

BETTER HEALTH FOR LONDON

The report of the
London Health Commission



This report is about better health for London. It rests on the 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.

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.

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 it easier to make the healthier choice.

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.

Let us Londoners look forward to the blossoming of better health across our capital city, in our homes and 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 note on the report

This report has been put together with the help of literally thousands of Londoners. The Commission has held engagement events, roadshows and hearing sessions, in order to listen to the views of Londoners about what they wanted for the health of their city.

You will hear and see this engagement throughout this report. There is also a huge amount of detailed work sitting behind this report and each recommendation, in terms of further statistics, data and analysis.

This evidence, and a longer, more detailed version of the report, notes on contributors and a full list of Commission members can all be found on the Commission's website:

www.londonhealthcommission.org.uk

Ambitions for London

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

Today, London is middle of the pack, ranked number 7 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.

Ranked number
7 out of **14**
comparable
cities around
the world

Today, London is middle of the pack, ranked number 7 out of 14 comparable cities around the world in terms of health, wealth and education. 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, which are supported by the full list of recommendations in the report (see appendix):

	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. 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.

A picture of London's health

London spends **£22.5bn** on health and social care services.
And employs more than **400,000 people** in the health sector.

Over **8,000** fast food outlets in London, many close to schools.

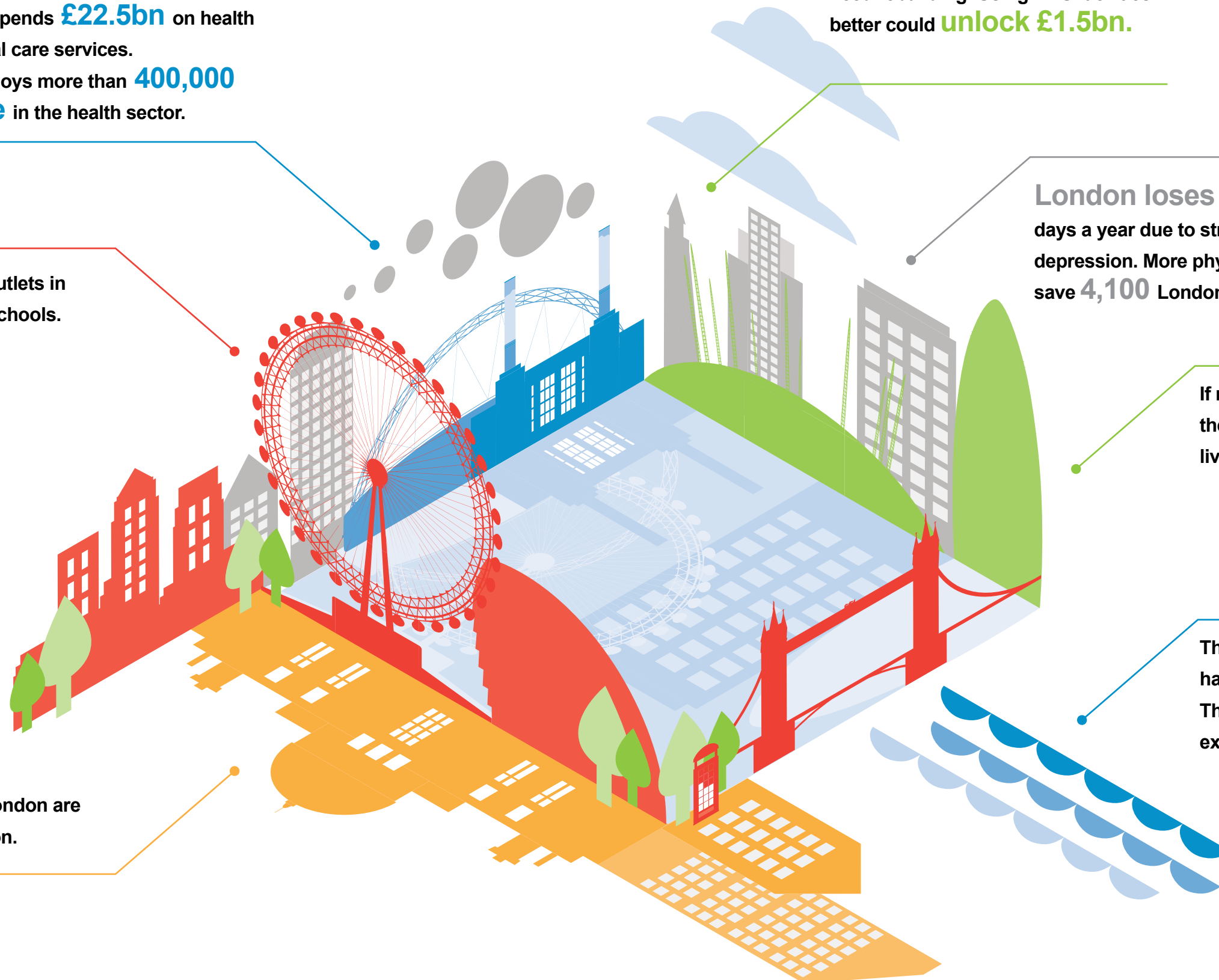
7% of deaths in London are attributable to air pollution.

A third of GP premises need rebuilding. Using NHS facilities better could **unlock £1.5bn**.

London loses **6.63m** working days a year due to stress, anxiety or depression. More physical activity could save **4,100** Londoners' lives per year.

If mortality rates at the weekend were the same as during the week, **500** lives could be saved.

The life expectancy of a man who has psychosis is **65 years**. This is the same as the typical life expectancy of a man in **1954**.

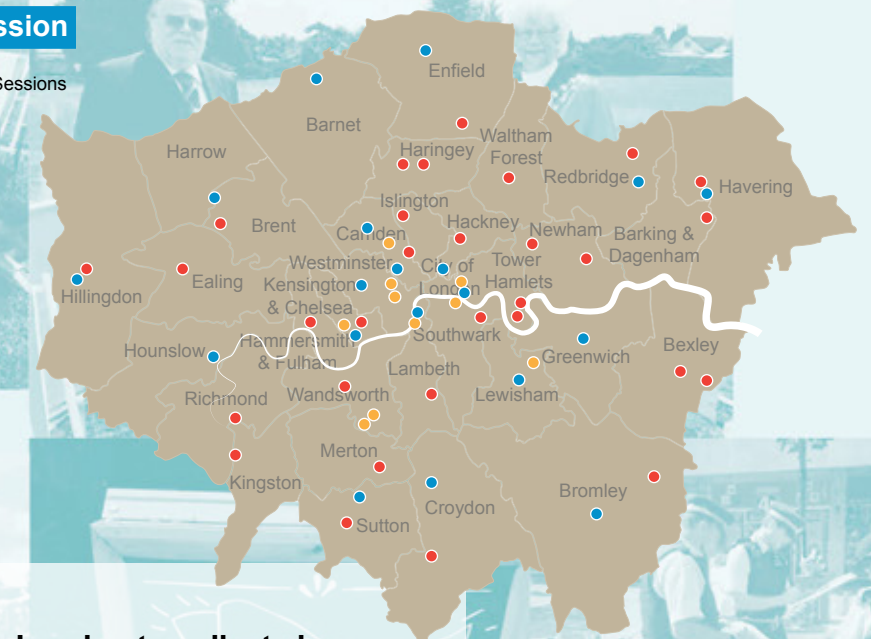


Engagement



Engagement events held by the Commission

- Commission Hearing Sessions
- Trust events
- Roadshows



The Commission has travelled all over London to collect views about the health of the city, involving more than **9,000** people. The GLA's Talk London online community of **4,000** people participated; more than **50** roadshow and NHS-based events were held, at least one in every borough; **250** written evidence submissions received; and **9** oral hearing sessions conducted. Every contribution has been analysed and considered.



