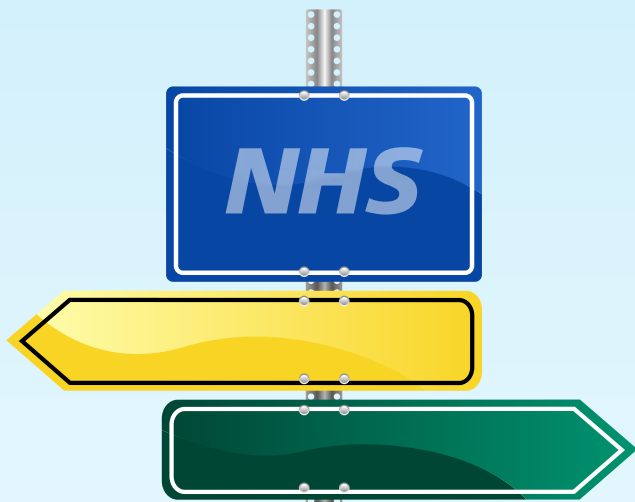


People's Inquiry into London's NHS

Supported by Unite the union, London and Eastern region

London's NHS at the Crossroads



Foreword

The London and Eastern region of Unite is extremely proud of our decision to sponsor the People's Inquiry into London's NHS.

This union represent tens of thousands of NHS workers in the capital but more than that, our members from all walks of life pay for the service and rely on the service.

Our members – from support staff to expert clinicians - have been heavily involved in campaigns to defend the service across the capital; fighting cuts and closures and raising concerns about service delivery and patient safety across the capital.

They have become increasingly concerned about the direction this government has taken the NHS, fearing that its true intention is to transfer this national asset to the private sector.

However, we realised that if we were to fully understand the scale of change, to understand if our alarm at government policies was truly well founded, it was essential to find out what was happening London-wide. We needed a picture of the NHS across the capital, which is why we established the Inquiry.

This report is possibly the first attempt to understand how the Health and Social Care Act 2012 is 'working' on the ground across London.

What we found was, sadly, not surprising. That Act has drained the NHS of an essential £3 billion which ought to have gone on patient care, and imposed horrendous and needless upheaval on the service.

Where there was once, very recently, a world-leading service, there is now confusion and all too often chaos. The implications that this approach will have for patient care, safe delivery and the commissioning of services are now becoming clear.

The NHS has been placed in a headlock by this government, trapped between the punishing financial restrictions and huge cost savings being imposed. Money is being wasted as administration has ballooned and costly agency staff are used to cover for staff cuts.

The decision by the health secretary to cut the wages of NHS staff for another year – ignoring the expert advice of the pay panel – will only drive more skilled professionals to the door, unable to afford the cost of living and caring in London.

Unite has always believed that the Act was going to lead to the dismantling and fragmentation of our NHS – and we are now seeing these consequences.

London is a world capital. Its communities, people and businesses will suffer unless this assault on the very service that ought to allow the capital's citizens to play a full part in the city's success is arrested.

Our hope is that this report will bring some sense to the debate raging on the future of our NHS. To those who are pushing for further cuts and more commissioning, we urge you to consider this evidence and think again.

I would like to thank our eminent panel members who gave up so much of their time and energy to ensure that this process and the report were successful and meaningful. Of particular importance are the panel's detailed recommendations. They not only point to how much damage has already been done to our NHS, but crucially they begin to provide a clear road-map of what needs to be done to put our NHS back together again.

Our NHS has given generations of ordinary people enhanced life chances, but is at the most dangerous moment in its 66 year history. This immense, collective effort to ensure decent health care for our people, is being systematically undermined.

The fight is now on to safeguard the service, to preserve it for future generations. As Bevan said, it will survive as long as folk have the faith to fight for it.

Unite has faith. The challenge is now with Unite, the Labour movement and concerned bodies to take up these recommendations. We need to discuss and debate them so we have a clear consensus about what needs to happen after the next election to put the NHS back together again.

Peter Kavanagh
Unite Regional Secretary
London and Eastern region



Foreword

It has been a pleasure and a privilege to chair this inquiry into Londoner's healthcare; to work with a panel of experts and benefit from their wisdom and experience. My thanks to each one of them.

My thanks also to the experts, managers, and frontline staff who took the time and trouble to come and share their experiences, facts, concerns and give us their evidence.

And of course a big thank you to Unite for initiating and so unselfishly supporting the Inquiry, allowing the Panel to choose who to speak to, what to ask, and to shape our own recommendations.

I am sure I speak for the entire panel when I say; I was truly shocked at the unravelling services, the complexity and the enormity of the difficulty involved in trying to plan and deliver cohesive, integrated services from the wreckage of a fragmented care landscape. The financial squeeze that services are under and the lack of certainty is made all the worse by a management vacuum at the strategic level.

As the facts and data in this document will attest, London is a special place; not just because it is our capital city but because of its rich diversity and make up and the increasing numbers of its citizens that are dependent on its health and care services.

From the evidence we have heard and seen it is clear there is no 'London Voice' in planning its healthcare future. It is next to impossible for the public to have any meaningful engagement with changes and future development. That cannot be right. If it really is 'Our-NHS' then 'our voice' must be heard and better models of public engagement must be found.

The Panel have made a wide ranging set of recommendations. They include the future of PFI, public engagement and funding, transparency, integration and right up-to-date the impact of Section 119 of the Care Bill (soon to be enacted).

These are eighteen recommendations that are evidence based, carefully thought through and offered in the spirit that sometimes a fresh pair of eyes, unencumbered by the pressures of the day-to-day, can see things differently.

The NHS will be the battle ground at the next election. We would ask all London MPs to consider our findings; give thought to the facts we have unearthed, a voice to the recommendations and a say for the people of London. The panel's job is done, but the work is just beginning.

Roy Lilley

Chair, People's Inquiry into London's NHS



Executive Summary

London's NHS is not isolated from the rest of the NHS in England: but it is special. Its population – equal to Wales and Scotland combined – is far larger than any other city in Europe, and is also far more diverse on almost any measure (age, ethnicity) and more unequal, with extremes of wealth and poverty.

While other big English cities have a single city council in control and relatively unified health commissioners, London is split into 32 boroughs and the City of London, with 32 Clinical Commissioning Groups. The mayor and Greater London Assembly have only limited powers to influence health and social care.

Nonetheless we recognise that many of the issues that have been discussed in the Inquiry have a national dimension, and also apply to health services in other towns, cities and rural areas. Many of the proposals put forward in the recommendations also clearly apply to the NHS as a whole: but the evidence we have examined in detail is based on London.

We would stress that while this has been a trade union-funded report, it is not simply a reiteration of a trade union critique of controversial changes. The Panel has seen the defence of NHS jobs and staffing levels and working conditions of staff in the context of the need to ensure the quality of patient care and we have been impressed by the way in which the trade union representatives and health staff who have presented evidence have shared this approach.

And while the debates often appear to focus on healthcare systems, hospitals and other buildings, or the financial pressures on commissioners and providers, we have never lost sight of the fact that the system should be there not to satisfy the ideological prejudices of governments or the entrepreneurial ambitions of individual managers or clinicians, but to deliver safe, effective and high quality care for patients.

The Inquiry

The People's Inquiry into London's NHS was established last autumn, supported by Unite the union's London and Eastern region, which gave full discretion to an independent six-person panel, chaired by former NHS trust chair Roy Lilley.

