Transcript of the Q&A with NHS commissioners

On 7 December 2016, Healthwatch Richmond held an event 'Major changes in the NHS'.

The meeting included an hour of questions and answers with commissioners. Below is an edited summary of these:

Richmond's Financial Recovery Plan

Q. What are the exact local changes to treatments? How are they decided upon?

A. We have great clarity of budgets, and use data to drive decisions – we can see where Richmond is an outlier in cost, and where it is a high referrer to a particular service.

Our policy changes have been discussed in board meetings, and are published in full in the Governing Body papers on our website. We've created an easy to read version of these.

As examples of what we've already looked at, Richmond spends £150,000 per year on bunions surgery, and £300,000 on sleep apnoea. There are studies that show 30% of those who've had a knee operation regret it, and a number of people could avoid a knee operation if they lost weight.

We've also considered grommets, varicose veins and tonsillectomies, where we are an outlier compared to south-west London. Thresholds are set in order to inform doctors' decisions. When there are changes, beyond regular business as usual change, we consult the public.

Q. These things affect patients' lives, how can you take them away?

A. As a GP, sometimes I have to tell people they don't need an operation, and other times I will tell them they do require an operation. On occasions, I and my patients do not agree. There is a lot of evidence from NICE and the Royal Colleges behind clinical judgement. We also have decision aids such as the Oxford Knee Score, which help decide each case for knee treatment.

Q. How will you involve local people in the changes?

A. We always involve patients and Healthwatch. We will continue to do that. We will have broader consultation and will shortly publish a survey that people can complete. (The survey has now closed. A full consultation on the IVF changes will follow shortly.)

Q. If your strategy fails, what's Plan B?

A. If we're not able to make the changes, there may be another tier of services where could we make further adjustments. We plan to exit 2017-18 in a sustainable position. If we're not able to do this, we will be directed by NHS England.

South West London's Sustainability and Transformation Plan

Q. Can you specifically outline the care that will contribute to achieving a '44% reduction in acute inpatient bed days' across south west London? What will happen to hospitals?

A. The new models of care are around locality teams and intermediate provision will contribute to this. We've modelled a reduction in inpatient bed days. We did a review in January of all the patients in acute care in south west London who didn't need to be there – it was 44%, though the figure was not surprising. Some of that was down to services not being in place so that patients could be elsewhere, some of it the efficiency not being in place to discharge patients quickly.

We are still doing the work on care locations. Our best working hypothesis, to be tested, is to have four district general hospital sites in south west London. The only fixed point is St Georges because it is a major trauma site. This is ongoing work and we're engaging with the public.

We'll try not to send some people into hospital in the first place, particularly older people and those with dementia. It's better being in familiar surroundings - most patients prefer being at home or close by.

Q. Will you commit not to make any closures until new facilities are available?

A. Yes. Nobody has made any reference to closures. We believe in light of the work there is to do – the financial and estate challenges - any changes would take quite some time and we have to think about how hospitals are safe. No decisions have been made.

Q. What is the plan for localising health services? Where will specialist services be?

A. A good example [of centralised services] is trauma – St George's Hospital is a trauma centre, and ambulances drive past other hospitals to get there. Rather like this, not all services have to be delivered on all sites – and this helps deliver the best care where we have it.

In local terms, we are developing plans in the four hubs in the borough [Teddington and Hampton, Twickenham and Whitton, Richmond and Kew and Barnes and Mortlake], each of which has about 50,000 people. We're working with Hounslow and Richmond Community Healthcare Trust for a 'hub-plus' model, so we can create a thorough locality proposition.

We recognise there is a gap on one side of the borough, and we're looking at how Barnes and Ham have the same opportunities.

There is funding for these changes. In the period to 2021, there's £54m available for making the locality changes, but we have to start the changes to access that money. There will also be some 'double running' of costs in the interim while we develop new services.

Q. You talk about encouraging people to look after themselves better by, for example using pharmacies as a first point of care for smaller issues, but a number of Pharmacies are expected to close due to funding changes. Where should we go?

A. We are absolutely committed to primary care. We don't commission pharmacies - NHS England does. There is a suggestion some pharmacies may be less viable, with a consequence for their funding, but many remain a crucial first point for patients.

Q. Patients have a lot of concerns around getting appointments. How will the 111 phone number help solve these issues?

A. Last year, 111 activities increased by around 15% in this borough. There is a selection of dedicated appointment slots at GP hubs for people who call 111, just as there is for those who visit their pharmacist. The 111 number is also being piloted elsewhere as an appointment 'front door' to the NHS.

Q. Can you seriously believe that closing sites will not affect services? Why cut services when they are already limited?

A. There's a lot of wastage throughout the system. In my GP surgery, of the 40 phone calls I made recently, about three needed a GP. Most could have seen a pharmacist or called 111.

Q. The Royal College of Emergency Medicine says the STPs could be catastrophic. Are you listening to clinicians?

A. This has been a clinically-led process. All the local provider organisations have been involved. What we believe is that patients would prefer to have services closer to home, to go to hospital when they need to, and be discharged efficiently. There is a clinical, quality and financial case for change. We've had large meetings with GPs, with very robust discussions. Everything is evidence based.

Q. Can the changes be afforded?

A. The NHS is delegated an amount of money. In an ideal world we would have as much money as possible for the NHS. It's not the world in which we live.

We believe we have a strong plan to address workforce, quality, estates issues. It's a huge change. We are going to give it our best shot within our financial windows. We have a responsibility to do this. We shouldn't be afraid of new ways of working.

Q. The STP has a section on emergency care. It talks about the reduction of emergency beds, longer journeys to hospital, and a longer wait for handover. Will this result in deaths?

A. There's no evidence that it will cause deaths. We remain committed to meeting national targets that state 95% of patients – arriving by ambulance or within A&E – must be seen within four hours. Everyone is assessed, and treated in order of clinical priority.