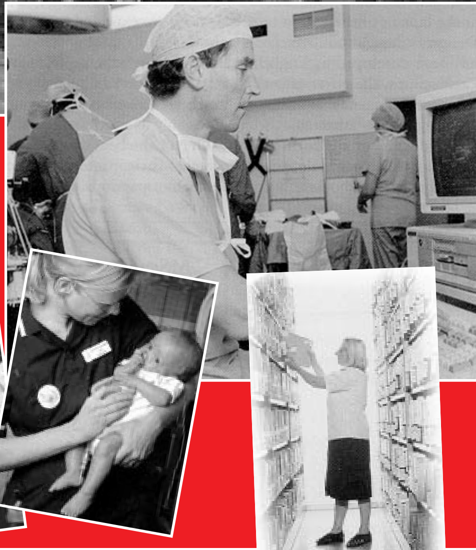


SW London hospitals Under PRESSURE

Researched and written for BWTUC by JOHN LISTER, Information Director of London Health Emergency

Published by Battersea and Wandsworth TUC

Under **Pressure**

A survey of health services in South West London (the new Strategic Health Authority area, covering the six London Boroughs of Wandsworth, Merton, Sutton, Kingston, Richmond and Croydon). Researched by JOHN LISTER of London Health Emergency for Battersea and Wandsworth Trades Union Council.

Introduction

Health services in South West London have been ripped apart by more than two decades of systematic underfunding, cuts, closures and privatisation. Capacity has been cut to the bare bones and the pressure on the remaining services has been jacked up to dangerous levels.

Staff pay has been held down to scandalously low levels, with the end result that hospitals like St George's are racking up multi-million pound deficits in agency fees as they try to balance the books. Hundreds of other staff have seen their jobs knocked down to the lowest bidder in the dash to privatise.

This was the year that we were supposed to turn the corner. Gordon Brown had pledged that budgets would be increased and that rather than cuts, service improvements would on the agenda. This report shows in graphic detail that not only has that not happened in South West London but that, in fact, our hospitals and primary care services are staring down the barrel of multi-million pound deficits that will require further cuts to balance the books.

Battersea and Wandsworth TUC represents not only those who work in our health services but those who use them as well. Our fight for high quality public services runs alongside our fight for decent wages and housing for the people we rely upon to run them.

This report will be used as a campaigning tool to argue the case for the investment that we need to drag services up to an acceptable level.

We are the real modernisers, not the accountants, bureaucrats and cuts merchants who have dragged us in to this shambles.

Geoff Martin
Battersea and Wandsworth TUC
Lead Organiser
February 2003

Executive summary

THE CURRENT cash crisis facing the main hospital Trusts in SW London – a £5-£7m deficit at Epsom/St Helier, £4m-plus at St George's, and an underlying recurrent £3.9m-plus deficit at Kingston – are the latest symptoms of years of under-funding of health services in SW London.

The body of the report shows the consistent pattern of under-resourcing and crisis measures running back to the early 1980s.

● The area has now received a below-average increase in spending for the next 3 years, with Wandsworth facing an estimated £5m shortfall over that period as a result of a new funding formula.

● The StHA calculates that more than 300 extra beds are required to meet local pressures over the next 3 years, but current plans fall almost 200 beds short of this – forcing health chiefs to contemplate sending local people to out-of-area NHS Trusts or costly private beds in order to meet government targets.

● The situation will be compounded in April by the imposition of the government's new London Patients Choice policy, which will encourage patients who have been more than 6 months on waiting lists to opt for treatment elsewhere: given the lack of local capacity in SW London, this will inevitably siphon even more cash out of the budgets of local Trusts.

● Local Trusts continue to be destabilised by sky-high spending on agency staff to fill nursing and other vacancies. But the diversion of more NHS patients for private sector treatment will further intensify the competition for scarce nursing and professional staff – worsening the plight of the NHS Trusts.

● The latest ill-conceived plans to replace Epsom and St Helier with a single PFI funded hospital to cover 800,000 people would have dire knock-on consequences for overstretched services at St George's, Mayday and Kingston.

● The most likely site for a single site hospital, the Sutton Hospital site, is too small to accommodate the number of beds and other supporting services that would be required to deliver adequate care to such a large catchment population, and the financial consequences for a health economy that is already reeling under existing pressures would be disastrous.

The report concludes by offering a number of recommendations:

● Runaway costs of employing agency staff to plug gaps in the full time NHS workforce have to be tackled. Because of national agreements covering NHS pay, this cannot be done at local level: it requires a fundamental rethink of government policy, including a substantial uplift in London weighting and a further increase in the pay for all grades of nursing staff. In addition, NHS Trusts must begin to take seriously the need for more flexible and family-friendly policies to enable them to retain and attract back nursing and other staff who prefer to work part-time or particular hours to suit family responsibilities.

● There is an urgent need for a thorough and independent audit of the financial situation in all local NHS Trusts, to establish a realistic baseline budget that will sustain the necessary level of services – and the additional money must be made available, to ensure that services are expanded as required on a stable and sustainable basis.

● This audit must also include the allocation of sufficient resources to enable the Trusts to build, staff and operate the additional 200 beds that have been identified by the Strategic Health Authority as required to deliver government targets for access, quality and waiting times.

● Any planned deals with private hospitals should be abandoned, and priority should be given instead to the most rapid possible expansion of local NHS capacity, alongside longer term plans for the renewal of old and obsolescent buildings.

● Privatised support services which generate profits at the expense of low pay for staff must be brought back in house, with staff properly reincorporated into the NHS team

● With the government currently able to borrow money on the international markets at 2% interest or even lower, all PFI schemes should be abandoned as too costly and inflexible to suit the needs of the NHS. Instead the government should make NHS capital available – if need be as a long-term low-interest mortgage – for the further upgrading of Epsom, and a new publicly-funded hospital to replace St Helier, and local treatment centres to complement the services already available in smaller local hospitals.

A local health economy in crisis

The South West London Strategic Health Authority, which was launched in April 2002 after a merger of three former health authorities, oversees a budget of £1.2 billion to cover the health needs of 1.3 million residents. The NHS in the six SW London boroughs employs 22,000 people.

By the autumn of 2002, just six months after it was launched, SWLStHA was reporting combined debts of £19.7 million, affecting the six hospital Trusts (£12.1m) in the area and the five Primary Care Trusts (£7.6m). A major driving force in this economic instability has been the chronic problem of staffing, most notably among nurses and other professional staff.

London as a whole suffers from major long-term problems in recruiting and retaining staff, exacerbated by the inadequate London weighting allowance, well short of the £6,000 a year plus free travel which has helped stem the recruitment crisis of the Metropolitan police. A recent official NHS report declared that the capital's Trusts and PCTs spent a thumping £446m on agency staff in 2001-2, half of it on nurses: but the situation has worsened, and the agency costs have soared even higher since those figures were compiled.

By the beginning of 2003, three of the four major hospital Trusts serving SW London were facing hefty deficits or wrestling with uncontrolled costs of agency staff:

Deficits

Epsom & St Helier Hospitals Trust admitted a £5m deficit, with staff under instruction to cut orders for stationery and avoid replacing office equipment, amid strong rumours that the shortfall may actually be as high as £7m. Other panic measures to balance the books include siphoning cash from capital into revenue this year and next, effectively scrapping smaller maintenance and development projects.

St George's Trust admitted a £4m shortfall, having parted on acrimonious terms with its former director of finance, Ian Perkin, who had incurred the wrath of the Trust board for exposing fiddled figures on cancelled operations and pointing out that the Trust would not be able to make savings of over £4m during this financial year. As recently as September 2002 more than half (51%) of all St George's 7,300 A&E patients waited longer than the government's target 4-hour maximum, compared with 44% at Kingston, 25% at Mayday and 23% at Epsom & St Helier.