The Panel held seven public hearings and one closed session for staff, hearing contributions from 95 people, including NHS commissioners, providers, hospital and primary care doctors and other NHS staff and their representative organisations, local politicians, academics, pensioners groups, campaigners and patients. It also received dozens of written contributions and presentations.

The Report

Edited transcripts of each of the public sessions, and many of the written presentations have now been published on the People's Inquiry website www.peoplesinquiry.org.

The Panel discussed the main themes and issues that had emerged from the hearings, and drew up an outline of 18 unanimous recommendations, which together with explanatory evidence now form the concluding part of the Inquiry's report.

The first part of the report, commissioned by the Panel, sets the social, economic and political context of the current situation in London's NHS, with a historical overview of the main changes and proposals that have shaped events since 2007.

London's NHS

London has a very large, growing, youthful and diverse population, with a birth rate that is still growing: it also has a growing population of older people who typically have more need to access health services. The capital has several of the ten most deprived boroughs in England, but also some of the most wealthy areas. With soaring house prices and a severe shortage of affordable housing it has higher than English average levels of homelessness, private rented accommodation and council housing.

The social inequalities are also matched by the inequalities in prevalence of mental ill-health and provision of mental health services, and London's mental health trusts have been hit – as have others across England – by cuts in spending, and now a differential squeeze on budgets which leaves mental health at a disadvantage compared with acute hospitals.

Planning services across the capital has been made more difficult by the abolition of the Strategic Health Authority, NHS London in April 2013, and the fragmentation of commissioning into 32 Clinical Commissioning Groups (CCGs), while NHS England retains centralised – and largely unaccountable – control over primary care and specialist services. The Health & Social Care Act 2012 has effectively increased the numbers of commissioners, while in practice imposing greater centralised control.

With no clear role being played by the newly-created Health & Wellbeing Boards chaired by local council leaders or the Health Watch bodies established under the Act. This creates a democratic deficit in which there is no clear path through which the views of local communities on controversial issues can be properly articulated other than through political protest and confrontation.

Finances

London's CCGs will have a budget of £10 billion from 2014-15, but from this are required to keep back reserves or retain surpluses totalling 3.5%. Cash allocations have been rising at below the actual increase in inflation and other rising costs for the NHS. This underfunding is set to continue or even get worse right up to 2021 under the current Chancellor's spending plans. In other words the NHS budget is formally "ringfenced" but in practice falling in real terms. NHS England has called for action to make further savings of £4 billion by 2021.

Services: primary care

London has fewer GPs per head of population than the rest of England and the Royal College of General Practitioners has calculated that an extra 16,000 GPs are needed in England by 2021 if primary care is to improve.

Hospitals and secondary care

Contrary to some misleading claims, London does not make higher than average use of emergency admissions, although more than half the admissions for mental health patients in London were emergencies.

London has fewer than its proportional share of general and acute hospital beds and these beds are running at higher levels of occupancy than in the rest of England. Previous plans which looked to expand London's bed capacity to deal with the rising population have now been abandoned, with London's hospitals far short of the bed numbers projected for 2016, and more set to close.

Private sector

London's NHS makes very little use of private hospital beds (less than 1% of admissions, most of these day cases), and relatively few community health services have been outsourced to private providers. The most substantial privatisation has been in hospital pathology services north and south of the Thames. The private sector has a chequered history of performance failures, and Hackney GPs have set a precedent by taking back out of hours primary care services from Harmoni.

Community health services

Community services have been the target for the largest share of efficiency savings since 2010. Despite plans which assume substantial shift of patients and treatments out of hospitals and "into the community", there is little or no concrete detail on how such services would be structured or delivered, or how they would be established.

Outside London there has been much more fragmentation and privatisation of community health services. In the capital the model has been largely one of services being delivered by local acute, mental health or community health trusts, with two areas (Bromley and Kingston) covered by social enterprises. However, Wandsworth CCG in line with Section 75 of the Act is proposing to break up its community health services and put them out to tender.

Social care

Local government has had to cope with an even bigger funding squeeze than the NHS. Social care has been especially hard hit over the years, having suffered a 20 percent cutback since 2011. London's boroughs not only have to juggle these cash constraints but also face the added burden of a local population with more complex needs. The capital has well below the provision of care home places than elsewhere in England. The outlook according to the Association of Directors of Adult Social Services is "bleak and getting bleaker".

Plans for London's NHS since 2007

Professor Sir Ara Darzi's report *A Framework for Action* mapped out plans for an expansion of healthcare in the capital to meet the needs of a rising population and address wide inequalities in health. It also proposed a substantial development of primary care, with the focus on large-scale "polyclinics" that would offer a range of services for primary care patients. It proposed the centralisation of hospital specialist services and the downgrading of some district general hospitals to "local hospitals", with minimal in-patient services, while others would be designated "major acute" hospitals.

The plan had its flaws, but many of the issues that were most controversial flowed not from the report but from the way it was subsequently used as a pretext for reconfiguration of hospitals without the necessary development of community and primary care.

After the banking crash in 2008, NHS London responded to the impending end of ten years of increased spending on the NHS by outlining plans for the capital to take more than its proportional share of the £20 billion cost savings proposed by a McKinsey report. It called for the closure of a third of London's beds – equivalent to around a dozen hospitals. And divided London into five sectors, in which the Primary Care Trusts were to work together in clusters to plan the reconfiguration of services around these objectives, using some of the arguments from the Darzi plan.

Prominent Tory leaders responded by campaigning against hospital closures in the run-up to the 2010 election, only to change direction immediately after taking office. Andrew Lansley unveiled the white paper that became the basis for his Health & Social Care Bill, and London's PCTs, still in their clusters, continued with their plans to reconfigure and downsize hospital services and going beyond general proposals to outline most of the plans which have since proved so contentious. They also relied heavily on some of the arguments and unproven assertions put forward by NHS London and McKinsey on how savings might be made.

PFI

In a number of areas the scale and unaffordable cost of contracts drawn up for building new hospitals with private capital under the Private Finance Initiative have become the driving force behind controversial policies. South London Healthcare Trust, containing two hospitals each with excessively costly PFI schemes ran up debts that triggered the intervention of the Trust Special Administrator – and plans to axe the neighbouring Lewisham Hospital. The giant Barts Health trust opened its £1 billion PFI development, and has since been forced into heavy-handed cuts in staffing in pursuit of £77m in cost savings. Further east the spiralling payments on the £240m Queens Hospital in Romford have driven plans by the Barking Havering & Redbridge Hospitals trust to downgrade its other main hospital, King George in Ilford.

Since April 2013

NHS England's London office has picked up where NHS London left off, arguing that the capital alone faces the prospect of a £4 billion gap between demand for care and resources unless far-reaching changes are made – along exactly the same lines as proposed by NHS London.

However, local plans for reconfiguration are no closer to securing public acceptance, or demonstrating convincing evidence that they can make the savings they are claimed to offer.

- In South West London, the Better Services Better Value project has been abandoned.
- In South East London the Save Lewisham Hospital campaign successfully challenged and blocked attempts to cut vital services.

