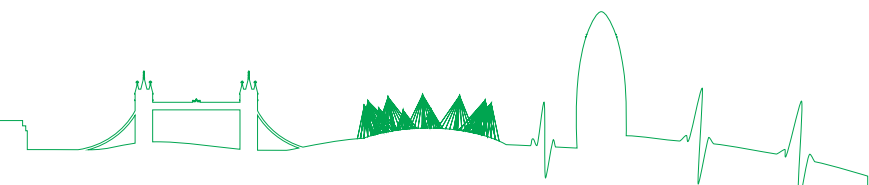
More than any new appointment, or any new partnership, the true leadership we need is from Londoners themselves. More important than any change we can make is to change our approach to change. The health and care system in London must put patients and members of the public at the centre of the way care is designed, planned, commissioned and delivered. Londoners are what make this city great; and Londoners are what will make our health and care system great, too. Patient and public engagement has shaped and defined this report. Let their contributions stand as an exemplar for us all.

The recommendations have been developed so that we can meet a set of clear, bold ambitions for our city. A city is its people: securing the best possible health for Londoners is what makes our city thriving and prosperous. Better health means all London's communities and families making different and better choices. There is no better time to start than now.

I would like to thank all the ordinary Londoners who have contributed their time, their energy and their ideas to this report, and every individual and organisation that contributed to the call for evidence and to the oral hearing sessions. They provided invaluable insights into health in London.

I would like to acknowledge the significant contributions from many individuals and organisations, without whom this report would not have been published. Space does not permit me to be exhaustive; I apologise to any whom I have omitted.

My fellow Commissioners helped to shape the overall conclusions of this report and have given me much guidance. Imperial College, Imperial College Healthcare NHS Trust, and The Royal Marsden NHS Foundation Trust have generously supported me with the time to chair this Commission.



The members of the five expert groups contributed a considerable amount of their time and expertise, especially Victor Adebawale, Yvonne Doyle, Peter Ellingworth, Andy Mitchell, Andrew Ridley, and Jeremy Taylor who chaired the various groups. I am grateful to Victoria Borwick, Edward Lister, Ruth Carnall and Amanda Coyle at the Greater London Authority for their support.

My thanks go to many colleagues in local government who contributed to this report, particularly Jules Pipe, Teresa O'Neill, Martin Smith, and John O'Brien. The deep engagement of London's local authorities has been one of the crucial differences between this and previous reports on London's health.

I would also like to thank Jeremy Hunt and officials at the Department of Health for their continual support and encouragement over the past year, and Simon Stevens and his colleagues at NHS England likewise. They generously found time to meet with me and my team throughout, and to offer constructive feedback on the proposals.

Anne Rainsberry, Helen Cameron, David Slegg and Simon Weldon at NHS England's London region dedicated significant time, energy and expertise to the report. My thanks go to Tom Kibasi, Shaun Danielli, Stephen Lightbown, Jacob West and the programme team for all their hard work in the preparation of this report.

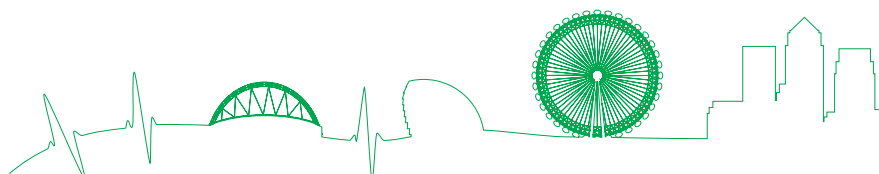
Finally, my thanks to the team at Imperial College, including Oliver Keown, Greg Parston, Emma French and Beth Janz for all their efforts and support.



Professor the Lord Darzi of Denham

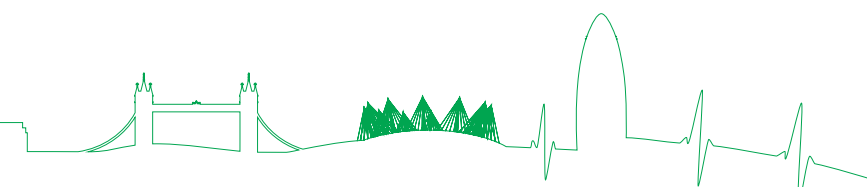
PC KBE FRS

Chair, the London Health Commission



Commission members

- [Professor the Lord Ara Darzi, Chair, London Health Commission](#)
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- [Colin Barrow, Executive Chairman, Alpha Strategic](#)
- [Sir Cyril Chantler, Chair, University College London Partners](#)
- [Professor Yvonne Doyle, Regional Director, Public Health England \(London region\)](#)
- [Len Duvall, Chair, Greater London Authority Oversight Committee and London Assembly Member](#)
- [Peter Ellingworth, Chief Executive, Association of British Healthcare Industries](#)
- [Dr Sam Everington OBE, General Practitioner and Chair of Tower Hamlets Clinical Commissioning Group](#)
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- [Professor Chris Ham, Chief Executive, The King's Fund](#)
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- [Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England](#)
- [Dr Chris Streather, Managing Director, South London Academic Health Science Network](#)
- [Jeremy Taylor, Chief Executive, National Voices](#)
- [Professor Chris Welsh, Director of Education and Quality, Health Education England](#)



Ambitions for London

London aspires to be the world's healthiest major global city.

Today, London is middle of the pack, ranked number seven out of 14 comparable cities around the world. London can do better, and match its cultural, economic and political preeminence by being the world's healthiest major global city.

Major Global Cities

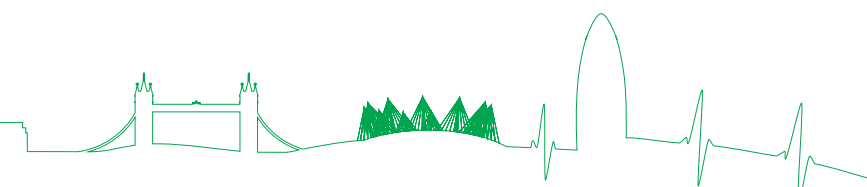
Comparator global cities	Rank among comparator global cities	Rank overall (out of 129 cities)	Health Index	Education Index	Wealth Index	Life expectancy
Hong Kong	1	1	0.88	0.66	0.77	82.5
Tokyo	2	3	0.86	0.76	0.74	82.4
Singapore	3	4	0.86	0.64	0.78	80.7
Madrid	4	7	0.82	0.75	0.75	-
Paris	5	8	0.82	0.73	0.78	82.3
Sydney	6	10	0.81	0.89	0.75	81.9
London	7	12	0.79	0.71	0.77	80.6
Toronto	8	13	0.79	0.79	0.76	82.6
San Francisco	9	14	0.78	0.80	0.79	81.3
New York	10	15	0.78	0.66	0.73	80.9
Shanghai	11	40	0.62	0.53	0.67	-
São Paulo	12	71	0.58	0.58	0.67	-
Mumbai	13	87	0.54	0.44	0.56	-
Johannesburg	14	122	0.30	0.62	0.62	51.0

Source: London School of Economics. 2011. Full report available online at: <http://lsecities.net/media/objects/articles/measuring-metropolitan-wellbeing/en-gb/> (last accessed 3 October 2014)



If we are to achieve the aspiration to be the world's healthiest major global city, we must improve the lives of all Londoners. We have 10 aspirations for our city:

Our aspirations for London		Our ambitions for London
1	Give all London's children a healthy, happy start to life	Ensure that all of London's children are school ready at age five Halve the number of children who are obese by the time they leave primary school and reverse the trend in those who are overweight
2	Get London fitter with better food, more exercise and healthier living	Boost the number of active Londoners to 80% by supporting them to walk, jog, run or cycle to school or work
3	Make work a healthy place to be in London	Gain 1.5 million working days a year by improving employee health and wellbeing in London
4	Help Londoners to kick unhealthy habits	Have the lowest smoking rate of any city over five million inhabitants
5	Care for the most mentally ill in London so they live longer, healthier lives	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 10%
6	Enable Londoners to do more to look after themselves	Increase the proportion of people who feel supported to manage their long-term condition to top quartile nationally
7	Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	General practice in London to be open 8am to 8pm and delivered in modern purpose-built/designed facilities
8	Create the best health and care services of any world city, throughout London and on every day	Have the lowest death rates in the world for the top three killers: cancer, heart diseases and respiratory illness; and close the gap in death rates between those admitted to hospital on weekdays and those admitted at the weekends
9	Fully engage and involve Londoners in the future health of their city	Year on year improvements in inpatient experience for trusts outside the top quintile nationally
10	Put London at the centre of the global revolution in digital health	Create 50,000 new jobs in the digital health sector



1. Better health for all

This goal of this report is reflected in its title: it is about better health for London – our mental health and our physical health, each as much as the other. It rests on the foundational belief that this city's people, its institutions, and its political, economic and cultural leaders have an obligation to help and support one another to achieve better health.

We start from a simple premise: that a truly great global city is a healthy city. That means a city that helps its people to make healthier choices; it means a city that focuses on improving the health of the most vulnerable; it means providing consistently excellent care for people when they need it; and it means a city that enables its health enterprise to prosper and to flourish to the benefit of all its citizens.

This chapter explores how we can improve health by facing our greatest public health challenges and supporting Londoners to make better choices for themselves.

What do we mean by Londoners then? The only thing that brings people together in London is that we all live in London. We are so diverse, we are a global city, we have a transient population... I think there is something about making London more of a place where people feel more enabled to take control of their lives.

**Dr Rosemary Gillespie, Managing Director,
Terence Higgins Trust**

If what we are seeking to deliver is a national health and care service, shouldn't it begin with the objective of avoiding unnecessary illness?

Rt Hon Stephen Dorrell MP



1.1 Better health for all, all for better health

Londoners want to lead healthy lives – health comes first for all of us, our family, friends, neighbours and colleagues. Health is the purest form of wealth. If London is to be the healthiest major global city, then all of us must be more aware and engaged about our health.

Better health for all means helping Londoners to make healthier choices. At the same time, it places an expectation upon Londoners: that they should contribute to improving their own health and that of their communities – whether at home, at work or at school. London has so much potential for better health.

Unlocking London's better health potential requires a new coalition that brings together local and regional government, the health service, the voluntary sector, employers, schools and colleges, transport, and the wider public and private sector. The Mayor has a crucial role in rallying all of London's people for better health. All Londoners can benefit and all can contribute.

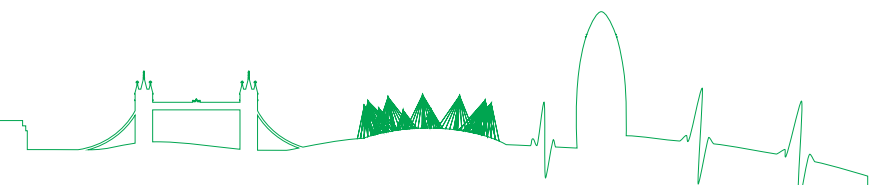
The NHS must be more open to those contributions. It must get better at listening to people, responding to them, and providing more convenient and relevant ways for them to share their views. Furthermore, it must give more choice and control to people over their own healthcare: people who take control of their healthcare are much more likely to take control of their own health.

As with many large organisations, public engagement doesn't always come naturally to the NHS. As the Commission has learned – through roadshows, polling and open events – it is crucial to actively seek out people's views. It requires all parts of the health and care system to work together to ensure that Londoners' perspectives properly inform the future of care.

More voice must be given to London's diverse communities, some of which can be hard to reach but all of whom want to be listened to, want to be more involved, and want to make a greater contribution. If the right initiatives and right attitudes are there, Londoners are ready to respond generously with their time, their effort, and their views.

Recommendation 1

All health and care commissioners and providers should innovatively and energetically engage with Londoners on their health and care, share as much information as possible, and involve people in the future of services.



1.2 Smoke free London

One of London's big killers, despite big improvements made in recent years, is smoking. London compares well to other cities but there are still 1.2 million smokers (18%) and 8,400 deaths a year. In fact smoking directly impacts on four of the top five biggest killers across London. Over 51,000 hospital admissions per year are attributable to the habit.

London boroughs with high smoking prevalence are also some of the poorest boroughs. Although there is a downward trend across most of London, there is a difference of 10% between the best and worst performing boroughs, and stark health inequalities are caused by smoking rates being much higher amongst people who work in manual or routine occupations.

Recent progress

Since the UK-wide legislation to make public venues smoke free was introduced in 2007, attitudes have changed. Now 78% of adults approve of the change, and 98% of venues are compliant. Making smoking less acceptable and more difficult has encouraged people to try quitting and discouraged people from starting.

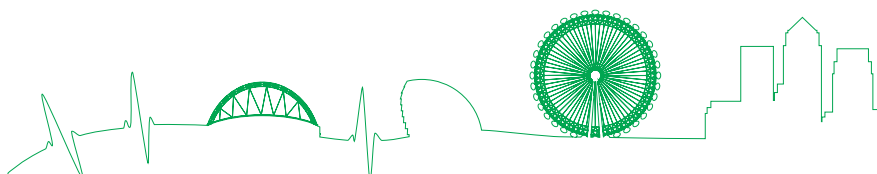
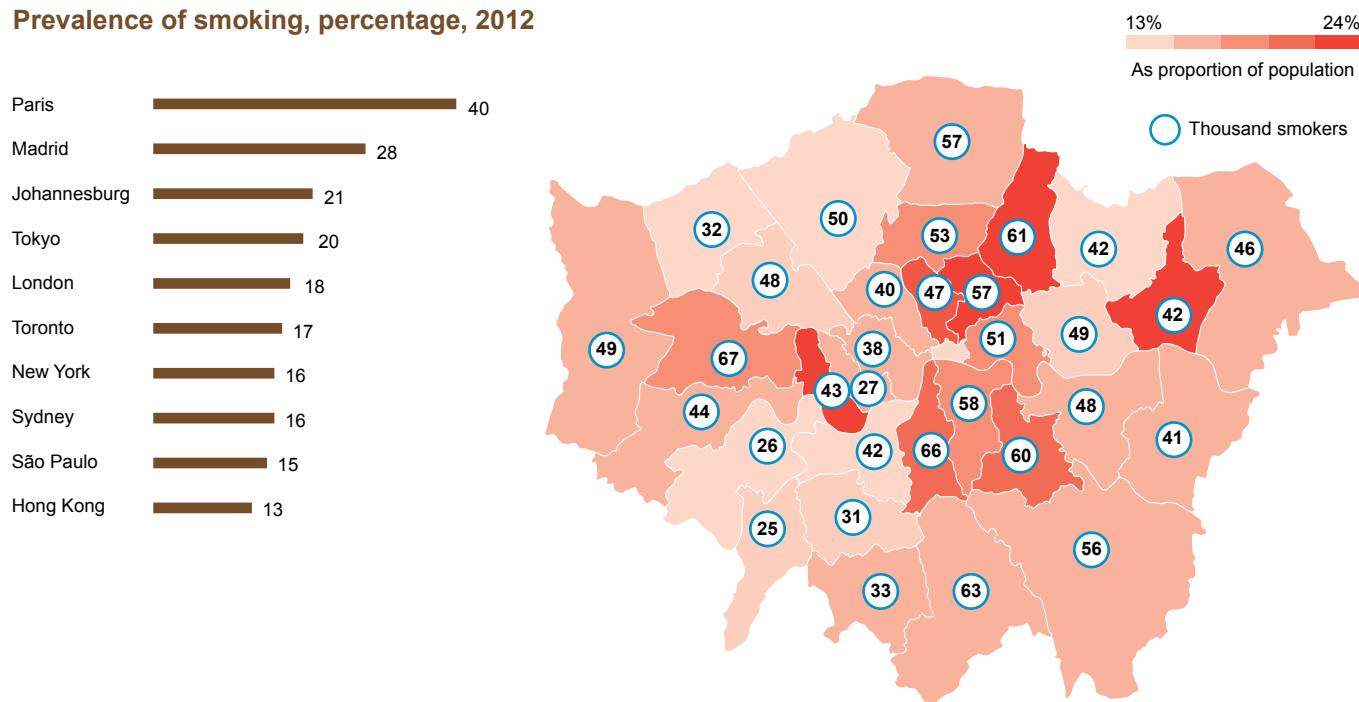
Going smoke free works. It saves lives and reduces smoking rates. National evidence has indicated a 2.4% reduction in hospital admissions due to heart attacks resulting from the smoking legislation. Cigarettes are now smoked less in all areas except those which are outside.

There have also been a number of other efforts to discourage smoking at a national level, many of them resulting from the adoption of the WHO Framework Convention on Tobacco Control. These range from tax reductions for nicotine replacement therapy to new forms of labelling to more stop smoking services. Legislation has been passed allowing the prohibition of smoking in cars with children under 18 and requiring all cigarettes to be put in plain standard packs but these measures have still to be implemented.

For the NHS and wider public services, the lifetime value of a person stopping smoking is huge – that's why stop smoking services must be supported and maintained as great public investment. They are one of the few health interventions that are more likely to reach people living in poverty, too.

London compares well to other cities on smoking prevalence but there are still 1.2 million smokers

Prevalence of smoking, percentage, 2012



London compared to other major global cities

Yet other major global cities are doing better than London at tackling smoking.

Over the past 10 years, New York City has achieved an overall decline in smoking, from 22% of adults to around 15%. Deaths from lung cancer have fallen by 12% and chronic lower respiratory disease death rates by 5.5% – as many as 50,000 early deaths are thought to have been prevented over the decade. As well as eliminating smoking indoors in public places, New York has banned smoking from the doorways to bars, cafes and restaurants, and from its famous Central Park.

Hong Kong has now made all public places smoke free – including beaches, restaurants, open air transport spaces, cafes and public parks. This has been backed by a £115 fine and has seen a 7% reduction in male smoking between 2002 and 2012.

In Australia, Canada and elsewhere in the US there are similar efforts across a number of states and provinces. In Kenya, smoking is not permitted outside doorways, on restaurant and pub/bar patios, in playgrounds, or on beaches. And just this year, Paris has announced

an experiment to make some public parks smoke free. *New York. Paris. Hong Kong. London?*

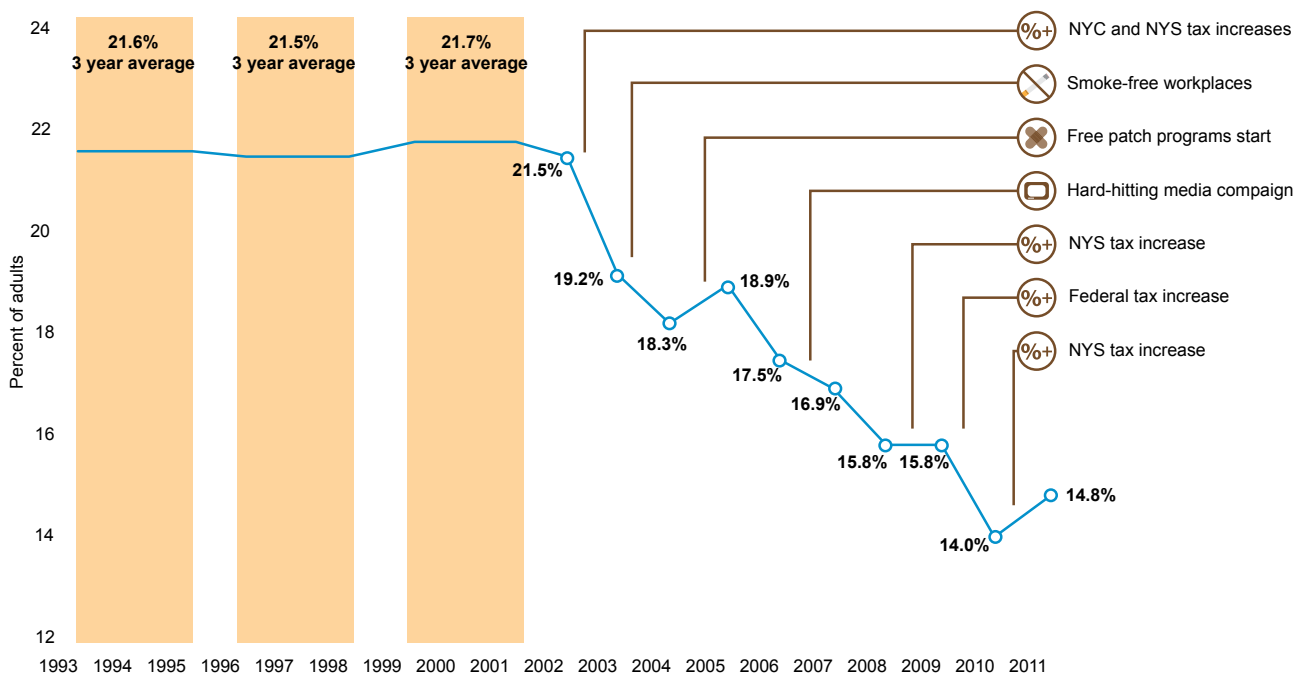
The Commission believes, and heard from many people it engaged with, that London should be a leader in becoming smoke free.

London is a uniquely green city: no other major global city has as many parks and open spaces. That 38% of London is green space is precious, a source of pride and pleasure for Londoners. The numbers are dizzying: London has more than 35,000 acres – that's equivalent to 20,000 football pitches – of green spaces.

London should lead the way for Britain, and the Mayor should lead the way for London by acting to make our public spaces smoke free. With 67 London schoolchildren starting smoking every day, urgent action is required.

We have an opportunity to set a better example for London's children by making parks and other places controlled by London's local and regional government smoke free. Imagine nearly 40% of London completely smoke free.

New York City's 'Tobacco Free Living' initiative 2002-2011



NYC – New York City
NYS – New York State

It will take concerted action from London's leaders:

- The Mayor should use his powers under the GLA Act 1999 to amend both the Trafalgar Square byelaws 2012 and the Parliament Square Garden byelaws 2012 to include smoking in the lists of 'acts prohibited within the square'.
- All Royal Parks should become smoke free – Hyde Park, Richmond Park, The Regent's Park, Kensington Gardens, Greenwich Park, St James' Park, Bushy Park, Green Park, and Brompton Cemetery. All appointments to the Board of the Royal Parks are made by the Mayor. The Mayor should request that the Board introduce a smoke free policy at their next meeting.
- The Board of the Royal Parks should propose amendments to the regulations (statutory instruments) governing the parks to give legal force to their smoke free status. These regulations are issued at the Royal Parks' request by the Department of Culture, Media and Sport.
- London councils should take coordinated action to make local parks and other public spaces controlled by local authorities smoke free, using their existing byelaw powers.
- Transport for London should place prominent 'smoke free' signage at all bus stops across the capital.

Smoke free London will be better for us all: a better example for children; fewer opportunities for smokers to smoke; less litter; more green and more pleasant places for us to come together for better health. It would be a powerful message for the iconic centre of our city and the political heart of our country to become smoke free. What better way to show our city's ambition to be the healthiest major global city?

Fighting illegal tobacco

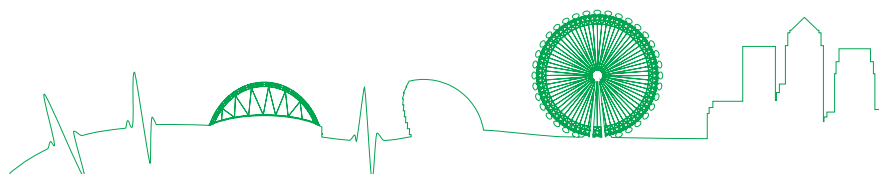
Perhaps surprisingly, the trade in illegal tobacco has been in decline nationally since the smoking ban was introduced. Nevertheless, it remains a problem particularly in poorer communities, with a typical illegal pack of cigarettes selling for £4 compared to £6-8 for legal packs.

This exploitative criminal activity gets around the high taxes aimed at discouraging smoking in the first place, and encourages people to smoke when they could not otherwise afford to. The effect on London's younger population is particularly iniquitous as illegal traders are happy to sell to children.

Currently, no license is needed to sell tobacco, despite the fact that it kills. This places a high bar on enforcement authorities who must demonstrate that the tobacco itself is illegal, since the act of selling it is not. Reintroducing licensing would make it much easier to control sales to children in particular.

Citywide working to tackle supply and demand of illegal tobacco is a strategy that's been very successful in the north and south west of England. The Mayor could play a major role in making this happen by convening a group including local authorities, the Metropolitan Police, London Fire Brigade, HMRC, trading standards, tobacco control alliances, crimestoppers, Public Health England and the Mayor's Office for Policing and Crime (MOPAC) to coordinate action, map activity and share information.

The Mayor could also include tobacco within MOPAC's priorities, and publish data on action on illegal tobacco. The Commission has explored the idea of a campaign on illegal tobacco, especially its sale to children and its links to crime, which would help strengthen such a strategy. This could involve public health posters with an accompanying 101 number to report crime.



Recommendation 2

The Mayor, Royal Parks, City of London and London boroughs should use their respective powers to make more public spaces smoke free, including Trafalgar Square, Parliament Square, and parks and green spaces.

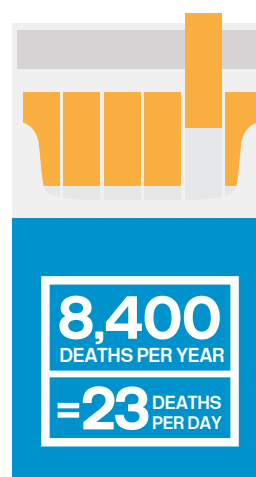
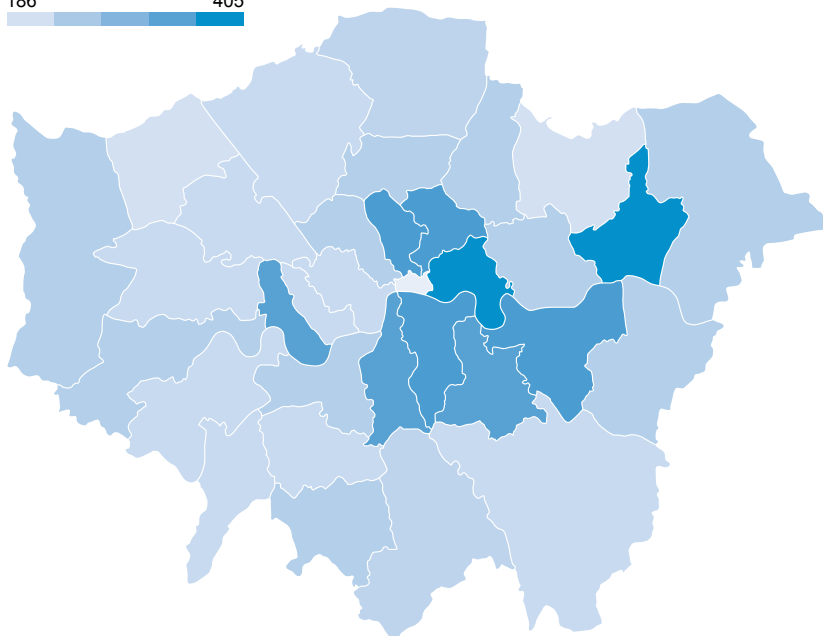
Recommendation 3

The Mayor should launch a fresh crackdown on the trafficking in and selling of illegal tobacco.

Deaths attributable to smoking in London boroughs

Rate per 100,000 people, 2010-2012

186 405



1.3 Better nutrition

It is no exaggeration to say London is facing an obesity emergency. More than half of the entire adult population in London is overweight or clinically obese – some 3.8 million people. This shocking statistic is borne out by comparison with other world cities – London now has more overweight and obese people than New York, Sydney, São Paulo, Madrid, Toronto or Paris.

Although London performs well relative to the rest of England, with the lowest levels of obese and overweight adults of all the regions, there is a wide variation of overweight and obese adults between boroughs where rates in some boroughs are 1.5 times greater than in others.

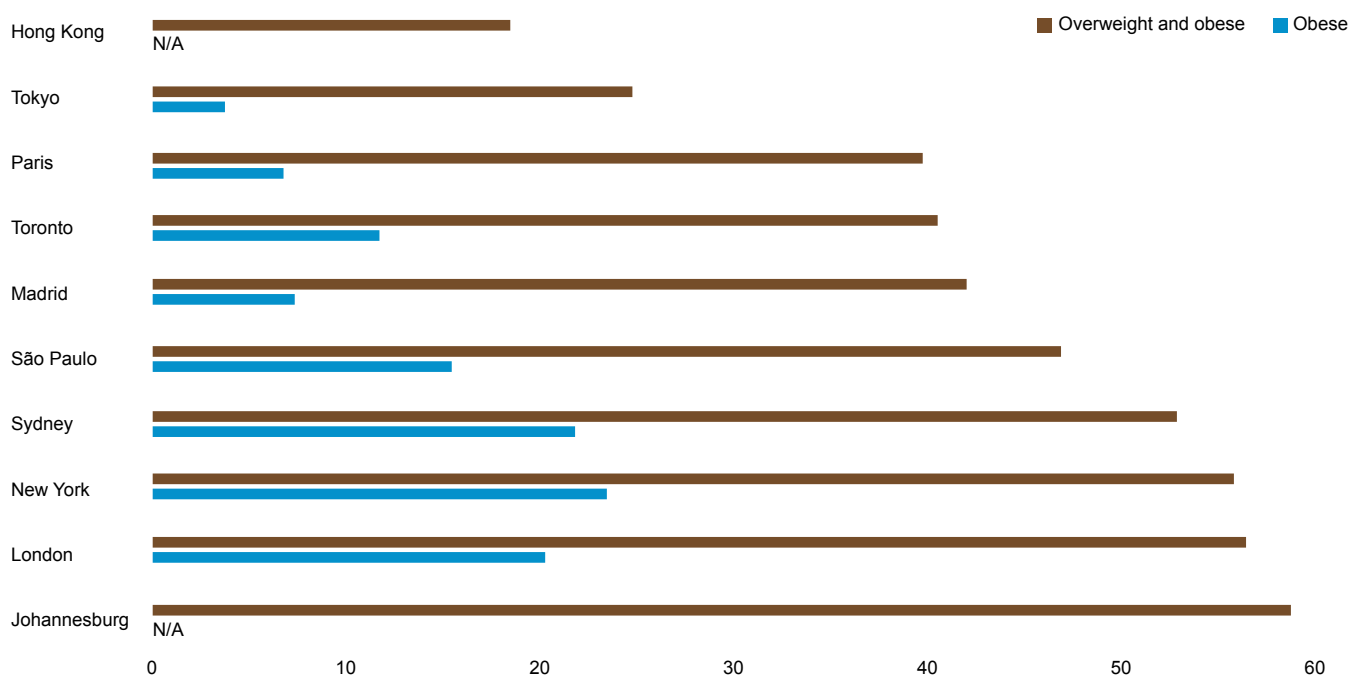
Obesity impairs lives. It raises the risk of serious physical health conditions such as diabetes, heart disease, stroke, and cancer. It drains energy during the day and causes sleeplessness at night. It affects our mental health too – our sense of self-esteem and happiness – and can stop us from leading the lives that we want and fulfilling our dreams for ourselves and our families.

Other global cities are taking action. New York has introduced compulsory calorie counts on restaurant menus, restricted the use of trans-fats, and launched a media campaign on sugar sweetened drinks. Paris has promoted locally produced food, introduced a food aid programme for those in poverty, and focused significant efforts on education. Tokyo, similarly, has had a strong focus on better food and nutrition education, whilst Hong Kong has a programme to promote healthy eating in schools, and healthy meals in restaurants. Toronto has set up mobile Good Food trucks and launched the Good Food Box, a community-led non-profit initiative for fruit and vegetable distribution.

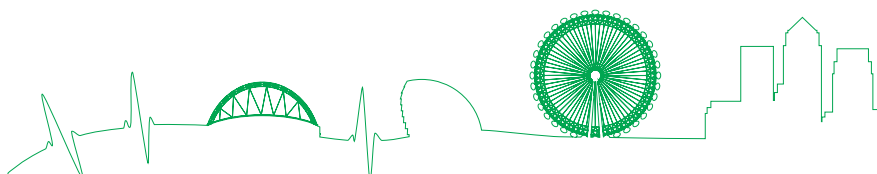
Helping Londoners to make better food choices

The number one thing people want is more information and awareness. That comes down to clear, simple, comprehensible labelling of food and drink. New York, for example, requires all chain restaurants and cafes (with 15 or more units) to display calories for every item on all menu boards and menus, in a font and format that is at least as prominent as price.

Percentage of obese and overweight adults in 10 world cities



Note: In Hong Kong and Tokyo, obesity is classed as BMI ≥ 25 instead of 30, therefore separate overweight/obesity measures are difficult to obtain

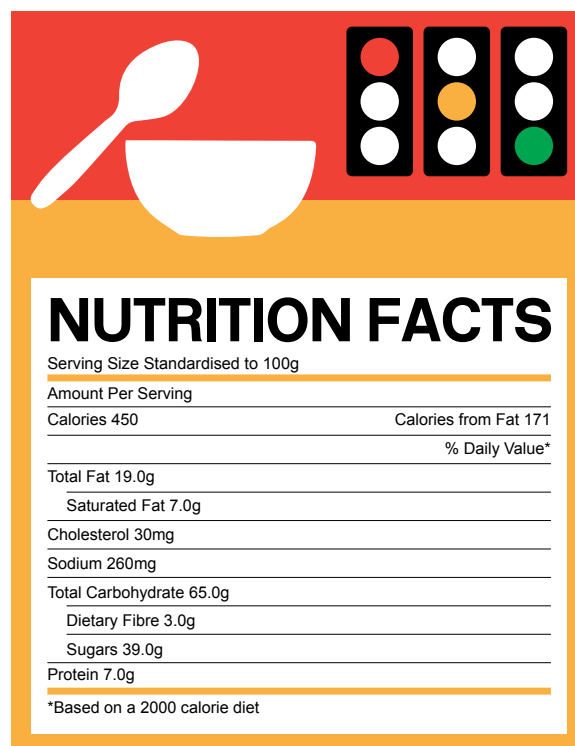


Traffic light labelling with an overall rating – rather than specific calories – appears to work better than multiple traffic lights or daily intake recommendations when people are asked to identify healthier foods. In a study by the Food Standards Agency, including ‘high’ ‘medium’ and ‘low’ ratings on foods using traffic lights helped people’s understanding.