Kingston Hospital reported in January that its budget for agency nursing staff of £1.4m was already overspent by £5 million, with the Trust as a whole projecting a break-even position only as a result of additional hand-outs totalling £1.9m from local PCTs and the StHA. The £3.9m of savings required during 2002/3 had all been one-off measures, leaving an unresolved problem for next year, with a "minimum recurring financial deficit of 5%" on a budget of £130 million. The Trust had got through the early winter "peak" of demand for emergency services only by opening 31 additional beds to save patients having to spend the night in A&E.

It seems as if there is more pressure to come, with additional tough targets for improved performance due to come into force in the next financial year, but insufficient new money to enable Trusts and PCTs to achieve the necessary expansion.

A symptom of the pressure faced by local Trusts came when it was revealed in October that emergency work at the specialist Pelvic Trauma Unit at St George's hospital – the only unit of its type in London – had been halted to make room for the treatment of more waiting list patients. Trust bosses intervened to insist that the treatment of pelvic trauma patients – mainly car crash victims – was bottom of the Trust's priorities with beds so scarce. Patients from other parts of the country should be admitted only when and if there was spare capacity.

Two days after pelvic trauma specialist Martin Bircher spoke out against the cutback in his unit's ability to treat severely injured patients, another outspoken St George's consultant, IVF specialist Geeta Nargund, was suspended after protesting at chronic shortages of specialist staff. She was told to have no further contact with her patients and not to talk to newspapers or the media. The suspension was denounced as unfair and unprecedented by Professor Stuart Campbell, a former colleague who had helped set up the Princess Diana of Wales Centre for Reproductive Medicine four years earlier.

The toughness of the regime in St George's was

underlined two months later with the sacking of Trust finance director Ian Perkin, who had warned that Trust cash savings targets were unrealistic, and who had supported a junior colleague who had protested at being asked to falsify figures on cancelled operations.

Behind the panic measures at St George's and the crisis in the Trusts lies an underlying financial problem that has not been resolved by the government's injection of new money into the NHS since last year. Indeed the new financial allocations announced for the local PCTs over the next three years are all below the national average uplift, giving an increase in SW London next financial year of 8.39% overall, with Croydon getting a higher rate of 8.7%, and the other three PCTs all getting just 8.3% – compared with an English average of 9.2%.

New formula

Wandsworth council in particular has complained that the Wandsworth PCT allocation has scaled down to the national minimum increase for the next three years – equivalent to £5 million of cash that will not be forthcoming to commission local services – as a result of a new funding formula.

As a result of this and other cash pressures, the StHA has concluded that the funding of the increased capacity required to deliver the government's targets in 2003/4 presents an "extremely challenging" financial scenario. The necessary additional activity to meet waiting time targets is costed at between £7m and £16.5m next year, with the need for an additional 76 beds. A further 56 extra beds (and funding) will be required in 2004/5 and 63 more beds in 2005/6.

The challenge is greater because two thirds of the extra beds are required to cope with projected emergency admissions, while SW London Trusts are expected to run at full tilt, with an average year-round occupancy level of 90%, compared with a national assumed occupancy level of 82%. Experience elsewhere in London shows that such high levels of bed occupancy tend to translate into bed shortages and trolley waits at times of peak demand.

So even the fresh injection of funds into the NHS which began with the 2002 budget has not been sufficient to meet the mounting pressures on hospital services in South West London.

This report, commissioned by Battersea and Wandsworth Trades Union Council, and researched by John Lister of London Health Emergency, aims to explain how the local NHS got into this situation, and to indicate the type of policies that are needed to equip the people of South West London with a sustainable 21st century health service.

20 years of pressure

The last 20 years have seen health services in South West London under constant pressure, suffering a succession of damaging cuts, which have undermined their ability to cope with local demand for care.

The South West London Strategic Health Authority, launched in April 2002, drew up a new Franchise Plan which acknowledged particular pressures on acute, nursing and residential beds, which, together with sufficient staff, are the key to delivering proper levels of emergency care and acute services in line with local demand.

In 1982, the five SW London boroughs had local access to 3,522 acute hospital beds (delivering emergency and waiting list treatment for short stay patients). By 1992, this total had fallen by over 26 percent, with further cuts continuing to erode hospital capacity in the last 10 years.

An even sharper reduction has taken place in the provision of long-stay NHS care for the elderly: in 1982 there were 1,368 "geriatric" beds across the five boroughs, but this number plunged by over 35% in the following ten years as the Tory government forced through its so-called "community care" reforms, and by a further 18% in the subsequent ten years to 2001 – giving an overall reduction of 47%.

The end of the 1970s were marked by hard battles against cuts in health care and hospital services in many parts of London, with key battles in SW

South West London Hospital beds

	1982 acute	**1992 acute**	**2001 acute**	**% change 1982-2001**
Croydon	616	562	538	
Kingston & Esher	524	375	571	
RTR	409	315	**22**	
Wandsworth	1109	851	770	
Merton & Sutton	864	515	616	
Totals	**3522**	**2618**	**2,516**	**-28.6**
	1982 geriatric	**1992 geriatric**	**2001 geriatric**	
Croydon	402	141	169	
Kingston & Esher	138	220	81	
RTR	296	167	85	
Wandsworth	194	160	159	
Merton & Sutton	338	195	230	
Totals	**1368**	**883**	**724**	**-47.1**

London including a 9-month occupation in an effort to save the popular St Benedict's Hospital from closure. The 1980s opened with the threat to close the South London Hospital for Women, one of the last surviving women's hospitals in the country, and the fifth hospital in Wandsworth to close in the previous five years. SWLHW was occupied by campaigners from July 1984 to March the following year.

The driving force behind the closures of beds and hospitals was the cash squeeze on health authorities, which was further tightened by Nigel Lawson's 1983 budget. Early in 1984 a GLC survey estimated that Wandsworth Health Authority was facing a £2.2m (2.6%) cut, adding up to a 3.3% cutback since the reorganisation of health authorities in 1982. Wandsworth HA plans included the axeing of over 300 jobs to balance the books.

Other SW London HAs facing real terms cuts included Kingston & Esher (£1m and Merton & Sutton (£1.6m).

Other hospitals in the area under attack included the Royal Hospital in Richmond, Cheam Hospital and the casualty unit in Merton & Sutton. 98 acute beds at Kingston Hospital were closed to save cash, while plans for privatisation that would axe jobs in support services sparked a 500-strong demonstration. In Croydon, Norwood Day Hospital was also facing the chop.

The squeeze on beds and services had pushed up local waiting lists across SW London to 15,466 in 1984, one in five of whom (3,203) had been waiting over a year for treatment. 18 years later, the numbers waiting had actually increased – to a March 2002 figure of 17,676: the big difference was the numbers waiting over a year, which had come down dramatically, to just 784 in March 2002, 4.4% of the total in the queue.

Only stooges need apply

1984 also saw revelations that the selection procedure used by SW Thames Regional Health Authority to choose members of District Health Authorities in SW London had been gerrymandered, with the Conservative Party drawing up a "hit list" of DHA members to be kept off at all costs – among them one Peter Hain, who was branded as "unacceptable" because he "attracted publicity".

But the 4-person Tory cabal charged with purging the health authorities of political undesirables were happy to nod through one Wandsworth DHA hardliner … who lived on his farm near Moreton in Marsh, Gloucestershire.

Later in 1984 came the publication of the SW Thames Region's 10-year plan, with proposals to axe front-line beds in its London districts by 23.5% – with a staggering 45% reduction in Merton & Sutton (down from 832 to 439 acute beds), and 48% in Wandsworth (down from 919 to 499). One of the healthworkers' unions (NUPE) in Wandsworth correctly warned that this would imply the loss of St James's Hospital and the Bolingbroke Hospital, leaving only St George's to provide acute services. Wandsworth DHA also faced the threat of a £20m cut in its budget over the next ten years.

