North West London's NHS

UNDER THE KNIFE

An updated survey of "Shaping a Healthier Future" – plans for healthcare in North West London. Researched by John Lister for Brent, Ealing and Harrow Trades Union Councils, June 2012.

The threat in NW London

Next month a major consultation is due to begin in North West London, on plans that could result in the loss of **1750 NHS jobs** in 12 months, and **5,600 jobs by 2015**, along with the downgrading and downsizing of many local hospitals and services, and the **closure of up to 4 of its 8 A&E units**: and history shows that the closure of an A&E is very often the prelude to a process of rundown of other services, and even closure of the whole hospital.

NW London has four of the capital's most cash-strapped Trusts, two of which (NW London Hospitals and Ealing Hospital) are in Brent, Ealing and Harrow (the others being Hounslow's West Middlesex, and Imperial College Healthcare (covering Hammersmith & Fulham and Westminster).

A McKinsey report for NHS London early in 2012 projected that *not one* of the non-Foundation hospital trusts in NW London would be viable by 2014-15, while three of them (**Ealing, NW London Hospitals and West Middlesex**) would not be viable "under any tested scenario"[1]: Ealing and NWLHT are hoping to tackle financial problems by merging into a single Trust, and rationalising services.

The NHS in the 8 boroughs of NW London is now organised as "NHS North West London" (NHSNWL), and faces an estimated **£1 billion cash gap** between resources and rising patient demand for treatment by 2015 (see table below). NHSNWL want to **slash £314m from NW London hospital budgets** over three years, and **cut £297m from health commissioning budgets**.

These cuts are part of a massive programme of cuts throughout England: the Health Service Journal estimates the total **cuts this year** (2012-13) by hospital Trusts at a massive **£2.35 billion**.

And they want to open up the health budgets of NW London to **"Any Qualified Provider**", to create the kind of **competitive market** in healthcare outlined in the government's highly controversial Health & Social Care Act. To do this means **undermining the financial viability** of established NHS providers, and reducing their capacity.

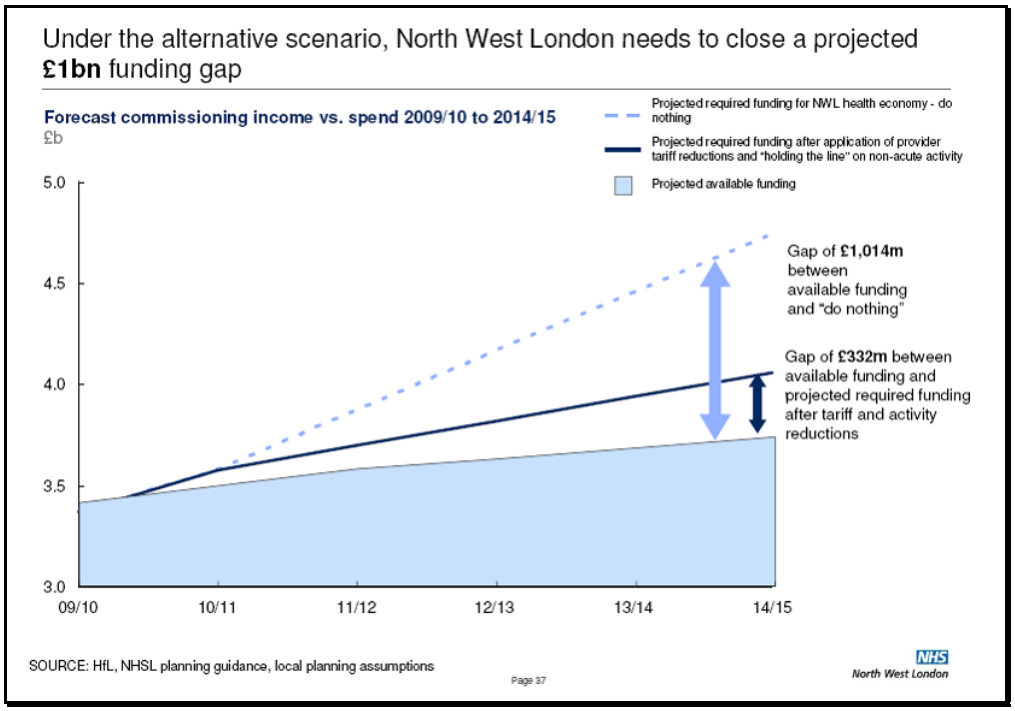
Cynical or clinical?

Although the plans for cuts are said to be the work of "clinicians", and are presented as improvements under the heading "Shaping a Healthier Future," in fact they are driven first and foremost by cash concerns – and the attempt to squeeze down spending.

[1] NHS London 'Acute hospitals in London: Sustainable and Financially Effective', February 2012, available: http://www.nhshistory.net/SaFE-report-February-2012.pdf

The plans (and the rationale for them) set out in the NHSNWL Commissioning Strategy (parts A and B)[2] are by no means new: they have been hatching behind the scenes for almost 3 years.

But in the meantime we have had the General Election in which David Cameron and Andrew Lansley famously (and of course completely dishonestly) promised to halt the closures of hospitals, A&Es and maternity departments. And in January 2011 the Health & Social Care Bill was first laid before parliament. So the plans that were drawn up so long ago are only being fully revealed to the public now that the controversial Health & Social Care Act is on the statute book.



For as long as the prolonged parliamentary debate continued on the Bill, other far-reaching changes were sidelined, including the quest for a massive, unprecedented £20 billion in "efficiency savings" in England's NHS by 2014.

Now the urgency of rushing through unpopular policies such as hospital closures and "centralisation" of services is increased by the short timescale for the implementation of the Act, especially the abolition of the Primary Care Trusts which have been the principal commissioners of local health services (and architects of the new cuts proposals), and the establishment of new "Clinical Commissioning Groups" (CCGs) by April 2013.

Health ministers, NHS bosses – and probably GPs too – are all keen for the blame for implementing what will be massively unpopular policies to be focused on the soon-to-be-abolished PCTs and the

[2] Available from NHSNWL website at http://www.northwestlondon.nhs.uk/publications/?category=3237-2012+Commissioning+Plans+%28QIPP%29+-d

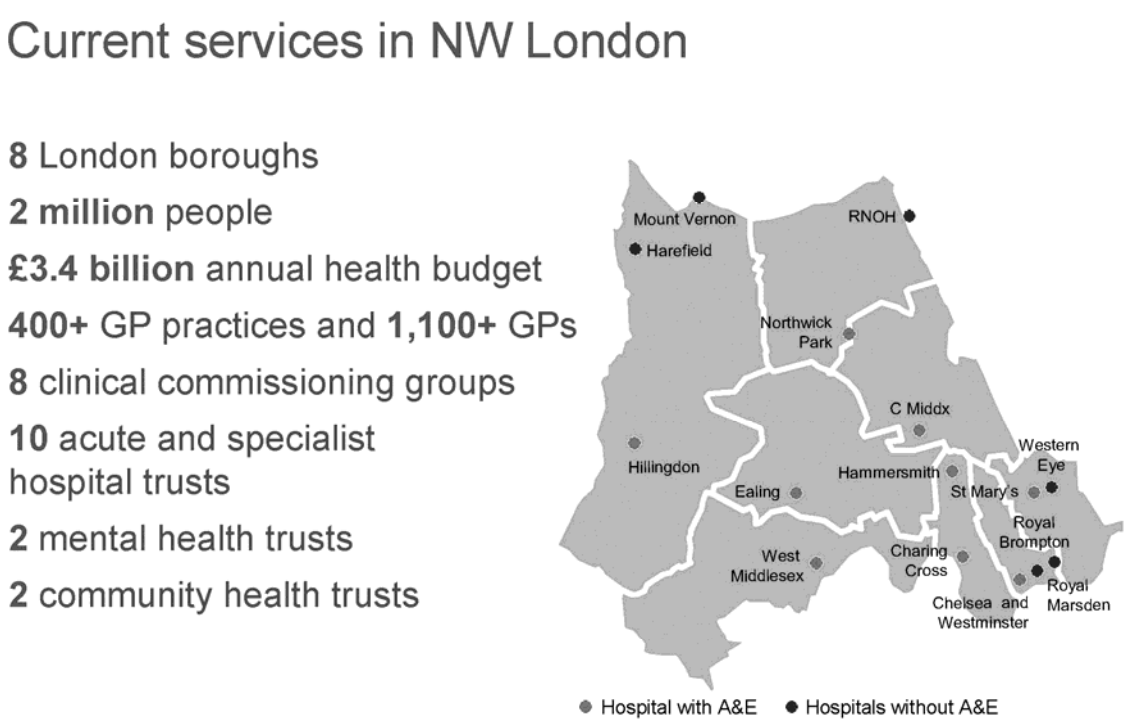
transitional "NHS North West London" rather than the embryonic CCGs which will soon hold the purse strings and have to take responsibility for future cuts to come. As a result North West London, like other sectors of the capital and many other parts of the NHS in England, faces a massive and short-term threat in which thousands of NHS jobs, along with popular and accessible services, including A&E units and whole hospitals, are set to be cut. The aim is to be implementing the cuts by December of this year.