Accordingly, the Commission believes that London should introduce traffic light labelling in all restaurants and cafes with more than 15 outlets nationally. This would avoid placing an unrealistic burden on small restaurant or café owners.

The initiative would be likely to be popular among Londoners – 73% of those polled said they would support restaurants and takeaway chains having to display nutritional information about calories, salt and fat. And 82% said such labelling would encourage them to choose healthier options.

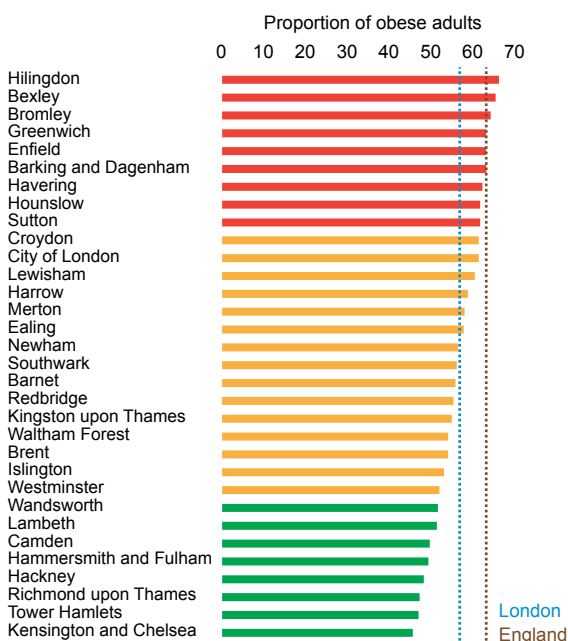
Calorie labelling vs. traffic lights



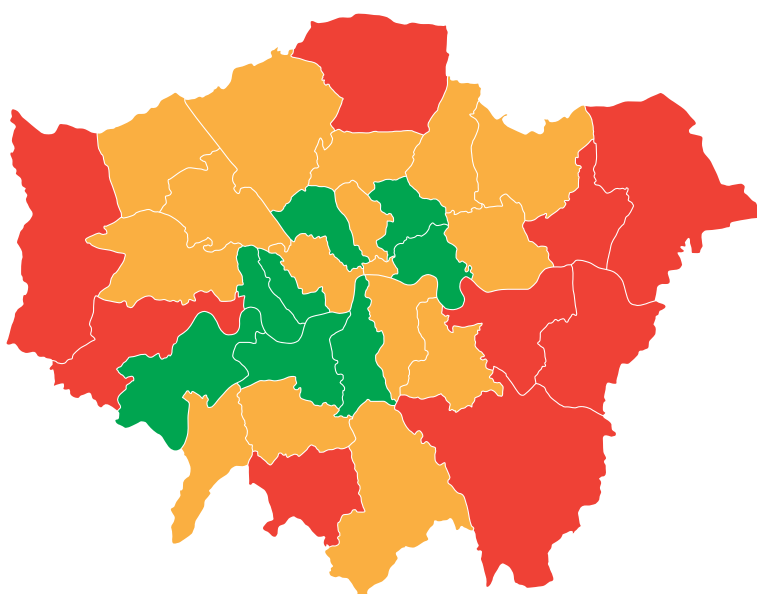
Proportion of overweight and obese adults in London boroughs

Proportion of overweight or obese adults, 2012

Better Similar Worse



Compared to London average



Piloting a new approach to problem drinking

London's pubs and bars are part and parcel of what makes it a great world city: places for Londoners to come together to socialise and to relax, providing employment and boosting the economy. But in parts of London, drinking alcohol is a problem. Not everyone drinks sensibly and alcohol related hospital admissions – and liver disease – are rising.

In the same way that smoking has generally declined in London, drinking and drunkenness have also shown a downward trend since 2009. But this means that binge and 'high risk' drinking are now concentrated in particular areas, where alcohol related admissions to hospital are highest.

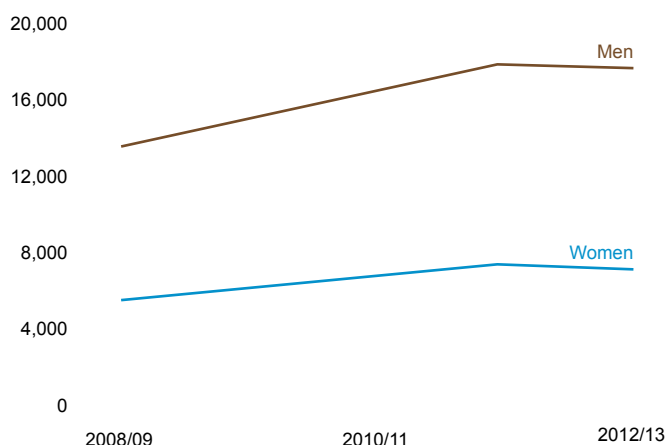
Research shows that increasing the price of alcohol reduces deaths and illness, lowers traffic fatalities, tempers violence and crime, and reduces risky sexual behavior and sexually transmitted infections. Where prices have gone up (in Saskatchewan province in Canada, for example), consumption has gone down. For these reasons, the Royal College of Physicians has recommended the introduction of a minimum price for alcohol at 50p per unit.

There has been a lively debate on alcohol pricing for some years now and some places, such as one of Canada's provinces, have taken measures to link pricing to alcohol reduction initiatives. In the UK, the Liverpool Health Commission has supported the introduction of the minimum alcohol price using local authority byelaws. Newcastle has introduced minimum unit pricing through a voluntary agreement in part of the city. London should collaborate with Liverpool, Newcastle and other cities on this initiative.

Particular boroughs face more severe alcohol problems than others. Since London boroughs are responsible for licensing of all venues that sell alcohol, an application could be made to the Secretary of State for Communities and Local Government to approve variations in licensing laws to enforce minimum prices in pilot areas.

The Commission found that 50% of the Londoners it polled would support a minimum pricing policy on alcohol. Perhaps more importantly, piloting a minimum price for alcohol in this way in just three London boroughs, at the RCP recommended 50p per unit, could avoid 215 hospital admissions a year and save the NHS £1 million over the same period.

Total number of alcohol related hospital admissions in London by gender/year



Exploring health tax powers for London

Taxation has long been used as a way to reduce consumption of harmful substances. Tobacco and alcohol are both heavily taxed, thereby raising their prices and lowering their consumption. In the face of the global obesity epidemic, more and more countries have introduced taxes aimed at reducing the consumption of unhealthy foods – those high in calories, sugar or salt. For example, France, Denmark, Hungary and Mexico have all introduced taxes on sugar-sweetened drinks.

The London Finance Commission recommended that London and its boroughs be given greater control over local taxes. More recently, a commission by the King's Fund on the funding of health and social care has suggested using the taxation system more intelligently to provide local incentives for a healthier population.

The recent debate over greater powers for city regions – fuelled by the Scottish independence referendum – has prompted further explorations of more financial devolution in a number of reports.

London needs this kind of well-thought-through policy initiative, backed by national authorities as well as by local and city mechanisms, and carefully assessed in terms of fiscal and economic effect, to become a healthier place for its inhabitants.

Recommendation 4

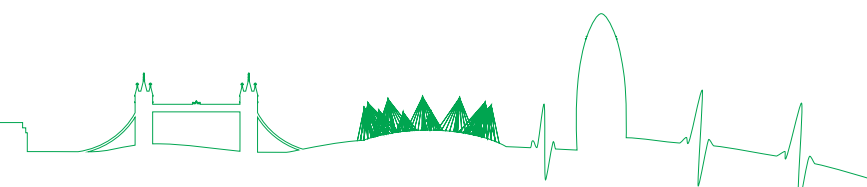
London boroughs should introduce mandatory traffic light labelling and nutritional information on menus in all restaurant and food outlet chains in London, by using their byelaw and licensing powers.

Recommendation 5

London boroughs afflicted by problem drinking should be supported if they choose to pilot a minimum 50p price/unit for alcohol through their byelaw and licensing powers.

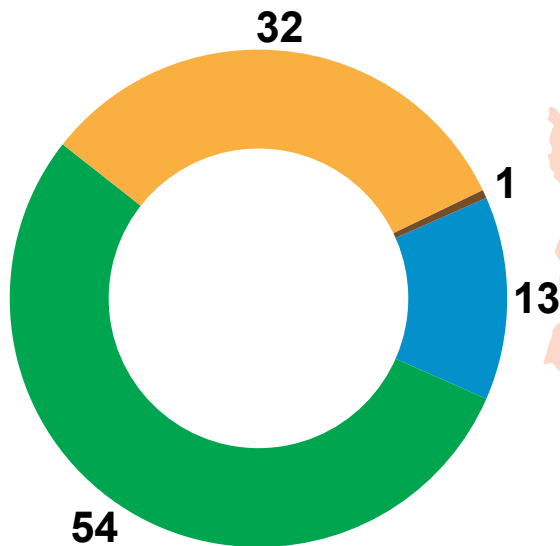
Recommendation 6

The GLA and London boroughs should include 'sin taxes' in their review of how London might manage devolved taxation powers, and if appropriate, make a case to central Government.

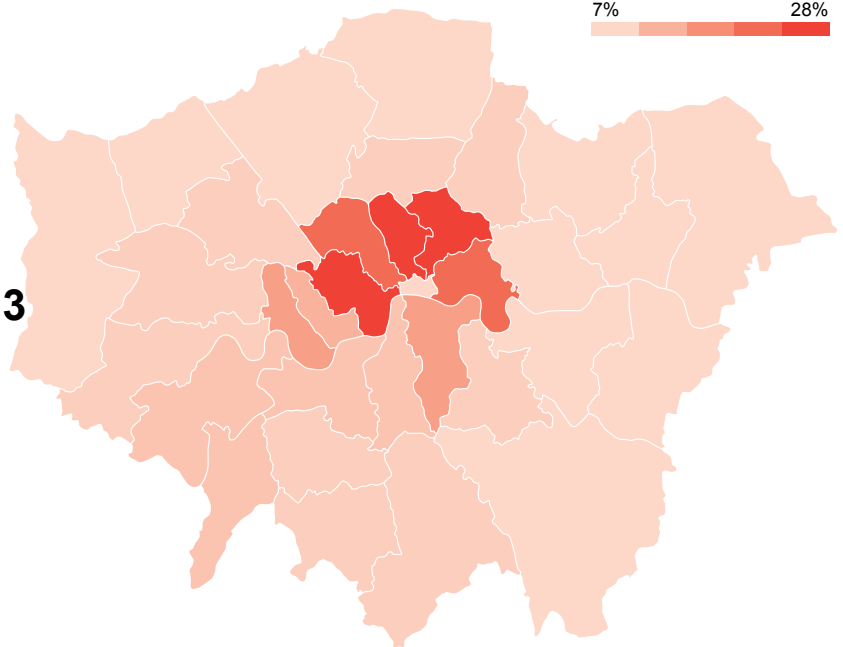


Currently 13% commute to work by walking or cycling with the highest rates in Inner London

■ Private transport
 ■ Other
 ■ Walk or cycle
 ■ Public transport



Commute by walking or cycling



1.4 Get fit London

Just as we have chosen to eat more, we have also chosen to exercise less. Just as we need to discourage consumption of too much food, we should positively encourage more Londoners to take more exercise.

Many Londoners exercise in their leisure time – playing sports, running, cycling, swimming or going to the gym. But too many of us do no exercise at all. Fewer and fewer of us work in jobs that require any physical effort whatsoever. There are 1.8 million adults in London who report that they do less than 30 minutes moderately intense physical activity each week. Only 13% of Londoners currently cycle or walk to work – despite half living close to their workplace.

We take short journeys to see friends or family, or pop to the shops, all by car. And we get to and from work and school by taking the quickest and easiest transport possible. TfL has identified 5.6 million walkable trips based on distance, age, time of day, heavy loads, and so on. Each day, there are some 4.5 million car trips under 2 km, 1 million bus trips, and 30,000 tube trips, that could be switched to walking.

When we go about our daily commute or travel around the city to see friends or family, we usually think about one thing: what is the quickest and easiest way to get there? We rarely think about the healthiest way to move around the city. A sedentary lifestyle has become the default for most of us.

It's time for a change. We must make active travel easier for Londoners, with a focus on walking. There is compelling evidence that there are huge health benefits from taking around 10,000 steps a day – better fitness, lower cardiovascular risk, and better mental health too. Evidence has shown that higher activity levels could prevent the deaths of up to 4,100 Londoners a year.



Getting London walking requires joint action from employers, the Mayor, local councils, and Transport for London. That's why the Mayor should dedicate 20% of his TfL advertising space to a campaign to get Londoners to walk more. TfL should alter signage in stations to encourage people to walk up stairs and escalators ('Stand on the right' should be replaced with 'Walk up on the left') as part of its rolling station improvement programme. And TfL's 'Legible London' programme – placing walking maps at convenient locations – should be celebrated and expanded to outer London.

Yet encouraging walking can only be the first step: Londoners should also be given positive incentives to walk.

Healthy commuting: enabling employers to promote active travel

Workplace-based campaigns in Australia, Japan, and the US, as well as in the UK, have raised average steps per day from 4,000 to 10,000. That's about another two miles walking each day. After eight months, two thirds of people reported improved fitness, and a third fewer people had high blood pressure. Average weight loss by participants in these kinds of schemes was 10lb/4.5kg. So employers can make a big difference to health.

It is in employers interests to do so. London employers lose 6.63 million working days each year due to stress, anxiety or depression. At a £30,000 annual wage, this equates to £1.1 billion in lost output. The average London firm of 250 employees loses £4,800 per week (£250,000 a year) due to sickness absence.

However, employers do not incur direct costs from their employees' health conditions since the vast majority of Londoners receive their healthcare through the NHS. This means businesses have less incentive to invest in employees' health and wellbeing than in other countries such as Germany or the US.

Indeed, 80% of all US companies with more than 50 employees have wellness programmes. In 2014, US employers will spend approximately £100 per employee on these programmes, and tie up £400 per employee in wellness incentives, such as payments for achieving 10,000 steps per day.

So, if we want to get London employers on board with helping to promote health, we need to act to make it easier for them to do so. The public sector should enable, rather than make, investment in employee health.

Transport for London should establish a scheme, paid for by employers, to incentivise walking the last mile to work and the first mile home. Employees tapping in or out with their Oyster or contactless card at least one mile from their registered office would collect points and be eligible for employer-financed transport rewards.

Transport for London's role is to move people around the capital as quickly and efficiently as possible. That is why the initial investment to set up the incentive scheme infrastructure should be covered by Public Health England and the NHS.

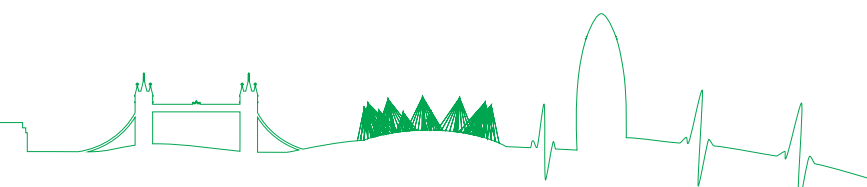
Healthy workplaces

Work plays a key role in keeping London and its people in good physical and mental health. With a working population of 4.5 million people, a comparatively high proportion of Londoners are of working age and in employment. This is good for London's productivity, good for prosperity, and good for Londoners' health.

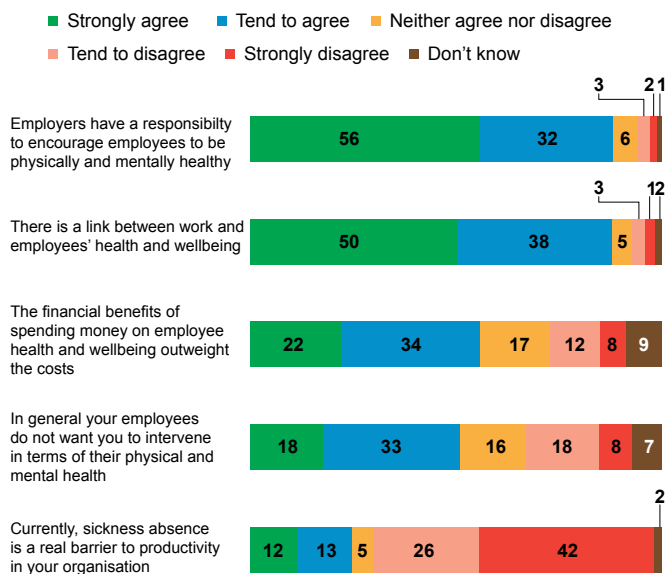
Many large employers have invested in health and wellbeing at work schemes. Companies as diverse as BT, Johnson & Johnson, GE, EDF, and the Royal Mail have implemented successful programmes that have improved health and improved corporate performance. The NHS, as one of the largest employers in the world, should be at the forefront of this agenda.

International research has shown that workplace health initiatives in other global cities, when supported by government resources or insurance plans, are highly effective. London can learn from the experience of other countries in incentivising businesses to do more about their employees' health.

In London, the Mental Health First Aid scheme teaches people how to spot a change in someone, start a conversation and encourage the right support before escalation and a greater cost. Implemented by the City Mental Health Alliance, it aims to create a culture where mental wellbeing is nurtured as part of good business



Employer attitudes to the health and wellbeing of their employees



practice in some of the City's largest firms. The alliance helps employers educate managers on how to foster good mental health, identify risks and recognise the triggers and signs of mental health problems.

The Mayor has recognised the issue of workplace health with his own London Healthy Workplace Charter. The scheme hosted and coordinated by the Greater London Authority supports business investment in staff health and wellbeing, and provides standards for workplaces. The Charter has estimated a return on investment of £9 for every £1 invested as a result of reduced sick leave and staff turnover and increased productivity.

Healthy leisure

London's professional football clubs have a huge influence over the city's people. The clubs should launch a 'fan challenge' to improve physical activity levels by offering club incentives, and using physical activity league tables to promote competition between clubs.

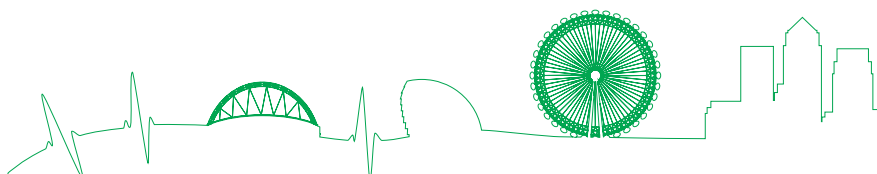
London could also do more to harness the benefits of its unusually large amount of green space, not only by curbing unhealthy activities in parks, such as smoking, but also by using them as a natural rallying point – as already happens informally and at a more local level – for healthy activity.

Londoners naturally gravitate to their parks for physical activity and sports. This could be more energetically encouraged by citywide initiatives, spearheaded by the Mayor, and supported by the NHS. Collectively, the prize of these initiatives would be more than just lost weight and a slimmer city.

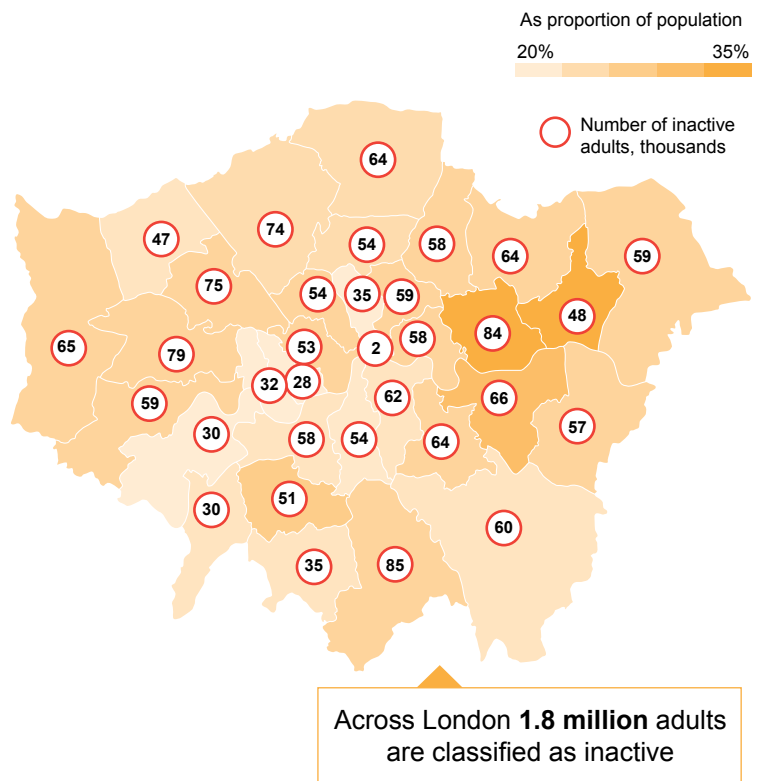
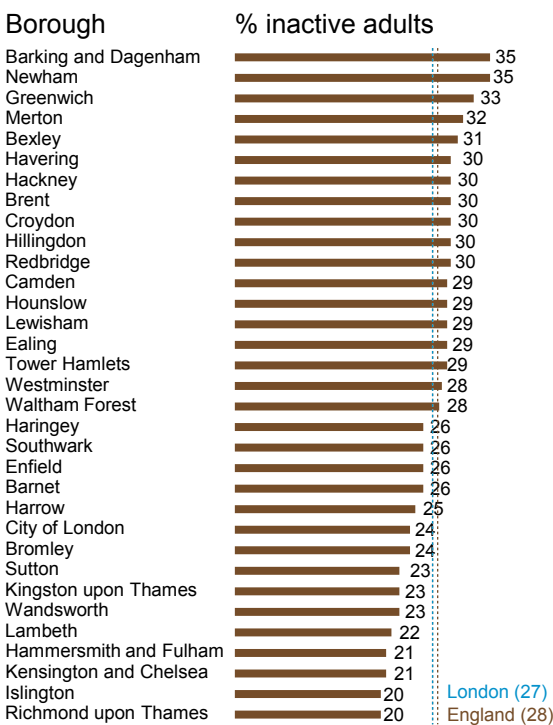
The Commission strongly supports the Mayor's cycle superhighways scheme, encouraging Londoners to travel around the city actively for work or leisure, improving health, and without the harmful emissions associated with other forms of transport.

Support employers to provide time for exercise. Working 8-10 hours and commuting doesn't leave much 'spare' time for exercise, especially to those with kids.

Member of the public at Imagine Healthy London roadshow at Croydon University Hospital



Londoners who do less than 30 minutes of moderately intense physical activity each week



Encourage firms and employers to subsidise gym memberships for employees: healthier staff would be an investment for an employer.

Member of the public at Imagine Healthy London roadshow at the Cheeky Monkeys Tea Party, in Crayford, Bexley

Actively use volunteers who are overweight/ leading unhealthy lifestyles to speak to children and say why they wished they changed their diets and exercise regime sooner.

Member of the public at Imagine Healthy London roadshow at East London NHS Foundation Trust

Recommendation 7

The Mayor should invest 20% of his TfL advertising budget to encourage more Londoners to walk 10,000 steps a day, and TfL should change signage to encourage people to walk up stairs and escalators.

Recommendation 8

The NHS, Public Health England, and TfL should work together to create a platform to enable employers to incentivise their employees to walk to work through the Oyster or contactless scheme.

Recommendation 9

The Mayor should encourage all employers to promote the health of Londoners through workplace health initiatives. The NHS should lead the way by introducing wellbeing programmes, including having a mental health first aider for every NHS organisation.

Recommendation 10

London Boroughs, the GLA and the NHS should work together to organise an annual Mayor's 'Imagine Healthy London' Day in London's parks, centred on an 'All-Borough Sports Festival' with health professionals offering health checks, and exercise and healthy eating workshops.

Recommendation 11

London's professional football clubs should promote health in stadiums and local communities through club incentives and competition.



1.5 Cleaner air

Poor air quality and air pollution contribute to Londoners dying nine months sooner than they should – 50% worse than the national average. 7% of all adult deaths in London are attributable to air pollution. And over 85% of the worst areas in England for nitrogen oxides and 'particulate matter' are in London.

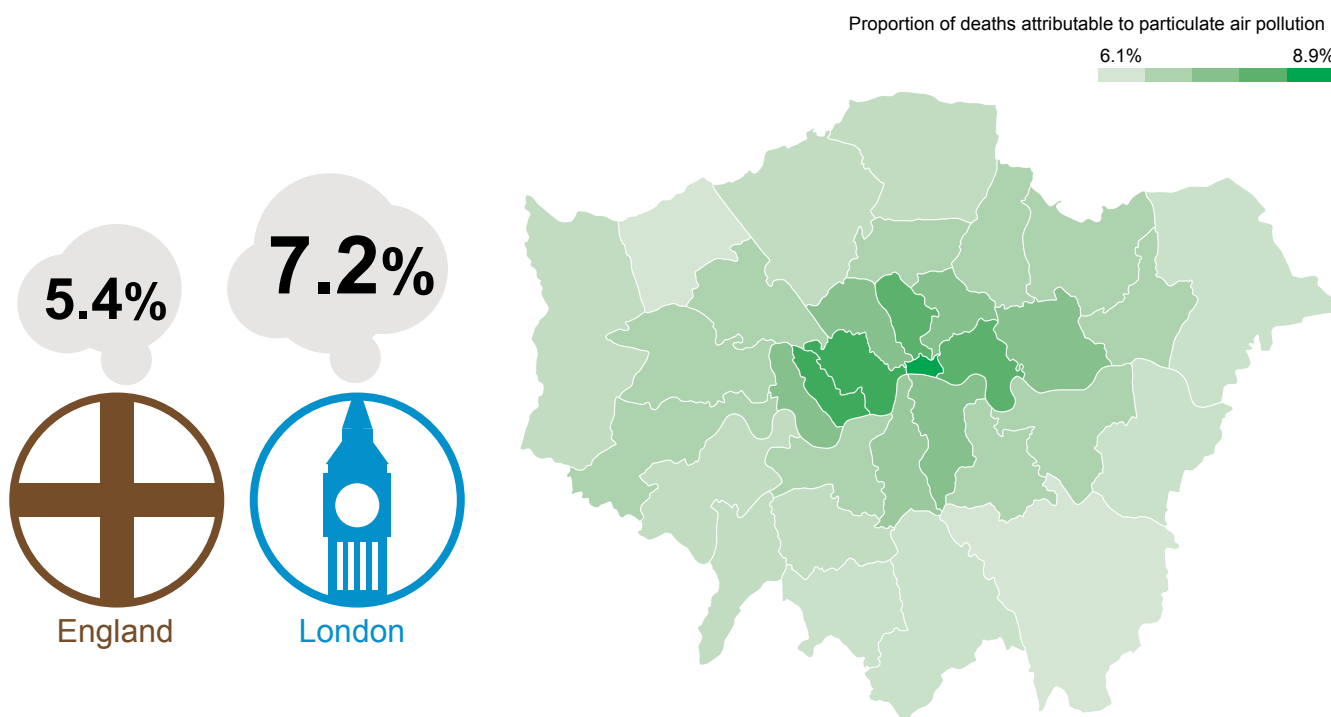
Virtually all this poor air quality is caused by traffic. London has especially high levels of 'PM10' particulates, primarily due to traffic. In central London, road vehicles cause more than half of these particulates. Long-term exposure is linked to asthma, lung cancer, and heart disease. London also suffers from nitrogen dioxide pollution – in Central London, more than 60% of this pollution is caused by transport.

If annual PM10 levels were reduced by just five micrograms per cubic metre, London would save 150 lives a year and prevent 643 hospital admissions which currently result from pollution-related respiratory or cardiac illnesses.

This is why the Mayor has proposed the Ultra Low Emission Zone (ULEZ) – an extension of the current Low Emission Zone which would see even tougher controls on vehicle emissions in central London. However, this is not proposed to be implemented until the end of 2020. Emissions from taxis and diesel cars are worsening, and the contribution of taxis is significantly greater in Central London where air pollution is at its worst.

London could improve its air quality by accelerating plans to convert taxis to zero emission capable vehicles. London's 25,000 taxis cause 10% of nitrogen dioxide pollution and 25% of PM10 levels in central London. The 15-year age limit should be reduced to five or 10 years, supporting the Mayor's announcement that all newly built taxis would need to be zero emission capable by 2018. The alternative is to leave dirty vehicles on the streets until 2033.

Deaths attributed to air pollution in London



The Mayor should also be more ambitious in his proposed ULEZ by aiming for near zero emission by 2025, expanding the size of the zone, and offering stronger financial incentives and disincentives.

London is not alone in being a world city with a pollution problem. Other cities with the same problem, like Paris and New York, are taking action to improve air quality, with restrictions on traffic and home and business heating oils.

Londoners would support such measures. In its own polling, the Commission found that 69% of Londoners thought air pollution affected their health, and 74% said they would support reducing the number of older, high emission vehicles.

It's no fun cycling on polluted, lorry and truck filled roads. It needs to be more enticing.

Member of the public at Imagine Healthy London roadshow at Edmonton Summer Festival in Enfield

Recommendation 12

The Mayor should accelerate planned initiatives on air quality in London to help save lives and improve the quality of life for all Londoners.



2. Better health for London's children

London has both a proud and shameful record when it comes to looking after its children. Out of the terrible slums of the Victorian era came reforms and support which would banish abject poverty and widespread homelessness among the young in London forever. But just as health and social care can save and improve lives, tragic stories still emerge of failures that could have been avoided.

Today, the challenges London presents to its youngest inhabitants remain as varied as ever. The new benchmarks are other global cities where children are doing as well as, or much better than, in London. Our capital needs to seize these challenges, build on its successes, invest in the foundations of its future prosperity, and tackle head on the problems parents and children face.

I often see kids on their way to/from school buying unhealthy drinks and sweets from off-licences- encouraging routes to school to avoid these, or educating kids about the impact of doing this could avoid them getting into unhealthy snacking habits in the first place.

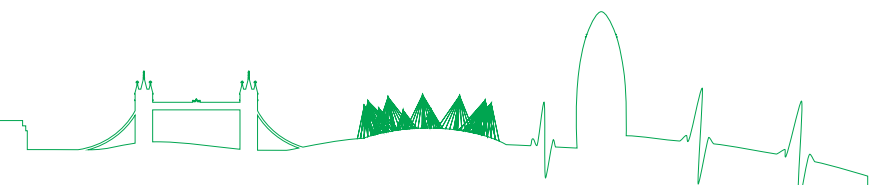
Member of the public at Imagine Healthy London roadshow at Big Day out in Whittington Park, Islington

2.1 Better parenting

Healthy child development is fundamental for good health and a happy life – a child's early years lay down the foundation on which the rest of their life is built. Level of development at age five is a crucial indicator of how a child's life – their health, education, and employment – will unfold. Today, just 53% of London's five-year-olds reach a good level of development at this age.

Child poverty levels in London are a third higher than in England overall: some 27% of London's children live in families who are below the poverty line, versus 20% nationally. The levels of child poverty in the poorest boroughs are nearly five times those of the wealthiest. By the age of three, children from families living in poverty are significantly behind in language development and school readiness compared to those from families above the poverty line.

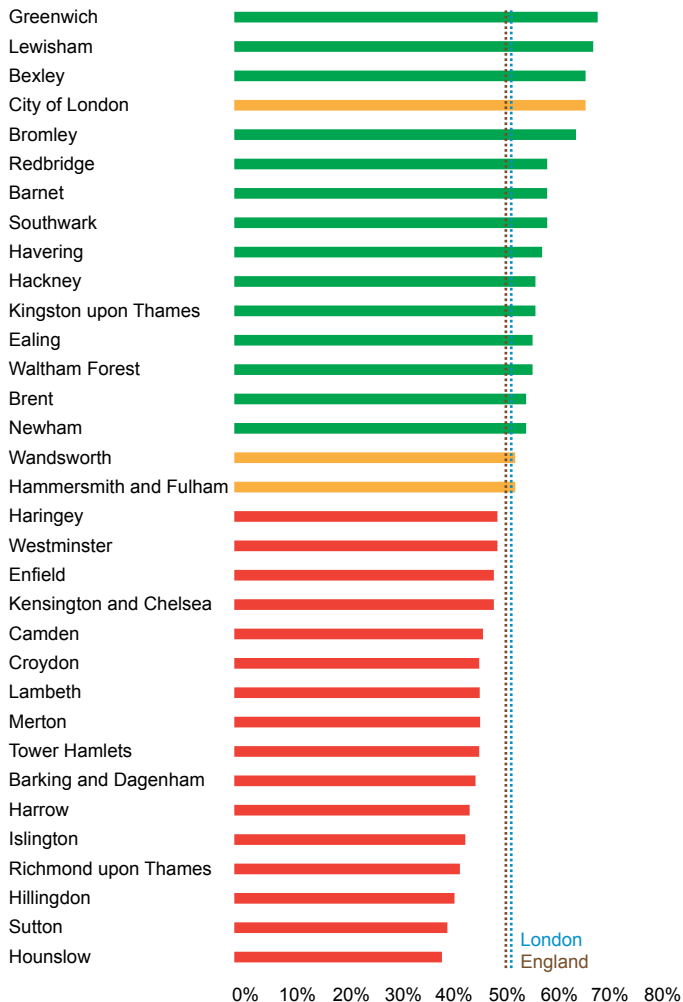
Poverty increases the chances of poor child development, but it does not make it inevitable. Better support for parents can result in better prospects for children. 'Positive Parenting Programmes' are found in 25 countries. In the UK, programmes in Glasgow and in Brighton have led to dramatic – close to 90% – improvements in parenting. It is essential that this starts early, sustains over time, and is locally tailored.



