

IMPROVING HEALTH AND HEALTH CARE IN LONDON

Who will take the lead?

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The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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Executive summary

This paper reviews the progress made in improving health and health care in London in recent years and analyses the financial and service challenges facing the National Health Service (NHS) now and in the future. It argues that although some progress has been made in improving care following Lord Darzi's review of London's health services published in 2007 (NHS London 2007), much remains to be done. The financial challenges facing the NHS in London are much greater than those anticipated at the time of the Darzi review, and budget deficits among commissioners and providers of care are considerably higher than those of other areas in England.

Even more important are variations in the quality of primary and secondary care and evidence that lives could be saved if some services were concentrated in fewer hospitals. NHS London, the strategic health authority, has led work to improve care but much of this work was halted by the Secretary of State for Health following the 2010 general election. With the impending abolition of NHS London in 2013, it is not clear where responsibility will rest in the future for leading complex service changes that will improve quality of care and patient safety.

In The King's Fund's view, there is a real risk of declining financial performance and a failure to tackle unacceptable variations in the quality of care in the reformed NHS. If this risk is to be avoided, there needs to be much greater clarity of roles and responsibilities. Clinical commissioning groups by themselves are unlikely to be able to provide the leadership required and they will need to work with the NHS Commissioning Board, local authorities and providers to bring about further improvements in care.

The time it takes to bring about complex service changes adds urgency to the work that needs to be done. The government must explain who will take the lead in improving health and health care in London and how the many different organisations that have an interest in doing so will work together to ensure that Londoners have access to health care of the highest possible standard within the resources available.

The following key points are made in the paper.

- The need to change the way in which health services are provided in London has been a recurring theme in a series of reviews stretching back to the end of the 19th century.
- These reviews have highlighted the poor health status of the population in some areas, variations in the quality of primary care and the inappropriate configuration of hospital services.
- The most recent review, *Healthcare for London: A framework for action*, led by Ara Darzi and published in 2007, offered a comprehensive analysis of the need for change and set out five principles to guide improvements in care.
- Lord Darzi's review originally focused on seven service areas and proposed that treatment and care should be provided in six locations: the home, polyclinics, local hospitals, elective centres, major acute hospitals and specialist hospitals.

-
- Following extensive consultation, NHS London has led implementation of these proposals and has brought about improvements in stroke and trauma care as well as leading the introduction of polyclinics. Work has also begun on improvements in other areas, including cardiovascular and cancer care and changes to the role of local hospitals.
 - The coalition government elected in May 2010 halted the implementation of Healthcare for London and instead emphasised the need for change to be led locally and to conform to four key tests:
 - support from general practitioner (GP) commissioners
 - strengthened public and patient engagement
 - clarity on the clinical evidence base
 - consistency with current and prospective patient choice.
 - The financial prospects for the NHS in London are much more challenging than anticipated at the time of the Darzi review and expenditure is likely to fall in real terms between now and 2015. Both providers and commissioners in London are forecasting deficits greater than in other parts of the country.
 - The urgency of the financial problems has been starkly illustrated by NHS London's modelling of the potential for acute trusts to achieve foundation trust status by 2014. Depending on assumptions made, only between two to six trusts out of eighteen are likely to be financially viable by 2014.
 - Even more important are continuing variations in the quality of primary care and secondary care and the need to address these variations to improve outcomes, for example by concentrating emergency care in fewer hospitals in order to save lives.
 - The government's requirement that all NHS trusts become foundation trusts by 2014 presents particular challenges in London given the combined pressures of financial constraints and the need to improve quality and patient safety.
 - The reforms also create uncertainty about where responsibility will rest for leading service change in the future, especially following the abolition of strategic health authorities and primary care trusts (PCTs).
 - Four approaches are discussed for taking forward the progress already made under Healthcare for London:
 - patient choice and clinical commissioners leading change in a market
 - the NHS Commissioning Board leading change through planning
 - local authorities leading change through health and wellbeing boards
 - providers leading change through academic health sciences partnerships.

It is unlikely that any one of these approaches will be fit for purpose to deal with complex hospital reconfigurations and the challenge is to find a way forward that brings together a bottom-up and top-down perspective, the expertise of commissioners and providers, and the contribution of local authorities.

Introduction

The King's Fund has a long history of supporting the development of health and health care in London. It is now some time since The King's Fund published its major reports on London's health care system: *London Health Care 2010: Changing the future of services in the capital* (The King's Fund 1992) and *Transforming Health in London* (The King's Fund 1997). Since *Transforming Health in London*, the major development has been the review by Ara Darzi in 2007, *Healthcare for London: A framework for action* (NHS London 2007), which provided the basis for change in a number of areas.

This paper looks at what has been achieved in London since the publication of Lord Darzi's review. It goes on to present an overview of the current financial position in London. The likely impact of the new government's NHS reforms is assessed and the report concludes with some suggestions for what is required to facilitate appropriate service change, improve the quality of care and improve the health and health outcomes of Londoners.

The paper is based on an analysis of relevant reports and reviews, supplemented by interviews with senior NHS leaders who were involved in the Darzi review or who have been affected by it.

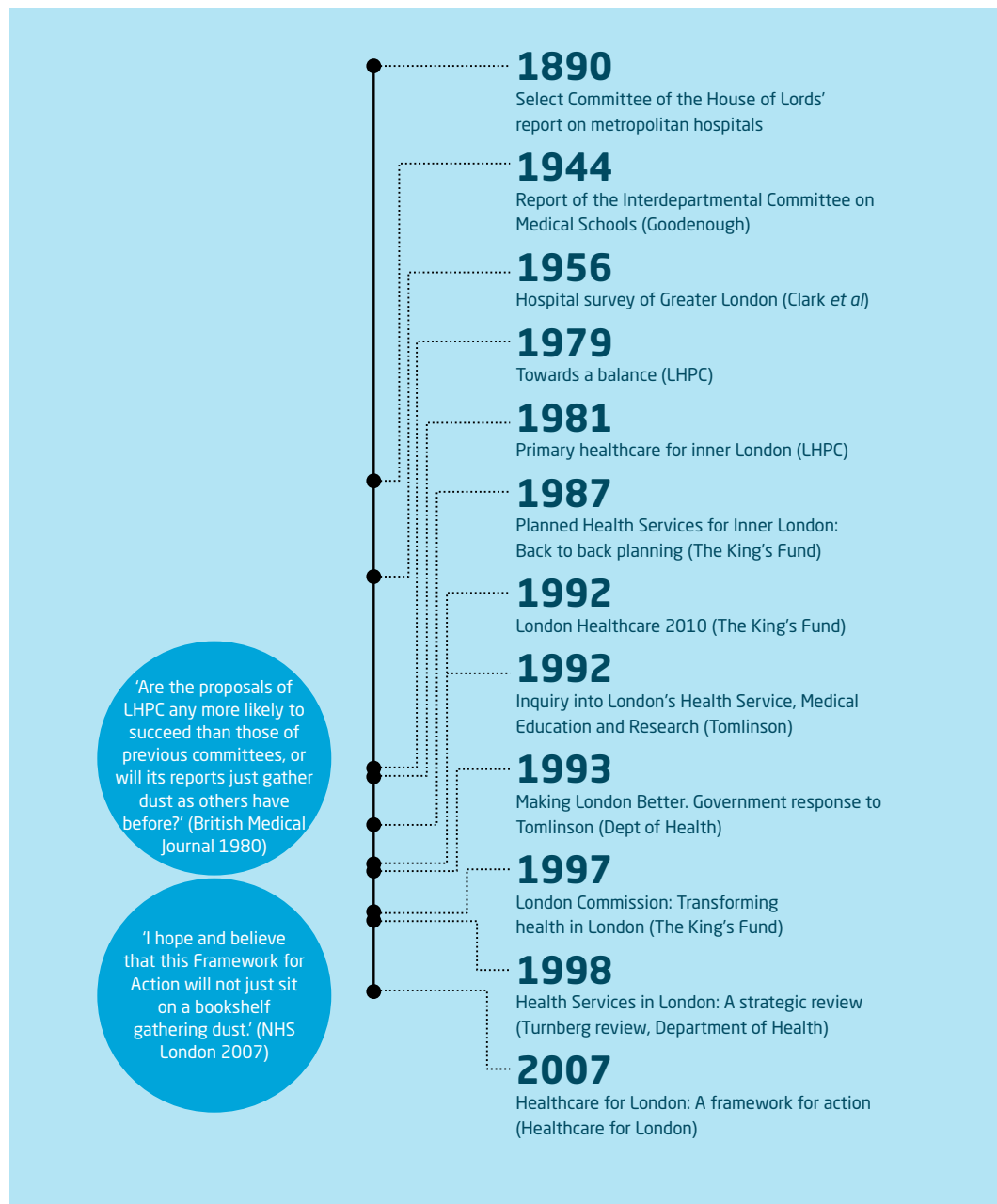
A history of plans for service change in London

A number of issues recur in all reviews of London:

- the variable quality of primary care in the capital and particularly in the inner city
- the poor health of the population in some areas of London
- the different patterns of hospitalisation between different areas of the capital
- the concentration of hospital services in inner-city areas.

The number and distribution of hospitals across the capital has always proved a thorny issue, but more recently there has been increased awareness of variations in the quality of secondary care. Successive reports – from the House of Lords Select Committee report in 1890 (Select Committee of the House of Lords 1890) to reviews in the 1940s, 1950s and into the 21st century – have noted the need to redistribute services in relation to need, especially by ensuring high standards of primary care in areas with poor health and by making high-quality secondary care available beyond those inner-city areas where specialist services have traditionally been concentrated (*see* Fig 1 overleaf).

Figure 1 120 years of London's health services



Although the Goodenough report in 1944 focused on improvements in medical education, it recommended the relocation of hospitals (St George's, Charing Cross and the Royal Free, Gray's Inn Road) out of central London. This focus on the need to develop more acute hospitals in the outer areas of London continued throughout the 1950s, 1960s and 1970s. In 1975 the London Co-ordinating Committee recommended the rationalisation of London hospitals. In 1980 the London Health Planning Consortium (LHPC) recommended reductions of almost 25 per cent in the number of hospital beds in central London as well as the rationalisation of acute hospital services.

For the first time we also find, in *Primary Health Care in Inner London*, a set of detailed recommendations for improvements in primary care (London Health Planning Consortium 1981). These included:

- improved incentives for the development of group practices
- discouragement of small list sizes

- improved opportunities for GPs to work in the inner city
- incentives for GPs to improve premises and to take on new patients
- ensuring services are available to population groups who are reluctant to use traditional services.

Working on behalf of the Inner London Health Authority Chairmen's Group, The King's Fund highlighted in *Planned Health Services for Inner London Back to Back Planning* (1987) the need for a London-wide approach to strategic planning of health services and recommended a series of acute bed closures going beyond those that the Thames regions were then planning (at that time strategic responsibility for London was divided between four Thames regional health authorities whose remit covered much of the home counties).

In a situation that in many ways mirrors the current one, the Conservative government introduced a set of market reforms in 1990 that led The King's Fund to undertake a detailed study of health services in the capital, leading to the publication of *London Health Care 2010* (The King's Fund 1992). This report concluded that the introduction of a market in health care would make the high cost of treatment in inner London unsustainable. The King's Fund recommended a £250 million investment programme in primary- and community-based care in London, to go hand in hand with the rationalisation of acute hospital services on to fewer sites and the consolidation of medical education and research.

The Tomlinson report (1992) – commissioned by the government – followed almost immediately and mirrored many of The King's Fund recommendations, although it was much more specific about where hospital closures should occur. *Making London Better* was the government's response to Tomlinson (Department of Health 1993) announcing closures of hospital services to increase efficiency in the acute and specialist hospital sectors, investment in primary care (through the London Implementation Group and the introduction of a London Initiative Zone) and the consolidation of medical education and research within London.

Making London Better proposed to consult on closures of various accident and emergency (A&E) departments including Charing Cross, St Bartholomew's, and one of Guy's or St Thomas'. Options were also being considered for the closure of Charing Cross hospital in west London, one of University College Hospital or the Middlesex in central London, St Bartholomew's in east London and Lewisham in south-east London. Some rationalisation of services in south-west London at St George's, Queen Mary's Roehampton, Kingston and St Helier was also being considered. However, such proposals met with resistance from the public, clinicians, the media and politicians. In addition the private finance initiatives (PFI) acted, initially at least, as a drag on any substantial development. The result was slow, piecemeal change with little impact on the efficient distribution of resources.

In response to continued financial strains on the London health care system, and in anticipation of the election of a new government in 1997, The King's Fund published a second major report on London's health care, *Transforming Health in London*. This report pointed to the patchy nature and poor quality of general practice, under-developed intermediate care and the crisis in mental health services. The King's Fund recommended a movement away from both 'market mechanisms' and 'command and control' to a system founded on negotiation within 'local health economies' based on clear policy frameworks set from the centre.

The new Labour government, elected in 1997, commissioned a past president of the Royal College of Physicians, Leslie Turnberg, to carry out yet another review of London's health services. The Turnberg report, *Health Services in London: A strategic review* (Department of Health 1998), took an overview of services and at the same time made specific recommendations in areas of London around the continuation of acute hospital services. This report differed from many that had preceded it in that Turnberg found there was not an excess of acute hospital beds in London. He called for:

- the re-evaluation of the closure of Guy's A&E
- long-term plans for the development of hospital services in west London
- the closure of inpatient services in Queen Mary's Hospital Roehampton in south-west London and at Harold Wood Hospital in outer east London
- the retention of only tertiary services at St Bartholomew's Hospital in inner east London.

Although a number of changes in the organisation of services in London along the lines suggested by Turnberg did take place after 1997 – including rationalisation of some acute hospital sites and most recently changes to the structure of primary care trusts (PCTs) (see Figure 2, opposite, for the current pattern of hospital services and 'clustered' PCTs) – it was still perceived that many of the perennial problems of London remained. These included:

- inefficiencies in provision of acute hospital services with poor use of estate and human resources
- a failure to transfer services into the community
- a need for more specialised care implying a concentration of specialised services on fewer sites
- continued issues of poor health in some parts of London
- continuing health inequalities
- dissatisfaction with services.