The local public will be asked their views in the consultation: it is important that the plans are firmly rejected, and the rationale for them is questioned – not least because the political sensitivities of driving through such heavy cuts in some finely-balanced constituencies are already high on the list of health bosses' concerns.

In other words a determined resistance might hold back or defeat some or all of the proposals.

The local threat in Brent, Ealing and Harrow

The whole NW London area has a total population of around 2 million people, and includes 14 hospital sites and 423 GP practices, with a total current budget for healthcare of £3.4bn per year.



Brent, Ealing and Harrow, the three boroughs which are at the centre of this report have a combined population of 829,000 (43% of the NW London total). They are the three most ethnically diverse of the NWL boroughs, and Brent and Ealing have some of the most socially deprived wards: in Harlesden the average male life expectancy is lowest at just 71.5 years, compared with the highest of 88.3 in the wealthiest part of Kensington & Chelsea.

However comparative figures show that despite significant inequalities NW London on average has levels of life expectancy around the London and England average, and on a number of measures is performing pretty well. On levels of smoking and obesity, too, most of the boroughs do better than the English average.

Hospital admissions for Chronic Obstructive Pulmonary Disorder (COPD) are below the London average, which in turn is below the national average, as are hospital admissions from A&E. So while services could be improved, these figures simply show there are plenty of places with more improvement to make than NW London, and the case for closing hospitals or remodelling health services is not clear from any of these statistics.

According to the Operating Plan for **the current financial year (2012-13)** the "efficiency savings" targets for PCTs in NW London are as follows (numbers rounded and simplified as £m):

PCT	**Budget**	**Efficiency savings target**	
	£million	£million	as % of budget
NHS Brent	**570**	**11.5**	**2.1**
NHS Harrow	**358**	**14.1**	**4.2**
NHS Ealing	**624**	**19.6**	**3.3**
NHS Hillingdon	430	15.1	3.7
NHS Hounslow	416	14.5	3.7
NHS Hammersmith & Fulham	372	14.2	4
NHS Kensington & Chelsea	379	14.8	4
NHS Westminster	507	17	3.5
North West London	**3,656**	**120.8**	**3.5**

Local acute hospital services are provided in BEH by the **North West London Hospitals Trust** (Central Middlesex and Northwick Park Hospitals) and by **Ealing Hospital Trust**. Their share of the budget

cuts adds up to almost £70m (£48.3m in NWLH – 12.8% of the total current turnover, £20.5m in Ealing – 8.8%) by 2015. Note that these are actual *cuts* in spending ("divestment") – and therefore require real cuts in staff and services.

The targets for savings by commissioners[3] in the three boroughs add up to £38m in 2013-14 and £36m in 2014/15, but Harrow has to make the largest percentage savings of any NW London borough (4.1% and 4.2%), compared with an average of 2.8% and 2.3% across all eight boroughs .

Across NW London the cost-saving schemes fall into six main categories:

- **Cutting back** on the contracts for acute, community and Mental Health providers: this is expected to raise two thirds (66%) of the total planned 'savings' (officially described as "Contract Management").
- **Diverting patients away** from hospitals and existing services and moving them into "lower cost settings of care" (many of which do not yet exist) and "care closer to home" (also largely non-existent) (14% of the total, and officially described as "Changing setting of care").
- **Reducing overall numbers** of patients accessing treatment – not necessarily the same as the much more complex issue of reducing the levels of medical need (7% of the total, referred to in the jargon as "Reducing demand")
- **Changing the ways in which patients access services** (again requiring investment and new services which have not yet been established) (5% of the total, described by NHS bureaucrats as "Pathway redesign")
- **Corporate 'efficiency savings'** through outsourcing, centralisation, shared services and the asset-stripping of estates (1% of the total, and generically described as "Back office and corporate savings" –)
- **Savings from prescribing and medicine management**, either by better use of generics, or by restricting access to more costly drugs and imposing limitations on GP freedom to prescribe (7% of total savings, described officially as "Reducing drug spend").

Slides presented as part of the Shaping a Healthier Future presentation (available on the NHSNWL website http://www.northwestlondon.nhs.uk/) make clear that these immediate cutbacks dovetail in with very large scale cutbacks proposed in hospital care in the next few years:

- **19% of "non-elective"** (i.e. emergencies and urgent referral) admissions to hospital . This is equivalent to **55,000 hospital admissions a year**, and would open the way to close **391 hospital beds**

[3] Commonly (and confusingly for many people) referred to in the NHS as "QIPP" targets (Quality, Innovation, Productivity and Prevention)

- **22% of outpatient appointments –** a massive 600,000 fewer to take place in hospitals
- **14% of A&E attendances** – 100,000 fewer to be treated.
- **14% of elective (waiting list) operations** – a reduction of 10,000.

In other words each of these "efficiency savings" is part of a reduction in the availability of services, and also raises questions about whether existing services that would close would be replaced at all. The financial impact on local hospitals of cuts on this scale could also throw the finances of already troubled Trusts into crisis: the non-elective cuts alone could cut hospital revenues by **£330m,** spending on outpatients by **£60m**, elective services by **£40m** – an overall cut of **20% of Trust income** (calculations conservatively based on figures in Darzi Technical Report 2007).

NW London currently has **3,200 acute beds** in its district general and teaching hospitals: the reduction of 391 would cut this by over **12%** – but, depending on where these closures take place, they are certain to mean much bigger reductions in particular areas, while others remain relatively unscathed. Acute beds in Brent, Ealing and Harrow are already upwards of **92% occupied**, so there is no slack to be cut without damaging services.

However even those Trusts which do not lose beds will face problems: hospitals which have to pick up additional caseload displaced by closures elsewhere are going to struggle to cope, and local residents there are likely to have to wait longer for treatment as they join a larger queue for local services.

Hospital provider code and description[†]	Finished consultant episodes	Admissions	Of which Emergencies	Waiting list
Hillingdon	61,430	56,585	25,036	17,109
Ealing	**52,037**	**44,948**	**21,227**	**11,438**
West Middlesex	54,092	43,099	19,266	11,704
Chelsea and Westminster	78,717	71,596	21,766	21,107
North West London	**115,722**	**101,738**	**42,011**	**28,340**
Imperial College	199,033	177,498	54,008	92,209

The latest Department of Health figures show that hospitals in NW London currently treat **495,000 in-patients a year**, 183,000 of them emergencies: **more than a third** of these emergencies **are treated in Ealing Hospital and NW London Hospitals Trust.** Again the knock-on impact of cutting back in these hospitals would destabilise others.