Only 53% of London's children reach a good level of development at age 5, with wide variation within London linked to deprivation and place

% Children in London achieving a good level of development aged 5 by borough, London, 2012

Better Similar Worse



The problem in London is that there is no pan-London systematic focus on pre-school and early years parental intervention. Significant results could be achieved through a pan-London programme of evidence-based parenting support targeted from maternity to children aged three years in the most vulnerable groups. This model of care would link midwifery, health visiting, Family Nurse Partnerships and the Troubled Families Programme and would focus on supporting basic parenting skills.

To ensure that programmes are evidence-based and providers are of the highest quality, the Commission also suggests:

- The development of a cadre of staff for early parenting support, who can link families with various charities, voluntary groups and statutory programmes of support
- That children's centres and other providers could receive a kite mark for quality
- The development of a network of academic units that can act as a resource for evaluation and evidence, and build more evaluation into major funded programmes at the business case stage
- Work with the charitable sector to understand how the funding gap for supporting parenting proposals could be addressed or matched via their funds

What happens in pregnancy and early years is determining what happens to our families and our population... you can go into a nursery and tell who is going to be using Providence Row in 30 years' time.

Mike Morris, Vice-Chairman, Alexandra Rose, Commission Hearing Session, 15 May

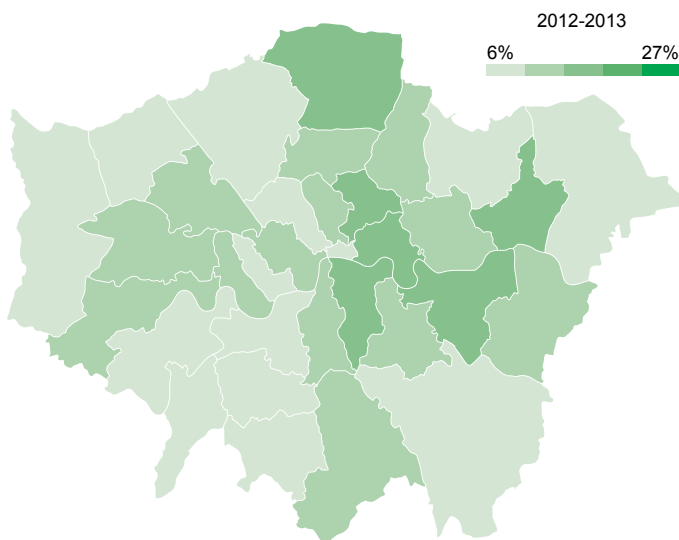
Recommendation 13

Health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three.

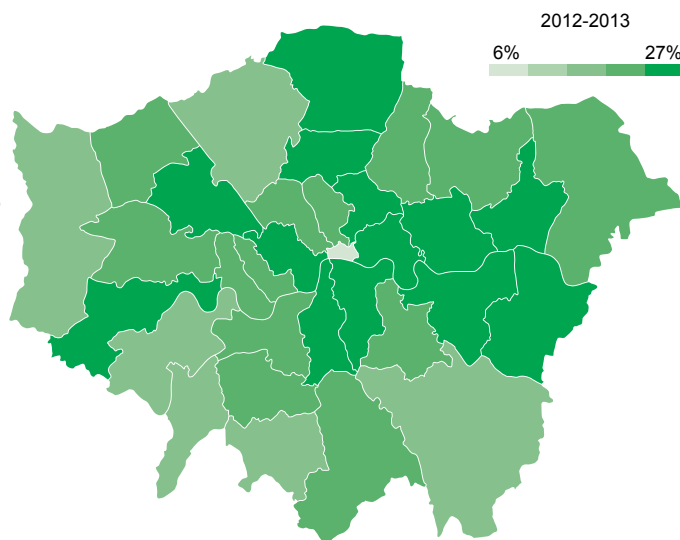


In parts of London a quarter of children leaving primary school are obese

Percentage of reception children classified as obese



Percentage of Year 6 children classified as obese



2.2 Tackling London's childhood obesity emergency

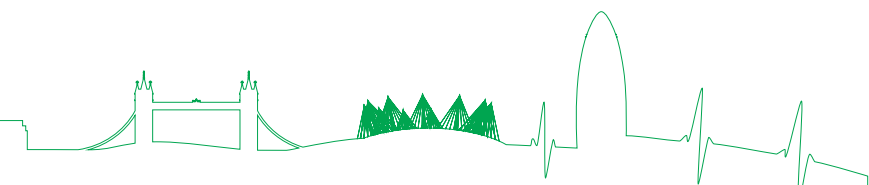
One of the most important influences on the health of children comes from what they eat. The food and drink industry know this, health and care services know this, and so do parents. And perhaps it is fair to say that in London, the amount of food and drink available to our children – at a price their pocket money can afford – is as varied as any other city in the world.

With this availability, though, come worrying statistics. London has the highest rate of childhood obesity of any peer global city, and the highest proportion of obese children in all the regions of England. In London almost 1 in 4 children in Reception and more than 1 in 3 children in Year 6 are overweight or obese. And obesity is a particular challenge for some of London's poorest and its minority communities, with the highest prevalence in poor areas and amongst Black African children.

Obesity has a substantial impact on the health of children – now and in the future. The Greater London Authority has calculated that the treatment cost of overweight children in London next year will be £36-195 million. Furthermore, obese children are much more likely to be obese adults, where even more serious health consequences occur.

The research on obesity gives a clear message: physical activity levels – though important for fitness and wellbeing – are weakly related to obesity, and are therefore not the main priority. The obesity crisis can only be solved by eating less food. Doubling a serving size means that people eat 22% more on average – and portion sizes have increased greatly in the last 30 years.

Other global cities have addressed calorie intake and food choices for children. New York, for example, has reduced salt and increased fibre in school meals – and banned deep-fat fryers. More than 1,300 city-contracted vending machines must now carry a healthier mix of products as part of food standards.



London has also seen some healthy eating initiatives spring up. We Are What We Do offers a healthy, popular and financially sustainable alternative to existing fast food outlets through the Box Chicken pilot in Newham. This is a mobile catering unit, which was set up to run from 12-5pm Monday to Friday for a month, providing healthy meals, and targeted at students at three local schools. In September 2014, cooking became compulsory in the curriculum for all children up to the age of 14.

Action to tackle childhood obesity is urgent. London's children need to be protected from junk food and learn to lead healthier lives at school.

2.3 Less junk food

Protecting London's children from junk food

Being exposed to more food also means we eat more. Having a takeaway near our house, commuter route, or workplace increases the amount of takeaway food we eat. This exposure is a particular concern for schools, since a quarter of the energy intake of young people is from eating snacks bought close to school. Having a fast food outlet within 160 metres of a school is associated with a 5% increase in obesity.

There are over 8,000 fast food outlets in London, many close to schools, and this number is increasing by 10% every year. A single typical fast food meal contains nearly 60% of recommended daily calories, half of recommended salt and saturated fat, and no portions of fruit and vegetables.

London's borough councils have begun to take bold action. Waltham Forest issued a new policy stating 'Planning permission will not usually be granted for Class A5 shops which fall within a 10 minute walking distance (~400m) from the boundary of either a school facility, any youth facility or any designated parks'.

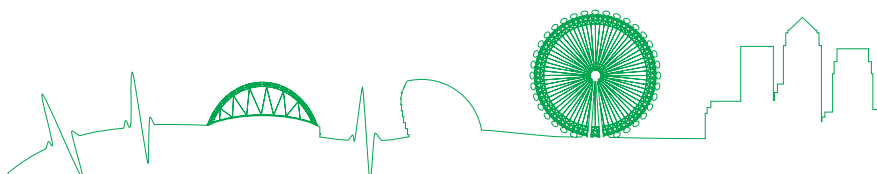
With 89% public support, Waltham Forest has been able to refuse some 82% of planning applications for fast food outlets. Barking and Dagenham has followed suit, and Tower Hamlets has restricted takeaway outlets to specific areas, where they cannot exceed 5% of total shops. But there have been legal challenges and councils have only won appeals on the basis of over-concentration and likely anti-social behaviour.

London councils should be more strongly supported by the Mayor and the Greater London Authority, building on the 'takeaways toolkit'. The next version of the London Plan should shift the burden of proof so that new fast food takeaways within 400 metres (10 minutes walk) of schools will have to provide evidence that their establishment will not have an adverse impact on health. Exclusion zones should be considered to restrict any new 'A5' (the planning designation for fast food outlets) uses within 400 metres of the boundary of any school.

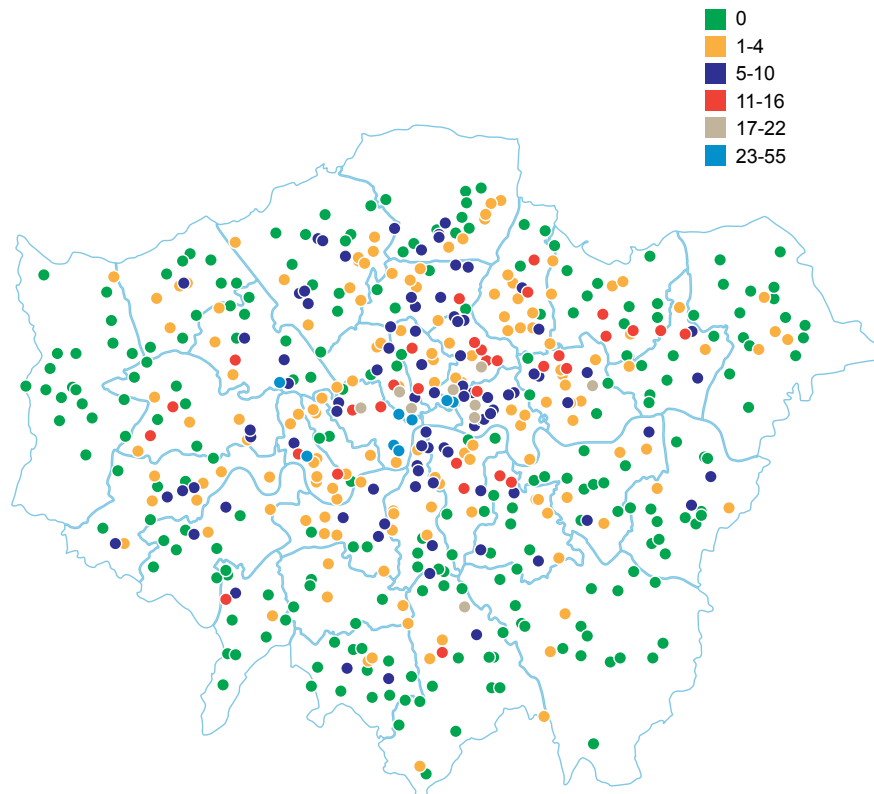
The Commission believes the time is now right to take a much stronger approach to reducing the availability of fast food to London's schoolchildren. In polling, 73% of those asked by the Commission said they thought the number of fast food outlets near schools should be limited.

I am always worried when I'm on the bus when primary schools come out and I see parents giving kids crisps, biscuits etc. Parents need more information.

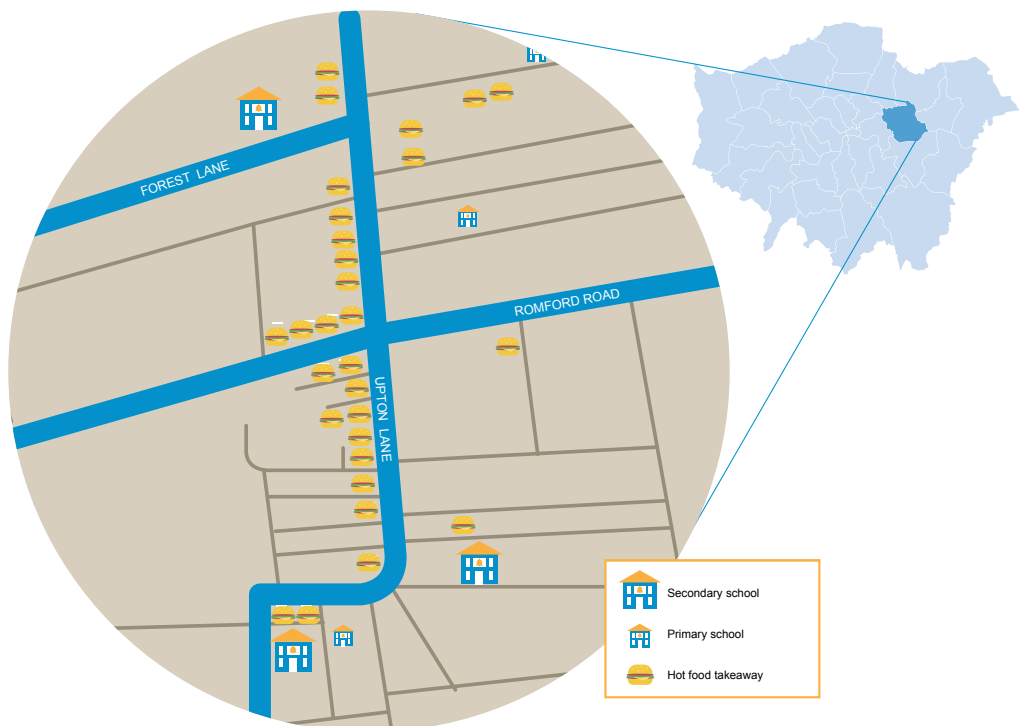
Member of the public at the Imagine Healthy London Roadshow King's College Hospital



Number of fast food outlets within 400 metres of secondary schools



Example – the Forest Gate area of Newham



Parents on a low budget need practical advice – show them how easy it is to cook a healthy meal.

Member of the public at the Imagine Healthy London Roadshow King's College Hospital

By talking to young people in school we found out that they really did want to go outside of school and have a meal because it was part of their independence...the reason they were eating from fried chicken shops was that it was within 500m of the school, it took them less than 10 minutes to get it and it was within their price range.

Kathleen Collett, Director of Research and Evaluation, We Are What We Do

McDonalds is the healthy end of the market in Tower Hamlets. We have 42 chicken shops per secondary school. Near one of the surgeries, it is not Mile End Road, it is Chicken Shop Mile.

Dr Sam Everington OBE, GP and Chair of Tower Hamlets CCG

Recommendation 14

The Mayor should use the 'London Plan' planning guidance to support local authorities in protecting London's children from junk food through tighter controls within 400 metres of schools and to promote access to healthier alternatives.

2.3 Healthier schools

If London is to do more to look after its children more carefully and provide them with a healthier future, more needs to be done in the places where children spend most of their waking hours – schools. More children say they get their information about health from either their parents or their teachers than from television or from the internet. So schools are the ideal place to get kids off to a healthy start in life. Indeed, every global city the Commission has looked at has made investments in school health.

Good education improves health; poor health harms education. Similarly, physical activity and exercise improves motivation, reduces unhappiness, and improves learning – today, just 55% of London's children are physically active. Education also lowers the chances of teenage pregnancy, with all its attendant health and life opportunity challenges, and influences rates of sexually transmitted infections.

Each day in London, the anti-smoking message fails to get through to the 67 children – more than two classrooms full – who start smoking. Smoking in the young is particularly damaging, increasing the risk of chronic breathing difficulties and cancer later in life. Schools are the obvious place to educate about and prevent smoking.



In London, the Mayor has been keen to extend the reach and impact of the GLA Healthy Schools London programme, a voluntary awards programme that accredits schools. More than 1,000 schools currently participate, and the goal is to have 2,400 (95%) registered by March 2016. The programme has led to more healthy school meals, better cooking skills, and more physical activity, including walking or cycling to and from school. The School Food Plan, and the designation of Croydon and Lambeth as Flagship Boroughs, will demonstrate the improvements in health and attainment that can be achieved by focusing on food.

There needs to be greater transparency about the health of London's schools. A Healthy Schools London dashboard could be created for schools and parents to allow comparison between schools on how they support the health and wellbeing of their pupils alongside educational attainment. This would build on data already published by Ofsted, and be implemented by the GLA through its Healthy Schools London programme.

Increase sports, dance and games in schools.
One hour of exercise or two half hour slots would be mentally stimulating and support behaviour management.

Member of the public at the Imagine Healthy London Roadshow at Dalston Square Community Dance showcase in Hackney

Recommendation 15

Local authorities, the GLA and Public Health England should work with Ofsted to ensure more data is published on school health and wellbeing.

Overall physical activity participation

levels for children – wide variation by borough

Proportion of children attending state school participating in at least three hours of high quality PE and school sport within and beyond curriculum



As a nation we need to have a conversation about what education is for... If we want rounded citizens, we need an education that is three-dimensional and rounded.

Dr Maggie Atkinson, Children's Commissioner for England

For schools with vending machines selling sugary fatty foods - get rid of these. Replace with fruit and healthy snacks. Send emails or letters to parents asking them to provide kids with healthy packed lunches (and give suggestions). There should be classes on healthy eating.

Member of the public at the Imagine Healthy London Roadshow at Granary Square, in King's Cross

2.4 Better children's mental health service

Half of all mental illness in adults starts before a child reaches the age of 14, and three-quarters of lifetime mental health disorders have their first onset before 18 years of age. So helping children is a particularly effective means of preventing or reducing the impact of mental health problems in later life. Indeed, the economic returns of early childhood intervention programmes exceed their costs by an average ratio of 1:6.

1 in 10 children and young people aged 5-16 have a diagnosable mental health disorder, equating to three in every class, or more than 100,000 across the capital. Between 1 in 12 and 1 in 15 deliberately self-harm – admissions have increased by 68% in 10 years. Conduct disorders and associated antisocial behaviour are the most common mental and behavioural problems in children and nearly always have a significant impact on functioning and quality of life.

Making a difference is possible. Mental health assessment in schools may have a role to play in preventing mental health problems and identifying children at risk of developing such disorders early on. Currently, assessments in school focus solely on the physical health of the child.

Increasing health literacy in schools and teaching coping strategies has been shown to reduce risk of mental illness among adolescents. Teaching and supporting the development of resilience in adolescence, for example, has the potential to prevent or reduce the long-term effects of mental illness.

Early intervention programmes work well, even with the most severe mental illness. Early intervention in psychosis has been proven to significantly improve the likelihood of recovery, the course of the illness, and symptoms eight years on. It reduces risk of relapse and cuts risk of suicide from 15% to 1%. Risk of being sectioned falls from 44% to 23% and, with an effective intervention programme, up to 35-40% of young people with psychosis can be 'diverted' away from the usual course of the illness and end up in employment (an outcome marker for success) with an effective intervention programme.



1 in 10 children suffer. That is three in a class of 30. So three in your maths lesson or your French lesson or your geography lesson of 30 children will be just about coping with getting up and getting themselves to school, but not much else. There could be all sorts of things going on in their lives.

Dr Maggie Atkinson, Children's Commissioner for England, Commission Hearing Session, 8 May

2.5 Better children's physical health services

London is a youthful city. More than 1.8 million Londoners are children and young people, a large and diverse group. Every Londoner would wish to see the highest quality care possible for every London child. Most children lead happy, healthy lives. Yet tragedy sometimes strikes.

The death of any child or young person is a tragedy: a life full of promise cut short, families shattered, and communities devastated. Deaths of children and young people are, fortunately, rare. Nonetheless, there are wide variations in mortality rates across boroughs, both for infants and older children. There is a threefold difference between the best and worst performing boroughs. And, whilst a small number overall, the death rates of children and young people in London's hospitals are higher than elsewhere in the country.

Whilst most causes of deaths are similar to those across England, there are some aspects that are unique to London. The city has a significantly higher proportion of children and young people who die of acute infections or acute medical or surgical problems. There are also more children and young people dying in emergency departments and hospital wards, with a significantly lower proportion in London dying at home.

Specifically, historic data has shown that London patients aged from 1 to 19 years old have higher than expected 'hospital standardised mortality rates'. These remain higher than other age group in London and higher than other regions of the country. The question is: why?

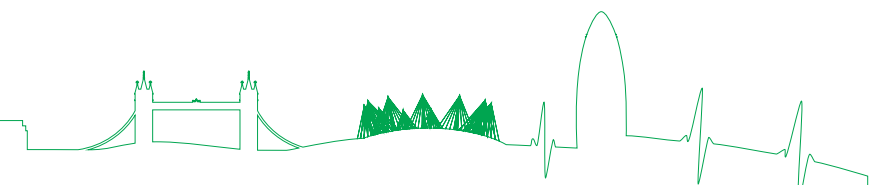
London's population

There are many factors that could explain the higher mortality rates for paediatric emergency admissions in London. For example, the capital has higher levels of immigration compared to the rest of the country with many people who do not speak English well. This may make people reluctant to seek help, and make it harder for them when they do so. Furthermore, it can also result in lower vaccination rates for preventable life-threatening diseases.

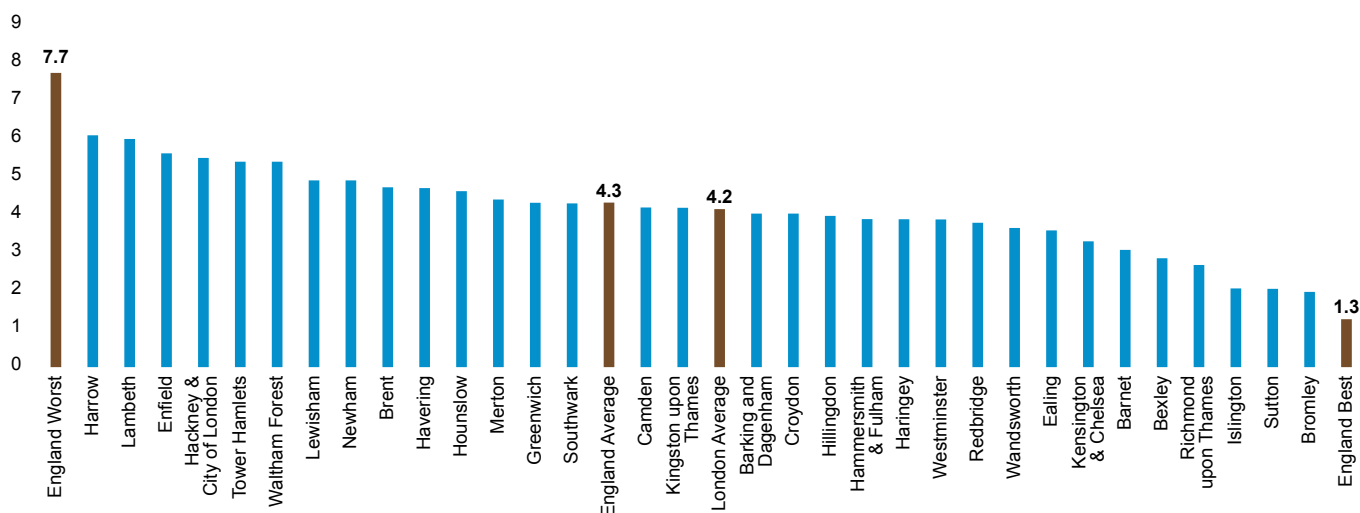
Care in general practice

Part of the answer may be explained by access to general practice. Nearly half (45%) of parents feel A&E is the most convenient option for accessing care for their child quickly, rather than their local GP. Attendance at A&E by under 16-year olds has risen by 35% in the last five years, and research suggests that 87% of attendances could have been treated in general practice.

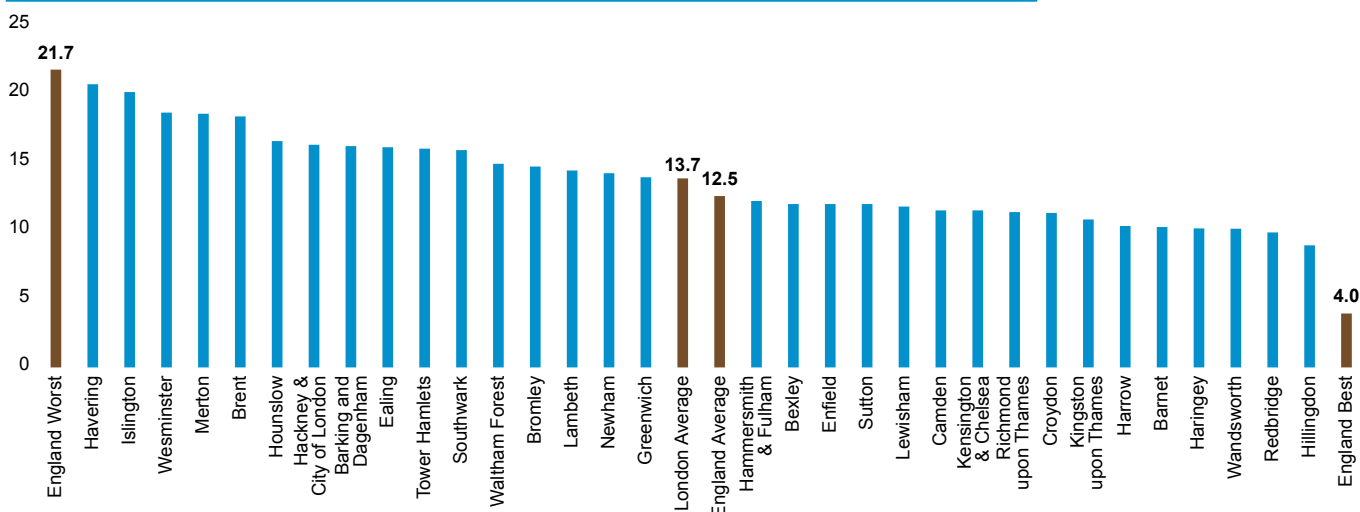
The National Children's Bureau (NCB) has said that young people have a much poorer experience of GP services than adults and parents. The NCB has highlighted the need for better paediatric expertise in GP practices and opening hours that meet the needs of working parents and their children. Introducing these measures could help reduce child deaths and relieve the increasing burden on A&E services.



Death rate per 1,000 live births (aged under 1 year), 2010-2012



Directly standardised death rate per 100,000 children aged 1-17 years, 2010-2012



Patients deserve to be treated with the same high standard of care whatever time of day or night they are admitted to hospital, whether that be at 11am on Tuesday morning or 10pm on Sunday evening.

The Royal College of Paediatrics and Child Health



Complex and continuing care

It would be misleading and wrong to suggest that general practice alone is responsible. Health and care services for children in London with continuing and complex care needs are fragmented and do not do enough to support families. Those with long-term conditions, complex care needs, mental and physical disabilities and terminal illness need to access different health care, social care, housing and other services, such as education, often simultaneously. Evidence suggests these services are hard to access, poorly coordinated between primary, secondary and tertiary care and that there are inadequate links between them.

Hospital care

Additionally, it is often thought that the high number of tertiary centres for children in London affects the apparent mortality outcomes for London – very sick children come to London for specialist care, and this may give the appearance of higher mortality in London and lower mortality in other places. Counter-intuitively, it may be that because London has the most advanced services, that it also has the highest mortality rates.

Nonetheless, hospital care for children and young people in London faces particular problems. Although there are multiple causes, case reviews have highlighted that regardless of where the child dies – in primary, secondary or tertiary care – there are often avoidable factors in secondary care. These include failings in the recognition and management of serious illness in children, such as errors by doctors in training and unsupervised staff; inadequate patient observation; failure to recognise complications and failure to follow national guidelines.

There are a multitude of underlying reasons. London's hospitals need to ensure that there are enough paediatrics staff, with the right skills, and sufficient experience and seniority for good clinical decision-making. Furthermore, the right staff, with the right skills, need to be available every day of the week.

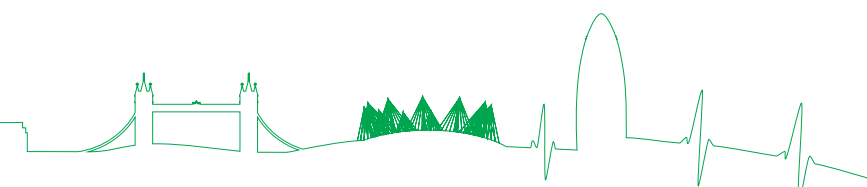
Surgical emergencies in children are 30% of the total cases. Given the limited availability of paediatric trained surgeons and anaesthetists, surgical services are spread too thinly to provide consistently high quality care, especially at weekends. This is despite a 50% increase in the paediatric consultant workforce over the past decade.

As a result, too many children are treated by surgeons who specialise in operating on adults, and the appropriate skill mix and environment to safely anaesthetise and recover children is not always available. This calls in to question the sustainability of local emergency paediatric surgical services. Indeed, it is likely that not all of London's providers of paediatric services have the required workforce to ensure high quality and safe services consistently across all seven days of the week.

There is a lack of planning and co-ordination of services across London which, whilst there are centres of excellence, has resulted in variation in quality. There is a need to progress, more quickly, to integrated systems of care that incorporate physical and mental health care provision, from primary and community care to highly specialised hospital services. Such systems should ensure delivery of care in line with relevant quality standards and clinical dependency requirements.

Recommendation 16

Health commissioners and providers should launch a process to address the variation in quality of care for children and to propose actions to improve outcomes.



3. Better care

London is a city of innovation with some of the best care available anywhere in the world. It should be a place where improving quality never leads to complacency, where each and every provider constantly strives to offer better and better care.

London has a history of successful change. For example, over the past seven years, the capital has undertaken radical reform of specialist stroke services, changes that are now hailed as ‘one of the greatest stories of modern medicine.’ Today, we have a 30 day mortality rate 17% lower than the England average, and we are saving around 100 additional lives per year with these improved services.

Better care starts with the individual, with making care personal. Understanding the holistic care needs of individual people, and how these patterns of needs are spread across the population, is the first step in improving care.

More personal care is founded on twin imperatives: empowering people who use services and empowering professionals and providers who deliver care. The first means involving people in their own care, and in the design of that care, treating them as peers and as partners, not subordinates. People who use services should be empowered to guide their care and manage their own conditions.

Empowering professionals and providers means ensuring that they have the resources necessary to provide good quality care. Health and care professionals should have the time to focus on their most complex patients and world class facilities and resources upon which to draw. All providers should be empowered to care for society’s most marginalised groups, for example, the severely mentally ill and the homeless.

As in every system, there are challenges to this vision. London faces a high burden of illness, both physical and mental, and health inequalities remain stubbornly widespread. Quality of care is too variable, and often does not meet people’s needs and expectations. Too often, providers feel squeezed in the current austere economic climate.

Yet London is ambitious. The Commission has found a health and care system determined to remake itself for the 21st century and to renew its promise to Londoners of providing the best care possible, available based on need not ability to pay.

If the 20th century was the century of evidence based care, the 21st century is the century of personalisation, it is about the people themselves.

Dr Charles Alessi, GP, Chairman of the National Association of Primary Care



3.1 Making care more personal

Providing better care for Londoners starts with understanding the needs of the individual. Londoners want care that reflects their individual wants and needs – care that is personal to them. Just as people are able to exercise more choice and control in other parts of their lives, so they want choice and control when it comes to their most important decisions: those about their health.

The NHS was founded on the principle of universality: that access to healthcare should be based on need, not ability to pay. Yet universal access has for too long meant care that is too impersonal. Access to the care an individual needs, regardless of means, should not mean access to the same care regardless of his or her needs.

Some wants and needs are indeed universal. All Londoners want to see their GPs in modern, convenient spaces, and all Londoners want access when they need it to specialist care delivered in real centres of excellence. Today, care is organised so that generalist doctors work in GP practices, specialists work in hospital trusts, mental health professionals work in mental health trusts, and so on.

Yet different people want different things from their care, depending on their individual circumstances. Broadly, people in work want quick, convenient care; older people want continuity and a focus on their social needs; those with long-term conditions want well-coordinated, efficiently planned care: people with intensive needs want care that comes to them.

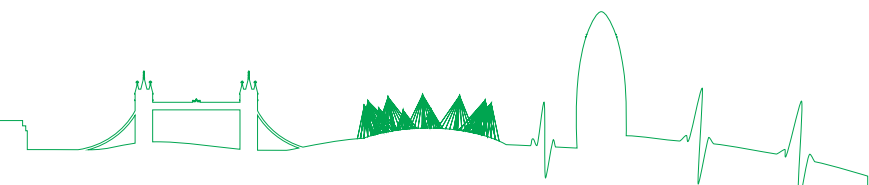
We believe that care should be more personal, planned around groups of people with broadly similar needs, rather than around groups of professionals with broadly similar skills. Rather than care provided around primary versus secondary, or mental versus physical, we should strive towards a system that holistically considers all aspects of care for a particular individual.

This understanding of the different needs of different groups is the foundation of the new approach proposed by this Commission. We propose a system in which care is provided for groups of similar individuals, in which people are treated as people, unique and complex, not as an ailment, condition, or piece of anatomy.

So, our maxim: start with Londoners, not London's NHS. Start with people and how best to meet their needs, their wants, and their expectations – not those of the system. Practically, it means more joint teams in the community, more joined up working, and more integration between health and social care. Complexity should be no barrier to quality.

A lot of my patients and a lot of people really have multiple issues, and we almost see that as a bad thing; that people are wrong because they have lots of different things that don't fall neatly into our categories. Actually people do have multiple issues, we have single issue services and we need to deliver services that recognise the complexity of the people that we are working with, rather than say, 'You have a left leg and I do right legs'. It is that simple.

Dr Tim Spicer, GP, Chair Hammersmith & Fulham CCG



Organising around groups with similar needs

Our approach is based on the idea that it is possible to group the population around similar needs. This means believing that two people with long-term conditions will have more similar care needs than a person with no long-term condition, or that two people with severe and enduring mental illnesses will be more similar than someone without one of these conditions.

We propose that care be designed around these groups, with joint teams working across specialties and current organisational boundaries to provide care. This would mean that a single team would be accountable for the mental, physical, and social care for people in different groups.

For example, this could mean that, rather than referring people with multiple long-term conditions to an array of outpatient appointments with different hospital-based specialists, we might have a team of specialists based in the community providing specialist advice directly to patients and GPs.