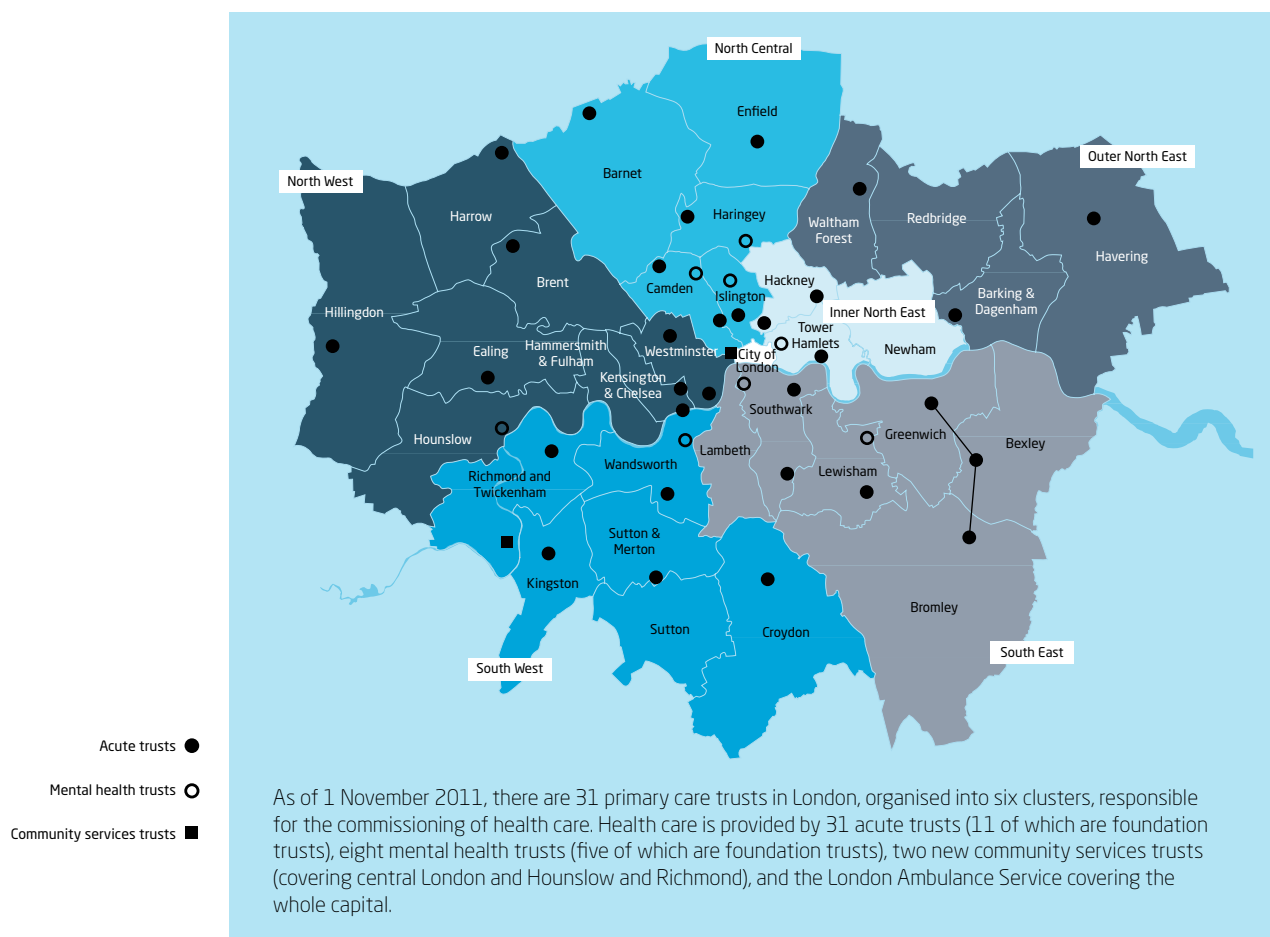
Eight years after Turnberg's recommendations, and with only piecemeal progress in changing London's health services, the organisational landscape in London changed again. This time the five strategic health authorities created in 2002 were replaced by a single authority for London. One of the new strategic health authority's (SHA) most important early acts was to commission another clinician – Lord Darzi – to review London's health system. The resulting report, *Healthcare for London: A framework for action* (NHS London 2007), set out proposals to bring about improvements in health and health care across the capital.

In the light of a difficult financial future, coupled with a challenging programme of organisational reform, this paper takes stock of Healthcare for London, drawing on the reflections of leading clinicians and managers in London. It describes and assesses the new financial and policy landscape as it may help or hinder future service reconfiguration; reviews the successes and unfinished business of Healthcare for London; and discusses the pros and cons of alternative scenarios for moving forward with redesigning London's health services for the greater benefit of patients and the population.

A key argument of the paper is that there is an urgent need to build on the successes of Healthcare for London to address the financial and quality challenges facing the NHS. Momentum has been lost through the government's decision to bring an end to the SHA-

led programme of service reconfiguration in favour of an approach in which change is led locally by commissioners. There is uncertainty as to where the locus of responsibility will lie in the future for leading work on complex reconfigurations of hospital services, and it is unlikely that clinical commissioning groups by themselves will have the resources and expertise to take these reconfigurations forward.

Figure 2 London's acute hospitals and PCTs



This creates a significant risk that the vision of improved health and health care set out in Healthcare for London will not be realised. To avoid this risk, there is an urgent need to clarify where responsibility for leading change will rest and the respective roles of clinical commissioning groups, the NHS Commissioning Board, local authorities and health care providers in bringing about further improvements in care. Put simply, it is essential that the capacity exists for providing what we have termed 'system leadership' (Dixon and Ham 2010) on issues affecting large populations where no one agency in the emerging organisational arrangements appears to have this as a clear part of its role.

Healthcare for London: what has been achieved?

The recommendations in *Healthcare for London* were based on a detailed analysis of why change was needed. This case was founded on eight reasons, most of which still apply today. These were:

- the need to improve Londoners' health in areas where the capital faced specific health challenges like HIV and substance abuse and a diverse and transient population
- the need to meet the public's expectations, reflected in higher levels of dissatisfaction with the NHS, including with GP services
- the need to tackle inequalities in health and health care with services often being provided in inverse relationship to need
- the need to reduce reliance on hospitals by providing more care in the community and other settings
- the need to provide more specialised care by concentrating some services in fewer hospitals able to deliver better results
- the need to ensure that London was at the cutting edge of medicine, for example by developing academic health sciences centres
- the need to use the workforce and buildings more effectively
- the need to make the best use of taxpayers' money.

The process of developing recommendations for change included a strong clinical and public engagement programme with clinical working groups considering various health care programmes in the areas summarised in the box opposite. Getting clinicians and health professionals involved in reviewing London's health services and recommending what needed to change was seen by those we interviewed as important to the strategy:

It was a brilliant piece of engagement work, the leadership of clinicians was excellent... clinicians, who felt that they could make a greater difference to patients through some of this than they would ever do as individual clinicians in practice.

Darzi articulated five principles that Healthcare for London applied to the seven service areas it investigated:

- services needed to be focused on individual needs and choices
- they should be local (ie, close to home) where possible but concentrated where necessary
- they should be integrated, maximising partnerships between services and professions
- prevention was better than cure
- there was a need for a focus on health inequalities and diversity.

This box summarises key recommendations for the service areas investigated by Darzi (adapted from NHS London 2007).

Summary of service recommendations from *Healthcare for London*

Maternity care and care of the newborn

Women should be offered genuine choice between home birth, a midwifery unit or an obstetric (doctor-run) unit. There should be more midwifery units, either at the same hospital as an obstetric unit or stand-alone.

Staying healthy

All public services should work together to help people stay healthy. A pan-London campaign for activity and nutrition should be linked to the 2012 Olympic Games. Improved sexual health, tuberculosis and immunisation services are all needed.

Mental health

Local treatment should be provided for most people with a mental health problem, with specialist inpatient care for the few who need it. Alternatives to medication are needed, including more 'talking therapies'.

Acute care

Many people attending accident and emergency (A&E) could be better cared for by GPs and nurses in new community clinics with extended opening hours. Trauma, stroke and emergency surgery patients should be treated in specialist centres by experts. Most urgent care for children should be provided in urgent care centres closer to home and paediatric inpatient care should be concentrated at fewer hospitals.

Planned care

People should be able to see their GPs for routine (not just urgent) care outside working hours. Specialist outpatient care and diagnostics should take place as close to the patient's home as possible alongside GP care. Many more operations should be performed as day cases, allowing the patient to go home the same day. Rehabilitation, combining NHS and social care staff where necessary, should take place much more frequently in the patient's home.

Long-term conditions

People with long-term conditions such as diabetes should be in control, at the centre of a web of care. This web is a whole array of different sources of support from specialist nurses to new technology.

End-of-life care

Personalised care is needed for people who are dying so that they can discuss their preferences, including where they choose to die, with professionals. Patients and carers should have a single point of contact to access professional help.

The review also set out a range of models of provision, including more health care at home and new polyclinics, designed to replace GP surgeries and to offer a greater range of services than were available from existing surgeries (*see box overleaf*). It suggested that local hospitals would provide the majority of inpatient care (*Healthcare for London 2008*), with elective centres for high-throughput surgery, some hospitals designated major acute hospitals for complex treatments and hospitals encouraged to specialise.

It also argued for London as a global centre for medical research and the need to foster this through, for example, academic health sciences centres along the lines of the Sunnybrook Health Science Centre in Toronto or the Massachusetts General Hospital in Boston. Most importantly, perhaps, *Healthcare for London* identified future growth in demand and a slowdown in funding growth as crucial drivers for change. As things have turned out, the global financial crisis and the major imperative to improve the quality of care are now critical to the need for change in the NHS.

Models of care recommended in *Healthcare for London* (NHS London 2007)

Six models of provision where the majority of health care will be provided in the future were recommended in *Healthcare for London*:

- home
- polyclinic
- local hospital
- elective centre
- major acute hospital
- specialist hospital.

Healthcare for London argued that much more care could be provided at home, including:

- rehabilitation after a hospital stay
- care for long-term conditions
- specialist treatment such as chemotherapy
- care to prevent hospital admission
- support for a home birth and end-of-life care.

It went on to suggest that, 'Polyclinics are a new idea and could include a range of services including GPs, community services, most outpatient services, minor procedures, urgent care, diagnostics (pathology tests and x-ray), healthy living classes, proactive management of long term conditions, pharmacies and other professionals such as opticians and dentists.' (NHS London 2007)

Local hospitals would provide all non-complex inpatient and day-case surgery to Londoners, caring for all but the most severe emergency cases.

Elective care centres would be there for non-urgent care, such as elective cataract treatment. Such planned work would be separated from emergency cases to achieve better results and lower infection risk.

Major acute hospitals would provide more specialised health services. They would treat enough patients to maintain the most specialised clinical skills of their teams. Some of these hospitals would be part of an academic health sciences centre, providing strong links between research and clinical practice.

Specialist hospitals working in areas such as paediatrics, ophthalmology and heart disease have existed in London for many years. However, *Healthcare for London* suggested that, 'Further specialist hospitals may develop as such specialisation allows the hospitals to concentrate on what they are good at.'

Darzi identified four immediate activities necessary for the NHS in London to show that it was serious about improving health care:

- early establishment of examples of how polyclinics would work by developing five to ten polyclinic pilots by April 2009
- London-wide reconfiguration of stroke services
- London-wide reconfiguration of trauma services
- improvement in the skill and capacity of the London Ambulance Service.

A four-month consultation process followed the publication of the report, and more than 5,000 responses were received from individuals and organisations. The responses helped shape which elements of *Healthcare for London: A framework for action* to progress. A range of projects were set up to take the work forward, including further consultations on the reconfiguration of stroke and trauma services.

In the view of those we interviewed, Healthcare for London showed the value of addressing the city as a whole and recognising that its health services necessarily operated in an interconnected way. A clear plan, with a clearly articulated case for change was a significant achievement.

The plan helped to mitigate and address some of the ad hoc development of specialist services, moving towards a more strategic approach to changing the way health services were delivered:

This approach to pan-London change management has taught us that commissioners can drive change, it has taught us that providers, getting together in networks, can drive change.

So what did Healthcare for London achieve and what's left to be done? We summarise progress in the rest of this section in the course of describing in more detail some of the key service areas covered by Healthcare for London:

- trauma and stroke
- cancer and cardiovascular services
- primary and community services
- acute care.

We also highlight areas where progress has been slow or non-existent. The assessment that follows is not intended to be comprehensive, but it offers a high-level overview of what has been achieved and areas of unfinished business.

Trauma and stroke

A consultation on improving London's stroke and major trauma services was carried out in early 2009 based on cases for change developed by clinically led groups (Healthcare for London 2009). The case for change in stroke services highlighted the heavy burden that stroke places on London's health care services and the wide variations in the quality of care and outcomes achieved across London. The case for change in major trauma services highlighted the high mortality rates in London versus international comparators – death rates for patients with major trauma were up to 40 per cent higher than those in the United States. Mortality from stroke in London compares well to other English regions, but improvements were still seen as possible. The subsequent public support for change enabled the reconfiguration of trauma and stroke services through a process of unit designation.

In the case of stroke services, hospitals were able to apply for designation as a hyper-acute stroke unit (HASU), a stroke unit (SU) and/or a transient ischaemic attack (TIA) service. As a result, eight hyper-acute stroke units were established, staffed by specialist teams with rapid access to high-quality equipment 24 hours per day, seven days per week. These are supported by 24 stroke units that deliver specialist treatment and intensive rehabilitation after patients have spent 72 hours in the hyper-acute stroke unit. People suffering a transient ischaemic attack will be seen in one of the 24 transient ischaemic attack services by an expert who will carry out further investigations, reducing the chance of patients going on to have a full stroke. As part of the work to develop London's stroke services there were also changes made to the structure of the Payment by Results tariff for London.

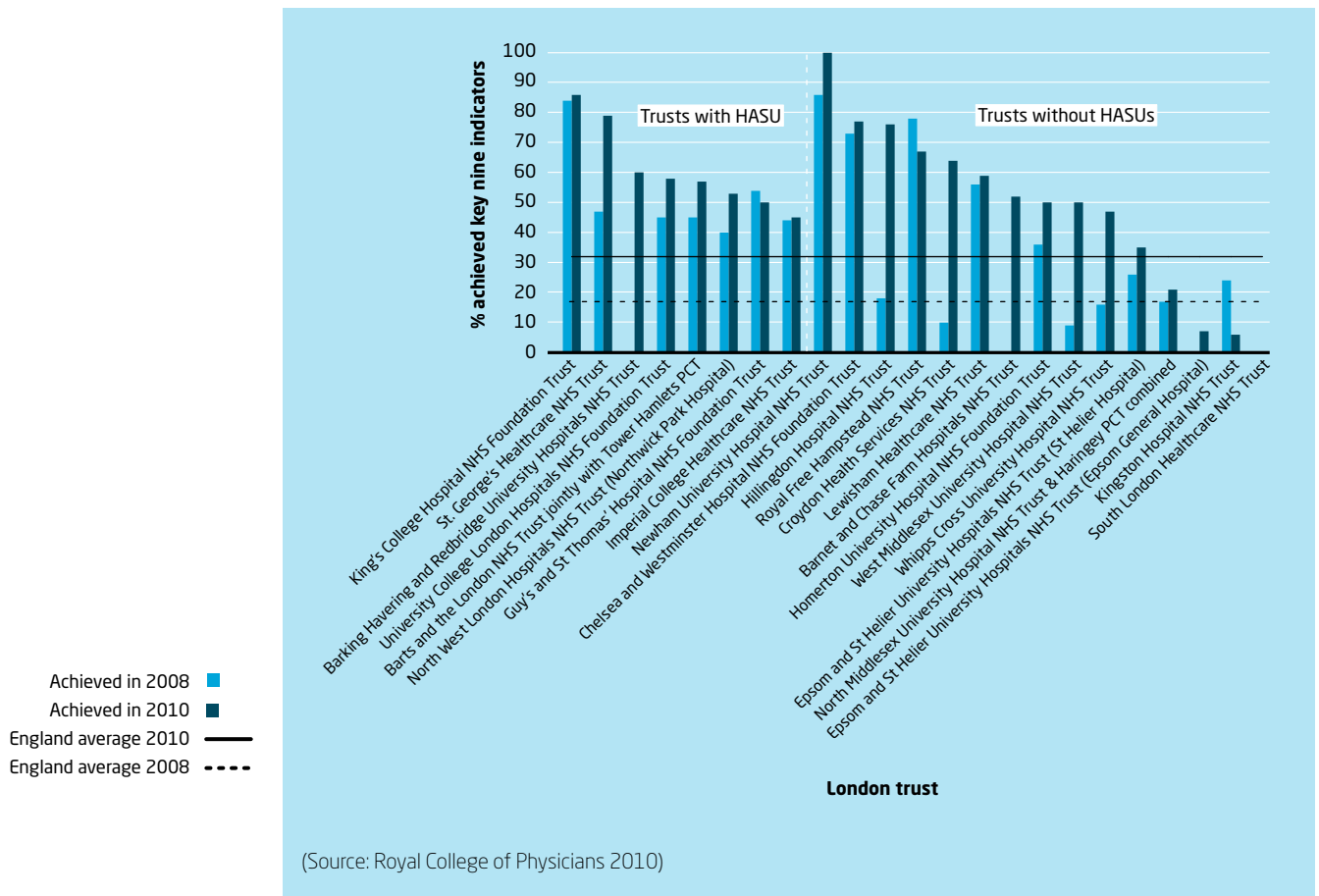
There is a general view that a key success for Healthcare for London has been the reorganisation of stroke services. There were a variety of reasons for this, not least being the overwhelming clinical case for change. This strong evidence base helped to engage clinicians early on, with a clear message that change would save lives. Equally, the ability to measure and show clear improvement in morbidity and mortality helped to cement the changes.

