FOLLOW UP QUESTIONS FOR NHS LONDON FROM JOSC

Work in response to the review

1. What is the progress with the review of NHS estates in London? When will this be completed and will the findings be shared with the JOSC?

The review is at a very early stage. We will have more idea on the timeframes in mid/late March.

2. What is the status of the work of the clinical working groups that have been established since the initial Healthcare for London? How will these and the work streams on mental health and children's services feed into the models of care currently under consultation?

These two working groups were established as part of the NHS-wide '*our NHS, our future*' review, as the original London pathway groups did not address mental health and children's services in the same way as the national review. The groups have been meeting since Oct 2007. These groups were tasked with developing a range of proposals and, in London, were framed within the context of the original HfL work, as an extension to the work already carried out.

The groups have now finished meeting, and are drafting their reports which will be submitted to NHS London in March. The proposal is for the London Commissioning Group to receive the reports and to ensure coherence and alignment between the two new sets of proposals and those which are currently subject to consultation.

In addition, the relevant representative members of the Clinical Advisory Group were asked to join the Pathway Groups, and therefore have an ongoing role in implementing any recommendations from the reports or the JCPCT.

3. NHS London mentioned the offer of providing funding to examine the transport and access implications of the models of care – do you have any further information on this?

NHS London is working in partnership with Transport for London to provide a facility for analysing the travel time and accessibility implications of changes to health service configuration. Uniquely it will focus on London's public transport, and is being designed with the Healthcare for London models of care very much in mind.

Implementation:

4. How will PCTs work together, or will local interests prevail (i.e. the possibility that PCTs may want to keep a hospital in their patch)? What will be the role of the SHA in managing these potential conflicts?

The current consultation is on a framework. Without prejudging the outcome of consultation, if for instance, a small number of stroke or trauma centres are recommended then these will be consulted upon in the same way as the framework for action i.e. pan-london, led by a JCPCT.

For local issues it will be for PCTs to consult either individually or in groups. The SHA will exercise its pan-London strategic leadership role and will work with PCTs to ensure appropriate alignment of their plans.

5. Is there a danger that a staged approach to implementing the proposals will lead to uncertainty and a gradual loss of services e.g. a 'salami slicing' of services from district general hospitals?

The framework is underpinned by the technical document which addressed high-level financial considerations. However we recognise that more work needs to be done and a project on local hospital feasibility and the establishment of ten pilot polyclinics will help us develop a more detailed model.

Comprehensive commissioning plans will need to be developed which will define strategic changes. The implications of these will be carefully appraised.

Of course a staged approach across London may also bring benefits. For instance, implementation in one area of London will lead to a greater understanding of the issues for others.

We recognise that all change has inherent risks we will need to manage that change, communicate with local organisations and people, share information and involve and consult locally. We will monitor and evaluate projects to ensure that lessons are learned and plans continually refined. If we don't do anything then changes may happen in an ad hoc fashion increasing the risk of service failure.

6. How do Foundation Trusts relate to the proposals - given their autonomy will this mean that it will be harder for PCTs to influence the services FTs provide?

All trusts can respond to the consultation. Implementation will be achieved through changed commissioning decisions which means that PCTs do have the ability to influence services. It will be no harder to work with FTs than Trusts.

7. How interdependent are the models e.g. does centralisation depend on further devolution?

The focus will be on access, quality and safety. Services will be arranged to optimise these factors but we recognise there are significant interdependencies.

Centralisation involves only one part of some pathways. So, for instance, the proposed model of care for stroke depends not only on better stroke facilities in fewer hospitals, but also on excellent rehabilitation facilities in local hospitals.

Centralisation doesn't depend on further devolution, however the desire to improve pathways overall may be a catalyst for it.

8. How dependent are the proposals on improved information technology?

The NHS generally has recognised the requirements for improved IT. The majority of Healthcare for London proposals are not dependent on such improvements and could be progressed with our current systems. Development of IT capability will however bring many benefits.

Some proposals do require new IT capabilities and we will need to consider how best to enable this. We recognise this as an issue and we are working with LPfIT to ensure opportunities are maximised.

We also need to acknowledge the progress already made in improving IT and information sharing. For instance there has been excellent progress around imaging and diagnostics (e.g. PACS), improving access to diagnostics.

9. How will commissioning decisions be taken on issues that cover more than one PCT? Will the SHA undertake a role in commissioning sectoral or pan-London services?

The PCTs already collaborate in sectors, through the London Commissioning Group (LCG), the Specialised Commissioning Group (SCG) and through lead commissioners for services.

The SHA is not a commissioner and won't become one. So PCTs will continue to collaborate – either all together or in groups – as they do now (for instance the SCG commissions over £700m of healthcare).