Similar does not mean the same. For example, a man in his 20s who has an inhaler has different needs from a man who is 55 and has chronic breathing problems. Yet the health and care system should ask the question in both cases about whether they need a care plan, in a way that they would not for someone with no conditions at all.

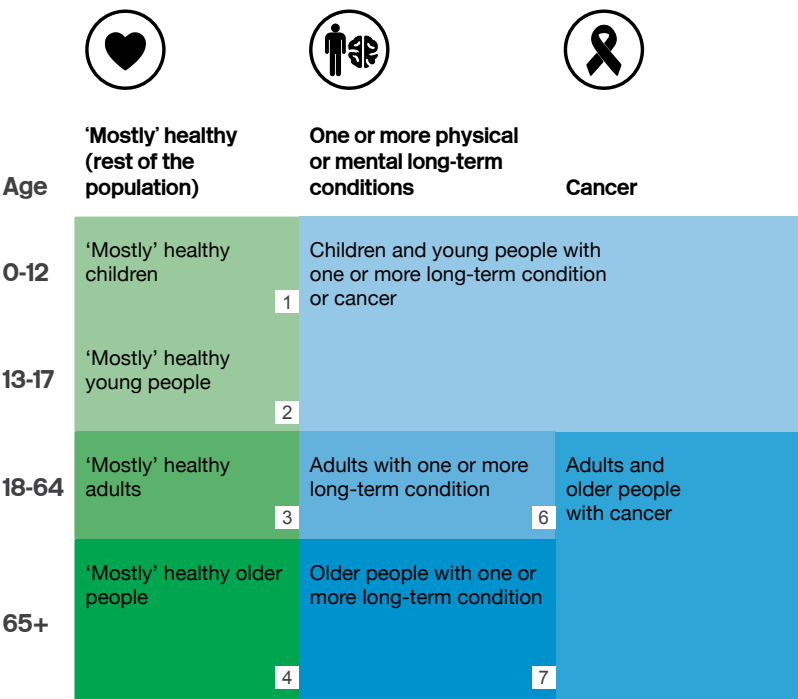
Care needs to be more personal, which means tailoring care to individual needs. Our approach is to achieve this by grouping the population by needs that are similar. A universal health system can't offer a bespoke service – London can't have eight million care models. But it can tailor care so that it is better suited to individual lives.

Personalisation needs to be clearly defined as identifying what the patient needs, healthcare or otherwise, and wrapping the services that address these needs around the individual. Increased emphasis is needed on pathfinders or navigators who can co-ordinate care and enable people to access care.

Participant, Alzheimer's Society and Care UK focus group

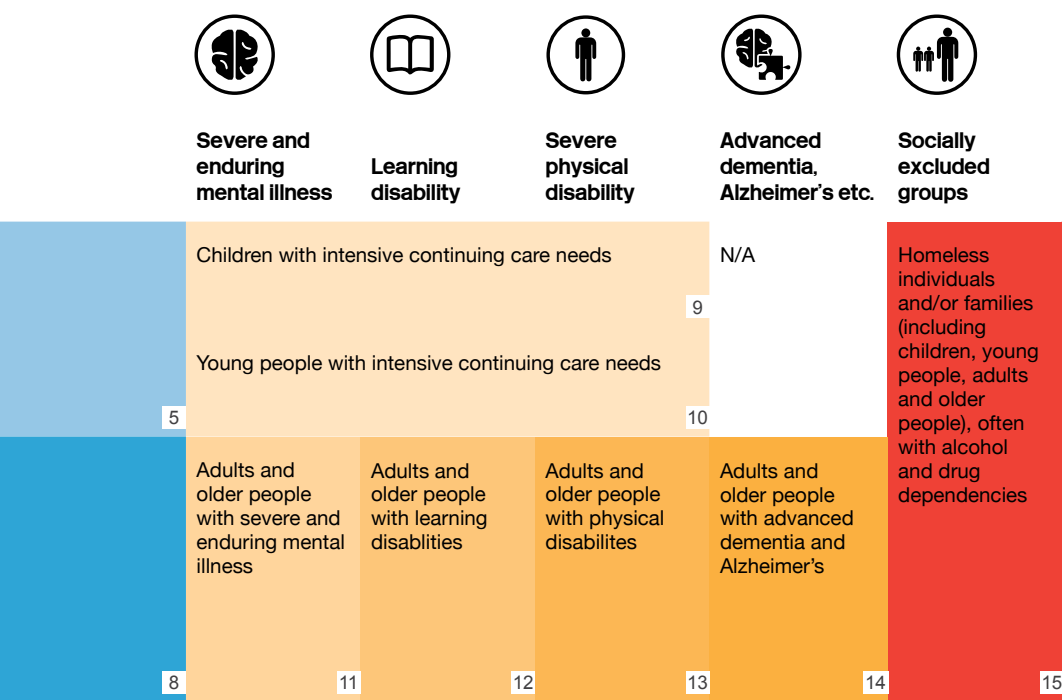
Principles of grouping

The groupings proposed by the Commission are based on the excellent work to develop this methodology by the 'Whole Systems Integrated Care' programme in North West London for adults, and applied to children and young people by Southwark and Lambeth Integrated Care. The grouping methodology was developed through a partnership between health and care professionals, lay partners, and experts, who considered a range of in-depth analysis of data from across health and social care as well as international evidence.



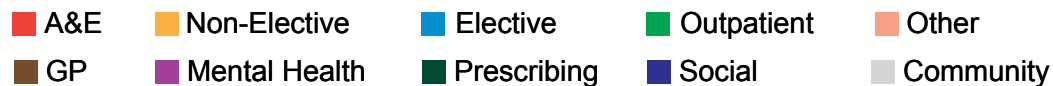
Four important principles underpin the definition of a group:

- 1. Broadly similar needs.** The first principle is that people in a group should have broadly similar needs – so that two people in a group are more similar to each other in their needs than they are to people in another group – based on specific characteristics that most define their care. For example, ‘severe and enduring mental illness’ is likely to characterise a person’s needs in a way that common mental health problems would not. ‘Severe’ physical disability includes only those who are FACS (Fair Access to Care Services) assessed as having substantial or critical needs. Someone who is registered as blind, but who has diabetes and Chronic Obstructive Pulmonary Disease (COPD), will remain in the long-term conditions group, because that is likely the primary need. Each grouping must consider a person’s physical, mental and social needs holistically.
- 2. Stable over time.** Groupings should be largely stable over time, so that care can be planned and organised with a long-term view. So, for example, most groups include conditions that are irreversible (such as long-term conditions like COPD). They do not include care that is episodic, such as needing elective surgery or pregnancy.
- 3. Based on good judgement.** Groupings should allow for individual professionals – in dialogue with patients – to assign a person to the group that works best for them. There will always be some exceptions – no approach to planning care is going to be perfect.
- 4. Budgets set for whole groups.** The final principle is that budgets should be set for a whole population group, not a single individual. Ultimately, the health and care system must provide for people’s needs, so there should be no question – explicit or implied – that spending is in any sense capped.



Services used by the 15 population groups

Key



'Mostly' healthy children 0-12yrs

Proportion of total cost per care setting, %



Total spend
£2.10bn

Spend per capita
£1,515

Population size
1,390k

'Mostly' healthy young people 13-17yrs

Proportion of total cost per care setting, %



Total spend
£0.38bn

Spend per capita
£860

Population size
442k

'Mostly' healthy adults 18-64yrs

Proportion of total cost per care setting, %



Total spend
£3.43bn

Spend per capita
£735

Population size
4,661k

'Mostly' healthy older people 65+yrs

Proportion of total cost per care setting, %



Total spend
£0.94bn

Spend per capita
£2,860

Population size
328k



One or more physical or mental long term conditions/cancer 0-17yrs

Proportion of total cost per care setting, %



Total spend
£0.12bn

Spend per capita
£3,395

Population size
38k



One or more physical or mental long term conditions 18-64yrs

Proportion of total cost per care setting, %



Total spend
£1.93bn

Spend per capita
£2,295

Population size
842k

One or more physical or mental long term conditions 65+yrs

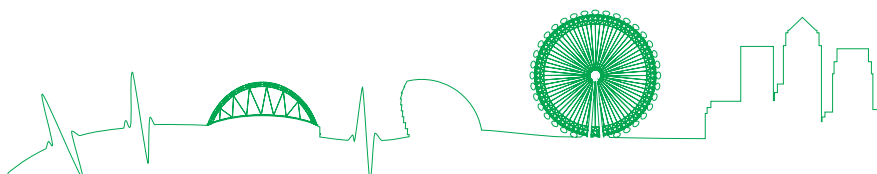
Proportion of total cost per care setting, %



Total spend
£1.89bn

Spend per capita
£3,908

Population size
484k





Cancer 18+yrs

Proportion of total cost per care setting, %



Total spend

£0.75bn

Spend per capita

£11,750

Population size

64k



Intensive continuing care needs 0-12yrs

Proportion of total cost per care setting, %



Total spend

£0

Spend per capita

£8,747

Population size

0



Intensive continuing care needs 13-17yrs

Proportion of total cost per care setting, %



Total spend

£0.01bn

Spend per capita

£8,083

Population size

1k



Severe and enduring mental illness 18+yrs

Proportion of total cost per care setting, %



Total spend

£1.36bn

Spend per capita

£22,024

Population size

62k



Learning disability 18+yrs

Proportion of total cost per care setting, %



Total spend

£1.46bn

Spend per capita

£57,295

Population size

26



Severe physical disability 18+yrs

Proportion of total cost per care setting, %



Total spend

£3.16bn

Spend per capita

£38,039

Population size

83k



Advanced dementia, Alzheimer's etc. 18+yrs

Proportion of total cost per care setting, %



Total spend

£0.34bn

Spend per capita

£19,317

Population size

18k



Socially excluded groups 0+yrs

Proportion of total cost per care setting, %

Total spend

~£0.03bn

Spend per capita

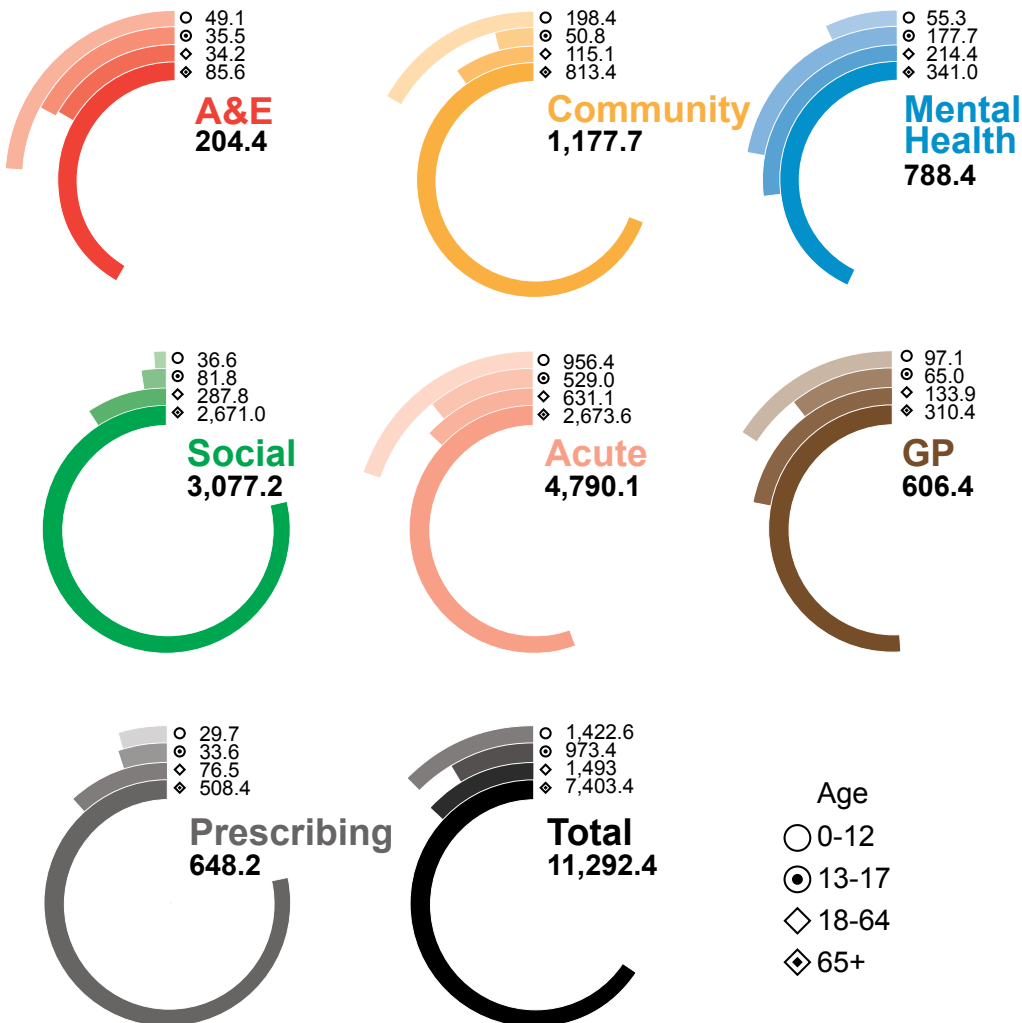
~£4,000

Population size

~7k

One way of understanding need is looking at how different age groups use different settings of care

£s per capita



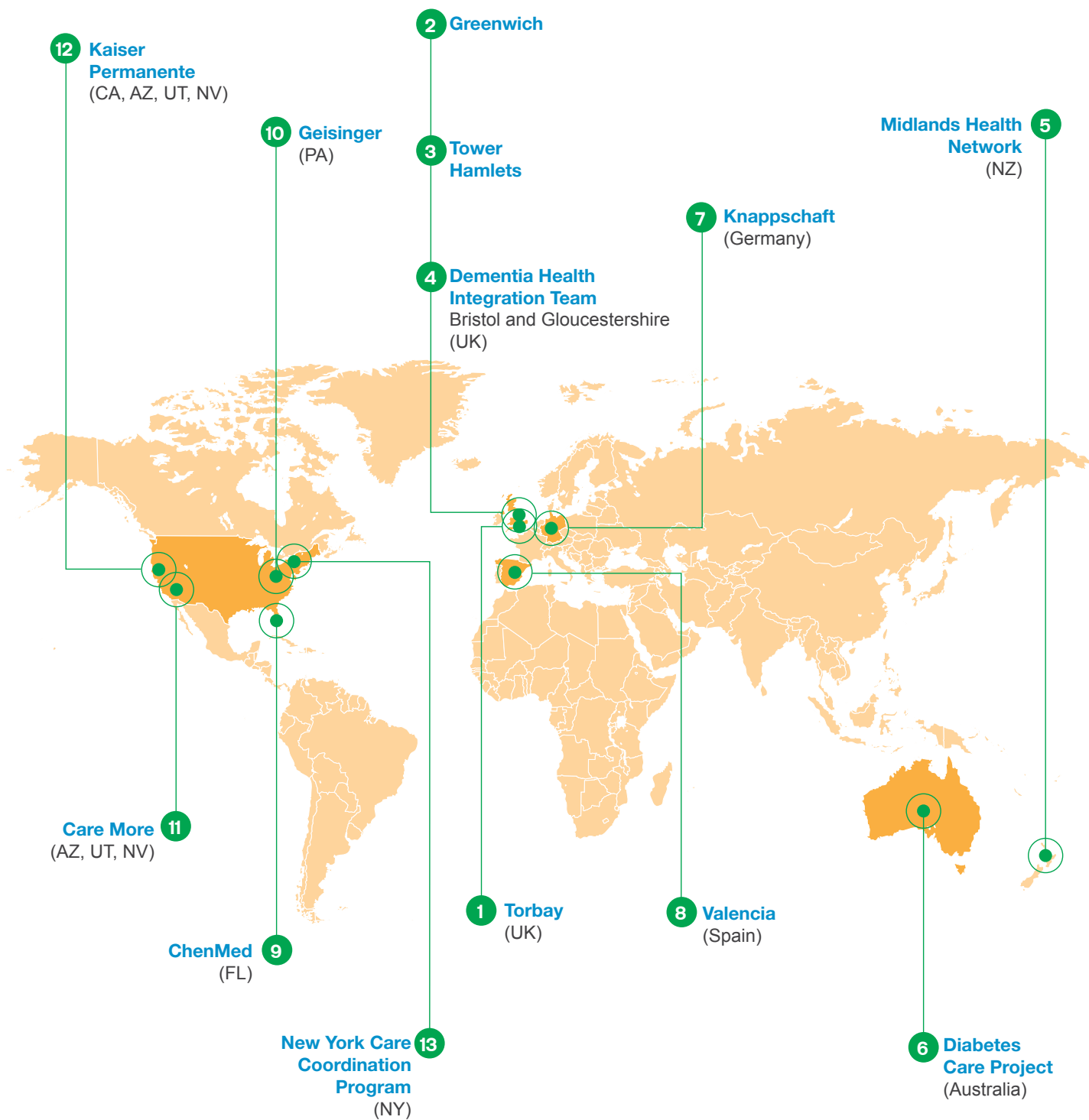
Recommendation 17

Health and care commissioners should commission holistic, integrated physical, mental and social care services for population groups with similar needs, with clearly defined outcomes developed by listening to people who use services.

The Commission has drawn a detailed 'map' of all 15 of these groups, reflecting the above conclusions and many more besides. These detailed population group maps are included in the evidence available on the Commission's website.



Global case studies reviewed by the Commission



3.2 Empowering people

Empowering people to have a more active and dynamic role in their own care is central to providing better and more personal care. People who use services and the professionals who provide care must work together as partners.

Empowering people in their own care involves three core steps. First, we need to listen to our people about what matters to them. Second, we must include patient voices in addressing these areas of concern, and give patients an active role to participate in re-designing the system. Finally, we must all work together to better educate people about their conditions, and empower them to work in partnership with their providers.

Listening to Londoners

In developing the new approach to more personal care, it was important for the Commission to engage, listen, and understand what 'real' people wanted from their care. The Commission's work to understand these issues among patients established the following:

- **Help to stay healthy.** A large proportion of Londoners live without major conditions and/or are not accessing the health and care system for diagnosed needs. Much of our city is healthy – or mostly healthy – and we should make sure the NHS helps people to stay well. Too often it is a national sickness service rather than a national health service.
- **People are open to innovation and to more self-care and self-management.** Over 50% of people with long-term conditions had never discussed self-care or self-management options such as training or education courses, support networks, or better health information. There was interest and willingness for technological solutions such as consultation by skype or smartphone across the board – including from older people with long-term conditions who were keen on telephone consultations and self-monitoring their condition.
- **London's GPs must be the accessible heart of new approaches to care.** There was agreement that the GP should coordinate care – older people with long-term conditions felt most strongly about this with 70% in agreement. Seeing the same doctor was relatively important for about half of all groups and especially for older people with long-term conditions. Access, however, is still a challenge, with roughly half of adults saying they had significant issues getting a convenient appointment, and about 35% of older people saying this.
- **Improving care for older people is vital for sustainability.** Those aged 65 and older have the greatest number of health issues; care for the average elderly person costs over five times the amount as for the average individual aged from 18-64. Managing this group's care better will be critical to ensuring sustainability of health and social care in London.
- **People with long-term conditions need to be better supported to manage their conditions with more integrated care.** People's health needs to be appropriately stabilised so that their conditions are not exacerbated. Among older people with long-term conditions, 50% felt that their health and care was not well managed, 75% of them did not have a personal care plan and only 10% had agreed one in the last 12 months.
- **Major opportunities to secure better care for those with disabilities.** Despite being a smaller proportion of the population, those with physical and learning disabilities cost the health and social care system a very large amount of money; per person – costs per person vary from £37,000 to £57,000 per year. Understanding how this money is spent in improving outcomes will be important in ensuring the right care for these people in particular.
- **Care for people with severe and enduring mental illness should be better.** London spends around £1.4 billion on around 62,000 patients with severe and enduring mental illnesses. London is often accused of being weak on improving outcomes for these people. Understanding how care can be improved is important given the large amount of money spent here.



- **London should be a dementia-friendly city.**
72,000 Londoners are living with dementia, two thirds of whom remain at home. Nearly 40% of people with dementia feel lonely, and 1 in 3 only leave their homes once a week. More awareness and support is necessary, an agenda being advanced by the London Dementia Action Alliance, in a city that has a long way to go to improve life for some of its most vulnerable citizens.

Working together in partnership

There are many opportunities to improve health and care in the capital. Yet perhaps the greatest opportunity is to forge a stronger, deeper partnership between people who use services and the professionals who provide them.

In today's world of a ballooning burden of long-term conditions, people expect to be partners in their care, making the decisions that best suit their needs. Dialogue with people who use services needs to be reframed, and made more personal, changing from 'what is the matter?' to 'what matters to you?' We must create lively forums during all re-designs of the system that actively engage the members of the public for whom these changes will matter the most.

During its evidence-gathering phase, the Commission found that the best work on improving the health and care system came where people who use services are embedded throughout the design of those improvements. Experience has demonstrated that so-called 'lay partners' can positively contribute to everything from defining care outcomes and care models through to the most technical discussions on NHS finances.

Health and care professionals are cherished by Londoners. Those professionals must renew the bond that exists between them and the people who use services. This can be achieved through a new era of mutual respect, sincerity and appreciation of the contributions that everyone can make.

Recommendation 18

Health and social care professionals should partner with people who use services to ensure that their voice is heard in designing and implementing improvements to care.

Helping Londoners look after themselves

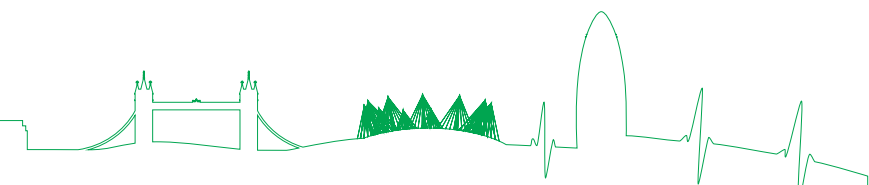
Londoners want to be able to look after themselves. They expect the health and care system to be there when they need it, but also to help them to help themselves. Perhaps counter-intuitively, people with the greatest health needs were amongst those who expressed the greatest desire to do more for themselves. Londoners want and expect to be able to take control of their health and their care.

It is clear that patients want more control over their health and that the NHS would be 'pushing at an open door', working with patient enthusiasm, rather than against it.

Patient Information Forum

I am an A&E consultant, so many of the people we see are effectively the product of the failure of the system. When bits of it don't work, you end up in A&E, it is the only place that is always open. I would like to change that model, because in almost every other aspect of our lives these days, as members of the public, we take control of what happens to us.

Dr Simon Eccles, Consultant in Emergency Medicine, Guy's and St Thomas' NHS Foundation Trust



The Commission's research has found that different parts of the population approach self-care differently. Some of the most important themes were the following:

- 'Mostly' healthy adults want greater support for self-care through easy access to medical information and health advice online.
- The parents of 'mostly' healthy children want more support to help keep their children well. This means more education, ease of access through use of technology, and regular communication with healthcare professionals, including the school nurse.
- 'Mostly' healthy older people are keen to have a personal care plan for physical and mental health, reviewed and updated yearly. They also want support for self-care, to manage minor ailments, and signposting to online resources to diagnose minor ailments and promote health literacy and wellbeing.
- Adults and older people with cancer say they want access to better health information and education on prevention, early signs of cancer, self-care, and treatment. They also want enhanced support at home for both themselves and their carers.
- Adults and older people with learning or physical disabilities want patients, carers and families to have direct access to health and social care information and education, as well as access to local support groups, and for services to be provided consistently across London.

To help people look after themselves more easily, it is vital to ensure they have the information they need. Partly, this is about better provision of information and about education, but it is also about encouraging an interest in health. Likewise, there must also be education for healthcare professionals to understand the capacity people have to look after themselves.

The Commission believes there is an opportunity to explore enshrining self-care and education about self-care in a more formal way, to give those who need it more authority and power to make the choices that will result in better care for them, in a way which is specific to their needs.

Recommendation 19

Health and care commissioners and the voluntary sector should promote the implementation of shared decision making, care and support planning, education for self-management, personal health budgets, and access to health records so that London becomes an exemplar in improving people's participation in their own care and treatment.

Recommendation 20

Health Education England, NHS England, and professional regulators should work together with the voluntary sector to develop education programmes for self-management of long-term conditions, which would enable more peer support and empower programme graduates to self-prescribe their own medication for their own condition.

3.3 Empowering professionals and providers for better care

More integrated care

For any individual, health is not a divisible concept. Rather, it is the health system that has chosen to create divisions in care. It is vital that care is more integrated, bringing together professionals with different skills in partnership with people who use services. This means providing care in multi-disciplinary teams, bringing health and social care together, and working more effectively across settings.

People living with long-term conditions and intensive continuing care needs are currently not receiving the best care that they could be which impacts on their quality of life and outcomes. There is a need for a more joined up approach with health and care working collaboratively.



More must be done to join up care. Today, three-quarters of people who have more than one long-term condition say their conditions are treated individually rather than as a whole. Nearly half of people under 65 say that they have to repeat their health history every time they see a health or social care professional.

The Commission found that people with long-term conditions wanted support to maintain their independence rather than solely to live longer (77% aged 16-64, 81% aged 65-74, and 84% aged 75+). Our system should be set up to support this with care coordinated with not only improved general practice but improved community services – pharmacy, district nursing, community nursing, allied health professionals, clinical scientists and social care services – all working together, and closely with the voluntary sector, taking a multi-sector approach to manage and care for patients differently.

Community services play a vital role in providing better joined up care for those that need it. There is a need for service providers and commissioners to work together, focusing on delivering better outcomes and placing people at the centre with services designed and delivered around their needs.

People with mental illness typically have poorer physical health than the general population; fewer than 30% of people with schizophrenia receive the recommended physical health checks; life expectancy for people with severe and enduring mental illness is 10-15 years lower than for the general population.

The Commission has discussed this challenge with the leaders of all the mental health trusts in London, who have committed to a set of shared ambitions for mental health care. They have set the goal to make a 10% improvement in life expectancy for people with psychosis within 10 years. They will lead an all-London, all-agency pledge to identify and treat psychosis in half of cases within two weeks and all cases within eight weeks of the first signs and symptoms.

For people who are under their care, London's mental health trusts pledge to proactively offer access to smoking cessation, blood pressure monitoring and treatment, and effective weight management programmes.

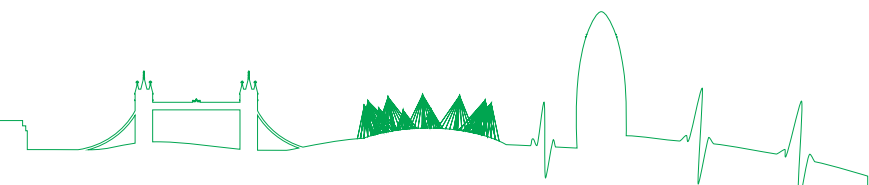
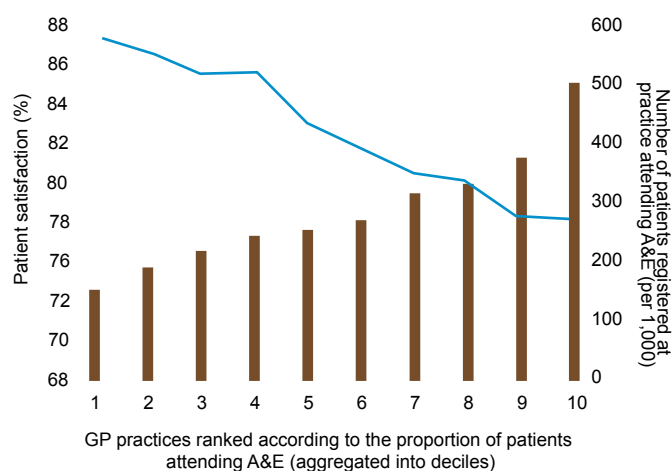
Similarly, at least 30% of people with a long-term physical health condition also have a mental health problem, and one third of GP appointments involve mental health issues. This is why it is vital that people's needs are addressed holistically.

Better GP care

Providing better and more personal care for Londoners means helping our GPs provide better care. For the vast majority of people in London, their local GP is the NHS. For many, the only contact they will have with the NHS in any given year – often for many years – is when they see their GP for occasional aches, pains or illnesses. And when they are more seriously sick, GPs act to coordinate care, referring patients on to hospitals or specialists.

It follows, therefore, that GPs will always be at the centre of any system-wide, capital-wide attempt to improve the health of London and Londoners. The Commission firmly believes that GPs are one of the greatest strengths of London's health system. Yet it also observes the urgent case for change, for both patients and professionals alike.

Poor satisfaction with GP services correlates with increased use of A&E



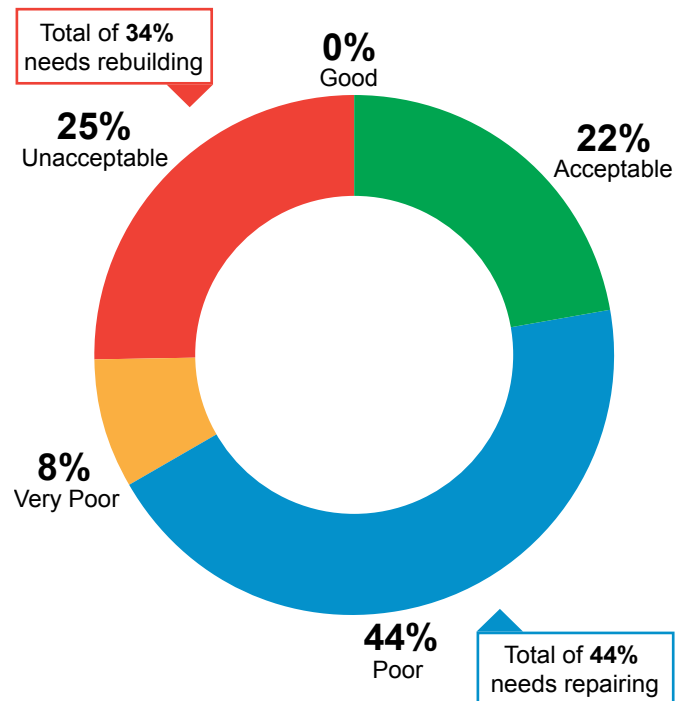
I think we are part of the health service which is very popular and praised by patients but we ourselves know that we are also broken. The access to general practice is not as good as we would like it to be... it is the Cinderella service. It is the poor sister, which is also, I would say, under-resourced and with too little focus.

Dr Tom Coffey OBE, GP, Wandsworth CCG

London's GPs are under unprecedented pressure. GPs face a rising workload, falling numbers, and a poor working environment, whilst spending is tumbling as a percentage of total expenditure on health:

- A 23% rise in consultations is expected between 2001 and 2021 due to a combination of rising workload, increasing complexity of care needs and the expectation of a growing range of services
- The proportion of GPs making up the medical workforce in London fell from 31% to 27% in the 10 years between 2003 and 2013
- GP premises in London are typically poorly converted residential buildings, 33% of which need to be rebuilt and 44% of which need substantial repairs, meaning a poor working environment for many of the capital's doctors
- A smaller share of the total amount of money spent on healthcare in London is going into GP care – as a proportion of total spend on healthcare in London it fell from 10.8% in 2004/5 to 8.4% in 2011/12.

Proportion of GP premises that do not meet disability access requirements



Perhaps not surprisingly, GP services in London are not as good as they should be. Nearly two-thirds of London practices perform worse than the England average in overall patient satisfaction. (Not only is low satisfaction a problem in itself, it is correlated with higher A&E use.) Access is variable, with 60% of practices in London performing worse than the England average, and the worst out-of-hours access score in the country. Referrals to outpatient departments by London GPs are around 40% higher than the England average.

The Commission believes that general practice needs more investment and more reform. Not one or the other but both. Investment without reform is irresponsible. Reform without investment is unachievable. Investment with reform is the only path forward.



GPs need to be educated and better informed about getting patients to think about health not illness.

Member of the public at the Imagine Healthy London Roadshow at Bexleyheath Broadway

Need to increase GP services and access. Having to wait several weeks for an appointment means you give up and often ignore minor problems that then become major.

Member of nursing staff at the Imagine Healthy London Roadshow at University College Hospital

Investing in London's General Practices

The health system must honour its rhetoric of more care closer to home with its financial choices. More investment is needed in both primary care facilities and in staff. This investment is needed precisely because it is the path to a health service that is high quality, that is affordable and that is sustainable.

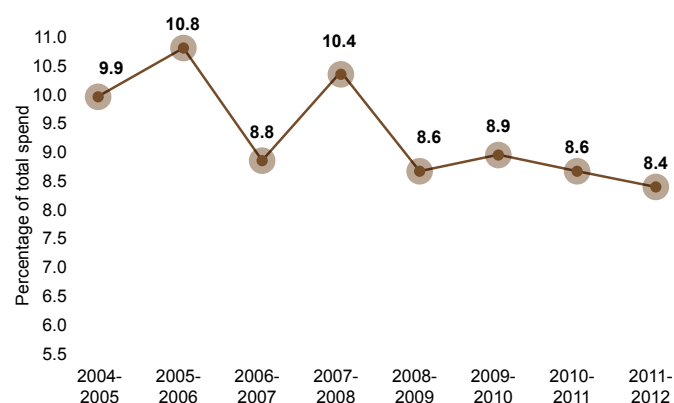
First, we must provide a modern practice accessible to every Londoner. Professionals deserve to work in modern GP practices, and patients deserve to be seen in them. The quality of facilities impacts on the quality of care, and London is letting both its patients and its health professionals down.

It is unacceptable that more than a third of London's GP practices are unable to comply with the Disability Discrimination Act. GP practices have faced chronic underinvestment, there is a lack of clear standards for these facilities, and GPs are not properly incentivised to invest in their practice buildings.