Croydon was due to lose a quarter of its acute beds under the same plans, along with a cut of £3.5m from the budget and the axeing of 176 beds for the elderly. The *Croydon Advertiser* correctly warned at the beginning of 1985 that:

"It is possible only to be pessimistic about the health service. As with unemployment, the issue is long term: over the next 10 years, severe cuts will be made in the number of Croydon beds and we fear cuts may begin in 1985."

A few months later Croydon HA was so strapped for cash that it was contemplating charging patients for meals and renting out its clinic at evenings and weekends to private medical schemes.

1985 brought news that SW Thames region offered the lowest level of provision of elderly care anywhere in the country, with targets set in their 10-year plan falling a massive 40% below the planning norms set down in 1976.

Meanwhile in Merton & Sutton the Tory government's privatisation offensive had led to the domestic services at St Helier Hospital being handed over to private contractors Mediclean. Campaigners fought back with a weekly leaflet "Mole's Eye View", which set out to expose the plunging standards and other problems with the contract, after sending an undercover investigator into the hospital to work for a few days and check out the situation.

The resultant pamphlet "I was a Mole in Mediclean" was a best seller for London Health Emergency, attracting interest from trade unionists facing privatisation all over the country.

Driving away the patients

As the squeeze on SW London services tightened, early in 1986 Wandsworth HA's General Manager Enid Vincent gave a candid summary of the strategy she was adopting to a health authority meeting, when she said:

"The only way to improve services is to run them down to such a level that no one will use them, and people will go elsewhere."

The DHA admitted that savings on the scale required could only be made "by making reductions in the amount of service given". Wandsworth announced that it would not accept patients from outside the district for hospital treatment, while cutting back on weekend work in gynaecology and other wards. Children's beds were to be axed immediately at St James's Hospital, which was to close altogether by 1988, and more ancillary jobs were to be cut. In total the District's Operational Plan estimated that a minimum of 252 jobs, but as many as 690 whole time equivalent posts might go as they struggled to balance the books.

The first sign of opposition at management level to the constant round of cuts came in Croydon, where the DHA in the spring of 1986 told the SW Thames Region that it was not prepared to cut more than the 100 elderly care beds it had already closed. The Region had called for the closure of 180, with more patients being sent to private nursing homes.

There was no such resistance in Merton & Sutton where the summer of 1986 saw a consultation on a number of "options" – each of which involved a cut of £5m from acute services spending by 1994. But the situation worsened during the year, and in November the HA announced that it had already overspent by £1.25m in the first eight months of the year.

The same meeting announced the closure of the world-famous Queen Mary's Hospital for Children in Carshalton, along with other closures including the Wandle Valley geriatric hospital and 80 acute hospital beds. The bed closures contributed to a District-wide Red Alert on January 19, while the Wandle Valley closure was rammed through as an "emergency" measure, with just one month of "consultation", and resulted in over 70 frail elderly patients being uprooted and moved in sub-zero temperatures to strange accommodation on January 10 1987.

Staff feel the pressure

Pressure was mounting on front-line staff, and in spring of 1987 a group of nurses at St James's Hospital wrote to district nursing management complaining at inadequate staffing levels on five wards and in the busy A&E department. They argued that "patients are being put at risk because of the shortage of staff."

By the summer of 1987 Merton & Sutton, having seen their plans to axe Queen Mary's run into problems, announced a new £2m package of spending cuts for the current financial year, and admitted they could not forecast the scale of the cuts that would take place in 1988.

The consequences of the privatisation of support services at Queen Mary's Hospital, Roehampton were exposed by a survey for the health union COHSE, which warned that cleaning standards had dropped to "danger levels". A devastating report listed problems including bloodstains left on operating theatre walls, filthy toilets and sluices, rubbish left for days, and visible layers of dust. The survey, which took place after a new contractor took over in May from the failed Sunlight contract, showed that there was little if any improvement by switching from one firm to another.

In October 1987 Kingston & Esher HA warned of "traumatic changes to come" as the district ran into a spending crisis, while Wandsworth predicted a shortfall for the current year of up to £3m. By the spring of 1988 a NUPE survey found that one in five nursing shifts at St George's Hospital was running below minimum safety levels, with over half of all shifts staffed only at emergency cover levels.

A London Health Emergency survey for the 40th anniversary of the NHS in 1988 pointed to the increase in pressure on hospital A&E departments in the SW London area, with the imminent closure of 200 beds at St James's Hospital, to cut £5m and balance the acute services budget. To make matters worse, the planned closure of the minor casualty unit

at Purley was announced. The same survey showed Kingston Hospital struggling as a result of staff shortages in sterile supply services, which in turn had reduced orthopaedic surgery. Despite an increasing caseload, Kingston faced a 5-year budget cut of £3.1million.

The pressures were also mounting in Merton & Sutton, where 90 acute beds had closed in just 6 months of 1987, and hospital services lurched between red and yellow alerts.

Management in Richmond, Twickenham & Roehampton began to flag up the possible closure of Queen Mary's Hospital as a District General Hospital, while the HA grappled with an overspend from the previous year – and cancelled planned service developments.

Management complained that "having sold all our readily saleable properties", and with nothing left in the kitty, "without extra funds, the longer term position is not pleasant."

By the end of 1989, the scale of the bed cuts had forced up waiting lists in the area: Croydon saw a 16% increase in the 12 months to September 1989, with numbers waiting over a year up 73%; but was also facing a projected £1.6m deficit on a HA budget of £69m. Kingston's waiting lists had rocketed by over 29% in the same 12 month period, with numbers waiting over a year up by 81%.

Even where waiting lists were not soaring, the cuts were taking effect: Merton & Sutton were to axe 87 beds, close the Wilson Hospital and the remaining surgical ward at the Nelson Hospital to claw back a projected £2m deficit on a £77m budget.

Preparing for the market

Wandsworth was still £2.7m adrift on a budget of £105m, even after making £1.5m of cuts: 25 beds had closed, and service cuts included a 10% reduction in open heart surgery and the closure of 10 neurosurgery beds. By the following spring, Wandsworth was looking to cut its inpatient caseload by 3,900 to balance the books before the introduction of the Tory government's controversial market reforms.

1990 saw the loss of 95 beds for the elderly at Croydon General Hospital, and waiting lists soaring upwards in Croydon – up 39% over 15 months. Wandsworth began the year with the biggest single package of cuts to have hit the NHS in 42 years, with £9m to be lopped off spending, the closure of 153 beds and a day hospital, the loss of 260 jobs, and service cuts to include a 33% reduction in family planning sessions. In Merton & Sutton 100 beds closed during the year, forcing waiting lists up 6%, to almost 50% above the 1982 level.

The introduction of the Tories' internal market system was swiftly followed by the announcement that there would be an inquiry into London's hospital services, to be chaired by Sir Bernard Tomlinson, a retired pathologist who had chaired the Northern Regional Health Authority.

The inquiry was a transparent manoeuvre to postpone any further controversial closures until after the impending General Election. But to give Sir Bernard a few ideas for hospitals to close, the King's Fund published its own proposals for the axeing of up to 15 major acute and specialist hospitals and replacing them with a £250m network of "community health centres".

Among the long catalogue of factual and geographical errors and foul-ups in the King's Fund report was the failure to spot three of the 44 major acute hospitals currently operating in the capital (omitting a teaching Hospital (St Mary's), Harold Wood hospital in Havering, and Queen Mary's Roehampton.

Tomlinson proposes surgery

The Tomlinson Report was eventually published in October 1992 (only after being leaked to the press the night before by London Health Emergency). It proposed the closure of 4,200 acute beds in inner London, despite mounting evidence that the capital was already struggling as a result of bed shortages.

SW London could count itself fortunate not to have any hospitals on the hit list, though there was a grim warning that a further review of specialist services would affect more hospitals. Indeed the revised Trust opt-out bid drawn up by St George's Hospital at the end of 1992 included a passing reference to the closure of Atkinson Morley's Hospital, with services to be transferred to the St George's site.