Money:

10. Where will the money come from to pay for implementation? It has been suggested that this will come from freeing up underused estates, but presumably money will be required to develop new services before old estates can be sold: will there be a transition fund to pay for this?

Some do not need extra money – e.g. improved pathways don't necessarily cost more; in fact good medical care costs less – 28% fewer babies die in children's heart units that perform more than 100 operations a year; a good surgeon has lower complication rates and therefore fewer readmissions; and the renal centre at Imperial has performed 40% more transplants with 30% less mortality than the original two centres.

Expenditure on proven methods of health improvement saves money. For instance stopping people smoking would reduce the need for operations in later life. It has been estimated that if people in London stopped smoking prior to an operation it would save between 2, 500 and 5, 300 complications a year and £1.5 to £4 million.

Better care for long term conditions (and urgent care such as for people suffering a stroke) means less disability and potentially a reduction in the associated health and social care costs.

The NHS is now receiving far more funding than was previously the case. Overall the NHS is now much more financially stable – this should facilitate prudent commissioning

and capital investment. We will ensure appropriate transitional arrangements to ensure service continuity.

11. What will be the impact on the finances of hospital trusts that undertake less activity than at present? Will these trusts cease to exist or will there be mergers to make them financially viable?

The local hospital feasibility project will allow us to appraise the relevant issues and develop detailed plans with appropriate understanding of the implications. However the issue needs to be seen in the expected continued growth in the use of NHS services – we estimate 57% to 77% growth overall over the next ten years.

Inequalities

12. How do the proposals address health inequalities, in particular in relation to funding of health services across London?

All projects are required to pursue opportunities to reduce inequalities as they develop specific proposals.

A major focus of these proposals is to reduce health inequalities. A provisional Health Inequalities Impact Assessment was undertaken as part of A Framework for Action.

The proposals focus on prevention of ill health and these will have a particularly positive effect on those experiencing most inequity. For instance, the high rates of smokers, teenage pregnancies and mental health patients in the most deprived wards is an unacceptable situation which we aim to address.

The framework proposes more GPs – again, these are especially needed in the most deprived areas of London.

The Health Inequalities Impact Assessment and the Equalities Impact Assessment will independently assess if our proposals will have a positive effect on those facing most inequity and we can then review our recommendations.

Additionally London Health Commission (commissioned to produce the HIIA and EIA) is working with Healthlink (commissioned to consult with traditionally excluded groups) to ensure good understanding of the issues of a broad range of groups most likely to be facing inequity.

The proposals aim to address quality, safety and access of services and health inequalities. However we recognise that funding can have a major impact on health inequalities. Therefore the SHA will work closely with PCTs both individually and as a group, to ensure appropriate funding is in place to reduce health inequalities.

13. The review proposes locating polyclinics on existing hospital sites to support the financial viability of local hospitals – how will this address location of healthcare by need? Will this entrench existing health inequalities and access problems?

This is not the only proposed location of polyclinics and they are not suggested because of financial viability.

Hospital polyclinics aim to provide better care for the large numbers of people presenting themselves at A&E who would actually benefit from primary care led facilities. However they present to A&E because there is a lack of suitable alternatives (especially in the evenings and at weekends). Hospital polyclinics could be one way in which this inequality is addressed.

Commissioners will need to determine what is most appropriate to meet local need. The proposals suggest putting a polyclinic on a hospital site if that makes sense for the local community, however piloting of polyclinics will help us understand some of the more complex issues.

Stakeholders

14. What is the potential impact of the proposals on local authorities, in particular cost? How were local authorities involved in the Healthcare for London review and how will they be involved in taking the proposals forward? Is there any work to develop models of social care that support the Darzi proposals?

We are about to commission, jointly with London Councils, a high level review of the potential impact on social care of Healthcare for London. We have a council Chief Executive and Director of Social Services on the London Commissioning Group and two Directors of Social Services being seconded part time to work on particular projects to ensure that all these issues are addressed.

A number of local authority representatives were involved either directly (e.g. as part of a working group) or indirectly (as part of engagement discussions) in the production of the original Healthcare for London report.

15. The NHS is a universal service that is free to all, whereas local authorities are increasingly focusing their services on those in most need. What work is being undertaken to address this contradiction? Could there be a reallocation of resources from health to social care?

This is a question for government as PCTs receive their allocations from the Department of Health. We would however be keen to explore opportunities to align and integrate our commissioning regimes where it is appropriate to do so.

16. What will be the impact on the LAS, particularly in relation to centralising some care in specialist hospitals? Will the LAS be funded to undertake this work?

The LAS is closely involved in all the work we're doing – they led the move to regionalise heart attack care so they are very supportive of the principle. We will engage with the PCT commissioner of LAS services to ensure that these services are appropriately commissioned and opportunities are maximised.

We have proposed better resourcing of training of LAS staff and are discussing possible location of ambulances at polyclinics.