Ealing hospital's emergency caseload, at 47% of its total admissions, is also the highest proportion of any of the other district hospital Trusts. **If its emergency services are closed it would therefore leave a much smaller proportion of its inpatient caseload to maintain the viability of the hospital.**

In any case there is clearly **little future for Ealing as a purely elective hospital**, because in in all three of the "options" being offered for consultation in the NHSNWL plan (Shaping a Healthier Future) that role seems to be filled by the more modern Central Middlesex Hospital .

The cutback team

The process of cutbacks is being led by "NHS North West London" (NHSNWL), a single management team formed from healthcare commissioners (PCTs) in the boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster. NHSNWL is not going to be around in the long term: it is a transitional body which sees its role as "supporting emerging Clinical Commissioning Groups, led by local General Practitioners (GPs), helping them to prepare for their future role as commissioners of local health services across North West London from April 2013, when the current PCT structures are due to be abolished".

NHSNWL organises its eight PCTs into three smaller 'clusters', of which Brent, Ealing and Harrow are one.

Much of its planning reflects the input of the US-based McKinsey consultancy, who have picked up contracts worth over £5m from NHSNWL, and who of course were the architects of the notorious 2009 scheme to cut £20 billion from NHS spending in England – which has now become the main reference point for PCTs and Strategic Health Authorities such as NHS London.

Before that, McKinsey, with their bizarre assumptions and out of date statistics were also the brains behind Lord Darzi's controversial 2007 plans to reconfigure hospital and health services in London, and much of the subsequent work by NHS London's "Healthcare for London" project, which laid the groundwork for the current plans mapped out by NHSNWL.

One of the main constant themes of the McKinsey/Darzi proposals is to **close down A&E units** – which, although they do not admit it, is a precursor to downgrading and downsizing hospitals. Plans for this were being worked up in secret in the dying days of the Labour government: now the ConDem coalition is aiming to drive them through.

The threat to A&E services

370,000 people from Brent, Ealing and Harrow were among the 1 million-plus in NW London who used A&E services in 2010-11. The future of these service remains high on the public's political agenda: yet we have been told in Shaping a Healthier Future that four A&Es in NW London are under threat.

The status of the Trusts in the sector is far from equal. Three are Foundation Trusts, generating comfortable surpluses (Hillingdon, Chelsea & Westminster, and the specialist **Royal Brompton and Harefield,** which does not take A&E cases). Two hospitals are positioned geographically in such a way as to make it almost impossible to close their A&E services without seriously jeopardising basic

NHS performance targets: they are **Hillingdon Hospital** (which also serves Heathrow airport and the M40 and M25) and **Northwick Park**.

In addition, **St Mary's Hospital**, Paddington, despite its ageing buildings, also has a trump card in defence of its A&E: it is a designated trauma centre for West London, making it virtually impossible to remove or downsize the A&E department without a major, complex and costly reorganisation of hospital services.

With three of the 8 A&E units therefore "safe", and **Chelsea and Westminster Hospital** running in top quality modern facilities, the threat seems to centre on **Central Middlesex hospital**, the closest A&E to Wembley stadium, where services are already running on restricted hours, and the small and relatively nearby **Hammersmith Hospital**. Both of these units already lack emergency surgery and trauma services. Each of the favoured options for change would close the A&E at central Middlesex. The status of Hammersmith is more ambiguous.

Also at risk is **Ealing Hospital**, with 84,000 A&E attenders in 2010-11 and 12,000 attending its Urgent Care Centre, but which according to a recent *Health Service Journal* report, confidential McKinsey briefings have projected as "site closed" by 2015. Advocates of closure argue that much of its A&E caseload is "minor cases," more appropriately dealt with by primary care, but the figures show few patients share this assessment. Even the most ambitious estimate of this less demanding caseload still indicates that Ealing treats 30,000 more serious cases each year. DoH figures back this up, showing Ealing Hospital treated 21,227 emergency admissions in the last year of statistics, in addition to urgent cases (for which figures are not readily available).

But if Ealing's emergency in-patient services were closed, handling **30,000 extra seriously ill emergency patients per year** would be more than enough to seriously disrupt any of the three neighbouring hospitals (Hillingdon, the tiny West Middlesex with less than 300 beds, or Northwick Park) which would have to pick up the strain – and find beds to put them in: even if this is equally divided 3 ways it would add **200 seriously ill patients per week**, **every week** to already busy and stretched hospitals. Much of the "clinical" rhetoric arguing the case for rationalising A&E services hinges on the issue of safety – but it's hard to see how the safety of the 30,000 most seriously ill patients would be anything but compromised by the closure of Ealing and additional journeys to more distant and busy hospitals which lack the resources to deal with them.

The fourth target for rationalisation is the dilapidated **Charing Cross Hospital** in Fulham: plans to close this hospital have appeared every so often since the late 1980s, but have foundered on the lack of resources and the practicalities of relocating all of the related specialist services which would become non-viable if the A&E were closed – not least the logistical nightmare of moving emergency patients from Fulham to any of the alternative hospitals along highly congested roads during daytime and evening traffic.

The political problem of closing ***two*** A&E units covering the borough of Hammersmith & Fulham also needs to be taken into consideration, especially given the creation by the Health & Social Care Act of Health & Wellbeing Boards and the continued role of Health & Scrutiny Committees, both of which could be platforms through which boroughs could obstruct and delay any closures.

From an NHS and financial point of view, if Hammersmith A&E were also closed, the closure of Charing Cross would leave Imperial Hospitals Trust with just St Mary's Hospital as a single site, and pose huge financial and practical problems in expanding its services to cope with the extended caseload, especially in the aftermath of the highly publicised collapse of the £1 billion PFI scheme to rebuild St Mary's as a health campus a few years ago.

Nonetheless Charing Cross would lose its A&E services under two of the three selected options. Central Middlesex and Hammersmith A&Es are to be axed under all three shortlisted options, and two of the final three options being put to consultation would close Ealing's A&E. BBC and other press reports have been briefed that four A&E units are to close, and that Chelsea & Westminster will be safe.

Local people are being offered a Hobson's choice of unpalatable options, each of which would severely reduce local hospital services in exchange for an unconvincing promise of up to £130m investment in "out of hospital care".

Why the focus on A&E?

Since the process of reconfiguration is being driven by financial pressures, the obsessive focus on diverting patients from A&E is hard to comprehend. **Spending on A&E is a very small share (5.1%) of London's hospital spending** and just 2.65% of total NHS spending in London: the proposed 14% reduction in A&E attendances in NHSNWL would save no more than **£8m**, even if none of the services was replaced.

Indeed the 2007-8 figures cited by McKinsey in its 2009 project for NHS London ("Delivering the Healthcare for London Strategy Affordability") show that A&E units treated 3.8m patients (p29), at a cost of £300m – an average of just £79 per case. It seems most improbable that if these are replaced by any alternative systems of care, it would achieve any significantly reduction in cost.

Many of the attempts to switch A&E caseload to "urgent care centres" and "minor injury" units and similar low level treatment facilities have proved to be **costly and inefficient failures** – some of which have already been abandoned. Only those which are co-located with A&E, and effectively act as a "triage", or primary care adjunct to an existing A&E, appear to have established themselves as successful and cost-effective.