LONDON HEALTH COMMISSION

#healthylon

Better health for all

Smoke free London

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. 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. Just as smokers' lungs are polluted, the lungs of our city – our parks and green spaces – are polluted by smoking. 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. Local authorities 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. The Mayor should also target illegal tobacco.

Listening to Londoners

Londoners want to lead healthy lives – health comes first for all of us, our family, friends, neighbours and colleagues. The Mayor, London's authorities and institutions, and all Londoners can benefit and 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. 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.

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. Obesity raises the risk of serious physical health conditions such as diabetes, heart disease, stroke and cancer. It affects our mental health, our sense of self-esteem and happiness.

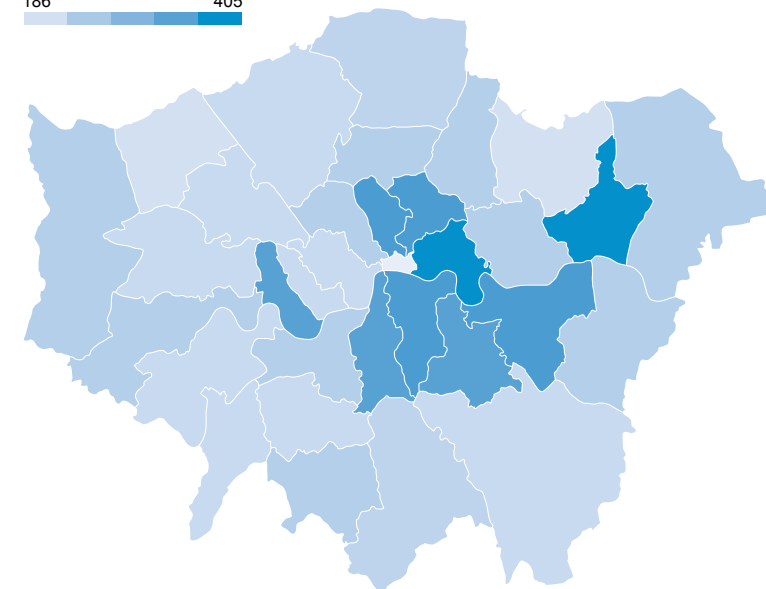
We need to help ourselves to make better choices. London councils should use licensing to require all chain restaurants and food outlets to include nutritional labelling on all menus.

Regrettably, a sugar tax for London alone is impractical. The London Health Commission gives its full support for a national sugar tax.



Deaths attributable to smoking in London boroughs

Rate per 100,000 people, 2010-2012
186 405



Better health for all

Tackling problem drinking

London's pubs and bars are part and parcel of what makes it a great world city. But in parts of London, drinking alcohol is a problem. Not everyone drinks sensibly and alcohol related hospital admissions – and rates of liver disease – are rising.

In the UK and around the world, others are taking action. The Liverpool Health Commission has supported the introduction of the minimum alcohol price using local authority byelaws. Newcastle has also 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 and, since boroughs are responsible for licensing of venues that sell alcohol, an application could be made to the Government to approve variations in licensing to enforce minimum prices in pilot areas.

More Londoners should be encouraged to walk, with joint action from employers, the Mayor, local councils, and Transport for London. The Mayor should dedicate 20% of his TfL advertising space to a campaign and alter signage in stations to encourage people to walk up stairs and escalators.

Employers can do their part too, recognising that a healthy workforce is a productive one. TfL should establish a scheme, paid for by employers, to incentivise walking the last mile to work and the first mile home.

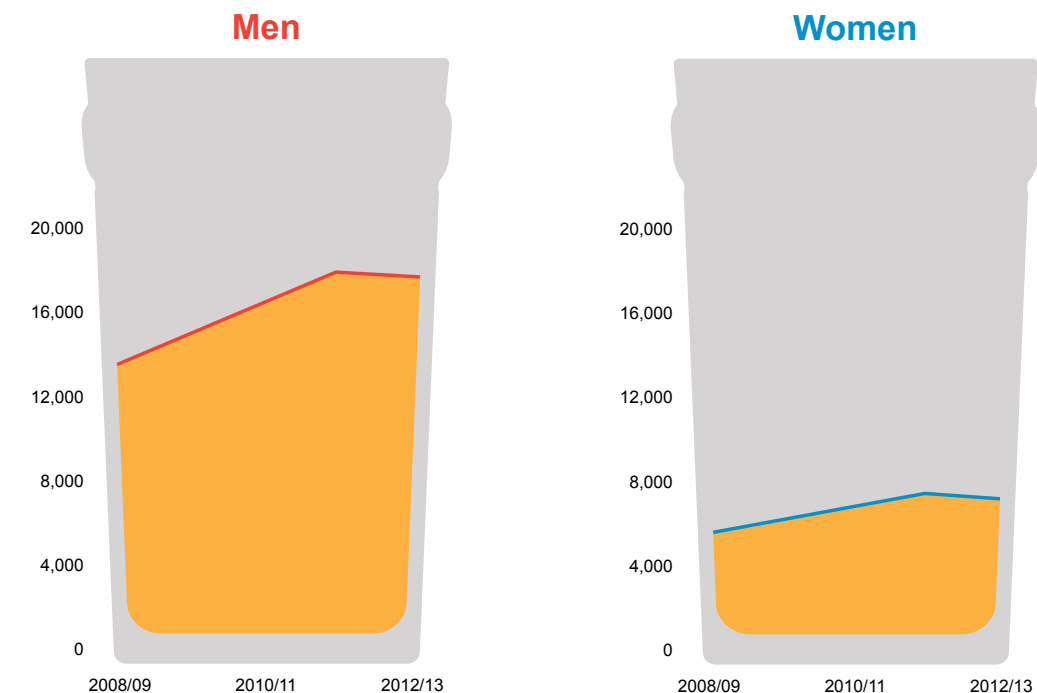
London's professional football clubs have a huge influence over the city's people and could also help, with a 'fan challenge' to improve physical activity levels by offering club incentives and by using physical activity league tables to promote competition.

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 for healthy activity.