The things that made stroke work: it's a relatively straightforward pathway, there was a good evidence base for the intervention, there was strong clinical backing for delivering an improved way of working and there was quite a clear clinical consensus that if we concentrated first on secure sites we could make a big difference.

Some evidence of improvement in performance is shown in Figure 3, opposite – a comparison of London trusts' scores on key stroke care quality measures in 2008 and 2010 (when seven permanent and one temporary hyper-acute stroke units opened).

Unpublished findings suggest that the changes had a significant impact on patient mortality and morbidity and that significant savings were generated (NHS London 2011c,e). Data from the National Sentinel Stroke Audit has also shown that compared to the rest of England, London HASU centres have been achieving higher rates of brain scans within 24 hours of admission, lower lengths of stay and higher proportions of thrombolysed patients (Royal College of Physicians 2010). The National Institute for Health Research has commissioned a formal evaluation of the stroke changes in London and Manchester; final results are expected by 2014, but preliminary results should be available earlier.

Figure 3 Performance of London trusts in key 9 indicators for stroke care: 2008 and 2010



In the case of trauma, four major centres were designated to provide a consultant-delivered service for seriously injured patients 24 hours a day, seven days a week with rapid access to diagnostics such as CT scanners as well as operating theatres (see Figure 4, overleaf). The centres have access to all the specialties required to treat serious injuries on site, such as neurosurgery, orthopaedics and plastic surgery. The major trauma centre acts as a hub for a local trauma system – working with a series of local trauma units. Ambulance services use agreed protocols to assess patients’ injuries and take them to the most suitable hospital for their injury. Rehabilitation services are provided in the major trauma centre, in the trauma units or in specialised rehabilitation centres such as those for patients with head injuries.

The new trauma set-up has shown improvements in access times for CT scanning and, compared with national survival rates for trauma patients in September 2010, the four trauma centres appear to have 37 additional survivors over and above the number expected (London Trauma Office 2010).

Figure 4 London trauma centres



Cancer and cardiovascular services

After stroke and trauma service reconfiguration, the greatest area of attention and activity has been cancer and cardiovascular services. Both reconfigurations have been clinically led and argue that new service delivery models are needed to address wide variations in care and outcomes across London and to improve health outcomes for the capital as a whole. In particular, they suggest that for rarer forms of disease there needs to be a rationalisation of services.

For cancer services the approach attempts to create a clear distinction between the commissioning and provision aspects of clinical networks. Commissioners have issued a specification for what is termed an 'integrated cancer system'. Collectives of providers have been asked to submit applications for designation as an integrated cancer system. The integrated cancer system is expected to show how it will meet minimum quality standards for specific cancers and have its own separate governance and management structures with board-level engagement from the constituent organisations. The expectation is that integrated cancer systems will be the main provider vehicle for cancer delivery from April 2012. In addition, the Health Improvement Board for London, chaired by the Mayor, has been established. One of its first priorities is to improve cancer outcomes through early detection and diagnosis.

For cardiovascular services a model of care has been drawn up suggesting a hub-and-spoke model for vascular services and rationalised pathways for cardiac surgery and treatment. This has resulted in some reconfiguration of current service provision.

Primary and community services

While there are examples of excellent and innovative primary care in London, overall the results of the GP patient survey show poorer performances than in other regions (see Table 1 overleaf). There are also wide variations in the clinical quality of general practice within London. For example, for coronary heart disease, primary care trusts (PCTs) with the highest average Quality and Outcomes Framework scores among their general practices were in the south and west of London, with much lower scores found in the north and east.

The results of the GP patient survey underline the importance of strengthening primary care provision in London by supporting all practices to match the standards achieved by the best. As one of our interviewees put it:

In terms of delivery mechanisms I think one of the key problems was, to put it crudely, a very under-developed primary care landscape with too much variability around quality, particularly in outcomes. Although there is some very good primary care in London, some is terrible.

Polyclinics were part of the Healthcare for London answer to poor primary-care performance. They would offer extended hours primary-care provision as well as a range of diagnostics, some specialist consultations and minor-injuries services. These services would be provided in modern facilities and would be co-located with other community services, such as district nurses and therapy services. Detailed commissioning and project-planning guidance was produced and an evaluation commissioned of early implementers. By April 2011, 32 GP-led 'hubs' were operational across London, with a further 15 planned. The outcome of the evaluation of the polyclinic model is still awaited.

In the view of those we interviewed, work to improve the quality of primary care has been painfully slow:

If you look at primary care across London and measure how much is changed over the last five years – and this was the key strategy in Darzi's plan – well it's pretty close to zero.

One of the reasons has been resistance to the idea of polyclinics by many GPs, as reflected in the following quote from one of our interviews:

XXX rushed ahead and created... polyclinics and... Darzi '8to8' centres. The hypothesis was that this would stop activity in the acute sector, which it didn't, so XXX ended up with a huge bill for all these new services and a massive overspend on acute... The GPs in XXX hate the polyclinics.

The autonomy of GPs and the reluctance of PCTs in many areas to use the levers available to them to challenge poor practice help explain the limited progress made to date. One notable exception is Tower Hamlets, where the PCT has succeeded in removing a number of GPs and persuading others to retire as part of a concerted effort to raise standards of primary-care provision in an area of great need.

A major new initiative to tackle the variation of quality in primary care, led by the newly established London-wide GP Council, is the development of a web-based primary-care dashboard that will provide general practices and their patients with a range of data and information about the quality of general practice. Experience in Tower Hamlets, and wider research evidence, suggests that this type of benchmarking and feedback can be a powerful driver of improvement. A core test of the current reforms is whether clinical commissioning groups will be more effective than PCTs in raising standards.

We return to this question in the final section of the paper.

Table 1 Summary indicators from GP Patient survey 2010-11

Scores = rank with 1 = best and 10 = worst		North East	North West	Yorkshire + Humber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West
Access	Ease of getting appointment with practice nurse	1	9	6	4	5	3	10	8	7	2
	Desire for surgery to be open at additional times	1	5	4	3	9	7	10	8	6	2
	Ease of getting into surgery building	1	8	2	7	6	10	5	9	4	3
	Able to see a doctor fairly quickly	7	9	8	5	6	3	10	2	4	1
	Able to book ahead for an appointment with a doctor in the past six months	4	9	8	10	5	3	7	6	2	1
	Ease of getting through on the phone	3	6	7	8	5	4	10	9	2	1
	Ease of speaking to a doctor on the phone	5	9	7	4	10	6	8	3	2	1
	Ease of speaking to a nurse on the phone	3	7	6	2	5	8	9	10	4	1
	Ease of getting tests results over the phone	1	4	6	7	9	3	10	5	8	2
Satisfaction	Overall satisfaction	2	4	5	8	9	7	10	6	3	1
	Recommend GP	2	7	6	8	9	5	10	4	3	1
	Rating of practice nurse giving you enough time	1	7	3	4	6	5	10	9	8	2
	Confidence and trust in doctor	2	4	5	8	9	7	10	6	3	1
	Satisfaction with opening hours	1	3	6	4	5	8	10	9	7	2
	Frequency of seeing preferred doctor	4	6	8	9	7	5	10	3	2	1
Respect and dignity	Rating of practice nurse treating you with care and concern	1	7	3	4	6	5	10	9	8	2
	Rating of practice nurse taking your problems seriously	1	7	2	4	6	5	10	9	8	3
	Rating of doctor giving you enough time	1	3	4	7	8	9	10	6	5	2
	Rating of doctor treating you with care and concern	2	3	4	7	9	8	10	6	5	1
	Rating of doctor taking your problems seriously	2	3	4	7	9	8	10	6	5	1
	Cleanliness of surgery	1	6	4	3	9	5	10	7	8	2
	Overheard at reception	7	9	2	5	6	3	4	8	10	1
Communication	Rating of practice nurse listening to you	1	7	2	3	6	4	10	9	8	5
	Rating of practice nurse asking about your symptoms	1	6	3	2	4	5	10	9	8	7
	Rating of practice nurse explaining tests and treatments	1	6	3	4	5	7	10	9	8	2
	Rating of practice nurse involving you in decisions about your care	1	3	2	4	5	7	10	9	8	6
	Rating of doctor asking about your symptoms	1	3	4	6	9	8	10	7	5	2
	Rating of doctor listening to you	2	3	4	7	9	8	10	6	5	1
	Rating of doctor explaining tests and treatments	1	3	4	6	7	9	10	8	5	2
	Rating of doctor involving you in decisions about your care	1	3	4	6	8	9	10	7	5	2
	Helpfulness of receptionist	1	6	5	8	9	4	10	7	3	2
Average rank score	2.0	5.6	4.5	5.6	7.1	6.1	9.5	7.1	5.5	2.0	

(Source: Department of Health 2011d)

Acute hospital services

A key recommendation from Healthcare for London was the creation of a more ‘tiered’ set of hospitals that would focus on particular areas or types of work, such as planned and emergency care. ‘Local’ hospitals would provide more routine care for non-complex patients. Elective centres would exist separately from urgent and emergency care and concentrate on, for example, hip and knee replacements. More specialist care would be provided in fewer, major units and specialist care, for example, for stroke and trauma would be provided in existing specialist centres – with additional centres as necessary. In addition, there would be a number of world-class academic health sciences centres bringing together the best clinical research and provision.

While some progress has been made in reconfiguring acute services (*see below*), across the capital as a whole many of the challenges identified in *Healthcare for London* remain. For example, analysis of 18 London trusts, excluding the Royal Orthopaedic or Great Ormond Street Hospitals, in the foundation trust pipeline identified 12 (66 per cent) acute hospitals that are struggling to meet the criteria to become foundation trusts and are facing significant financial pressures, which many believe will only be addressed by substantial service reconfiguration. As one of our interviewees put it:

The disposition of hospital services in London now is broadly speaking the same as it was certainly 10 if not 20 or 30 years ago. They still have a huge amount of duplication of services in hospitals that are only a 15 minute bus ride away.

Reconfiguration is particularly needed to address the persistent and wide variation in quality and outcomes in London – in part a result of the large number of hospital providers:

Some are brilliant, but some are bloody awful. There’s this London feeling that you have to have a little bit of everything on the end of every street corner, which has excused some real mediocrity.

Variations in quality are illustrated by recent analysis by NHS London of outcomes in emergency care:

Findings have demonstrated that stark variation in service provision is present in London. Variation exists between sites in London and, within individual sites, huge variation also exists between provision during weekdays compared to that at weekends... This reduced service provision at weekends is associated with higher mortality.

(NHS London 2011a)

The report suggests that 500 deaths could be avoided if the mortality rates at weekends were the same as those occurring during the week. One of the implications of this analysis was that emergency care needed to be concentrated in fewer hospitals to ensure that consultant cover was available 24 hours per day, seven days per week.

The recent decision by the Independent Reconfiguration Panel (IRP) (2011b) and the Secretary of State’s endorsement of reconfiguration involving Chase Farm Hospital provides a signal that changes in acute services may now be more likely (Campbell 2011). Plans for reconfiguring hospitals in north-east London, involving the closure of emergency and maternity services at King George Hospital in Ilford, is further evidence of the willingness of the government to support changes where there is clinical evidence to support them (IRP 2011a; Department of Health 2011a).

The future role of health and wellbeing boards is of interest given that it was a local authority (Enfield) that brought the Chase Farm Hospital case to the Independent

Reconfiguration Panel. The potential benefits of local authority involvement were emphasised by one of our interviewees:

Giving local authorities a much stronger leadership role on health and responsibility for ensuring the co-ordination of commissioning in their borough is potentially a real opportunity... if they rise to that challenge that means they have to take responsibility for improving health services not just reacting to NHS proposals... intelligent leadership by local councils could make things possible that are not easily possible now.

Having made this point, the time taken to bring about changes to hospitals, such as Chase Farm in north London and King George Hospital in north-east London, underlines the challenges in reconfiguring services. In the case of Chase Farm, proposals were originally put forward in the 1990s and it was not until 2011 that the Secretary of State gave agreement for changes to happen.

While this may be an exceptional example, it nevertheless illustrates the protracted processes involved and the need in future to expedite decision-making while also allowing for proper engagement by the public and their representatives. There is considerable complexity in building up community and primary-care infrastructure while disinvesting in some secondary-care services. Perceptions by politicians and the public that they might lose services, and worries on the part of hospitals that they might be seen as 'second tier' or downgraded organisations ('the local hospital'), have no doubt served to slow down, if not block, movement on some Healthcare for London plans. The politics of service reconfiguration often outweighs the clinical arguments for change and the failure to explain to the public why change may be needed has compounded the problem.

The factor that may facilitate reconfiguration in future is increasing awareness of the risks to patient safety and quality of care if all hospitals seek to continue to provide services like maternity care, A&E services and emergency surgery. The improvements already achieved in stroke care and the potential to make similar progress in emergency care – illustrated by the NHS London review – make it clear that safety and quality are the over-riding considerations. It is on this territory that the debate about the future role of hospitals needs to take place rather than in relation to the financial challenges facing the NHS, which, although real and growing, are not the main reason why the current pattern of service provision is unsustainable.

Proposed trust and hospital mergers

Against this background, a number of trust and hospital mergers are intended as commissioners and providers plan for a harsher financial future while also seeking to improve the quality of care (*see* Table 2 opposite). These proposed mergers would leave only 12 trusts with one acute hospital site. Four of these would be vertically integrated, with acute and community services working together.

Barts and East London Healthcare and North West London both argue the need for change on the basis of financial and clinical drivers, and as a path to achieving foundation trust status.

We believe a merged organisation will be authorised as a Foundation Trust in due course, an outcome that seems unlikely under other scenarios.

(North West London Hospitals Trust 2011)

Table 2 Current multi-site trusts and proposed mergers

Current/proposed (in italics) organisation name	Constituent hospitals (trusts)	Turnover £m
Guy's and St Thomas' NHS Foundation Trust	Guy's and St Thomas'	992
Imperial	Hammersmith, Charing Cross and St Mary's	920
South London	Queen Elizabeth – Greenwich, Bromley and Queen Mary's Sidcup	438
Barking and Havering	Queen's and King George's	407
Barnet and Chase Farm	Barnet and Chase Farm	349
<i>Barts and East London Healthcare (BELH)</i>	<i>Royal London, St Bartholomew's (BLT) Whipps Cross (WCUHT), Newham (NUHT) and community services</i>	<i>1,000</i>
<i>North West London</i>	<i>Northwick Park, Central Middlesex (NWLHT), Ealing (EHT) and community services</i>	<i>600</i>
<i>St George's and St Helier</i>	<i>St George's (SGHT) and St Helier (SHUHT) (early stage of negotiation)</i>	<i>Not known</i>

In the case of North West London, the argument for merger hinges in part on the belief that the merged trust will be able to provide larger, more specialised teams that will increase the senior medical input to care and also facilitate more integrated working. The Barts and East London Healthcare (BELH) case – whose outline business case was approved by NHS London in February 2011 – emphasises the benefits of integration between secondary and tertiary services.

As a single organisation we immediately lose organisational boundaries, with single teams working across multiple sites – without the need for inter Trust referrals or approvals. In neurosurgery, we will be able to ensure seamless emergency advice and onward care without the need for inter Trust contracts as the neurosurgeon will own the patient and will be part of a single BELH team. For similar reasons the current cancer network will work better, with faster access to experts, diagnosis, and treatments.

(Barts and East London 2011)

While both business cases outline the need for savings greater than thought achievable within the current trust configuration, the balance sheet positions are different. The emphasis in the case of Barts and East London Healthcare is weaknesses in underlying balance sheets and capital and the consequent threats of failure. In North West London, local commissioners plan a significant shift of activity from hospital to community. The trusts face future income reductions of 23–24 per cent and will need to find savings of £125 million by 2014/15 (North West London Hospitals Trust 2011). North West London Hospitals Trust also carries a historic deficit of more than £16 million that it hopes will be written off. The strategic outline case suggests that the merger will generate more than £35 million of savings from:

- reducing management costs
- improving productivity to the best of the three sites
- consolidating teams, locations and rotas and moving some services
- improving estate utilisation.