Attendances at Accident & Emergency Departments
Includes data from Minor Injury Units, Walk in Centres and NHS Organisations

2010-11

Brent Urgent Care Centre - Central Middlesex Hospital	1,115
Chelsea and Westminster Hospital NHS Foundation Trust	107,991
Ealing Hospital NHS Trust	84,224
Ealing Mini Ucc	12,234
Hammersmith and Fulham Primary Care Trust	20,491
Hillingdon Primary Care Trust	7,987
Imperial College Healthcare NHS Trust	248,189
Kensington and Chelsea Primary Care Trust	23,596
North West London Hospitals NHS Trust	274,570
The Hillingdon Hospital	22,702
The Hillingdon Hospital NHS Trust	102,944
West Middlesex University Hospital NHS Trust	97,666
Westminster Primary Care Trust	40,090
Total NW London	**1,043,799**

As the local figures show, some of these units in NW London are hardly used at all: the **Ealing Mini UCC** attracts an average of just over 30 patients a day, while **Brent 'Urgent Care Centre' is patronised by just over 20 people per WEEK**, questioning the wisdom of this very limited provision while the rest of NW London Hospitals Trust is struggling to cope with over 750 A&E attenders per day.

In any case there has only ever been limited, if any, evidence to back the controversial claim in the Darzi 2007 report that 50% of A&E caseload could be safely diverted to polyclinics (most of which of course were never built and do not exist) and 10% 'decommissioned'. All of the figures and projections on A&E services in the Darzi report and other NHS London documents have subsequently been discredited by a detailed Department of Health-commissioned report by the **Primary Care Foundation**, which investigated real patients in real A&E units, and found that **as few as 10% and a maximum of 30% of A&E attenders** could safely be consigned only to primary care.

The **College of Emergency Medicine** has gone further and stated clearly that claims by Darzi, McKinsey and NHS London that 60% of A&E attenders could be diverted to primary care are "fiction". No new evidence has emerged since then to challenge this judgment, so it appears that any plans for A&E closures put forward by NHSNWL based on McKinsey's assumptions will be a wild gamble, based on wishful thinking rather than serious evidence-based proposals.

The real motives for A&E closures

While the direct impact of closing an A&E – especially if it is replaced by alternative services in the community, or requires expansion of other A&E units in neighbouring hospitals – is in itself a marginal cost saving[4], its attraction for NHS bureaucrats is that it opens up more possibilities for cutbacks and closures in the longer term. Almost every hospital closure in London and elsewhere since the late 1970s has begun with the closure of A&E: it marks the start of a tried and tested sequence of events, and in itself helps to create a phony "clinical" justification for the continued process of downsizing and then closing a busy local hospital.

This salami-slicing of services was demonstrated at Queen Mary's Hospital in Roehampton back in the early 1990s, and more recently has been applied to Queen Mary's in Sidcup. First A&E opening hours are cut back, and trauma services are removed, reducing services to out of hours medical emergencies. Then maternity services are cut back and then closed. Piece by piece the key elements that go in to making a district general hospital were hacked away, with each block removed from the package triggering others to fall – like some giant game of NHS Jenga.

With A&E goes paediatrics, ITU, High Dependency Units and Coronary Care. With maternity goes women's care. With the loss of trauma goes orthopaedics. Emergency surgery is pronounced "unsafe" or "unsustainable" and removed. Each element takes a range of supporting services with it, until the hospital is allowed to wither away: and each cutback also makes it harder to recruit medical staff and qualified nurses, opening up arguments that further cuts are required because staffing levels are inadequate.

To cap it all, trendy arguments are wheeled out by the King's Fund, McKinsey and other hired hands suggesting that new "settings" can deliver services more efficiently and effectively than hospitals: **the only snag is that these "settings" and services exist only on paper, lacking the funds, facilities, staff and any political commitment to make them a reality. The vague promises of services "closer to home" wind up with the actual closure of hospitals that local people value and depend upon, but nothing to replace them.**

That is the cynical process dressed up in "clinical" arguments that NW London can expect. It is already being carried out in North London (Chase Farm) North East London (King George's), South East London (Queen Mary's Sidcup) and now South West London (St Helier).

[4] Even Lord Darzi's Technical Report back in 2007 estimated the cost of an A&E-type consultation in a Polyclinic to cost £66, compared with £81 in a "major acute or specialist" hospital (2007:23). But another NHS London sponsored study of 6 London PCTs in 2008 estimated the average cost of an A&E attendance was just £68 (PA Consulting, *Study of Unscheduled Care in 6 Primary Care Trusts Central Report,* page 27).

Other hospital services

Echoing previous NHS London plans and McKinsey proposals, NHSNWL assert (with no evidence) that **switching outpatient appointments away from acute hospitals to "community settings"** presents "a significant opportunity" to reduce costs. It's not clear why this should be the case given the greater managerial complexity and the time consumed in travelling by scarce professional staff from one scattered outpost to the next to see small numbers of patients. No figures or evidence are offered. No new settings and facilities are planned.

NHSNWL also welcomes the government policy of opening up more and more NHS services to **"Any Qualified Provider" as a way to "open up the landscape to a wide range of providers"**. The first to be opened up in this way will be continence services, hearing and diagnostic services, by September 2012.

It remains to be seen whether private companies will be attracted to delivering services in some of these backwater areas neglected by the NHS for many years, and if so on what terms: profits (or "surpluses" for social enterprises) can only be made by increasing the fee per patient, or by reducing the skill mix of staff and the actual level of provision from its present inadequate level.

Savings are even anticipated by **changing the setting of deaths**: "benchmarking suggests that deaths in hospitals can be reduced by up to 14%" although NHSNWL admit this will take some time to achieve, postponing any cash savings until a later date.

Meanwhile another glib assertion is that hospitals can weather the storm caused by the wholesale loss of income as their services are switched to new settings, **by improving "productivity"** (e.g. "through seven-day working") – implying an increased level of exploitation of front-line and support staff, who face year-on-year pay freeze, and working with depleted numbers to cope with a rising caseload. Nowhere is it explained how this fits with improving or even maintaining the quality of care for patients, or retaining scarce nursing and professional staff.

But then, in a classic exercise in "Deliverology" NHSNWL lists a whole raft of statistics, ever increasing numbers of which will have to be supplied by hard-pressed Trusts to measure their performance, even as commissioners do their very best to reduce their revenue from treating patients: "Each year, the Cluster will release new contractual metrics to promote better performance across a range of performance measures". **It's hard to imagine more ways in which hospital staff and management could feel demeaned, exploited and abused.**

Mental health under the axe

Mental health covers a spectrum of issues, but as a category of spending is the biggest item on the NHS budget – consuming far more than cancer or cardiac services.

On the lower end of the severity scale, levels of depression in most parts of NW London are slightly lower than the London average, and in all areas significantly lower than the England average. However the picture for more severe mental illness is different: much of NW London is on or above the London average levels for incidence of psychosis, and London in turn is higher than the England average. Both Brent and Ealing are above the London average, although Harrow is slightly below.

Spending on mental health as a percentage of budget is above the England average in every NW London borough but Hillingdon, which is well below: spending in Ealing and Harrow is also above the London average.

All this might indicate that resources and services need to be focused on those with the greatest and most complex mental health needs, **but the focus of NHSNWL is on *cutting back* on mental health spending, by £20m (6%) this year and overall by £43-£54m by 2015.** The focus is on improving the integration of mental health in general hospitals (liaison services in A&E departments), "shifting settings of care" (from inpatient services to community or from community to primary care) – glibly described as "liaison, referral and support to primary care" – and an "integrated approach to physical and mental health" which is seen as the way to secure reduced outpatient attendances, A&E attendances and admissions to hospital among patients with long term mental health problems.

None of this addresses the steady growth in the numbers of local people suffering from dementia. Mental health providers, just like other NHS Trusts, are apparently expected to save huge sums of money by measures that are only described in the vaguest terms, and which require significant investment which has yet to begin.

NHSNWL admits £24m needs to be invested to secure the net savings it hopes to make: but until the new services are in place the existing system is the only choice for patients and professionals.