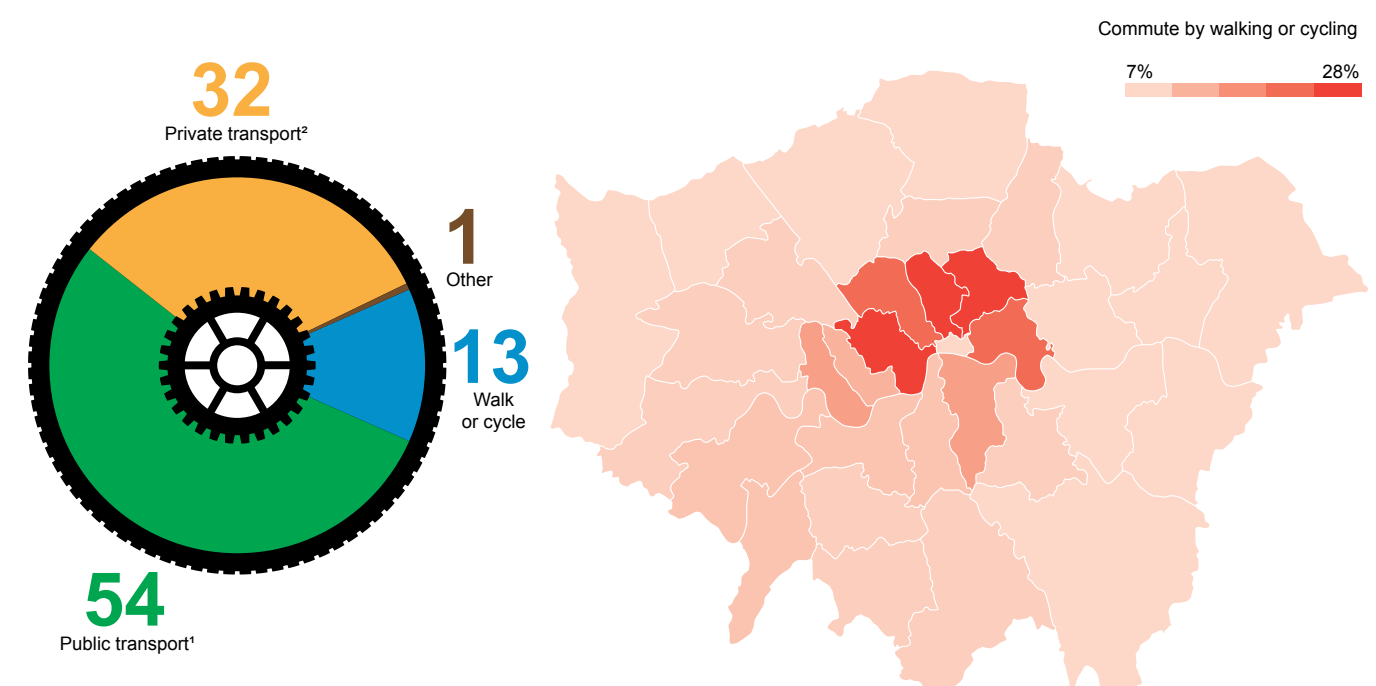
Getting London fitter

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 and cheap alcohol, we should positively encourage more Londoners to take more exercise.

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



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



Better health for all

Cleaner air

Poor air quality in London contributes to people dying nine months sooner in the city than they should – 50% worse than the national average. Some 7% of all adult deaths are attributable to air pollution.

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 5 or 10 years, supporting the Mayor's announcement that all newly built taxis would need to be zero emission capable by 2018.

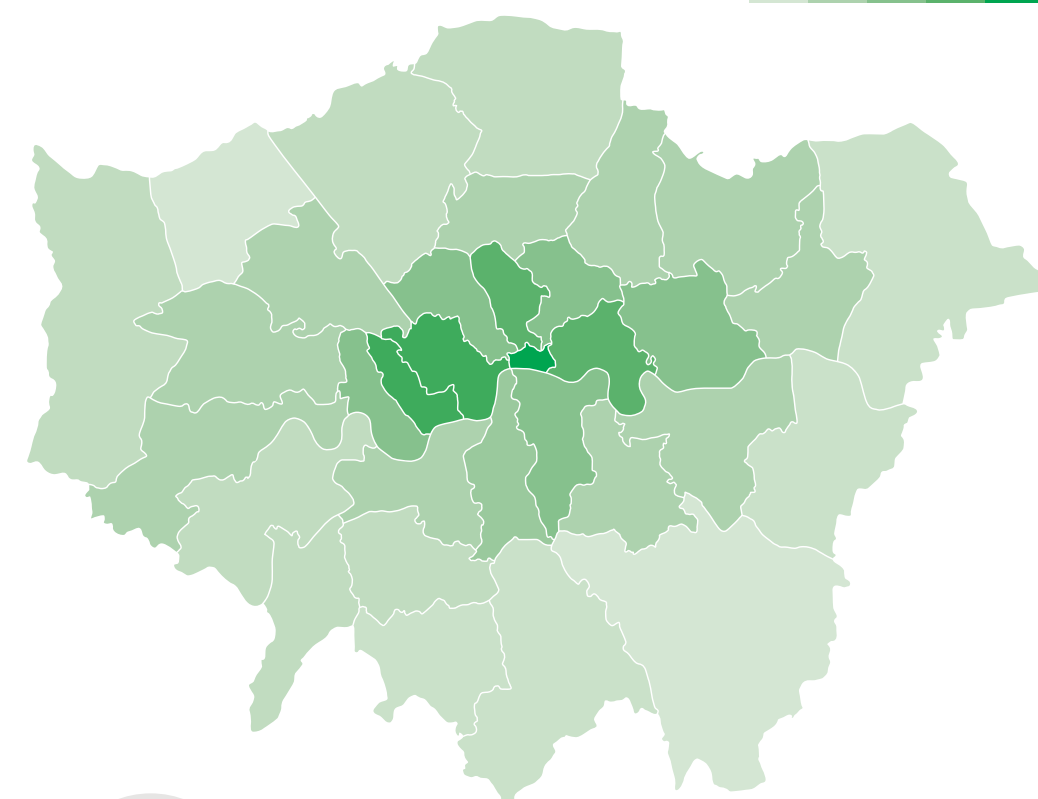
The Mayor should also be more ambitious in his proposed Ultra Low Emission Zone by aiming for near zero emission by 2025, expanding the size of the zone, and offering stronger financial incentives and disincentives.

50%
worse than
the national
average

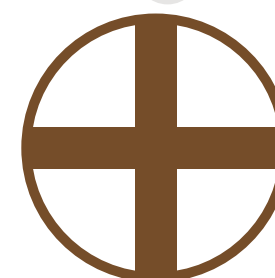
Deaths attributed to air pollution in London

