

# Leading health care in London

Time for a radical  
response

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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# About the authors

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Chris has advised the World Health Organization (WHO) and the World Bank and has served as a consultant to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, an honorary professor at the London School of Hygiene & Tropical Medicine, and a companion of the Institute of Healthcare Management.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation.

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As Policy Director, Nigel led the Confederation in developing and influencing health policy on behalf of members and NHS organisations. At the same time he oversaw the Confederation's well-respected policy and communications services and the NHS European Office. He joined the Confederation from his former role as director of the London Health Economics Consortium at the London School of Hygiene & Tropical Medicine, where he remains an honorary visiting professor.

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# Preface

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The aim of this report is to provide an update on the service changes taking place in the NHS in London, and in particular to address the question of who will lead these changes in the NHS structures that came into effect in April 2013. The report builds on an analysis published by The King's Fund in 2011. It describes the service changes that have occurred in the past 18 months and goes on to explore the role of different organisations in leading change in the future. It emphasises the complexity of the new structures and the uncertainty embedded in them.

The challenges facing health and health care in London are growing more urgent by the day. The recent restructuring of the NHS, coupled with the incoming coalition government's decision to halt work relating to the 2007 report *Healthcare for London: A framework for action* (NHS London 2007), have introduced distractions and delays. These distractions could not have come at a worse time and have been compounded by the loss of experienced leaders. Finding a way to build on the progress made to date and deal with unfinished business should be a major priority for the NHS as a whole.

The issues discussed in this report reflect a challenge affecting the NHS throughout England following the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs) and in the absence of a designated system leader. We argue that the new structures now in place are unlikely to provide the leadership needed to meet the challenges facing the health system in the capital. We also argue that the complexity and urgency of London's challenges may require a radically different approach to that adopted in the rest of England.

**Chris Ham, Nigel Edwards and Beatrice Brooke**

May 2013

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# Executive summary

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- Much remains to be done to implement service changes in London called for in Lord Darzi's 2007 report, notwithstanding progress since our last review in 2011.
  - Financial and service pressures facing health care providers in London are growing. Progress must be accelerated as a matter of urgency, now that the new NHS organisations are in place.
  - The NHS reforms have created a much larger number of organisations in London and their purposes are not always well aligned; the risks of incoherence and inconsistency are high.
  - The implementation of further service changes depends on the establishment of 'constellations of leadership' around different issues. These constellations include commissioners, providers, local authorities and other stakeholders as appropriate.
  - Reorganising the NHS in London in such a fundamental way has made a challenging situation much more difficult, and this has been compounded by the Health Secretary's decision in 2010 to halt the work that was already under way.
  - It is not clear that the new structures will be able to rise to the challenges that lie ahead – and they are by no means a permanent solution.
  - A sudden and serious deterioration in the performance of health services which are already facing major challenges could lead to direct intervention by one or more of the national bodies responsible for overseeing services in London.
  - Consideration should therefore be given to commissioning and providing services differently in the capital because of the serious challenges that exist and the urgency associated with resolving them.
  - One option would be to concentrate responsibility for commissioning in a London-wide strategic body and to establish three provider networks. These could be based on the new academic health sciences networks, learning from the experience of the Veterans' Health Administration.
  - This would make better use of the clinical and managerial leadership experience that exists, and on which further rapid progress in implementing service changes depends.

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# 1 The context of service change in London

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Health care in London has been the subject of reviews extending back to 1890. The most recent, *Healthcare for London: A framework for action*, led by Lord Darzi, set out the case for comprehensive changes to hospital, community health, primary care and mental health services (NHS London 2007). These changes were designed to improve health and reduce health inequalities; to reduce reliance on hospitals by providing more care in the community and other settings; to provide more specialised care in fewer hospitals able to deliver better results; and to ensure that London was at the cutting edge of medicine by developing academic health sciences centres. It was expected that the NHS London strategic health authority (SHA) and primary care trusts (PCTs) would lead the implementation of these changes.

An analysis carried out by The King's Fund in 2011 reported on progress in implementing the recommendations contained in *Healthcare for London: A framework for action* (Appleby *et al* 2011). It found that there had been most progress in improving the quality of some forms of specialised care, notably stroke care with a shift from more than 30 hospitals providing stroke services, to the designation of eight hyper-acute stroke units (HASUs) (Farrar *et al* 2013). It is estimated that among the population of stroke patients in London in a year, this will result in 238 fewer deaths, within 3 months of stroke (Farrar *et al* 2013). Work had also begun to improve trauma care, cardiovascular care and cancer care. Three academic health sciences centres were established in London in 2009 as part of a national policy led by Lord Darzi in his then role of health minister.

There was less progress in implementing other aspects of the *Healthcare for London* report. In the case of primary care, attention focused initially on the establishment of polyclinics which were to offer extended hours primary care provision as well as a range of diagnostic services, some specialist consultations and minor injuries services. It was expected that these services would be provided in modern facilities and be co-located with other community services, such as district nurses and therapy services. Some polyclinics are now operational, but they have had mixed success and there has not been a large-scale implementation across London (Farrar *et al* 2013), and so the impact on the experience of most Londoners has been limited. Meanwhile, wide variations in standards of primary care remain (Raleigh *et al* 2012).

Our 2011 report found that progress in changing the role of local hospitals had also been limited. Partial exceptions to this were plans to implement changes to the role of Chase Farm Hospital in north London, under discussion for almost 20 years, and plans to reconfigure accident and emergency (A&E) and maternity services in north-east London to address concerns about quality of care at Barking, Havering and Redbridge University Hospitals NHS Trust. There are many reasons why changing the role of local hospitals is difficult, including the time it takes to establish the case for change and to undertake public consultation. Perceptions by politicians and the public that valued local services might be lost and local hospitals downgraded often make it difficult to get agreement on proposed changes to where care is provided.



Delays in bringing about service changes were compounded by the coalition government's decision shortly after the 2010 election to halt the Healthcare for London programme established by the SHA to implement the recommendations of Lord Darzi's 2007 report. The government's decision was prompted by a dislike of top-down change led by SHAs and by a preference for locally led service reconfigurations agreed after full public involvement. The Secretary of State at the time, Andrew Lansley MP, set out four tests to be fulfilled before proposals for change would be accepted: support from GP commissioners; strengthened public and patient engagement; clarity on the clinical evidence base; and consistency with patient choice.

Although the Healthcare for London programme was formally halted in 2010, the SHA and PCTs continued with much of the work that had been initiated. This reflected widespread recognition that the existing configuration of services was unsustainable and that much remained to be done to implement the recommendations of the *Healthcare for London* report. The prospect of several years of no growth in NHS funding added to the pressure for this work to continue, with a number of NHS trusts in London forecasting sizeable deficits even before the financial squeeze began to have an impact on the NHS. Modelling undertaken by NHS London showed that by 2014 only two acute trusts in London could make NHS foundation trust status without any change to service configuration; a maximum of six could do so only on the basis of optimistic assumptions about integration and heroic efficiency improvements (NHS London 2012). This gave further indication of the challenges lying ahead.

The coalition government's plans for the reform of the NHS in England announced in 2010 entailed the abolition of the SHA and PCTs, which begged the question, who would take the lead in doing so in future? This point was made by Lord Darzi in a parliamentary debate 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?*

(Hansard 2010–12)

The King's Fund's analysis in 2011 raised similar questions. It noted the risk of a vacuum in 'system leadership' in the reformed NHS, and suggested four possible approaches to filling this vacuum:

- patient choice and clinical commissioners leading change in a market
- NHS England leading change through planning
- local authorities leading change through health and wellbeing boards
- providers leading change through academic health science partnerships.

The analysis suggested that it was unlikely that any one of these approaches on its own would be fit for purpose in dealing with complex hospital reconfigurations. The challenge was therefore to find a way forward that brought together bottom-up and top-down perspectives, the expertise of commissioners and providers, and the contribution of local authorities in the absence of a designated system leader.

With the changes to the organisation of the NHS now being implemented, and financial pressures on health and social care increasing, this paper revisits the Fund's 2011 analysis with two questions in mind. First, what further progress has been made, if any, in taking forward the recommendations of *Healthcare for London: A framework for action*? Second, is it any clearer who will lead this work in future when clinical commissioning groups (CCGs) and NHS England take on some of the functions formerly carried out by PCTs and the SHA?

Our interest in seeking answers to these questions derives in part from the Fund's historic role in relation to London's hospitals and in part from our monitoring of the impact of the government's health reforms. London is in many respects different from other parts of England in terms of how health services are organised. But the question of system leadership in a more devolved and fragmented health system is one that is being raised across the country. Work we have undertaken in the last year has enabled us to extend the thinking reflected in our 2011 analysis and we have drawn on it in preparing this report.

The issues discussed in this report have important implications for the health of Londoners. If there is lack of clarity around responsibility for leading change, then there is a risk that unacceptable variations in the quality of care will persist, and financial and service performance will deteriorate. If this were to happen, the people of London would be faced with the prospect of a health system unable to provide the world class outcomes envisaged in Lord Darzi's report. The well-publicised difficulties faced by some NHS trusts in London, discussed below, underline that this is a real and not simply a hypothetical possibility. It is for these reasons that there needs to be urgent and focused attention on these issues by public service leaders across London, and at a national level, if acceptable standards of care are to be maintained while long overdue changes in primary care, community and hospital services are implemented.