In the Barts and East London Healthcare *Outline Business Case* there is a similar shopping list of opportunities, totalling over £60 million. In both cases the savings predicted from the mergers will go only part way to addressing the financial challenges they face. For example, in North West London a further £90 million savings will need to be generated by 2014/15.

Palmer's analysis of experience in South East London (*see* box below) would suggest that if the full clinical and financial benefits are to be realised from mergers, there should be some reconfiguration of services along patient pathways in order to support best practice care and release the greatest efficiencies. He argues there should be:

a significant change in the way emergency and network services are currently provided, from a system where all hospital trusts provide a full range of broadly similar secondary services to one in which there is greater differentiation of roles along pathways.

(Palmer 2011, p 27)

Reconfiguring South East London hospital services: 'A Picture of Health'

The South East London health economy has been immersed in a major reconfiguration exercise (called A Picture of Health) for the past six years and that predated Lord Darzi's review. Reconfiguration proposals were approved by the Joint Committee of PCTs (JCPCT) in 2008 after three years of work following expressions of support for the scheme from the National Clinical Advisory Team and an extensive public consultation. Vocal local opposition to change resulted in significant delays to implementation, as proposals have been subject to repeated opposition and review.

Following referral by the Joint Overview and Scrutiny Committee in May 2009, the then secretary of state endorsed the Independent Reconfiguration Panel's recommendations to support the PCTs' decision. Despite formal approval, the changes were then subject to further scrutiny after the moratorium on service change imposed in May 2010 by the new coalition government. The SHA, NHS London, subsequently reviewed the plans to ensure they met the four tests set out for reconfiguration processes by the Secretary of State for Health.

It was not until December 2010 that the SHA confirmed that A Picture of Health met the four tests for reconfiguration, with explicit but not universal support from local GP commissioners. This decision came at the same time as A&E and maternity services at Queen Mary's, Sidcup, were forced to close on a 'temporary' basis on the grounds of safety. Now that approval for the proposals has been given, these changes will become permanent and the existing site will be re-developed as planned.

(Source: Palmer 2011)

Drawing on the experience of South East London, Palmer contends that merging or linking local hospitals with specialist hospitals is more likely to bring about improvements in the quality of care than simply merging local hospitals, especially local hospitals with a history of financial and quality challenges. This has begun to happen in some areas through the development of networks or partnerships based on the three academic health sciences centres in London.

Academic health sciences centres and partnerships

London's academic health sciences centres (AHSCs) were established in 2009 as part of a policy to establish a number of centres in England in line with the recommendations set out in the review Lord Darzi led for the then government on improving the quality of care across the NHS. The centres are:

- UCL Partners – established as a federated model. The original partners were University College London (UCL), Great Ormond Street Hospital for Children NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, Royal Free Hampstead NHS Trust and University College London Hospitals NHS Foundation Trust.
- King's Health Partners – comprised King's College London, Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust.
- Imperial AHSC – set up as a partnership between Imperial College NHS Trust and Imperial College London with a single centralised leadership.

Recently, following a review by Lord Darzi, it has been reported that Imperial College Healthcare NHS Trust plans to launch a new academic health sciences partnership covering north-west London, which will function alongside the existing academic health sciences centre and follow the model employed by King's Health Partners and UCL partners. The latter has also indicated that it will expand to include Barking, Havering and Redbridge NHS Foundation Trust and Homerton Hospital NHS Foundation Trust, following the early addition of Barts and the London Trust and Queen Mary's University of London. The emphasis on academic health sciences centres becoming the hub of more broadly based partnerships that link specialist hospitals and universities with local hospitals and other services is consistent with Palmer's argument on how services should be reconfigured to address financial and quality challenges, although it is too early to assess whether this approach will deliver improvements in care.

Health inequalities and public health

Wide variation in health inequalities, linked in part to poverty, was a key feature of the case for change of Healthcare for London. One of the powerful statistics used was the fact that while life expectancy in London is similar to the national level, travelling eight stops on the Jubilee line from Westminster to Canning Town means a difference in life expectancy of seven years. There was large variation in other areas of public health such as smoking, infant mortality and teenage conception.

Despite underlining the importance of public health issues in London, Healthcare for London drove little change in this area. One suggestion as to why the recommendations made on public health were not taken forward was that while they were 'nice to do' they were not the core business of the NHS:

There has been London-wide work done on screening, smoking cessation and on immunisation, but they weren't the recommendations in HfL [Healthcare for London], so I think the thing about public health is that you can see evidence of some London-wide initiatives, but that the HfL [Healthcare for London] report didn't come up with the right recommendations.

In some quarters this was linked to a perception that the author of the Healthcare for London review was a hospital-based specialist whose expertise in public health was less clear than in the areas where progress has been made. The establishment of the London Health Commission during this period did provide a focus for analysis and debate about public health issues and health inequalities but the commission did not have the authority to carry through the analysis into action. It remains to be seen whether the recently established London Health Improvement Board will achieve more success.

Conclusion

Healthcare for London has delivered some successes. Improvements in outcomes driven by the reconfiguration of stroke services are now a nationally cited example of the benefits of reconfiguration. Progress has also been made in areas such as trauma, cancer and cardiovascular care, albeit with more work to do to realise the full benefits. For those working in London, Healthcare for London created a sense of strategic cohesion and direction that had been lacking, while for clinicians it provided a powerful platform for their voice and engagement. In many ways it is surprising that more has not been done to publicise and celebrate these successes and to explain to the public and other stakeholders the improvements in care that have resulted.

A pre-election commitment by the Conservative party resulted in the Secretary of State for Health, deciding to bring the Healthcare for London programme to an end shortly after the election. This decision was based on a dislike of change being led top-down and a preference for service reconfigurations to be led locally by clinicians and with full public engagement. Accordingly, the government set out four tests that needed to be met before proposals for reconfiguration would be accepted (Department of Health 2010). These were:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice.

Despite the formal ending of the Healthcare for London programme, some of the work that had been initiated was continued as part of London Health Programmes led by NHS London. The box opposite summarises ongoing work that has not been discussed in this section. Despite this, much of the momentum that was built up before the election has been dissipated.

These factors help to explain why there is a huge amount of unfinished business. How this will be tackled over the coming years remains to be seen. As we describe in the next section, although Healthcare for London emphasised the slowdown in funding as part of its case for change, the financial future to 2014/15 is now known and is more challenging than anticipated in 2007. Moreover, the policy landscape is also changing with further reforms for the NHS and heavy downward pressure on management costs. The distraction created by major organisational change has taken time and attention away from work on service reconfiguration, with inevitable delays as a consequence.

Ongoing London health programmes

Adult emergency services

A clinical review of London's emergency care services was undertaken as part of the clinical quality and safety work. It resulted in publication of a case-for-change document and a set of commissioning standards.

Children and young people

Comprehensive reviews have been undertaken of tertiary and emergency paediatric services. This was followed by publication of commissioning guides for commissioners and the outline for a new model of care, which is being taken forward by PCT clusters working with clinical commissioning groups.

End-of-life care

Clinical and commissioning groups were established and produced a range of guides for commissioners and providers and an economic modelling tool. These have been handed over to London commissioners.

London and south-east England specialised burns project

A project was commissioned by specialist commissioning groups to ensure that services are clinically and financially sustainable, while providing the best possible patient care and outcomes.

Maternity

A project developed a model of care with some recommendations. This is used by commissioners to develop local services in 2011/12.

Mental health

A case for change and models of care were developed and implementation is supported until April 2012.

Tuberculosis

Development of a London plan scheduled for approval by commissioners in Autumn 2011.

Unscheduled care

There is a project to develop commissioning guidelines and a single consistent model for urgent care centres.

Pathology

Following Lord Carter's 2006 review of pathology services in England (Carter 2006) a pan-London review is now in implementation phase, with development of pathology 'hubs' and 'hot labs'.

Orthopaedics

There is a review of effective commissioning of hip and knee replacements in conjunction with the Department of Health Right Care team.

The new financial and policy landscape

Two issues dominate any discussion of how health care services might change in London: funding and policy on NHS reform. The former presents problems with few upsides, not just for London's health services, but across the NHS – although, as we note below, some financial issues are more acute in London. The latter can be seen as presenting opportunities, but also potential difficulties, to co-ordinated service redesign in London.

The financial imperative

The future funding assumptions that underpinned, and, in part, provided a justification for the service reconfiguration proposed by Healthcare for London could have been seen at the time as somewhat pessimistic. As part of the analysis supporting Healthcare for London, the overall spend across London's health care system between 2010/11 and 2014/15 was projected to increase by around 2.4 per cent per annum in real terms compared with more than double that in recent years for example. With the benefit of hindsight, and following the 2010 Spending Review, such assumptions now appear almost wildly optimistic. While NHS funding in England is protected relative to other spending areas, the actual cash increases to 2014/15 are likely only to cover inflation, leaving little or no real increase. In addition, central government funding to London local authorities has reduced by 11.2 per cent in 2011/12 and will fall by a further 7.6 per cent in 2012/13. Intensifying pressures on social-care budgets are likely to impact on the NHS, for example through delayed transfers of care from acute hospitals.

In the short term, the 2011/12 allocation was boosted by the carry over of £392 million (2.3 per cent of resource limits) of aggregate primary care trust (PCT) and strategic health authority (SHA) surpluses in 2010/11 (*see* Figure 5 on p 24). First quarter projections for the end of 2011/12 suggest a similar amount will be carried over into 2012/13. The aggregate outturn for 2010/11 also obscures the fact that NHS London helped bail out six PCTs and contributed money to four trusts. The Challenged Trust Board (CTB) was set up by NHS London in 2008/9 with agreement by London PCTs to invest in a collective fund to tackle historic debts across London as part of the region's medium-term financial strategy. In essence, the board redistributed £200 million – mainly to PCTs, and on the basis of an analysis of the causes of the deficits (NHS London 2011b).

The size and complexity of some trusts' debts suggest a continuing redistributive role in 2011/12. While there were (albeit relatively small) aggregate deficits across NHS trusts (excluding foundation trusts) in 2010/11, projections for the end of 2011/12 suggest an increase in the deficits of four trusts from £19 million last year to over £106 million by April 2012 (*see* Figures 6 and 7 on pp 25, 26). The actual position is worse than these figures suggest, with a number of trusts using non-recurring funds to tackle deficits. It is worth noting that the financial challenges facing PCTs and trusts in London are much greater than those facing PCTs and trusts in the rest of England. All three PCTs in England forecasting deficits by the end of 2011/12 are in the capital as are five of the six trusts forecasting a gross operating deficit in the same period (Department of Health 2011e).

The difficulties of the medium-term financial situation have been starkly illustrated by analysis carried out by NHS London into the potential for London's acute trusts to achieve foundation trust status by 2014. Even under fairly heroic assumptions concerning productivity improvements over the next few years, the modelling carried out by NHS London (Sustainable and Financially Effective [SaFE] (NHS London 2011d)) suggests that net deficits for 18 acute trusts will grow to around £170 million by 2014 and that only six trusts are likely to be in a viable financial position by this date. This may be an optimistic assessment and one certainly sensitive to relatively small changes in the modelling assumptions. For example, an additional 1 per cent inflation reduces the number of viable trusts to just two – with 16 considered to be not viable in any test scenario. The potential estimated net deficit is £170 million: this compares to the position in 2010/11, where four trusts reported total deficits of £19.8 million, and the 2011/12 projected position that six trusts will end the year in total deficit of £106.8 million.

Only 16 out of 42 trusts have made the transition to foundation trusts. With the deadline for trusts (including the London Ambulance Service, three mental health trusts, two community service trusts and 20 acute trusts) to become foundation trusts set as 2014, it will take a herculean effort to meet this date. This has been recognised by the National Audit Office (NAO), which has stated that the challenge to ready trusts for foundation trust status is greatest in London (*see box below*).

NAO foundation trust pipeline analysis

The NAO's analysis of the challenges involved in ensuring trusts achieve foundation trust status over the next few years highlighted London's circumstances as an especially problematic case:

Compared with the other nine regions, London has the lowest proportion of trusts that have achieved foundation trust status (38 per cent), and the highest number of trusts (26) still in the pipeline. The SHAs we spoke to in other regions agreed that, while some individual trusts in other parts of the country face similar problems, the concentration and complexity of challenges in London are not replicated elsewhere.

There are some complex specialist teaching hospitals in London, and individual trusts with local challenges, but also a number of strategic issues. Problems in London are complex, but NHS London's broad assessment is that:

- *there are too many hospitals, relative to the population, in parts of the capital, leading to duplication of services;*
- *in parts of the capital there is an imbalance between primary and secondary care, so hospital accident and emergency departments are too often used by people with relatively minor health problems who should be treated in the community;*
- *in some trusts there is more capacity, some of which has been funded through PFI investment, than commissioners need;*
- *PFI contracts limit the flexibility some trusts have to reconfigure their services and they have associated long-term financial commitments; and*
- *there is still scope for productivity and efficiency improvements in many trusts.*

(Source: NAO 2011, pp 31–32)

The overall funding squeeze is exacerbated for London by the current weighted capitation allocation formula which – on the current methodology – suggests a significant shift of money out of London and to the rest of the country. Below we look at this as well as related financial issues: PFI commitments, planned cost improvement programmes and broad measures of system efficiency.

Figure 5 2010/11 outturn for PCTs and forecast outturn for end of year 2011/12 (as at first quarter)