Proportion of deaths attributable to particulate air pollution

6.1% 8.9%



5.4%

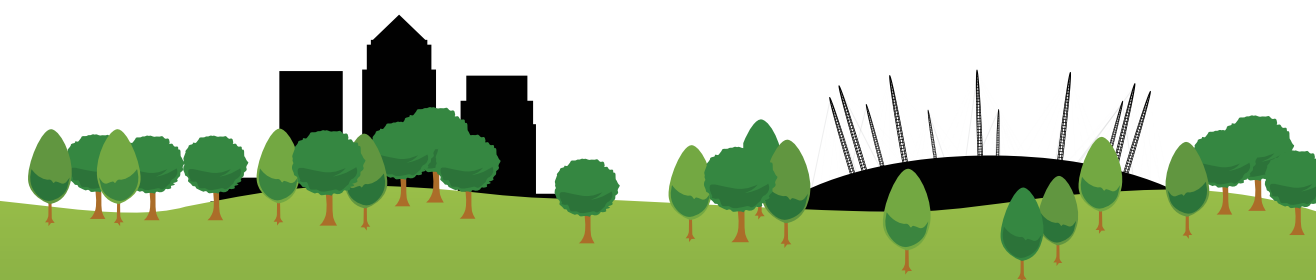
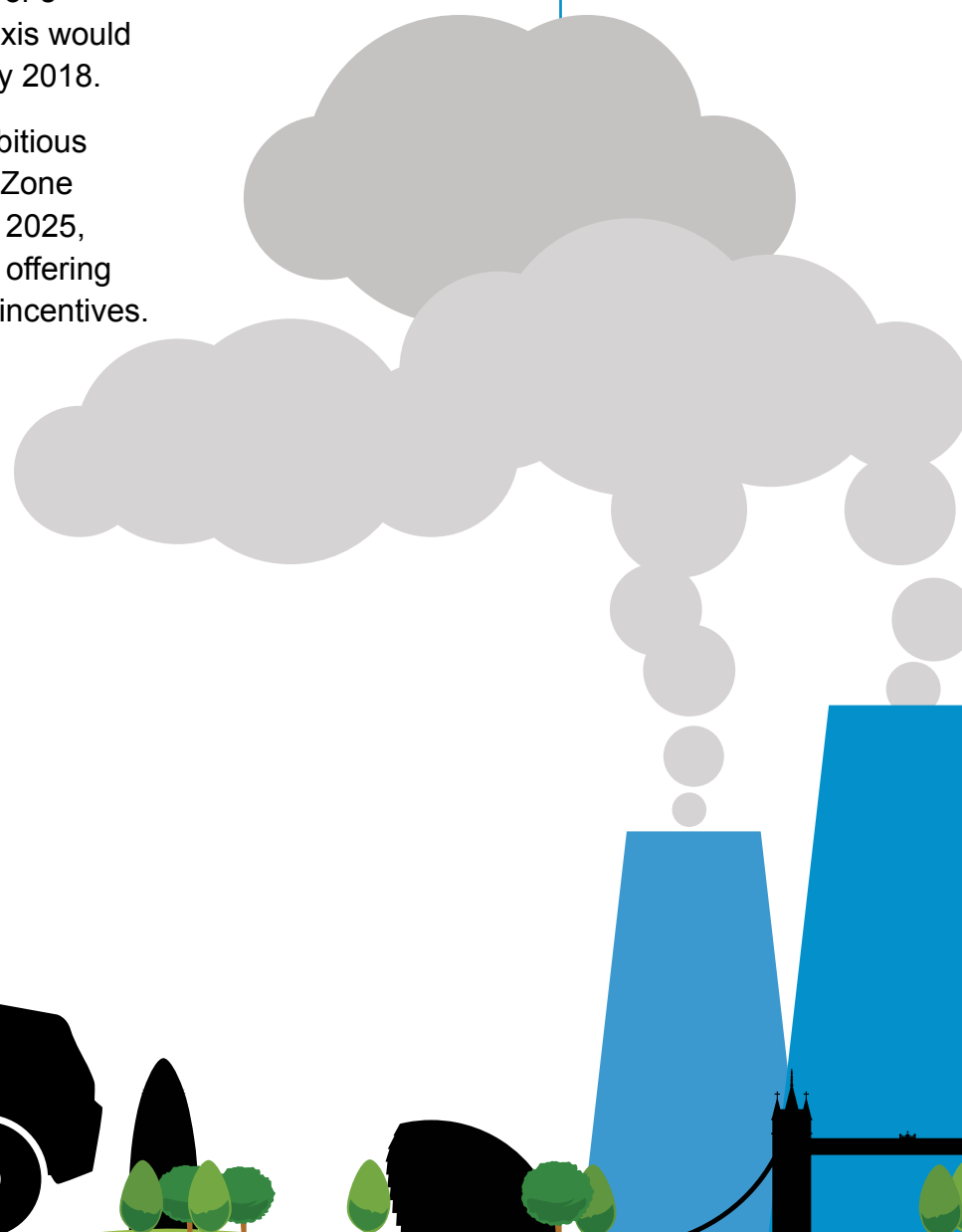


England

7.2%



London



Better health for London's children

Better parenting

Healthy child development is fundamental for good health and a happy life. Level of development at age five is a crucial indicator of how a child's life will unfold. Yet today just 53% of London's five-year-olds reach a good level of development at this age.

The problem in London is that there is no London-wide systematic focus on pre-school and early years parental intervention. Significant results could be achieved through a London-wide programme of parenting support for the most vulnerable groups.

Staff providing early parenting support could also be developed, to link families with various charities, voluntary groups and statutory programmes of support. Children's centres and other providers could receive a kite mark for quality, and a network of academic units could be developed as a resource for evaluation and evidence. The charitable sector should be tapped into to understand how the funding gap for supporting parenting proposals could be addressed.

53% of London's five-year-olds reach a good level of development at this age with wide variation within London linked to deprivation and place

Childhood obesity

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 one in four children in Reception and more than one in three 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. We need to help our children make healthy food 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. Healthier alternatives should also be promoted.

Healthier schools

If London is to do more to look after its children, 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.

Good education improves health; poor health harms education. Similarly, physical activity and exercise improves motivation, reduces unhappiness, and improves learning – today,

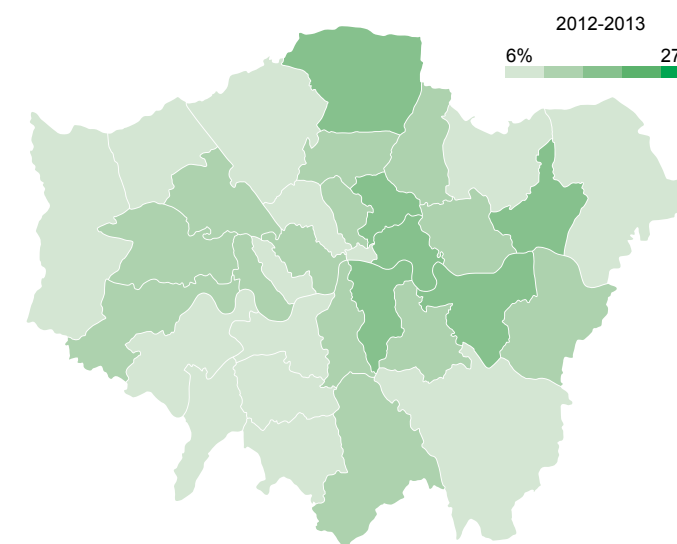
just 55% of London's children are physically active. Education also lowers the chances of teenage pregnancy, with all its attendant health and life opportunity challenges, and influences rates of sexually transmitted infections.

Each day in London, the anti-smoking message fails to get through to the 67 children who start smoking. Smoking in the young is particularly damaging. Schools are the obvious place to educate about and prevent smoking.

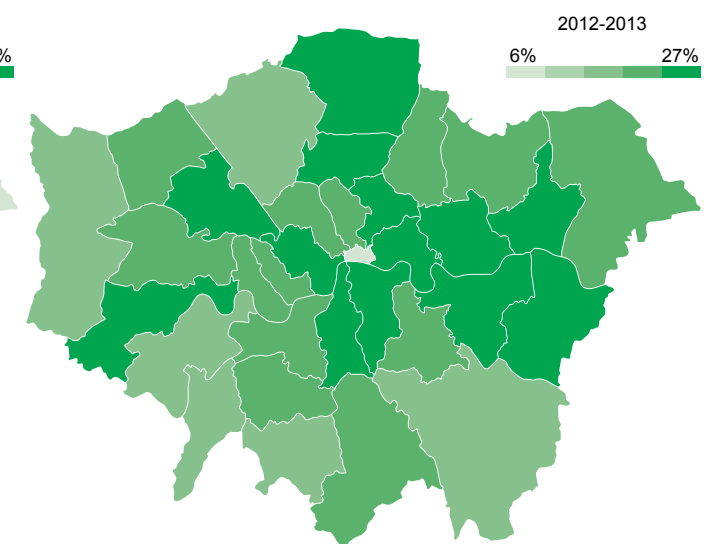
There also needs to be greater transparency about the health of London's schools. A Healthy Schools London dashboard could be created for schools and parents to allow comparison between schools on how they support the health and wellbeing of their pupils alongside educational attainment.

