

# **NHS and public health reforms: the outlook for London**

Issues Paper  
November 2012



## Summary

This Issues paper summarises information received by the London Assembly's Health and Environment Committee on the implications for the health service in London, of the structural changes and budget efficiencies that the Department of Health is making. The paper draws on discussions from a recent meeting of the Committee with Dame Ruth Carnell, the Chief Executive of NHS London, the Strategic Health Authority for London.<sup>1</sup> The paper highlights a number of key concerns that have been raised and which we will return to at a future meeting with Dame Ruth in February 2013.

## Background

When the Health and Social Care Bill was enshrined in law on 27 March 2012, it marked a momentous step towards what has been described as "arguably the biggest re-organisation the (NHS) service has seen in its 63-year history" and "the biggest shift in power and accountability it (has) ever seen".<sup>2</sup>

The Health and Social Care Act sets a new structure for NHS management and commissioning, and for responsibility and accountability for public health, due to be in place by April 2013. Key changes include the:

- Abolition of 10 regional health authorities and 152 primary care trusts (PCTs) across the country, which have been responsible for most commissioning;
- Transfer of responsibility for most commissioning to newly formed Clinical Commissioning Groups (CCGs) made up of General Practitioners and other health professionals;
- Setting up of a National Commissioning Board (NCB) to oversee the Clinical Commissioning Groups and to take responsibility for commissioning specialist services, dentists and primary care; and
- Transfer of responsibility for public health issues like obesity, alcohol misuse, smoking and sexual health to local authorities from April 2013, with oversight from a new national body, Public Health England, which will also be responsible for health protection.

For London as in other parts of the country this will mean a sizeable change to the framework within which healthcare will be delivered and funded across the capital. The Strategic Health Authority, NHS London, along with the 31 PCTs across London will no longer exist.<sup>3</sup> The London Assembly recognises the scale of the challenges the reforms outlined in the Act will bring. However, our main concern is to ensure that the quality of healthcare across London is not compromised during the transition to the new structures, and that beyond April 2013, mechanisms are in place to ensure a London-wide perspective can be maintained on improving healthcare and public health outcomes.

The London Assembly has tracked developments and progress on transition to the new structures, regularly meeting with Dame Ruth Carnall DBE, Chief Executive NHS London, and Dr

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<sup>1</sup> Health and Environment Committee meeting, 12 September 2012, See <http://www.london.gov.uk/moderngov/ieListDocuments.aspx?CId=256&Mid=4616>

<sup>2</sup> Never Again? The story of the Health and Social Care Act 2012, The Kings Fund and the Institute for Government, 2012 [http://www.kingsfund.org.uk/publications/never\\_again.html](http://www.kingsfund.org.uk/publications/never_again.html)

<sup>3</sup> Appendix 1 summarises the NHS and public health structural and management changes and progress to date. Appendix 2 shows a diagram of the emerging structure and CCG boundaries.

Simon Tanner, Regional Director of Public Health, NHS London and Health Advisor to the Greater London Authority (GLA).

An update briefing on 18 January 2012 highlighted a range of financial, operational and strategic risks to implementing the new structures in London.

At a further briefing on 12 September 2012, the Health and Environment Committee reviewed progress on implementing the changes and discussed their impact with the NHS London officials, Dave Buck of The Kings Fund, Professor Renton and Amanda Coyle, GLA.

This Issues paper looks at the progress made, highlighting the continuing challenges in seeking to manage the risks and deliver a fitting legacy. It also points out key considerations and steps that will need to be taken in the run up to April 2013 and beyond, to ensure a system is in place that is responsive to London's health needs.

### **What are the challenges?**

There are four key challenges:

- I.** The challenge to complete the transition, deliver efficiency savings and develop a fitting legacy within the remaining timeframe.
- II.** The urgent need to substantially improve the productivity of acute hospital trusts and, where it is not possible to do so by April 2013, to put an appropriate strategy in place.
- III.** On public health specifically, the challenge to manage the transfer of responsibility, secure sufficient funding for London and ensure equity in individual borough funding allocations.
- IV.** To bring some definition to the lack of clarity on how a strategic overview on NHS services and public health will be maintained within the new structures.