By the summer of 1993 it was already clear that Queen Mary's Roehampton, the hospital the King's Fund forgot, was likely to be among the casualties of the specialties review, with the loss of its plastic surgery services. This in turn would reduce the caseload to QMH's A&E unit, which had already been challenged as 'too small' to remain viable.

But the SW Thames Region went one step further,

and set up its own Review of SW London hospital services, a review conducted within the framework of a new financial squeeze arising from the "capitation funding" formula in the Tory market reforms.

Wandsworth HA stood to lose £16m a year from its budget, the merged Kingston & Richmond HA £6.6m and Merton and Sutton £4.2m – an overall reduction of £26m. Only Croydon remained largely unscathed.

The Review came up with five options ranging from across the board cuts at all hospitals, to the effective total closure of two of the three non-teaching hospitals in the area – QMH, Kingston and St Helier. But Health Secretary Virginia Bottomley delayed any decisions, and the Review's final findings still had not been published by the end of 1994.

During this time the financial crisis of the now merged Merton, Sutton and Wandsworth HA had festered: the combined HA still faced a combined shortfall of £22m – but now two rival Trusts, St Helier and St George's, were battling it out for the lion's share of an inadequate acute services budget.

The Nelson Hospital was poised to lose its last few in-patient beds while plans were drawn up for the sale of the site. And the future of Atkinson Morley's Hospital remained in limbo, as major capital plans ground to a halt in the NHS following the introduction of the Tories' Private Finance Initiative.

In June 1994 the chief executive of Mayday Healthcare Trust reported "yet again an unprecedented rise in emergency admissions, and finding beds even in the height of summer is proving a problem." He promised management action and a full report. NHS funding was refused for an MRI scanner at Mayday, forcing the Trust to seek a private sector partner to raise the necessary investment.

Mayday, Mayday

By April 1995 Croydon Community Health Council's newsletter drew attention to a "beds crisis" at Mayday Hospital, pointing out that emergency admissions during January and February had been running 20-25% above the previous year, with increased numbers of trolley waits.

The CHC rejected management prevarication over whether or not more beds were needed, and insisted that "The bottom line is that a hospital like Mayday must be provided with enough beds to meet such contingencies" [as a surge in demand]. In fact the opening of extra beds for emergency admissions was still being debated in September 1997: by then levels of emergency admissions had risen still further, and were another 4% up on the previous year, with summer admissions running at winter levels.

The concerns over front-line services at Mayday had also been underlined during a CHC visit to the Cardiac Care Unit in February 1995, which found only 4 CCU beds to cope with demands from Croydon's 330,000 population – and insisted that at least 7-8 beds were required. The CHC also argued that cardiac care was under-funded.

May 1995 saw the publication of the Specialty Review on Neuroscience services, and again raised the threat of closure at Atkinson Morley's – held up only by the lack of any costings (or capital) for the move to the St George's site. The promised consultation paper failed to appear by the end of the year.

In October 1995, Croydon CHC complained of the effects of a "cash crisis" triggered by a funding gap in mental health services. But the winter of 1995 saw the beds crisis in SW London hospitals catapulted to public view, as six angry consultants got together to sign a letter to the South Thames Regional Health Authority, with a copy to *Hospital Doctor* magazine.

The consultants, from St George's, St Helier, Queen Mary's Roehampton, Kingston, Mayday and Epsom hospitals protested first and foremost at the "lack of beds across the SW London area and the detrimental effect of this on patients."

They went on to lift the lid on the government's confused thinking on hospital bed cuts and chaotic market reforms:

"There was a view that hospitals should continue to reduce beds as a consequence of increased day case surgery and increased community care and social services.

"However there is instead a steady increase in medical emergencies requiring admission and increasing difficulties in discharging patients. … In one hospital there has been a 22 percent increase in admissions through A&E compared with this time last year.

"These patients first fill the medical beds and then have to overflow into unsuitable beds in surgical wards: on December 4 one Trust reports 42 medical 'outlyers' in surgical wards, and one reported 90.

"When all beds are full, the emergencies (often very sick) log-jam back into A&E, 'overnighting' on trolleys which are insufficiently supervised, uncomfortable and extremely stressful for both patients and staff. … Neighbouring Trusts are unable to help, as

they face the same problem. …

"The financial issues of the 'contracting process' make the current situation more ridiculous. We had understood the philosophy of the reforms was 'money following the patient'. Instead Trusts struggling to cope with emergencies report that they are told by purchasers [Health Authorities] that they will not be paid for the extra work they do. One Trust reports they are owed £1.25 million for emergency work – the purchaser is declining to pay."

Medical directors in revolt

Early in 1996 this letter was followed up by an even more damning critique of the pressures on beds and emergency services, this time in a letter signed by every Medical Director in South Thames Region, and sent to Health Secretary Stephen Dorrell. In addition to reiterating the points from the earlier letter, this second text went on to urge the government urgently to review:

"The proportion of the GNP to be spent on health care. Currently this is second from bottom in the European Union.

"The concept of Care in the Community, with the shift of resources to Primary Care away from hospitals needs clarification. Where does the government's ideal pilot model exist? What are its costs?

"How much is spent supporting the bureaucracy, annual contracting and the purchaser/provider split?

"Encourage cooperation rather than competition across the various sectors of Health and Social Services."

By early 1996, St George's Trust had lurched £2.5m into the red, and been forced to cancel all waiting list admissions because of a shortage of beds. In a confidential document leaked to London Health Emergency, managers admitted that they could not cut this much from spending without affecting "the range and probably the quality of the services provided by the Trust".

Their plans included axeing 50 NHS beds, while pumping scarce cash into a new 26-bed private patient unit. But the document on the planned closure of Atkinson Morley's still hadn't been published.

In February 1996 UNISON published a detailed "Diary of Disaster", chronicling a year in the life of staff in the casualty unit at St George's Hospital. The document, taken from actual contemporaneous noted by staff shows the regularity of bed shortages, delays in treating patients, and the demoralising pressures on staff

Axe over Queen Mary's

Meanwhile there were fresh fears over the future of A&E services at Queen Mary's Hospital, Roehampton after an Audit Commission report declared that units handling fewer than 50,000 cases a year were no longer viable. QMH had been treating 36,000 cases a year, but this had risen to 43,000 by 1996. Managers from Kingston Hospital had already been involved in confidential talks on "joint working", and one of Queen Mary's main purchasing health authorities, MSW – seeking to slash up to £10m a year from the £142m acute services budget – were contemplating steps to force a merger.

In the spring of 1996 MSW were forced to admit that would have to place further restrictions on services to contain a cash gap, which was set to rise to a massive £33 million by the year 2001. Kingston and Richmond HA faced a £25 million deficit.

With the backroom cuts discussions reaching fever pitch, health chiefs from the Queen Mary's Roehampton Trust took the bizarre step of volunteering to close their casualty department and flog off the bulk of their site, in return for a small new unit carrying out a bit of elective surgery.

At a public meeting the Queen Mary's bosses attempted to sell their plan as a pre-emptive move designed to "save the hospital". The claim was met with derision by local people.

A new rumour, confirmed by a local health manager, was that Queen Mary's would be closed down completely and replaced by a small annex of Kingston Hospital built on the A3.

In early August the health authorities issued a report which advocated the removal of emergency surgical and orthopaedic work from Queen Mary's. A further consultation document was expected to recommend the axing of emergency paediatric, gynae and obstetrics, with the closures planned to take

effect from April 1 1997. The board at QMH spent the winter submitting a planning application for building luxury flats on 17 of the hospital site's 23 acres of land.

The implications for health services in South West London for the coming winter and beyond were horrendous, and London Health Emergency helped launch a new group, the South West London NHS Defence Campaign, to tie the issues together and to ensure that Queen Mary's is not left to fight alone.

In July 1996 K&R HA discussed a financial strategy which warned of the need to cut spending by up to £25m over 5 years, and "urgent plans to reduce expenditure in 97/98 by up to £7m".