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



Better health for London's children

Better children’s mental health services

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. One in ten 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 to hospital have increased by 68% in 10 years.

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 the risk of mental illness among adolescents. Early intervention programmes work well, even with the most severe mental illness.

Better children’s physical health services

The death of any child or young person is a tragedy and, fortunately, is 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.

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.

The National Children’s Bureau has highlighted the need for better paediatric expertise in GP practices and opening hours that meet the needs of working parents and their children. This could help reduce child deaths and relieve the increasing burden on A&E services.

But it would be misleading and wrong to suggest that general practice alone is responsible. Health and care services for children in London are hard to access, poorly coordinated between primary, secondary and tertiary care, and there are inadequate links between them.

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.

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, available every day.

There is a lack of planning and coordination of services across London. There is a need for more integrated systems, spanning primary and community care to highly specialised hospital services, and linking with education and voluntary sector, to ensure better outcomes for London's children and their families.



Better care

Making care more personal

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’.

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

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.

Our maxim is: 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.

We propose that care be designed around 15 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.

More specific detail on these groups, their organisation and their needs and costs, is included on the Commission’s website.

Empowering people and professionals

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.

We need to listen to our people about what matters to them, we must include patient voices in addressing these areas of concern and give patients an active role in re-designing the system. We must all work together to better educate people about their conditions, and empower them to work in partnership with their providers.

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?’

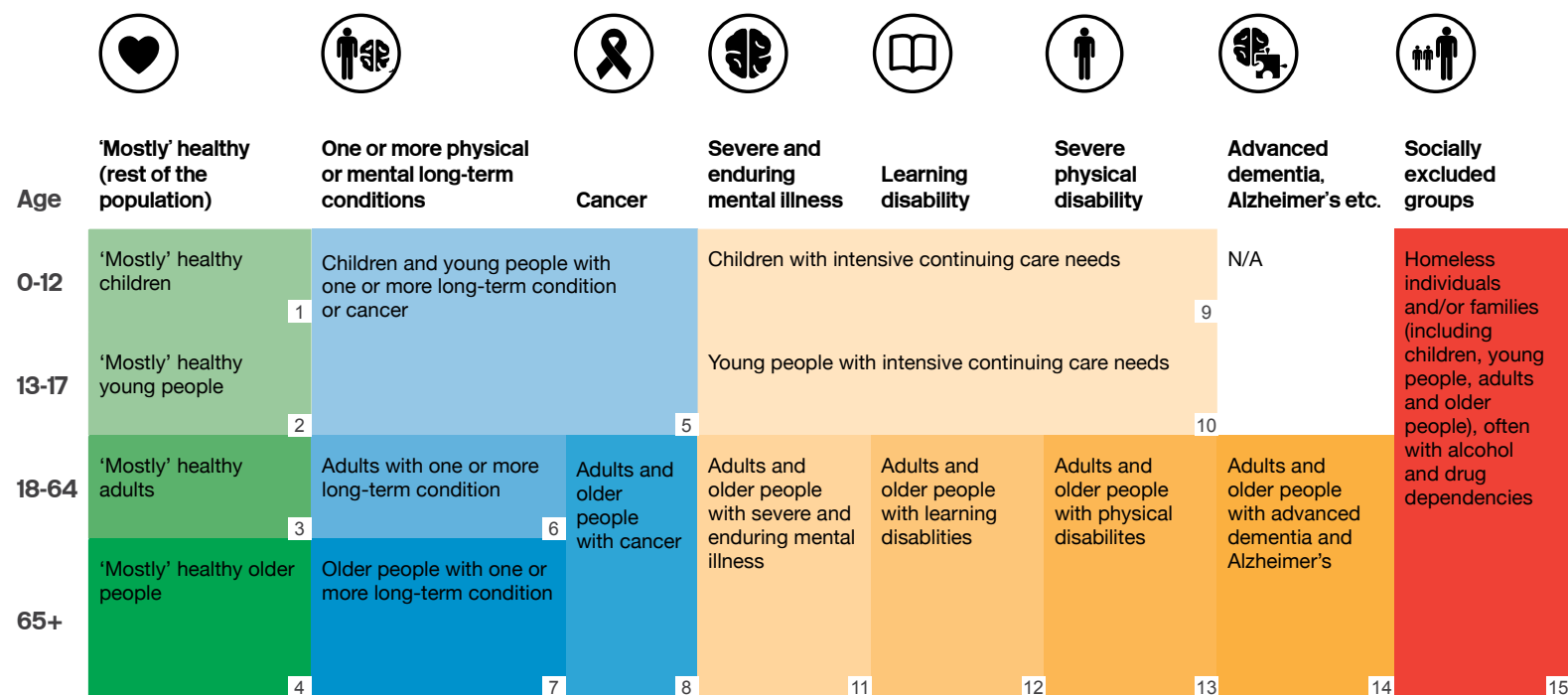
The best work on improving the health and care system happens when people who use services are embedded throughout the design of those improvements. Experience has demonstrated that so-called ‘lay partners’ can positively contribute to this.

London should also do more to help people look after themselves, providing the information they need to do this. Partly, this is about better provision of information and education, but it is also about encouraging an interest in health.

The Commission believes there is an opportunity to explore enshrining self-care and education about self-care and self-management 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.

More must also 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.

Community services play a vital role in providing better joined-up care. 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.



Better care

Better GP care

For the vast majority of people in London, their local GP is the NHS. 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.

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

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 and accessibility.

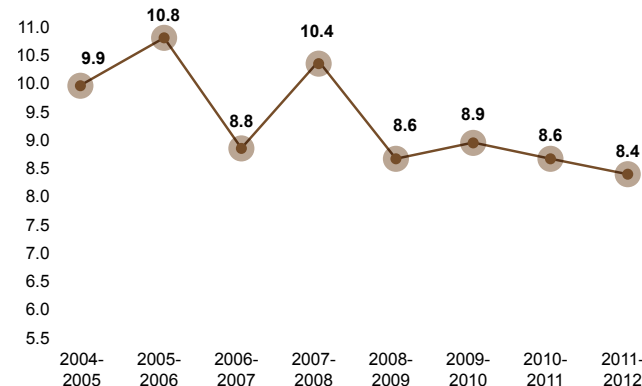
The Commission believes that general practice needs more investment and more reform, and is proposing an investment programme totalling £1 billion of public capital over the next five years. NHS England should also rebalance expenditure from specialised services to primary and community services, specifically general practice.

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. 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. Technology used to access care should be more prevalent, and more up to date.