That is why the Commission proposes an investment programme totaling £1 billion of public capital over the next five years. The Commission has calculated that this would enable every Londoner to be treated in a purpose-built or purpose-designed, modern facility.

Many of these new or refurbished facilities should be co-located with other services, including diagnostics, specialist care, and social care, perhaps through a 'hub and spoke' model. The best models should be determined locally.

Proportion of spend on general practice by commissioners in London 2004-2012



It is vital that these investments are planned and managed through a partnership of CCGs, NHS England, and local authorities, and with appropriate professional consultation. The opportunity to include wider public services – such as employment, child care, libraries and education – should be explored.

This scale of investment would represent just 4% of the national NHS capital budget over the next five years, and 26% of London's share (assuming it is equally distributed across the country based on population).

Recommendation 21

The Department of Health and NHS England should launch a five-year £1 billion investment programme in GP premises so that all Londoners are able to access care in modern purpose-built/designed facilities.



Second, we must ensure there is fair investment in general practice. Over the past decade, investment in general practice has declined as a proportion of total spending on the NHS, despite successive governments committing to care closer to home.

The Commission believes that NHS England should rebalance expenditure from specialised services to primary and community services, specifically general practice. There should be an increase in the proportion of expenditure on primary care each year for the next five years.

Recommendation 22

Health commissioners should increase the proportion of total London NHS spending dedicated to GPs and primary and community services and facilities.

Joining investment with reform

Investment must be met with reform. The GP community needs to revitalise itself to improve access, raise quality, and achieve more integrated care. Londoners should be able to expect better care. Instead of various GP practices offering a wide and unpredictable variety of services of varying quality, there should be a clear range of services which patients can expect in their own or a neighbouring practice.

Raising standards, matching care to needs

The old systems that drive regimented appointment times should be set aside, and care should better reflect the different needs of different patients. Today, many GPs will spend significantly longer with older patients or those with multiple long-term conditions. The system as a whole, however, is too geared towards the 10-minute appointment.

In the future, GPs should be expected to deliver consistently high standards of care, and should be empowered to respond more flexibly to the different needs of different groups in the population. As new standards become commonplace over time, they should become increasingly ambitious, and more differentiated to reflect different needs of population groups.

Londoners should be able to select practices that best serve their needs, based on clear information, choice and ease of switching from one practice to another. Finally, technology used to access care should be more prevalent, and more up to date.

Try and keep one GP (in multi GP practices) to follow through referrals/follow-ups/treatments for each patient to ensure continuity. GP open on weekends/evenings would definitely take a load off of A&Es, with easier and immediate appointments for emergencies.




Member of the public at the Imagine Healthy London Roadshow at Country Fair Eastbrookend Country Park, in Barking and Dagenham

Recommendation 23

Commissioners should set ambitious new service and quality standards for GPs in London, tailored to the different population groups of patients they serve.



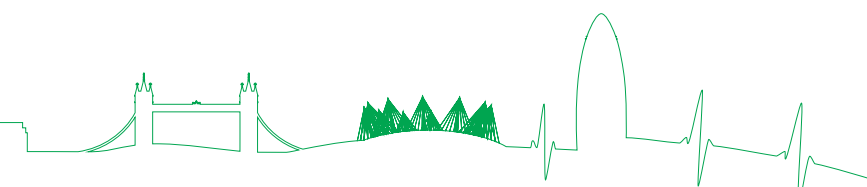
We asked Londoners what they expected from general practice, and this what they said...

		
Proactive care that supports healthy lives	Coordinated care that supports people with complex needs	Access options that suit people's different needs
<p>Patients should be involved in co-designing services – particularly people with long-term conditions or disabilities, and their carers, who are often experts in their own needs and the care that works best.</p> <p>GPs should be able to signpost patients to local activities and groups that can improve their wellbeing, life satisfaction, general mental health, and which can reduce feelings of isolation – particularly for older people and carers.</p> <p>GPs should act as gatekeepers for healthy lives, referring patients to public health services, such as smoking cessation, where appropriate.</p> <p>Routine mental health screening should be offered by all practices, to enable early detection of possible symptoms of depression and other mental illnesses.</p> <p>Prevention should be part of everyday business – this is particularly important for people who do not access services very often or who may not be registered.</p>	<p>Care should be customised to individuals, including the provision of personalised care plans that treat people holistically. Care plans should adapt as people's needs change.</p> <p>Patients who have complex needs and need coordinated care should receive multi-disciplinary reviews to enable all of their conditions to be treated as effectively as possible.</p> <p>Care should be coordinated between general practice and other healthcare providers, as well as social services, to ensure all patients receive seamless care.</p> <p>There should be improved coordination with secondary care particularly following discharge from hospital or treatment.</p> <p>Information sharing between providers will mean that patients are treated by health professionals with up to date knowledge of their health status and needs.</p>	<p>People should have rapid and convenient access to GPs at a time and location that suits them – for example, near to a person's workplace for the working-age population.</p> <p>Flexible offering of appointments, including time of day, same-day appointments, advance bookings and being able to request a named GP, should make it easier to get an appointment at a convenient time with a GP who knows patients' medical histories and who is familiar with their conditions.</p> <p>People should be able to access a wider range of services within a network of GPs, with extended opening hours and appointments available seven days of the week.</p> <p>People with long-term conditions or complex needs should be able to request longer appointments with GPs they know.</p> <p>Flexible ways of booking and holding appointments (e.g. online, Skype, email) would make it easier for people to get appointments – particularly younger people who are more open to using technology.</p>

Ending professional isolation through more collaboration

As the Commission has noted, the size of practices has a big impact on their ability to provide a wider range of services and offer more integrated care. While there are many small practices with good continuity of care and high satisfaction ratings, they are simply not set up to offer a modern range of services, and are affected by professional isolation. Working within networks can address this and many of the other issues facing GPs.

Working at network as well as practice level to improve quality and outcomes increases peer support, and helps to provide seven-day care by sharing workloads. It can achieve economy of scale through sharing 'back office' resources, and improves the ability to attract and retain the workforce through merging part time positions and creating opportunities for career progression. It will also enable GPs to support collaboration with other providers, which will enable multi-disciplinary teams to deliver more coordinated, person-centred care.



Recommendation 24

NHS England and CCGs should promote and support GPs working in networks to reduce professional isolation, to provide a wider range of services and to provide more appointments at more convenient times.

More convenient care

Today, most people still register with just a single practice. While this will remain the best option for many people, such as those with long-term conditions or older people, for others such as healthy working adults, this may not be the most convenient option.

If patients in London were able to access a network of practices, it would make care much more convenient and accessible, support the development of scale by practices, and enable networks to be either local or non-geographical, for example offering practices in stations and near people's homes.

This would need to be supported by clear clinical governance, shared funding for patients, and integrated information systems. But the Commission believes this would have a dramatic impact on the convenience of GP care in London and it would be very strongly supported – 92% of Londoners polled by the Commission said they thought seven-days-a-week GP services were important.

I work in London but live in Kent. It would be good to be able to drop in to a GP near my work.

Member of the public at the Imagine Healthy London Roadshow at The Cray Festival, in Bromley

Recommendation 25

NHS England and CCGs should allow patients to move freely within GP networks, so those registered with one GP practice are able to access services from other practices within the same network.

Tough decisions for better care

In some areas, GP care has been persistently and unacceptably poor, despite successive improvement efforts. The Commission believes that every Londoner is entitled to high quality care, not just some Londoners.

Where local GP practices have persistently failed to improve, NHS England and CCGs should work together to allow new providers – perhaps other, more successful local practices – to set up new GP services, perhaps by offering 'capitation premiums'.

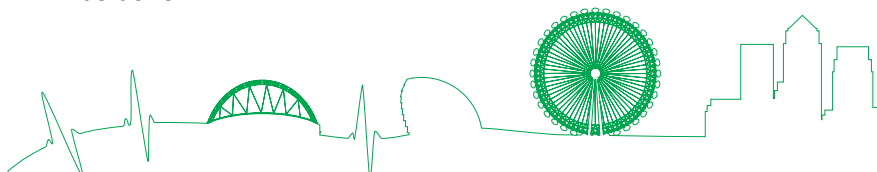
Recommendation 26

NHS England and CCGs should put in place arrangements to allow existing or new providers to set up new GP services in areas of persistent poor provision in London.

Better urgent and emergency care

Londoners rightly expect the NHS to provide consistently high quality care seven days a week. Yet the evidence shows important variations in outcomes for patients depending on the day of the week that they are admitted to hospital as an emergency. If mortality rates at the weekend were the same as during the week, analysis suggests that perhaps as many as 500 lives could be saved.

London is taking this agenda forward through the application of 'London Quality Standards'. These are helping to promote improvement and move the capital's providers towards more consistent quality of care across every day of the week. More remains to be done.



3.4 Better specialist care

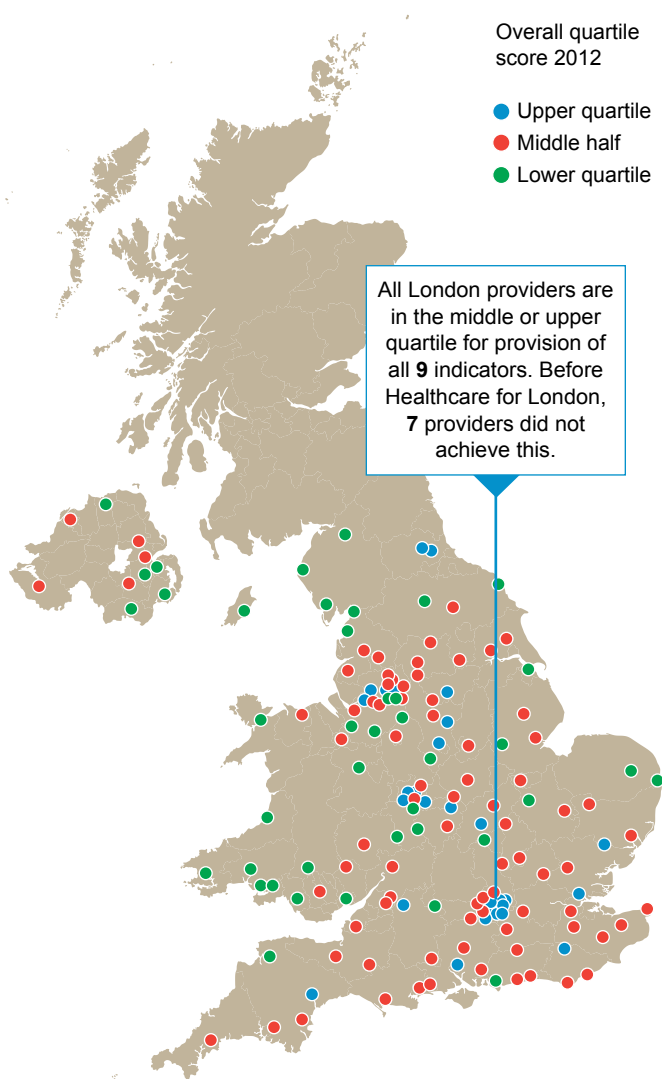
In order to provide better, more personal care, we must also improve our specialist services. Many recent reforms in the type and quality of specialist care in London have been very successful. For example, the Healthcare for London programme set out ambitious proposals for specialist care to be provided at scale, to ensure care was carried out by the most skilled professionals with the best equipment available.

While further progress based on these important, life-saving principles has been made in London, still there is much more to do in specialist areas like cardiovascular, cancer, and elective orthopaedic services in particular.

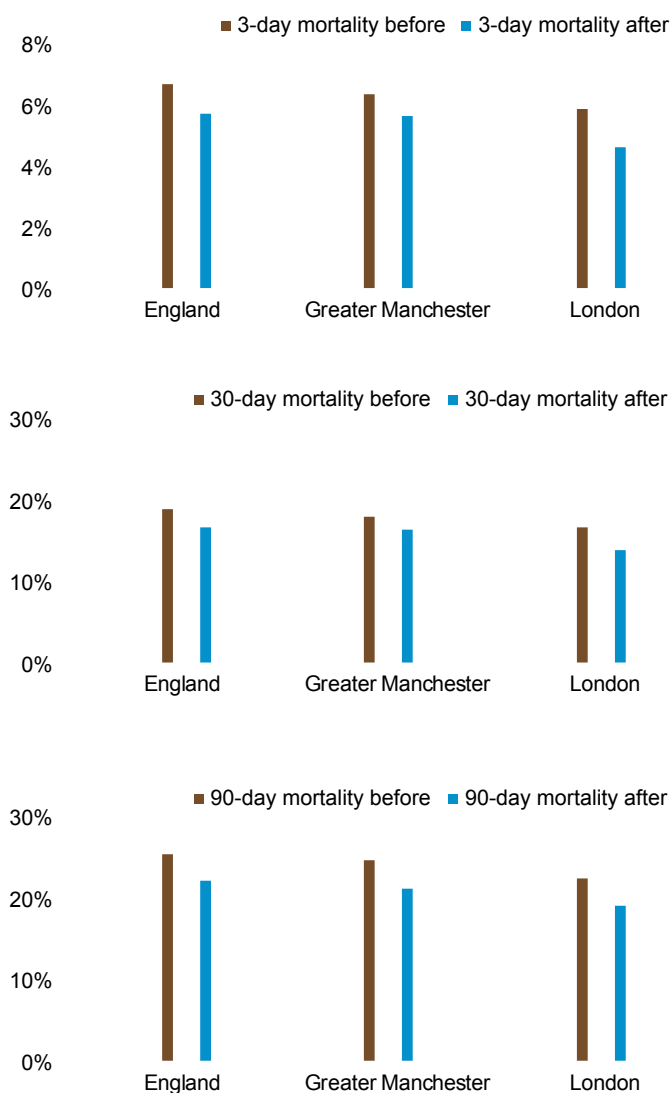
More widely, the Commission believes that the momentum created by life-saving initiatives for specialist care like Healthcare for London should be given new impetus. Other parts of the specialist care system that could benefit from the same approach should be actively directed towards reform, and those programmes which are already under way should be accelerated.

Specialist centres of excellence produce better outcomes

Patients receiving all 9 indicators (bundle of care)



Mortality rates before and after reconfiguration



Cardiovascular services

In 2008, only seven of the 19 sites in London performing emergency and elective arterial vascular surgery met minimum recommended volumes. By 2013, fewer hospitals were performing low volumes of procedures, and the highest mortality rate following elective abdominal aortic aneurysm repair by any London provider was 3.6% – a dramatic drop from 8.5% just five years earlier. These successes should be celebrated.

Consolidating the existing providers of cardiovascular procedures into specialised centres of excellence would cement these improvements further. Proposals to change vascular services in North Central and North East London have been approved – when implemented, they are expected to save 1,000 lives per year. This will result in the largest cardiovascular surgery centre in England, at the Bart's Heart Centre. Proposals for South and North West London are yet to be announced. With so many lives at stake, London's NHS must finish the job.

Cancer services

Despite some progress in recent years – fewer, better units now treat rarer cancers, for example – cancer services as a whole are in need of significant improvement. In the past year, cancer patients in England have rated nine out of the 10 worst trusts as being in London. Services are fragmented, there is not enough cancer specialisation to make the most of the latest advances in treatment, and not enough patients are involved in clinical trials.

Two Integrated Cancer Systems have been established: London Cancer (North Central London and North East London) and London Cancer Alliance (South London and North West London). London Cancer has proposed to consolidate some rarer cancer services into five specialist centres of excellence and proposals for change are expected from London Cancer Alliance in 2015. The pace of change must be accelerated if care is to be improved.

Elective orthopaedic services

Finally London needs to consider improving the provision of elective orthopaedic services, such as hip replacements.

Patient outcomes for patients undergoing elective orthopaedic procedures currently vary depending on where Londoners live and are treated. In some areas they are eight times more likely to develop an infection while in hospital, in others they may stay in hospital for up to a week longer. Some patients will wait less than nine weeks for elective treatment and some will wait for more than 19 weeks.

An elective orthopaedic centre has been established in South West London, which achieves excellent outcomes for patients, but change has not been achieved across the whole of London, and not quickly enough. A similar approach to improving this kind of care should be explored, as a first step towards possible reform of elective orthopaedic services across London.

I think there is a great opportunity for the Mayor and London to drive a real high quality level playing field, getting the right patient to the right surgeon with the critical mass, with the volume and therefore, the best outcomes. You can get the lowest complication rate and you can make massive savings, but the upside is you would improve the quality of care no end.

Professor Tim Briggs, President of the British Orthopaedic Association

Recommendation 27

Health commissioners should improve specialist care by accelerating efforts to create centres of excellence for cancer and cardiovascular services, launching a new programme to review elective orthopaedic services, and ensuring London Quality Standards are implemented.



3.5 Better care for marginalised groups

Better care for people with mental illness

More than a million Londoners will experience mental ill health this year. More than 100,000 of them will be children. Half a million Londoners will experience anxiety and depression. Mental ill health is all around us. It is experienced by our family, it is experienced by our friends, it is experienced by our colleagues – and it is experienced by ourselves. On average, mental ill health affects thirteen people on the busy bus with us in the morning, more than a hundred people on the tube train on their way into work, three of the children in our child's school class, and 10 of our fellow mums and dads.

Mental illness affects a greater proportion of people in London than anywhere else in England. The city itself often exacerbates this, and yet people with mental illness are less likely to receive treatment than anyone else in the health and social care system. Just a quarter of people with mental health problems receive treatment compared to, for example, 92% of people with diabetes and over 75% of those with a heart disease.

Despite the number of Londoners affected by mental illness, the care they experience is often poor. While satisfaction with NHS services is generally high, mental health service users report the lowest levels of satisfaction (69% versus 89% for pharmacists, the highest score).

The outcomes are similarly poor. London should feel deeply ashamed that people with severe and enduring mental illness die more than a decade earlier than those without. That people with mental illness are less likely to access physical healthcare has been known for many decades; little has been done to proactively address it.

Meanwhile the costs of mental health extend well beyond health and social care. Close to £7.5 billion is spent each year on the direct costs of addressing London's mental health problems. Compounding these costs are the costs of lost employment, with only 10 to 16% of people with a mental health condition, excluding depression, in employment, despite 85% expressing a desire to work.

Our mental health care must improve urgently. More can be done to provide ongoing, effective and reliable support for people with long-term mental illness. Here's how:

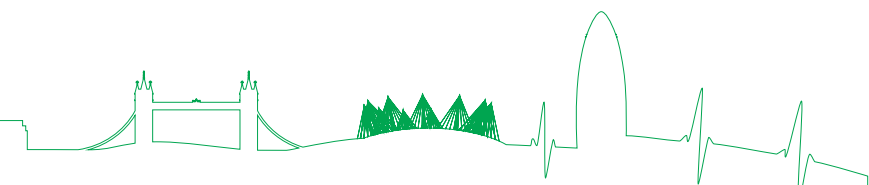
First, we must provide better, more innovative support for people suffering from mental illness. Young people are at particular risk of loss to follow-up, partly due to problems with the transition from child to adult mental health services.

Support for self-care has been shown to be particularly effective in children and young people. The use of smartphones and tablets is widespread among London's young people and the NHS must find ways to adapt to meet the needs of potential mental health sufferers, such as by using smartphone applications to monitor mood. Projects such as the Big White Wall have shown significant outcomes.

Recommendation 28

Health and care commissioners should ensure that all Londoners have access to digital mental health support, in the languages that they speak, and using the latest technology.

Second, we must ensure good access to psychological therapies and early intervention services. These have been shown to have significant benefits in terms of mental wellbeing. Increasing Access to Psychological Therapy (IAPT) programmes have been successful in improving the availability of such services through primary care, as well as providing employment support, advice, and education about the links between physical and mental health problems for people with long-term conditions. However, London has the lowest rates of recovery and improvement associated with IAPT in England, demonstrating that there is still work to do in this area.



Early intervention in psychosis has also been shown to have significant benefits, increasing not only wellbeing but also the employability of people with mental illness which leads to significant economic gains. Despite these benefits, there is a shortage of early intervention services in London, in terms of both diagnosis and subsequent treatment, with waiting times as long as one year or more, meaning that many will hit a point of crisis well before they get treatment.

Early diagnosis and intervention can be encouraged through the mental health tariff, work on which is currently underway. Some 21 care clusters for adults and older people have been developed, with an associated set of evidence-based treatments and interventions available to each group. This has the potential to result in better, more timely care for patients and cost savings to the system.

One of the things we have done quite successfully over the last 20 years, and there are all sorts of problems about the levels of investment in mental health, but we have changed an inpatient, large-institution-based specialty into something that is out in the communities and is vertically integrated, and I think some of it is frankly snobbery from within general hospital care.

**Dr Chris Streather, Managing Director,
South London Academic Health Science Network,
Commission Hearing Session, 8 May**

Recommendation 29

NHS England should strengthen the role of mental health in primary care, with a particular focus on timely access to psychological therapies and early intervention services, and on improving the capacity and capability of GPs to care for people with mental illnesses.

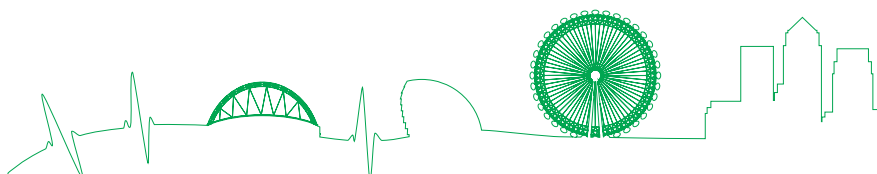
Third, we must improve specialist services. Substantial change is needed for specialist services to reduce the reliance on inpatient care. Bed occupancy for adult psychiatric wards averages 101% whilst the numbers of acute beds are falling. Too many people are waiting too long to get the mental health services they need. And yet, paradoxically, there is too great a reliance on inpatient care – more specialist care should be available in the community, which would relieve the pressure on inpatient beds.

Mental illness is often only diagnosed once people are in crisis, and the health service's focus, and associated spending, is skewed towards treating people at this point. There is a need to redress the balance in favour of prevention, early diagnosis and early intervention in order to limit both the personal and the economic costs of mental illness.

Crisis care itself is in crisis. Too many people cannot get the help they need, when they need it, and experience wards that are neither safe nor therapeutically appropriate. A recent survey revealed that only 14% of people with mental ill health said that they felt they had all the support they needed when in crisis. Mental health service provision across London must be strengthened, with a focus on outcomes.

More joined up working will be vital to address this. The police are an essential partner, often being the first group to come into contact with people in crisis, and responsible for taking them to a place of safety. The Mental Health Crisis Care Concordat, signed by professional groups from within healthcare, social services and policing and due to launch in London in October 2014, is a very welcome development.

Fourth, we must provide more, better care in local communities to tackle the gaps in physical healthcare and diagnosis rates among the mentally ill. Today, one of the most significant issues for people with mental illness is delayed diagnosis. The symptoms are complex, confusing and easily missed resulting in many people going undiagnosed for months or even years. Additionally, physical health amongst the mentally ill is often not treated to the same standard as in the rest of the population.



To tackle these issues, the mental health trusts will lead an all-London, all-agency pledge to identify and treat psychosis in half of cases within two weeks and all cases within eight weeks of the first signs and symptoms – this may seem like a long time but would represent a revolution in detection. Furthermore, for people who are under their care, the trusts pledge to tackle smoking and excessive alcohol consumption, and to improve diet and exercise.

Mental health trusts should proactively offer access to smoking cessation, blood pressure monitoring and treatment, cancer screening and treatment, and effective weight management programmes to all people under their care. Commissioners should ensure that all people with severe mental illness receive an annual health check including cancer screening with an action plan to treat identified health issues. Finally, they will establish an international cities conference, taking place every other year, to share the best ways to deliver excellent care, and to report on progress against their ambitions and pledges.

Recommendation 30

Health and care commissioners should develop a pan-London multi-agency (including the police and ambulance service) case for change and model of care for child and adult mental health patients in crisis.

Better care for homeless Londoners

At any one time, hundreds of people sleep rough in the capital. The numbers are rising, exacerbated by reductions in accommodation and other support due to funding cuts to both the third sector and local authorities. The homeless population has a life expectancy of only 43-47 years, compared with 80-84 for the general population, and is more afflicted by mental ill health than any other population. Often, homelessness reflects not only unfortunate circumstances, but a crisis in an individual's ability to cope with life's challenges.

It is common for people who are homeless to suffer from a number of complex and inter-related health problems, with almost a quarter having physical health, mental health, and substance use needs. This commonly includes drug or alcohol dependence, mental ill health, and respiratory conditions. There are significant public health risks of infectious, multi-drug resistant tuberculosis – indeed, 1 in 10 people with tuberculosis have a history of homelessness.

This is exacerbated by the fact that often the homeless cannot manage their own conditions, due to a combination of chaotic lives, low literacy, poor access to care, and, regrettably, often hostility from health professionals. This makes them much more likely to receive care at A&E or the hospital, which is inefficient and costly and degrades the quality of their care.

Homeless people and rough sleepers are a transitory population, meaning that homelessness is necessarily a London-wide issue. It therefore demands a pan-London approach. While there are examples of good services, they are too often fragmented and poorly linked with mainstream health and care services.

A pan-London approach could be achieved by appointing a single 'lead' integrated care commissioner for London's homeless. This could either be NHS England (London) or one of London's CCGs acting on behalf of all of the others, and working in close collaboration with local authorities for social care and housing needs. This would rely on shared information from across local councils and the health service.

There are successes to build on in London. For example, London Pathway is a model of integrated healthcare for single homeless people and rough sleepers. The Mobile X-Ray Unit in London provides mobile TB screening from a van which visits prisons and homeless hostels. The challenge is for good services to be available across the whole of the capital.

Homelessness instinctively jars with Londoners. The Commission heard a strong message that London needs to act together as a city to improve the health, care and lives of some of our most vulnerable people.



There are lots of excellent examples of isolated services across London. We need to join things up.

Dr Penny Louch, Homeless Medical Centre, Tower Hamlets

I am very restricted by borough boundaries. A Pan-London approach is absolutely essential.

Maxine Radcliffe, Lead Nurse, Great Chapel Street Medical Centre

Recommendation 31

Health and care commissioners should develop a pan-London, multi-agency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by a single lead commissioner.



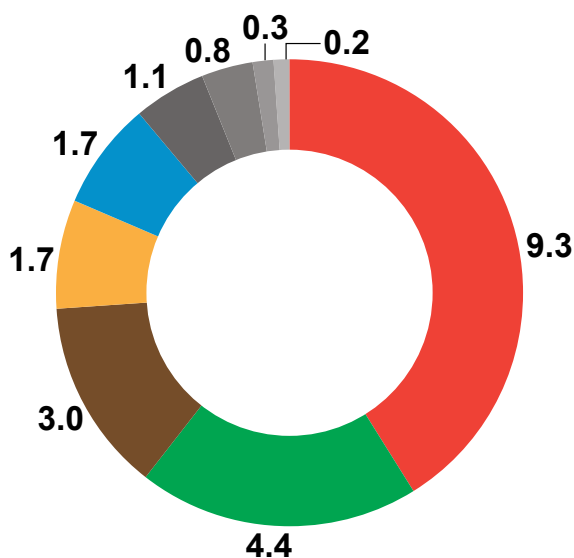
4. Maximising science, discovery and innovation to enhance economic growth

4.1 Introduction

London has a proud past and a promising future of boundless possibilities in science, discovery and innovation. Our city is home to many of the world's leading medical academic and scientific institutions. Some of the most important innovations in modern medicine hail from here: from antiseptics to penicillin and from hormones to DNA.

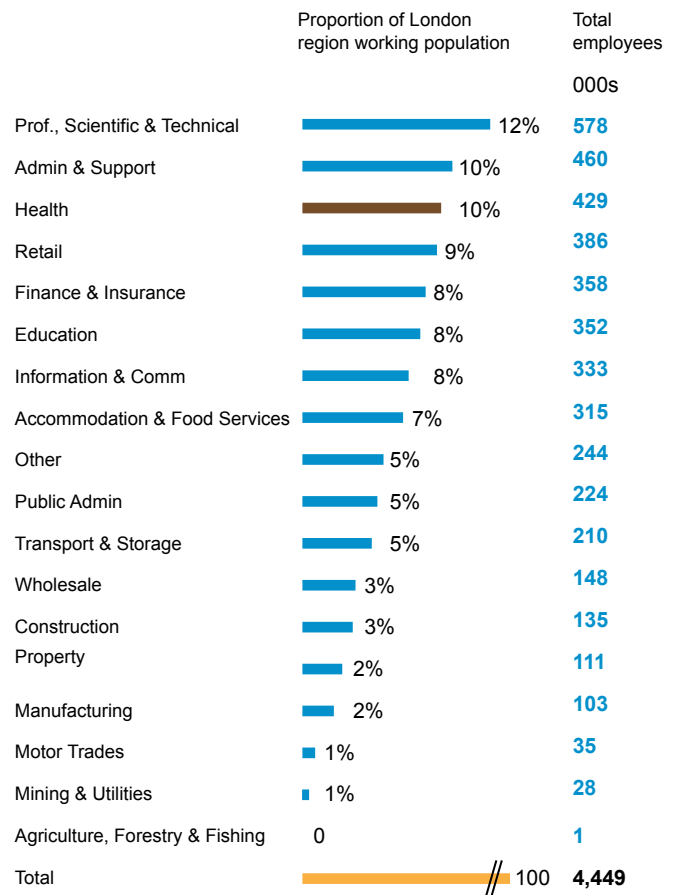
Our city has huge assets on which to build: thriving research and development in the life sciences sector, a large and diverse population, countless valuable datasets, global corporations and top class talent. London and the wider South East of England possess formidable talent and research pedigree. London's health and social care spend stands at £22.5 billion and its health sector employs more than 400,000 people.

Total health and social care spend: £22.5bn



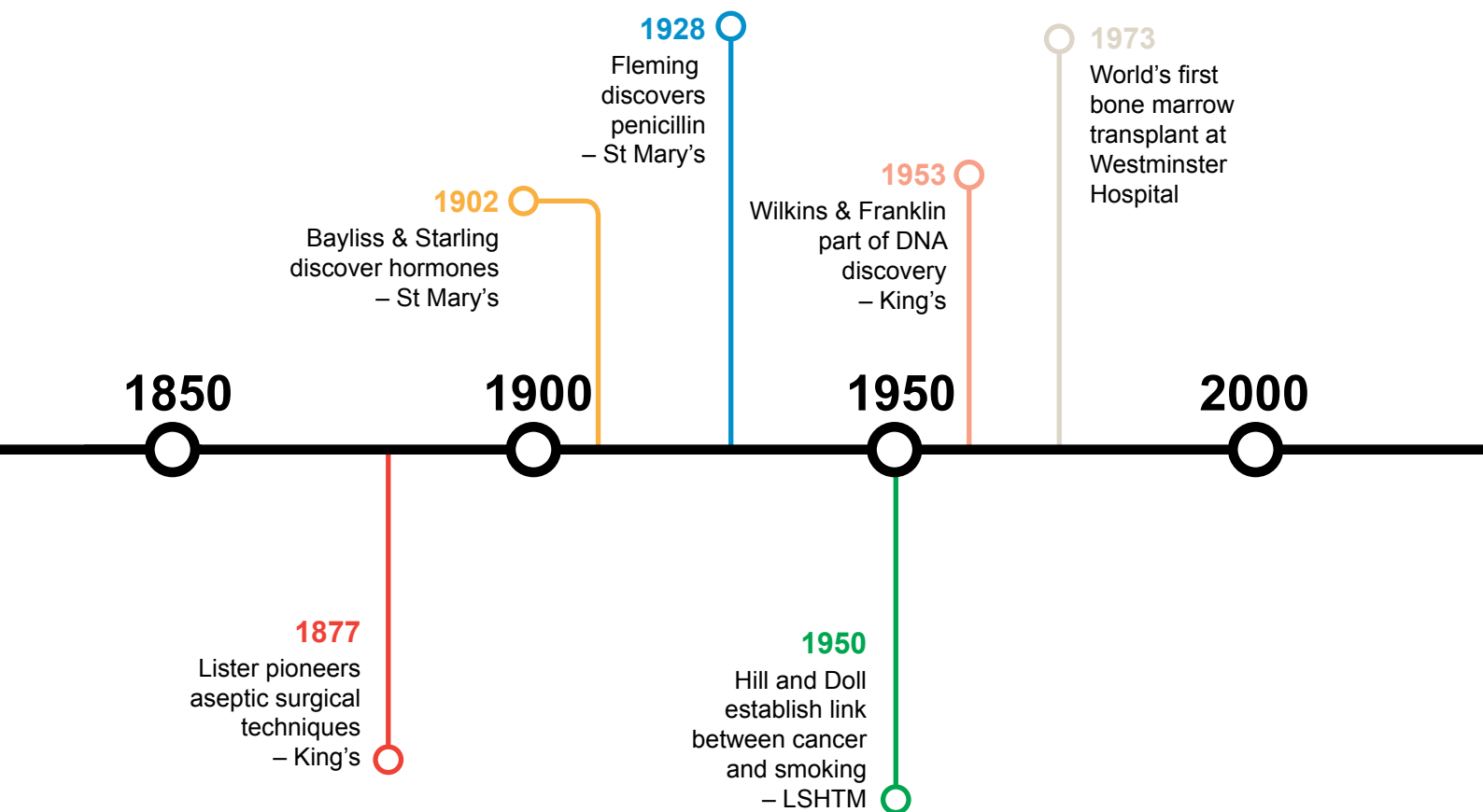
Additional **£2 billion** contribution from the Life Sciences sector

Sector employment in London



All the crucial elements for sustained success are present in our capital and in the South East of England: we are uniquely placed to become a leading global hub in life sciences. Indeed, five out of six of Britain's Academic Health Science Centres (AHSCs) are found in London, Oxford and Cambridge. They have accomplished important successes in informatics, imaging, genomics and other new therapies.

