Introduction

This Briefing gives an overview of the NHS in London at the beginning of a new political and financial era in the NHS. It is a background briefing on healthcare in London following the recent publication of the white paper *Equity and Excellence: Liberating the NHS* (hereafter referred to as “the white paper”). This paper does not consider in detail the implications of emerging policy – this will be set out in separate documents from the NHS Confederation.

London and its health services are unique. London encompasses the biggest health authority region in England, both in spend and the number of people served. It is also the most diverse, with 90 different ethnic minority groups making up over 30 per cent of the city’s population. London is home to some of the most wealthy, and most deprived, people in Britain, and its population is particularly young and mobile, with large numbers of people both migrating to and leaving the capital each year. All of these factors present particular challenges for healthcare services.

London’s population and NHS services

London’s health services provide care for more than 7.6 million residents, or 12.5 per cent of the total English population, at a cost to the NHS of around £14 billion a year. Another 1 million people commute in or visit the city each day, many of whom also make use of the city’s healthcare. The high numbers of people coming in and out of the city presents particular healthcare challenges, such as ensuring new arrivals are able to access the right NHS services. Despite some notable achievements in recent years – for example, death rates from breast cancer have fallen in the capital by about 25 per cent in 20 years and the number of GPs has increased by 20 per cent in the ten years to 2009 – there remain significant health challenges for Londoners and London’s NHS.

London’s population is growing rapidly due to high birth rates and...
levels of migration. Demand for health services is also increasing due to both the rising population and changes in the way people use services. The city’s population is expected to increase from 7.6 million to up to 8.7 million by 2026.

London has a relatively young population, although the proportion of older people is growing. In 2007, 24 per cent of the population was under the age of 20, with 12 per cent over the age of 65. The age profile of the capital puts particular pressure on maternity and paediatric services, but it is expected that in the future London will have an increasing number of older people with long-term conditions such as diabetes, coronary heart disease, respiratory problems, hypertension and dementia, as well as an increasing need for care.

London also experiences a higher proportion of people with serious mental health problems than the national average, and this is linked to the high levels of deprivation, homelessness and drug and alcohol misuse.

NHS services in London are currently provided through 71 trusts, many of which are also teaching, specialist or academic centres. Their breakdown, and a number of the key organisations which support them, are outlined in figure 1 below.

**Healthcare in London is changing**

Healthcare is changing as a result of greater specialisation and the need for more effective care for people with long-term conditions. At the same time, demand for NHS services in London is increasing. Visits to A&E increased by 8 per cent between 2004 and 2008 and calls to ambulance services increased by nearly 20 per cent.

In order to provide better care for Londoners, the NHS has concentrated certain clinical services onto fewer sites. There is strong clinical evidence that providing some types of specialist care in high-volume, well-resourced centres can improve the quality of care and save lives. The greater volumes of patients brought about through consolidating services mean doctors become better at spotting problems and treating them quickly. Consolidating services also allows the latest equipment to be placed alongside the most expert clinicians. As techniques and technology have developed over recent years, access to the best specialty services rather than close proximity has become the key for patient safety and improving survival rates.

In London, some heart attack and stroke services, and also services for major trauma patients, have been consolidated in order to improve the quality of care. In 2006, eight heart attack centres were established in London to enable patients access to specialist care 24 hours a day, including primary angioplasty...
where required. Previously patients received thrombolytic (clot-busting) drugs for heart attacks, which has a lower success rate than primary angioplasty\textsuperscript{16}.

As with the heart attack centres, eight hyper-acute stroke units (HASUs) have been established to improve stroke care in London through specialist centres. Clinical evidence has shown that where patients can access specialist stroke services, including CT scanning and thrombolysis, 24 hours a day, they have better outcomes.

New major trauma centres at St George's Hospital, St Mary's Hospital and King's College Hospital will join the established major trauma facilities at the Royal London Hospital this year to treat patients with serious, complex and often multiple injuries, such as those which result from a serious car crash. These centres bring together specialist teams including neurosurgeons, vascular specialists, orthopaedic surgeons and trauma nurses. It is estimated that the new stroke and trauma services will together save around 500 lives a year\textsuperscript{17}.

The London Ambulance Service plays a key role in delivering these new consolidated services; their ambulance staff are trained to ensure patients can be taken to the most appropriate (not necessarily the closest) centre.