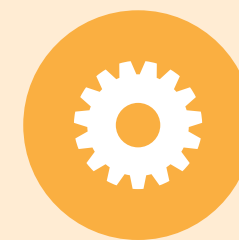
If patients in London were able to access a network of practices, it would make care much more convenient and accessible, support the development of scale by practices, and enable networks to be either local or non-geographical, for example offering practices in train stations and near people's homes.

Where GP practices persistently fail to improve, new providers – such as other more successful local practices – should be allowed to set up new GP services.

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



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



Proactive care that supports healthy lives

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.

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.

GPs should **act as gatekeepers for healthy lives**, referring patients to public health services, such as smoking cessation, where appropriate.

Routine mental health screening should be offered by all practices, to enable early detection of possible symptoms of depression and other mental illnesses.

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.



Coordinated care that supports people with complex needs

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.

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.

Care should be **coordinated between general practice and other healthcare providers, as well as social services**, to ensure all patients receive seamless care.

There should be **improved coordination with secondary care** particularly following discharge from hospital or treatment.

Information sharing between providers will mean that patients are treated by health professionals with up to date knowledge of their health status and needs.



Access options that suit people's different needs

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.

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.

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.

People with long-term conditions or complex needs should be able to request **longer appointments with GPs they know**.

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.



Better care

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.

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 – for example, cardiovascular, cancer and elective orthopaedic services – should be actively directed towards reform, and those programmes which are already under way should be accelerated.

Better care for people with mental illness

Mental ill health is all around us. It is experienced by our family, our friends, our colleagues – and 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.

Over 1m
Londoners per
year experience
mental illness

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.

Despite the number of Londoners affected by mental illness, the care they experience is often poor, as are the outcomes.

London should feel deeply ashamed that people with severe and enduring mental illness die more than a decade earlier than those without. 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.

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.

Second, we must ensure good access to psychological therapies and early intervention services.

Third, we must improve specialist services. Substantial change is needed for specialist services to reduce the reliance on inpatient care. 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.

Fourth, we must provide more, better care in local communities to tackle the gaps in physical healthcare and poor diagnosis rates among the mentally ill.

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.

Mental health trusts should proactively offer access to smoking cessation, blood pressure monitoring 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.

Better care for homeless Londoners

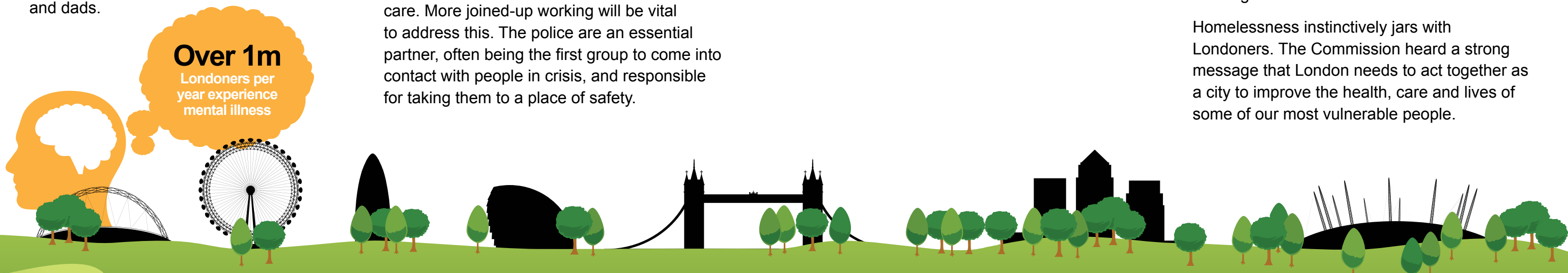
At any one time, hundreds of people sleep rough in the capital. The homeless population has a life expectancy of only 43–47 years, compared with 80–84 for the general population, and is more afflicted by mental ill health.

It is common for people who are homeless to suffer from a number of complex and interrelated 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.

Homeless and rough sleepers are a transitory population, meaning that homelessness is necessarily a London-wide issue.

A London-wide 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.

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.



Maximising science, discovery and innovation to enhance economic growth

Digital health

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.

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.

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, and 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.

Obtaining the evidence base required to demonstrate the impact of new digital technologies can be very difficult. Unlike traditional medicines, there are no standardised clinical trials for new digital products. Yet these new technologies have the power to change the way in which care is

delivered, but also how patients of the 21st century can access care.

That is why a new Institute for Digital Health and Accelerator should be launched, that partners with – and is embedded across – all our Academic Health Science Centres and Networks (AHSC/AHSN).

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.

The Institute for Digital Health should also directly support digital health innovators through an 'accelerator programme'. 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, or how to conveniently access the nearest and best social and healthcare services.

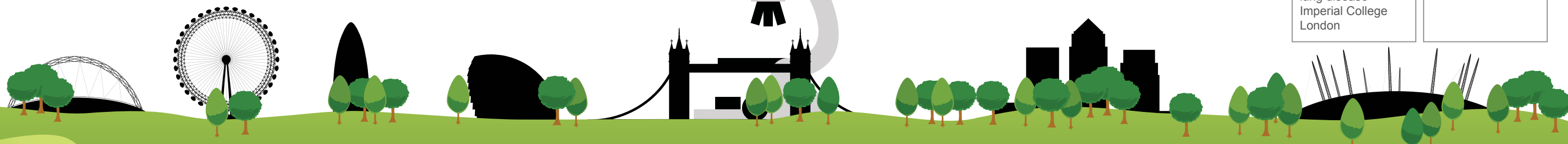
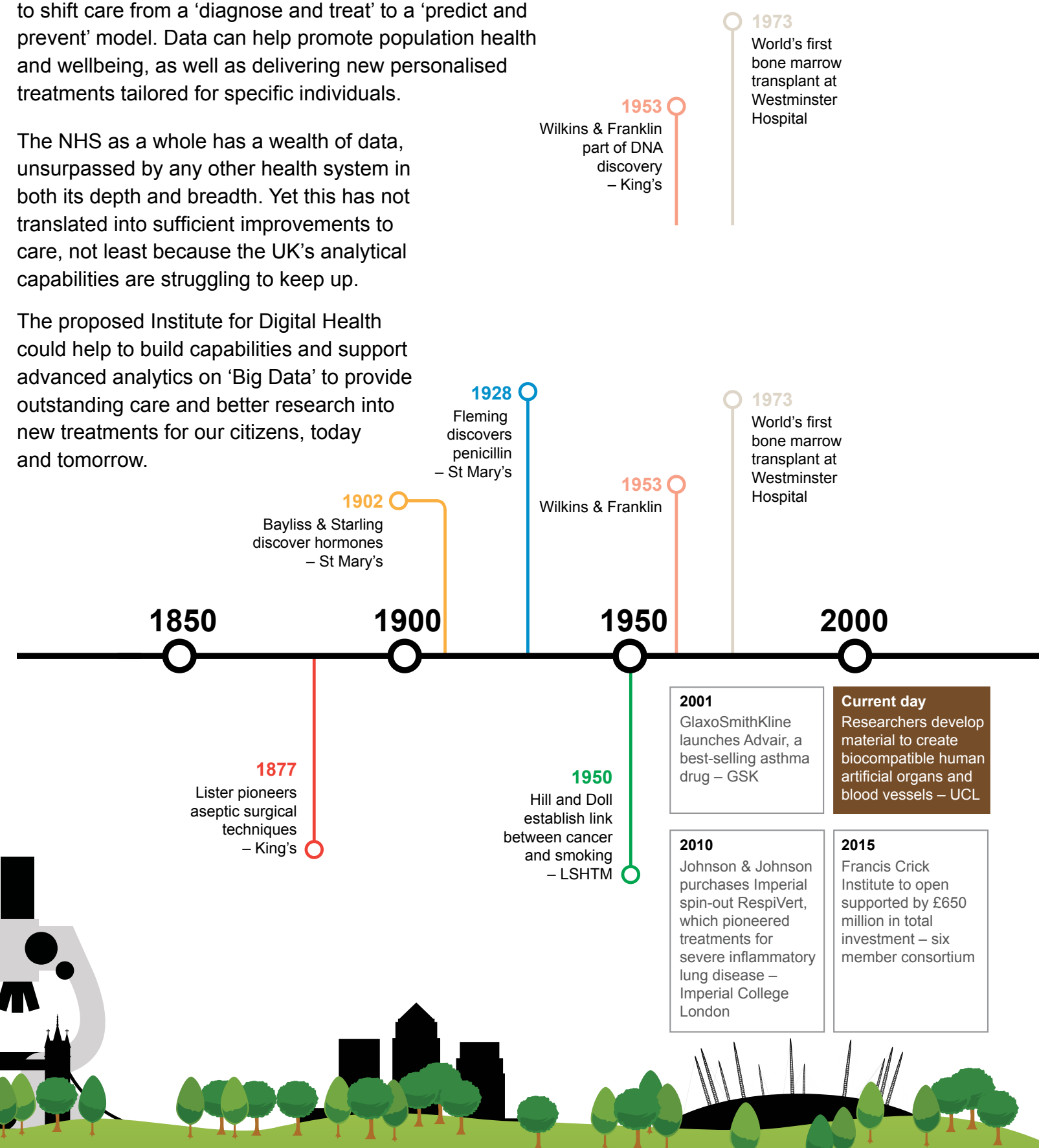
Big data