Community Services: cuts in staffing costs

No sector of health care is safe from the cuts. **Even the community sector, which might be seen as the beneficiary of cutting back on the use of hospitals, is facing hefty reductions in the name of productivity.**

NHSNWL asserts (with no explanation or detailed breakdown) that "benchmarking" local community services against other London providers "indicates there is an approximately 16% opportunity to reduce costs by achieving best in London cost-per-head".

But they recognise that this could destabilise the providers, and opt instead for a target of **cutting costs by 11% in 2012/13.**

Again this appears to be based on guesstimates, wishful thinking and statistics rather than any actual appraisal of local health needs, the pressures on staff and the need to maintain the quality of services.

Conclusion: a major threat to local services

Thousands of jobs are at stake across NW London if the proposed cutbacks take place as planned.

According to official projections by NHSNWL 1750 staff in total, 1,000 of them clinical staff could lose their jobs THIS YEAR (2012-13), with a total of 3,900 clinical jobs and 1640 non-clinical by 2015.

Those left in post will be landed with much heavier workloads, but of course face the pay freeze, and real terms pay cuts and increased pension contributions that are being imposed on other public sector workers. With the NHS being one of the major local employers, this is a major economic factor for Brent, Ealing and Harrow, and large numbers of working women could be added to the rising numbers of jobless as the recession grinds on.

But the biggest concern is the entirely vague basis on which NHSNWL is seeking to drive through these changes. There are huge gaps in the plans, even bigger gaps in the evidence on which they are supposedly based, and inconsistencies in the figures that suggest that NHSNWL is basing itself on a wing and a prayer rather than a clear blueprint. This is another reason why the plans have to be argued as the product of clinicians, and why it is important to give the impression that sections of the local public have already signed up, if health bosses are to bamboozle local communities into accepting their half-baked plans to cut spending.

The consultation process is getting under way, promising that:

- No decisions will be made before the end of the consultation period
- Following the public consultation, the Joint Committees of Primary Care Trusts (JCPCT) will make the final decision.
- The Joint Health Overview and Scrutiny Committee (JHOSC) will scrutinise our consultation plans. The JHOSC is made up of representatives from each of the local authorities in NW London
- There will be a period of 3-4 months following consultation where we will consider responses before we make any decisions

Yet we already know that crucial decisions have been taken in shaping the options that have now been made public, giving limited choices to local people in how they can respond. The consultation echoes the notorious Darzi “consultation” in 2008, offering only vague promises and abstractions, not identifying what will close when.

The Shaping a Healthier Future documents also promise to "be clear, transparent, understandable, based on evidence, and independently verified and analysed": we have already seen that this is not happening so far.

The aim is clearly to confront the public with a 'fait accompli', and get the public to accept "principles" before putting concrete closures to the test. **Nowhere, therefore is there a definitive picture of what would be provided and where under the new plan.** In particular there is no clarity on how and where the £130m would be spent on providing "out-of-hospital care", therefore giving people little idea what is really on offer, even if the money were actually available and ready to spend.

To make matters worse, cutbacks in NHS care run alongside continuing and unrelenting cutbacks in social services provided through local government. Those caught in the middle of this are the most vulnerable – the elderly, the frail, the housebound. And because social care is also subject to means-tested charges, there is the double danger of losing NHS care and having to fork out large sums for dwindling council-commissioned services.

Nowhere is there any discussion of how the poorest people and those with any mobility problems are supposed to travel miles across NW London to access the newly-centralised services which will no longer be local to them, or how much it would cost them and any relatives who may have to visit loved-ones in the few surviving hospital beds.

The plans are not fit for purpose: the cuts that are proposed cannot be delivered without devastating local services, and riding roughshod over the views and needs of local people. The answer to the consultation is already clear: JUST SAY NO – and press for local councils, local papers, community organisations and local politicians to say the same.

A fightback is possible.There are examples from around the country of local communities standing up a saying NO to cutbacks and closures like this. **In 2009-10 a successful campaign was waged in defence of the A&E at Islington's Whittington Hospital.** The local community mobilised alongside health professionals and trade unions, and put sufficient pressure on ministers to force a U-turn. That hospital and its services are still open delivering care to the local population.

In 2008 a vigorous campaign by the people of Banbury, in support again of health professionals and staff at Horton Hospital won a ruling by the Independent Reconfiguration Panel overturning plans to close maternity and cut other services. Here, too, the gains have been lasting and significant for local people.

The present government ran for office against New Labour in 2010 on the back of campaigning across the country against cutbacks and closures in local hospitals, with many demonstrations led by local Tory MPs. Andrew Lansley as Shadow Health Spokesperson and David Cameron as Tory leader pledged to stop closures of A&E and maternity services – although this promise has been largely broken in the period since they took office.

NW LONDON NHS **UNDER THE KNIFE**

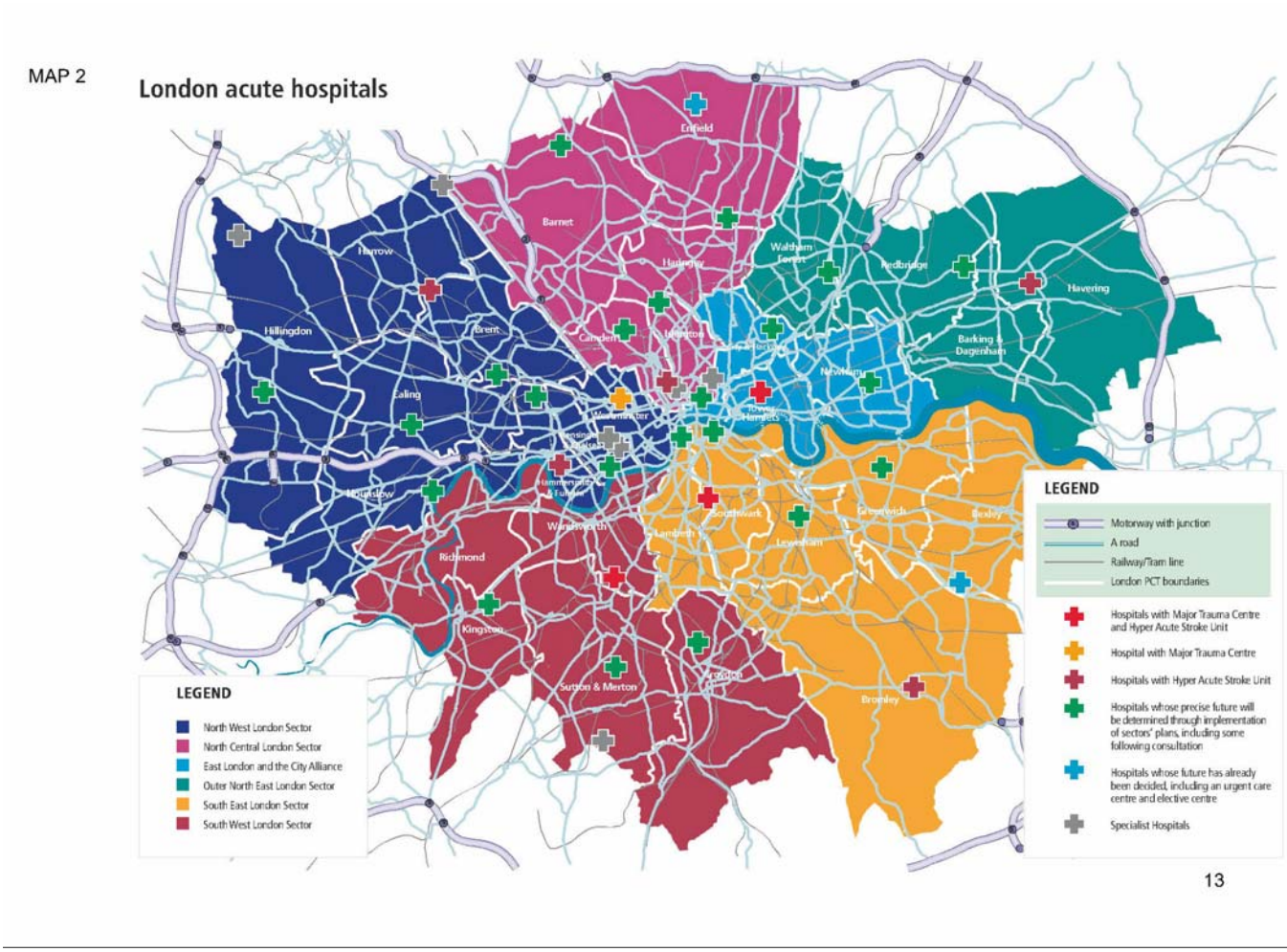
The proposals for NW London will be widely unpopular, and the arguments for them are disingenuous, attempting to rope in naïve and ill-informed sections of the local community and sign them up for a package of heavy cutbacks under the guise of “Shaping a Healthier Future”. Behind the façade of

