King's Fund Response to the *Healthcare for London: A Framework for action* NHS London consultation

Introduction

For too long the quality of health care provided in London has not been good enough, and often those with the greatest needs have been least well served. *Healthcare for London: A Framework for Action* provides an important opportunity for the capital to begin to address these issues – to examine the best way to provide the best care within the resources at its disposal, to improve health and to provide a fairer system which meets the needs of all its citizens. As the review document makes clear, the challenge is considerable, but *Healthcare for London* provides a compelling argument that the capital can do better. There have been many missed opportunities in the past – as NHS London has made clear, this must not be another one.

Our understanding is that *Healthcare for London* does not claim to be a precise blueprint for how and where London's health services should be organised. Rather, it signals a starting point – it aims to be a catalyst for change, helping local health economies and services (some with a London-wide span) to find the best way to improve the health of Londoners, tackle longstanding inadequacies in quality and access, and create the ambition to deliver services that are among the best in the world. In particular, it recognises the challenge of responding to new technologies and techniques, managing the increasing number of patients with long-term conditions and, in some way, linking GP community services and hospitals into a functioning network of health and social care services. This is an ambitious agenda, and it is worth making the point that London, as the rest of the country, is already facing a massive programme of change including: national service frameworks, which set out approaches to care in specified areas; new systems of payment; the

introduction of greater patient choice. NHS London will need to ensure it has the local capacity to take on an ever -increasing programme of change.

It is a truism that changing the way the NHS provides its services is difficult, and making the right changes even more so. There is always a case to be made for caution – especially where change involves difficult trade-offs between the key factors of access, quality and cost on the basis of often incomplete, uncertain or contested evidence. We would suggest that the NHS should push ahead with change where the evidence of benefits is strong, but should act with more caution where it is weak.

The nature of the consultation – based on *Healthcare for London: A Framework for Action* – is somewhat unusual. As the consultation document states:

> 'This consultation is about a framework. It is not about any individual service or building. If proposals to change a service are put forward in the future they will be subject to a separate discussion, consultation and scrutiny.'

We therefore recognise that as concrete proposals for changing services emerge, further consultation will be necessary.

Our response focuses on the changes proposed on the configuration of London's health services; we comment on the costings used to underpin the proposed changes and address some of the specific service recommendations. We also raise important issues concerning the implementation of change and the nature of the roles of NHS London and the economic and organisational environment in bringing about such change.

Future need and costs

It was quite understandable that the report undertook some basic costings around future patterns of service, and, given the time constraints and the difficulty of making accurate predictions, these estimates necessarily had large margins of error. Our analysis suggests that the figures in *Healthcare for London* are based on a

number of assumptions, each of which has a significant degree of uncertainty. We believe that it is not possible to be confident without more detailed work that (a) the NHS in London cannot continue (financially) in its current state and (b) that the alternative model would create £1.3 billion savings as *Healthcare for London* suggests might be possible. Given the level of uncertainty, the arguments for change should not significantly rest, in our view, on financial consideration alone, but on the need to improve the quality of and access to care and the more detailed cost of making the changes required at local level.

Public health

The health service has a clear and distinct role to play in keeping people as healthy as possible, not merely in treating them when they are ill, and this should be articulated more clearly. NHS commissioners should particularly invest in preventive approaches for those with chronic health problems. All health professionals, particularly GPs, should be trained in skills to support healthy living, and incentives in the system should be aligned to encourage these activities.

There is good evidence to suggest that the social context in which people live, work and play is important in enabling people to stay healthy (Jochelson 2007). We therefore welcome the idea that the NHS at all levels in London will advise, support and work alongside local authorities and the Mayor of London, who have direct responsibility for services such as public transport, urban planning, and leisure facilities, to ensure that they deliver improvements in public health. However, partnership working has not always been effective; we hope that Local Strategic Partnerships and Local Area Agreements will provide a framework for ensuring better coordination between PCTs and local authorities as well as other partners (Thorlby *et al*, forthcoming).