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 delivering new personalised treatments tailored for specific individuals.

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.

The proposed Institute for Digital Health could help to build capabilities and support advanced analytics on 'Big Data' to provide outstanding care and better research into new treatments for our citizens, today and tomorrow.



Maximising science, discovery and innovation to enhance economic growth

Dementia research

Today, 72,000 Londoners suffer from dementia. Ten years from now, nearly a third more will. By 2025, one million people in the UK and over 60 million globally will have dementia. The annual financial impact on the UK is already £26 billion, with a further £8 billion attributed to the value of carer’s work.

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

A Dementia Research Institute in London could potentially connect a network of partners to enable faster progress in prevention and earlier diagnosis, research, translation of discovery science to care delivery, development of public policy, and education, training and capacity to support better dementia care and outcomes.

More clinical trials

Clinical trials are necessary to develop new drugs and to translate scientific advances into patient therapies and treatments. However, the UK has historically lagged behind other European countries in the number of trials that it conducts.

It takes too long to navigate the necessary approvals, it is too difficult to recruit patients, and quality and timely delivery is too challenging. To improve the 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. The rest of London should take a similar approach.

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.

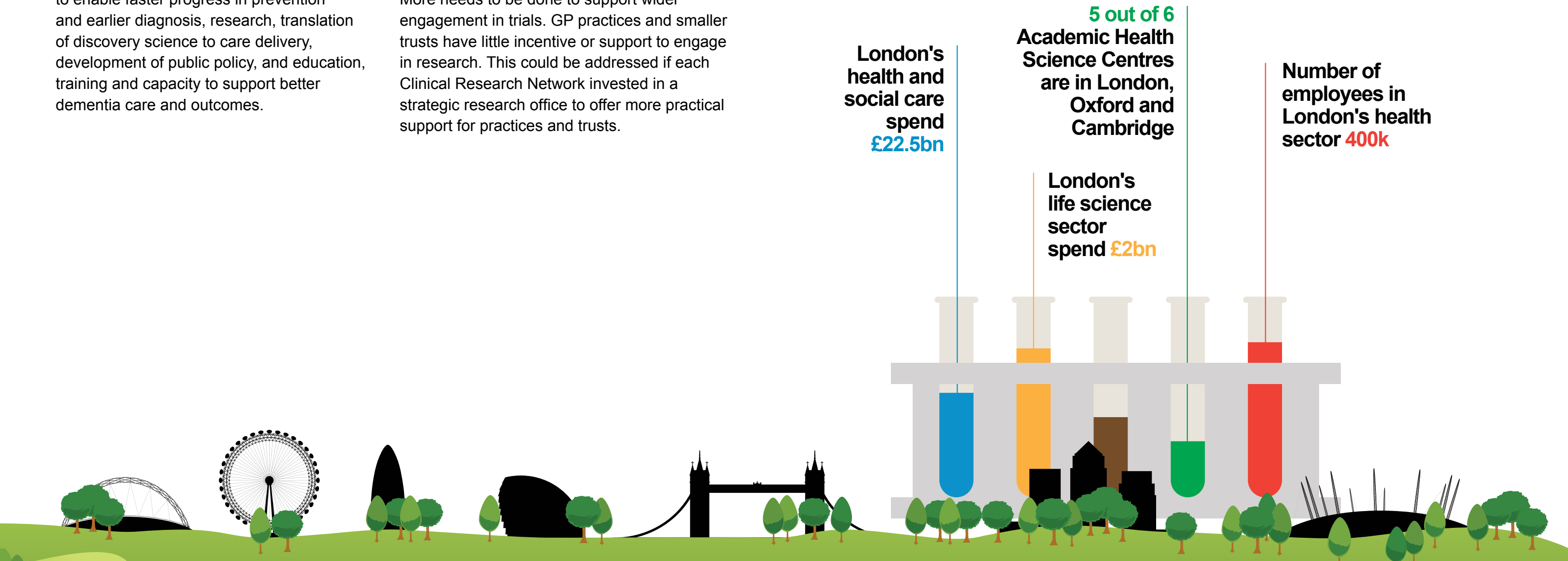
Adopting innovation

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.

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.

Measurement can improve the pace and scale of adoption, but measurement of process without a link to clinical outcomes provides little incentive for care providers. Further academic rigour and experience could be tapped to better understand how measurement might be used to improve uptake of innovations in the NHS.

Commissioners should seek out more support and advice on the latest innovations from Academic Health Science Networks. 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.



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 technical.

Better 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. 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.

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 evidence submissions were received. The GLA's Talk London online community, with 4,000 members, participated. Representative samples of London's population were polled.

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.

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.

Any new initiatives should be careful not to duplicate the good work that already exists, particularly in the third sector, which has some excellent examples of effective engagement. 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.