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## 2 Major developments in London since 2011

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This chapter outlines the major developments in London since the Fund's analysis at the end of 2011. The chapter covers the following themes:

- the financial and quality context
- foundation trust status
- community and integrated care
- primary care
- specialist care
- public health and health inequalities.

### The financial and quality context

Four of the five most financially challenged NHS trusts in the country are in London. These trusts together forecast a joint deficit of £120 million by the end of 2012/13 (Department of Health 2013b). Among the 18 foundation trusts in London with a financial risk rating of 1 to 5, where 1 represents the greatest risk and 5 the lowest, at the time of writing 6 have a rating of 3, the minimum requirement for foundation trust authorisation. This means that Monitor, the independent regulator for foundation trusts, has some regulatory concerns but a significant breach is unlikely. Of the remaining foundation trusts, 10 have a rating of 4 and 2 have a rating of 5, meaning that Monitor has no regulatory concerns (Monitor 2013).

In 2012, a set of 27 quality and safety standards for acute medicine and emergency general surgery in London's hospitals were published by London Health Programmes (which was set up by NHS London and evolved from the work of the Healthcare for London programme and NHS Commissioning Support for London). The standards stipulate that the assessment, treatment and care of patients admitted as an emergency should be consultant-led, seven days a week.

A London-wide audit on compliance was conducted by an audit team of clinicians and patients during 2012–13. The audit report showed that no one hospital met all of the standards, and the majority still had substantial work to do to ensure that all standards were in place. Across all hospitals, half of the standards were either met or due to be met by April 2013, and half remained unmet. Nine of the standards were met by fewer than 30 per cent of hospitals, and 5 of these related to consultant-delivered care (London Health Programmes 2013).

The programme of work has since been expanded and standards have now been published on emergency departments, critical care, the pathway for fractured neck of femur, paediatric emergency services, maternity services, inter-hospital transfer and acceptance, and urgent care services. Commissioners are expected to reflect the

London standards in their commissioning intentions and to set time frames for them to be achieved. The quality and safety programme will now be led by NHS England's London office.

What progress has been made in responding to these financial and quality challenges? Service reconfigurations have now been proposed for each of the London sectors (*see* Appendix, pp 28–32). These reconfiguration proposals include a reduction in the number of hospitals providing accident and emergency (A&E) services, acute medical, surgical and paediatric care, and obstetric-led maternity services, and the concentration of planned surgery. Across London, there would be a reduction of 8 full 24-hour A&E units if these proposals proceed. Changes proposed in north-west London are the first to be led by clinical commissioning groups (CCGs).

## Foundation trust status

London's hospitals and health services have to date been less successful in achieving foundation trust status than hospitals in other regions. Since the end of 2011, only two acute NHS trusts in London have achieved foundation trust status – Royal Free London NHS Foundation Trust in 2012, and Kingston Hospital NHS Foundation Trust in 2013. Among the remaining London NHS acute trusts, Barnet and Chase Farm NHS Trust and West Middlesex University Hospital NHS Trust announced that a stand-alone foundation trust application was not financially viable and that they were seeking a partner. Subsequently, Barnet and Chase Farm NHS Trust has confirmed that it has a transaction planned with Royal Free London NHS Foundation Trust, while West Middlesex University Hospital NHS Trust is exploring a potential partnership with Chelsea and Westminster NHS Foundation Trust. Elsewhere in north London, The North West London Hospitals NHS Trust and Ealing Hospital NHS Trust are continuing to explore a merger. The merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust is now complete, resulting in the creation of Barts Health NHS Trust.

The challenge of securing a merger partner where trusts face significant financial difficulties is demonstrated by the experience of Epsom and St Helier NHS Trust. In 2012, St George's NHS Trust announced that it would no longer be proceeding with a merger with St Helier, while Ashford and St Peter's Hospital NHS Foundation Trust announced that it had been unable to develop a financially viable plan for Epsom Hospital. Epsom and St Helier NHS Trust is now awaiting a decision from commissioners as to whether to proceed to formal consultation on service reconfiguration in south-west London. This will inform the likely timeline for a potential transaction. Overall, 53 per cent of NHS trusts in London are yet to achieve foundation trust status, a higher proportion than any other region.

Not only this but also some of the most challenged NHS trusts are located in London. These include South London Healthcare Trust which in 2012 was reported to be losing more than £1 million each week, and was expected to have an accumulated debt of more than £200 million by April 2013. The scale of these challenges led to the use of the Regime for Unsustainable NHS Providers for the first time. A Trust Special Administrator was appointed to develop recommendations within a time-limited process for addressing the trust's financial problems and ensuring high-quality care.

In January 2013, the Secretary of State approved the administrator's recommendation for the trust to be dissolved, with each of its hospitals taken over by neighbouring trusts and with the requirement to make £74.9 million of efficiencies. The dissolution of the

trust is due to be completed by 1 October 2013. The administrator also recommended that addressing the issues facing South London Healthcare Trust required service change across the south-east London health economy. The Secretary of State accepted changes to maternity, A&E, paediatric and elective services, with some amendments (Department of Health 2013a).

Also in south London, the Board of the King's Health Partners Academic Health Science Centre – which brings together King's College London, and three foundation trusts (Guy's and St Thomas', King's College Hospital, and South London and Maudsley) – is considering the establishment of a new organisation to exploit opportunities to improve the quality of care and academic research. Various organisational models are under consideration including the merger of the foundation trusts. If the merger goes ahead, it would result in the establishment of the largest NHS foundation trust in England, encompassing tertiary, secondary, mental health and community services.

## Community and integrated care

A common theme in reconfiguration proposals for London is the aspiration to develop more integrated care and to deliver more care in primary and community settings. For example, the principles underpinning the vision for services in north-west London are for care to be: localised where possible; centralised where necessary; and in all settings, integrated across health, social care and local authority providers to improve patient care. The north-west London reconfiguration proposals commit to an investment of £190 million in out-of-hospital services (NHS North West London 2013).

A number of whole-system integrated care initiatives have been developed across London including in Southwark and Lambeth (King's Health Partners); Waltham Forest, East London and City; Barking and Dagenham, Havering and Redbridge; Outer North West London; and Inner North West London. These bring together a range of partners including acute hospitals, community health care, mental health, general practice, social care and the third sector, to develop more integrated models of care, particularly for older people and people with long-term conditions. The Southwark and Lambeth Integrated Care model, for example, involves risk stratification of all older people, proactive annual assessments to identify risks early, case management to co-ordinate care for the 5,000 older people with multiple needs, and specific investment programmes focused on preventing falls, on dementia, nutrition and infection pathways (see [www.slicare.org](http://www.slicare.org)).

Through the community budgets pilot in west London (a tri-borough project across Westminster, Hammersmith and Fulham, and Kensington and Chelsea), health and social care commissioners are developing a whole-system integration proposal. This will bring together funding on local public services and will aim to deliver integrated and cost-effective services and improved outcomes. The operational plan estimates net savings of £70 million annually once the projects are fully implemented (National Audit Office 2013). London Councils have estimated potential savings of between £125 million and £375 million by 2017/18 through greater health and social care integration across the whole of London, with a more holistic approach to care and better alignment of services and support (London Councils 2013).

NHS England's London office will be taking forward work on integrated care, and has agreed a shared work-plan with the London branch of the Association of Directors of Adult Social Services. Initially, the intention is to focus particularly on the needs of frail older people, people with dementia, people with one or more long-term conditions, and people nearing the end of their lives.

## Primary care

The variable quality of primary care, particularly in inner London, has long been a theme of reviews of health and health care in London (Tomlinson 1992; The King's Fund 1997; NHS London 2007; Appleby *et al* 2011). Although quality in general practice shows steady improvement over time, progress in reducing variations remains slow. The King's Fund's recent analysis of general practice in London, commissioned by NHS London, recognises its significant contribution to improving health and health care in London, despite the considerable demographic and socio-economic challenges facing general practice in the capital. However, the report also highlights the continuing variations in quality and outcomes between areas and practices (Raleigh *et al* 2012). For example, patients in London report a less positive experience of GP services than the national average across all domains of patient experience, and there are large variations between London practices, although overall satisfaction levels remain high (80 per cent) (Health and Social Care Information Centre 2012). The distribution of GPs across the capital also remains inequitable; in 2011 there was a twofold variation in the number of GP full-time equivalents (FTEs) per 100,000 unified weighted population between London primary care trusts (PCTs) (Raleigh *et al* 2012).

The establishment of polyclinics was a key recommendation of Lord Darzi's 2007 review (NHS London 2007), and aimed to address poor performance in primary care. Polyclinics were to bring together in one location larger groupings of GPs, alongside a range of community and secondary care services, such as urgent care, outpatient services, minor procedures and pharmacy. By 2009, the thinking had shifted to a broader vision for 'polysystems', with polyclinic services linked to wider primary and community health services, and acting as a hub for more networked and integrated structures for local health care delivery. An independent evaluation by the London School of Hygiene & Tropical Medicine and Imperial College London concluded that based on the evidence collected, the polysystem policy did not have significant impacts on the key goals of the programme, namely service development and improving access, quality of care and patient experience, and had not generated significant cost savings. The evaluation did however highlight the challenges of evaluating a large-scale change programme operating in a system of constant flux, and issues with data quality and availability (personal communication with evaluation team 2013).