- In North West London the Independent Reconfiguration Panel has raised concerns over the two larger proposals – for downsizing Ealing and Charing Cross hospitals – in the Shaping a Healthier Future project and set the process back.
- In North East London the plans to cut King George Hospital fly in the face of chronic pressure on beds and services at Queens Hospital.
- In North Central London, where campaigners for the Whittington Hospital have fought off two attempts to cut services, the one closure that has gone ahead, in Chase Farm Hospital, has gone badly wrong, leaving Barnet Hospital struggling to cope.

Meanwhile, with primary care services under pressure, and GPs expected to shoulder much of the extra work if hospital services are closed, no plans have emerged to follow on the Darzi proposals for investment and expansion.

Financial snapshot

While most London CCGs are forecasting a surplus by April 2014, many on the basis of having made use of contingency reserves, almost half the capital's remaining NHS trusts have found themselves up against large and rising deficits as commissioners seek ways to reduce patient referrals and Monitor cuts the tariff price paid for each treatment.

It seems clear that London's NHS is at a decisive point: if it continues on the course projected by the current government, senior analysts are already warning that huge gaps will open up between resources and demand – gaps which policy proposals from McKinsey and other management consultants have not been able to bridge.

Recommendations from the People's Inquiry into London's NHS

The Panel agrees from all of the available evidence that the present trajectory of financial constraint and fragmentation, if unchanged could lead to increasing strains on frontline services and commissioning budgets, primary care, mental health and community health sectors.

A change of course is urgently needed. That's why we argue that London's NHS is now at the crossroads. Our recommendations map out an alternative way forward to keep services intact and get them working more effectively together to serve patients.

The People's Inquiry recommendations seek to address the issues that have emerged as themes across London, drawing from the evidence we have heard and the expertise and views of our Panel.

Recommendation 1: Review the spending constraints that threaten the future of services

The Panel are convinced that the levels of financial restraint proposed for the next 6-7 years are unsustainable without serious damage to the quality and availability of NHS services, both in London and in England as a whole. There is no locally-based funding of the NHS, which has always drawn its resources from general taxation – and therefore no specifically London answer.

1.1 WE RECOMMEND that the planned allocations of funding to the NHS are revised significantly upwards at the first available opportunity, returning to real terms increases each year which at least match the increased cost and demand pressures on NHS providers.

1.2 WE RECOMMEND that, in line with the findings of the Francis Report and with our general call for more transparency and accountability, all NHS senior managers should be subject to a duty of candour about the situation they face and required to speak out openly where they face unacceptable choices driven by resource constraints. This would put the duty to explain back onto the politicians and ministers whose decisions are responsible: they alone must be required to justify their priorities and decisions to the electorate.

1.3 WE RECOMMEND a review should take place of the funding formula and tariffs paid for care in London. For years it has been alleged that London was overprovided but it is not clear whether funding or tariffs recognise the actual population, the additional population treated in London and the additional costs faced by Londoners.

Recommendation 2: Reinstate strategic overview

2.1 WE RECOMMEND the creation of a new type of London Strategic Health Authority, on a model which does not replicate the former structure of NHS London, but which encompasses a democratic element, possibly with involvement of the GLA, London boroughs and CCGs. Once again London is not a special case on this issue: we also feel that similar new-style SHAs with democratic input should be established to cover natural regional populations elsewhere in England.

2.2 WE RECOMMEND the strategic body that primarily relates to London and its various needs should take over the commissioning of primary care in the capital from the remote control of NHS England and its three London local area teams (LATs), which appear to have little if any accountability to or interaction with Londoners.

Recommendation 3: Transparency and accountability

3.1 WE RECOMMEND that all bodies taking and shaping decisions over NHS provision and commissioning should be public bodies and required to hold regular and well-publicised meetings in public and to publish its board papers and policy discussions. It, and all of the organisations delivering publicly-funded care and services should also be subject to Freedom of Information legislation.

3.2 WE RECOMMEND that commissioners make use of the powers they already have within the procurement process to stipulate that acceptance and accountability under the FOI Act should be a standard requirement for any private company or social enterprise seeking NHS contracts.

3.3 WE RECOMMEND that any limited business secrecy at the time of negotiation of contracts with public, private or social enterprise providers should be followed by the prompt publication of the eventual contract as agreed, along with relevant supporting information.

3.4 WE RECOMMEND the use of open book contracting as the basis for contracting to help avoid accusations of overcharging.

Recommendation 4: Integration of care in and outside hospital

4.1 WE RECOMMEND a halt to the costly and complex extension of competition and piecemeal tendering of NHS community services – especially given the problems already being faced in some areas by private providers such as Serco and Virgin in delivering community services of acceptable quality at a profit.

4.2 WE RECOMMEND an alternative route of integration of community services with existing NHS and foundation trusts where this has not already happened, as part of a renewed initiative to establish joint working with NHS and borough social service departments. This type of arrangement, if properly designed, with trusts being given appropriate incentives for outcomes and adequate investment in community services and links with primary care, would better facilitate supportive discharge and give genuine incentives to secondary care to reduce admissions.

4.3 WE RECOMMEND the maintenance of incentives for trusts to continue to have short waiting times and recognise that a return to waiting lists to regulate supply and demand is not acceptable.

Recommendation 5: Swift reversal of aspects of the Health and Social Care Act

5.1 WE RECOMMEND the obligations to competition imposed by the Act be repealed at the first available opportunity, along with steps to restore the explicit duty of the secretary of state to provide a universal service, as proposed in Lord Owen's short Bill.

Recommendation 6: Repeal clause 119 of the Care Bill and reconsider the TSA Failure regime

6.1 WE RECOMMEND that there should be reconsideration of the TSA regime and that clause 119, which has been passed as this report is finalised, should be swiftly repealed by whichever government takes over in 2015. We don't accept that rushed and top-down processes can ever secure serious local acceptance of controversial proposals.

6.2 WE RECOMMEND a London-wide needs assessment and analysis of patient flows and existing resources, to be drawn up without delay for the new Strategic Health Authority at the earliest possible opportunity, by a panel including public health experts, commissioners, providers and local authorities. The assessment should specifically include areas of service that have commonly been overlooked or ignored by reconfiguration proposals – such as healthcare for children, and mental healthcare for adults, children and adolescents and older people.

Recommendation 7: A renewed initiative to improve the quality and accessibility of primary care

7.1 WE RECOMMEND that an investment programme in primary care is reinstated as a priority of a new Strategic Health Authority for London, linked with the needs assessment we propose in Recommendation 6.2. We note that part of this must involve realising long-standing promises and aspirations to ensure all GP practices in London are able to make use of modern, accessible local facilities in a health centre.

7.2 WE RECOMMEND a further initiative to expand the workforce of GPs for the future by those planning medical education through Health Education England in conjunction with the three Local Education and Training Boards that cover London.

Recommendation 8: Review the allocation of resources for mental health services

8.1 WE RECOMMEND a moratorium on any further service reductions in mental health, pending a rapid, full-scale review of the resources available and the pressures on all sectors of mental health services and provision in London, to be followed by swift action to respond to the gaps and shortfalls and resources that are identified.

Recommendation 9: A review of the tariff set by NHS England for specialist forensic mental health services

9.1 WE RECOMMEND as a matter of urgency that NHS England, and its London regional office review its flawed tariff for forensic and other specialist mental health services in the light of an overview of the average cost per episode and the effectiveness of treatment and revise its tariff accordingly.