Better information

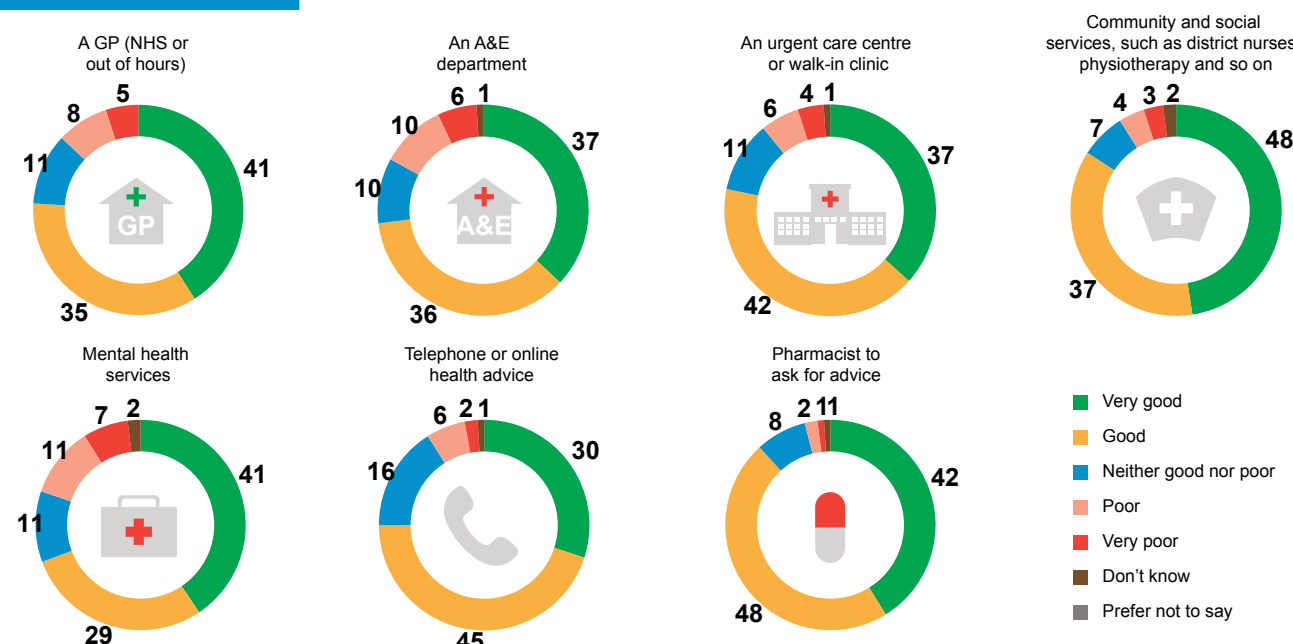
Londoners understand the need for appropriate information to be shared with an individual's care team in a timely and secure way.

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, and to provide consent and filter sharing of their information. They should, as a result, 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. 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.

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



Making it happen

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.

However, reforming such complex funding allocations takes time, and requires multiple levels of decision making. In the meantime, some areas of London are being overpaid and others underpaid.

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.

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.

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.

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.

This approach has its advantages – money follows patient choices, providers are paid for results, and it keeps waiting lists down. Nonetheless, it has many drawbacks too – duplication because similar services are funded by different organisations, gaps in provision, siloed working arrangements, and providers 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. The whole budget for these groups in a particular place is then handed over, tied to an agreed set of quality outcomes.

This approach has significant advantages. It gives providers a strong incentive to invest in more personal, more preventative care. It enables providers to holistically judge and deliver the best care for an individual. It causes providers to ensure care takes place in lower cost settings, and to ensure it is carefully coordinated.



Making it happen

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. Yet because we all pay for the NHS through taxes, we don't have the same influence over those who care for 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.

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 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.

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.

The NHS estate

The NHS is one of the largest owners of land and buildings in London with a hospital footprint three times the size of Hyde Park, a book value of the entire estate is £11 billion, and more than 1,400 GP practices. 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 backlog maintenance on this estate would cost £600 million.

Perplexingly, modern facilities, built through the private finance initiative, remain under-utilised in many sites across London. 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.

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

There must 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.

The capital regime for hospitals in London is also complex. 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, the public subsidy of them through lower capital charges should be ended. At the same time, the rules on the retention of capital receipts should be reformed, so that trusts automatically have the right to retain 50% of receipts. This would represent a powerful shift in expectations, and remove an excuse for inaction.



Making it happen

Planning and coordination

There is also 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 capital regime and estates planning have 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.

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. 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.

But London can be a challenging place to live and work. Turnover is high within London and there are significant recruitment challenges in some areas.

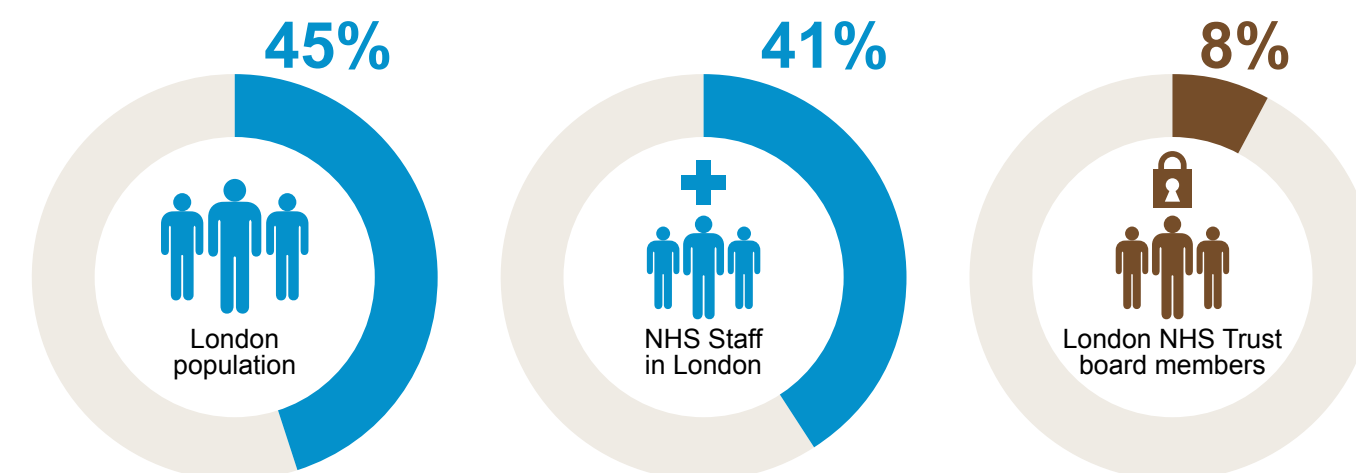
Staff cite the high cost of living as the number one issue, particularly the availability of affordable housing.

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.

Surprisingly, London has a poor record on diversity, with a significant gap between the diversity of the workforce and the local population, and of Trust leadership and senior management. This has been highlighted by studies showing that under-representation adversely impacts on the provision of services across London.

The popular Darzi Fellowships in Clinical Leadership have been a highly valued initiative. There are opportunities to widen and deepen the programme to primary and social care roles.

As options for future workforce training are considered, 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 rewards 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.



Making it happen

Better leadership

There is a clear gap in leadership for the better health agenda in the capital. That is why the Commission recommends the appointment by the Mayor of a London Health Commissioner, 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, to 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 London-wide 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. Nor would the Commissioner have any role in the management of the NHS, or in service 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.

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.

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.

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. Its 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.

Implementation

A health and economic impact assessment of our proposals has concluded 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, and with the voluntary sector.

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.



SUMMARY OF RECOMMENDATIONS

More detail on each of these recommendations, and the analysis which lies behind them, is available from the Commission's website: www.londonhealthcommission.org.uk

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.

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.

Recommendation 57:

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

Recommendation 58:

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

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.

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.

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.

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.

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.

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.