To support quality improvement and tackle variation in the quality of primary care, the London-wide Local Medical Committees have worked with GP leaders, NHS London and PCT cluster chief executives to develop a set of outcome-based standards for measuring quality, access and patient experience in general practice (General Practice Outcome Standards). The standards cover areas such as screening, diagnosis and the ease of making appointments. Patients and the public can compare the results on a new website ([www.myhealth.london.nhs.uk](http://www.myhealth.london.nhs.uk)) which provides Londoners with health advice and information about a range of other local health services. General Practice Outcome Standards have now been extended nationally to cover all practices in England.

Over the next 12 months, NHS England's London office will be working with a range of stakeholders to develop an additional set of patient-led evidence-based quality standards that define what a patient should expect to receive from primary care services. These will initially focus on three key priorities: access, long-term conditions and prevention. The standards will underpin and shape a vision for primary care transformation and inform strategic thinking over the next five to ten years.

NHS England's London office is developing a Primary Care Transformation Framework, which acts as a resource to support CCGs in their new responsibilities for improving



primary care, and indicates what NHS England's London office is looking to commission from primary care. The framework highlights the case for change in primary care, the potential benefit of general practice operating at scale and the importance of working across organisational boundaries. Other key messages include the need for: a whole-population and more proactive approach; a new patient paradigm with patients involved as partners in the care process; and a drive for continuous improvement.

## Specialist care

Evidence has continued to show improvements in quality of care following the changes to stroke services in London. In 2010 the National Sentinel Stroke Audit showed that five of the eight top stroke services in the country were in London, and 2012 data shows that figure has increased to seven. An independent evaluation of the changes estimates that among the population of stroke patients in London in a year (6,438), within 3 months there will be 238 fewer deaths and within 10 years there will be a gain of 4,492 Quality-Adjusted Life Years. It also finds that the costs of treating this population will be £5.4 million lower within three months after stroke (due to reduced length of stay) and £21.3 million within 10 years (due to a lower number of patients admitted to institutional care and a smaller number of disabled people) (Farrar *et al* 2013).

Following the focus on stroke and trauma services in 2010/11, attention and activity over the past 18 months has now focused on new models of care for cardiovascular and cancer services. The models were proposed in 2010 by London commissioners following clinically led service reviews, with the aim of addressing variations in care and outcomes and improving outcomes for London as a whole. For vascular surgery, the review recommended a hub-and-spoke model with a shift from 19 to 5 hospitals providing arterial vascular surgery in London. Seven designated central units have so far been established, and further consolidation may follow. The units are staffed by vascular specialists, operate 24-hours a day seven days a week, and are linked with local units that continue to deliver the majority of vascular services.

UCL Partners recommended further concentration of specialist cardiac services in north-central and north-east London in February 2013. The proposed reconfiguration involves the development of a specialist Heart Centre at the new Barts Hospital, with cardiovascular services moving from University College London Hospital's (UCLH) Heart Hospital and from the London Chest Hospital (part of Barts Health NHS Trust) in late 2014 or early 2015. The proposed cardiac centre would provide a single regional unit to serve 6 million people across north-central and north-east London, south and west Hertfordshire, south Bedfordshire and south-west and mid-Essex. Engagement activity with patient groups, staff and other stakeholders is now under way, with the ultimate decision to be made by commissioners.

The new model of care for cancer services proposed by London commissioners in 2010 involved making a clear distinction between the commissioning and provision aspects of cancer clinical networks, with the development of collectives of care providers, referred to as 'integrated cancer systems'. Two integrated cancer systems have been delivering pathways of care since 2012. *The London Cancer Alliance* serves west and south London, while *London Cancer* covers north and east London. London Cancer is currently engaging on proposals to improve services for urological cancer across the whole pathway by consolidating services with the development of a single specialist surgical centre for kidney cancers in north and east London and west Essex (proposed to be the Royal Free Hospital), and a specialist surgical centre for bladder and prostate cancers (proposed to be UCLH) (UCL Partners 2013).

## Public health and health inequalities

Since our 2011 report, public health has undergone a change that is at least as radical as the reorganisation of the NHS. In April 2013, London local authorities took on responsibility for improving and protecting local health and well-being, and providing a number of mandatory services, including sexual health and NHS health checks.

Across the 33 boroughs, there are 25 Directors of Public Health, some of whom are responsible for one borough, some for more than one. The recruitment to posts in London historically has been a challenge. At the time of writing a number of posts had been filled with temporary appointments, raising some questions over continuity and over whether these appointments would have sufficient strategic influence (Local Government Association 2012). There have also been concerns over whether calculating the new local authority budget allocations on the basis of differences in premature mortality rates is appropriate for London, given its younger-than-average population and its greater need for mandated demand-led services, such as sexual health (London Councils 2012).

Across the public health system, including in London, a great deal of attention has been given to issues of transition to local authority arrangements and the transactional requirements of moving staff between employees. Unsurprisingly therefore, there has been relatively slow progress in the development of a more transformational approach. A number of observers in London think that the capital has fallen some way behind other major cities that appear to have had less difficulty in making this transition.

The Mayor remains statutorily responsible for outlining a pan-London strategy for health inequalities, as well as for transport, spatial development, housing and economic development. As explored in the next chapter, a new London Health Board, chaired by the Mayor, has been established to replace the London Health Improvement Board, which ceased to exist at the end of March 2013. The new London Health Board is to have a broader remit than just public health, and will work to champion the health needs of people across the capital and promote London's life sciences sector (*see box, pp 12–13*).



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## 3 Who will lead service changes in future?

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Our assessment of the work done to take forward *Healthcare for London* illustrates progress in making changes in a number of services and areas of the capital since our previous analysis. It also underlines the enormity of the financial and service challenges that lie ahead. These challenges serve to emphasise the need to be clear where responsibility for leading improvements in health and health care will rest in future. To shed light on this, we interviewed a number of senior managers and clinical leaders in London with the aim of understanding their views on the role of different organisations in providing leadership in future.

This section of our report draws on information gathered during these interviews, work we were commissioned to undertake for NHS London, and a number of seminars and discussions held at The King's Fund. It illustrates the difficulties facing commissioners, providers, local authorities and other stakeholders in providing system leadership in a context in which there is no longer a designated system leader, like the former strategic health authority (SHA). It also points to the emergence of different constellations of leadership on different issues.

In our view, there are major questions as to whether the momentum built up by *Healthcare for London* will be sufficient to sustain progress. With the NHS in London under increasing pressure, both financially and in relation to the performance of services, there is a serious risk that the far-reaching organisational changes taking place will at best delay and at worst de-rail service improvements which are long overdue in many cases. The loss of some experienced leaders accentuates this risk, and places additional pressure on those currently leading NHS organisations and local authorities to find a way through the complexity that is the new NHS.

### Does London need system leadership?

Among those we interviewed, there was almost universal praise for the role played by NHS London in leading changes in services for stroke, trauma and heart attacks. Despite this, some interviewees asked whether there were many more issues analogous to these and questioned the need for an overall system leader. This strand of opinion is concerned about the concentration of decision-making and is suspicious of regional bodies. Those holding this view note that many strategic issues identified over many years have only partially been resolved and that major change has often been driven by one-off exercises, such as the Tomlinson Report (1992) and the review led by Lord Darzi (NHS London 2007). However, even among the most sceptical, there is acknowledgement that there are a number of key issues that require a system response.

The alternative view is much more positive about the role of system leadership in London – particularly in the light of more recent experience. This view argues that there is a need to deal with some pressing strategic issues, now more than ever. There is also a belief that the current financial situation and scale of organisational change requires the exercise of direct authority to manage that change. This would be in addition to the consensus-building and less formal mechanisms advocated by those who are more cautious about the need for London-wide system leadership. Those in favour of such leadership for London point to the often disappointing impact of voluntary efforts to make change across sectors and even of more formal attempts such as the London cancer networks which are seen as having had mixed results. The problem with these and other approaches is that they do not seem to have managed to break participants out of a tendency to work in narrow silos.

On balance, it was felt that one aspect of the previous model would be missed – notably the exercise of visible leadership to support major changes, particularly the management of difficult politics, and to provide protection from central government interference in local decisions. Interviewees also thought that it would be important to ensure London had a voice on key issues when national policy may disadvantage London. This begged another question: who would provide system leadership and articulate London's voice in future?

### Who will provide leadership and on which issues?

The government's intention is that in the new NHS, commissioners should lead service changes with much greater leadership by GPs than has historically been the case.

It can be argued that, in the new structures, leadership of service changes in London that are essentially local would be best provided at the borough level by clinical commissioning groups (CCGs). By extension, service changes that cut across boroughs or sectors of the capital and which require collective action will need to be led by a number of CCGs working together with NHS England. For London as a whole, leadership is best provided by NHS England, because of its oversight of the capital, in collaboration with bodies such as the London Clinical Commissioning Council and the Clinical Senate (*see box overleaf*).