The NHS in NW London should not be sacrificed for George Osborne’s vicious £20 billion cuts, which are designed to make working people pay the cost of bailing out the bankers and paying for their tax cuts. The £20 billion cuts target must be opposed, and the NHS funded in NW London and elsewhere to enable it to maintain standards and local services to those who need them.

Dr John Lister,
Information Director,
London Health Emergency
June 2012

Appendix

HISTORICAL BACKGROUND: NHS London plans in 2010



In April 2010 the future of more than half of London's **40 acute and specialist hospitals** was hanging in the balance as the capital's NHS chiefs drew up plans behind closed doors[5]. A detailed map of the capital in NHS London's ***"Integrated Strategic Plan 2010-2015"***[6] showed **23 hospital sites** where the future was undecided, and two whose future had been decided, and which were to lose most of

[5] Three out of five "sector" plans for health care still officially under wraps in mid-April – although the North West London sector plan has now been "published" courtesy of the BBC (http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_ae.pdf) after a leaked version was put on the BBC London website. It appears that the one for South East London is still not even complete, although an "Executive Summary" has been published.

[6] "Integrated Strategic Plan 2010-2015", First State Report, (Healthcare for London) NHS London January 2010, http://www.london.nhs.uk/webfiles/Corporate/First%20Stage%20Report.pdf

their acute inpatient and all of their emergency services. By contrast **just 15 of the 40 sites were planned definitely to remain**, whether as "major acute" hospitals or one of 7 specialist hospitals.

But this has never been part of a genuine rebalancing of services, in which reduced hospital spending would be compensated by expanded primary care and community-based services. The proposed reductions in hospital care and "shift of activity" to supposedly "lower cost settings" have since 2009 run alongside a squeeze on the community services and primary care – and cuts in mental health services too. And the same period has seen council spending on social care services for older patients brutally cut back, year after year.

The five "sectors" (North West, North Central, North East, South West and South East) which were set up by NHS London to draw up more detailed proposals outlined plans for cuts ("efficiency savings") totalling £2.6-£3.4 billion by 2016/17[7] – equivalent to 19%-24% of the £13.9 billion allocated to London's PCTs for 2010/11[8].

Hospital cutbacks

No area of London could feel that its hospital services are secure: even those hospitals which were expected to remain were expected to face massive financial pressures, wrenching demands for superhuman increases in "productivity", and the increased caseload as additional patients travel for care from surrounding areas where hospitals have closed.

NHS London had previously told the press of its intention to close a third of London's hospital beds – equivalent to around 5,700 acute beds, or 8,500 if mental health and geriatric beds are included[9]. The acute bed total is equivalent to around a dozen medium-sized district general hospitals, suggesting that the days could be numbered for up to half the hospitals whose future NHS London has thrown into doubt.

But community services, including mental health, were the biggest single target for potential "savings" in the *Integrated Strategic Plan*, and also face a drastic new drive to cut costs, including putting services out to tender.

Yet the document's reluctance to address the ***costs*** of alternative service provision, and the staffing and other practical issues involved in reconfiguring services to replace A&E and hospital care, gives a clue to the fact that the main driving force is not quality of services but the quest for cash savings.

[7] Enfield (North Central) , Hillingdon, Westminster (North West) Croydon and Kingston (South West) Bexley and Greenwich (South East)
[8] Department of Health 2009-10 PCT revenue allocations, at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091447.pdf
[9] Bed figures here and elsewhere in document extracted from Department of Health 'Beds Open Overnight in England', 2008-9 and 2004-5, (and previous years) available from http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781

It is one thing to claim that in a different system "87 percent of children and young people attending A&E services could be better treated in primary and community care" (ISP:2), but it is quite another to put in place a viable system that can convince the public that it offers appropriate services and can replace the existing hospital care that the majority of the public know, trust and love, as angry campaigns against A&E closures across the country can show.

Darzi's plan 2007

Lord Darzi's 2007 report "Healthcare for London: a framework for action"[10] outlined a wholesale reorganisation of primary care (into "polyclinics") and hospital services, seeking to centralise specialist services, shift huge numbers of minor A&E and outpatient appointments into primary care, and in the process downgrading many district general hospitals into lesser "local hospitals" and elective treatment centres.

Darzi himself claimed that his proposals could perform the magic trick of the century – and both improve services while also cutting spending by £1.5 billion a year by 2016.

However this view left a lot of questions unanswered, not least on how hospitals across the capital were expected to remain financially viable while obliged to absorb a massive loss of income as services are switched away and – under the government's "payment by results" formula – the money follows the patient … out of Trust budgets. The total cost, if all of the proposed shift of A&E and outpatient care were carried through could be up to £1 billion in total, creating chaos in hospital finances [11].

The strategy to save cash

In 2009 NHS London drew up a set of "affordability assumptions," based on McKinsey figures[12]. They included some frighteningly irresponsible suggestions.

- Non-acute services were expected to **reduce the numbers of staff employed by a staggering 66%.**
- **GP consultation times** with each patient were to be **cut by 33%.**
- **Prescribing costs** were to be slashed by **10-15%.**

[10] http://www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/aFrameworkForAction.pdf
[11] Lister (2010) London's NHS On The Brink (BMA London)
[12] NHS London Strategic Planning Guidance Appendix 1: HfL affordability assumptions). http://www.london.nhs.uk/publications/tools-and-resources/commissioning--2009-10-strategic-plans-and-world-class-commissioning-assurance-process

- More than **half of all outpatient appointments** (55%) and **60% of A&E attendances** were expected to shift from hospitals to "polysystems" (most of which have never been built).
- **Emergency admissions** to hospital for complex Long Term Conditions were to be cut by 10% and those for non-complex LTCs by 30%.
- Huge numbers of services were to be **"decommissioned"** – 7% of elective operations, 30% of outpatient appointments (leaving just 15% of outpatient work remaining in hospitals) and 10-15% of diagnostics.

None of these outlandish proposals, most of which flowed from evidence-free McKinsey powerpoint slides was accompanied by any concrete explanation of how it should be achieved, or by whom, or how these changes would do anything but massively undermine access to health care and the quality of services offered to patients.

Some of these proposals and assumptions are clearly still at the centre of plans by local PCTs and NHSNWL: but some (such as the proposal for a massive 66% reduction in non-acute services (community health) staff, a cut in GP appointment times and an across the board cut in prescribing costs) appear to have been scaled right back, or quietly put on the back burner by PCTs.