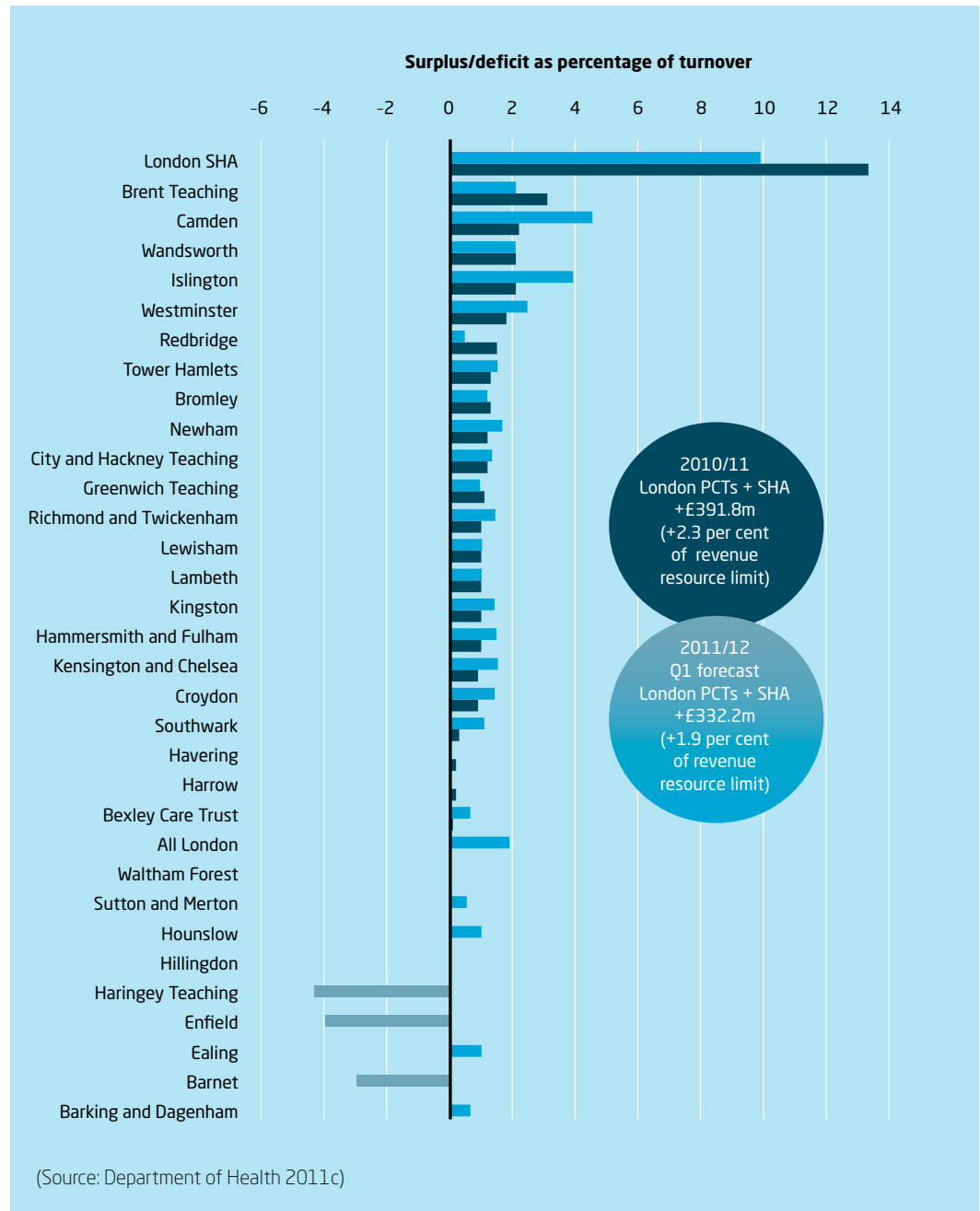


Figure 6 2010/11 outturn of NHS and foundation trusts

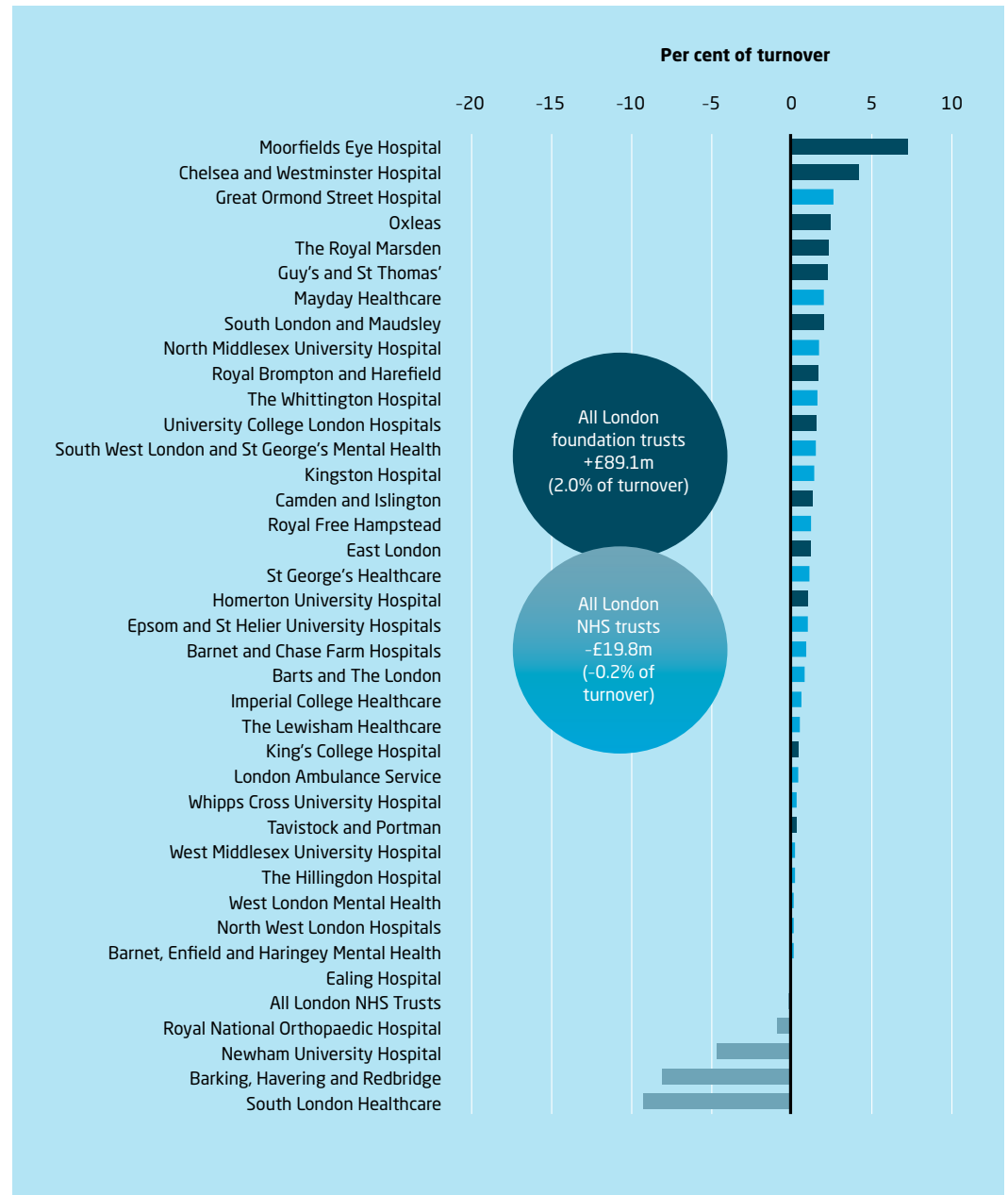
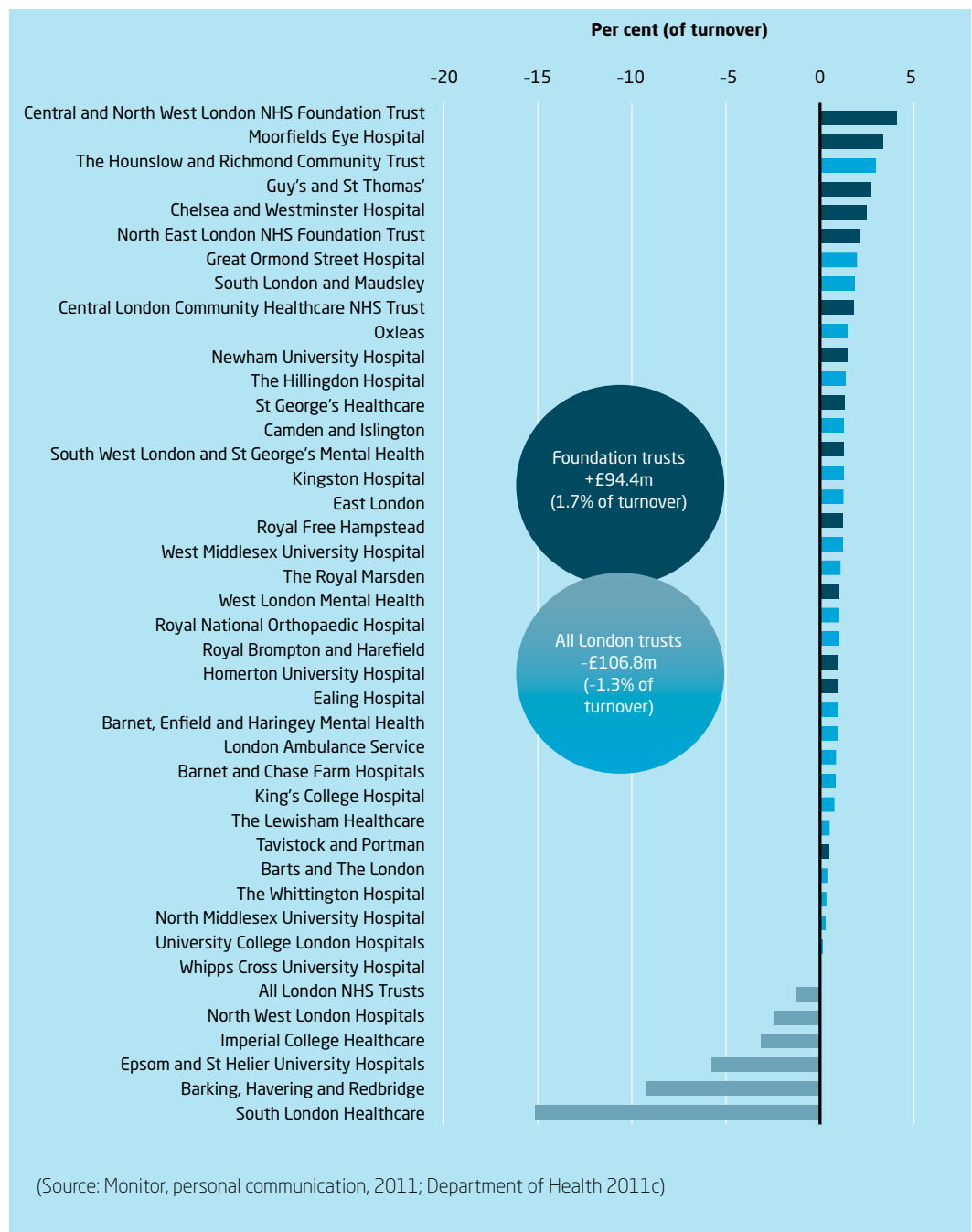


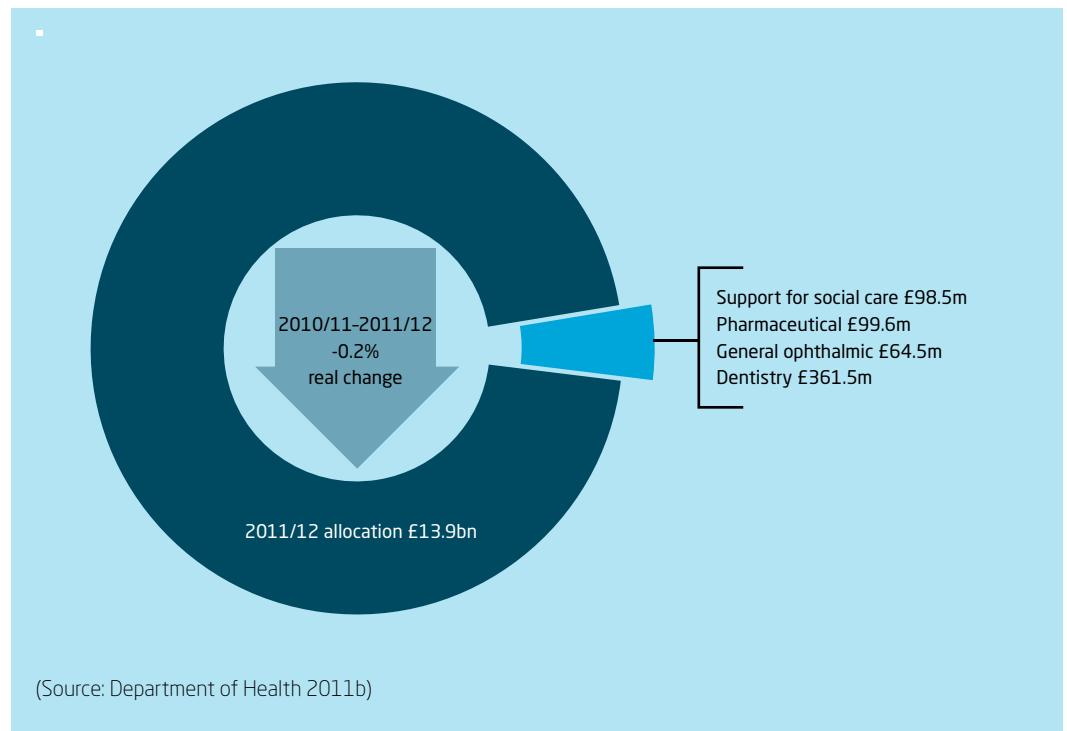
Figure 7 Forecast 2011/12 outturn (first quarter) trusts and foundation trusts



PCT allocations

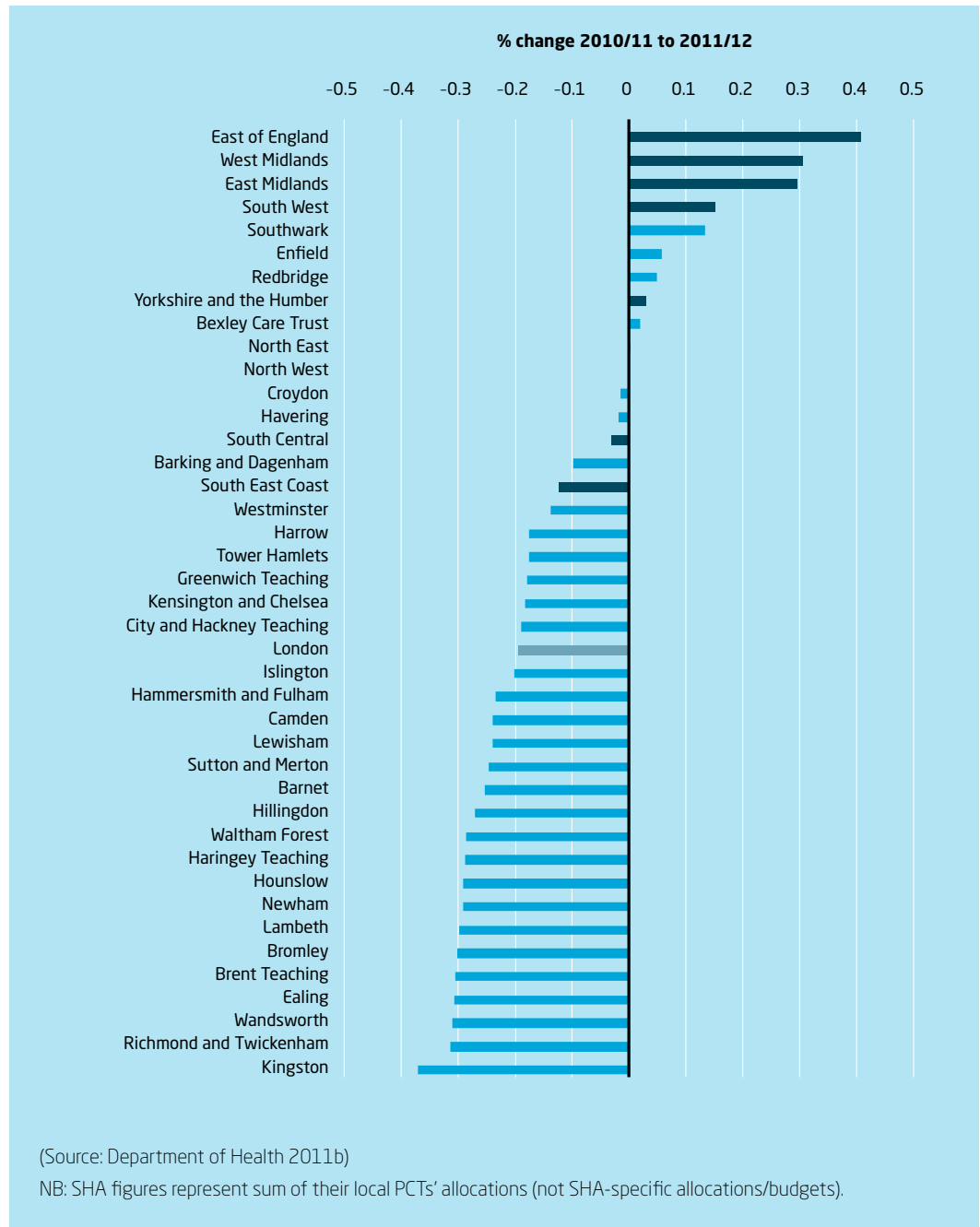
For London, the situation could be slightly worse than a real freeze in funding depending on decisions about the allocation formulae and movement to target allocations. PCT allocations for 2011/12 provide for a cash increase of around £384 million – a rise of 2.7 per cent, but a likely real decrease of around 0.2 per cent (based on the GDP deflator, not NHS-specific inflation which, due to the public sector pay freeze, may be less than the estimated 2.9 per cent GDP deflator for 2011/12) (see Figure 8 opposite). This is the largest reduction in allocations of any region. It is worth noting that part of all PCTs' allocations is earmarked for spending to support social care. In London this amounts to nearly £99 million in 2011/12.