Depending on the issues under discussion, other stakeholders are also likely to have an important part to play, including NHS providers, local authorities and health and wellbeing boards, and national bodies such as the NHS Trust Development Authority, Public Health England and Health Education England. Simply describing the emerging organisational landscape in this way underlines the complexity of the structures that have been put in place and the need to ensure they operate effectively.

## London's new health and public health bodies

### NHS England's London office

NHS England consists of central, regional and local offices. The four regions, including London, provide sub-national clinical and professional leadership; undertake direct commissioning of some services; and co-ordinate planning, operational management, and sub-national emergency preparedness. This includes, for example, co-ordinating the senate and networks, performance oversight, and involvement in large-scale reconfigurations. Local offices are responsible for commissioning primary care services, assessing and assuring CCGs, and managing local partnerships and relationships (NHS Commissioning Board 2012a). London is structured in a different way to the other regions. To recognise its distinct pattern of services and relationships, it has an integrated mix of sector and local structures, and a larger regional structure which includes a transformation team (NHS England 2013).

### Public Health England, London

Public Health England operates at a national, regional and local level, with 4 regions and 15 local centres. The regions are focused on the functioning and professional development of the public health system, and assuring delivery in local centres. Meanwhile, the centres develop and maintain local relationships including with local authorities and the NHS, and lead on delivery of health protection, health improvement, and other public health services for their local area. As with NHS England, London is organised differently to other regions. There is no separate regional office but instead a single London centre that brings together delivery functions and professional support functions (Department of Health 2012b).

### The London Clinical Senate

NHS England has divided England into 12 geographical areas, with London as one area. Each of these areas has a clinical senate. The London Clinical Senate takes an overview of health and health care for a whole population and provides independent strategic advice and leadership for CCGs, health and wellbeing boards, providers and NHS England's London office. Senates have a role in overseeing major service change, promoting the sharing of innovation, and identifying opportunities to improve outcomes and value. They bring together a range of health and wider care perspectives, including public health, social care and patient voice. Senates are established and supported by NHS England, and are non-statutory (NHS Commissioning Board 2013).

### London strategic clinical networks

Strategic clinical networks are a new type of multidisciplinary network that advise commissioners on standards and best-value pathways. They aim to adopt a whole-system approach to enable change across very complex pathways of care. Each of the 12 geographical areas has four strategic clinical networks that cover: cardiovascular disease; maternity and children; mental health, dementia and neurological conditions; and cancer (although in London alternative cancer structures may be maintained). Networks are established and supported by NHS England, with which they have an annual accountability agreement for the quality improvement work they carry out. Like senates, strategic clinical networks are non-statutory. There are a number of other types of network in the new system, some of which will be developed by NHS England, others by CCGs, and some by providers (NHS Commissioning Board 2012b).

## London's new health and public health bodies *continued*

### London Health Board

The London Health Board, chaired by the Mayor of London, will aim to champion the health needs of people in London (including making the case for appropriate resourcing), provide leadership on health issues of pan-London significance, and promote London's life sciences (research) sector. Representation on the board includes NHS England, Public Health England, local authorities, London Clinical Commissioning Council, London Clinical Senate and academic health science centres. Its remit is broader than the shadow London Health Improvement Board, which was focused just on public health (and ceased to exist from 31 March 2013) (Greater London Authority 2013). See [www.londonhealthboard.org.uk](http://www.londonhealthboard.org.uk)

### London Clinical Commissioning Council

The London Clinical Commissioning Council is a membership organisation of the 32 London CCGs which aims to enable collaboration and joint decision-making between CCGs on pan-London issues. It is based on the principle of subsidiarity – only decisions requiring a wider perspective are considered, to avoid compromising the statutory nature of individual CCGs. Through the London Clinical Commissioning Council, CCGs are also able to collaborate on a sub-London basis on a wide variety of issues, such as local service reconfiguration or risk-sharing agreements. The London Clinical Commissioning Council aims to enable CCGs to speak with a unified voice and to have a co-ordinated dialogue with other London bodies and stakeholders. It also provides peer support, networking and development opportunities for CCGs. It is directly accountable to its membership CCGs.

### London Local Education and Training Boards

Health Education England is a Special Health Authority that provides national leadership and oversight for the strategic planning and development of the health and public health workforce. It allocates education and training resources to Local Education and Training Boards (LETBs) which are then held to account for how these resources are locally invested. There are 13 LETBs across the country including 3 in London. The LETBs identify and agree local priorities and training, plan and commission education and training, and act as a forum for developing the whole health and public health workforce (Department of Health 2012a).

## Collaboration between clinical commissioning groups

Major service reconfigurations affecting several NHS trusts are most likely to require collective action across boroughs and sectors. This is illustrated by the example of north-west London where eight CCGs have collaborated on the major review of acute services and on how to deliver more care out of hospital, with significant support from the primary care trusts (PCTs) and the SHA. This example illustrates the potential of CCGs to provide system leadership in a way that builds on the achievements of *Healthcare for London* but with GP leaders in a much more visible role than previously.

The unanswered question is whether CCGs in other parts of London would be willing and able to emulate this example, which our interviewees recognised is not yet typical of developments in commissioning elsewhere in the capital. Much may depend on the

support available both through NHS England's London office and the London Clinical Commissioning Council, especially where CCGs have not established the clinical leadership and management support needed to work in collaboration with peers. CCGs are also likely to need access to independent clinical advice, and there are plans to develop a regional London Clinical Advisory Team for this purpose.

There will also be some issues that require CCGs to collaborate across London, such as over ambulance services.

## NHS England

Issues that entail changes to the provision of specialised services will be led by NHS England's London office which is responsible for commissioning these services. This may require action across London and/or in sectors of the capital, depending on the services affected. The importance of specialised services in many of London's hospitals means that NHS England is likely to have a more prominent role in leading service changes in London than in other parts of the country. Decisions made in this domain will have a significant influence on the shape of local services and could cut across local CCG commissioning plans if there is not careful co-ordination.

NHS England will also work with CCGs in promoting the implementation of recently published quality and safety standards in London's hospitals, including the development of 24/7 consultant cover where appropriate. The Clinical Senate is likely to be a key player in issues of this kind given the importance of visible clinical leadership when services are being concentrated to deliver improved outcomes. The Senate has established a valued role in supporting the implementation of *Healthcare for London*, and seems certain to be a source of advice to commissioners in the emerging structures.

As well as specialised services commissioning, NHS England's London office has responsibility for commissioning primary care services. While there is welcome clarity about where responsibility lies for leading change in primary care provision, it is much less apparent that NHS England will have the scope to make change happen. NHS England will need to work in collaboration with CCGs and draw on their local knowledge of primary care provision to convince sceptics that it should have this role. Only if this happens will necessary and overdue improvements in primary care be made.

NHS England's London office will be different from the SHA even though its role may appear similar and many of its personnel will be former SHA staff. Whereas the SHA had a degree of independence that enabled it to withstand pressure from government and to deal with problems without them escalating to the Department of Health, NHS England's London office will be the regional arm of a national body with much less discretion to deviate from centrally determined policies. It will also be focused on commissioning with the SHA's role of overseeing the performance of NHS trusts transferred to the NHS Trust Development Authority (*see below*). The creation of new silos may mean some issues gravitate to the centre for decision whereas in the past they could be resolved by the SHA with its responsibilities for both commissioning and provision.

## The NHS Trust Development Authority and regulators

A major uncertainty is how NHS England's London office will work with the NHS Trust Development Authority. The latter is responsible for supporting NHS trusts in becoming foundation trusts or in finding an alternative future if they cannot. There is a potential tension here between achieving the government's objective that all NHS trusts should become foundation trusts and doing so in a way that is consistent with the service changes that are needed. While the former objective may require NHS trusts to

retain services to strengthen their financial performance, the latter may demand that they relinquish some services in order to improve outcomes for the population as a whole. This is not a new dilemma but the reforms have created the potential for future conflict between NHS England and the Trust Development Authority.

Another potential tension is the role of market regulators in handling service and organisational changes – a role that has not yet been fully tested. Monitor, the Office of Fair Trading and the Competition Commission all have duties to assess proposed changes in where services are provided and to scrutinise proposed mergers. This raises the possibility that changes to address the growing service and financial challenges in London may be delayed or rejected because of the activities of the regulators. There are also risks that further use of the Regime for Unsustainable NHS Providers may lead to recommendations that conflict with the plans of commissioners unless the latter are closely involved in the development of these recommendations.

These examples illustrate the inconsistency and incoherence involved in reforms that have created a much larger number of NHS organisations whose remits are not always well aligned (Edwards 2013). As we argued in our 2011 report, one of the risks this creates is that service changes will be more difficult to implement as new organisations are established. There will also be more opportunities for some of these organisations to delay changes even where they may be led by CCGs. How the tension is handled between commissioners leading service changes and regulators assessing their impact is a critical but largely unknown factor. This is worrying in a context where service and financial pressures facing providers are increasing and when delays will make their resolution more difficult.

### Providers and academic health sciences networks

As these issues are worked through, the challenge will be to put into practice the government's intentions that change is led by commissioners in a context where commissioning has often been described as the 'weak link' in the chain of recent NHS reforms in England. Already there are signs that providers have themselves proposed changes in service provision, stepping in to fill the vacuum created by the abolition of NHS London and the PCTs. Examples, as explored above, include proposals in south London to merge three foundation trusts and develop a stronger partnership with King's College, building on the King's Health Partners academic health science centre; and proposals to change the location of cancer and cardiac services for north and east London, developed by a network of providers under the aegis of UCL Partners. Although initially the focus of some developments has been on new organisational forms, these are likely to be a prelude to providers seeking opportunities to improve the provision of care by relocating services.