Maternity and newborn

The recent findings of the Healthcare Commission's review of maternity services suggest that the performance of trusts in London is worse than that in other parts of England (19

out of 27 London trusts were 'least well performing') (Healthcare Commission 2008). The challenges for maternity services of a rising birth rate and increasing medical and social complexity of the pregnant population may be particularly acute in the capital, but maternity services need to respond to these challenges and ensure they provide all women with a safe, high-quality experience. The King's Fund's independent inquiry into the safety of maternity services in England recently identified a number of problems that mean maternity services are not as safe as they could be and make a number of recommendations as to how maternity teams and trusts can do more to ensure safety (O'Neill 2008). Among their recommendations they highlight the need to deploy staff effectively as well as to employ sufficient staff.

The Royal Colleges are shortly to publish a set of standards with auditable indicators. These should form the basis of commissioning for maternity services. Although it is important to offer women a choice, births at home or in birth centres need to be adequately resourced and these services linked to obstetric-led units to ensure appropriate care if a woman's or baby's condition deteriorates. Research being conducted by the NPEU as part of the Birthplace study will in due course provide evidence of the relative safety of different birth settings; without that evidence, it is difficult for women to make informed choices. There is also a paucity of data on morbidity including surgical complications following caesarean section.

It is worth noting that apart from the idea of one-stop centres (although such models exist under the Surestart scheme) all the consultation's aspirations for the services expectant mothers should be offered – from early needs assessments to care provided by a single team – are already a reality in most areas of London. Proposals to provide routine antenatal and postnatal care in the community must ensure that women with particular health needs (ie. women with mental health problems, diabetes, etc). are referred to the appropriate specialist care

Mental health services

The developments set out for mental health in the consultation document seem to reflect current – and , indeed, past –consensus views. Aspirations to provide better housing and employment support, and to address the needs of minority communities, have long been known to significantly improve mental health care and outcomes. Early intervention and improved access for young people aged 14–25 is also important. However, many younger children, including those of primary school age, also have significant emotional problems that need to be better identified and addressed; we believe that work in this area being undertaken under Strand One of the Young London Matters programme should inform the final recommendations.

The consultation proposals refer to decreasing admissions to mental health units. Although bed reconfiguration is worth examining in the context of continuing efforts to treat people in the community and reduce hospital admissions, Hospital Episode Statistics data suggests that in fact the number of admissions to facilities in London's mental health trusts rose from 24,510 in 2005/6 to 27,007 in 2006/7, after a fall from 27,367 in 2004/5. There remains huge pressure on London's psychiatric beds (which often operate at over 100 per cent occupancy) and it is by no means clear that any significant further reduction in bed numbers is tenable given that an episode of hospital care remains the most appropriate intervention for many seriously ill people. In addition, bearing in mind that the average length of stay for patients in a psychiatric unit is measured in weeks rather than days, there is a need for social and recreational activities on wards to assist patient recovery and reduce violent incidents.

Long-term conditions

There is considerable evidence that supporting patients with long-term conditions to self -manage improves outcomes (Coulter and Ellis 2006). Although the expert patient programme is well established not all patients who could benefit from self-management are referred and furthermore this model may not suit all patients. A range of approaches, making best use of information technology, needs to be offered and reinforced by all health care professionals with whom the patient is in contact.

Many PCTs are using the tool developed jointly by the King's Fund, New York University and Health Dialog to predict Patients at Risk of Readmission (PARR) or other similar tools (seewww.kingsfund.org.uk/current_projects/predictive_risk/index.html). However, not enough is known about what interventions are most effective and how to prevent admissions to hospital. Some PCTs are putting in place innovative systems of care such Croydon PCT (the Virtual Ward) and Newham PCT (part of the Department of Health funded Whole Systems Demonstrator sites). These initiatives need to be evaluated and the learning extended to other health communities across London and the rest of the country.

Patients with long-term conditions benefit from access to multidisciplinary teams including social care support. Consideration should be given to the role of specialists within these teams There is some evidence that specialist outreach services are more expensive than the equivalent hospital-based service (Imison *et al*, forthcoming). NHS London needs to work with PCTs and providers to establish the most cost-effective way of delivering high-quality multidisciplinary care for people with chronic conditions.

End-of-life care

Embedded in the recommendations for improving end-of-life care are three key principles: the need to identify all those needing end-of-life care; the need to systematically record and share preferences for how and where that care should be delivered; and the need for a more robust approach to commissioning and assuring the delivery of complex services, often integrated across a range of service providers. We would endorse these key principles while recognising that their implementation will present significant challenges.