Recommendation 10: Breathe life into the organisations that are supposed to represent local patients and communities giving HEALTH WATCH bodies the statutory powers that were previously held by Community Health Councils (CHCs)

10.1 WE RECOMMEND that Health Watch England is closed down and local Health Watch bodies are separated from the Care Quality Commission (CQC) and modelled on the old CHCs. They should link up with local community organisations, pensioners groups and other community organisations, and be given the statutory powers to inspect hospital and community services, to object to changes which lack public acceptance and to force a decision on contested changes from the Secretary of State.

Recommendation 11: Councils must make underachieving and narrow Health & Wellbeing Boards (HWBs) into genuine platforms for the planning and scrutiny of public health, health and social care in each borough

11.1 WE RECOMMEND that if the HWBs are NOT given a role in shaping local health care as part of revisions to the Act after 2015, then local Health Watch bodies, with the additional powers proposed in Recommendation 10.1, should be merged with their local HWBs.

Fusing together these two organisations gives the opportunity to create a single, clear and authoritative, democratic voice for local people that will monitor and scrutinise local health and social care services, plan for future developments, but also champion patient complaints.

Recommendation 12: Further investment in ambulance services, and greater clarity on “pathways” of care

12.1 WE RECOMMEND an urgent review of emergency ambulance services to establish the resources needed to meet and sustain target standards, along with a review of the system of pathways of care, to quantify the resources required to make these a reality rather than an empty phrase, or simply another complex task dumped onto already overstretched GPs.

12.2 WE RECOMMEND that there should be an obligation on ambulance control to notify callers well in advance in cases where it’s clear that delays are inevitable in the dispatch or arrival of an emergency ambulance.

12.3 WE RECOMMEND an appraisal of the costs, benefits and viability of the expanded network of Patient Transport Services that would be required for LAS to provide reliable services that could enable less mobile patients to travel further for outpatient treatment in the event of hospital reorganisation.

12.4 The unclear status and functioning of pathways of care needs to be clarified to ensure that local services are viable and clearly understood by all of the health professionals involved and explained to patients and carers, along with any implications for them.

Recommendation 13: Respond to Royal College of Midwives concern over staffing levels and maternity units

13.1 WE RECOMMEND further research to establish the evidence for the clinical safety of stand-alone midwife-led units in the context of the social conditions in London. The RCM, Royal College of Obstetricians and Gynaecologists and service users should be engaged in the development of a new London-wide and nation-wide strategy for safe, accessible and patient-friendly maternity care, and the necessary investment and development of the workforce and training required to make this possible.

13.2 WE RECOMMEND a full review of plans to further centralise obstetric and paediatric services. International comparisons indicate the UK system may be excessively centralised already. We remain unconvinced that centralisation is the appropriate response to problems of achieving compliance with the European Working Time Directive.

Recommendation 14: Post-Francis report staffing levels: the impact of Cost Improvement Programmes

14.1 WE RECOMMEND that lessons from the Francis Report, not only on understaffing but on the negative consequences of bullying, and the obligations on management to speak out when faced by resource constraints that potentially threaten the quality of care be taken on board for all sectors of the NHS.

14.2 WE RECOMMEND that further research be commissioned by the trades unions – and preferably also by NHS managers – on the impact on staff morale, performance, recruitment and retention of downbanding staff to pay grades appropriate for less qualified staff.

14.3 WE RECOMMEND that the establishment of authoritative and appropriate guidelines would be an important step towards accountability and averting further failures as a result of under-staffing in acute hospitals. But an agreed standard is needed.

14.4 WE RECOMMEND trades unions and professional bodies should come together to carry out practical and comparative research to establish the basis for firm national norms on staffing levels and skill mix for each category of healthcare provision, and to publicise their findings as widely as possible and campaign for these to be adopted.

14.5 WE RECOMMEND that equivalent norms should also be developed for mental health, community services and in allocating district nursing and health visitor caseloads.

Recommendation 15: Improve communication and management relations with staff and provide adequate protection for whistleblowers

15.1 WE RECOMMEND commissioners introduce an explicit contractual requirement for trusts and NHS-funded providers to develop partnership working with trade unions which can create constructive ways of addressing concerns on the safety and quality of patient care. This should be coupled with a requirement to protect whistleblowers where such measures have not been developed or proved unresponsive.

15.2 WE RECOMMEND that nursing staff, doctors and other professionals at all levels must be empowered to insist on the high standards set out in their respective professional codes of professional conduct if they are to be held accountable for any failures to do so.

15.3 WE RECOMMEND that where services cannot be sustained at safe and acceptable quality of patient care for lack of funds, NHS management should make it clear to commissioners, politicians and the public that these services will be closed unless more funding is provided.

Recommendation 16: Policies to avert PFI-driven financial failures

16.1 WE RECOMMEND that payment by results tariffs for each hospital should be adjusted for the actual costs of their capital, at zero net extra cost to the Treasury.

16.2 WE RECOMMEND fresh efforts to find ways to reduce the costs of existing PFI schemes and stem the flow of PFI payments, especially those going to offshore companies in tax havens.

Recommendation 17: Independent review of the evidence base for the clinical case for reconfiguration

17.1 WE RECOMMEND the commissioning of an INDEPENDENT REVIEW of the evidence for the various reconfiguration processes taking place across London by a combined panel of academics representing each side of the argument – and if necessary further research to answer the questions that have been raised. The findings, which will also have implications for many other reconfiguration proposals in England, should be widely published and disseminated to inform evidence-based policy.

Recommendation 18: An end to constant cuts in social care budgets and a review to establish nationally-agreed eligibility criteria for social care support

18.1 WE RECOMMEND that this interface of health and social care be a main focus of the London-wide needs assessment we called for in Recommendation 6.2, to identify the resources required for the expansion of these services in the capital.

18.2 WE RECOMMEND that this development should include a programme of improved training – and therefore enhanced status – for care workers, who need to be integrated as part of the health and social care team. This means an end to low cost, low value, low quality contracts with private providers whose profits depend upon zero hours contracts, which save money for the employer at the expense of fragmented, unsatisfactory care for service users. As contracts come up for renewal, services involving zero hours contracts should be brought back into the public sector so that scarce staff resources can be used efficiently and services can focus on the needs of the client.

The People's Inquiry

The Inquiry was initiated by the London and Eastern region Unite the union, as a project to address the consequences in London of government policies including the unprecedented squeeze on NHS funding and the implementation of the sweeping top-down reorganisation of the Health and Social Care Act 2012. With no light at the end of the financial tunnel, analysts forecast continued, increased, financial pressures on the NHS through at least to 2021.

Costs have been further increased by the Health and Social Care Act. Its Section 75 regulations impose a legal requirement on local Clinical Commissioning Groups to put more and more NHS services out to competitive tender. This will further fragment services, and reduce public accountability, while increased managerial costs will divert more resources and management attention away from frontline care, and open up new opportunities for profit-seeking private companies to carve off slices of the NHS budget, destabilising existing NHS services.

With NHS managers seeking cost savings and arguing the clinical need for reconfiguration of hospitals and diversion of patients to services closer to home, debate has raged in all parts of the capital over the shape of healthcare services, and the capacity of any new services to meet the growing health needs of London's rising 8.3 million population¹, or to address the stubborn problem of health inequalities.