Another indication of how providers are starting to lead change is the establishment of three academic health science networks in London, which stem from earlier work by academic health science centres and partnerships. These networks may in time become the voice of London's providers, including articulating the potential synergy between education, research and the provision of specialised services. The challenge the new networks face is to balance the natural desire to compete with each other on some issues while finding common cause in collaborating on others, a challenge some of those we interviewed felt would be insurmountable. If collaboration is to be effective, it will require the development of appropriate leadership and management infrastructure to enable the networks to ensure London's voice is heard at a national level. Even then, the inherent weakness of networks and their reliance on voluntary co-operation may make it difficult for them to act in this way (Carnall in Timmins 2013).



Many of the most experienced NHS leaders in London are to be found among providers. It would therefore be natural if providers showed leadership on changes in service provision not only while the new commissioning organisations are becoming established but also on a continuing basis. The improvements in stroke care and vascular surgery that have occurred show what can be achieved when providers are willing to lead change. The risk here is that this will perpetuate a health care system which has traditionally favoured investment in acute hospital and specialised services at the expense of primary care and services in the community. There is also the question of how regulators will respond and whether they will deem service changes initiated by providers to be anti-competitive?

## The Mayor and local authorities

Local authorities and the Mayor of London both have a leadership role in public health in the new NHS. As outlined above, the Mayor has a number of statutory responsibilities, including in relation to health inequalities, although no funding or powers have been transferred. In discharging these roles, the Mayor and local authorities will need to work closely with Public Health England. The recently established London Health Board has no budget of its own, but could make a potentially important contribution on public health issues that require a London-wide focus such as tackling obesity and health inequalities and dealing with alcohol-related conditions, sexual health and infectious diseases.

Other pan-London and local public health networks and collaborations are starting to emerge, such as the London network of Directors of Public Health, although roles and accountability are still unclear. Similarly, health and wellbeing boards are likely to be an important focus at borough level for discussion of issues that affect both the NHS and local government. Just as there are tensions within the NHS between the role of CCGs and NHS England, so too there is scope for conflict between London boroughs and the Mayor over who should lead on these and other public health issues. It is not yet clear how these will be handled in practice.

Although the new London Health Board will have a broader remit than just public health, the extent to which the Mayor or the boroughs wish to extend their involvement in service changes within the NHS remains to be seen, particularly given the unpopularity often associated with these changes. Indeed, it was notable that the Mayor's office chose to stay out of the debate about the changes proposed by the special administrator to tackle the challenges of the South London Healthcare NHS Trust. This decision was praised by some of the experienced NHS leaders we interviewed who feared that the Mayor's involvement might introduce further delays into overdue changes in service provision.

Notwithstanding this decision, local authorities have the power to delay and influence proposed changes to service provision through the work of overview and scrutiny committees. They may also begin judicial review proceedings where they object to proposed service changes, as is currently happening in south London through Lewisham Council and in north-west London through Ealing Council (Clover 2013). This is again where health and wellbeing boards could play a constructive role as a forum in which CCGs and local authorities debate issues and seek common ground before they become matters of public and legal dispute.

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## 4 Where next?

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At a seminar we organised last year, it was suggested that the NHS in London is moving away from a system in which a ‘head gardener’ had responsibility for designing and cultivating the landscape to a self-regulating eco-system in which no single individual or organisation is in charge. It follows that in the absence of a designated system leader, there will need to be a process of mutual adjustment when aligning a large number of participants, networks of both individuals and organisations, and stakeholders from different sectors in the new system, sometimes with quite different objectives. The new NHS and public health system is still taking shape, but the complexity of the emerging eco-system can be seen in Figure 1 overleaf.

The NHS lacks experience in implementing improvements in an eco-system because change has more typically occurred through concentrated leadership. In rising to the challenge of managing change in the new environment, everyone involved will have to learn how to handle the new arrangements and many will have to adjust to different roles, relationships and ways of working – while also dealing with growing and unprecedented financial and service pressures. The temptation will be for parts of the emerging system to seize control and try to reassert old models and behaviours in order to deal with uncertainty. If this temptation is to be avoided, then participants in the NHS eco-system will need to learn new behaviours quickly and demonstrate that they are able to take forward the work that started under *Healthcare for London* without the leadership formerly provided by the strategic health authority (SHA) and primary care trusts (PCTs).

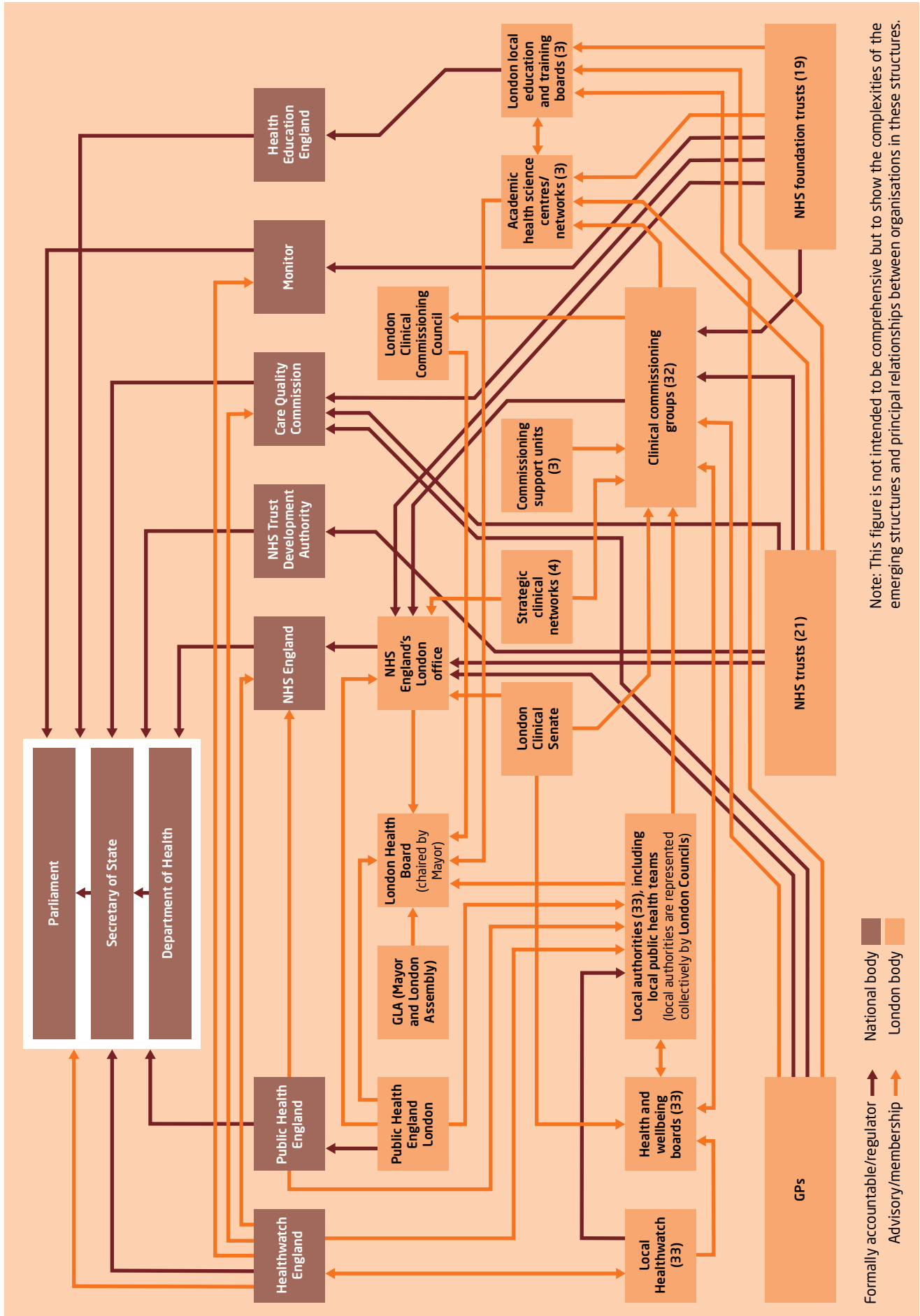
This means that developing ‘constellations of leadership’ on different issues is now the priority. This entails acknowledging that system leadership through mutual adjustment is vulnerable to a well-known set of behavioural issues that are potentially toxic and could undermine the emergence of the self-regulation on which further service change depends. These behavioural issues include:

- deviation from previously agreed processes
- sending representatives who do not have appropriate decision rights
- revising decisions that have already been made
- failure to deliver previously agreed commitments
- passive aggressive resistance
- invoking higher powers to justify changes in decisions in the middle of the process
- failure to participate adequately in implementation.