In September an LHE survey of the purchasing plans of MSW and K&R, which had outlined the need for cuts totaling £22.5m, warned that K&R were contemplating cuts that would axe 75% of all waiting list operations from April 1997, while MSW was looking for an even bigger reduction – 80%, with particular emphasis on hip and knee replacements.

Go private, or go without

As the winter closed in, the situation was getting so bad for Sutton residents that St Helier Trust chief executive Nigel Sewell went on record in the *Sutton Guardian* (22 November) saying that people needing non-emergency surgery such as hip replacements had the choice between going private or moving out of the area.

Responding to the cuts package proposed by MSW Health authority, Sewell warned that the hospital could have to close 120 beds, turn away over 4,000 patients, and axe 150 jobs. He was unusually frank:

"If these proposals are implemented, I believe that people who do not have life-threatening conditions will suffer disabling pain and discomfort for long periods. Some may even die waiting for the treatment they need."

By early 1997 the pressure from campaigners, aided in this context by the political pressures of the looming General Election, forced the government to pump in an extra £6m to bail out MSW. But services were struggling to cope: in St Helier hospital stroke victim Geoffrey Coppin hit the headlines after waiting 54 hours on a trolley in A&E for the lack of a bed: the hospital also ran out of linen.

The *Sutton Guardian* in January quizzed St Helier bosses over two closures of the hospital's A&E unit: it reported fears of a £9m deficit for 1997. Kingston Hospital reported a peak of 45 patients waiting overnight for a bed one night in the January; St George's had up to 23 "overnighters". Mayday Hospital too was jammed full.

Brown sticks to Tory limits

However the change of government on May 1 1997 did not yield the expected relief for health services. Chancellor Gordon Brown stuck to his commitment to stay within Tory cash limits – and St George's set the pace in squeezing services, announcing a list of 14 operations that would not be available for the remainder of the 1997-98 financial year: these included hip and knee replacements, cataracts and tonsillectomies.

The cuts – which followed on redundancies – were in response to the decision of MSW to slash elective surgery budgets by 16% and day case operations by 18%.

Two weeks after the election, St Helier closed one of its busiest surgical wards trying to save £900,000 – only to be forced to reopen its shortly afterwards to cope with a backlog of patients.

Mayday Hospital reported financial problems, worsened by the loss of income from neighbouring health authorities. In June Croydon Health Authority chief Terry Hanafin insisted that the HA was not making cuts in the current year, but warned that the situation for 1998/99 could be worse. The HA then proceeded to circulate and invite public consultation on various proposals for cuts in the next financial year – which were roundly opposed by local people including GPs on the Local Medical Committee.

The final closure date for A&E services Queen Mary's Roehampton was announced as August 1 – though the recent experience from the closure of QMH's maternity unit should have warned local Trust bosses that staff displaced in such closures tend to depart rather than transfer to other local Trusts.

In fact, managers knew full well that the closure of the A&E service would herald the death knell of Queen Mary's as an acute hospital. By October the decision to axe its burns unit and transfer services to the Chelsea and Westminster Hospital had also banged another nail in the coffin.

Only after almost every service had closed or

announced a closure date did the SW London Hospital Review publish its report, recommending the closure of the few services that were left.

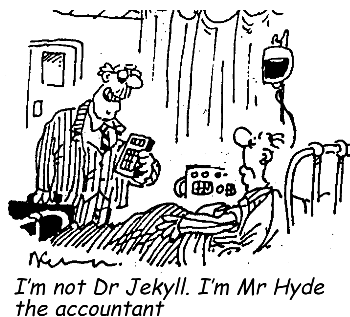
Death knell of Queen Mary's

Cynically, the Report argued that it was the lack of precisely the on-site services that had just been given the chop that made it necessary to close the rest: "the lack of such comprehensive services would compromise service quality".

Patients from QMH should instead go to a new, temporary, 3-storey building on the Kingston Hospital site. Most of the QMH land would be sold off to speculators, leaving a minimal vestige of community services, limb fitting and a minor injuries unit. As Health Emergency commented:

"Within just 12 months, without ever consulting the public on their true intentions and by flatly denying the obvious truth, a team of anonymous suits have got away with killing-off a much-loved local hospital, brick by brick."

In November 1997 a new view on the chaos of the Queen Mary's Hospital run-down was presented in an independent report by city consultants Llewelyn Davies, commissioned by Wandsworth council. The study echoed many of the criticisms made by campaigners and union activists, finding four main reason to object to the conduct of the SW London health authorities involved:



I'm not Dr Jekyll. I'm Mr Hyde the accountant

The SW London Review had failed to carry out any assessment of health needs in the areas served by Queen Mary's and Kingston Hospital.

It seized on Queen Mary's first and foremost from a consideration of how many services could be closed down: there was no consideration of whether QMH could be developed to attract additional caseload or services.

It underestimated by £4m the costs of closing services at QMH: it left out the costs of the temporary buildings required at Kingston Hospital.

It made no attempt to explore any possible savings from redeveloping Queen Mary's to provide its full range of services.

The Llewelyn Davies report also challenged the notion that concentrating services into fewer bigger units would save money or improve clinical standards. And it hammered the vague proposals for what services should remain at Roehampton: day surgery and acute medical beds are among the options ignored by the HA's reviews.

'The River Runs Dry'

In the autumn and winter debate raged over the dramatically titled service framework document drawn up by MSW HA for the following financial year, entitled 'The River runs dry'. MSW plans revolved around their efforts to confront a £23m funding gap. The chosen device was a draconian package of rationing of services deemed "low priority".

The HA imposed a virtual blanket ban on * Vasectomies; * Sinus surgery; * Varicose veins; * Some hernias; * Some cataracts; * Cruciate ligament reconstruction; * Some hip and knee replacements; * Plastic surgery for post-burn scarring; * Hysterectomy for fibroids; * Sterilisation. All these would only be available under "exceptional circumstances".

St George's share of the cuts was a reduction of £5.5m, which seemed set to trigger another round of job losses. In December 1997: St George's Trust warned that it was being asked to implement "unsustainable" cuts. MSW effectively admitted that the squeeze on their budget meant that local Trusts could be funded for little more than emergencies and urgent cases.

Croydon HA's December meeting was asked to approve service cuts including a cutback of routine waiting list work, and cuts in community and mental health services, to save £900,000. The Service and Financial Framework for 1998/99 was based on the need to tackle cash pressures adding up to more than £5m. Health visiting, school nursing , occupational therapy and other community services bore the brunt of planned cuts – triggering an angry local campaign.

On January 13 1998 over 70 local campaigners staged a highly successful early morning vigil for QMH outside the hospital's main gate, issuing an appeal for Health Secretary Frank Dobson to step in and save the hospital. Letter from Kingston CHC on QMH & replacements

As the run-down of Queen Mary's continued, the consequences of the squeeze on services became clear in July 1998, where figures showed waiting lists rising in Merton Sutton and Wandsworth. Fears were also raised that the replacement services to be provided at Kingston Hospital were likely to be 150 staff

short of the 700 required. In July it became clear that QMH was not only shutting down key services, but going out with £4.4m deficit. Eventually on August 5 1998 Queen Mary's A&E was downgraded to a minor injuries unit, and other services closed.

The shock-waves of the cash squeeze continued in the summer with the announcement of a 'shotgun marriage' merger between St Helier Hospital and Epsom District hospital. This was despite the fact that Epsom chiefs had previously flatly rejected a merger proposal: it turned out that their enforced change of heart flowed more from their massive unresolved deficits than from any warmer view of the St Helier Board.

Queen Mary's closes

In September 1998, Queen Mary's Roehampton finally closed its doors as a district general hospital, leaving Kingston and St George's to pick up the pieces. It was already clear that Kingston's A&E unit was struggling to cope with the extra demand at peak periods. In August 1998 the number of patients forced to wait overnight for a bed rocketed to almost 200.