## **I. Delivering the transition on healthcare and public health**

The scale and complexity of the reform programme is daunting. Dame Ruth Carnall gave a clear example of the sheer size of the challenge at the Committee's meeting on 12 September 2012. She referred to some 75 new organisations being formed from the existing six (now five) PCT clusters and Strategic Health Authority, and a 50 per cent reduction in commissioning operational costs. She also emphasised the necessity for "clarity on structural arrangements", and the need for early senior appointments to allow sufficient handover time from 'old' to 'new'; the ideal timing for the handover being from October 2012.<sup>4</sup>

Having achieved agreement to a handover period of six months Dame Ruth is more confident that the goal ahead is achievable and comfortable with the pace of progress.<sup>5</sup> The new arrangements in London (with the exception of Public Health England and some specific change programmes such as the one on improving outcomes for cancer care), have been operating in shadow form since 1 October 2012.

There is now clarity on what the clinical commissioning structure will look like in London. Thirty two clinical commissioning groups (CCGs) will be responsible for commissioning specialist services, dentists and primary care. The bulk of them (just over two thirds) will be fully accredited by the end of the year, with the remainder by the end of January 2013. London will house one of four regional hubs and three local area teams. The former will provide support to the NHS National Commissioning Board (NCB) that will oversee CCGs, and the latter will support the pan-London arrangement for direct commissioning and the delivery of service innovation.

### **Progress on public health**

While progress has been made on the public health front, the outlook is less defined. In January 2012, the priority was to establish certainty on structure and funding. Budget allocations had not yet been published, making it difficult for there to be effective dialogue with local government about the 'how and when' of the process. Dr Tanner, Regional Director of Public Health, stressed the challenge of establishing a new national system – Public Health England – alongside implementing a huge change at local level. Local level changes will involve the merger of old and new mechanisms and partnerships to bring together the wide range of public health services and functions.<sup>6</sup>

Public Health England (PHE), a newly established body, will coordinate public health work nationally.<sup>7</sup> PHE sits within the Department of Health and will assume full statutory responsibility in April 2013. While it has been confirmed that PHE will be supported by four regional hubs, one in London and a number of local units, the latter is yet to be confirmed.

At local level, boroughs will be required to appoint a Director of Public Health, and establish a Health and Wellbeing Board (HWB) to help discharge its functions under the Act. These are: to ensure plans are in place to protect the health of the local population, responsibility to ensure that NHS commissioners receive the public health advice they need,

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<sup>4</sup> Page 8. See also pages 3 - 5, Health and Public Services Committee transcript, 18 January 2012

<sup>5</sup> Page 1 Health and Environment Committee transcript, 12 September 2012

<sup>6</sup> Page 27, Health and Public Services Committee transcript, 18 January 2012

<sup>7</sup> PHE incorporates the work of a range of predecessor bodies, from the Health Protection Agency to the National Treatment Agency for Substance Misuse, to the nine Strategic Health Authorities to the 152 PCTs

the provision of sexual health services, NHS health check assessments, the National Child Measurement Programme, and responsibilities for commissioning specific public health services.

Boroughs have started the process of combining their teams and sharing leadership with a shared Director of Public Health. There are now six groupings: Barnet and Harrow, Brent and Hounslow, Camden and Islington, Lambeth and Southwark, Redbridge and Waltham Forest and City, Hackney and Newham.<sup>8</sup>

HWBs are operating in shadow form in all London boroughs. But already considerable variations are emerging in the joint strategic needs assessments that need to be made, in their interpretation, and how they are fed into the Health and Well-being Strategies. Work by The Kings Fund has shown that the strategies are in very different places.<sup>9</sup> While disparity is not necessarily a bad thing, some underlying analysis of why it has occurred is valuable to maintain perspective and overview, and to rule out any negative inference that might be drawn from it. Some form of monitoring will be required. By whom, remains an unanswered question.

One suggestion is that the London Health Improvement Board (LHIB), a partnership between the Mayor, London Councils and NHS London, assume the function. Currently operating in shadow form, the original ambition was to put the board on a statutory footing from April 2014, with a sizeable budget (up to £14 million) to be drawn from each of London's 32 boroughs and the City of London. This seems a sensible progression. But the omission of the LHIB from the draft Social Care Bill has unsettled things. However, we have been assured that the outlook remains positive given the willingness of the relevant partners, along with Government, to consider and pursue alternative approaches. How it will work in practice remains to be seen.