1. Closing hospital beds

Seeking a higher level of savings than Darzi's plan offered, NHS London threw the net wider in its search to cut spending, centred on the claim that not only was London "too reliant on hospitals", but it also had "a higher number of beds than the national average (3.7 versus 2.8 per 1,000 population)" (ISP:3). Since hospital beds are expensive to run, this in the NHS London view translates into an urgent case for closures.

One central problem with this argument is that the basic assertion was based on false figures.

The "national" figure quoted by NHS London appears to divide the number of beds in *England* by the *whole UK population*, giving an artificially low figure: the true England figure is that there are a total of 159,386 beds and a population of 51.4 million (ONS 2009), giving 3.1 beds per 1,000, significantly more than the 2.8 claimed by NHS London. And the capital, according to Department of Health figures[13], then had 25,627 beds, and a population of 7.6 million in 2007[14] giving 3.37 beds per 1,000. Given the heavy historic concentration of teaching hospitals and specialist (tertiary) care in London, and its extensive commuter population, this was not an extraordinary additional number.

Nor are hundreds of beds standing empty in London ready for easy closure. DoH figures show that London's beds are consistently more intensively occupied than the England average: total beds,

[13] DoH 'Bed availability and occupancy 2008-9' http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/index.htm
[14] http://www.statistics.gov.uk/cci/nugget.asp?id=1132

acute beds, mental health beds and "general and acute" are all running at above national average occupancy, according to the latest DoH figures: and in NW London general and acute beds in Ealing and NW London Hospitals, at 93% and 97% occupied, are well above the NHS and London average.

Local experience in general hospitals across the capital is that acute bed occupancy often approaches 100%, and that these peaks are not limited to the traditional "winter pressures". This chronic pressure is one reason why after a very rapid, and above national average reduction in acute bed numbers in the 1990s, London uniquely saw a slight upward correction, with a small (4.7%) increase in beds between 1999 and 2009[15].

Although NHS London drew up plans to divert literally millions of patients with less serious conditions away from A&E departments, and even more millions of outpatient appointments away from hospitals and into "polysystems", none of these changes would make any impact on the need for hospital beds, since these patients don't use beds anyway.

The proposal to provide "more care in the community and less in hospitals" (ISP:4) might result in a reduction of pressure for beds, but remains vague, and did not appear to be linked with any commitment to expand community based services to fill the resulting gap in care.

NHS London's plan to "stop clinical interventions that have little or no benefit" (which appears to mean cutting back on elective services wherever they feel they can get away with it) could also have an impact on demand for hospital beds – especially if these interventions are seen as including joint replacements. Again the evidence for these claims (first promoted by McKinsey in 2009) is absent, and the criteria for implementing this policy are not defined. The policy itself did not and does not seem to represent any clinical consensus, since it is clear that considerable numbers of patients are still being referred for such interventions by their GPs in the belief that they DO indeed offer real benefit, and consultants and other staff are continuing to deliver them.

The NHSL plan to save £60 million through "targeted investment in prevention" seemed a welcome proposal, although the limited scale and impact of current preventive measures would suggest caution before counting the savings that could be delivered over the short term in what is inevitably a long-term (if relatively small) investment.

2. Shifting caseload to primary care

NHS London needed bigger savings than the2007 Darzi report claimed to offer, so they went even further than Darzi's already ambitious proposals to shift care out of hospitals and into supposedly lower-cost "settings". Darzi's proposal (set out in his 2007 Technical Report[16]) for 50% of A&E

[15] Historic figures extracted and compiled by London Health Emergency from DoH (Government Statistical Service) ***Bed availability for England 1992-93*** – ISBN 1 85839 162 8

[16] http://www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/FFA-Technical-Paper.pdf

attenders to be shifted into polyclinics was therefore jacked up in NHS London's 'Planning Guidance' to 60%. And Darzi's suggestion that 40% of outpatient appointment should be transferred to polyclinics was also increased – to 55% (ISP:4fn).

NHS London's plans claimed to be based on a 2008 report from PA Consulting, the *Study of Unscheduled Care in 6 Primary Care Trusts Central Report*[17]. This was a detailed and nuanced 180-page study of caseload in six varied London PCTs , which says that of the "minor" patients attending A&E departments for treatment, one in three "were assessed to require an A&E clinician in the appropriate skill mix to treat them". In addition to this, and making a similar point, *Primary Care and Emergency Departments* by the Primary Care Foundation was published in early March 2010[18] it had been commissioned by the DoH to: "provide a viable estimate of the number of patients who attend emergency department with conditions that could be dealt with elsewhere in primary care" (p 4).

It found that relatively few patients attending hospital Accident and Emergency departments could be classified as needing only primary care – suggesting that NHS London had drastically overstated the case for shifting work out of A&E. The 102-page report specifically took issue with "widespread assumptions that up to 60% of patients could be diverted to GPs or primary care nurses", and argued that the real figure is as low as 10-30%. (page 5).

The extensive study of patients in actual A&E departments also found no evidence that providing primary care in Emergency Departments "could tackle rising costs or help to avoid unnecessary admissions." The report's authors argued that: "Cost benefits may exist, but the evidence is weak" (page 8).

It was very weak. Even Lord Darzi's Technical Report back in 2007 estimated the cost of an A&E-type consultation in a Polyclinic to cost £66, compared with £81 in a "major acute or specialist" hospital (2007:23). The study of 6 London PCTs estimated the average cost of an A&E attendance was just £68 (page 27): NHS London (ISP:2) calculated that an A&E visit cost an average £75, but it is not clear whether this was further proof of the efficiency gains in hospitals or another statistical blooper from NHSL.

An Audit Commission Report *More for Less* pointed out in November 2009 that PCTs, which had sought to do so for years, had failed to achieve the planned shift of activity: "The national figures for 2008/9 suggest that there was no shift from hospitals to care closer to home in the community: either in terms of investment or activity." [19]

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[17] Healthcare for London (2008) *Study of Unscheduled Care in 6 Primary Care Trusts Central Report*

[18] *Primary Care and Emergency Departments* is available at http://www.primarycarefoundation.co.uk

[19] Audit Commission (2009) More for Less (page 1). http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20091111moreforless.pdf

The same study concluded with what is a grim warning to the NHSNWL managers two years later, who are again seeking savings from reducing demand for hospital services:

> "whatever the anecdotal local evidence, the headline national numbers suggest that PCTs made little or no in-road in 2008/09 to transferring work from hospitals into the community or in dampening demand, either in terms of investment or activity. The most that can be said for demand management is that growth might have been higher without these local initiatives. **On the basis of these figures, demand management is unlikely to make a significant contribution to any savings required in the short term.**" (page 7)

Shifting outpatients into primary care

Much emphasis was laid by NHS London's 2009 planning guidelines on the idea of shifting 55% of outpatient appointments out of hospitals – where there are existing facilities and administrative structures geared up to dealing with the very large numbers involved – and into primary care, where no such experience exists.

No evidence was presented to suggest that it would be any cheaper or more efficient to deliver outpatient care in these smaller, scattered institutional settings than in the established hospital department that patients know and understand, and where other resources are also centralised.

55% of London's outpatient caseload was then equivalent to over 5 million patients per year: to commit to such a vast switch of services over the next few years was always wildly ambitious, and two years later little has yet been done.

The original 2007 Darzi plan suggested a total of 150 polyclinics, each dealing with around 25,000 outpatients a year – giving a total of around 3.75 million appointments (Technical Report: 25): that in itself would have been a logistical nightmare in the efficient use of consultant time. NHS London in 2010 proposed fewer centres (just over 100), but shifting more outpatient appointments – a formula for long, uncomfortable queues and massive patient dissatisfaction.