Figure 8 London PCT 2011/12 allocations



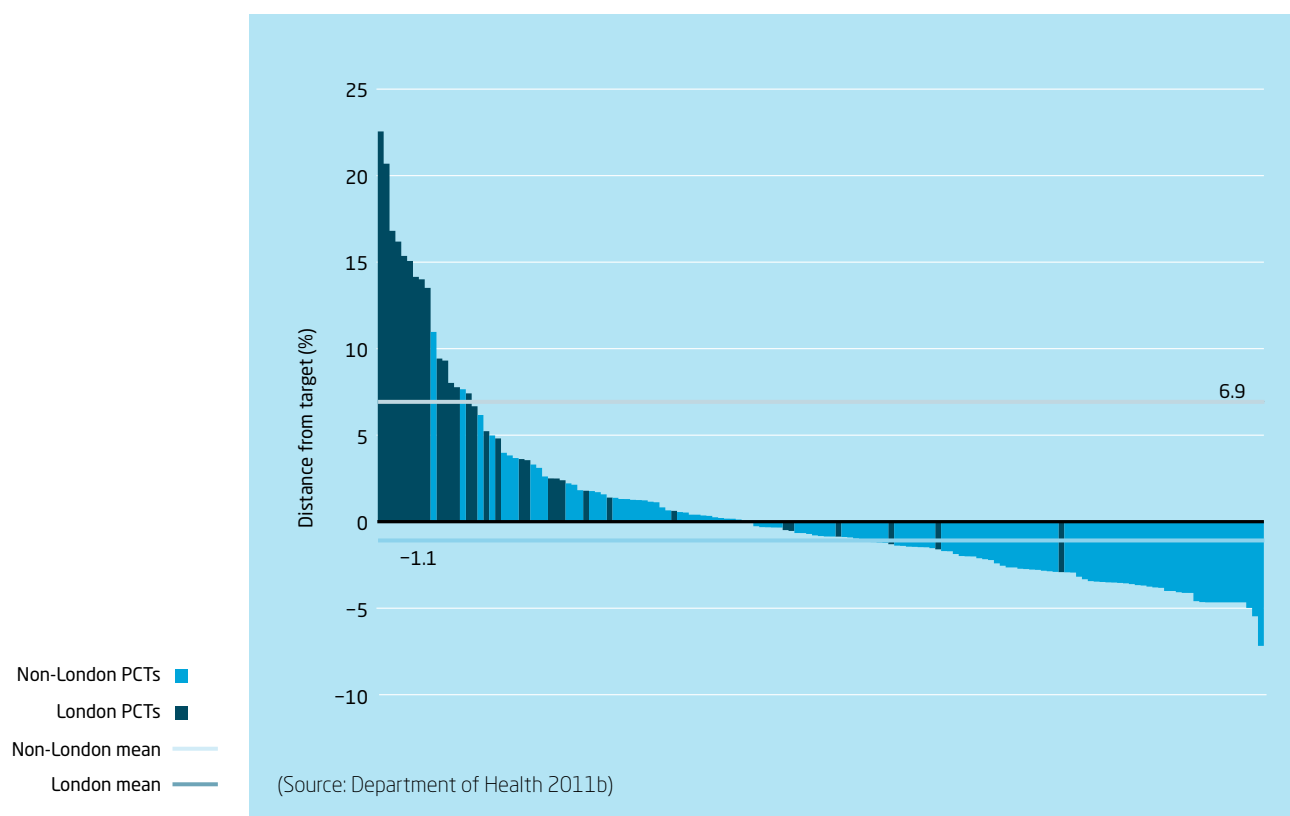
As Figure 9, overleaf, shows, PCT allocations vary across London – ranging from real increases of around 0.13 per cent for Southwark PCT to a real reduction of 0.37 per cent for Kingston. These figures include a planned under spend for 2011/12 which significantly reduces PCTs’ spending powers – leaving an effective real cut in 2011/12 of around 2 per cent to 3 per cent across London.

Figure 9 Real changes in PCT allocations and aggregate regional (SHA) positions: 2010/11 to 2011/12



Compared with non-London PCTs, on the current allocation formula, PCTs in London are much more likely to be over-provided for (that is, to receive more than the weighted capitation formulae suggest they should). Across the whole of London, PCTs are currently over-provided by around 6.6 per cent – equivalent to £867 million (the amount that, over time, should shift out of London) and amounting to the combined budgets of three PCTs: Islington, Richmond and Twickenham and Kingston PCT (see Figure 10 opposite).

Figure 10 Distribution of PCTs' distance from target allocations for 2011/12



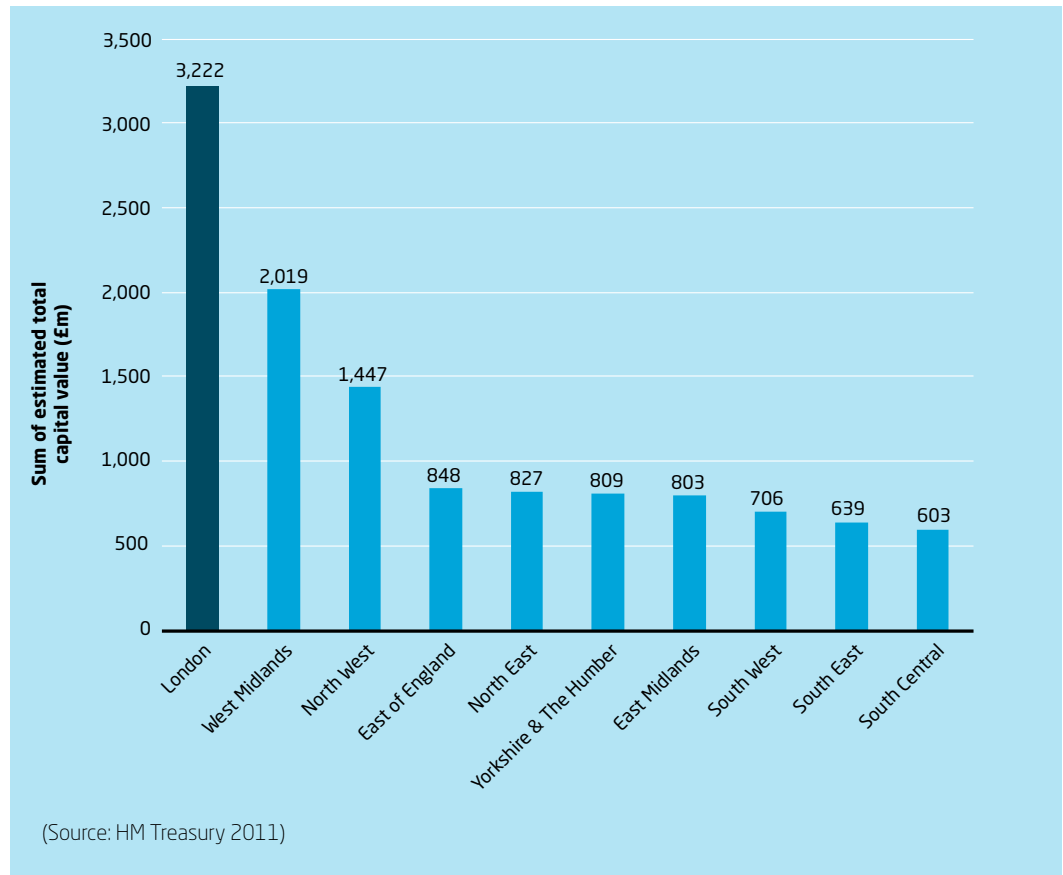
PFI commitments

There are currently 116 capital schemes across the NHS in England funded through the private finance initiative (PFI) with a total estimated capital value of £11.9 billion. In terms of total spend London's health system accounts for a disproportionate share of this – around 27 per cent or £3.2 billion (£403 million for social-care projects, £2.8 billion for acute trust schemes – see Figure 11 overleaf). One London trust – Barts and the London – accounts for 10 per cent of the total NHS PFI commitment.

Between 1998/99 and 2009/10 approximately £1.9 billion had been paid by London trusts in unitary charges for their PFI schemes. And between 2010/11 and 2048/49 an estimated £19 billion will be spent. While future payments appear large it should be noted that they include payments for ongoing services (such as catering and estate management) and account for estimated future inflation, although are undiscounted. Figure 12 overleaf shows annual unitary payments for London trusts' PFI schemes relative to payments across the whole of the NHS in England. On average, on current schemes, London pays around £420 million per annum in unitary payments – around 3 per cent of London's total revenue budget in 2011/12 and an average of around 9 per cent of turnover of those trusts with a PFI scheme.

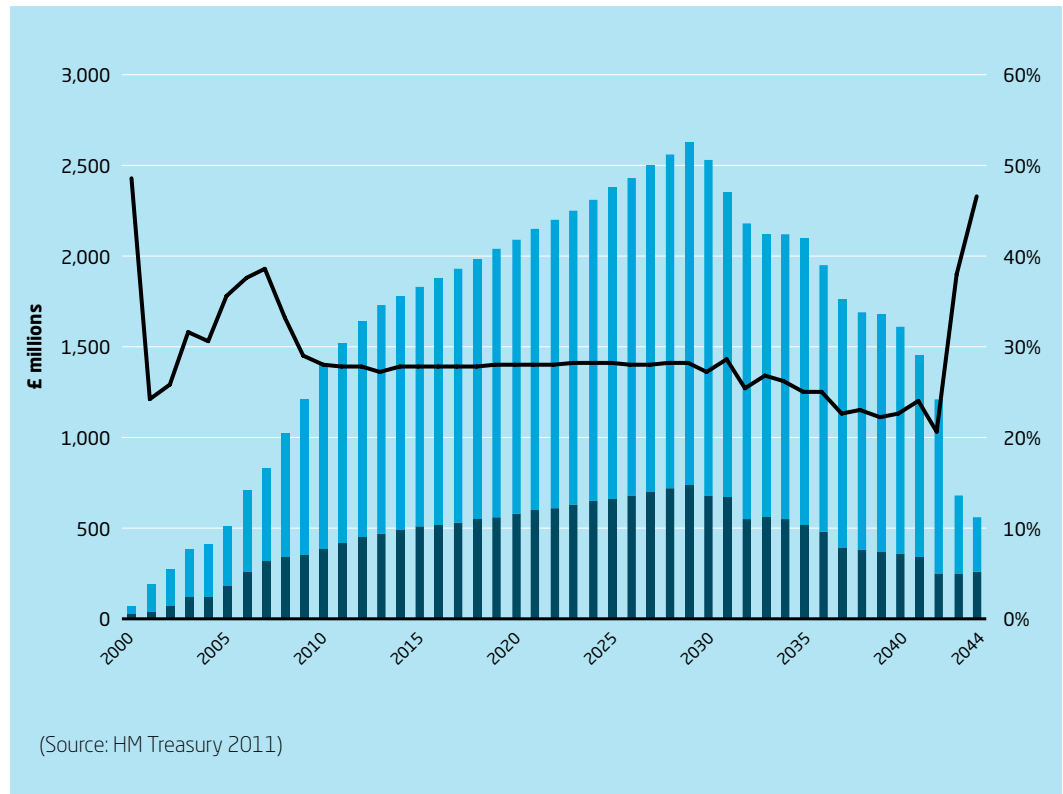
The impact of PFI schemes on a trust's financial viability and scope for flexibly responding to changing circumstances will of course vary from trust to trust and will depend on the size of the scheme and contractual details, among other things. However, the National Audit Office, quoting NHS London, has noted that for some London trusts, current PFI contracts limit their flexibility to reconfigure services (NAO 2011).

Figure 11 Estimated capital value of NHS PFI projects: by region



London trusts' share of total PFI payments across whole of NHS

Figure 12 London and non-London trusts' annual unitary payments

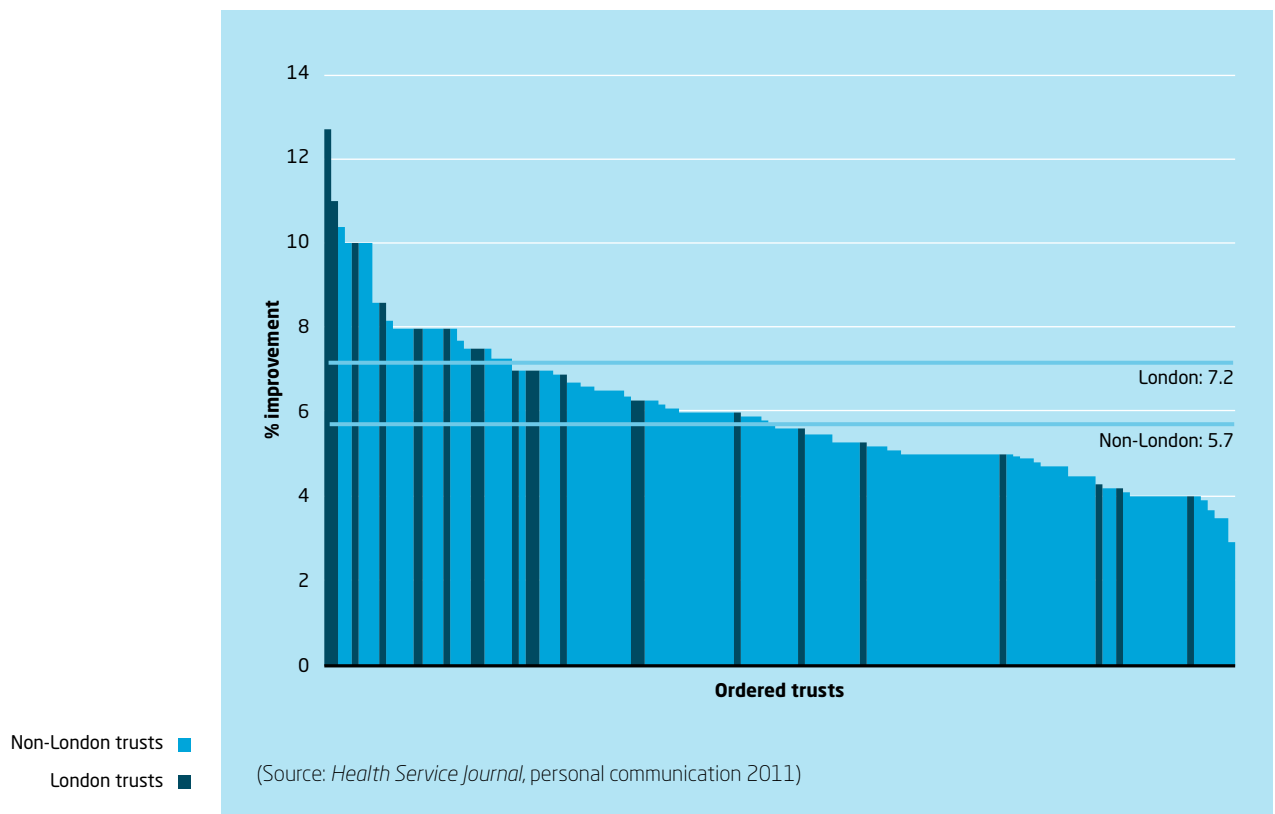


Planned cost improvement programme: 2011/12

While the global productivity challenge across the whole NHS budget in England is estimated at around 4 to 5 per cent each year to 2014/15, as a recent *Health Service Journal* survey revealed, for 2011/12 the majority of trusts have set themselves cost improvement targets ranging from 5 to 10 per cent (Clover 2011). The reason for the higher burden on trusts than the overall NHS productivity challenge of 4 to 5 per cent is in part due to departmental policy concerning the tariff – which has been reduced in real terms – and other factors such as a need for trusts to rectify historic financing problems in order to move to a position to become foundation trusts.