Valiant efforts are also being made to move forward despite the uncertainty of the finances. NHS London is working with senior borough leaders and has agreed on a number of areas of practical development that can go ahead without the certainty that comes with a finalised budget. An announcement on funding allocations is expected imminently.

**Key consideration** for further follow-up at our February 2013 meeting: A multiplicity of new bodies, partnerships and organisations are being formed and will take time to become established and develop fully functional links that are needed to ensure consistency across London. Going forward there are a range of issues that need to be tackled at a strategic level ensuring: coherence in HWB strategies, London-wide issues are identified and acted upon, HWBs are held accountable and necessary performance improvements are addressed.

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<sup>8</sup> Page 5, Health and Environment Committee transcript, 12 September 2012

<sup>9</sup> Page 11, Health and Environment Committee transcript, 12 September 2012

## II. Efficiency savings and financial management

The main financial pressures come from the balancing act that needs to happen between delivering efficiency savings and managing the costs of transition, and possibly of greatest concern, supporting the Acute Trusts and Primary Care Trusts that are in deficit, to maintain financial balance overall.

From 2011/12 to 2013/14, NHS London will contribute over £2 billion of efficiency savings<sup>10</sup> under the label of the NHS' national efficiencies programme QIPP – the Quality Innovation Productivity and Prevention programme.<sup>11</sup> In addition, around £13 million has been set aside for staff support and development during the financial periods 2011 to 2013, and around £7 million towards the costs of redundancy.<sup>12</sup>

The QIPP savings are set against the backdrop of a persistent and growing annual operating deficit across a number of Acute Trusts. Last year a deficit of £96m was reported across seven Acute Trusts in London.<sup>13</sup> However, this deficit must be seen in the context of an annual overall surplus of £442 million. Dame Ruth has stated that she is confident that, “we are not going to find ourselves in overall deficit, ...where we were five years ago...we will live within the targets that we have set and ...deliver a small overall surplus for the year (2012/13).”<sup>14</sup>

But if the Acute Trusts' deficits are not curbed, NHS London's contribution to QIPP along with service provision across the capital could be compromised. London has a high proportion of Acute Trusts that have yet to achieve Foundation Trust (FT) status. Only six of the 18 non-Foundation Acute Trusts in London are likely to make FT status by 2014/15.<sup>15</sup> Without this status, Trusts are likely to struggle to compete for business from CCGs, since they have not been able to demonstrate effective financial management and/or high service quality.

### Managing trusts' deficits

We have already seen the impact of the financial pressures some trusts are up against, particularly those brought on by unforgiving Private Finance Initiative contracts signed many years ago. The South London Healthcare NHS Trust, which runs three hospitals, (Queen Mary's in Sidcup, the Queen Elizabeth in Woolwich and the Princess Royal University Hospital in Bromley) was subject to the Government's Unsustainable Provider

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<sup>10</sup> London's projected efficiency savings under QIPP as approximately one billion in 2011/12, £600 million in 2012/13 and £500 million in 2013/14. See pages 12 and 13, Health and Public Services Committee Transcript 18 January 2012

<sup>11</sup> The NHS has plans to make up to £20 billion in efficiencies over a four-year period (to 2014/15), to deliver service improvements through The NHS reported £5.8 billion QIPP savings for 2011/12; £3.9 billion savings were reported in Q3 and £1.9 billion in Q4. The Chief Executive's annual report acknowledges the strong start to the four-year QIPP programme but notes ongoing challenges over the remainder of the period due to increased demands from an ageing population, and the increasing costs of drugs and medical technology.

<sup>12</sup> Page 16 Health and Environment transcript, 12 September 2012

<sup>13</sup> The Quarter, Quarter 4 2011/12, 21 June 2012, Department of Health: published as part of the NHS Chief Executive's annual report 2011/12. <http://www.dh.gov.uk/health/files/2012/06/the-year-and-q4-June2012accessible-version.pdf> Deficits for 2010/11 and 2009 were £19,839,000 and £2,868,000 respectively.