There is much to be learnt about how to implement effective commissioning in this area and how to redesign services around these principles.

Concentrating services

Healthcare for London makes a clear case for delivering more services on fewer sites in areas where the evidence on both quality and safety is strong, such as the care of patients who have suffered strokes (National Audit Office 2005) or trauma (Detriades *et al* 2005) . Change in these areas is probably best led on a London-wide basis. But the specifics still need to be worked out and agreed by local commissioners. They should not be contracting for services that do not meet quality and safety standards. NHS London is right to suggest this is a matter of urgency – patients' lives should not be put at risk by outmoded models of care.

In addition, there is *prima facie* evidence that Londoners would gain from further concentration of a number of other, complex, procedures (Murray and Teasdale 2005) . *But the case for making such changes should be worked out on a more systematic basis, making use of a wide range of evidence on the three main factors – access, cost and quality.*

The financial and clinical implications for hospitals of losing activity must be assessed, taking into account the implications of shifting care to other settings. The driving force for change must be what benefits patients, not what benefits institutions.

Polyclinics

On developing polyclinics, the consultation acknowledges that different communities will find different models, but that the central idea – of providing some hospital-based services at a more local level, and providing a 'one-stop shop' to a wider range of GP services – is flexible enough to meet the varying needs of different parts of London.

Bringing together GPs and other primary care services with secondary care physicians and a range of other services into one new location would improve access to care for services formerly provided in hospitals, but for services currently supplied from GP surgeries access costs for patients may rise. The balance between

these gains and losses can be worked out only when specific schemes are proposed and their service content and location determined.

The evidence for shifting GP services to polyclinics is currently weak [see Annex 1]. The available literature suggests that improvements in quality cannot be assumed; co-locating professionals does not necessarily generate co-working (Black *et al* 1007) and larger practices do not seem to secure improved health outcomes for patients (Saxena *et al* 2007). Primary care based provision can prove more expensive than hospital care, whether provided by a consultant on an outreach basis (Bowling *et al* 1997) or by a GP (Coast *et al* 2005). Community-based urgent care services can also be costly and may not reduce demand for A&E services (Sakr *et al* 2003). The transitional costs of co-locating GPs in polyclinics would clearly be expensive, and there would be a significant management task – this would need to be planned for.

There are other, less ambitious models for polyclinics in the UK and elsewhere, including 'hubs' that incorporate some GP practices and serve others which remain in situ. Given the limited evidence in this area, there is a case to proceed with pilots that can be monitored and evaluated accordingly. It may be that the more decentralised 'hub' model may serve as the least disruptive way forward provided the costings can be made to work.

Implementation issues

On implementation, it is not clear how much public support there is for change of the kind proposed in *Healthcare for London* (Ipsos Mori 2007). As NHS London acknowledges, it will be difficult to achieve the support of the public unless there is clinical and staff support for change, and none will be possible without a 'mission to persuade' by NHS London using compelling evidence. The evidence presented in *Healthcare for London* is compelling in some areas, for example, concentrating stroke services and emergency care, but, as we have noted, is less compelling in other areas, such as for the introduction of polyclinics. If there were adequate public and staff support, the significant implementation challenges include the need for: funding for service development and infrastructure and transitional costs;

adequate lead time to build the necessary infrastructure; support for a change in working practices that will need strong local leadership and commissioning, in particular in the case of consolidation of primary care onto fewer sites.

In addition, as we note above, there is a need to emphasise more strongly that *Healthcare for London* represents only a starting point for change. There is a danger of creating high public expectations of immediate improvements in services when in reality change – especially of the magnitude proposed by *Healthcare for London* – inevitably takes time.

Given the proposed scale of investment and disinvestment, it will be important to determine where the need for change in London is greatest – for example, areas where GP services are particularly poor, or likely to be in the future. In addition, given the speculative nature of some of the proposals – particularly polyclinics – it would be advisable to ensure that the impact of the initial investments in polyclinics is fully evaluated.