The NHS in England is facing a two-way squeeze driven by cost savings and spending cuts, and by the coalition government's Health and Social Care Act. As a result London's NHS has been faced with:

- The imposition of counterintuitive and unpopular reductions in access to acute services prior to supposed improvements in primary and community care, rendering acute facilities and services surplus to requirements.
- Rhetoric claiming choice and competition as guiding principles for the NHS despite evidence of top down intervention reducing choice and competition in the name of cost saving as the overriding concern.
- Supposed concern for clinical quality requiring centralisation of services – while no action is taken to address issues of insufficient trained staff or of the consequences of reduced access to services, particularly for hard to reach groups.
- Most of all, the testimony of the NHS staff and patients, which flies in the face of reassurances that the NHS is getting better and set on an improving course.

The Inquiry's aim was to investigate the impact of these issues and ongoing policies on services, patients, the wider public - and the staff who deliver frontline care, many of them fearing for their jobs, and facing continued increases in workload.

Our Panel

The Inquiry began with assembling a distinguished, independent panel, bringing together campaigners, senior health professionals, trade unionists and well-known media commentators to assess the evidence. A six-strong Panel was formed.

In the chair: **ROY LILLEY**, former chair of an NHS Trust, independent blogger (nhsManagers.net) and health policy analyst, writer, broadcaster and commentator on health and social issues.

Other Panel members:

POLLY TOYNBEE, political and social commentator for The Guardian and author, previously the BBC's Social Affairs editor.

Dr LOUISE IRVINE, who has been an inner city GP for 20 years, and also a GP trainer and programme director. She is chair of Save Lewisham Hospital campaign.

SUE RICHARDS, former professor of public management at the University of Birmingham, and from 2005 to 2010 seconded to the cabinet office as director of strategic leadership at the National School of Government. She is co-chair of the campaigning organisation **Keep Our NHS Public**.

NALEDI KLINE, who has worked in the NHS as a registered nurse, midwife, and health visitor with many years of frontline practice, mainly in London, and is currently head of professional standards: health visiting and school nursing at a large London NHS Trust. Naledi was one of 50 BME Pioneers in this year's Health Service Journal (HSJ) awards and runner up in the CPHVA manager of the year award for 2013.

FRANK WOOD, member of the executive committee of Unite the union representing over 90,000 health workers. He has worked in the NHS for over 25 years in pathology services. He is chair of the joint trades unions at Kings College Hospital.

The Panel has been supported by the work of researcher, **Dr JOHN LISTER**, a journalist with almost 30 years' experience of campaigning in London against NHS cutbacks and privatisation as information director of pressure group London Health Emergency.

The Inquiry began by organising a series of seven public hearings, five in localities across the whole of London, and two sessions to address primarily London-wide issues, to be held in Westminster.

The information we gathered

From the beginning the Inquiry made clear it was eager to hear and receive evidence from all sides.

The Panel wrote to ALL groups involved in the NHS changes - campaigns, pensioners' organisations or patient groups, local politicians, NHS trust boards, Clinical Commissioning Groups (CCGs), Health Watch, Health & Wellbeing Boards, NHS England, GPs, London boroughs, charities, non-profit providers, and community organisations.

It issued a special invitation to health workers – no matter what their job or pay band, or what trade union or professional body they belonged to, if any: and as a result of staff requests, we designated part of one hearing as a closed session where staff could give evidence to the Panel in confidence, without fear of victimisation.

The Panel was especially keen to hear people's views at first hand, through presentations in the public hearings, which were recorded and transcribed – a total of over 30 hours of oral testimony, and over 140,000 words of raw transcript.

Full edited transcripts have now been published of all seven public hearings at www.peoplesinquiry.org.

The Panel also received well over 50 written submissions, ranging from specific letters from individuals up to full-scale powerpoint presentations and extensive documents from organisations including the Royal College of Midwives, the Nuffield Trust, the Better Services Better Value project team in South West London, the Save Lewisham Hospital campaign, the Royal College of Midwives, Professor Allyson Pollock's team at Queen Mary University, health policy experts Seán Boyle and Roger Steer, hospital consultants and prominent health professionals, and local campaigners.

Who we spoke to

Among the 95 people who gave evidence in our hearings or directly to the Panel were

- former NHS London chief executive Dame Ruth Carnall (now advising Mayor Boris Johnson);
- NHS England's London regional director Dr Anne Rainsberry;
- Dr Mark Spencer of the NW London Shaping a Healthier Future project;
- Dr Marilyn Plant and the team from the Better Services Better Value project in SW London;
- trust chief executive Sir Robert Naylor of UCLH;
- trust medical director Dr Martin Baggaley of South London & Maudsley trust;
- trust Finance Director Trevor Shipman of Central and North West London trust;
- trust chair Jane Atkinson and director Jackie van Rossum of NELFT;
- former Lewisham CCG chair Dr Helen Tattersfield;
- the chair of the GLA health committee Dr Onkar Sahota;
- the leader of Ealing council Julian Bell;
- the Mayor of Lewisham Sir Steve Bullock;
- Dr Clare Gerada, former chair of the RCGP;

- seven MPs (Siobhain McDonagh, David Lammy, Jeremy Corbyn, Virendra Sharma, John McDonnell, Andy Slaughter and Heidi Alexander);
- Professor Cathy Warwick, General Secretary of the Royal College of Midwives;
- Anita Charlesworth – then chief economist of the Nuffield Trust, now chief economist at the Health Foundation
- six hospital consultants;
- and six GPs.

In addition we also heard from many trade unionists, pensioners' representatives and active local campaigners.

We are most grateful to all of our witnesses for taking the time to discuss with us, and the wealth of information, experience and ideas they presented.

What we did with the evidence

The transcripts, written submissions and summaries of the main points were brought together into a draft which was discussed by the Panel on December 20, and it was agreed that the detailed discussion and endorsement of the Panel would focus primarily on a series of policy recommendations that flow from the evidence put before us.

These recommendations were developed, and refined at a further detailed discussion of Panel members on February 11, and a finalised text, along with a wider overview and contextual document has been developed from that discussion, giving all Panel members the chance to change or amend.

The result is a series of **18 unanimous recommendations** addressing what appear to be the main issues to be resolved to make London's NHS work efficiently and ensure accessible, high quality and reliable service to the capital's diverse population, and civilised working conditions for the thousands of NHS staff who deliver these services.

The Panel, working with Unite the union, will seek ways of publicising these recommendations and urging political parties to adopt them between now and the 2015 general election.

Introduction

There are few issues of concern affecting London that do not also affect other parts of the NHS in England. What is distinctive about London is the concentration of services, the scale and diversity of the population, the extremes of wealth and poverty, and the level of fragmentation and the extent to which the absence of any strategic body impedes the development of coherent and integrated services.

A few basic facts and figures help to establish what's special about London. London had a population of 8.3 million at mid-2012, just under one in six (15.8%) of the 52.6 million people in England. Projections suggest that London's population will grow by 13 per cent by 2031. In addition, an estimated one million commuters and visitors travel in to the city each day, adding to the largest, most densely populated, and ethnically diverse city in Europe.

Two fifths of the population live in boroughs which are among the most deprived 10% of areas in England. Rates of TB, sexually transmitted infections, and blood borne infections are all much higher in the capital than elsewhere in the country.

At the end of 2013 the NHS in London employed just over 180,000 staff in 22 acute trusts, 9 mental health trusts, two community health trusts, five specialist hospital trusts (Great Ormond Street, Moorfields, Royal Brompton and Harefield, Royal National Orthopaedic and Royal Marsden) and 32 Clinical Commissioning Groups (CCGs).