And just after the beds closed at Queen Mary's Kingston management admitted that 90 out of the 130 "extra" beds opened to cope had closed again for lack of staff – prompting 100 frustrated nursing staff at Kingston Hospital to stage an angry protest outside the gates. Later in September the health authorities that had forced through the closure of QMH in pursuit of cash savings were forced to admit that they would save nowhere near as much as they had expected.

October 1998: a UNISON report responding to the planned merger of St Helier and Epsom Trusts warned that it needed to be viewed in the context of continuing cash pressures on MSW health authority, and soaring demand for emergency services. UNISON warned that the merger could, as in other mergers, herald a process of "rationalisation" of services, with a possible long term aspiration for a single site hospital to cover the entire catchment area – possibly to be built on a new greenfield site.

Even the sacrifice of Queen Mary's – which by spring 1999 Kingston & Richmond bosses admitted they had seriously bungled – couldn't balance the books of SW London's NHS. It also became clear that Kingston & Richmond HA was carrying over accumulated debts of £5.4m into another financial year, and its financial position was officially described as "precarious". By early February only 29% of A&E patients needing a bed were being admitted to Kingston Hospital within two hours. The HA warned that

"No provider should assume any investment for development unless specifically agreed by KRHA in writing."

A London Health Emergency spring 1999 survey of Trust deficits showed St George's £5.6m (more than 4% of its budget) in the red and St Helier £3.7m. Merton Sutton & Wandsworth Health Authority admitted that even after cuts totalling £10.4m in 1998/99, the shortfall to be carried over into the new financial year was £12.5m.

Its plans involved cutting a hefty £16m from the 'local health economy' – effectively passing the back to local Trusts: even the newly-formed Merton & Sutton Community Trust was told to make cuts of £1.4m (4% of its budget).

To make matters even worse, it had emerged that St Helier would inherit a multi-million deficit – later revealed to be £4.6m – when it merged with Epsom in April. Once again Trust bosses had consistently denied that they were keeping the full details secret from the public, only to be exposed in the end. The combined impact of the deficits was to demand the Trust cut spending by almost £8m (7% of its budget).

In January 1999 Kingston & Richmond HA heard that not only did the HA itself face a deficit of £4.5m but "the main local provider trusts are also in deficit in the current year". MSW HA also took stock of the situation, noting that while most local Trusts had accepted the need to make "cash releasing cost improvements" (cuts) of 3% across the board, St George's had drawn up plans to cut just 2%: "They have indicated that to plan for this [3%] level of savings will require an instruction from the NHS Executive."

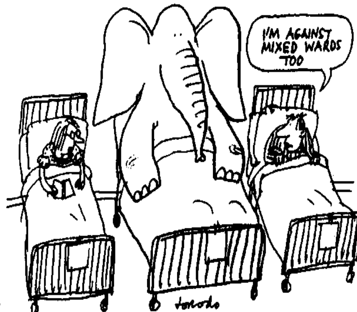
Divisions over PFI

Meanwhile there were divisions in the ranks of SW London purchasers, with Croydon health authority lodging an objection to the plans for – and possible costs to them of – the PFI-financed cardiothoracic and neurosciences block on the St George's site, to replace Atkinson Morley's Hospital. The scheme would commit Croydon to buy a guaranteed minimum level of services from the new unit for the next 15 years – at an increased cost of £200,000 - £700,000 a year.

At its meeting at the end of September 1999,

Kingston& Richmond was presented with figures showing the mounting levels of activity at Kingston Hospital's A&E – from 18,380 attenders in the first quarter of 1998/99 to 22,249 a year later – a 21% increase. The HA noted the "corresponding decline in the department's ability to admit patients within 2 or 4 hours". Numbers of patients waiting in A&E overnight for beds had increased threefold over the same period.

In October 1999 the Chelsea and Westminster Trust issued a report on maternity services which exposed the pressure that hospitals across south and west London had been working under since the closure of the maternity unit at Queen Mary's. It revealed that 680 mothers from the Putney, Roehampton, Tooting and Wandsworth area were expected to use the maternity unit at C&W in 1999/2000. The growing pressure on their service meant that since May 1999 they had been "turning away in excess of 40 maternity bookings a month due to lack of funded and staffed capacity."



The report also revealed that St George's had been forced to "cap" their birth rates at 325 a month and "have closed on several occasions recently". Kingston had been capping since May 1998, although they were "not considering any additional expansion at the moment" and were "over committed across the Millennium".

The Strategic Outline Case for the development on the Queen Mary's site was finally published in November 1999 . Although the plans were based on a complete new build, and included provision for the location of Primary Care Group Offices on the site, they did not include any extension in hours for the limited minor injuries unit, or provision for acute medical beds other than services for the elderly. Wandsworth Council drew attention to the planned running costs of the new unit, which showed an annual deficit of £787,000 with the potential to roll up to over £2 million in the first three years.

Kingston under pressure

Even as the St Mary's plan was published, Kingston & Richmond HA was again discussing the pressures on A&E at Kingston Hospital, which were clearly under pressure, despite the Trust's downward revision of previous figures. Numbers of overnight stays in A&E had continued to rocket upwards, with 734 in the second quarter of 1999/2000. The HA at the same meeting heard that it was facing an accumulated deficit of £9.6m, and set out a cost reduction plan £7.5m.

By February 2000 waiting times were still soaring at Kingston Hospital A&E, with 40% of emergency admissions waiting for two hours or more for a bed, and 18% waiting over four hours. By April the HA was told that fewer than half (49%) of the Kingston Hospital patients needing a bed could be admitted within two hours, against a Patients Charter target of 100%. April also saw a new threat to the future of Teddington Hospital, one of London'a last surviving cottage hospitals, as it was forced to close 20% of its beds for lack of staff.

In June 2000 London Health Emergency warned that the Business Case for the redevelopment of services on the Queen Mary's Hospital site fell well short of the package that was required to take the pressure off the acute units at Kingston and St George's and needed to be reconsidered in light of the government's NHS Beds Review. The Business Case showed that the new development at Queen Mary's was constrained by financial pressures in the local NHS and particularly the £1.5 million deficit carried forward from this year.

The government's NHS Beds Review, published in February, proposed that an additional 3,000 beds should be created to equip the service to cope with growing demands. Nowhere is the need for increased bed capacity more pressing than in South West London. LHE urged the South West London Community NHS Trust to upgrade their plans and to expand the range of services proposed for the QMUH site in light of the government's recent announcements on the NHS.

An indication of the pressures on local services was given by figures published in July by the Epsom & St Helier Trust, showing numbers of A&E attendances and emergency admissions actually increasing to winter-time levels into the summer months. From early May the Trust had upwards of 33 medical outliers in surgical beds each week.

In July 2000 Kingston & Richmond HA was told that the proportion of cancelled operations had worsened, and was "worse than at any time in the

last 3 years" K&R patients suffered double the English average of delays in admissions through A&E.

Some of the problems in reducing waiting times were explained when in August 2000 Kingston Hospital Trust Board heard that acute beds in the hospital were running at 99% occupancy.

By March 2001, the pressure on front line hospital Services in South West London reached crisis point, with St George's in Tooting forced to close its doors to emergency cases for a night and Kingston Hospital racking up ambulances in the car park at the same time.

Squeeze on surviving hospitals

The problems stemmed from the sustained cuts and closures which had ripped through the area in recent years, not least of which was the closure of inpatient services at Queen Mary's Hospital in Roehampton nearly three years earlier.

Kingston was caught in a squeeze which had been tightened by the subsequent closure of emergency services at Ashford Hospital in Middlesex.

Meanwhile, managers at Epsom and St Helier Hospital put forward proposals to close down the main maternity and paediatric services at Epsom Hospital without even bothering to consider the impact that such a move would have on other hospitals like Kingston, East Surrey and Guildford.