There are nonetheless legitimate reasons why organisations need to change course in the middle of a process. Working out the rules of engagement and the necessary leadership behaviours will be important, documenting these and testing them against a number of possible scenarios is vital. These could include testing what would happen in the event of external political involvement in a decision taken collectively, or exploring how to



**Figure 1** Principal formal relationships between health bodies in London



handle defection or bad behaviour and so on. Brokering these agreements, holding the participants to them and dealing with problems with the process will require leadership at a London-wide level. This is where the Mayor could play a constructive role in future.

There is no certainty that the emerging constellations of leadership will be sufficient to tackle the problems that the reforms have created, either intentionally or accidentally. There is a significant risk that the 'clear and credible system leadership on health and health care' that we argued was needed across London in our 2011 analysis will be lacking (Appleby *et al* 2011). Working through different constellations of leadership on different issues presents a major challenge to an NHS where heroic, pace-setting leadership styles tend to predominate.

Experience in Greater Manchester (*see box below*) suggests that this process of adjustment and learning not only takes time but also requires leadership that is both collective and shared. Although local authorities have experience of working in this way, NHS leaders will need support in learning how to bring about change through the use of influence and persuasion and through working with peers over whom they do not have hierarchical control. This is precisely the shift The King's Fund has argued for in its reports on the future of leadership and management in the NHS (The King's Fund 2011, 2012), and it will require continuing investment in leadership and organisational development to achieve.

### The experience in Greater Manchester

Greater Manchester has a population of approximately 2.8 million and is a relatively self-contained health system, with most activity undertaken by providers within the boundary of Greater Manchester and with local authorities and clinical commissioning groups (CCGs) that are co-terminous.

The 10 local authorities have a strong history of collaboration. The Association of Greater Manchester Authorities has existed since 1986 as the voice of local communities, and in 2011, a statutory Combined Authority was established, which is initially overseeing the strategic planning of transport within Greater Manchester.

There is also a strong history of collaboration between health commissioners and since 2004 the PCTs in Greater Manchester have operated as a formal Association of Greater Manchester PCTs. Such partnership working delivered successful Greater Manchester-wide approaches to the reconfiguration of maternity and children's services, and stroke services.

The PCTs evolved into NHS Greater Manchester (PCT cluster) and established *Healthier Together* – a review of the whole health and care system. The review has provided a strong basis for CCGs to work together and CCGs have recognised the need to reform the urgent care system and primary care in order to create a sustainable financial system in the acute sector. The financial challenges have driven partnership working across Greater Manchester, including among acute trust chief executives.

Where possible, the NHS Greater Manchester (PCT cluster) and particularly the managers stepped away from the leadership role with the aim of CCG chairs becoming strong clinical leaders, with support from the PCT cluster medical director. This principle is likely to be continued by NHS England's Greater Manchester office

*continued overleaf*

### The experience in Greater Manchester *continued*

which hopes to move to a more supportive role, with CCG chairs leading discussions with local politicians around hospital reconfiguration. However, the lack of management capacity to drive forward *Healthier Together* is a concern and potential solutions are currently being discussed, including CCGs pooling part of their management allowance.

A Greater Manchester-wide CCG formal governance structure has also been established – the Association of Greater Manchester Clinical Commissioning Groups. This aims to:

- support CCGs in sharing information and good practice
- provide a focus for the development and reporting of joint work across the CCGs and reducing unnecessary duplication of effort
- provide a properly constituted forum for issues where CCGs consider it beneficial to their own objectives to have a collective decision of the Greater Manchester CCGs in the spirit of mutuality, or to address issues requiring formal agreement by the Greater Manchester CCGs
- provide a basis for collaborative commissioning between CCGs in Greater Manchester consistent with the intentions of the Health and Social Care Act 2012.

The Association of Greater Manchester CCGs has identified three categories of decision-making: consultative (sharing information and good practice); collaborative (electing to work together); and collegiate (formal collaboration with specific criteria on decision-making).

Work continues to support partnership building between all public sector bodies in Greater Manchester. The Association of Greater Manchester Authorities established the Greater Manchester Health Commission (similar to the London Health Improvement Board) over five years ago to look at the determinants of health inequalities and ill health. The group is based on the principle of partnership through influence, advice and evidence and does not have any statutory powers. It has had success around fuel poverty, cycling and obesity, and played a local and national role in promoting minimum alcohol unit pricing. This group has now evolved into the Greater Manchester Health and Wellbeing Board, and continues to have an advisory function.

### Possible outcomes

The account offered in this report underscores the conclusions of our earlier analysis, namely that no single approach to system leadership is likely to be sufficient. CCGs, NHS England's London office, providers, local authorities, and other stakeholders will all have a role, the nature of which will depend on the issues in question. Many other bodies both at a national level and in London will have expertise to offer and will expect to play a significant part in improving health and health care.

At least two outcomes are possible. An optimistic view would foresee the new arrangements as more effective in implementing service changes than those they replace. This is because of the involvement of a wide range of participants, and the opportunity this creates to achieve greater buy-in to these changes than has often been the case in the past. Advocates of this view include those who are critical of decision-making and leadership that is reliant

on strategic planning and is concentrated in bodies like the SHA. They point to past examples of plans to reform London's health services that have often achieved very little. Implicit in this view is an often-unstated preference for markets and devolved decision-making rather than planning when implementing change.

The pessimistic view would foresee the risk of service changes being incremental and slow to achieve in the absence of strategic planning and designated system leadership. Advocates of this view invoke the experience of NHS London in the last six years, specifically the ability of its leaders to join an overview of London's needs with leadership by clinicians, as illustrated by the improvements in stroke care that have been achieved. The complexity of organisational arrangements in the reformed NHS arguably make it more difficult to build on the achievements of *Healthcare for London* at the very time when the financial and service pressures facing London's health services require change to be more rapid than ever before.

Whichever view is adopted, there is no doubt that reorganising the NHS in London in such a fundamental way has made an already difficult situation much more challenging. The huge distraction of major restructuring and the loss of experienced leaders, coupled with the Health Secretary's decision to halt work in train, could not have come at a worse time. That this work has continued under the radar is no mean achievement and it has created a context in which all those involved in health and health care in London can begin to tackle unfinished business.

## No permanent solution

It is clear to us that both the formal structures that have been established and the emerging constellations of leadership we have described contain significant weaknesses and are by no means a permanent solution. For example, several interviewees observed that London may have too many CCGs which on their own will not be able to negotiate on equal terms with powerful providers. This is part of a much bigger problem, namely the fragmentation of commissioning that has occurred as a result of the reforms. CCGs, NHS England's London office and local authorities are now all involved in commissioning some services but none has responsibility for the population as a whole in the way that primary care trusts did. Finding a way of reintegrating commissioning budgets and responsibilities through collaboration and effective governance between CCGs, NHS England and local authorities, not to mention Public Health England, is a major unresolved challenge not only in London but across the country.

There may also be too many provider organisations, although their number is certain to fall given that some NHS trusts have already declared that they are unable to become foundation trusts in their own right. Others seem likely to follow. While the establishment of fewer larger trusts may enable some service changes to be implemented more rapidly in future, the autonomy of foundation trusts may create barriers to changes that affect more than one organisation. The absence of a designated system leader capable of planning service changes that affect providers across sectors of London, and where appropriate across the capital as a whole, means that much hinges on the willingness of foundation trusts to co-operate and plan where services are best provided for the greater good of the population.

The constellations of leadership we have described are still in the process of being formed. To extend the metaphor of the eco-system, evolution will shape how the new system develops and will determine whether the outcome is positive or negative. The difficulty is that evolution takes time and the urgency of the service and financial pressures facing the NHS in London means that time is at a premium. The nature of these pressures is illustrated by the application of the Regime for Unsustainable NHS Providers in south

London (the first time this had been done anywhere in the NHS), the extent to which financial deficits in NHS trusts are concentrated in the capital, the fact that London has the lowest proportion of foundation trusts in England, evidence of wide variations in quality in acute hospitals and primary care, as well as continuing inequalities in health.

In this context, a sudden and serious deterioration in the financial or service performance of health services could result in intervention by national bodies such as NHS England, the NHS Trust Development Authority, Monitor or the Care Quality Commission. There are already indications that this is beginning to happen in response to evidence of widespread challenges in meeting the four-hour standard within accident and emergency (A&E) departments. It has also been suggested that NHS England will take on a leadership role in relation to service transformation and reconfiguration. In the event of a major and systemic crisis in performance, NHS England could feel impelled to override the authority of CCGs and other stakeholders by reclaiming power and concentrating decision-making – especially if ministers seek to reassert their authority over the direction of the NHS, notwithstanding the constraints on their powers introduced by the Health and Social Care Act 2012.

Direct rule from Whitehall or Leeds would then supersede devolved decision-making. Should a state of emergency in London's health services be declared, it would have the ironic but not entirely surprising consequence of recreating a designated system leader, following the logic that if such a leader did not exist it would be necessary to invent one. There are of course historical precedents for this, including the establishment of the Tomlinson Inquiry in 1991, although arguably the challenges facing the NHS in London are much greater today than in the past.

## An alternative for London

For these reasons, London may require an alternative to the new NHS and the evolution that we have outlined. One possibility can be found in the experience of the Veterans' Health Administration which underwent a major transformation in the 1990s. Although the parallels are not exact, there are important similarities between the challenges facing the Veterans' Health Administration then and those in the NHS in London today, including an over-reliance on hospitals, the under-development of primary care, and variations in outcomes and quality of care.