<sup>14</sup> Page 18, Health and Environment transcript, 12 September 2012

<sup>15</sup> Page 5, Acute hospitals in London: Sustainable and financially effective, February 2012, NHS London <http://www.nhshistory.net/SaFE-report-February-2012.pdf>

Regime in July 2012.<sup>16</sup> The Trust is facing financial difficulties spending a reported 14 per cent of its income on repayments to a large Private Finance Initiative (PFI) debt of around £2.5 billion. The Special Administrator's initial proposals are currently subject to consultation.<sup>17</sup>

Other Trusts are experiencing similar problems. In the summer (2012) media reported that Ealing Hospitals Trust was facing a similar fate.<sup>18</sup> Also the Barking, Havering and Redbridge University Hospitals Trust was reported to be earmarked by Government to be put on some form of special measures following warnings from the Care Quality Commission (CQC) that it was struggling to meet its financial commitments.<sup>19</sup> We understand that the CQC registration has since been lifted.

NHS London has set up a fund to help those Trusts that have historically experienced financial problems but have managed to 'put their house in order', bringing their in-year position into balance.<sup>20</sup> But what we are seeing are those remaining small number of trusts for whom it would appear, solutions to their problems lie beyond a financial injection to stimulate cash flow.

A range of contributory issues to "profound structural problems" will prevent some Trusts from making FT status in their own right, were highlighted.<sup>21</sup> Over the years, money has continued to be allocated to hospitals regardless of location or suitability to service the local population, failing to take account of changing demographics. The lack of foresight in signing up to long term contracts possibly without detailed thought or provision for changing economic times has contributed to the problem.

We heard that "this has been a long-run thing, which we have not faced up to as a system, either in London or nationally, and it is about time we did."<sup>22</sup> New structures will be in place in five months time. A clean slate will need to be created, possibly using methods that will cause financial pain in the short-term, such as extricating affected trusts from onerous contracts, to deliver long-term gain. However, what will be critical is to ensure that trusts do not find themselves in such a position again.

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<sup>16</sup> For more information about the regime and the Trust's position, see:

<http://mediacentre.dh.gov.uk/2012/07/12/south-london-healthcare-nhs-trust-to-be-put-into-the-regime-for-unsustainable-nhs-providers/>

<sup>17</sup> The public consultation was launched on 2 November and will close on 13 December.

<http://www.tsa.nhs.uk/>

<sup>18</sup> 26 June 2012 <http://www.telegraph.co.uk/health/healthnews/9356064/Six-other-NHS-trusts-at-risk-of-bankruptcy.html>

<sup>19</sup> 26 June 2012 <http://www.guardian.co.uk/society/2012/jun/26/health-trust-financial-danger-list?newsfeed=true>

<sup>20</sup> Page 18, Health and Environment Committee Transcript, 12 September 2012

<sup>21</sup> Page 19, Health and Environment Committee Transcript, 12 September 2012

<sup>22</sup> Page 21, Health and Environment Committee Transcript, 12 September 2012

**Key consideration** for further follow-up at our February 2013 meeting: NHS London's focus is on working with poorer performing Trusts to improve their productivity. But even with this support some trusts will not rapidly make it as Foundation Trusts in their own right. For some in that category, their problems will be resolved through mergers or integrating the services they provide with a wider range of services, including mental, community and local services. Luton and Dunstable Hospital NHS Foundation Trusts is one example that was cited. But, we were told, there will be some that will still not make it. Our immediate concern is therefore for the residents and patients in those areas – to ensure that they have access to good quality of care and are not in any way disadvantaged. But London Government's leverage is weak here.

Equally pressing is the question of how a strategic overview of Trust finances will be maintained once NHS London is gone. Again Londoners could expect to look to their Government for such an overview: but at present the ability to generate this is not available.



### Public health funding allocations

Nationally, around £5.2 billion, approximately four per cent of total health spend (£92 billion), will be allocated to public health, with £2.2 billion going to local authorities, £2.2 billion to the NCB, £220 million to Public Health England and £600 million to the Department of Health.