In addition to changes in acute hospital care, London's health services have been focused in recent years on developing better community services through improved primary and community care in order to prevent illness, reduce hospital admissions and reduce inequalities. In response to these needs and following the Darzi review of healthcare in London, polyclinics and GP-led health centres were introduced with an aspiration to improve access to GP services (including through longer opening hours), and also to a wide range of diagnostic and outpatient services and clinics for people with long-term conditions\textsuperscript{18}.

Even prior to the recent white paper, these new centres were working collaboratively with other GPs in networks. There are around 6,000 GPs working in London.

Mental healthcare in London has also been changing. An increasing amount of care is being provided in the community by dedicated mental health teams and outside acute hospitals. This is to enhance care by enabling people to remain with family and friends, so far as possible, while in treatment. There are currently around 470 community mental health teams working in London. Due to increased community care, the number of hospital beds for mental health patients has reduced by around 13 per cent (or over 850 beds) since 2001.

Quality of care is variable

The quality of services in London's hospitals is variable, with pockets of excellence as well as under performance. Seven NHS hospital trusts in London were rated as “excellent” for both the quality of services and use of financial resources by the Care Quality Commission in 2009\textsuperscript{19}. However, London also has a number of trusts which are struggling. During the first half of the 2009/10 financial year, of trusts found to be under-performing by the Department of Health, the majority were in London\textsuperscript{20}. The reasons for this assessment vary, but include poor performance on measures of service user experience, national standards and targets and issues of financial management.

There are also problems with access to GPs in some areas of London. Of all strategic health authority (SHA) regions, London has the lowest proportion of people reporting to be “very satisfied” with the opening hours of their GPs and the lowest proportion able to book ahead for an appointment. The city also has the highest percentage of people saying they didn’t see a GP in the last six months because they couldn’t be seen at a convenient time\textsuperscript{21}. Furthermore, there is variation in GP distribution, with fewer GPs per head, and a greater concentration of small or single-handed practices, in some deprived areas\textsuperscript{22}.

More work needed to reduce inequalities

The health of Londoners is dramatically different for people of different social backgrounds. Life expectancy for men in London ranges from 71 years in the Tottenham Green ward in Haringey to 88 years in the Queen’s Gate ward in Kensington and Chelsea\textsuperscript{23}. Poorer health, including poorer mental health, often goes hand in hand with deprivation, and London is home to both some of the wealthiest and most deprived...
people in England. London’s children are particularly deprived when compared to other regions, and experience high rates of obesity, teenage pregnancy, tooth decay and poor rates of immunisation\textsuperscript{24, 25, 26}.

The SHA, NHS London, has prioritised reducing deaths from cancer and cardiovascular disease in London to help reduce the inequalities gap. While life expectancy is improving across London, meeting plans to reduce deaths from cancer has proven challenging\textsuperscript{27}.

The table below (figure 2) demonstrates that there is wide variation in London in the levels of physical activity by household income. Low levels of activity are associated with health complications such as obesity, diabetes and cardiovascular disease. NHS London has launched a major campaign, Go London, to increase physical activity across the capital in the run up to the 2012 Olympics.

This complements the range of other public health initiatives and the Mayor of London’s health inequalities strategy (2010).

It is well recognised that the health system cannot tackle the problem of health inequalities alone – housing, local authorities, other community agencies and employers all have a part to play. Encouraging improved health requires attention to all aspects of society, including economic inequality and quality of life in early years. The white paper sets out plans to move responsibility for public health to local authorities in recognition of the influence they have over the wider determinants of health.

### Financial constraints and doing things differently

In 2008/09 around £14 billion was spent on healthcare in London\textsuperscript{28}, out of a total NHS budget of £102 billion. Historically, London’s NHS has received additional funding in recognition of its high number of teaching hospitals and research facilities. However, its share of funding for NHS research, teaching and general healthcare has been reduced in recent years to compensate for this perceived over-funding. There is vigorous debate about how the funding formulas should be constructed and whether they adequately acknowledge London’s costs and need.

NHS London estimates that by 2016/17, London’s NHS will face a funding shortfall of between £3.8 and £5.1 billion per year, based on projections of anticipated activity, costs and funding levels\textsuperscript{29}. Cost and demand for NHS services in London are expected to outstrip funding increases and therefore require significant efficiency savings to reinvest in services.

NHS London estimates that overall demand for NHS services in the capital will rise by an estimated 4 per cent a year to 2015, while funding increases will vary by between 0.5 and 2.3 per cent.