The plans were exposed by LHE and UNISON as fatally flawed, and in the teeth of massive public and staff opposition they were eventually knocked back. However, that may not be the end of the story.

Some senior managers and consultants have long had their eyes on the option of building a single PFI hospital on the Sutton/Royal Marsden site to replace the main services at both Epsom and St Helier. With the buildings at St Helier crumbling, there has for many wars been a need to rebuild the hospital: but instead the staff have been forced to struggle on in unsuitable accommodation with vague promises of jam tomorrow.

In the Autumn of 2001, Kingston and Richmond Health set out plans which it hoped would tide local Trusts through a possible £4.4m deficit. This included deferring placements for vulnerable patients for 6 months "unless there is a risk to the individual or to other people". But it warned that: "Whilst a forecast of financial balance remains official policy, it is evident that the level of high risk is increasing dramatically, and moreover much of the high risk is translating into real overspend."

Despite an unexplained 10% drop in A&E attendances at local hospitals, there had been a sharp rise in numbers waiting overnight in A&E, which the HA admits "result from a lack of available beds". In June Kingston Hospital Trust admitted just 76% of A&E cases to the wards within four hours, against the government target of 100%. In July 2001 this fell to 63%, and in August despite a ten percent drop in A&E attendances, it fell again, to just 61%. Ominously, the number of elective patients waiting more than a year for admission had risen to 483 – nearly double the target figure for the end of the year. These figures during the "quieter" summer months showed that the pressure was now on all year round, and not just in the winter.

Meanwhile the situation was worsened by Richmond Council, which had run out of money and called a halt to new social care placements. This meant that patients who should have been transferred from hospital to social services accommodation would instead have to stay on medical wards.

Special measures

The previous winter, in the run up to the general election, special measures had been put into place to avoid a winter crisis in the NHS, including putting extra social services accommodation on stream to take the pressure off acute beds.

Meanwhile Merton Sutton and Wandsworth Health Authority (MSW) in September 2001 received a chilling report on the failure of its two key hospital Trusts to meet demand for emergency or waiting list treatment.

But the HA pointed out it did not have the extra cash it needed to open extra beds that would enable St George's and Epsom & St Helier Trusts to cope with the extra pressures during the winter months.

The HA's Performance Improvement Plan set out a stark picture of the situation in local Trusts, with St George's facing the greatest problems:

- Cancelled operations almost doubled in number
- Numbers of patients waiting over 4 hours on troll leys increased by a massive 76% in the three months from April - normally a quieter period.
- In August alone 177 patients waited over 12 hours in "beds in a supervised area" of the A&E

department – for lack of proper beds on wards.

The Trust's waiting list had increased during the summer and was over 900 (15%) above plan. But day cases, too faced delays: numbers waiting over 15 months are 80% above target, while numbers waiting over 12 months are 43% higher than planned. 2388 are waiting over 13 weeks for a first out-patient appointment, 64% above plan, while around 700 have waited over 26 weeks – 71% behind target.

Epsom & St Helier, which had just been branded the "worst hospital in the country" in a devastating report from government inspectors, was facing a four-fold increase in cancelled operations, long trolley waits and too many patients kept waiting over 13 weeks for outpatient appointments.

Both Trusts said they could open another 82 temporary beds each to relieve the pressure. But despite appeals for help from MSW, the NHS Regional Office refused to step in and give the Health Authority - which had no contingency funds - the cash for extra beds.

The December 2001 Board Meeting discussed a familiar set of problems at Kingston Hospital:

"Winter arrived in September this year with a big increase in emergency admissions. The number of overnight 'sleepers' in the department has risen to over 400 a month (in August there were 99). … the number of patients who have an overall length of stay less than 4 hours has dropped to only 54%."

In February 2002 Croydon HA discussed costings for private operations to reduce long waits to national target levels, revealing that by the end of December the HA had paid for 278 operations at a cost of £973,000 – an average of £3,500 each.

Queen Mary's caught in PFI bureaucracy

By the spring of 2002, the building of the promised community hospital on the bulldozed area of the Queen Mary's site in Roehampton was still stuck on the drawing board, as a result of the Byzantine procedures required by the Private Finance Initiative.

In March 2002, just before Gordon Brown's announcement of a massive injection of extra cash to the NHS – to begin a year later in 2003 – the scale of the deficit to be inherited by local Primary Care Trusts was assessed by Kingston & Richmond HA. It didn't look too promising:

"To achieve a balanced position high risks of around £15m had been identified (shared by 2 PCTs and Kingston Hospital Trust). The PCTs and KHT have been asked to produce recovery plans by the end of March."

The situation was made no easier by the need to take money from each of the PCTs across SW London to fund the new structure of Strategic Health Authorities which from April 1 replaced the old HAs of MSW, K&R and Croydon. K&R estimated that PCTs would have to chip in £4m a year each – though it is far from clear what the StHAs are supposed to do, and whether or not they will do anything to improve health services.

The new monster HA covers nine NHS Trusts and five Primary Care Trusts (PCTs) – Croydon, Kingston, Sutton & Merton, Richmond & Twickenham, and Wandsworth. But unlike the previous structure, it is now the PCTs, rather than the Health Authority which will hold the purse strings and decide on the commissioning of 70% of NHS activity. According to the Department of Health, it will be the StHAs which (from October this year, when they take on their full powers) will be "responsible for the performance management of NHS Trusts, Primary Care Trusts and Workforce Development Confederations."

So what, exactly will the StHA do – and who are they? SW London StHA has a chair (James Cochrane), a chief exec (Julie Dent), five full-time directors and five 'non-exec' directors. Don't even bother asking how or why they were chosen, or to whom they are accountable in South West London. Apparently most of the non-exec members come from Kingston or Richmond. Don't expect them to be in touch, or asking your concerns.

The StHA will meet in public about five times a year – but between times will have more "seminars" behind closed doors. But it may not matter who they are or where they come from, since it seems from Department of Health guidelines that the main job of a StHA is to draw up a "Franchise Plan" setting out "what the Chief Executive envisages achieving" and "how the Chief Executive will deliver the NHS Plan".

Everybody else seems to be playing a supporting role.

Neither sound strategy nor new resources

The initial SW London StHA Capacity Plan headed in completely the wrong direction: it projected a reduc-

tion in numbers of hospital nursing staff, a standstill in numbers of emergency hospital admissions, a modest 4% increase in waiting list treatment – but no extra beds. The financial details were sketchy in the extreme – perhaps because the new HA hadn't worked out how to tackle the £10m deficit it had inherited from the old MSW health authority.

By May 2002 Kingston Hospital Trust, noting that it had received one-off payments totaling £7m to support services during the previous year, warned that under current projections they were facing £4.3m shortfall for 2002/3: "Therefore the financial position remains 'at risk' pending final resolution of the financial sums".

The Trust also outlined plans that would leave most waiting list totals largely unchanged, with the exception of ensuring that no patient should wait over a year. Waiting times in A&E remain a problem, with Kingston achieving just 60% waiting less than 4 hours in the department, compared with a national target of 90%.

Another unknown factor has been how effective the PCTs will be at purchasing and providing services. According to the Health Service Journal many were expected to be hindered by "inexperienced managers, unproven processes and fledgling support systems".

The jury is still out on the performance of PCTs in SW London, though they have been thrown in at the deep-end, inheriting a grim legacy of cuts, a constant barrage of new government targets, and financial pressures spanning two decades.

Ironically, this latest reorganisation of the NHS was originally described by the government as "Shifting the balance of power away from central government to frontline staff, who have a day-to-day understanding of patients' needs and concerns." Ministers claim it is supposed "to help empower patients and to help staff and patients have their say on the future."

It is a safe bet however, that – as before – the very last people to find out what our new StHA is planning, and the last people to be asked their views or listened to, will be the health workers and patients who were supposed to be "empowered" by their introduction.

A bitter future for you?