However, the focus of this government's efforts has not been on making it easier to get this large system to work efficiently and to cope with the growing demands of a complex population. Instead London's NHS – like the rest of England – has just suffered a massive reorganisation that has left it increasingly fragmented, bureaucratic and uncoordinated, with no strategic body to plan and monitor developments. Indeed, on present spending plans, the NHS in England is set to face an ever-tightening financial squeeze, at unprecedented levels, for at least another 6-7 years, completing a decade of flatline funding and rising costs.

At the level of performance measures it appears that, in the spring of 2014, London's NHS providers have somehow managed to cope with the growing demands on them through three whole years of cost savings – largely, it has to be said, as a result of the ongoing freeze on NHS pay, which has cut the value of many NHS salaries by up to 16% in real terms.

However it's clear that the next year of reducing tariffs alongside increased demands for productivity savings will be even harder for providers. The Chancellor's 2013 spending round also set out plans for even more drastic cutbacks in public spending from 2015, suggesting that the following five years to 2021 will be extremely difficult financially. In addition the NHS will face the continuing effects of the competition measures unleashed by the Health and Social Care Act, which effectively block mergers and threaten further instability and fragmentation.

One of the long-planned and hotly contested A&E closures, Chase Farm Hospital, has gone ahead and gone badly, underlining the many unresolved questions over the viability of other reconfiguration plans. There is still no evidence that switching services from hospitals into community services – however beneficial its effects may be – saves money.

It seems clear that London's NHS is at a decisive point: if it continues on the course projected by the current government, senior analysts are already warning that huge gaps will open up between resources and demand – gaps which policy proposals from McKinsey and other management consultants have not been able to bridge.

A change of course is urgently needed. That's why we argue that London's NHS is now at the crossroads. Our recommendations map out an alternative way forward to keep services intact and get them working more effectively together to serve patients.

The structure of this report

The People's Inquiry set out to explore the extent to these problems, and the responses from NHS management, NHS staff, local communities, campaigners and elected politicians. It has developed a deeper and more sophisticated understanding of the current situation, the main proposals that have been put forward – and the critique of those proposals by campaigners and analysts.

In compiling the report, Inquiry researcher John Lister was asked to set out a brief summary of the situation in 2014, the social conditions, the new structures established under the Act, the situation in primary care, acute and mental health hospital care, community services and social care, and the current financial situation as far as it can be assessed for purchasers and providers.

To set a clear context for the Inquiry findings, we have also included a short history of the changes and plans developed for reconfiguration of services in London since then Professor, now Lord Ara Darzi published his landmark proposals for changes in 2007 A Framework for Action, and NHS London established the Healthcare for London project which ran up to April 2013.

A short, updated summary of the state of play in each of the plans drawn up under the direction of Healthcare for London for reconfiguration of services in the five clusters of Primary Care Trusts – which underlie the proposals now being advanced by Clinical Commissioning Groups – is also included. This helps to set the scene for some of the evidence we have heard, along with a very brief overview of some of the issues of contention that have been raised by critics of the reconfiguration proposals as the debates have continued.

This creates the basis for setting out the Panel's 18 unanimous recommendations, with some additional supporting explanation of how they relate to the evidence that has been discussed.

The Panel seeks to promote the widest possible discussion of these recommendations in political parties, local communities, local government, and among the health workers who are at the sharp end of many of the changes and resource pressures.

We invite comments and further contributions at www.peoplesinquiry.org.

We hope that the Inquiry can open up a fresh and more informed debate on the way forward to develop a coherent strategic approach, together with local plans that genuinely take account of the concerns and views of local communities and open up channels of communication that do not force those with concerns to rely on mass street-level protest, confrontation and costly court action.

London's NHS in 2014

Social determinants of health

London is unlike any other British city in its sheer size, diversity and complexity of administration. It is by far the biggest city in Europe, and it acts as a magnet attracting a variety of people from across the UK and around the world.

A 2012 report by the London Health Observatory comparing London with other large British cities found that London had the highest proportion of ethnic groups, with 41% of its population, well over double the English average. With 30% of its population non-white, compared with an England figure of 12.5%, London's proportion is only exceeded by Birmingham.

London's population is also younger than the English average, with a lower percentage of over 65s than any big city other than Manchester. The fastest growing age band has been the 40-60 age group, but the largest single age group is aged 15-39. The younger adult population also goes with London's exceptionally high birth rate, which we have heard is putting maternity services under pressure. The rising population of children is putting pressure on paediatric services, although children's health needs are commonly ignored in the various proposals for reconfiguration of hospital and other services.

But while the younger population grows, so too do numbers of older people. Reports point out that the number of over 65 year olds is growing rapidly in London, and set to increase by 19% by 2020. This age group are typically the most significant users of health services.

Perhaps surprisingly, London's incidence of drug abuse, while just above the English average, is below most big cities. Moreover, due to the mix of rich and poor, Londoners have a higher life expectancy than the English average, or any comparable British city. However there is also three times the English average of HIV, and more than three times the English incidence of TB, far bigger than other cities.

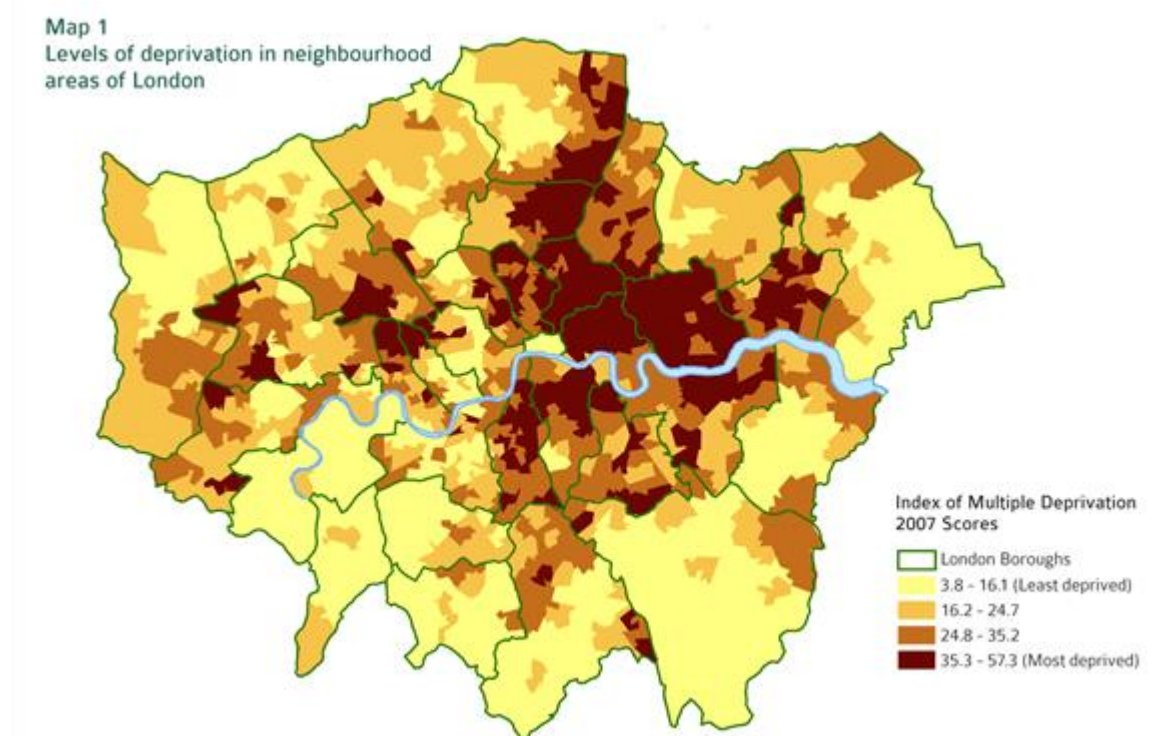
Estimates in the *Technical Paper* that accompanied Lord Darzi's 2007 report *A Framework for Action* attempted to look forward to assess the likely changing burden of various common conditions. They expected the prevalence of diabetes to increase from 4.5 per 1,000 population to 5.7 per 1,000 by 2016; child obesity was seen as an increasingly serious problem; but prevalence of cancer was expected simply to follow the growth of population, and the prevalence of heart disease was expected to fall with reducing rates of smoking. Pressure on primary care was expected to be substantial, with a 70% increase in GP consultations from 28 million a year in 2005 to 48 million in 2016, or even a higher possible projection of 54 million.