Earlier this year, Pfizer and the Global Medical Excellence Cluster announced the launch of a novel major funding stream for drug discovery research projects in rare diseases, one of the top 10 global academic-pharma alliances of 2014. The consortium will focus on exploring the human genome to find new treatments for the world's 6,000 recognised rare diseases, which affect about 60 million people across Europe and the US.

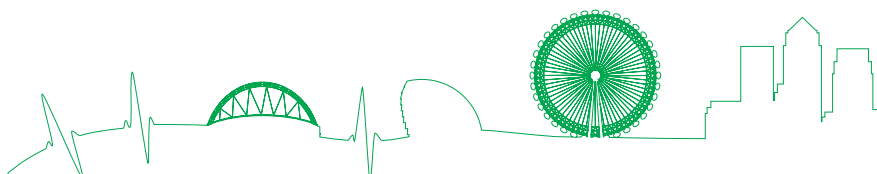


The Strategy for UK Life Science and other recent reviews have suggested how the city and the south-east could strengthen their world-leading position. A deal-making portal and pan-London IT infrastructure were prioritised. The Mayor and South East AHSCs recently launched MedCity. It raises our prominence in life sciences by collaborating with industry on early stage research and attracting foreign investment.

Next year, the Francis Crick Institute will be launched. It will be a globally-leading scientific institution, driving drug discoveries. By linking to the AHSCs and their associated Academic Health Science Networks (AHSNs), the new discoveries have the opportunity to feed into reduced times for new treatments to travel from bench to bedside (today, the global average is nearly two decades).

The National Institute for Health Research and the Medical Research Council have invested to improve recruitment for clinical trials, improving our attractiveness as a place for research. In the past five years, the number of patients participating in commercial trials has increased six-fold to 30,000 nationally in 2013.

Nonetheless, other global hubs are fiercely competing for investment and for talent. Greater Boston has committed to a 10 year \$1 billion investment, has pioneered biotechnology, and so has attracted many large pharmaceutical companies. It was named the top life sciences cluster in each of the past three years. San Francisco has seen the explosion of bioscience, with the industry's 140,000 employees achieving exports of \$2.7 billion. Singapore is determined to become Asia's health and biomedical science hub through low tax rates and significant investment.



2001

GlaxoSmithKline launches Advair, a best-selling asthma drug – GSK

Current day

Researchers develop material to create biocompatible human artificial organs and blood vessels – UCL

2010

Johnson & Johnson purchases Imperial spin-out RespiVert, which pioneered treatments for severe inflammatory lung disease – Imperial College London

2015

Francis Crick Institute to open supported by £650 million in total investment – six member consortium

There are many strengths to build on to sustain and enhance our place as a global leader. In the face of fierce international competition, London and the greater South East must ensure that our long history of scientific endeavour and discovery is nurtured, grown, invested in and promoted, locally and around the world.

The ambition for health and life sciences in London is to create a twin industry to financial services in economic importance and global significance. The region is home to six of the world's best universities. London and the greater South East is one of the leading regions in the world for game-changing science.

Kit Malthouse, Deputy Mayor for Business and Enterprise at the GLA

4.2 New opportunities in digital health and big data

The digital health revolution

London has the potential to lead the way in the new health economy and in global trends in digital health. The interface between health and technology has the potential to revolutionise the way that people manage their health and care. The Handle my Health app, for example, enables people to access their health data and to track their results.

London has great assets. The creative and tech industries are strong in our city. A new advanced informatics research hub is being developed by the Farr Institute. With its strength in the creative and tech industries, London is uniquely placed to foster entrepreneurship and become the world's leading digital health hub.

Yet London remains a difficult market in which to launch digital health products, particularly for small and medium sized business. It is too hard to access capital, to access clinical input, and to get products purchased and adopted by the NHS. As a result, too many entrepreneurs decide to launch their products overseas rather than at home.

Given London's intrinsic strengths, it should be the place where digital health innovations are created and tested. More support can be provided for innovators to undertake local development with patients and clinicians, helping to demonstrate the impact of their products. That is why a new Institute for Digital Health should be launched, that partners with – and is embedded across – all our Academic Health Sciences Centres and Networks.

This city should define the new frontier of research in digital health. Our city should be the place that develops global standards for conducting digital health clinical trials and the evidence base for digital health interventions.

Just as NICE was the global pioneer for traditional health technology assessments during the last decade, London should be the pioneer for digital health technology assessments in the decade ahead. This would make London the natural destination for innovators wanting to develop, test and trial their products.

The Institute for Digital Health should also directly support digital health innovators through an 'accelerator programme'. The programme would support the Academic Health Sciences Networks to identify the opportunities for digital health to improve patient care and population health. This would help innovators to focus their efforts on the right things, co-create their solutions with patients and frontline professionals, and provide a route to rapid scale up.

Similar examples globally have shown the value of adopting a needs based approach to developing solutions for local needs. The New York eHealth Collaborative (NYeC) works closely with 23 hospitals across New York. In the past year, it has created more than 120 jobs and two of its companies achieved major scale-up.

The Institute and its AHSN partners should develop an app strategy that addresses areas of importance for Londoners, such as mental health, self-management of long-term conditions, obesity or how to conveniently access the nearest and best social and healthcare services, to support the delivery of better patient experience, clinical outcomes and more effective use of resources.

Succeeding in the digital health revolution will require collaborative effort. Innovators, regulators, research funders, centres, and networks must all work together, across the whole of London and the south-east. We must move fast: other countries have embarked on similar endeavours, such as the Scripps West Wireless Institute on US West Coast, recently established and with similar ambitions.

London has all the opportunities, assets and advantages to lead in digital health. It must act to make best use of these and seize the advantage.

Big data

The amount of data the world is collecting is growing by 50% each year. Substantial benefits across the NHS could be achieved with better data analytics and use of information, to underpin service transformation. The Institute for Digital Health would be well-placed to independently assess and inform health providers of these opportunities.

The amount of data available opens up new possibilities to shift care from a 'diagnose and treat' to a 'predict and prevent' model. Data can help promote population health and wellbeing, as well as improving care. And current trends in personalised medicine may accelerate so that large clinical, genome and phenome datasets mean new, more tailored novel treatments for patients as well as new ways of understanding the effectiveness of current treatments outside of the clinical trial environment.

The Health Informatics Collaborative, for example, is an investment by the National Institute for Health Research (NIHR) to connect data from five Biomedical Research Centres (BRCs) in cancer, rare diseases, intensive care and hepatitis. This initiative will enable data sharing for research purposes.

There is an opportunity to build on this by expanding into disease areas which are more prevalent in the population. The AHSC/N executive group should support the NIHR to expand and further improve the data connectivity between the BRCs in the South East.

The NHS as a whole has a wealth of data, unsurpassed by any other health system in both its depth and breadth. Yet this has not translated into sufficient improvements to care, not least because the UK's analytical capabilities are struggling to keep up.

World-famous companies including Google, Johnson & Johnson, GSK, and Intel all have innovation and data research centres in the capital. London is also the central hub for a large number of data science experts who support analysis in other industry sectors.



Yet other countries are pressing ahead at pace. The US has invested in an open-data initiative, and has provided significant funding for the Patient Centred Outcomes Research Institute, which aims to link multiple datasets across care providers for internal and external users to define and reward high quality, low cost care.

The proposed Institute for Digital Health, working in conjunction with partners such as the Farr Institute could help to build capabilities, and support advanced analytics on 'Big Data' to provide outstanding care for our citizens, today and tomorrow.

Working within the standards established by the Health and Social Care Information Centre (HSCIC) to ensure trustworthy use of data and the protection of patient privacy, building capabilities in undertaking advanced analytics would bring major benefits, across the entire spectrum of care and the whole health and care system.

A number of existing datasets exist which could be linked together. This would be done by designated safe-havens – secure environments for the linkage, storage and analysis of personal data within the NHS. Designated NHS safe havens should always remain responsible for managing and linking all identifiable data.

The Institute for Digital Health, and its supporting partners would provide a collaborative platform for safe and secure access to anonymised datasets, regulated by the HSCIC. With careful stewardship there is an opportunity to make London a unique population globally, where advanced research and trustworthy use of data could be undertaken for the benefit of its citizens.

The Commission has secured in-principle commitments from some of the world's leading healthcare companies to invest resources and people in the new Institute, subject to the proposal attracting government support. Letters of support have been sent to the Mayor from Johnson & Johnson, Medtronic, Phillips, Novartis, and Merck. Together, these companies have a market capitalisation in excess of \$500 billion.

Increasing global trends in use of 'Big Data'

United Kingdom

MHRA has recently granted breakthrough status for innovative medicines – use of 'Big Data' will ensure better understanding of the patient impact of drugs

France

In France, drug companies need to produce data to prove their drugs are working in the real world every three years

Netherlands

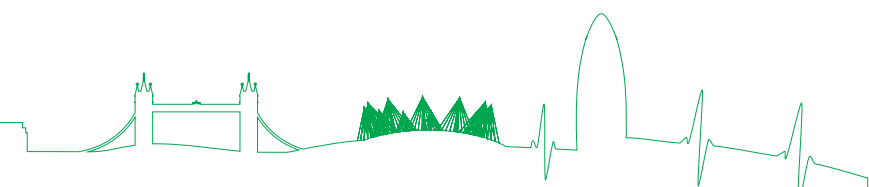
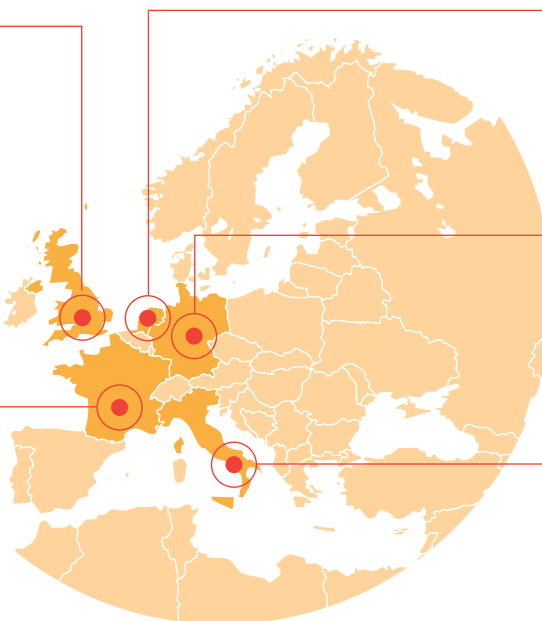
In the Netherlands, data demonstrating real world effectiveness of all new drugs is required every three years for continuing reimbursement

Germany

Germany wants to understand the patient related benefits of new drugs at the approval process

Italy

In Italy, all patients on new oncology drugs need to be tracked on a registry to understand the real world impact of treatments on patient groups



4.3 An institute for Dementia Research

Today, more than 72,000 Londoners suffer from dementia. Ten years from now, nearly a third more will do so. By 2025, one million people in the UK and over 60 million globally will have the disease. The annual financial impact on the UK is already £26 billion, and a further £8 billion attributed to the value of carer's work. The World Dementia Envoy noted earlier this year that progress on dementia research has been 'achingly slow' and 'a cure [will be] impossible without a shift in approach'.

The UK presidency of the G8 has shown global leadership in addressing this societal and medical challenge. The Prime Minister has made a dementia commitment and issued a Dementia Challenge: that there should be first-rate academic research in dementia and a significant increase in research spending.

It is surprising, therefore, that the UK currently lacks an institute of global significance. A Dementia Research Institute could bring together the breadth of expertise and interdisciplinary working partnership to make significant progress to meet the challenges.

London and the greater South East have world renowned academic institutions, including Imperial, UCL (Queen Square), King's College (Institute of Psychiatry), London School of Hygiene and Tropical Medicine (LSHTM) and LSE (London School of Economics). All have both leading research capabilities in both drug discovery and experience in policy.

Care City is currently being established in North East London to specifically strengthen its dementia community care research and developing new ways to support local frailty services. There are initiatives on dementia being led both by the UK's Prime Minister and by the G7 group of nations.

A Dementia Research Institute in London could therefore potentially connect a network of partners across the UK and beyond to enable faster progress in prevention and earlier diagnosis, research across the pipeline of treatments, translation of discovery science to care delivery, development of public policy on creating dementia-friendly environments and communities, and education, training and capacity to support better dementia care and outcomes.

Recommendation 32

The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Digital Health and Accelerator for London, coordinated by MedCity and the AHSNs.

Recommendation 33

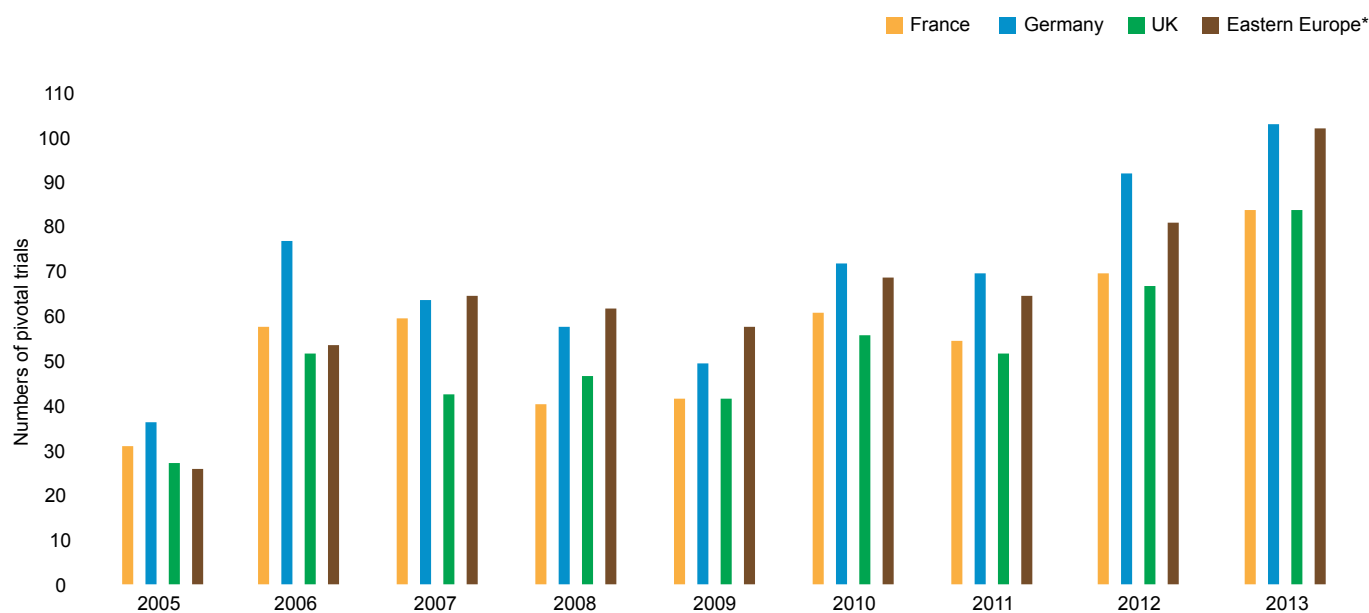
London's AHSCs should support and help to expand the Health Informatics Collaborative funded by NIHR to improve knowledge sharing for research purposes.

Recommendation 34

The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Dementia Research to bring together expertise in basic sciences, technology and social policy to address the dementia crisis.



Number of clinical trials in pivotal trials submitted to the European Medicines Agency



*Czech Republic, Estonia, Hungary, Latvia, Poland –
not single approval process for clinical trials – separate markets

4.4 More clinical trials

Clinical trials are necessary to develop new drugs and to translate scientific advances into patient therapies and treatments. They have many benefits: early access to the latest treatments, enhanced research, and improved clinical practice. They are also a source of revenue and a route to attracting top talent. However, the UK has historically lagged behind other European countries in the number of 'pivotal' trials that it conducts.

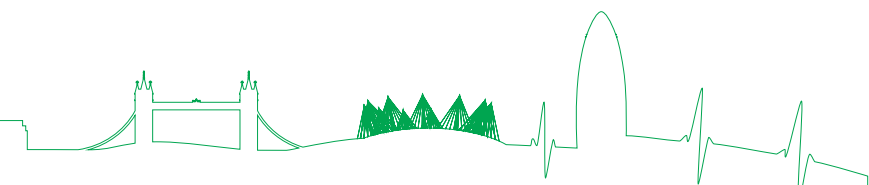
The UK lags behind since it takes too long to navigate the necessary approvals, it is too difficult to recruit patients, and quality and timely delivery is too challenging. Other than in North East London, permission must be sought and negotiated from each separate NHS organisation for each new trial site, a repetitive time and resource consuming process.

UCL Partners in Central and North East London has established a single process – a 'unified gateway' – for all commercial trials, saving significant time and cost. It has taken the mean turnaround time for approval from 104 days to 17 days over the last year, with significant impact on commercial trial activity. All trusts across UCL Partners are now designated as a Quintiles Prime

Site (Quintiles is the world's largest contract research organisation). Recruitment and trial quality at this UCL Partners Prime Site now exceeds 95% of all trials.

The rest of London should take a similar approach. All sites in London should work closely with the Health Research Authority (HRA) to ensure London is the first place nationally to be ready for HRA single approval. All sites in London's three Clinical Research Networks (CRNs) should harmonise their processes to accept model contracts, standard cost structures, pharmacy, radiation, information governance and research passport assurances from the HRA.

London would be a national leader by ensuring HRA Approval was adopted by all sites across London and all sites agreed to a single contract enabling prompt initiation of studies by June 2015.



More needs to be done to support wider engagement in trials. GP practices and smaller trusts have little incentive or support to engage in research. This could be addressed if each Clinical Research Network invested in a strategic research office to offer more practical support for practices and trusts.

These strategic offices would help align research activities to therapeutic areas which would impact on the clinical needs of their local populations. They would help trusts undertake later Phase III trials and GPs participate in novel real world studies with help from the NIHR Clinical Trials Unit.

This would increase research activities across London and the South East, give patients the option to access to novel treatments regardless of geography, and increase the number of patients who would participate in clinical research. By doing so, it would make London and the South East an even more attractive place to undertake commercial research.

Recommendation 35

London's providers should work with the Health Research Agency and Clinical Research Networks to create a simple and unified gateway for clinical trials in London.

Recommendation 36

Clinical Research Networks should establish a strategic clinical research office to increase late phase research/novel real world studies in smaller NHS Trusts and GP practices.

4.5 Adopting innovation

Innovation advances our ability to treat and manage disease, to alleviate suffering, and to improve the experience of care. It is vital that innovations are adopted so that we close the gap between what we know and what we do. The NHS has been historically impressive at invention but poor at diffusion. Too many innovations stay put for too long.

The fifteen Academic Health Science Networks (AHSNs) established across England a year ago have been working with their local communities and external partners (including patient groups and industry) and together to drive improvements in innovation adoption for health and wealth gain.

From this experience, three things are clear. First, there is no 'silver bullet' to improve rates of adoption of existing innovations. Second, there is much to be gained from measuring adoption rates as part of the wider performance framework. Third, the innovation system needs to be re-engineered from a 'push' to a 'pull' model. Each of these is examine below, in turn.

Improving adoption

The challenges faced regarding innovation adoption in health care are systemic and complex: there is no simplistic solution. Each challenge requires robust assessment of the enablers within a given context and the pooling of expertise and resources. The AHSNs and AHSCs (and their evolving patient, academic, clinical and industry networks) provide a unique opportunity to harness this expertise, focused around a defined set of well understood, shared challenges.

Academic Health Science Partnerships (bringing together the centres and their networks) spanning the discovery to care continuum have already created horizontal and pull mechanisms for innovation adoption, and have established mechanisms to share and build capability. However, adoption is also enabled by changes at system level in relation to, for example, culture, incentives, procurement, commissioning and measurement.



Measuring adoption

Adopting proven innovation should be part of the day job for clinicians and managers in the NHS. This means measures of innovation should be included within, rather than outside, the core NHS performance framework. More importantly, the measures themselves should focus on the outcomes of adopting innovations (such as lives saved, quality of life, improved experience and efficiencies) rather than the process of adopting new approaches.

Measurement can improve the pace and scale of adoption. Further academic rigour and experience could be tapped to better understand how measurement might be used to improve uptake of innovations in the NHS. The Innovation Scorecard, for example, measured uptake in 48 medicines, which were largely picked on the basis of available data and without any link to clinical outcomes.

The scorecard should be redesigned: to be effective it should be much more locally owned and co-developed with the communities of patients, clinicians, researchers, and industry convened by the AHSC/Ns. It should focus on those interventions (new medicines or other interventions) that will have the greatest clinical impact for patients, linked to outcomes, and connected to whole system changes.

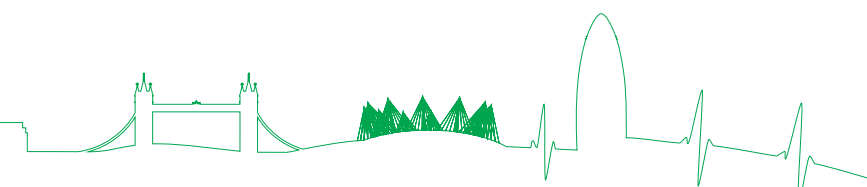
The scorecard should enable commissioners to be held to account by patients and innovators for funding access to newly approved therapies, in the context of their clinical and system level economic benefits, and facilitate better outcomes through highlighting variation of care delivery across local provider organisations through peer-to-peer comparison and support and through transparent accountability to patients for these variations.

Rethinking the innovation system

Innovation is a complex social and technical process spanning invention through to improved outcomes and wealth creation. Improving 'adoption' rates in the NHS requires a re-engineering of the health innovation process to create greater pull for change – ensuring ideas are rooted in patient and clinician need, with users and future adopters playing an integral role from the outset.

The AHSNs provide the partnerships to progress this agenda along the whole discovery to care continuum. Yet they risk being slowed in their work by the cluttered innovation and quality improvement landscapes. AHSNs, NHS Improving Quality (IQ), Interim Management And Support (IMAS), Commissioning Support Units, and Strategic Clinical Networks all have some work in similar areas. The Commission believes that all innovation and improvement functions in care delivery should be further consolidated and channeled through the AHSNs.

Commissioners should seek out more support and advice on the latest innovations from AHSNs. The whole system – led by patients – needs a way to hold itself to account in the adoption of innovation for the delivery of world class care. A revitalised Innovation Scorecard could be one enabling tool to help achieve this. Furthermore, London and the South East should seize the opportunity to collaborate across all five AHSC/Ns by developing processes to share knowledge on the success of great initiatives. This will ensure the maximum benefit is realised for all.



Recommendation 37

NHS England should strengthen London's AHSNs by further consolidating and channeling all innovation and improvement programmes through them.

Recommendation 38

AHSC/Ns should forge greater links with Commissioners to advise on the use of latest innovations for patient benefit and to support delivery by providers.

Recommendation 39

AHSNs in the South East should continue to collaborate – specifically on systematic knowledge sharing to improve adoption of innovation – to make South East England a leading region internationally for the adoption of the latest healthcare technologies and innovations.



5. Making it happen

This report sets a bold agenda for improving health and care in London. Its implementation will rely on the passion and commitment of Londoners to make change happen. There are important changes that need to be made to the way that the health and care system operates to enable that change to happen. Many of these are necessarily more technical.

This section address six specific areas, each in turn.

- [How the NHS engages with Londoners](#)
- [The way NHS information is handled in London](#)
- [How the NHS pays for services in London](#)
- [The NHS estate in London](#)
- [The NHS workforce in London](#)
- [Future NHS leadership in London](#)

5.1 Better engagement with Londoners

Challenges in engagement

One of the dilemmas facing the NHS in London today is that, although there is strong recognition that it belongs to everyone, people do not feel involved in it. Too often, the system feels remote from those who use it. There is a perception that important decisions are made opaquely and without sufficient consideration of people's views.

Over the past 60 years, health and care services have been designed by providers rather than by people who use services or frontline professionals. Too often, this has resulted in services that do not sufficiently reflect the needs, wants, or talents of the people that use them. There is a mismatch between the many groups, structures and organisations that articulate 'patient voice' and the impression that the system isn't listening.

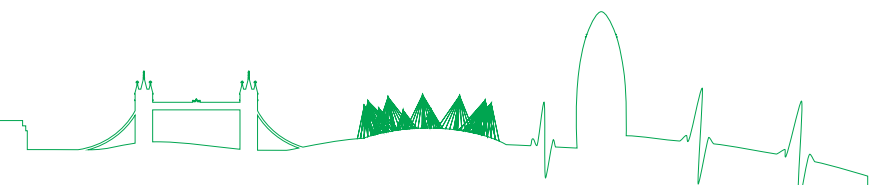
There are too few opportunities for citizens to shape the strategy and priorities of the NHS. The NHS needs to be more open and collaborative in seeking answers to the problems it faces, through a different conversation with the people who own it, and want to be active in its future. There must be more recognition of the value of the reality of the lived experience of care, as much as the clinical and technical requirements of the care system.

Opportunities to improve engagement

Citizens and organisations must be offered a direct, transparent route for their voices to reach the heart of NHS decision making, in a way that cannot be ignored. Truly listening to people who use services means changing care as a result of their views, not simply acknowledging their right to express themselves. There must be depth as well as breadth of patient engagement.

New initiatives must be developed that empower the public with new opportunities to participate and the ability to hold the health service to account, openly and fairly, for whether it has listened and acted. This will give the NHS a new and valuable source of opinion and evidence.

London has an opportunity to lead the way for England. Our city should embed the engagement of people in designing, delivering, using and evaluating services at every level – across the city, in communities and among individual citizens. The traditional hierarchy of power must be inverted, placing people at the top, communities at the centre, and the city underneath.



Any new initiatives should be careful not to duplicate the good works that already exists. This is especially true of the third sector, which has some excellent examples of effective engagement. Furthermore, the process of engagement must never be allowed to become more important than the substance of what people offer, nor more important than the people themselves.

Experts on engagement consider that in order for true engagement to happen, it must include four essential elements:

- 1. Engagement means listening properly, in the view of those who are being listened to.** People must perceive that they are recognised for their legitimate contributions and must certify that their opinions are being acknowledged and responded to intelligently.
- 2. True engagement entails a transfer of power.** People must be able to recognise that their views are actually influencing and shaping outcomes. Those engaged are decision-makers and co-producers.
- 3. The design of those services which are the focus of engagement need to be fully understood and easily explained by the recipients of services.** If service design is too complicated or confusing to those using the service, it is not an improvement.
- 4. Outcomes from the engagement process need to be agreed as being relevant to the individuals and communities involved in the engagement process.** Those engaged must recognise improvement in the quality of their lives as a consequence of engagement.

Looking ahead, London and the NHS should tap into the new NHS Citizen initiative which is being established by NHS England, to develop its own brand and drive its own engagement.

Engagement in the London Health Commission

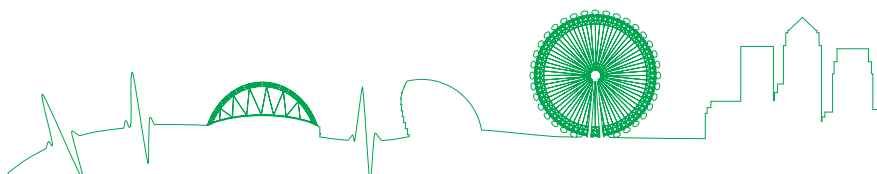
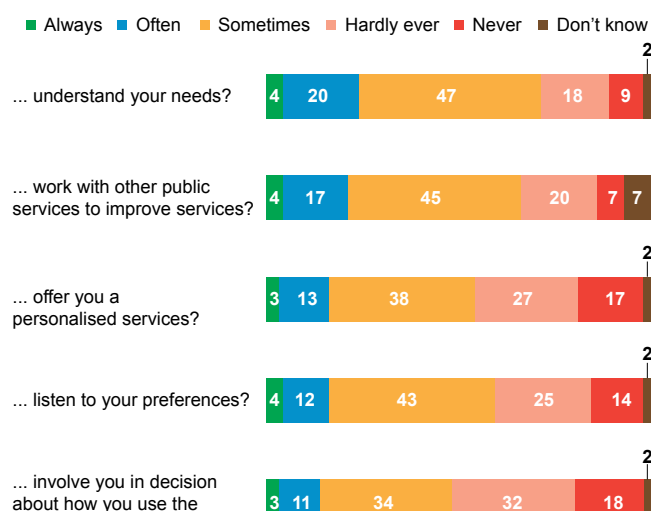
The Commission itself has sought to use best practice and exemplary engagement to develop its report and make its recommendations. Significant time and resources have been invested to try to ensure this report is based on quality, in-depth, substantial engagement and evidence from Londoners.

The Commission travelled to every borough and widely across the NHS. Nine oral hearing sessions took place and more than 250 written submissions were received. The GLA's Talk London online community, with 4,000 members, participated. Representative samples of London's population were polled for their views on health, on care and on the Commission's proposals.

Over the year, more than 9,000 people have been involved in more than 50 events. Every contribution – whether by email, on paper, or verbally – has been analysed, shaping the Commission's conclusions and recommendations.

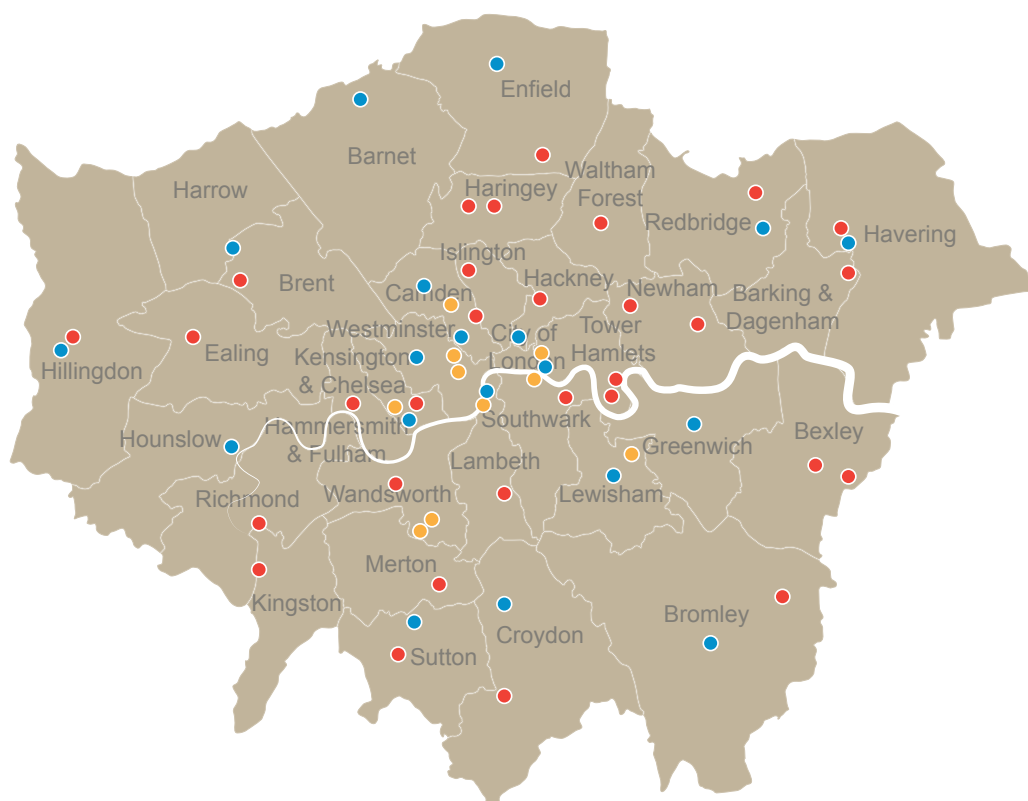
Public services in England do not tend to make best use of people in the design process

How often, if at all, do you think organisations that deliver public services...

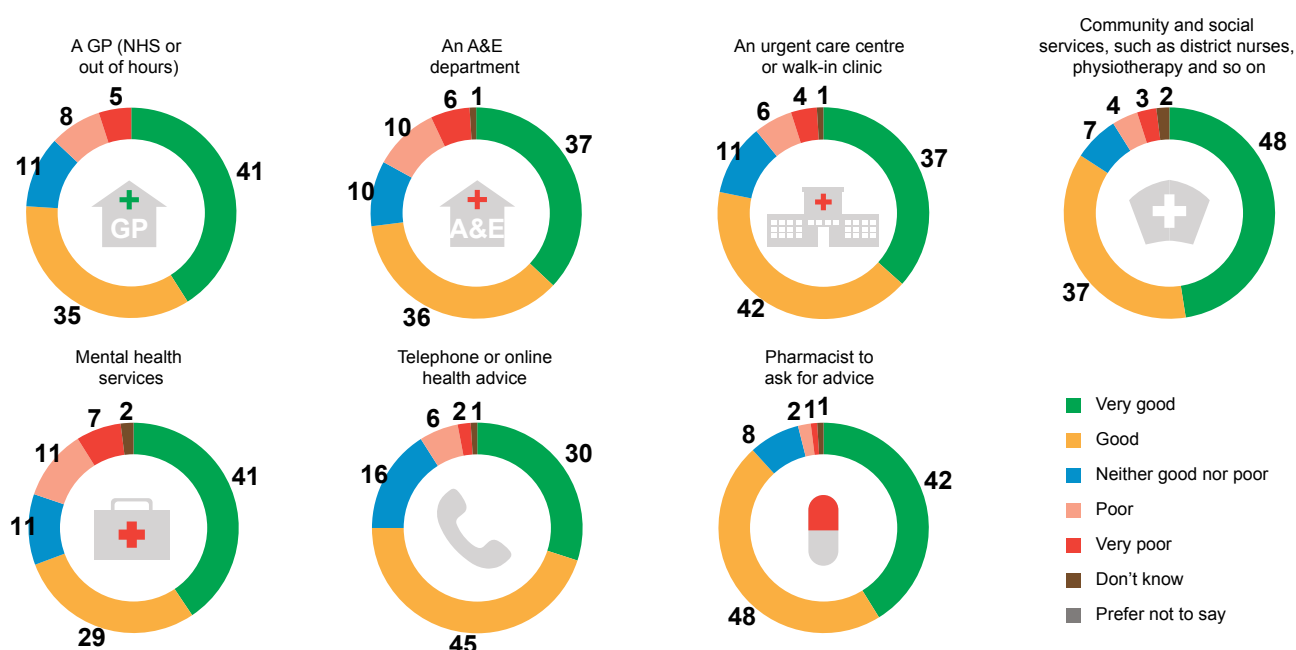


Engagement events held by the Commission

- Commission Hearing Sessions
- Trust events
- Roadshows



We asked Londoners how they would rate their most recent experience of the following healthcare services...