The transformation in the Veterans' Health Administration was based on many changes that happened in parallel. The most salient of these from the perspective of this report included the establishment of 22 regionally based integrated service networks each comprising a number of hospitals and other health care facilities in place of the fragmented, hospital-centred system that existed at the time. Networks received a population-based capitated budget to deliver care to veterans using services in their areas and were expected to meet a number of demanding performance targets, mainly focused on the outcomes and quality of care. The administration's headquarters acted as a strategic funder and commissioner of services from the networks, and reviewed their performance on a regular basis.

Adapting this model to the capital, it would be possible to envisage a London-wide strategic funder and commissioner relating to three provider networks, based on the footprint already established by the academic health sciences networks. Each network would be led by experienced leaders, both clinical and managerial, and would receive a capitated budget to cover the costs of care for the populations they serve. Network leaders would have freedom to reconfigure services, which in the case of the Veterans' Health Administration involved a substantial reduction in hospital capacity and a major investment in out-of-hospital care in people's homes and through the strengthening of

primary care. Patients would be able to exercise choice within networks and would also be able to go outside the network for their care with the costs reimbursed through resource transfers between networks.

Competition in this model, again learning from the Veterans' Health Administration, would focus on the use of data to compare the performance of networks in what is often described as benchmarking or yardstick competition. This would be led by the London-wide strategic commissioner and would focus on the performance of the networks against the standards specified by the commissioner relating as far as possible to outcomes and quality of care. The strategic commissioner would comprise clinical and managerial leaders and would work closely with bodies such as the Clinical Senate and the London Clinical Commissioning Council in specifying standards and reviewing performance. The rationale for proposing a radically different model such as this is the urgent need to resolve the challenges facing health and health care in London and concern that the solutions currently available are unlikely to be fit for the task.

Such a model would not require further major structural change. Provider networks would be based on the academic health sciences networks and would comprise the NHS foundation trusts, NHS trusts and other providers operating in the areas they cover. To be sure, network leaders would need to be able to possess real authority to implement service changes at the pace required, but they would do so in a system where provider integration was virtual rather than real. Similarly, the London-wide strategic commissioner would be based on NHS England's London office and it would engage directly with the London Clinical Commissioning Council and CCG leaders in carrying out its functions. CCGs would work closely with health and wellbeing boards on issues that are essentially local in nature, with the ability to commission services directly within the framework set by the strategic commissioner. These services could include primary care provision, which in our view is better commissioned by a body like a CCG than by NHS England's London office.

While structural change may not be required, London would need to be exempted from the regulatory regime currently being established across England. To be specific, rules on competition and mergers would have to be either changed substantially or suspended to enable the strategic commissioner and its provider networks to bring about the service reconfigurations that are needed. This may be an unpalatable course for the government but the alternative is to perpetuate the provision of services of widely varying quality as well as the allocation of additional resources to London at the expense of the rest of the country in order to deal with growing financial deficits. There is an inexact but not entirely inappropriate parallel here with the banking crisis of 2008 when the rules on state aid and mergers were changed in the face of deep and unprecedented difficulties in the banking sector.

For the avoidance of doubt, the approach we have advocated would not involve reinventing a strategic health authority by another name. Rather, it would entail a strategic commissioner working closely with CCG leaders learning from recent experience of *Healthcare for London* in which system leadership has gone hand-in-hand with clinical leadership. Likewise, provider networks would comprise the most experienced managerial and clinical leaders working in tandem in the way that has already begun to happen in academic health science partnerships, drawing on local expertise in their sectors within a London-wide strategic framework. Such an approach would be neither top-down nor bottom-up but would combine elements of each learning from experience in other sectors where working across a series of dualities is essential in bringing about system-wide change as we have argued in previous work (Appleby *et al* 2010).

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# Conclusion

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The issues we have reviewed here are relevant not only to London but also to the NHS in the rest of England. Although the need for service change and the complexities entailed are greater in the capital, similar challenges exist elsewhere and underline the need to be clear where leadership responsibility lies in future. Providing system leadership in the absence of a designated system leader is one of the most pressing requirements if the unprecedented financial and service pressures facing the NHS are to be tackled with the urgency that circumstances demand. This is partly a question of understanding which constellations of leadership need to lead on which issues, and partly a question of developing the style of leadership required when no single organisation has been identified as the designated system leader.

It also means having the courage to recognise that in some contexts – of which London is the most extreme example – the new structures that have been put in place are unlikely to be able to deliver the changes required. As we have argued, in these contexts a radically different approach is required – one that is able to implement overdue service changes at scale and pace in an NHS facing unprecedented challenges. In the absence of courage, the prospect is of a health care system that is unable to deliver consistently high standards of care, and that is financially unsustainable. The stakes could hardly be higher.



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# Appendix: London acute hospitals and their configuration: changes since December 2011

North-east London developments	
<b>Trust and hospital mergers and acquisitions</b>	<p><b>Barts Health NHS Trust</b></p> <p>Trust created on 1 April 2012 following the approved merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust.</p>
<b>Service reconfigurations</b>	<p><b>Health for North East London</b></p> <p>Key proposals:</p> <ul style="list-style-type: none"> <li>■ Reduction in the number of hospitals providing traditional A&amp;E and acute medical, surgical and paediatric care from six to five. King George Hospital (part of Barking, Havering and Redbridge University Hospitals NHS Trust) to no longer provide A&amp;E and acute medical surgery, but instead to provide extended primary care and 24/7 urgent care services and new short-stay assessment and treatment services for adults and children.</li> <li>■ Reduction in the number of hospitals providing maternity birthing services from six to five with King George Hospital no longer providing maternity delivery services but continuing to provide antenatal and postnatal care; a new midwifery-led unit to be developed at Queen's Hospital (part of Barking, Havering and Redbridge University Hospitals NHS Trust).</li> <li>■ Most planned surgery to move from Queen's Hospital to King George Hospital.</li> <li>■ Specialist paediatric care to be delivered at The Royal London (which will further develop its current role as a specialist centre) and Queen's Hospital; Whipps Cross, Homerton and Newham to retain 24/7 paediatric services, but children needing specialist surgical or high-dependency medical care to be transferred to The Royal London.</li> <li>■ Complex vascular surgery to be performed at The Royal London and Queen's Hospital.</li> <li>■ King George Hospital to also deliver diagnostic services, a child health centre, outpatient facilities including long-term condition management, cancer day care, renal dialysis and inpatient and day care rehabilitation services.</li> </ul> <p>In December 2010, the Joint Committees of Primary Care Trusts (PCTs) approved the Health for North East London proposals. Following a review of the proposals by the Independent Reconfiguration Panel the Secretary of State for Health agreed for the changes to go ahead in February 2012.</p> <p>Barking, Havering and Redbridge University Hospitals NHS Trust has consolidated its maternity services on the Queen's site. Changes to A&amp;E services are currently planned for 2015.</p>

North-west London developments	
<b>Trust and hospital mergers and acquisitions</b>	<p><b>Ealing Hospital NHS Trust and North West London Hospitals NHS Trust</b> (see <a href="http://www.nwlh.nhs.uk/stronger-together">www.nwlh.nhs.uk/stronger-together</a>)</p> <p>Proposed merger approved by the Competition and Co-operation Panel in June 2012. The next step will be for the boards of the two trusts to develop a full business case.</p> <p><b>West Middlesex University NHS Trust</b></p> <p>Trust board decided in September 2012 that a stand-alone foundation trust application was not feasible and announced its intention to seek a partner. A range of organisations expressed interest in partnering with the trust. In April 2013, the trust board selected Chelsea and Westminster NHS Foundation Trust as its preferred partner. The next step will be to submit a strategic outline case to the NHS Trust Development Authority for approval to develop a business case.</p>
<b>Service reconfigurations</b>	<p><b>Shaping a Healthier Future</b> (see <a href="http://www.healthiernorthwestlondon.nhs.uk">www.healthiernorthwestlondon.nhs.uk</a>)</p> <p>Key proposals (of the preferred option presented and approved):</p> <ul style="list-style-type: none"> <li>■ Reduction from nine to five hospitals with a 24/7 A&amp;E and urgent care centre. These will be at Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital (part of North West London Hospitals NHS Trust), St Mary's Hospital (part of Imperial College London NHS Trust), and West Middlesex Hospitals.</li> <li>■ Central Middlesex Hospital (part of North West London Hospitals NHS Trust), Hammersmith Hospital (part of Imperial College London NHS Trust), Ealing Hospital and Charing Cross Hospitals to have 24/7 urgent care centres and will no longer have 24/7 A&amp;E services.</li> <li>■ Central Middlesex Hospital to be developed in line with local and elective hospital models of care.</li> <li>■ Hammersmith Hospital to be developed in line with local and specialist hospital models of care.</li> <li>■ Ealing and Charing Cross Hospitals to be developed in line with the local hospital model of care proposed by the CCGs.</li> <li>■ The Hyper Acute Stroke Unit currently provided at Charing Cross Hospital to move to St Mary's Hospital, and Western Eye Hospital to move to St Mary's Hospital.</li> <li>■ Investment of more than £190 million in out-of-hospital care to improve community facilities and the care provided by GPs and others.</li> </ul> <p>The proposals were approved by the Joint Committees of PCTs in February 2013.</p> <p>For acute services, a target date of 2016 for implementation is currently envisaged, with improvements in out-of-hospital care to be in place before major changes to hospital services are implemented.</p> <p>In March 2013, Ealing Council resolved to refer the Joint Committee of PCTs' decision to the Secretary of State for Health.</p>