With big extremes of inequality in pay along with inflated housing costs, transport and other costs, it should be no surprise that the proportion of people living in relative poverty is also the highest in the UK. In the three-year period 2007/08 to 2009/10, 28 per cent of people (2.1 million) were in

households in London with incomes below the poverty threshold. Child poverty in London is 50% above the English average, with 31% of children in London living in families on low income receiving means-tested benefits.

All these figures are based on London-wide averages, which may obscure the extent of the stark variation in London, between different boroughs and also within some boroughs, with exclusive areas concentrating extreme wealth, and others containing severely deprived populations. There is a variation between boroughs of 7.2 years life expectancy for males (and 4.6 for females) between London's highest and lowest boroughs: but the variation in healthy life expectancy is much larger – 13.6 years for men and 12.1 years for women.

According to an NHS London Health Inequalities Network (LHIN) report in 2012², London has the second highest rate of incapacity benefit recipients in the English regions. Tower Hamlets (thanks to Canary Wharf) is East London's largest local economy with a gross value added per capita 68% higher than the London average – but also has the second worst level of unemployment in England and Wales (45%), with over a third claiming incapacity benefit.



Source: *Fair London, Healthy Londoners* (London Health Commission 2009): based on 2001 Census.

The LHIN report also makes the link between ill health and low income or poverty: a higher share of Londoners with a health problem are out of work compared with elsewhere in England.

Health is a major contributor to why Londoners are economically inactive, e.g. the majority of Londoners on incapacity benefit have preventable and/or treatable conditions (47% mental health; 15% musculoskeletal; 6% circulatory or respiratory...)

The prominence of mental health among the conditions preventing people accessing employment can be seen as correlating with the higher average proportion of spending on mental health by London's commissioners: 16% in London in 2010, compared with 13% in England. However incidence of mental illness varies sharply between boroughs, with mental health problems twice as common (20% of adult population) in deprived parts of London, compared with 10% in the least deprived. It is also more common among lower income manual workers than those with managerial and professional occupations. Admission rates for psychotic disorders were 8 times higher in deprived inner London City & Hackney than in Sutton & Merton in SW London.

A recent report for the Mayor of London³ on mental health in the capital points out that mental health – as in the rest of England – is the single largest source of the disease burden: “close to £7.5 billion is spent each year to address mental health in the London community” – including health and social care, benefits to people living with mental ill health, and costs to the education services and criminal justice system. One child in ten in the capital – 110,000 young people – are thought to have a clinically significant mental health problem. The estimate for health spending is £2.8 billion – significantly higher than the LHIN estimate above, which suggests 16% of London's health budget is spent on mental health.

However the mayor's report does not point out that London's mental health services – like those across England – have also had to undergo cutbacks in resources in the last few years as the sustained period of growth in health spending has come to an end, with much reduced budget increases falling short of inflation in 2011-12.

The National Survey of Investment in Mental Health⁴, which has since been scrapped by the government, reported in 2012 that London was among the areas that had begun to cut back on mental health spending (reducing investment by 4.2% in a year). Investment in the three traditional priority areas (crisis resolution, early intervention and assertive outreach) had fallen across England in 2011-12, while investment in older people's mental health services had also fallen by 1%. As a result of the cuts, London for the first time was no longer the highest spender per head on mental health services.

London's level of statutory homelessness (measured in 2009-10) was also 50% higher than the English average, although lower than Sheffield and less than half the level of Birmingham. It may be surprising that this is not higher in London, since house prices have remained much higher than most other parts of the UK. The average London house price in June 2013 was £425,000 compared with £242,000 for the UK. This was 8.1% more than a year earlier, compared with the UK increase in price of 3.1%.

Partly as a means to ensure people could live close enough to work in public services and other jobs paying less than elite wages, London has the highest proportion of socially rented housing in England: 24% of homes in London were rented from local authorities and social landlords in 2010,

compared with the UK average of 18%. More people than elsewhere are also unable to buy a home, and forced to rent from private landlords: over a quarter (26%) of homes were privately rented in 2010, above the UK average of 17%.

The new structures of London's NHS

Unlike many other big cities in Britain and Europe, neither the NHS nor local government has any unifying strategic public body in charge. Local government is split between 32 boroughs and the City of London, while a Greater London Assembly, with far fewer powers than the former Greater London Council which was scrapped by Margaret Thatcher in 1986, and an elected Mayor give a rather misleading impression of coordination across the capital's 600-plus square miles.

The mayor, Boris Johnson, has been rather more proactive than his Labour predecessor, and established an independent health commission, headed by former Labour Health Minister Lord Darzi to explore ways in which healthcare in the capital can be improved. The former chief executive of NHS London, Ruth Carnall, has also been recruited as an advisor to the mayor.

A detailed report on the scale and impact of mental health problems in the capital has already been published. The Greater London Assembly has also established a Health Committee that conducts its own reviews of key issues of health policy and health care provision. However the scope for action from either body is limited both by the limited powers of the Mayor and the Assembly, and by the lack of any corresponding London-wide body in the NHS with the scope to take strategic action.

Instead London's NHS, which enjoyed a brief period of a single Strategic Health Authority (later renamed NHS London) after more than 40 years of being carved up into separate regional health authorities, is again without any strategic body in control. NHS London was scrapped in April 2013, with the implementation of the Health and Social Care Act.

In place of NHS London, the capital has again been divided into three local area teams (LATs) of NHS England. While these are apparently linked in one regional office, there is little information on what they do, or how they are organised.

Unlike NHS London, and the previous strategic and regional health authorities, these teams do not meet in public, or publish board papers. Occasionally they publish policy pronouncements, with little if any prior or planned public engagement: each of these policy documents appears obediently to follow the pattern set by the parent body, NHS England.

Clinical Commissioning Groups

Along with the abolition of NHS London, 32 primary care trusts (PCTs) which had held budgets for their local borough populations for around 10 years, commissioned services and increasingly begun to work together in five clusters" covering different geographical areas, were also scrapped. They in turn have been replaced by a similar number of Clinical Commissioning Groups (CCGs), although not all of these follow borough boundaries.

The new structure means that some adjacent CCGs have been free to implement strikingly different commissioning policies, and CCGs are not obliged by the Act to work together with neighbouring CCGs: in fact new regulations were required in 2013 even to allow them to cooperate.