As Figure 13, below, shows, the average cost improvement programme (CIP) for London trusts (7.2 per cent) is around 1.5 percentage points higher than non-London trusts (5.7 per cent), with a range of 4 per cent to 12.7 per cent. The value of the CIPs in London for the 21 trusts out of 40 surveyed by the *Health Service Journal* amounts to £607 million – around £29 million per trust (compared with £17 million per non-London trust).

Figure 13 2011/12 trust cost improvement programme targets



Broad system efficiency

A very broad measure of the efficiency of PCTs and trusts is captured by the reference cost index (RCI). The RCI shows the actual cost of an organisation's mix of activity compared with the same mix delivered at national average cost. An RCI less than 100 means an organisation has lower costs than the national average given the types and volumes of work it carries out. Conversely, an RCI greater than 100 means an organisation has higher costs than the national average.

As Figures 14 and 15, overleaf, show, relative costs vary across trusts and PCTs. While London trusts are the most costly (57 per cent greater than national average) and least

costly (20 per cent below national average), variation across trusts is broadly similar to that for the country as a whole.

Figure 14 Reference cost index 2009/10: trusts

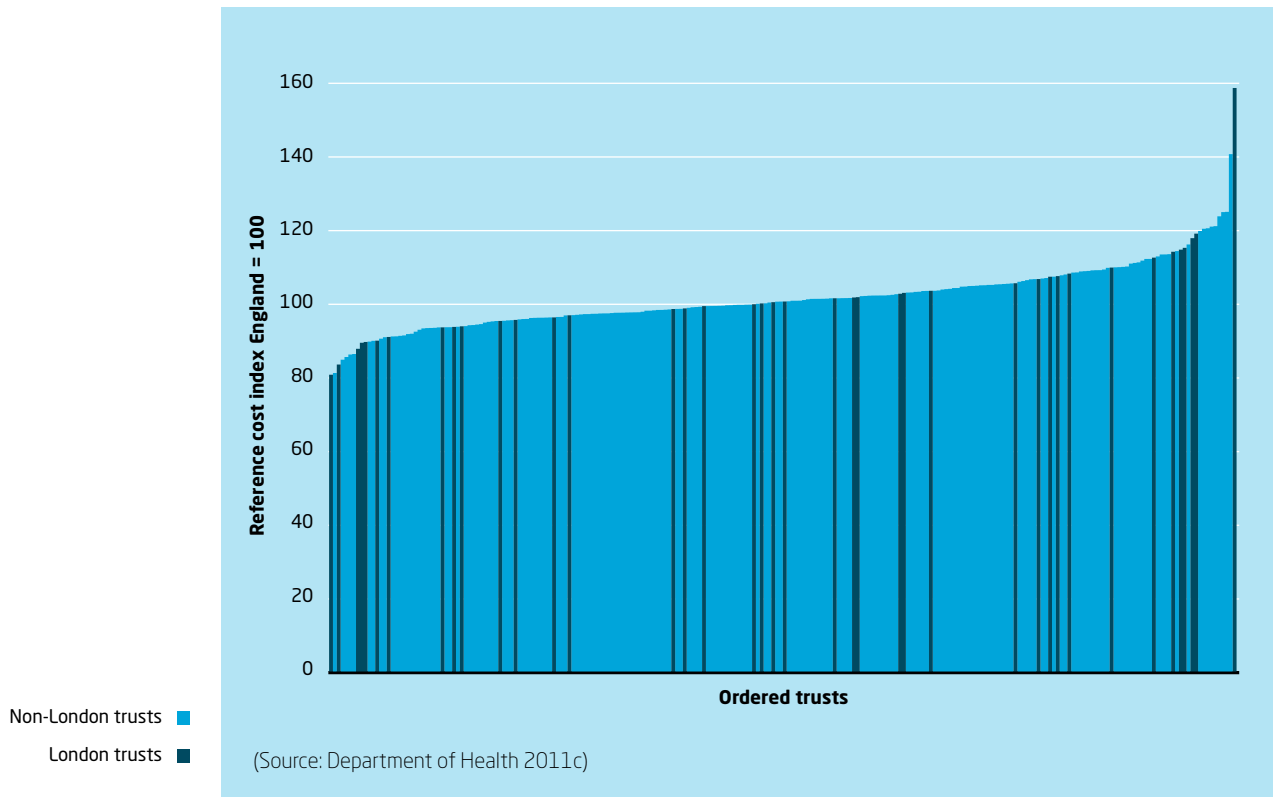
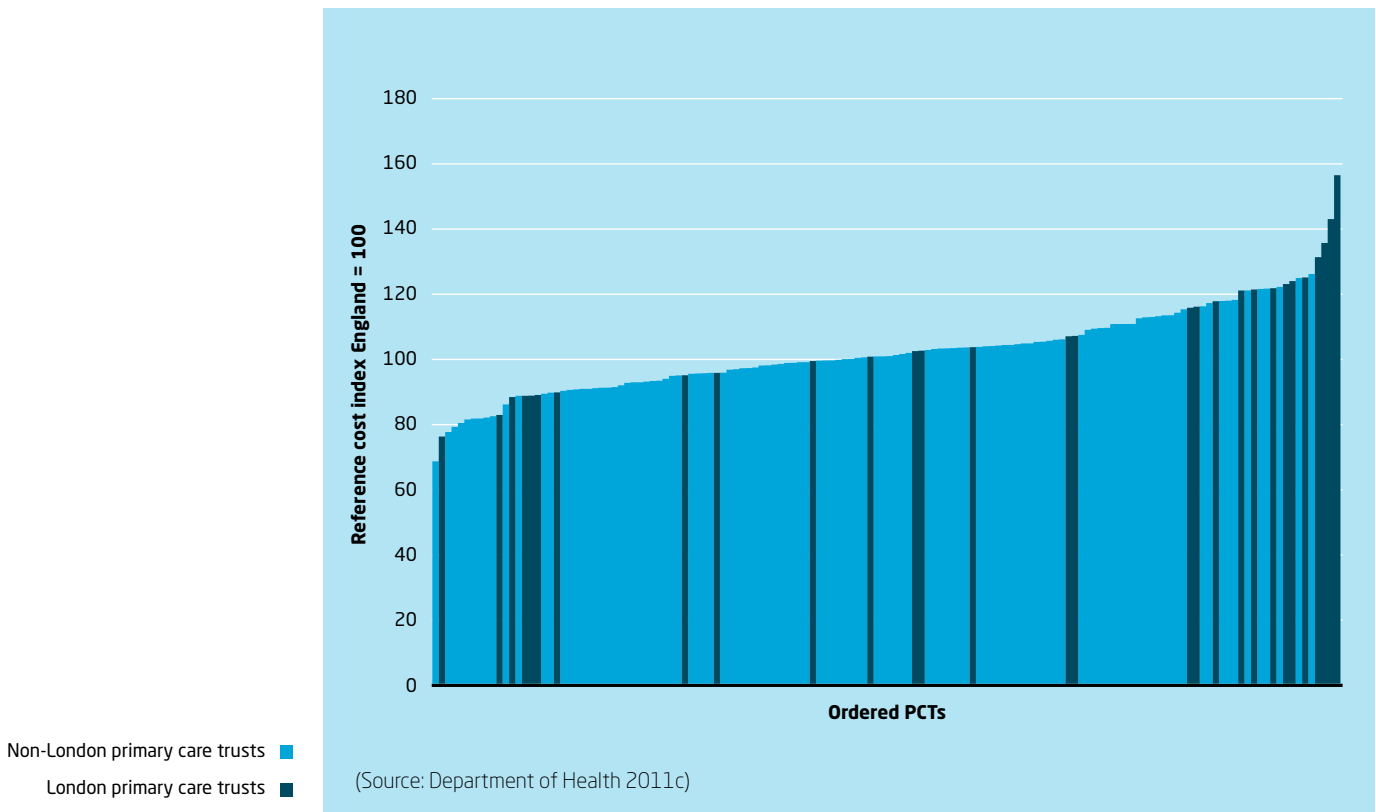
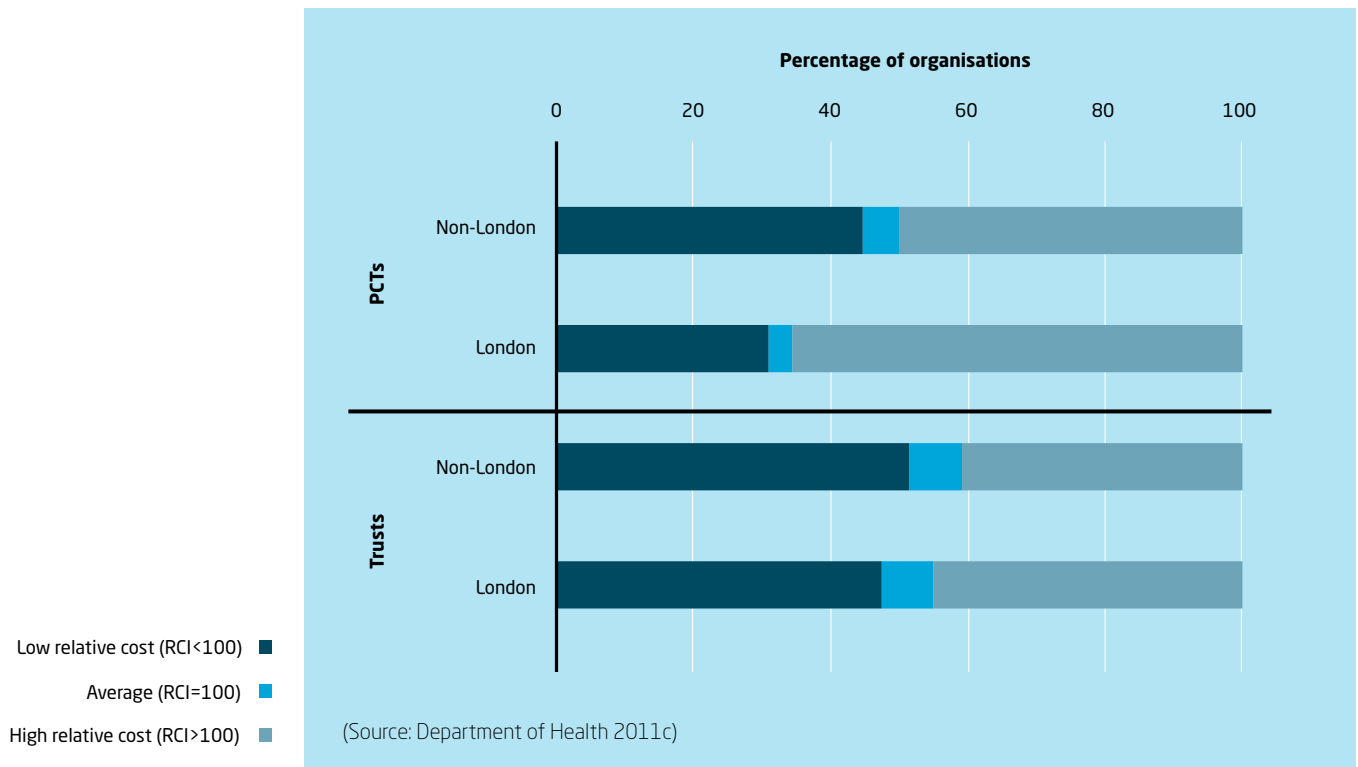


Figure 15 Reference cost index 2009/10: PCTs



However, London PCTs appear to have higher costs than expected compared with non-London PCTs. As Figure 16 shows, below, around two-thirds of London PCTs report an RCI greater than 100, compared with around half of non-London PCTs.

Figure 16 Proportion of NHS organisations with relatively low or high costs (2009/10, reference cost index measure)



Overall, the financial situation facing London's NHS over the next four years is likely to be tighter than the rest of the country and will represent a huge challenge – as reflected in the scale of the cost improvement programme targets trusts are set to deal with this year. The urgency of the need to grapple with London's configuration of services is underlined by the results of NHS London's SaFE financial modelling of the potential for London's remaining acute trusts to achieve foundation trust status by 2014. This modelling highlights the nature of the task facing commissioners – including the emerging clinical commissioning groups – in acting now to avoid existing financial problems becoming much greater in future. Even more important is the need to take forward planned mergers and hospital reconfigurations as set out in the previous section of this paper to improve the safety and quality of care, for example, in relation to emergency surgery.

The new policy environment

While in many ways the financial situation facing London is a significant challenge, there is some clarity about the nature and scale of the issue. For now at least, the same cannot be said about government policy on NHS reform. Following a government-initiated 'pause' in the passage of the Health and Social Care Bill as a result of opposition and disquiet about aspects of the Bill's reforms, in June 2011 the coalition government announced revised plans for the reform of the NHS and related local authority services. The main elements are outlined below.

- The direct role of the Department of Health in performance managing the NHS will be reduced and SHAs will be abolished along with many centrally determined targets.

- Competition will be retained as a spur to improvement and the new economic regulator, Monitor, will act to prevent anti-competitive behaviour.
- PCTs will be abolished and replaced by clinical commissioning groups responsible for the allocation of about 60 per cent of the NHS budget; the allowance for management costs will be about half the present level.
- The role of patient choice will be strengthened and commissioners will have a duty to promote choice through the 'any qualified provider' policy.
- NHS foundation trusts will become the universal model for NHS service provision although the timetable for achieving this has been extended.
- The NHS Commissioning Board will be responsible for commissioning specialised services as well as services provided by GPs and other primary-care contractors.
- National and local commissioners will be supported by clinical networks of experts and by 'clinical senates' operating at a regional level.
- Local authorities will have a greater say in how the NHS operates through new health and wellbeing boards.

Although the broad outline of the new system is reasonably clear, how it will work in practice is not. The organisations being created will take time to find their feet and to establish effective working relationships with other parts of the new system. It is possible, for example, that the NHS Commissioning Board will develop effective local or regional arms that will to some degree fill the gap left by the abolition of SHAs. But whether this will happen and whether it will happen soon is hard to forecast. Any conclusion about how the new arrangements will work must therefore be tentative, but some inferences may be drawn.

The pressure to improve

The main drivers of improvement in performance over the past 10–15 years – targets and performance management and national service frameworks – will not have as strong a role in promoting improvement once the reform proposals have been implemented. Instead, the coalition government is expecting that greater clinical engagement in commissioning will lead to better decisions on what services to provide and how to provide them and it hopes that patient choice will drive improvements both in cost and quality.

However, the new commissioning organisations are small and their budgets will be reduced below the level enjoyed by PCTs, as part of the drive to cut management costs. Although greater local clinical engagement will be helpful in bringing about some kinds of change – for example, improved access to diagnostics or community-based services where entry is relatively easy – the large acute-care providers will continue to be the strongest organisations in the system and may become stronger given the range of horizontal and vertical integration anticipated.

Patient choice could lead to effective competition in some markets, such as planned and elective care. In a health care system like London, the scope for choice is greater than in many other parts of the country, where monopoly provision, protected by distance and access costs, reduces its potential. However, there are reasons for doubting that choice, by itself, whether exercised by patients or commissioners, will be an effective improvement mechanism (Dixon *et al* 2010).

First, the data available on the quality of care is very limited. The coalition government has acknowledged this and has indicated that it intends to improve the information to

support patient choice. But these proposals will take some time to implement, so it will be a while before patients can access outcome data across the board.

Second, Monitor's duty to promote competition, set out in the first draft of the Bill, is to be removed. While it will retain an important role in responding to specific issues as they arise, such as when commissioners make it hard for new providers to enter the market, it will not be required to take active measures to promote competition. Moreover, the government has indicated that it intends not to require hospitals to provide access for other providers to facilities, such as diagnostics, that in theory could help break down barriers to entry.

Change at sector or London-wide level will become more difficult

While some changes can be driven at local level by clinical commissioning groups, others cannot. The new system, particularly the abolition of the SHA, will make it harder to achieve change where this involves complex restructuring of hospital services across a wide area. As Palmer (2011) has shown for South East London, even under the existing regime change was difficult to achieve. This was because of the scope for independent action by NHS trusts and foundation trusts, the obstacles posed by existing PFI contracts and local resistance to change. Palmer also highlighted the inability of PCTs to lead change and the need for the SHA to intervene to find a way forward.