North-central London developments	
<b>Trust and hospital mergers and acquisitions</b>	<p><b>Barnet and Chase Farm NHS Trust and Royal Free London NHS Foundation Trust</b></p> <p>In March 2013, the Royal Free NHS Foundation Trust board decided to proceed with developing an outline business case for the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust, with a view to completing the transaction in early 2014.</p>
<b>Service reconfigurations</b>	<p><b>Barnet, Enfield and Haringey Clinical Strategy</b> (see <a href="http://www.bcf.nhs.uk/about_us/beh-strategy/index">www.bcf.nhs.uk/about_us/beh-strategy/index</a>)</p> <p>Key proposals:</p> <ul style="list-style-type: none"> <li>■ Emergency care to be concentrated at Barnet Hospital and North Middlesex University Hospitals, with the expansion and redevelopment of emergency services at these sites; Chase Farm no longer to provide 24/7 A&amp;E and instead to develop urgent care services including assessment centres for children and older people.</li> <li>■ Consultant-led obstetric and neonatal services to be concentrated at Barnet and North Middlesex University Hospitals, with the expansion and redevelopment of services at these hospitals, including midwifery-led birthing units at both; consultant-led obstetric and neonatal services to no longer be provided by Chase Farm Hospital.</li> <li>■ Chase Farm Hospital to be created as an elective care, outpatient, urgent care and diagnostics centre.</li> <li>■ Improvements to local primary care and community services.</li> </ul> <p>The Clinical Strategy was endorsed by the Secretary of State in September 2011, following endorsement by the Independent Reconfiguration Panel. In November 2012, NHS London approved the full business case for nearly £35 million investment at Barnet and Chase Farm Hospitals, to facilitate the change in service provision. In December 2012, the Treasury and Department of Health approved the full business case for £80 million investment at North Middlesex University Hospital, to create the capacity required by the Barnet Enfield and Haringey strategy.</p> <p>Implementation is progressing, with the transfer of services scheduled for November 2013.</p>

<b>South-east London developments</b>	
<b>Trust and hospital mergers and acquisitions</b>	<p><b>Guy's and St Thomas' NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, and King's College Hospital NHS Foundation Trust</b></p> <p>In February 2013, the Board of King's Health Partners – an academic health science centre which brings together King's College London and Guy's and St Thomas', King's College Hospital and South London and Maudsley foundation trusts – agreed to proceed with the next stage of developing a full business case for proposals to create a new, single academic health care organisation. The full business case process will consider various organisational models, including a possible merger of the three foundation trusts. The full business case process is expected to conclude in autumn 2013.</p> <p><b>Princess Royal University Hospital (South London Healthcare NHS Trust) and King's College Hospital NHS Foundation Trust</b></p> <p>In January 2013, the Secretary of State accepted the Trust Special Administrator's (TSA) recommendation that Princess Royal University Hospital be acquired by King's College Hospital NHS Foundation Trust (see below).</p> <p><b>Queen Elizabeth Hospital (South London Healthcare NHS Trust) and Lewisham Healthcare NHS Trust</b></p> <p>The Secretary of State accepted the TSA's recommendation that Queen Elizabeth Hospital merge (by acquisition) with Lewisham Healthcare NHS Trust (see below).</p> <p><b>Queen Mary's (South London Healthcare NHS Trust) and Oxleas NHS Foundation Trust</b></p> <p>The Secretary of State accepted the TSA's recommendation that the core estate at Queen Mary's Hospital be transferred to Oxleas NHS Foundation Trust (see below).</p>
<b>Service reconfigurations</b>	<p><b>TSA review of South London Healthcare NHS Trust and the NHS in south-east London</b> (see <a href="http://www.tsa.nhs.uk/home">www.tsa.nhs.uk/home</a>)</p> <p>Following the review by the TSA, in January 2013 the Secretary of State accepted the TSA's recommendations, with some amendments. The key changes to services and organisations are as follows:</p> <ul style="list-style-type: none"> <li>■ South London Healthcare NHS Trust to be dissolved by October 2013.</li> <li>■ As above, Princess Royal University Hospital to be acquired by King's College Hospital NHS Foundation Trust, Queen Elizabeth Hospital in Woolwich to be merged with Lewisham Healthcare NHS Trust, and Queen Mary's to be transferred to Oxleas NHS Foundation Trust and developed into a 'hub' for the provision of health and social care in Bexley. Over the next three years, the hospitals are required to make £74.9 million of efficiencies.</li> <li>■ A reduction in the number of obstetrician-led maternity units from five to four, replacing the current unit at University Hospital Lewisham with a stand-alone midwifery-led birthing centre; and each obstetrician-led unit to also have a midwifery-led birthing centre.</li> <li>■ University Hospital Lewisham to become a centre for non-complex elective procedures to serve the entire population of south-east London.</li> <li>■ The co-location of paediatric emergency and inpatient services with four A&amp;E units, with paediatric urgent care provided at Lewisham, Guy's and Queen Mary's hospitals.</li> <li>■ Lewisham hospital to have a smaller A&amp;E service with 24/7 senior emergency medical cover and the ability to admit patients requiring short, relatively uncomplicated treatments or a temporary period of supervision; patients with more serious conditions will be taken to King's, Queen Elizabeth, or St Thomas' Hospitals.</li> <li>■ The Department to pay for excess costs of PFI buildings at Queen Elizabeth and Princess Royal Hospitals and to write off the accumulated debt of the trust.</li> </ul>

South-west London developments	
<b>Trust and hospital mergers, de-mergers, and acquisitions</b>	<p><b>Epsom and St Helier NHS Trust</b></p> <p>A transaction to de-merge Epsom and St Helier NHS Trust's two component hospitals to enable Epsom Hospital to be acquired by Ashford and St Peter's Hospitals NHS Foundation Trust was halted in October 2012. This was due to Ashford and St Peter's Hospitals NHS Foundation Trust being unable to develop a financially viable plan for Epsom Hospital.</p>
<b>Service reconfigurations</b>	<p><b>Better Services Better Value (BSBV)</b> (see <a href="http://www.bsbv.swlondon.nhs.uk/">www.bsbv.swlondon.nhs.uk/</a>)</p> <p>The Case for Change published in October 2011 originally considered only the four south-west London acute hospitals (Croydon, Kingston, St George's and St Helier), because a transaction was then in train for a de-merger of the Epsom and St Helier Hospitals NHS Trust (with Epsom Hospital to be acquired by Ashford and St Peter's Hospitals NHS Foundation Trust, as above).</p> <p>In August 2012, the BSBV Programme Board put forward its preferred option:</p> <ul style="list-style-type: none"> <li>■ The centralisation of emergency care at Croydon, Kingston and St George's Hospitals, each with expanded emergency departments, an integrated urgent care centre and children's A&amp;E.</li> <li>■ Centralisation of maternity care in three expanded obstetric-led maternity units, to be located at Croydon, Kingston and St George's Hospitals, with co-located midwifery-led units.</li> <li>■ St Helier Hospital to cease providing emergency and maternity services but to retain a stand-alone urgent care centre, and to develop a planned care centre for non-emergency surgery.</li> <li>■ Dedicated children's assessment wards at Croydon, Kingston and St George's Hospitals, with specialist paediatric staff centralised at St George's.</li> <li>■ Major improvements in GP and community services.</li> </ul> <p>However, in autumn 2012, the Programme Board agreed to delay consultation and look again at proposals in light of the suspension of the proposed merger of Epsom Hospital and Ashford and St Peter's NHS Foundation Trust (which led to the inclusion of Epsom Hospital in the review), and NHS Surrey's wish to be more fully involved.</p> <p>Key proposals now include:</p> <ul style="list-style-type: none"> <li>■ Three hospitals, rather than the current four, to have an A&amp;E department and obstetrician-led maternity units, alongside midwifery-led units.</li> <li>■ A network of inpatient children's services at three acute hospitals with St George's as the hub, improved children's community services, and all five hospitals to continue to see children with urgent needs and as outpatients.</li> <li>■ Further work to be done on the feasibility of a stand-alone midwifery-led maternity unit.</li> <li>■ A planned care centre for all inpatient surgery for the region, on a separate site from emergency care, also providing day case surgery for the local population.</li> <li>■ Outpatient and day surgery facilities in all five hospitals.</li> </ul> <p>There are also plans for improvements to out-of-hospital services (laid out in the plans produced by each of the local CCGs). Proposals include increased investment to improve out-of-hospital care, with more services offered in the community (GP surgeries, local care centres and local hospitals) and at home.</p> <p>In February 2013, the BSBV Programme Board agreed that further work was needed to engage local stakeholders, particularly Surrey Downs, and in May 2013 developed a draft pre-consultation business case. The seven CCGs have now agreed to form a local committee (also including NHS England) to decide whether the proposals should go to public consultation. The committee is expected to meet once NHS England has completed its assurance process which aims to ensure that the programme is ready to move forward to public consultation.</p>