BRIEFINGS FOR CYNICAL COMMISSIONING GROUPS (1)

Reconfiguring hospital services

How to get away with it

All the guidance you need to turn any popular and successful local general hospital into a clinic – or housing development.

ONE: The title.

Make sure your consultation has an absurd, happy-clappy title that belies its real purpose: many have already been tried -- Shaping a Heathier Future, A Picture of Health, Better Care Closer to Home, Healthier Together. Use one of these or make up another.

TWO: The smokescreen.

Make sure your consultation document begins with at least 10-15 pages of general twaddle on public health. All you need is a series of truisms on local prevalence of disease, mortality statistics, smoking, drugs, alcohol and other health issues, deprivation, ethnic mix and inequalities. And of course preventive health.

Anything will do. Of course none of this bears any relation to the plans you are putting forward. This is not the real reason for change, or a basis for your proposals.

In fact you are likely to ignore these issues altogether when you close hospitals and services in the most deprived areas with the best services for those most in need. This is what has happened in NW London and SE London.

THREE: The threat.

You need to work in a subtle hint of financial pressure, while strenuously denying of course that your plans are finance driven. References to value for money are always helpful. Don't overdo it, or repeat too often, and try not to link your cutbacks to cash savings.

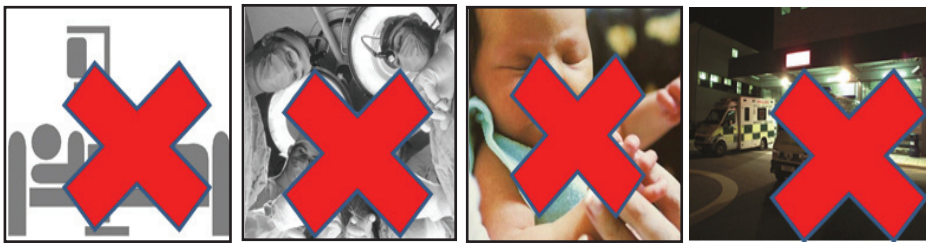
FOUR: The "safety" catch.

Make a strong play for your credentials as upholding "safety" and improving patient care. Not only does this divert from what you are actually doing, but the "safety" card can prove very handy as an excuse for the second wave of cuts that will inevitably follow on once the first wave is in place.

Having reduced a site to elective services only and removed ITU etc, you can pick your time to argue (obviously with regret) that it can't be properly staffed, and more services need to close – perhaps "temporarily," and then permanently … for "safety" reasons. This way you can get away with closures without any consultation at all.

FIVE: Target A&E!

Make a beeline for closing an A&E, possibly replacing it with an Urgent Care Centre – not because you can make big savings from A&E (which is very cheap to run), but because once you push through that closure you have cleared the path to closing the rest of the hospital. Some services will automatically close alongside A&E, others can be saved for later. The threat to an A&E will also draw almost all the attention of local public campaigning and press coverage, letting you get on with other cuts with little disruption.



SIX: Closer to home

Imply – or even promise – you will replace hospital care with a range of services "closer to patients' homes" or "in the community". Never mind the fact you're ***closing*** the nearest hospital, or that there is no evidence these services can replace A&E – or that there's no money to pay for them.

SEVEN: Figures of fun

A reconfiguration needs more than just closures: it needs a ready supply of dodgy plans appearing to cut costs, improve 'productivity' and 'focus resources'. One ready source is the McKinsey report from 2009 which first mapped out ways to 'save' £20 billion from the NHS – through measures including the rationing or exclusion of elective treatments including hip and knee replacements, cataract operations … or cutting doctors' consultation times.

Lard every argument with plenty of dodgy figures. Take your pick for example about which inflated proportion of A&E patients you want to claim might be treated in primary care or in community services if they were ever to be made available: so far we have seen claims of 60%, 70%, 75%, 77% and 80%.

Other old favourites include imaginary *travel times* to more distant hospitals.

EIGHT: Turn a deaf ear

Ignore any questions on embarrassing figures and issues that might discredit your argument – such as figures showing the continued rise in emergency admissions and referrals, the pressure on hospital beds, the spiralling workload on over-stressed staff, the levels of deprivation and other specific needs of a local population, etc. Just ignore them.

NINE: Keep it vague

Wherever possible avoid offering any concrete plans for alternative services. You are trying to save money, not spend it. Your only concrete plans, with timescales for implementation should be your cuts and closures.

Remember it's always easier not to make a promise than to break one.

TEN: Control the consultation

Remember the consultation process is your way of brushing aside popular resistance and informed criticism. So make sure your consultation document is decorated with the full gamut of spurious options and skewed questionnaires giving no chance to say NO to your cuts.

Set up a series of poorly advertised, one-sided meetings for you to rattle on to small audiences at inconvenient times and inaccessible locations, and inadequate numbers of patchily distributed documents: make sure translations are only of summaries and appear late in the consultation – if at all.

The one thing to remember is never, ever to answer any awkward questions that may be raised or address genuine concerns in your response to the consultation. You can rely on ministers to push through your plans.

That's it! If you follow these simple steps you can gag the opposition and push your plans through. You will be unpopular, of course – but, hey, you will keep your job, even as others lose theirs.

This handy guide compiled by John Lister, www.healthemergency.org.uk