Complexities in NHS funding and growing demand mean that despite the relatively generous financial allocations for the year 2010/11, there are NHS organisations in London that are likely to continue to experience significant levels of debt and will be reliant on finance from elsewhere in the NHS to continue delivering services. In addition, expected reductions to local authority funding are likely to put pressure on the NHS to take greater responsibility for aspects of social care, such as care at

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**Figure 2: Physical activity levels by household income, London 2007/08**

<table>
<thead>
<tr>
<th>Income (£)</th>
<th>0%–15,599</th>
<th>15,600–20,799</th>
<th>20,800–25,999</th>
<th>26,000–31,199</th>
<th>31,200–36,399</th>
<th>36,400–51,999</th>
<th>52,000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>35%</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Mayor of London
Confederation viewpoint

The NHS in London has made significant progress in delivering improved and high-quality healthcare over the past decade, but there is still much to do. There are significant challenges for health and healthcare in London: there are serious health inequalities among the population; the quality of care is not always good enough; access to primary and community care needs to be improved; and hospital services need to eliminate pockets of poor performance.

As the NHS Confederation set out in its report *Rising to the challenge: health priorities for government and the NHS* (2010), urgent action is required to root out inefficiencies in the system. Reducing costs and redesigning services will be needed, while adhering to the Government’s key tests for reconfigurations – that they have strong public and patient engagement, consider patient choice, have support from GP commissioners and are based on sound clinical evidence.

While implementing the necessary changes, we must not lose sight of the things that matter to patients such as the quality of care, patient experience and safety. Delivering the improvements needed during a time of financial austerity and organisational change will doubtless be a challenge, particularly around the public health and health inequalities agenda which, arguably, is the capital’s number one health challenge. It will require determination and effective partnerships between GPs and other clinicians, patients, local

Organisational structures are changing

The way in which health services are planned and purchased at a local level has changed over the years and will change further following the publication of the white paper. Currently, however, it is PCTs that are responsible for commissioning health services and planning for the health needs of their local people. In London, PCTs have joined together as six ‘sectors’, made up of between three to eight PCTs, to coordinate the commissioning of acute hospital services and to help improve the quality and efficiency of services. Each sector is led by a chief executive who reports to the chief executive of NHS London, and is supported by an executive team.

The recent white paper sets out ambitious proposals for changing the way in which health services are commissioned and planned. It proposes taking responsibility for procuring most health services away from PCTs and giving it to groups of GPs, while establishing an independent NHS commissioning board to ensure primary care services such as general practice and dentistry are provided to local communities. Under these plans, PCTs and strategic health authorities would be abolished from 2012/13, while local authorities would gain greater responsibility at a local level for health improvement.

The organisational responsibility for community services such as health visiting and community nursing, which have until recently been provided by PCTs, is also changing. By the end of the 2010/11 financial year community services will need to be provided by other organisations such as acute hospitals, mental health trusts, social enterprises or new community foundation trusts.

There are also financial challenges associated with the NHS estate in London. Much of it is between 30 and 100 years old and no longer suitable for modern healthcare needs. To modernise the estate, there has been a series of new builds and renovations financed by private finance initiatives. However, much of the estate still requires updating if it is to enable effective and efficient care.

Discussion in London about how to make the required efficiency savings reflect those being had more generally within the NHS. The NHS Confederation’s *Dealing with the downturn* (June 2009) outlined a number of areas where savings could be made, including:

- redesigning services to remove overlaps and duplication in services that have evolved over time, thus improving the productivity of staff
- shifting resources from clinical interventions that have little or no benefit to those that reduce the risk of ill health and demand for healthcare services
- adopting best practice and creating smooth patient flows
- working with partner organisations to reduce operating costs.

Home for older people following a hospital stay.

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authorities and other key partners to ensure that Londoners continue to get the best from their NHS. The publication of the white paper on health reform and the white paper on public health (expected late 2010) are the start of a process, not the final word, in the debate on the future of the NHS in London.

For more information on the issues covered in this Briefing, contact the NHS Confederation’s London Relations Manager, Creina Lilburne, at creina.lilburne@nhsconfed.org

References
For all references in this Briefing, please see the appendices at www.nhsconfed.org/publications

Further information
The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS. Our ambition is a health system that delivers first-class services and improved health for all.

We work with our members to ensure that we are an independent driving force for positive change by:

• influencing policy, implementation and the public debate
• supporting leaders through networking, sharing information and learning
• promoting excellence in employment.