Conspicuous silences: mental health, older people, workforce

Among the issues ignored by the Integrated Strategic Plan was mental health, which had clearly been facing severe pressures in a number of PCTs and sectors across the capital, and had been singled out for less publicly visible cuts. And while older people will clearly be the recipients of a large share of whatever services are to be delivered, *not one* of the NHS London, sector or PCT documents in 2010 included a specific section addressing the care of older people, or looking at the issues of ensuring "seamless care" between a cash-strapped NHS on the one hand and social services with ever more restrictive "eligibility criteria" on the other. It's no better two years later in NW London, where exactly the same gaps can be seen where there should be policy.

The NHS workforce in London also appears to be consistently regarded as a problem rather than an asset, accused (ISP:3) on the strength of a of Deloitte report of being less "productive" than health staff elsewhere, and expected to simply cope with endlessly growing workloads in the community and primary care, and deliver enormous productivity increases – at the behest of PCT commissioners and SHA directors whose own level of productivity has remained a matter for speculation.

North West London

The Sector Plan drawn up for North West London early in 2010 warned of a huge looming cash gap for both commissioners and providers, with £796m to be taken from hospital budgets through shifting work elsewhere, "decommissioning" services, "cost improvement plans" and other cuts, while the commissioners were also seeking to bridge a projected gap of up to £547m (NWLISP:53-56)[20].

As a result NW London faced some of the more drastic upheavals in the capital, which the Plan declared would "inevitably result in fewer beds in the acute sector" and "substantial acute hospital reconfiguration" (NWLISP:2).

The "Working hypothesis" map showed just two hospital Trusts were definitely designated as "major acute" hospitals – Imperial Hospitals Trust (which incorporates St Mary's, Charing Cross and Hammersmith Hospitals) and Northwick Park (part of North West London Hospitals Trust).

There was even a question mark over whether Hillingdon Hospital, the most westerly site and closest to both the motorways and Heathrow airport, should be a major hospital or a "local hospital plus". Its future was being "reviewed".

However the Plan was not specific about how many A&E departments should close altogether, or how many would be downsized to urgent care centres. It was proposed that Chelsea and Westminster Hospital – which handled 97,000 A&E cases in 2009, along with 40,000 inpatients and 19,000 day cases – should be effectively downgraded to a "specialist and local hospital," as was Central Middlesex Hospital.

The biggest doubts in 2010 and ever since have hung over the future of Ealing Hospital and the financially challenged West Middlesex Hospital in Isleworth. Ealing was to be merged with the newly-merged PCT provider services in Ealing, Brent and Harrow to become an 'Integrated Care Organisation' (as has since taken place) but:

> "all involved acknowledge that this will, over time, reduce the level of acute services on the Ealing site" (NWLISP:51)

[20] This document is still most easily available via the BBC who were at first the only source of it when first leaked http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_ae.pdf

In other words the hospital was expected effectively to wither away and close, leaving nothing more than a polyclinic at best on the site.

The West Middlesex board had apparently "clarified that they do not believe that their organisation has an independent future". There was speculation that it might follow Hinchingbrooke Hospital, in Huntingdon as one of the first to have its management put out to tender, and it could be reduced to a local hospital or to purely an elective centre (NWLISP:51) – although the massive and continuing cost of its PFI hospital building would be enough to put off almost any private bid.

Shifting patients out of A&E

Then, as now, NWL asserted in 2010 that "There is good evidence that a large proportion of A&E attendances could be more appropriately treated by primary care rather than by an acute specialist" (NWLISP:16).

The Plan went on to state:

> "Historically the sector has experienced a high dependence on A&E access for unscheduled care. On average there are 268 A&E attendances per 1000 population compared to the national average of 270" (NWLISP:31)

In other words the sector remained **LESS** dependent upon A&E than the national average. The local figure has since reduced further. Nonetheless NWL has never been willing to not let the facts get in the way of a good argument, and insisted that a large proportion of A&E attendances could be more appropriately treated by primary care.

NWL also followed NHS London's lead in seeking to switch outpatient appointments from hospitals to the community, appearing to enlist the support of the National Primary Care Research and Development Centre for this view, despite research from the same centre which questioned the impact of this switch on cost and quality[21].

The NWL plan was to cut outpatient caseload at hospital to just 15% of the current level, by "decommissioning" 30% of outpatient attendances, mainly by reducing follow-ups, and switch 55% of the remaining workload to 25 planned polysystems by 2014 (NWLISP:29). Elective care would be concentrated in dedicated elective centres.

On primary and community care, NWL proposed a 12 hours-a-day "urgent care service" in each local community, with access to diagnostic services, and integration of the management of Long Term Conditions to avoid hospital admissions. All this would clearly require additional staff and resources in the community, as would improved capability to manage hospital discharges to avoid unnecessary bed days (NWLISP:31).

[21] See Sibbald, McDonald and Roland (2007) Shifting care from hospitals to the community: a review of the evidence on quality and efficiency, ***Journal of Health Services Research & Policy*** Vol 12 No 2, 2007: 110–117

Cash crunch for providers

As if all of these proposals to remove work (and therefore income under the "payment by results" system) from hospitals were not clear enough a statement of intention, the ISP made it quite clear that the lion's share of the spending gap in NW London would have to be carried by the providers, who faced a hefty £252m loss of income from the transfer of care to "lower cost settings" plus another £92m from "decommissioning" of existing activity (cutting out follow-up outpatient appointments, and treatments deemed by McKinsey and NWL sector bureaucrats to be of limited or no clinical value).

This gap of £361m in Trust finances was supposed to be offset by £203m in "savings" from the services transferred to other settings (exactly how savings of this scale could be secured was not explained), plus another £78m from "decommissioned activity".

In other words a jobs massacre.

On top of these questionable savings, the Trusts were also required to generate another £361m in "cost improvement programmes" and a further £91m of savings in some undefined way by 2014/15.

So the cash gap from the provider's point of view was a massive £796 million by 2014 (NWLISP 53-56) – made up from £344m in lost income plus £452m in "efficiency savings". This was more than a third of the combined £1.98 billion income of all six acute Trusts[22].

And even the most optimistic level of savings from reconfiguration of hospital systems was £6m-£40m, dependent upon turning one hospital into a polyclinic (NWLISP:55) – leaving a huge question over how such enormous cash savings could possibly be made in NWL London providers.

NWL declared – belatedly, and after outlining the cuts – that it was planning "further work to test the future viability of acute providers" (NWLISP:55).

Cash gap for commissioners

The Strategy concluded that NWL commissioners also faced "a funding gap – of between £168-£547m by 2013/14, after the expected reduction in provider sector tariff (NWLISP:56). This explains the plans to shift acute activity to "lower cost settings" (which was hoped would save £52m), and improve management of long term conditions and decommission activity (to save £64m.) But NWL also wanted to force more "improved efficiencies in primary and community settings" to generate another £168m in savings.

[22] Ealing Hospital income £130m; Imperial Hospitals £897m; NW London Hospitals £345m; Hillingdon Hospital £181m; West Middlesex £143m (DoH The Quarter #3 2009/10) Chelsea & Westminster FT £280m in 2008-9 (Annual report).

Huge projected savings were described only in the vaguest terms, making it impossible to assess the likely impact. In short, the numbers just did not stack up. It was clear even then that if the £20 billion efficiency target for the NHS remained unchanged, a number of Trusts in NW London did not have a viable financial future.

Conclusion

Plans for North West London since 2009 have all centred on achieving massive "efficiency" savings, most of them through cutting the actual level and volume of services provided, restricting patient numbers, downsizing departments and hospitals, and cutting the workforce.

There is little if any evidence to support the claim that these changes are "clinically driven" or led by clinicians rather than accountants and city management consultants. There is not a shred of evidence to show that the resulting levels of service will be sufficient to meet health needs in NW London or accessible to those sections of local communities who need them most. NW London NHS is under the knife, and these cuts could prove fatal.

Dr John Lister
Information Director, London Health Emergency
June 2012