BMJ

BMJ 2013;347:f4711 doi: 10.1136/bmj.f4711 (Published 29 July 2013)

EDITORIALS

Leading healthcare in London: time for a radical response?

King's Fund report should have been even more radical

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London's health services have not been short of reviews, blueprints, and plans over the past 20 years.[1 2] The latest, published by the King's Fund,[3] describes the current healthcare landscape across London within the context of the new NHS and the progress made in implementing Lord Darzi's recommendations in his 2007 report, *Framework for Action*.[2] Developments in London since 2011 are outlined in this new report. Most notable is the step change in outcomes for patients with stroke, after the major reorganisation of stroke services.[4] The attempts to integrate services across whole systems are also described, but it is too early to assess their effect.[5] However, we do know that London compares poorly with the rest of England with respect to its hospitals' progress towards foundation trust status, proposed service reorganisations continue to falter in the face of sustained public opposition, and Lord Darzi's vision to deal with the variation in quality of primary care has gained little momentum. In sum, the NHS in London is already in a "difficult situation" at a time when it is also establishing the complex web of new bodies that comprise the new NHS.

By so clearly describing all the new structures and their remits, this report exposes some of the fundamental problems now facing the new NHS in London (and, the authors argue, elsewhere in England but to a lesser extent). These include overlapping and unclear roles (for example, NHS England's London office, the London Clinical Senate, and the London Clinical Commissioning Council are all concerned with service reconfiguration), the creation of new silos, and—crucially—the dismantling of system leadership. We hardly need reminding that these changes come at a time of severe financial and service pressures, have resulted in the loss of experienced leaders, and are "compounded" by the health secretary's decision to "halt work in train" implementing the Darzi recommendations.

The authors therefore argue that "a radically different approach is required." Their prescription is to draw on the reforms implemented by the Veterans' Health Administration (VA) in the United States. When faced with similar challenges, the VA established integrated service networks that received population based capitated budgets to deliver care and were expected to meet quality and outcomes performance targets. The administration's headquarters acted as the funder of services and reviewed performance. The authors argue that this model could be adapted to London with a city wide strategic funder or commissioner and three provider networks. These could be based on the academic health science networks (AHSNs),[6] one of the recent major developments described in the report, of which there are three covering London. Competition, led by the strategic commissioner, would be facilitated through the use of benchmarking data. While this model would not require further structural change, the authors propose that London should be exempted from the regulatory regime being established across the rest of England—that is, rules on competition and mergers would need to be suspended.

The proposal to introduce a system wide, population based, capitation budget based on outcomes rather than on activity will be attractive to those commissioners who are beginning to embrace a population health perspective. However, this model is also built on a strong provider lead that, as the authors themselves acknowledge, risks "perpetuating a health care system which has traditionally favoured the acute hospital." Secondly, they acknowledge that this model depends on a willingness to plan services for the greater good of the population. Although the AHSNs can demonstrate precedence here (that is, with respect to their role in the reorganisation of acute stroke care), this remains a big ask for organisations with competing interests.

While these proposals are interesting, they do not go far enough. Why not, for example, consider the abolition of the purchaser-provider split?[7] Why not question the need for such a complex and costly regulatory system for the market in healthcare? We would also argue in favour of networks of providers that would be given population based capitated budgets. However, we also suggest that they should be expected to meet local and national standards monitored by a much simplified structure of regional and national bodies comprising the range of stakeholders concerned with public health and

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healthcare, including patients, and health and social care professionals. Many of the new organisations created by the reforms would not need to exist, saving management costs. We might also think more radically about how to improve the variation in quality of primary care, assiduously neglected by successive governments. For example, we could think through the implications of these provider networks providing the full range of health and social care services needed, by directly employing general practitioners and other primary healthcare professionals, and even social care professionals. With thoughtful incentives within these networks, real progress could be made in rectifying the imbalance between care undertaken in and out of hospital.

For these proposals to work, more nettles need to be grasped. These include the need for an independent "broker" to oversee major changes involving providers with competing agendas, and for robust information systems to monitor the repercussions of such changes at one point in the system on health and social care services elsewhere in the system. Finally, the role of the public is underplayed in this King's Fund report, and no organisation will be "free to reconfigure services" until we change the nature of public conversations about healthcare provision.

Competing interests: We have read and understood the BMJ Group policy on declaration of interests and declare that RR is programme director in population health for UCLPartners, which is one of the three AHSNs serving London. We declare no other competing interests.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Tomlinson B. Report of the inquiry into London's health services, medical education and research. HMSO, 1992.
2 NHS London. Healthcare for London: framework for action. NHS London, 2007. www.londonhp.nhs.uk/wp-content/uploads/2011/03/A-Framework-for-Action.pdf.
3 Ham C, Edwards N, Brooke B. Leading health care in London: time for a radical response. King's Fund, 2013.
4 Hunter RM, Davie C, Rudd A, Thompson A, Walker H, Thomson N, et al. Impact on clinical and cost outcomes of a centralized approach to acute stroke care in London: a comparative effectiveness before and after model. *PLOS One* [forthcoming].
5 Nuffield Trust and Imperial College London. Evaluation of the first year of the inner north west London integrated care pilot. Nuffield Trust in partnership with Imperial College London, 2013.
6 Fish DR. Academic health sciences networks in England. *Lancet* 2013;381:e18-9.
7 West D. Sir David Nicholson announces major review of NHS strategy. *Health Service Journal* 6 June 2013. www.hsj.co.uk/news/commissioning/exclusive-sir-david-nicholson-announces-major-review-of-nhs-strategy/5059398.article.

Cite this as: *BMJ* 2013;347:f4711