The city and its people have responded generously with their time and their contributions to this Commission. We hope we have lived up to our aspiration and their generosity. Only those who have been engaged can judge whether our efforts have been met in our results.

Engagement is being really clear about what matters to people, by working with them to ensure they can share in their own decisions about their own health. It is also about sharing power with those who have the least of it.

Jeremy Taylor, Chief Executive, National Voices

So going back to my hobby horse, public community engagement is really very, very powerful, if you get it right, in terms of change on the health and wellbeing agenda.

Gail Findlay, Director of Health Improvement, University of East London

Recommendation 40

NHS England should develop a single London-wide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen initiative and the Imagine Healthy London brand.

Recommendation 41

The Mayor should create a Citizens' Health Panel to oversee the engagement and involvement of Londoners, ensuring the capital's existing expertise and community diversity is fully represented.

5.2 Better health information

Benefits of better health information

Better health information has many benefits. It can help people to understand their health and wellbeing, to make decisions about their care, and to better look after themselves. Flowing timely information to professionals can help them to deliver better, safer care, to plan better care and better services, and to understand what they do well and where they could improve. Information technology can provide new and convenient ways for people to access health and care advice.

Better information sharing is a theme across all advanced health systems. Health systems in Europe, North America, Asia and Australia are all making significant investments to improve their ability to share information that improves the quality of direct patient care, and enable the better planning of care and services.

Initiatives such as Co-ordinate My Care demonstrate the benefits. It helps patients in their last year of life by helping to ensure their end-of-life wishes are known and fulfilled. The clinician and patient jointly create a personalised care plan which is shared with the right people at the appropriate moment. Myhealthlocker uses electronic personal health records at South London and Maudsley NHS Foundation Trust to allow patients to access their care plan online and give them control over their health information.



An absence of appropriate and timely information can be frustrating, particularly for people with more complex needs. They report having to describe their needs over and over again, within and across different organisations. Not knowing a patient's medication history can have serious safety implications, especially during an emergency admission to hospital.

Londoners understand the need for the appropriate information to be shared with an individual's care team in a timely and secure way. Some 86% of people polled agreed the people involved in their care should be able to access and share up to date information on them and their health where necessary.

NHS England is supporting local places to invest in the infrastructure for information sharing to improve care. It has also introduced new requirements for GP practices to offer and promote online appointment booking, online repeat prescriptions, and online access to summary information in their patient records.

At the same time, London is advancing the transparency agenda, with the myhealthlondon website providing greater transparency about services in the capital, and Healthwatch websites supporting citizen engagement in accessing and improving local services.

There are challenges ahead. The archaeology of NHS IT systems is as bewildering as it is complex. Information governance regulations are a source of anxiety, frustration, and a convenient excuse for inaction. Information is too often 'pushed' from above rather than 'pulled' from the frontline to improve the quality of care.

Where next

The Commission believes people should be empowered through access to their own health information, which is also shared among those who need it to provide care. People should be able to access data held within their health records 24/7; they should be able to provide consent and filter sharing of their information; and as a result they should be able to be true partners in care delivery, contributing to clinical conversations and taking greater responsibility for their own care.

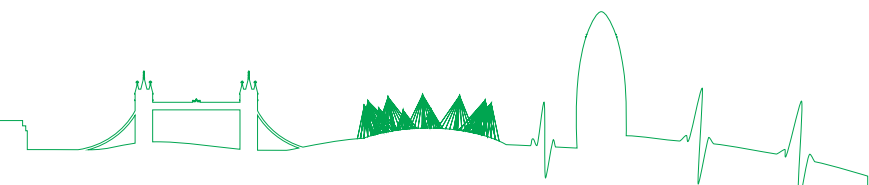
With consent, relevant information should be shared flexibly and efficiently with all those involved in care, making use of existing systems. Safeguards should be in place to protect Londoners' privacy and confidentiality; information should be secure and shared only as needed.

As greater sharing of data and patient information aids better care, so should it enable the easier introduction of more personalised care. The first step in understanding what a group of patients really needs is to look at data concerning their condition, their care, and their expectations. London has the data, but it is not always that easy for commissioners to access it.

For this Commission, data about how patients use services, about their condition and their care, has been essential to our work on understanding population groups in London. The Commission wants health and care commissioners to have access to the same information for their local populations, in line with legal requirements, to support higher quality care.

Recommendation 42

AHSNs, CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality.



Recommendation 43

The National Information Board should designate London as an incubator for innovative health information, providing investment and support.

Recommendation 44

Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care.

Recommendation 45

NHS England should fund and trial patient-reported outcomes measures linked to payments to London providers.

5.3 Funding and payments

CCG funding

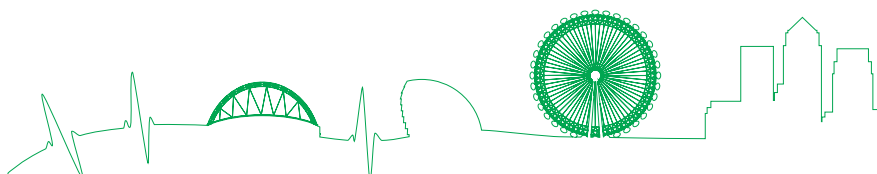
Today, the total CCG budget is allocated to each individual CCG according to a nationally agreed formula that is intended to reflect the care needs of each local population. The allocation varies significantly from one part of London to another. The most well-funded CCGs receive 54% more money than those with the least funding. Needs in London are different; but they are not that different, as shown by the differences in deficits and surpluses.

There is a nationally agreed timeline to change allocations, recognising the mismatch between actual and calculated care needs and therefore funding. Unlike other regions of England, the CCGs in London are in overall balance – this means that once the changes are implemented, London as a whole will receive the same sums of money as today. The capital neither loses nor gains.

The inequities, however, are greater in London than almost anywhere else. Four out of five of the most over-funded CCGs in England are in London; conversely, six of the fourteen most under-funded CCGs are also in London. There is clear pattern with inner London CCGs over-funded and outer CCGs under-funded.

Reforming such complex funding allocations however takes time, and requires multiple levels of decision-making. In the meantime, some areas of London are being overpaid and others underpaid. Many require dramatic whole-system transformation programmes, urgently, and services need to be commissioned more intelligently with GPs, hospitals, and other providers all working together to jointly commission what their patients need.

Some parts of the capital, such as CCGs in North West London, have already developed joint financial strategies to reflect the interconnectedness of their health economies and to promote financial stability. There is a strong case for CCGs in other parts of London to follow suit.



Recommendation 46

London CCGs and Strategic Planning Groups should consider developing local initiatives to promote greater equity in financing the health and care system.

Recommendation 47

NHS England should make clear the budget for the London Region of NHS England and for London CCGs for the duration of future spending review periods.

Budget setting

Good planning requires clarity and stability in budgets, so that commissioners and providers of care can invest in improving services. Significant gains could be made by extending the horizons for strategic planning in London.

Importantly, the proposed shift to more integrated care requires long-term investment in preventative health by providers. For providers to undertake such investments, they need to be assured of multi-year contracts to care for a particular population. Greater clarity on budgets is therefore essential for more integrated care.

London Transformation Fund

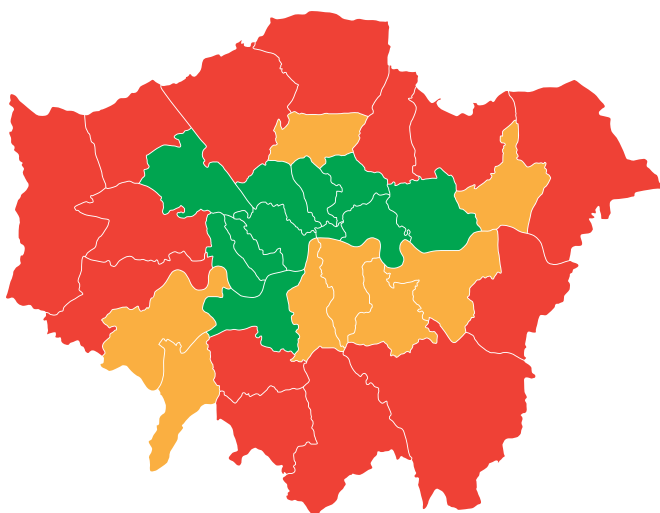
This report sets an ambitious agenda for NHS commissioners in London. It proposes wide ranging changes to the way that the NHS operates – from investment and reform in general practice to new ways of commissioning services and listening to people who use those services.

Significant effort will be required if the NHS in London is to deliver against these recommendations. It will require investment of time, energy and money in change. Those changes need to be led by commissioners, who will need a dedicated team to take them forward.

Furthermore, it will require significant investment in programmes to improve health and care. It is proposed to create a London Transformation Fund that will be jointly managed by NHS England's London region and CCGs. Investments in improvements in care would be agreed with local health economies in London.

Difference from target allocation

■ Variance < -3% ■ Variance -3% to +3% ■ Variance > 3%



Recommendation 48

NHS England and CCGs should establish a shared transformation budget for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies.

Capitated budgets for integrated care

The NHS budget is distributed to care providers through multiple different payment mechanisms. Some providers are paid fixed sums of money for their services; others are paid on a tariff for different services; many have specific targets and incentives built into their payments; and all are paid through complex contracting processes which specify many requirements.

This approach has its advantages. It means that money follows patient choices about where they wish to be cared for. It means that providers are paid for their results, rather than simply their efforts, helping to keep waiting lists down. It pushes providers to accurately record the work that they do. It can result in focused improvements in quality of care.

Nonetheless, it has many drawbacks, too, especially when paying for the care of people with complex needs. There is duplication because similar services are funded by different organisations. There are gaps in provision as services are purchased piecemeal. Working arrangements are siloed since different budget processes result in different priorities. Crucially, providers are focused on treating people when they are sick rather than helping to keep them well.

To meet these challenges, other countries have trialled making a single provider – or a consortium of providers working together – accountable for all the care needs of a particular group of people (e.g., people with multiple long-term conditions). The whole budget for these groups in a particular place is then handed over, tied to an agreed set of quality outcomes. This is a capitated payment system.

This approach has significant advantages. It gives providers a strong incentive to invest in more personal, more preventative care, since they are accountable for the full costs, typically over three to seven years. It enables providers to holistically judge and deliver the best care for an individual, meaning care can be more personal. It causes providers to ensure care takes place in lower cost settings, and to ensure it is carefully coordinated. It grants the freedom to innovate and adjust care to open up new boundaries of efficiency.

It does carry some risks. If providers misjudge – or investments in prevention fail – providers can go into deficit, since they carry the financial risk, rather than commissioners. If the duration of contracts is too short, providers have the perverse incentive to defer care rather than to invest in prevention. Unscrupulous providers might seek to ration access to services, meaning robust regulation is required.

For capitated payment systems to work, four major changes are necessary. First, there is an intensive need for data to calculate the capitated budget. Second, commissioners across health and social care need to work together to pool, procure and manage integrated care. Third, providers need to develop new care models to improve services for people – with regulators working out a new framework for them to do so. Finally, co-design and co-production with people who use services is essential throughout.

Recommendation 49

NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups, such as elderly people with long-term conditions.



Personally Controlled Payments

In most parts of our lives, we pay directly for the services we receive. If we are not satisfied, we can take our custom elsewhere, or invoke our consumer rights. Since we all pay for the NHS indirectly through taxes, we don't have quite the same influence over the institutions that provide care to us. Whilst the health service should always remain free at the point of need, the absence of payments from individuals is one of the reasons why care can sometimes be unresponsive to individual needs.

It must be possible to empower patients whilst remaining true to the NHS's founding principle. That is why the Commission proposes to empower patients to control a proportion of the payment providers receive from NHS commissioners. Personally Controlled Payments would mean that individuals would be able to decide whether or not a hospital receives a portion of its income relating to their own care.

The money would not be transferable – it couldn't be used in the private sector, for example – and if unpaid it would remain in the NHS, to be invested by the NHS. It would be 12.5% of the total payment – it would not be a voucher – and would mean that local commissioners would still control the vast majority of payments. The retained money would be put into a fund to be reinvested by commissioners in higher quality services.

Deciding whether to pay or not would be entirely subjective – down to individual experiences of care. And that is the point. The idea of Personally Controlled Payments is to make providers pay more attention to the lived experience of care. They should be focused on areas of persistent poor performance.

The Commission believes that this approach should be piloted in maternity care in London, where despite some excellent care, too much care has been stubbornly poor. Each year more than 130,000 women give birth in London, so this is a huge issue for London women, children and families.

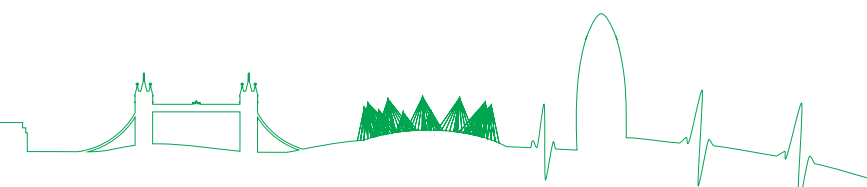
Less than half of pregnant women attend their first antenatal assessment by 12 weeks in London. More than 80% of London trusts were below the national average in the proportion of women rating the care they received during labour and birth as good or excellent. In the Care Quality Commission's measures of satisfaction with maternity care, London trusts scored lower than the national average in 41 of 44 categories.

Even more seriously, the maternal mortality rate in London is twice that of the UK, and has risen each year for the past five years. 70% of the direct maternal deaths were found to have involved shortfalls in care which, if managed differently, might have saved lives.

Empowering mothers-to-be with Personally Controlled Payments for maternity care could dramatically improve their experiences of care and start a revolution in empowering Londoners in their relationship with the NHS.

Recommendation 50

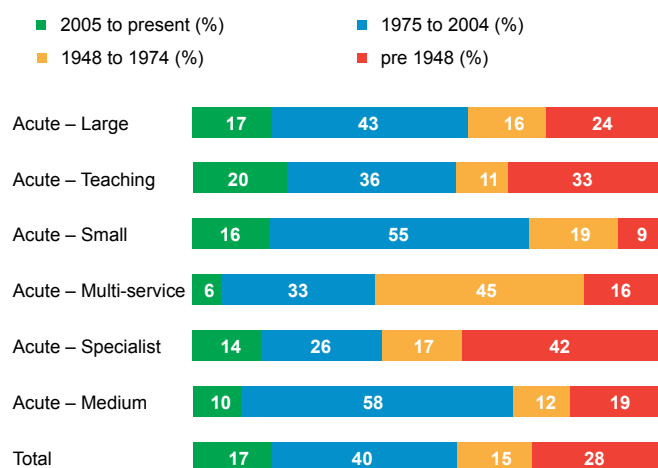
NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers.



5.4 The NHS estate in London

The NHS is one of the largest owners of land and buildings in London: the figures are dizzying. The physical footprint of London's hospitals is around 1,000 acres – that's three times the size of Hyde Park, and larger than the City of London. The book value of the estate is more than £11 billion, with around 70% belonging to acute hospital trusts. The remainder comprises mental health (nine trusts comprising 85 sites) and community health trusts. There are more than 1,400 GP practices, and their buildings are valued at around £1.5 billion.

Age profile of London's NHS acute estate



Despite the scale of the NHS, the quality of NHS estate is highly variable. London has some of the finest hospital buildings in the world, such as the facility at University College London Hospital on Euston Road, and some of the poorest hospital facilities in Britain, such as Northwick Park, which has the highest backlog of maintenance in the country.

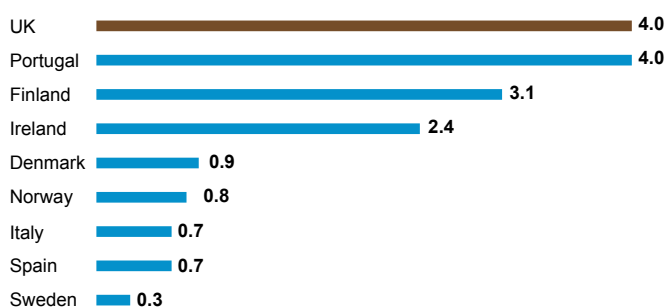
Indeed, more than 40% of NHS hospitals are over 30 years old and 28% pre-date the founding of the NHS in 1948. Purely dealing with the backlog of maintenance needed across this estate would cost in the region of £600 million. Similarly, a large proportion of primary care estate such as GP surgeries is not fit for purpose – a third need to be rebuilt and 44% need repairs, if they are to be compliant with the Disability Discrimination Act.

A high-level assessment of capital efficiency – capital turnover – suggests that NHS assets may be under-utilised by around 15%. If this capital could be unlocked, it would be worth around £1.5 billion. The majority lies in acute hospital trusts where as much as £1-1.2 billion could be surplus to requirements. This would have the added benefit of reducing running costs by around £200 million annually.

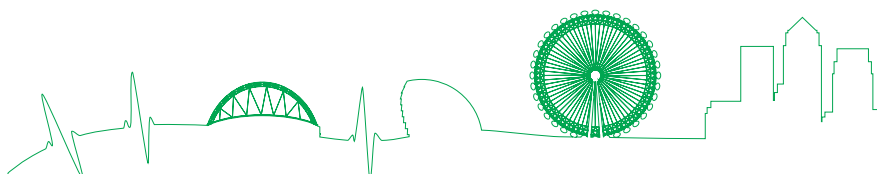
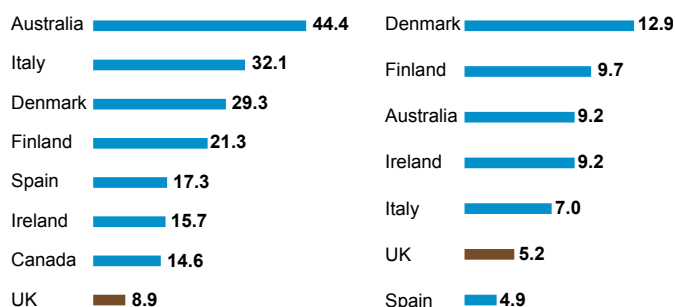
Perplexingly, modern facilities, built through the private finance initiative, remain under-utilised in many sites across London. These include whole floors at Barts and the London NHS Trust, and major areas of Central Middlesex Hospital.

The NHS allocates the highest capital spend on buildings, and the lowest on medical equipment in the Beveridge peer group

Spend on health buildings, % 2010



Spend on sophisticated medical equipment



If the NHS were to better use its own property – for example by providing more care outside hospitals and in the community – it would be a major opportunity for the city as a whole. There is, for example, a need for 550,000 new homes by 2021 and 118,000 new school places by 2016/17.

The UK overall allocates the highest spend to buildings in its international comparison peer group partly driven by concentrating certain national specialist centres in high cost locations. Conversely, the UK spends less than its peer group on advanced capital equipment (such as MRI or CT-PET scanners).

Taken together – the best and worst hospitals, swathes of GP practices not fit for purpose, and low overall efficiency of assets – these are the signs of a chronically stumbling capital system in the NHS which the service has failed to fix for many decades.

The root causes are fragmented, over-complex, and inconsistent rules around both the decision-making about and the funding of the NHS estate. There is inconsistency in the way different parcels of property are dealt with, and no London-wide strategic overview of how the land and associated issues should be managed in a way that best helps patients.

Given that 80% of patient contacts with the NHS are in GP practices, and 70% of the assets are in hospitals, the Commission has prioritised improving these two parts of the NHS family.

5.5 Overhauling the GP estate in London

London's GP practices are largely found in converted residential buildings – many are in poor condition. This means poorer patient experience and poor working conditions for London GPs. Often, even the most basic disabled access requirements are not in place.

There are two main reasons why London's GP practices are in such a parlous state. First, there has been chronic under-investment in the estate. Second, GPs are strongly incentivised to remain in existing residential conversions rather than moved to modern purpose-built facilities.

Investing in General Practice premises

As set out in the 'Better Care' chapter, significant investment – some £1 billion – is required in the GP estate in London. The Commission has calculated that this investment, over five years, would secure modern general practice that is accessible to all Londoners.

It is vital that these investments are led through a partnership of CCGs, NHS England, and local authorities. The opportunity to include wider public services – such as employment, child care, libraries and education – should be explored.

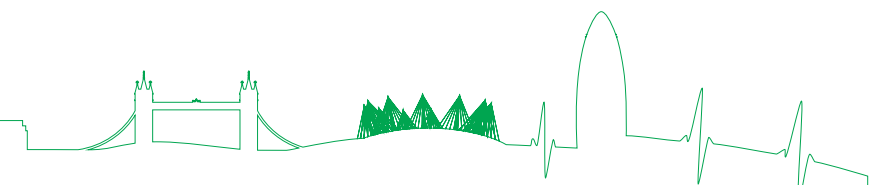
This scale of investment would represent just 4% of the national NHS capital budget over the next five years, and 26% of London's share (assuming it is equally distributed across the country based on population).

Changing the incentives for primary care

There must also be a much closer link between the funding of the GP estate and the quality to which it is maintained, through defined standards when commissioning services. Those practices not compliant with accessibility requirements that are offered purpose-built or purpose-designed facilities through the investment programme but refuse them should be decommissioned.

Recommendation 51

NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices, and require practices to comply with disabled access requirements or accept new facilities.



5.6 Overhauling the hospital estate

in London

The capital regime for hospitals in London is extremely complex, with multiple 'pain points'. There are significant issues with the current rules regulating capital: a lack of clear standards or an enforcement process for ensuring they are met; too little incentive to dispose of surplus estate due to the combination of artificially low cost of capital and restrictions on retention of capital receipts; and no option to manage assets across the wider public sector.

There are also issues with the process, structures, and capabilities for capital planning. There is a fragmented approach to funding; limited strategic links between estates strategy and the role that estates need to play in commissioning care; and poor capabilities in managing estates across London including setting strategy, managing property and supporting disposals.

There are three steps that need to be taken: incentives must be altered to encourage more efficient use of capital; trusts should be given more options for disposals of assets; and there must be more joined up planning across the NHS and with local authorities.

Incentives

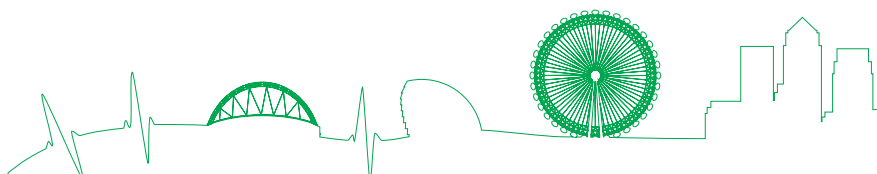
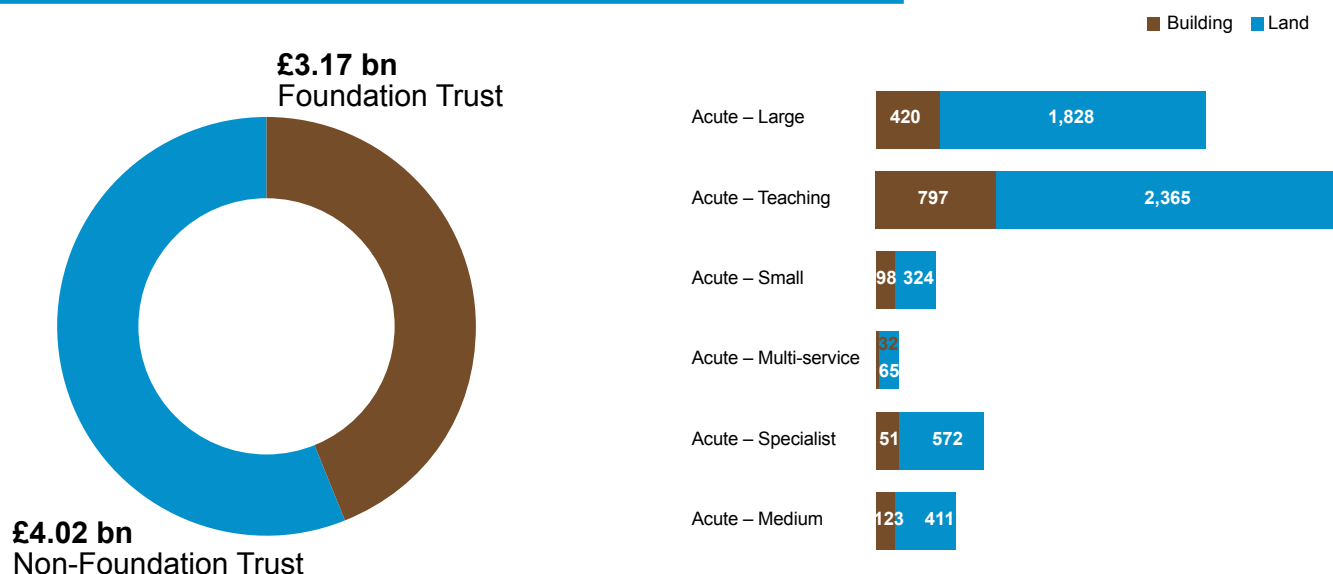
Today, capital charges in the NHS are low whilst asset price inflation is high. This means trusts have little incentive for the efficient use of capital. This, combined with risk averse attitudes, means that many trusts engage in 'land banking' – holding on to surplus assets for extended periods, as a hedge against future deteriorations in their financial position.

Incentives should be changed so that trusts put greater focus on capital efficiency, invest more in high quality facilities, and more land is freed up for housing and other economic growth. The obvious place to start is with those assets that are freestanding, and are clearly unused, such as derelict former hospital buildings.

Since these assets are no longer used for the public good, from 2016/17, the public subsidy of them through lower capital charges (3%) should be ended. This means that trusts will be required to pay the market cost of capital on these assets (8%).

At the same time, the rules on the retention of capital receipts should be reformed. Today, foundation trusts retain 100% of any proceeds from asset sales. Whilst in practice NHS Trusts are permitted to retain proceeds from disposals, they must secure consent from HM Treasury and the Department of Health. At a minimum, this provides an excuse for inaction, and in some cases, a real disincentive (trust behavior suggests they defer disposals until they achieve foundation trust status).

The total book value of NHS acute estate land and buildings in London



The Commission proposes these rules are changed so that trusts automatically have the right to retain 50% of receipts. The remaining 50% would need to be agreed in the same way as today. This would represent a powerful shift in expectations, and remove an excuse for inaction.

Disposals

More options for disposals should be open to trusts and transformation programmes. A new programme should be launched with the GLA single property unit to give trusts the option of transferring assets for redevelopment and disposal. The receipts would revert to the trusts. Trusts choosing to transfer unused assets to the programme, would cease to attract any capital charges, thus avoiding the consequences of the removal of the capital charge subsidy on unused assets.

Other options should include the ability to apply for asset transfers across the public sector. Today, trusts must dispose of surplus assets at full market value, even when there are obvious local needs for other public uses such as schools, community centres or affordable housing. The rules are set this way so that HM Treasury determines the distribution of public capital between sectors.

The Commission believes that this leads to suboptimal outcomes for local people. Transformation programmes should have the option of applying to a central committee comprising HM Treasury, the Department of Health and the Department for Communities and Local Government for permission to transfer assets to other parts of the public sector at district valuer figures, rather than full market value. This would also create an incentive for more joint working between the NHS and local authorities on service change plans.

Planning and coordination

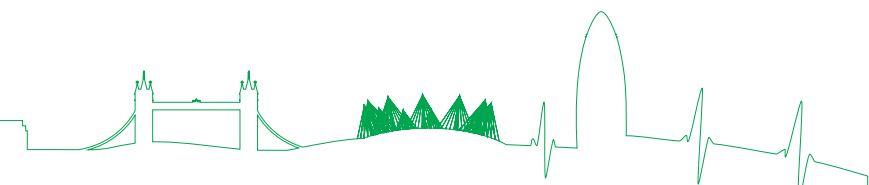
Finally, there is an obvious gap in strategic capital planning, which is insufficiently linked to service planning. Today, the system revolves around the individual affordability of schemes proposed by each individual organisation, without regard for the wider health economy.

That is why the Commission proposes that Strategic Planning and Capital Boards are developed to ensure that estates planning and a comprehensive asset database are part of strategic planning. The new Boards would work in conjunction with NHS Property Services and Community Health Partnerships to:

- develop and maintain a comprehensive asset database of all the different NHS estate in London and make public what estate exists, the quality of the estate and how effectively it is being used.
- ensure estates planning is a core element of five year strategic plans for whole health economies. Coordinate and align estates planning with commissioning and mandate that commissioners must include strategic planning on estates into their five year plans.
- support re-investment of released capital, through a new or current mechanism to make strategic decisions, including measures to enable providers to avoid the 'estates trap', and ensure capital is used to further the goals of health and care in London, bringing together NHS commissioners, providers and local authorities.

The capital regime and estates planning has long languished in the 'too difficult' category. Fundamental reform has not taken place and as a result, patients and their care have suffered, with services frequently being delivered in buildings and facilities which would shame any other city with global ambitions to offer its citizens the best quality of life and care of anywhere in the world.

The proposed package of measures represents a significant step in the right direction; the Department of Health, Monitor and HM Treasury must now act with pace and determination to progress implementation.



Recommendation 52

The Department of Health should end the public subsidy for hospital assets that are no longer used for the public good by raising capital charges from 3% (public dividend capital rate) to 8% (the market cost of capital) from 2016/17.

Recommendation 53

The Department of Health should agree with HM Treasury that NHS Trusts in London routinely retain 50% of any capital receipts, with the remaining 50% agreed with the TDA and local commissioners, so that Trusts have an incentive to dispose of surplus assets.

Recommendation 54

The Trust Development Authority and Monitor should work with the GLA to establish an unused NHS buildings programme in London so that Trusts are encouraged to transfer assets for redevelopment and disposal (receipts would revert back to the Trusts).

Recommendation 55

Transformation programmes should be able to apply to a joint HM Treasury, Department of Health, and Department for Communities and Local Government committee for permission to transfer assets from the NHS to other parts of the public sector at District Valuer figures.

Recommendation 56

NHS commissioners and providers and local authorities should create Strategic Planning and Capital Boards to ensure that estates planning and a comprehensive asset database are part of wider service planning.

5.7 Supporting the NHS workforce

The NHS is one the largest employers of Londoners. We are fortunate to have extraordinary clinical and professional talent, dedicated, passionate and caring staff. Healthcare is delivered by a team – each member is valuable; each makes a vital contribution. From the cleaners who prevent infections to the porters who get patients to theatre on time to the world-renowned surgeon pioneering new techniques, each team member matters.

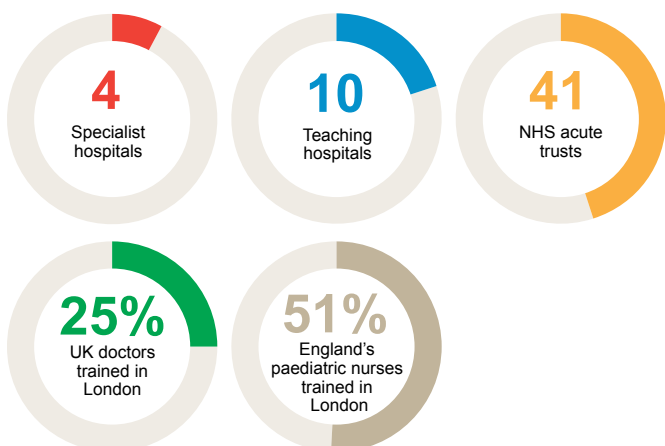
Quality of care comprises the hundreds of thousands of personal, human interactions each day. Witness to triumph and tragedy, to our most joyful and most distressing moments, NHS staff are present in all our lives. Their dedication, compassion and professionalism are the essence of high quality care.

Securing high quality education and training

London has a national and international role in education and training. A quarter of NHS doctors are trained in the capital. More than half of England's children's nurses are trained here. Our city provides links to high quality, internationally renowned research. Nearly 40 departments were awarded a top 5* or 5 rating for research excellence in health and health care subjects – far more than in other regions.



London is the largest health education region



Health Education England is considering a number of options for how future workforce training and the associated funding should be allocated. Options include a capitated model, with some element of weighting, though this would not take account of over-subscribed training or the quality of training on offer. Funding could be based on an option blending quality with local labour market conditions, which would make a better use of London's training assets.

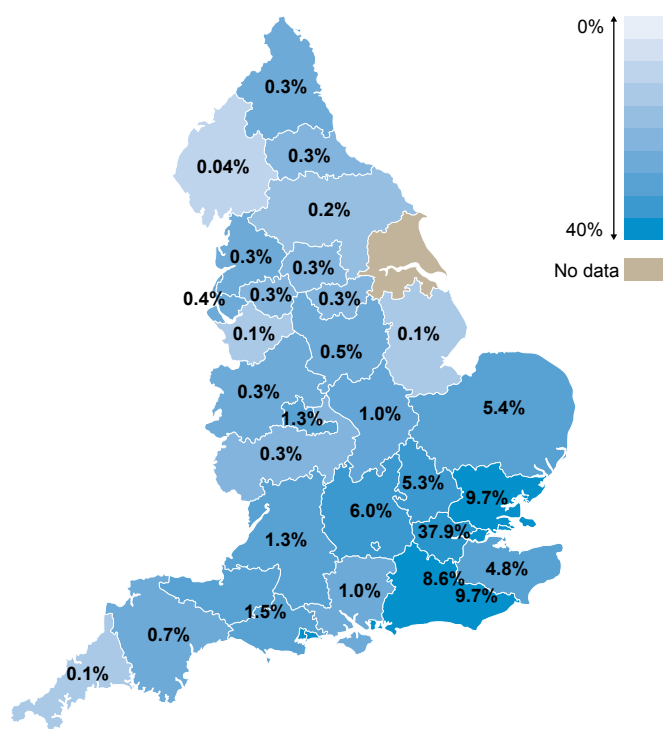
The Commission believes that locating training in centres which are popular with students and which offer high quality is the most appropriate option. It has a number of benefits: it supports student choice; it reward excellence by concentrating training in high quality centres; it makes best use of existing assets for the wider national benefit; and it better delineates the difference between training and service delivery.