London was set to receive 21.2 per cent from the total (local authority) funding pot. The figures from the Department of Health (DH) baseline estimates public health spend per local authority area for 2012/13, show a wide variance in London borough allocations.<sup>23</sup> Some London PCTs are in line to receive up to six times more than others, with allocations ranging from £4.7 million to £29 million per borough. This equates to a variation of £102 per person with borough level spend ranging from £20 to £122.

Interim recommendations published by the Advisory Committee on Resource Allocation (ACRA) in June 2012, if adopted, will result in a reduction in London's share of the funding, from 21.2 per cent to 17.6 per cent.<sup>24</sup> While some boroughs will benefit from the new allocations, the overall outlook for London is not welcome. The Mayor and Chair of London Councils have expressed their concerns about the likely impact the reduction will have on resources and the ability for boroughs to provide vital services such as for sexual health and drug misuse, in a joint letter to the former Health Secretary.<sup>25</sup>

**Key consideration** for further follow-up at our February 2013 meeting: ACRA's proposed reduction in funding for London raises concerns about whether boroughs at the lower end of allocation will receive enough to fulfil their new responsibilities in 2013/14. Duncan Selbie, Chief Executive of Public Health England has said that he hopes that final formula and funding allocations are announced in November. The two key concerns for London will be to ensure London receives its fair portion of funding overall and that it is equitably distributed at borough level to match funding need.

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<sup>23</sup> Baseline spending estimates for the new NHS and public health commissioning architecture, Department of Health, February 2012  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132535](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132535)

<sup>24</sup> Healthy Lives, Healthy People: Update on Public Health Spending, Department of Health, June 2012  
<http://phbulletin.dh.gov.uk/2012/06/29/public-health-funding/>

<sup>25</sup> <http://www.lgcplus.com/topics/health/boris-wades-in-to-public-health-funding-row/5049431.article>

### III. Maintaining quality of care

As part of the transition of healthcare services there are various proposals to reconfigure local services to deliver efficiencies and improved care. The public consultation launched by North West London NHS Trust set out plans to concentrate accident and emergency departments (A&E) and emergency surgery units on five sites in the region as opposed to nine, effectively closing A&E departments at Charing Cross, Ealing, Hammersmith and Central Middlesex hospitals.

A&E restructures across other parts of London are at various stages of consideration – St Helier Hospital in Carshalton, King George in Ilford and Chase Farm in Enfield – are earmarked for closure. The A&E unit at St Helier was recommended for closure in May 2012. A 12 week public consultation due to start in the autumn has been deferred. The A&E units at King George in Ilford and Chase Farm in Enfield are due to close in early 2013 and in autumn 2013 respectively.

The proposed closures will impact on a significant proportion of London's residents. The priorities must be to ensure:

- The capacity of remaining units to deal with the increase in patients, such as the increased demands on resources, and the potential for increased waiting times;
- Hospitals do not become vulnerable to closure per se because it does not provide an A&E service;
- That response times are not compromised. Journey times are likely to increase and impact on emergency response resources;<sup>26</sup> and
- That adequate transport links are in place or introduced as appropriate.<sup>27</sup>

The London Ambulance Service (LAS) has confirmed that it will need to make allowances for longer journey times that may result from A&E closures, as over 90 per cent of their journeys are under non-emergency conditions i.e. without blue lights and sirens, and in normal traffic conditions. Further investment might be needed to deal with longer journey times and ensure the continuation of a safe service.<sup>28</sup> These issues will be raised at the Committee's December meeting on the reorganisation of A&E care.<sup>29</sup>

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<sup>26</sup> Campaigners have warned that patients could face 45-minute journeys for emergency treatments if the closures go ahead. London Evening Standard <http://www.standard.co.uk/news/health/it-could-take-45-minutes-to-get-to-ae-as-units-close-7959287.html>

<sup>27</sup> This has been experienced in other parts of London, as raised by Roger Evans AM during an Assembly plenary debate (11 July 2012). See <http://www.london.gov.uk/moderngov/ieListDocuments.aspx?CId=0&MId=4503&Ver=4>

<sup>28</sup> London Ambulance Service written submission to the Health and Environment Committee, 4 September 2012

<sup>29</sup> This meeting will take place on 12 December 2012 at 2.00 pm. For more information see <http://www.london.gov.uk/moderngov/ieListDocuments.aspx?CId=256&MId=4619>

## IV. Strategic overview post April 2013

The Assembly supports NHS London's ability to provide a strategic overview of London's health economy. Post April 2013 a number of significant challenges will remain for both healthcare and public health delivery. A strategic overview is therefore needed to ensure successful delivery of the reforms, that the health equalities agenda is delivered, and that there is transparency of decision-making and accountability of decision-makers.