Under the government's proposals there is no clear locus for analysis of the problems facing the London health care system as a whole, devising plans to solve them and implementing the measures proposed. Experience over the years has shown that outside agencies such as The King's Fund can carry out analysis of problems and publish proposals to deal with them, but the chances of these being implemented are low. Consequently, there needs to be clarity about where responsibility for leading service reconfigurations will rest and how the new organisations being established will play a part in addressing the huge amount of unfinished business in Healthcare for London.

NHS London was successful in bringing about change in selected areas, such as stroke and trauma, because it was able to assemble a convincing case for change and secure the commitment of clinicians and NHS organisations. There are signs that a London-wide focus will develop through informal arrangements between clinical commissioning groups, the London Clinical Senate, the London-wide GP Council (LGPC) and the mayor's office. The senate met for the first time in October 2010, with more than 120 leading doctors, nurses and allied health professionals invited to join and act as a clinical sounding board for plans to improve health services in the capital. The LGPC is the single forum representing all 38 of London's clinical commissioning groups. It met for the first time in October 2010 and comprises representatives from the Royal College of General Practitioners (RCGP), the London Deanery, professional executive committee chairs and GP borough commissioning leads from across the capital, plus two associate medical directors from NHS London. How well resourced and how effective these bodies can be at analysing London-wide problems and devising and implementing plans to resolve them remains unclear.

Conclusion

The NHS in London faces greater financial challenges than anticipated at the time of the Darzi review. Budgetary deficits among commissioners and providers are considerably higher than in the rest of England and there are major challenges in enabling all NHS trusts to become foundation trusts by 2014. As more organisations seek to become foundation trusts, it is important that service configuration supports improvements

in quality that are long overdue and does not create further organisational obstacles to these changes. Healthcare for London argued that greater integration of care should be encouraged to address the challenges facing services in the capital and yet with limited exceptions (such as the Whittington Health initiative in north London involving an acute hospital merging with community health services and pilot programmes focused on older people and diabetes in north-west London) this has not been seen as a priority. While there are developments in other parts of London to bring community health services and acute hospitals into closer alignment, moves to achieve closer integration between services in hospital and those outside remain relatively under-developed.

It is not clear how service changes involving complex hospital reconfigurations will be taken forward when the SHA and PCTs are abolished. There is also a risk that in the absence of clear leadership across the capital financial performance will deteriorate and unacceptable variations in the quality of care will not be tackled. The lesson from experience of implementing the Darzi review is the need to engage clinicians in the process of making improvements through effective system leadership. The question that this raises is who will provide system leadership in the reformed NHS?

Options for the future

There is no doubt that the momentum generated by Healthcare for London has been severely dissipated through a combination of ministerial decisions to put Healthcare for London plans on hold, the distraction created by organisational change and the financial environment during and following the 'pause' in the Health and Social Care Bill. As one senior London manager has put it:

The last year for the health service has been an absolute disaster. It's knocked us back a long, long, long way... and then on top of that, dismantling the strategic plan and the overlay that had gone right back to the beginning – all the stakeholders signed up – and then saying... you cannot strategically plan, it all has to be fragmented and the planning has to come up from grass roots rather than be... 'imposed' by the SHA [strategic health authority] – which I don't think it ever was actually. It was actually very consensual and collegiate, with some tough implementation, which is how it should be.

Although the Healthcare for London programme no longer exists, work continues on many of its key aims under the new productivity agenda – the quality, innovation, productivity and prevention (QIPP) initiative. Much of this work is now being taken forward by the six primary care trust (PCT) clusters, with support from London Health Programmes. The Sustainable and Financially Effective (SaFE) analysis commissioned by NHS London is a further recent example of ongoing work that reinforces the case for change and that in turn has led to a series of work streams (*see* box below) to support PCT clusters, and in future clinical commissioning groups, to build on what has been achieved to date.

SaFE work streams

1. Foundation trust pipeline analysis.
2. Clinical quality and safety: case for change acute medicine and emergency general surgery.
3. Commissioning Strategy Plans 2011/12 – 2013/14.
4. Intervention regime for failing NHS trusts.
5. Handling of trust deficits.
6. Improving productivity through London-wide plan.
7. Analysis of evidence base for integrated care.
8. Implementing service reconfigurations.
9. Putting in place urgent care model.
10. Taking forward mergers and acquisitions.

In the light of the upheavals of the past 18 months and the prospect of a future dominated by the productivity and reform challenges, two key issues face London's health care service. First, there is a need to return to the rationale for change set out by Lord Darzi in his review. At the heart of this rationale is the need to:

- improve health outcomes
- reduce health inequalities
- improve the quality of primary and secondary care
- improve patient safety
- make the best use of available funding.

Taking forward the work that has started under Healthcare for London will deliver further improvements in health and health care for Londoners, build on examples of excellence and best practice, and ensure more consistent standards of care. Simply providing additional funding, even assuming this were an option, would not deliver these results because they depend as much on how resources are used and services are organised as on the resources available.

Understanding what further changes are needed to improve patient care is one thing, achieving such change is another. The second key issue therefore is what structures, organisations, management, incentives and system 'levers' are needed to facilitate change. As our review has shown, the history of health care in London is littered with well-argued analyses that have had limited impact on practice. To the extent that Healthcare for London is an exception, it is because of the work done to engage clinicians in making the case for change and taking the actions needed to act on this case in the context of a credible plan for reform. The challenge is how to use these insights in a context where the SHA will not exist from April 2013 and when the notion of planning in the NHS is distinctly out of fashion. The urgency facing the NHS in London in taking forward the work that has started means that the uncertainties created by the ongoing reforms to the NHS need to be resolved quickly to avoid a prolonged period of delay that will only accentuate the financial problems that exist and mean that patients in some areas continue to receive care of an unacceptable standard.

It is against this background that we outline four approaches to leading change in the future:

- patient choice and commissioners leading change in a market
- the NHS Commissioning Board leading change through planning
- local authorities leading change through health and wellbeing boards
- providers leading change through academic health sciences partnerships.

Patient choice and commissioners leading change in a market

One approach would be for changes to be led by commissioners from the bottom-up, informed by patient choice and the knowledge of GPs. The Secretary of State has argued that four key tests must be passed for service changes to proceed. As has been stated by Sir David Nicholson in service reconfiguration guidance (2010), these tests will apply not only to future change, but existing proposals too.

The new commissioning groups are in many ways better placed than PCTs to meet these tests through the involvement of GPs and their understanding of patients' needs. Whether

such an approach will adequately address the sort of service reconfiguration needed in London remains doubtful.

As Palmer (2011) has pointed out in a close examination of the reconfiguration issues in south-east London for The King's Fund:

...market forces are unlikely to deliver desirable service reconfiguration... in the case of south-east London, primary care trusts were either unwilling or unable to intervene to tackle the challenges facing acute hospitals... General practice commissioners face formidable obstacles in being more effective than PCTs in leading complex service reconfigurations...

The report showed that strong commissioning by the SHA was essential in making change happen and in overcoming local resistance to improvements in care that were needed to address concerns about patient safety and the quality of services. As he noted, this raised questions as to where responsibility for taking forward service redesign will rest when SHAs are abolished and the ability to take a strategic view and provide leadership across larger populations is removed.

The NHS Commissioning Board leading change through planning

One way of addressing Palmer's concern would be through a group dedicated to leading service change across the capital. Between now and April 2013, such a group could be based on the SHA working with the six PCT clusters, either individually or in combination as necessary. Following the planned abolition of PCTs and SHAs, this role could be taken on by the NHS Commissioning Board through its regional arm, with the continuing involvement of the London Clinical Senate and the LGPC.

The attraction of a planned approach is that it has the potential to bring together the clinical, financial and planning expertise that clinical commissioning groups may lack in leading service reconfigurations in London. In concept, it might be possible for clinical commissioning groups to acquire this expertise through commissioning support units, but in practice this seems improbable in a context in which PCTs have struggled to develop the capabilities needed to undertake this work and clinical commissioning groups will be expected to work within much tighter management cost limits. If this approach is taken forward, then it will need to be implemented in a way that ensures involvement by clinical commissioning groups as well as other key stakeholders.

Current plans for the NHS Commissioning Board make it doubtful that this model can work because the regional arms of the board are unlikely to have the capabilities that NHS London has developed to lead work of this kind. In essence, regional arms will be a part of the NHS Commissioning Board with limited range of functions and expertise. They will be established primarily to be a means of implementing national priorities. There are also doubts as to whether it will be possible to fund a set of commissioning arrangements in London involving one regional arm, six sub-regional sectors and an anticipated 38 clinical commissioning groups with the resources expected to be available for commissioning support.

Local authorities leading change through health and wellbeing boards

An alternative approach would centre on health and wellbeing boards having a key role in leading reconfigurations in their areas. Health and wellbeing boards have the advantage of bringing elected councillors into the process of service changes and therefore lending greater democratic legitimacy to the process. It is possible to envisage how boards might

collaborate to create the capacity to address reconfigurations affecting more than one area either by working in partnership with existing bodies like London councils and/or by working with the mayor's office.

One potential vehicle is the London Health Improvement Board set up by London councils and the mayor in 2011 to provide a focus for work to improve health in the capital. Under current arrangements, commissioners are responsible for leading service changes, including consulting on these changes, and there have been no suggestions that this role would transfer to health and wellbeing boards. If boards or the London Health Improvement Board were to become more involved in work on reconfiguration, they would therefore need to do so in close collaboration with clinical commissioning groups and the NHS Commissioning Board.

Providers leading change through academic health sciences partnerships

A fourth, more radical, approach would involve providers leading the process of service change. While this would run counter to the emphasis on clinically led commissioners being in the driving seat, it would have the advantage of placing responsibility in the hands of organisations that tend to have the most experienced leaders in the NHS in London. This process might begin by building on the work being undertaken in the three academic health sciences centres and could extend to other parts of London through the partnerships that are being established and extended by these centres.

One approach would involve creating service networks linking specialist and local hospitals working in the same area, with community and other services also being engaged where appropriate. The moves already made to develop greater integration between organisations and services in some areas of London foreshadows an approach along these lines, and is in line with evidence on the benefits of integrated care (Curry and Ham 2010). It also resonates with Palmer's (2011) assessment of the lessons learned from the south-east London reconfiguration discussed above.

Provider-led reconfiguration would need to be supported by strategic commissioning centred on PCT clusters, and, in time, clinical commissioning groups and the NHS Commissioning Board, to ensure that the views of the public and patients were heard in decisions on service change. Parallels can be found in the transformation of the Veterans Health Administration (VA) in the United States in the 1990s, where a fragmented hospital-centred system was reorganised into a series of regionally based integrated service networks. Network leaders reduced reliance on hospitals substantially and increased the use of services in the community, while also improving quality (*see box opposite*).

They did so within the framework set by the VA headquarters in Washington DC, which took on a role akin to a strategic commissioner. A radical solution to the challenges in London would be to adapt the approach taken in the VA by establishing a number of integrated provider networks in the capital charged with reconfiguring services and taking forward unfinished business from Healthcare for London. This would need to be done in a way that was consistent with the emphasis on patient choice and provider competition and did not result in the emergence of unresponsive and inefficient monopoly providers.

The transformation of the Veterans Health Administration

In the mid 1990s the VA underwent a major turnaround under the leadership of Ken Kizer. At the time the VA was widely perceived to be a failing health care system and on his appointment Kizer instituted a wide-ranging programme of reforms. One of these was to organise the VA's services into 22 (now 21) integrated service networks. Each network comprised several hospitals, primary-care centres, nursing homes and other community-based facilities, such as counselling centres. Networks went under the name of Veterans Integrated Service Networks (VISNs) and they became the basic budgetary and management units within the VA. VISNs were allocated a budget based on the number of veterans they served and network directors were responsible for managing the full range of services within these budgets. Over a five-year period the VA closed 55 per cent of acute hospital beds, reduced bed day use by 68 per cent, and improved the quality of care. These changes were facilitated by the move from a fragmented hospital-centred system to integrated-service networks and the allocation of budgets to networks covering all forms of care. In addition, a new performance-management regime was introduced under which network directors were held to account for delivering objectives set out in explicit performance contracts agreed with the VA headquarters in its role as the overall system leader or strategic commissioner. Kizer has described how he adopted a blended strategy for system-wide quality improvement, combining central direction or regulation with the use of competition and rewards to motivate network directors to outperform their peers within the VA.

(Source: Kizer 2001)

A mixed model

Each of these approaches has strengths and weaknesses and for this reason it is unlikely that any one alone is likely to be fit for purpose. The challenge facing policy-makers at a national level and in London is to find a way of taking forward work that is long overdue in a way that combines a bottom-up and top-down perspective, brings together the expertise of commissioners and providers, and draws on the contribution of local authorities through health and wellbeing boards. There are distinct echoes here of work on making change happen in big companies that focuses on the need to work across a series of dualities to achieve results (Pettigrew 1999).

In arguing that a mixed model is needed for some of the challenges that remain in London, it is worth emphasising that a number of these challenges may be dealt with effectively by one or other of the approaches set out here. In the case of health inequalities and public health, for example, health and wellbeing boards are potentially best placed to provide leadership. Likewise, when it comes to improving the quality of primary care, clinical commissioning groups could take a lead provided that the NHS Commissioning Board is prepared to work closely with groups in discharging a responsibility which, at the time of writing, will formally rest with the board.

The areas in which an approach involving a wide range of organisations and stakeholders is most desirable are those requiring complex changes in hospital services. This is particularly where the inherent weaknesses of the top-down approaches that have had limited successes in the past and the bottom-up approaches that have failed to deliver

change in south-east London need to be overcome. With the NHS reforms placing emphasis on clinical commissioning groups, the onus will be on these organisations to engage different stakeholders in the work that needs to be done and to create the capacity to take it forward by retaining the expertise that has been built up in NHS London and PCT clusters for as long as it is needed.

Conclusions

Whatever solution is adopted, there is a need for absolute clarity of roles and accountabilities in view of the complexity of the organisational arrangements in the reformed NHS and the opportunities this creates for necessary changes to be deferred or delayed. Although some critics of the government's reforms have warned of an impending car crash (Porter 2011), our worry is that there will be a traffic jam in which nothing much happens at all. As we have emphasised, there is a significant risk that the vision of Healthcare for London and of the need to improve the quality of care to patients will be lost as attention is diverted elsewhere.

To make these points is to underscore concerns expressed by Lord Darzi in a recent debate in the House of Lords on the Health and Social Care Bill:

...nothing in the Bill explains how strategic change will be made to the NHS. With perhaps 300 consortia, how will the necessary changes be made on a regional level? The programme that I led, Healthcare for London, built an alliance of hundreds of clinicians and managers across the capital to improve care. It led to London becoming the world leader in stroke and cardiac care... How will similar improvements happen in future?

(Darzi 2011)

Unless this question is answered, it must be doubted whether the changes that are needed, and that are increasingly overdue, can be made.

The example cited earlier of emergency care and the prospect that 500 deaths could be avoided by concentrating services in fewer hospitals illustrates the high stakes involved in this debate. Failure to put in place the means to take forward the work that Healthcare for London started will, in effect, result in policy-makers condoning the continued provision of services that are of poor quality at best and unsafe at worst. The corollary is that with the right leadership there is a real prospect of making substantial improvements that have long been advocated, but rarely delivered. The prize to be won is a health care system that delivers consistently high standards of care to patients and that works with partners in local government and other sectors to improve health and tackle health inequalities.

None of this will be easy and renewed efforts are needed to communicate what has been achieved to date and why further changes are essential. In order to deal with unfinished business and bring about change through the effective use of financial and clinical resources, it is a priority to establish who will take the lead. The requirement for clear and credible system leadership on health and health care across London has never been greater. Without it, there is a clear and present danger that financial performance will deteriorate still further, and that unacceptable variations in the quality of primary and secondary care will persist.

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