A fundamental issue which needs to be addressed more fully is what is the best way to achieve improvements in services in London. Is it the role of the strategic health authority to mandate and lead change? How far should we rely on regulation to police quality and access and how far on the local contracting system (mediated through commissioning)? There is a case for NHS London to develop principles to guide when it will or will not intervene to mandate change – principles which could be agreed with other parties and made explicit.

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Appendix 1: Assessment of the research evidence of costs and benefits relating to the Polyclinic Model outlined in *Healthcare for London*

+ positive change; **X** negative change; **=** stays the same; **?** absence of evidence

	Access	Quality	Cost	Summary
GP services moved to polyclinic	**X** Patients have further to travel for GP services.	**+/?** Some association between larger list sizes and positive scores on process measures of quality, though "large" here means around 13,000. The association does not extend to care outcomes. Not clear that co-siting GPs with specialists influences care.	**?** No available evidence on costs of providing services in larger practices or polyclinic-like structures compared to smaller or traditional GP practices.	Access is reduced. Quality may be improved but not clear. Cost impact is unknown.
Outpatient services moved to polyclinics *Performed by hospital specialists*	**+/=** Patients have less far to travel, or in the case of polyclinics co-sited with hospitals, equivalent distance. Outreach outpatient clinics associated with shorter waiting times than hospital clinics.	**=/+** Outcomes for patients are equivalent to those attending hospital-based appointments and outreach clinics are associated with higher patient satisfaction levels.	**X** Outreach clinics staffed by hospital specialists have higher costs and lower patient through-put than hospital-based counterparts.	Access is improved in terms of distance to facilities and waiting times. Quality is equivalent to hospital care and patient satisfaction higher. Costs are higher than hospital care.
Performed by GPs	**+/=** As above.	**=/?** Studies conducted in a limited number of treatments have found the quality of GP-delivered outpatient care to be equivalent to that of hospital-	**X** Studies of GPSI dermatology services found that GPSI care was consistently more expensive than hospital-	Access is improved in terms of distance to facilities and waiting times. Quality is equivalent to hospital care.

		based specialist care.	based care.	Costs are higher than hospital care.
Diagnostic services moved to polyclinics	**+/?** One study found shorter waits in a primary care-based ultrasound service. Direct access (irrespective organisational infrastructure) to diagnostics after primary care appointment delivers shorter waits.	**+/?** One study found the quality of stored images and reports was equivalent for a primary-care based ultrasound service. Direct access referrals have been found to be appropriate.	**=/?** One study found costs were roughly equivalent. There is evidence that direct access can significantly reduce costs for both the NHS and patients.	One study found shorter waits and equivalent costs and imaging quality in a primary care based ultrasound service compared to a hospital based service. Direct access to diagnostics can deliver shorter waits and significantly reduce costs. This does not require a polyclinic structure for its implementation.
Urgent care services moved to polyclinics	**+/=** Studies have found shorter waits in Minor Injury Units (MIUs) compared to A&Es, though the presence of MIUs and Walk-In Centres does not reduce waiting times at local the A&E.	**?** No available evidence on doctor (versus nurse)-led community based urgent care facilities. Quality of care in nurse-led MIUs is slightly lower than A&E but not unsafe.	**X** One study of a nurse MIU found slightly higher costs compared to minor injury care in local A&E and higher consequence costs due to much higher referral to follow-up rate. Also evidence that these types of facilities do not reduce demand at local A&Es.	Access could be improved through shorter waiting times. Quality may be less high than hospital but still safe. Costs of MIUs are higher.
Minor surgery moved to polyclinics *performed by GPs*	**+/=** Patients have less far to travel, or in the case of polyclinics co-sited with hospitals, equivalent distance.	**=/X/?** Evidence from dermatology services provided by GPs with special interests (GPSIs) finds equivalent outcomes. But also evidence that in removing lesions GPs perform excisions less adequately than hospital specialists.	**?/X** There is little recent evidence directly comparing costs, but a number of studies have reported that minor surgery by GPs supplements rather than replaces hospital care. This has significant cost implications.	Access is improved through reduced travelling distance. Further research required on quality - equivalent outcomes have been found in dermatology, but lower quality in surgical excisions. Overall services costs may be increased since such services

				tend to supplement, not replace existing hospital-based services.