However, NHS London will be abolished and both The King's Fund and NHS London have highlighted the strategic vacuum this will create in terms of identifying a lead for future region-wide service reconfigurations and service improvements in areas such as cancer care and the quality of acute and emergency care in evenings and at weekends.<sup>30</sup> The NCB will have a London hub, but its role will be to implement national policies, and commission services at a London-level, rather than to deliver service reform.

The role of Regional Director of Public Health (currently a role within NHS London), will no longer exist under the new structures. The GLA Act specifies that the Regional Director of Public Health or similar person should be the statutory health advisor to the GLA; it is still unclear who will fill this post.

**Key consideration** *for further follow-up at our February 2013 meeting: How can London Government ensure that there is a strategic overview of the regional health economy and what institutional arrangements need to be put in place to ensure that this happens?*

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<sup>30</sup> [http://www.kingsfund.org.uk/publications/london\\_health\\_review.html](http://www.kingsfund.org.uk/publications/london_health_review.html) ; Transcript of the Health and Public Services Committee meeting with NHS London – January 2012 available at [www.london.gov.uk/assembly](http://www.london.gov.uk/assembly)

## Conclusion

Delivering a legacy of service improvement is a key priority for the outgoing NHS London Chief Executive, but this will undoubtedly be challenged by the transition to the new emerging system and targets for efficiency savings.

We have highlighted our continued concern about what happens to Trusts that fail to make Foundation Trust status, and in particular what will be done to maintain quality standards, staff and patient safety in any failing organisation. There are also concerns about equality in care standards across the capital.<sup>31</sup>

There are separate but linked concerns over the sustainability of the current configuration of Acute Trusts in London. When the new focus on concentrating specialist care in a few hospitals<sup>32</sup> is combined with the need to make major efficiency savings, and the drive to provide more care out of hospitals, it seems likely that the current configuration of Acute Trusts will be unsustainable.<sup>33</sup> However, any changes will cause deep anxiety in many local communities unless they can be properly explained and validated.

The London hub of Public Health England (PHE), the London Health Improvement Board and the GLA Health Policy team will all have a role in improving Londoners' public health and reducing health inequalities. The Assembly supports the establishment of a London Health Improvement Board and will continue to press the Mayor to ensure that he prioritises its creation