Under this methodology, consistent measures would be needed for education quality, such as the Quality and Contract Performance Management (QCPM) framework in London, which has been used to deliver continuous improvements in education quality. There would also be the potential under this system to formalise existing links between centres of excellence, such as London, and areas which are less popular with students.

Recommendation 57

Health Education England should ensure that education and training funding continues to support choice, foster excellence, and secure higher quality care.

Destination of leavers from London Higher Education Institutions in England (2009/10)



Improving recruitment and retention

London can be a challenging place to live and work. Turnover is high within London and there are significant recruitment challenges in some areas. Nearly two-thirds of graduates move out of London within a year of completing their education.

London has low retention rates and high vacancy rates, and an ageing workforce in some professions. Vacancies in London in nursing and social care are higher than the national average, as is staff turnover in the NHS more broadly. London has a higher proportion of GPs aged 60 and over, in school nursing, district nursing and health visiting, a significant proportion of the workforce are in their 50s.

Staff cite the high cost of living as the number one issue, particularly the availability of affordable housing. Other world cities face similar challenges. Both New York and Tokyo offer financial incentives to encourage doctors to work in under-served areas.

In London, efforts to find a solution have included High Cost Area Supplements for NHS staff. Nonetheless, these are insufficient to bridge the cost-of-living gap; and there are currently no London-wide affordable housing policies specifically aimed at key workers.

The NHS could use its large footprint to contribute to solving the problem. New developments of NHS estate could include affordable housing for health and care staff. New housing delivered in this way could even be split to cover other key worker areas where affordability is a problem, so that a third of the new housing would be provided for NHS staff, a third for other key workers, and a third for the wider population in need of access to affordable homes.

Recommendation 58

NHS Trusts should be permitted to include affordable housing as part of wider site redevelopment plans, working in partnership with local authorities.

New roles fit for the future

The Commission has proposed a new way to approach care – population groups. Analysis of those groups show very different needs. The most obvious change is a significant shift to home and community settings of care.

More training should be delivered in the community. This will require Local Education and Training Boards (LETBs) to significantly increase the proportion of funding spent on training in these settings and maximise investment in ongoing staff development, focusing training and development on capabilities to suit new models of care, such as generalist skills and supporting citizens to self-care.

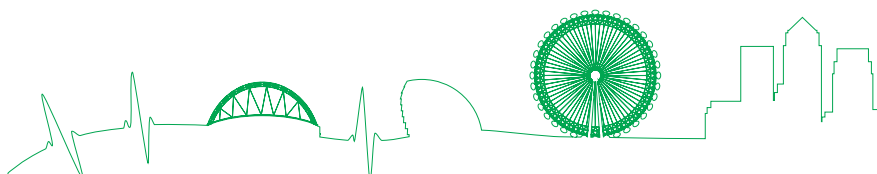
There are examples of good practice in London, particularly Community Education Provider Networks. These bring together health and social care service providers, community groups, and education providers and offer learning alongside care delivery. These should be built on.

Recognition of academic leadership in primary care is vital to improve the care system. London's universities should also aim to increase the number of academic posts in primary care to improve our knowledge and understanding of what works.

Furthermore, there appear to be opportunities to reduce the duplication of roles and tasks. As society ages, and long-term conditions become more prevalent, more and more people will need more and more care at home. New hybrid health and social care worker roles should be explored, defined, commissioned and trained.

Recommendation 59

Local Education and Training Boards, Health Education England and employers should shift more training to general practice, community and integrated care settings, and explore the creation of new hybrid health and social care roles.

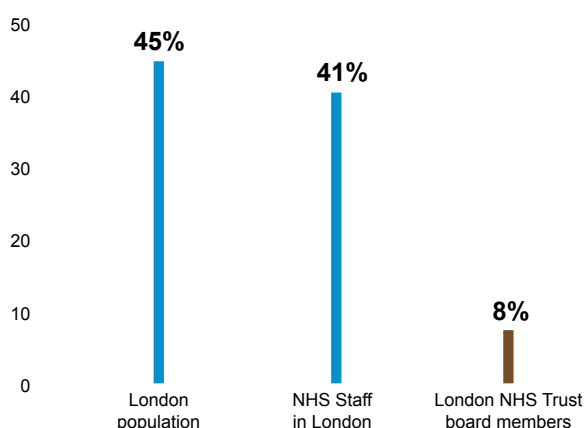


Investing in the leaders of tomorrow

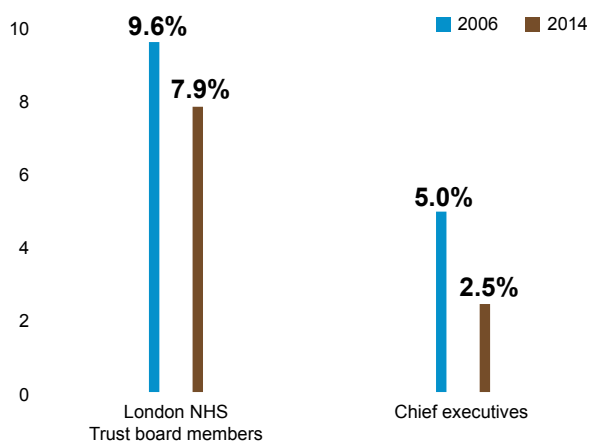
The shift to more integrated care – with multidisciplinary care teams drawn from different organisations – demands nuanced leadership skills. Leaders will need to be able to energise people from different organisational cultures, to be able to inspire and enthuse diverse teams, and to be able to ensure the whole team remains focused on the most important team members – patients themselves.

These new requirements of NHS leaders come against a backdrop of a poor record on diversity in London. There is a significant gap between the diversity of the workforce and local population, and among Trust leadership and senior management, as has been highlighted by studies showing that under-representation adversely impacts on the provision of services across London.

BME background



BME background 2006-2014



The popular Darzi Fellowships in Clinical Leadership have been a highly valued initiative. The 12-month programme for junior doctors involves project work covering service redesign, quality and safety improvement and leadership capacity building.

The scheme began in 2009 focusing on trainee doctors. There are now around 60 Darzi fellows, drawn from all types of Trust and who are multi-professional. There are opportunities to widen and deepen the programme.

Recommendation 60

The London Leadership Academy and London LETBs should recruit a wider range of NHS and social care professionals to the Darzi Fellowship programme.

5.8 Better leadership in London

London Health Commissioner

The social determinants of health are largely outside the scope of those who deliver healthcare, with risks driven by individual behaviour (smoking, diet, exercise) in the context of societal influences (housing, schools, employment) and environmental factors (air quality, physical environment).

The reforms introduced by the Health and Social Care Act 2012 recognised that better health could not be effectively delivered by the NHS in isolation. Responsibilities now also sit with the London boroughs and Public Health England.

The present division of responsibilities recognises the complexity of health and health improvement. Nonetheless, it also means there is a greater need for coordination to achieve concerted action. There is a clear gap in leadership for the better health agenda in the capital.

That is why the Commission recommends the appointment of a London Health Commissioner by the Mayor, supported by a dedicated team, and with a significant budget from Public Health England.

The Commissioner would provide a critical focal point to drive the recommendations in this report for better health, and through this improve the health and wellbeing of all Londoners, especially those who are less advantaged.

The Commissioner would work closely with the boroughs, the NHS and Public Health England to address issues of joint concern. There are many health issues in London that do not respect borough boundaries. For example, air quality is a pan-London issue. Similarly, recommendations such as making parks and other green spaces smoke free, or changing planning guidance for takeaway outlets near schools, all require joint action.

The Commissioner's role would not be to provide technical advice to the Mayor on the implications of outbreaks of communicable disease or other issues. That role should continue to be fulfilled by the Regional Director of Public Health for London. In the future, the RDPH for London should report to both the Commissioner and to the Chief Executive of Public Health England.

Nor would the Commissioner have any role in the management of the NHS, or in services changes. There were calls for the Commission to recommend the recreation of a Strategic Health Authority for London. These were carefully considered and rejected as both unworkable and undesirable.

Recommendation 61

The Mayor should appoint a London Health Commissioner to champion health in the capital, supported by combining the London region of Public Health England and the GLA health teams; the Mayor should request the Department of Health for the Commissioner to receive a significant budget from Public Health England.

Working better together

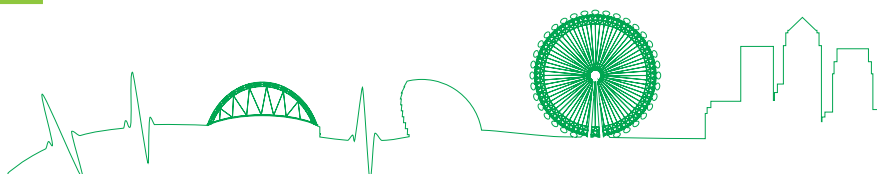
In recent years, the health and care system in London has increased the role of partnership working. Relationships between CCGs and local authorities are going from strength to strength. It is vital that partnerships between local commissioners remain the principal point for commissioning health and care services. It is anticipated that local authorities and CCGs, through Health and Wellbeing Boards, will drive significant improvements in the health and care of Londoners.

There will be times when improvements will need to be pursued by multiple CCGs and boroughs simultaneously. In public health, for example, challenges such as air quality naturally lend themselves to a multi-borough approach. Similarly, many of the large acute hospitals serve multiple boroughs, and so delivering more joined up care – such as getting more specialists to join in integrated care models with local GPs – will require collaboration across CCGs.

When CCGs and their local authority partners wish to collaborate, more support and decision-making powers should be devolved to them from the London region of NHS England. The obvious way to do this is through existing arrangements such as the strategic planning groups.

Recommendation 62

NHS England should further empower CCGs to work together – with their local authority partners – to improve care across multiple boroughs, by devolving further decision-making powers to strategic planning groups.



Improving transparency in decision making

Good leaders have the courage to openly debate proposals, to listen to feedback, and to adapt and change their course in response to what they hear. It has been observed that too many NHS decisions appear to be taken behind closed doors.

London's leaders must be committed to greater transparency. It's leaders have good intentions – they are committed people who are passionate about improving health and care – and should have nothing to fear from greater openness.

That's why the Commission proposes new measures to ensure that decision-making is transparent, and seen to be so.

Recommendation 63

London should be the most transparent region of England's health and care system by including representation of people who use services on decision-making committees, by holding meetings in public, and publishing meeting documents online.

Implementation

The health and economic impact of our proposals has been assessed. It will be published alongside this report. The findings are that the measures in this report, if implemented, will have a significant, positive impact on the health and care of Londoners, and will improve the financial sustainability of the health and care system in London.

One of the great strengths of the Commission has been its independence. It has allowed genuinely free and creative thought – resulting in a report bursting with well-designed, detailed proposals. These proposals have been shared extensively with senior stakeholders across government. There has been extensive engagement with the private sector, with employers, with the voluntary sector too.

During the past year, members of the Commission and the programme team have met with senior officials from HM Treasury, the Cabinet Office, local authorities, the Greater London Authority, NHS England, Transport for London, the Department of Health, the Department for Communities and Local Government, the Department of Education, the Department of Business, Innovation and Skills, the Metropolitan Police, the London Fire Brigade, the London Ambulance Services, and almost all of London's mental and physical health trusts and health and care commissioners.

This means that the proposals have been developed to considerable detail and are ready to be taken forward for implementation. Nonetheless, the Commission has the power to recommend not the power to decide. As a consequence, each of the institutions and organisations to whom recommendations are made will need to consider their responses.

Once it has been decided which recommendations are to be taken forward, the Mayor and GLA should convene all the principal actors together, develop a delivery plan, and support its implementation.

Recommendation 64

Once all the bodies named in this report have set out their responses, the Mayor should convene and personally chair a group to prepare a unified delivery plan. This group should then continue to oversee progress in the implementation of the recommendations in this report.



Summary of recommendations

1. Better health for all

Recommendation 1:

All health and care commissioners and providers should innovatively and energetically engage with Londoners on their health and care, share as much information as possible, and involve people in the future of services.

Recommendation 2:

The Mayor, Royal Parks, City of London and London boroughs should use their respective powers to make more public spaces smoke free, including Trafalgar Square, Parliament Square, and parks and green spaces.

Recommendation 3:

The Mayor should launch a fresh crackdown on the trafficking in and selling of illegal tobacco.

Recommendation 4:

London boroughs should introduce mandatory traffic light labelling and nutritional information on menus in all restaurant and food outlet chains in London, by using their byelaw and licensing powers.

Recommendation 5:

London boroughs afflicted by problem drinking should be supported if they choose to pilot a minimum 50p price/unit for alcohol through their byelaw and licensing powers.

Recommendation 6:

The GLA and London boroughs should include 'sin taxes' in their review of how London might manage devolved taxation powers, and if appropriate, make a case to central Government.

Recommendation 7:

The Mayor should invest 20% of his TfL advertising budget to encourage more Londoners to walk 10,000 steps a day, and TfL should change signage to encourage people to walk up stairs and escalators.

Recommendation 8:

The NHS, Public Health England, and TfL should work together to create a platform to enable employers to incentivise their employees to walk to work through the Oyster or a contactless scheme.

Recommendation 9:

The Mayor should encourage all employers to promote the health of Londoners through workplace health initiatives. The NHS should lead the way by introducing wellbeing programmes, including having a mental health first aider for every NHS organisation.

Recommendation 10:

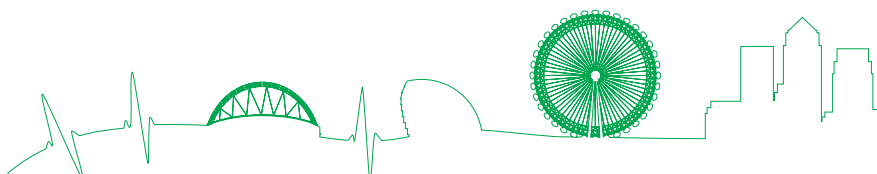
London boroughs, the GLA and the NHS should work together to organise an annual Mayor's 'Imagine Healthy London' Day in London's parks, centred on an 'All-Borough Sports Festival' with health professionals offering health checks, and exercise and healthy eating workshops.

Recommendation 11:

London's professional football clubs should promote health in stadiums and local communities through club incentives and competition.

Recommendation 12:

The Mayor should accelerate planned initiatives on air quality in London to help save lives and improve the quality of life for all Londoners.



2. Better health for London's children

Recommendation 13:

Health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three.

Recommendation 14:

The Mayor should use the 'London Plan' planning guidance to support local authorities in protecting London's children from junk food through tighter controls within 400 metres of schools and to promote access to healthier alternatives.

Recommendation 15:

Local authorities, the GLA and Public Health England should work with Ofsted to ensure more data is published on school health and wellbeing.

Recommendation 16:

Health commissioners and providers should launch a process to address the variation in quality of care for children and to propose actions to improve outcomes.

3. Better care

Recommendation 17:

Health and care commissioners should commission holistic, integrated physical, mental and social care services for population groups with similar needs, with clearly defined outcomes developed by listening to people who use services.

Recommendation 18:

Health and social care professionals should partner with people who use services to ensure that their voice is heard in designing and implementing improvements to care.

Recommendation 19:

Health and care commissioners and the voluntary sector should promote the implementation of shared decision making, care and support planning, education for self-management, personal health budgets, and access to health records so that London becomes an exemplar in improving people's participation in their own care and treatment.

Recommendation 20:

Health Education England, NHS England, and professional regulators should work together with the voluntary sector to develop education programmes for self-management of long-term conditions, which would enable more peer support and empower programme graduates to self-prescribe their own medication for their own condition.

Recommendation 21:

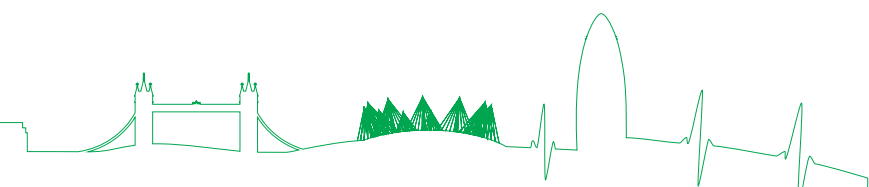
The Department of Health and NHS England should launch a five-year £1 billion investment programme in GP premises so that all Londoners are able to access care in modern purpose-built/designed facilities.

Recommendation 22:

Health commissioners should increase the proportion of total London NHS spending dedicated to GPs and primary and community services and facilities.

Recommendation 23:

Commissioners should set ambitious new service and quality standards for GPs in London, tailored to the different population groups of patients they serve.



Recommendation 24:

NHS England and CCGs should promote and support GPs working in networks to reduce professional isolation, to provide a wider range of services and to provide more appointments at more convenient times.

Recommendation 25:

NHS England and CCGs should allow patients to move freely within GP networks, so those registered with one GP practice are able to access services from other practices within the same network.

Recommendation 26:

NHS England and CCGs should put in place arrangements to allow existing or new providers to set up new GP services in areas of persistent poor provision in London.

Recommendation 27:

Health commissioners should improve specialist care by accelerating efforts to create centres of excellence for cancer and cardiovascular services, launching a new programme to review elective orthopaedic services, and ensuring London Quality Standards are implemented.

Recommendation 28:

Health and care commissioners should ensure that all Londoners have access to digital mental health support, in the languages that they speak, and using the latest technology.

Recommendation 29:

NHS England should strengthen the role of mental health in primary care, with a particular focus on timely access to psychological therapies and early intervention services, and on improving the capacity and capability of GPs to care for people with mental illnesses.

Recommendation 30:

Health and care commissioners should develop a pan-London multi-agency (including the police and ambulance service) case for change and model of care for child and adult mental health patients in crisis.

Recommendation 31:

Health and care commissioners should develop a pan-London, multi-agency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by a single lead commissioner.

4. Maximising science, discovery and innovation to enhance economic growth

Recommendation 32:

The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Digital Health and Accelerator for London, coordinated by MedCity and the AHSNs.

Recommendation 33:

London's AHSCs should support and help expand the Health Informatics Collaborative funded by NIHR to improve knowledge sharing for research purposes.

Recommendation 34:

The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Dementia Research to bring together expertise in basic sciences, technology and social policy to address the dementia crisis.

Recommendation 35:

London's providers should work with the Health Research Agency and Clinical Research Networks to create a simple and unified gateway for clinical trials in London.



Recommendation 36:

Clinical Research Networks should establish a strategic clinical research office to increase late phase research/ novel real world studies in smaller NHS Trusts and GP practices.

Recommendation 37:

NHS England should strengthen London's AHSNs by further consolidating and channeling all innovation and improvement programmes through them.

Recommendation 38:

AHSC/Ns should forge greater links with Commissioners to advise on the use of latest innovations for patient benefit and to support delivery by providers.

Recommendation 39:

AHSNs in the South East should continue to collaborate – specifically on systematic knowledge sharing to improve adoption of innovation – to make South East England a leading region internationally for the adoption of the latest healthcare technologies and innovations.

5. Making it happen

Recommendation 40:

NHS England should develop a single London-wide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen initiative and the Imagine Healthy London brand.

Recommendation 41:

The Mayor should create a Citizens' Health Panel to oversee the engagement and involvement of Londoners, ensuring the capital's existing expertise and community diversity is fully represented.

Recommendation 42:

AHSNs, CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality.

Recommendation 43:

The National Information Board should designate London as an incubator for innovative health information, providing investment and support.

Recommendation 44:

Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care.

Recommendation 45:

NHS England should fund and trial patient-reported outcomes measures linked to payments to London providers.

Recommendation 46:

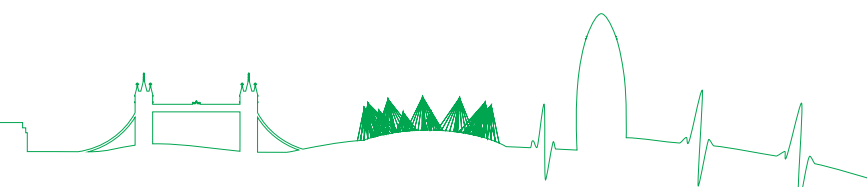
London CCGs and Strategic Planning Groups should consider developing local initiatives to promote greater equity in financing the health and care system.

Recommendation 47:

NHS England should make clear the budget for the London Region of NHS England and for London CCGs for the duration of future spending review periods.

Recommendation 48:

NHS England and CCGs should establish a shared transformation budget for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies.



Recommendation 49:

NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups, such as elderly people with long-term conditions.

Recommendation 50:

NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers.

Recommendation 51:

NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices, and require practices to comply with disabled access requirements or accept new facilities.

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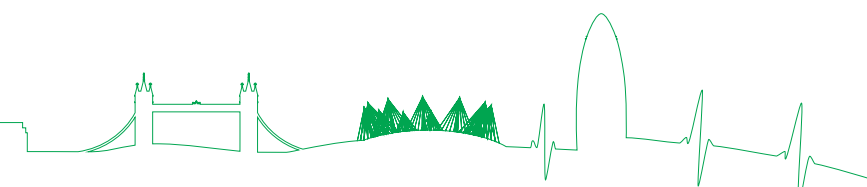
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Glossary

Acute services

See secondary care.

AHSCs (Academic Health Science Centres)

Partnerships between universities and healthcare providers focusing on research, clinical services, education and training, and intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients. AHSCs have related functions to AHSNs but are smaller scale.

AHSNs (Academic Health Science Networks)

Regional organisations within the NHS which aim to bring together health services and academic and industry members to improve patient outcomes and generate economic benefits for the UK by promoting and encouraging the adoption of innovation in healthcare.

Bed occupancy rates

The number of hospital beds occupied by patients expressed as a percentage of the total beds available.

Binge drinking

Drinking lots of alcohol in a short space of time or drinking to get drunk. Usually defined as consuming eight or more units in a single session for men and six or more for women.

Biotechnology

The use of living organisms or their components to produce useful, usually commercial, products.

Capitation payment

A system based on payment per person, rather than payment per service provided.

Care clusters

Groupings of service users based on their characteristics. They are a way of classifying individuals using mental health services that is intended to form the basis for payment. The Mental Health Clustering Tool (MHCT) is used by clinicians to support their decision to allocate a service user to a care cluster, which is then the basis for Payment by Results (PbR) in mental health.

CCGs (Clinical Commissioning Groups)

Independent statutory bodies that include the local GP practices in their area. A CCG has control of a local health care budget and 'buys' local healthcare services on behalf of a local population.

Chronic diseases

Conditions which are of long duration and generally slow progression, and can be controlled with drugs or other treatment but not cured e.g. diabetes, COPD, arthritis and hypertension

Chronic lower respiratory diseases

A group of diseases which affect the lungs. It includes asthma, bronchiectasis, and chronic obstructive pulmonary disease (COPD), an umbrella term for emphysema and chronic bronchitis.

Class A5 shops

Hot food takeaway shops.

Clinical Research Networks

The clinical research delivery arm of the NHS, providing the infrastructure to facilitate high quality clinical research studies.



Clinical trials

A particular type of clinical research that compares one treatment with another. It may involve patients or healthy people, or both.

Community care

Long-term care for people who are mentally ill, elderly, or disabled which is provided within the community rather than in hospitals or institutions.

Conduct disorder

A psychological disorder that can occur in childhood or adolescence, presenting itself as a repetitive and persistent pattern of anti-social behaviour.

Digital health

The convergence of the digital and genetics revolutions within healthcare, with the goal of reducing inefficiencies, improving access, reducing costs, increasing quality, and making medicine more personalized and precise.

Elective services

Non-emergency services.

Foundation Trusts

NHS hospitals which have a degree of independence from the Department of Health.

FSA (Food Standards Agency)

The government body responsible for food safety and food hygiene across the UK. It works with local authorities to enforce food safety regulations and its staff work in UK meat plants to check that standards are being met.

GLA (Greater London Authority)

The top-tier administrative body for Greater London. It consists of a directly elected executive Mayor and an elected 25-member London Assembly with scrutiny powers. It is a strategic regional authority, with powers over transport, policing, economic development, and fire and emergency planning.

Health and Wellbeing Boards

Local Authority committees which bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

Health Education England (HEE)

A special health authority of the NHS, with responsibility for education, training and workforce development.

Health inequalities

Differences in health state or status between individuals or groups. These can be measured in various ways such as socioeconomic group, gender, ethnicity or geographical location. Health inequalities may be partly biological in origin but may also be the consequence of human activity.

Health promotion

The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

Healthcare for London: A Framework for Action

A report published in 2007, setting out a strategy to meet Londoners' health needs over the next five to 10 years.



HRA (Health Research Authority)

A Special Health Authority responsible for promoting and protecting the interests of patients in health research and for streamlining the regulation of research.

Imperial College London

A research university specialising in engineering and medicine.

Infant mortality rate

The number of deaths in the first year of life per 1,000 live births.

Innovation Scorecard

A tool to allow patients and the public to see which NHS Trusts are adopting the latest NICE-approved treatments and drugs most quickly.

Integrated care

A concept that brings together the delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion, in order to improve services in terms of access, quality, user satisfaction and efficiency.

Interventions

Actions to promote behaviour that optimises mental and physical health or discourage behaviour considered to be potentially damaging to health. In medical terms this may be a drug treatment, surgical procedure, diagnostic test or psychological therapy. Public health interventions include actions to help someone to be physically active, eat a more healthy diet or stop smoking.

King's College London

A research university which is a centre for medical teaching and biomedical research.

King's Fund

An independent charity working to improve health and health care in England.

LETBs (Local Education and Training Boards)

Committees of the national body Health Education England (HEE), responsible at a regional level for the training and education of NHS staff, both clinical and non-clinical.

Life sciences

The sciences concerned with the study of living organisms, including biology, botany, zoology, microbiology, physiology, biochemistry, and related subjects.

London Finance Commission

An independent commission established by the Mayor after his election in May 2012 to help improve tax and public spending arrangements for London in order to promote jobs and growth.

London Leadership Academy

The pan-London leadership development organisation for the NHS in London.

London Plan

The Mayor of London is responsible for producing a planning strategy for London: the London Plan is the name given to the Mayor's spatial development strategy.

Low Emission Zone

A traffic pollution charge scheme with the aim of reducing the tailpipe emissions of diesel-powered commercial vehicles in London. Only vehicles that do not conform to higher emission standards are charged: the others may enter the controlled zone free of charge.

LSE (London School of Economics and Political Science)

A university specialising in the study of social sciences.



LSHTM (London School of Hygiene & Tropical Medicine)

A university specialising in research and postgraduate education in public and global health.

LTCs (Long term conditions)

See chronic diseases.

Monitor

An executive non-departmental public body sponsored by the Department of Health. It acts as the regulator for health services in England.

MOPAC (Mayor's Office for Policing And Crime)

The strategic oversight body which sets the direction and budget for the Metropolitan Police Service on behalf of the Mayor.

Mortality rates

The proportion of a population that dies within a particular period of time. The rate is often given as a certain number per 1,000 people. See also infant mortality rate and standardised mortality rates.

NHS England (London)

The NHS England area team responsible for commissioning London's specialised and primary care services and holding CCGs in London to account.

NHS IQ (NHS Improving Quality)

Part of NHS England, set up to provide improvement and change expertise to support improved health outcomes.

Obesity

Abnormal or excessive fat accumulation that may impair health. Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify obesity: a BMI greater than or equal to 30 is obese for an adult, while for a child it is defined as a BMI above the 95th percentile.

Ofsted

The Office for Standards in Education, Children's Services and Skills inspects and regulates services that care for children and young people, and those providing education and skills for learners of all ages.

Outcomes

The impact that a test, treatment, policy, programme or other intervention has on a person, group or population. Depending on the intervention, outcomes could include changes in knowledge and behaviour related to health, or an improvement or deterioration in someone's health, symptoms or situation.

Personal care plan

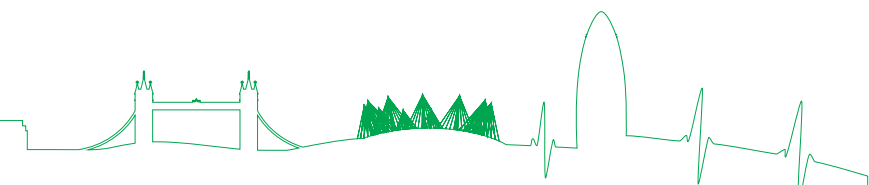
A plan developed by the patient and their healthcare professional that contains information about the individual's health, lifestyle and options for treatment or care, with the aim of giving the patient greater ownership and responsibility in the management of their care.

PHE (Public Health England)

An executive agency of the Department of Health, set up to protect and improve the nation's health and to address inequalities.

PM10

Particulate matter, i.e. particles of soot (carbon), metals or inorganic salts. They vary in size and shape and are usually classified according to size categories: typically less than or equal to 10 micron is known as PM10.



Poverty line

Official definitions usually use relative income to measure poverty: an income threshold is set and those who fall below it are regarded as in poverty. In the UK, key government measures take 60% of median income as the poverty line.

Primary care

Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.

Secondary care

Healthcare provided in hospitals. It includes accident and emergency departments, outpatient departments, antenatal services, genitourinary medicine and sexual health clinics.

SEMI

Severe and enduring mental illness such as bipolar disorder or schizophrenia

SMEs

Small and medium-sized enterprises. The main factors determining whether a company is an SME are number of employees and either turnover or balance sheet total.

Social care

Care services for people who need extra help because of their age or physical or learning disabilities, and for children in need of care and protection. Examples are residential care homes for elderly people, support for people living in their own homes, and services for looked-after children.

Standardised mortality rates

Death rate of a population adjusted to a standard distribution, often for age. As most causes of death vary significantly with people's age and gender, the use of standardised death rates improves comparability over time and between geographical areas.

Strategic Clinical Networks

Advisory groups of clinical experts covering a particular disease group, patient group or professional group. Time-limited to five years, they aim to help improve care using evidence-based best practice.

Strategy for UK Life Sciences

A government strategy published in 2011, setting out a long-term vision to re-establish the UK's global leadership in life sciences and support the growth of British life science small and medium-sized enterprises.

TDA (Trust Development Authority)

A Special Health Authority of the Department of Health, responsible for overseeing the performance management and governance of NHS Trusts and managing their progress towards foundation trust status.



Tertiary care

Care for people requiring complex treatments, usually in a specialist centre. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.

TfL (Transport for London)

A local government body responsible for most aspects of the transport system in Greater London.

Third sector

Also known as the voluntary sector, it describes social activity undertaken by organisations that are not-for-profit and non-governmental.

UCL (University College London)

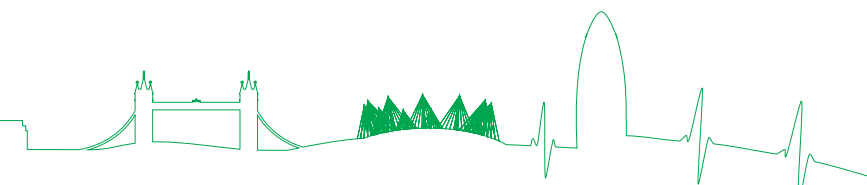
One of the top research-led universities in the UK and a centre for biomedical science.

UCL Partners

A large London-based AHSC with over 40 higher education and NHS members.

WHO (World Health Organisation)

The United Nations specialised agency for health. It is responsible for providing leadership on global health matters and its aim is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's constitution as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.



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Chinese

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Arabic

إذا أردت نسخة من هذه الوثيقة بلغتك، يرجى
الاتصال برقم الهاتف أو مراسلة العنوان
أدناه

Bengali

আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি
(কপি) চান, তা হলে নীচের ফোন নম্বরে
বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

Greek

Αν θέλετε να αποκτήσετε αντίγραφο του παρόντος
εγγράφου στη δική σας γλώσσα, παρακαλείστε να
επικοινωνήσετε τηλεφωνικά στον αριθμό αυτό ή το
δρομικά στην παρακάτω διεύθυνση.

Gujarati

જો તમને આ દસ્તાવેજની નકલ તમારી ભાષામાં
જોઈતી હોય તો, કૃપા કરી આપેલ નંબર ઉપર
ફોન કરો અથવા નીચેના સરનામે સંપર્ક સાધો.

Hindi

यदि आप इस दस्तावेज की प्रति अपनी
भाषा में चाहते हैं, तो कृपया निम्नलिखित
नंबर पर फोन करें अथवा नीचे दिये गये
पते पर संपर्क करें

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ
ਵਿਚ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਹੇਠ ਲਿਖੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਹੇਠ
ਲਿਖੇ ਪਤੇ 'ਤੇ ਰਾਬਤਾ ਕਰੋ:

Turkish

Bu belgenin kendi dilinizde
hazırlanmış bir nüshasını
edinmek için, lütfen aşağıdaki
telefon numarasını arayınız
veya adrese başvurunuz.

Urdu

اگر آپ اس دستاویز کی نقل اپنی زبان میں
چاہتے ہیں، تو براہ کرم نیچے دئے گئے نمبر
پر فون کریں یا دیئے گئے پتے پر رابطہ کریں

Vietnamese

Nếu bạn muốn có văn bản tài liệu
này bằng ngôn ngữ của mình, hãy
liên hệ theo số điện thoại hoặc địa
chỉ dưới đây.

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