A classic example of this has been the repeated attempts of successive health authority bosses to bulldoze through their strategy of reducing hospital provision in Merton, Sutton and mid Surrey to a single, PFI-funded general hospital, most likely on the Sutton Hospital site.

This would mean the closure of both Epsom and St Helier hospitals: a new hospital to take their place would have to cover a massive catchment population of 800,000 – far larger even than the 500,000 that has previously been proposed by those seeking mergers and rationalisation.

But given the hugely inflated costs of PFI projects, it is clear that such a hospital would not only create serious access problems from various parts of the catchment area, but would be too small to cope with the pressures that already have Epsom, St Helier and other SW London hospitals struggling to cope.

A similar plan was drawn up three years ago, but eventually withdrawn by health chiefs in the teeth of bitter and vocal local opposition right across the area, led by health unions. Objections centred on the need to develop new services around two hospitals, and in particular challenged the notion of a single maternity unit to cover the area, which would have created impossible new pressures on surrounding maternity units in Kingston, St George's and Mayday hospitals.

But now with the publication of a new document "A Better Future for You" the discredited scheme has been revived, as health bosses try to bounce local people into accepting a "direction of travel" towards a single site hospital despite a lack of any concrete proposals on where it might be, where the additional proposed "Local Care Centres" would be located, or how much the whole scheme would cost.

Measuring the gap in services

A new StHA attempt at capacity planning, published in January 2003 shows some signs of coming to grips with the legacy of under-funding and service cuts that have cramped the NHS in South West London for so long.

While it still assumes that local GPs will refer fewer than the national average number of patients for hospital treatment, it nevertheless projects a much larger than average increase in first attendances at hospital outpatient clinics, and in waiting list treat-

ment. It also projects a much higher than average increase in emergency admissions (most notably at St George's, where the rate of increase in emergency admissions is predicted to be more than double the national average), and much higher bed occupancy, with an average of 90% of beds occupied throughout the year.

As a result of these assumptions, the most recent StHA estimates are that an additional 8,700 hospital admissions will be required during the next financial year, with continuing growth in demand for the following two years. The consequence is a need for an extra 309 beds over three years, of which just 116 have been identified as potentially available, leaving a gap of 193 (62%). Two thirds of these, by StHA calculations, are required to deliver emergency admissions.

'I drink to forget I'm on an NHS waiting list'

The StHA insists that, since "new build is not a viable solution in the short term":

"In 2003/4 additional activity will have to be sourced from the private sector or from other NHS Trusts outside the Sector [StHA]."

However this use of the private sector is likely further to compound the staffing problems faced by local NHS hospitals and services. A recent official study on London's NHS workforce pointed to one of the key issues in the capital is the "intense competition" for the "limited pool of skilled staff" from "a large private healthcare sector".

The StHA calculates that the additional costs of the 8,700 episodes of in-patient care that will need to be provided will be at least £7m in 2003/4 and could be as high as £16.5m. During 2002 the StHA remarked that among the "exceptionally high costs" faced by PCTs in meeting government targets for access and quality were the increased costs both for Wandsworth PCT and for Sutton and Merton PCT of funding treatment in the private sector

Because of the chronic shortage of beds and investment in local services, much of this money will flow out of the local health economy to private hospitals or NHS Trusts elsewhere.

This outflow of resources is likely to be increased by the introduction of London Patient Choice, a new system under which patients waiting over 6 months for certain specialities will be offered the choice of treatment in another hospital.

Since we already know that NHS hospitals in SW London will be well short of the capacity they require to deliver treatment to local people, there is a very strong chance that this policy will result in both the patients and the money being transferred out of the area, or out of the NHS.

London Patient Choice began in 2002-3 with cataract treatment, but is to be extended from April 2003 to cover orthopaedics, general surgery, ENT and other specialities.

The latest available waiting list figures show that over 4,000 people in SW London had been waiting six months or more for treatment in one of these named specialities – almost half of them for orthopaedic operations, which tend to be relatively high cost: if we assume an average of £3,000 for the cost of the operations, this could mean around £12 million a year could be drained out of the local health economy – worsening the plight of cash-strapped Trusts like St George's, Epsom/St Helier and Kingston.

Even finding this cash to cover the Patient Choice policy is likely to prove a major problem, with the cash allocations to PCTs in SW London for the next three years running well below the national average.

Conclusion

Kingston Hospital Trust in January summed up its financial position, one that appears to have prevailed in one form or another throughout SW London's NHS for most of the last 20 years:

- A significant recurring budgeted deficit
- A range of new cost pressures the total level of which is likely to be unaffordable by Commissioners [the PCTs]
- A project under development that is aimed at improved service delivery but the full financial impact of which is not clear.
- A changing external environment in that the new NHS policies are being introduced – Patients Choice, Financial Flows – with inherent uncertainties
- Major capital investment with a potential cost pressure.

It is clear that a sustained programme of action is needed to equip SW London's health services for the 21st century and the level of pressure they face from the health needs of local people.

- Runaway costs of employing agency staff to plug gaps in the full time NHS workforce have to be tackled. Because of national agreements covering

NHS pay, this cannot be done at local level: it requires a fundamental rethink of government policy, including a substantial uplift in London weighting and a further increase in the pay for all grades of nursing staff. In addition, NHS Trusts must begin to take seriously the need for more flexible and family-friendly policies to enable them to retain and attract back nursing and other staff who prefer to work part-time or particular hours to suit family responsibilities.

● The recurrent deficits that have dogged local Trusts for at least two decades are the outcome of chronic under-funding. It is a nonsense for NHS purchasing/commissioning bodies to pretend to have balanced their books when this has only been done at the expense of imposing unrealistically low prices on the provider Trusts – effectively transferring the crisis to the front line of care. There is an urgent need for a thorough and independent audit of the financial situation in all local NHS Trusts, to establish a realistic baseline budget that will sustain the necessary level of services – and the additional money must be made available, to ensure that services are expanded as required on a stable and sustainable basis.

● This audit must also include the allocation of sufficient resources to enable the Trusts to build, staff and operate the additional 200 beds that have been identified as required to deliver government targets for access, quality and waiting times.

● The resort to private sector providers to plug gaps in local NHS capacity is both costly and self-defeating. Not only does it siphon vital cash from local NHS Trusts, but it also increases the level of competition between the NHS and the private sector for nursing and other staff. Vacancies created this way in the NHS establishment are often then filled with even more expensive agency staff – inflicting even further damage on the NHS, and perpetuating the shortfall in capacity. Any planned deals with private hospitals should therefore be abandoned, and priority should be given instead to the most rapid expansion of local NHS capacity, alongside longer term plans for the renewal of old and obsolescent buildings.

● Private contractors must be removed from the provision of hospital support services. Their role for the past two decades has been to cut the pay and conditions of staff and to run down the quality of services. The constant threat of privatisation has been used as a weapon to hold down the pay of other NHS staff, with dire consequences for morale. A modern health service would see all support staff directly employed on decent pay and conditions that would eliminate the two-tier workforce.

● The need for investment in new hospital facilities in Epsom & St Helier is obvious: but the scheme that is being promoted through underhand means – for a single site, PFI-funded hospital on the Sutton site – is too expensive and too small to solve the long-standing problems in a catchment area of 800,000. With the government currently able to borrow money on the international markets at 2% interest or even lower, all PFI schemes should be abandoned as too costly and inflexible to suit the needs of the NHS.

● Instead the government should make NHS capital available – if need be as a long-term low-interest mortgage – for the further upgrading of Epsom, and a new publicly-funded hospital to replace St Helier, together with local treatment centres to complement the services already available in smaller local hospitals, and any other capital investment required to equip SW London's hospitals to meet local needs in the 21st century.

LONDON HEALTH EMERGENCY, now in its 20th year of campaigning, is a pressure group for the NHS in the capital which also has affiliated trade union bodies and campaigning organisations across the country. It publishes a tabloid quarterly newspaper, and can be contacted at health.emergency@virgin.net or on www.healthemergency.org.uk.
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