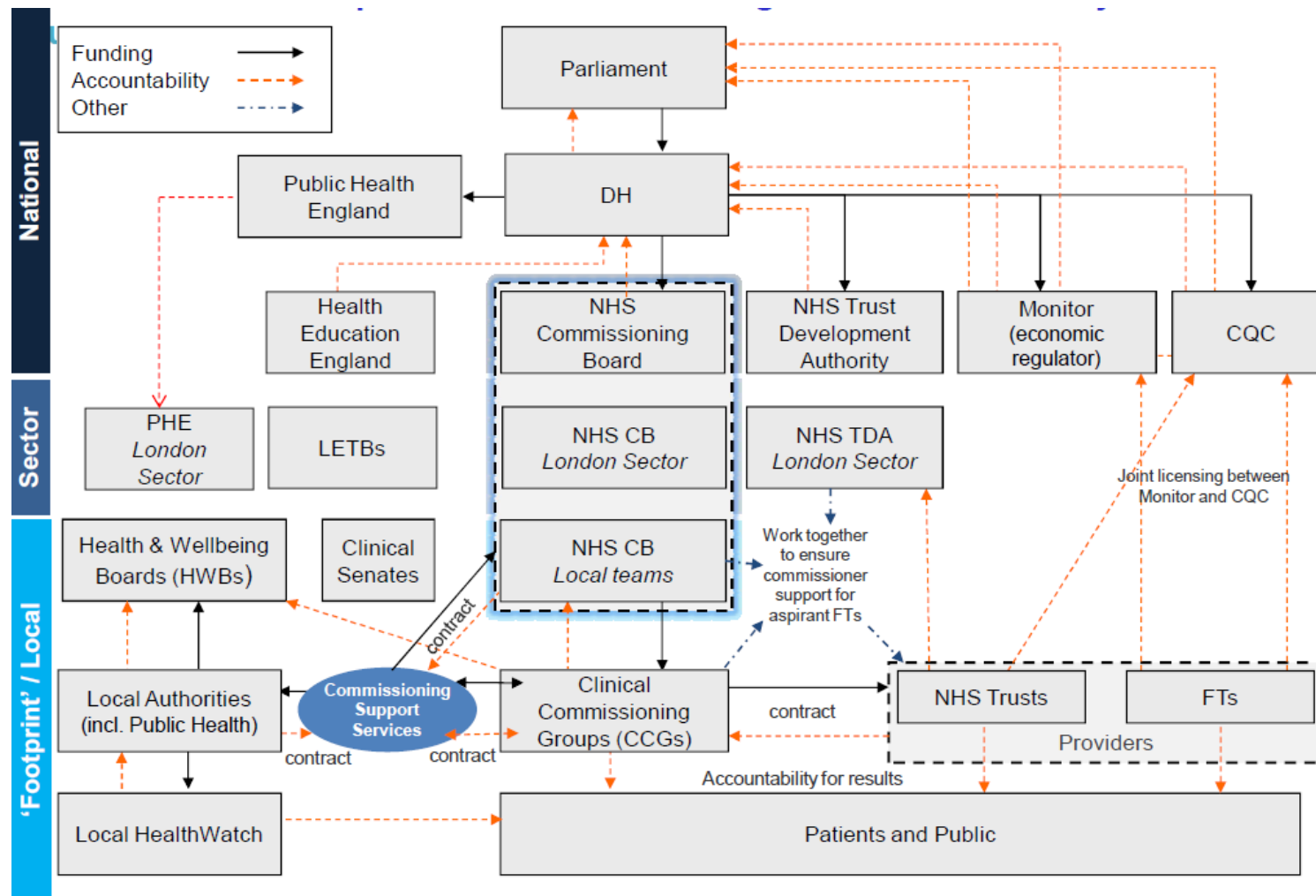
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<sup>31</sup> The population size to be served by newly formed CCGs are estimated to be around 32,000 larger than served by existing PCTs. The average CCG population will be c. 275, 450. The average PCT population is c. 243,724. There will also be an increase in the South West and the North East regions. Page 6 Health Service Journal, 31 May 2012

<sup>32</sup> Changes to the models of care for stroke and major trauma that focus specialist care in a few hospital locations have shown improvements in patient outcomes, and similar changes are likely for other conditions.

<sup>33</sup> Acute hospitals in London: Sustainable and financially effective, February 2012, NHS London  
<http://www.nhshistory.net/SaFE-report-February-2012.pdf>

## Appendix 1 The emerging NHS and public health structure



Source: NHS London

## Appendix 2 Emerging Clinical Commissioning Groups in London



Source: NHS London

## Health and Environment Committee

Murad Qureshi (Chair)	Labour
Jenny Jones (Deputy Chair)	Green
Andrew Boff	Conservative
James Cleverly	Conservative
Nicky Gavron	Labour
Stephen Knight	Liberal Democrat
Kit Malthouse	Conservative
Onkar Sahota	Labour
Fiona Twycross	Labour

## Views and information

The Committee met the following guests on 12 September 2012:

- Dame Ruth Carnall DBE Chief Executive, NHS London
- Dr Simon Tanner Regional Director of Public Health, NHS London and Health Advisor to the Greater London Authority
- Dave Buck Senior Fellow, Public Health and Inequalities, the Kings Fund
- Professor Adrian Renton Director, Institute for Health and Human Development, University of East London
- Amanda Coyle Assistant Director of Health and Communities, Greater London Authority

The transcript of the discussion is available at:

<http://www.london.gov.uk/moderngov/ieListDocuments.aspx?CId=256&MIId=4616>

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