The CCGs have taken over only part of the commissioning work that was previously controlled by PCTs: the commissioning of specialist services and GP services and the budgets for them have been transferred to NHS England.

Other community health services – including health visiting– have also been taken over on an interim basis by NHS England, and are due to transfer to local government from 2015, where they will join public health services, which have already been separated from their previous position in the NHS.

Public health budgets are supposed to be protected in local government, but already there are questions being asked over the resources that might be available for local implementation of the proposals drawn up nationally by Public Health England, a body which has already been criticised as ineffective.

Commissioning Support Units

London's 32 CCGs are supposed to be guided by the work of three Commissioning Support Units (CSUs) that were established and are still run by NHS England, with increasing involvement of the 'Big 4' accountancy and consultancy firms, and other external advice. However CCGs and trusts alike appear to regard many of them as ineffective and an obstacle rather than an asset. The CSUs are to be floated off as independent bodies by 2016, although some CCGs have already made clear that they want to bring their services in-house.

The capital is also now blessed with three Local Education and Training Boards, accountable upwards to Health Education England, which are supposed to plan the training and education of the professional workforce for the future.

Health & Wellbeing Boards and greater complexity

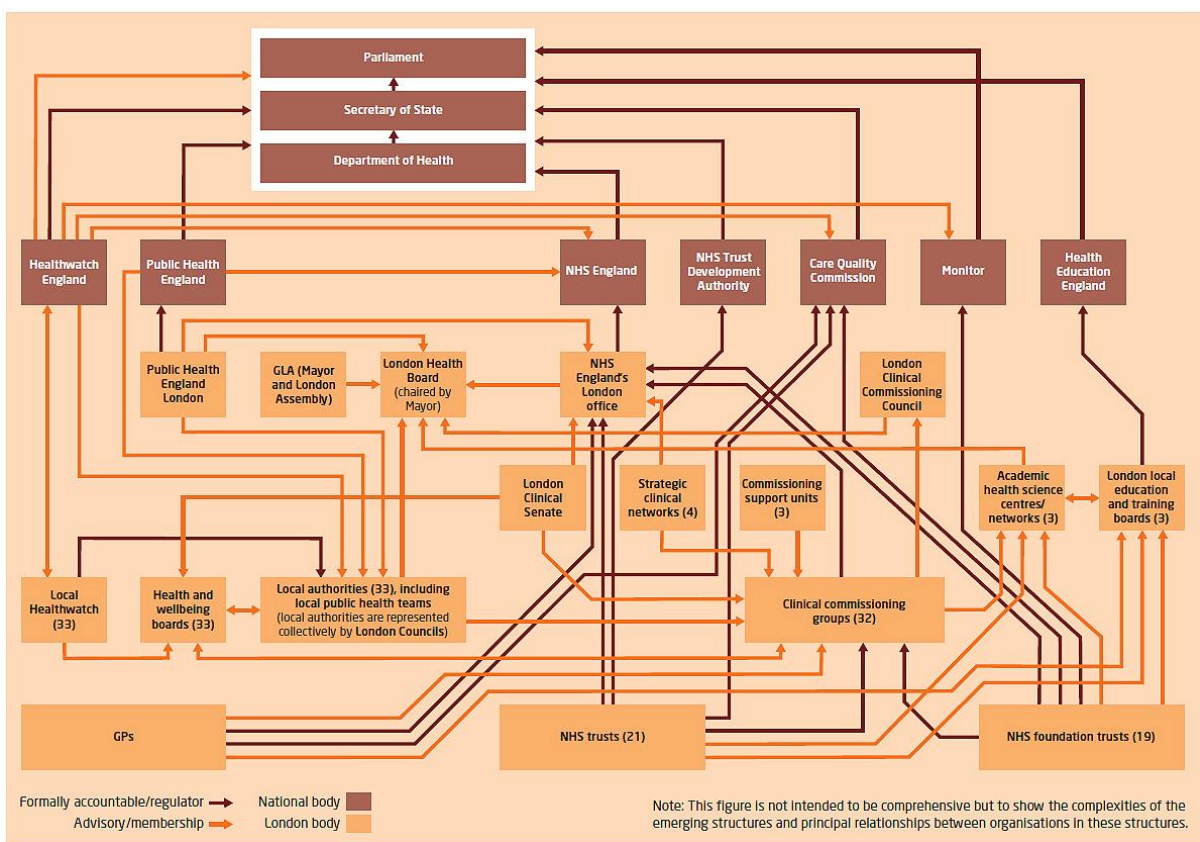
The picture is further confused by the introduction of 32 Health & Wellbeing Boards, bodies run by local government, apparently in partnership with CCGs, and which are steered towards the discussion of public health and the integration of social care, and which have an increasing role from 2015 when they take charge of pooled budgets for integrating health and social care through the Better Care Fund.

As Ruth Carnall pointed out in evidence to Panel members, with the three local area teams (LATs) of NHS England presiding over the whole set-up, this new structure means that "London went from having effectively seven commissioning bodies in 2012, to 74 in 2013". It's still not clear how this is expected to run more efficiently or cheaply than the previous system.

Ruth Carnall also told Panel members that in creating the new, competitive, market-based system through the Health and Social Care Act, Conservative Health Secretary Andrew Lansley at first

attempted to stop the concentration of London's stroke services into fewer specialist units, which had been agreed and consulted on by 2009, with agreement to set up eight hyper-acute stroke units with associated networks, and four trauma networks.

The basic concept had been embraced by clinicians as a way to improve these specialist services and save lives. However Lansley favoured a competitive system, in which any hospital would be free to offer specialist care, leaving the market to decide which units would prosper and succeed. Only the strength of professional commitment to the reorganisation in London ensured that what has become a flagship policy for reconfiguration was carried through.



Above: the King's Fund's attempt⁵ to simplify the post 2013 structures of London's NHS.

In fact, far from devolving power to local CCGs, the new system has resulted in a more strongly centralised service. For GPs, NHS Trusts and Foundation Trusts alike, the lines of responsibility flow UPWARDS through the bureaucrats in the new NHS England regional office. Foundation Trusts are also accountable upwards to the regulator Monitor and the Care Quality Commission (CQC).

NHS Trusts, of which London still has 21, are responsible to the Trust Development Authority (TDA) as well as directly to NHS England. As a result, London's NHS providers have less control over their own decisions and policies than they did before: and as we will see they also have less money, and even less to come in the next six years.

The King's Fund's diagrammatic view (above) of the new structures in London created by the Health and Social Care Act (and other initiatives by the mayor and GLA) clearly illustrates the complexity of the new system. What could possibly go wrong?

Health Watch

What is also clear from the King's Fund diagram is just how marginal are the new bodies that have been set up under the Act to represent the local public and service users – Local Health Watch, as subsidiaries of Health Watch England. There should be one functioning in each London borough. But it's already clear that they lack both the legal powers of the old Community Health Councils (CHC) (which were scrapped by Alan Milburn in 2003), of which they are the latest descendants, but also the expertise and links with the community that made the best CHCs a real force to be reckoned with whether on service quality, changes in services, or representing patients with complaints.

Health Watch groups are supposed to be resourced by local authorities, but it has only just come to light that a quarter of the funding that was supposed to be funnelled to local Health Watch groups from the Department of Health through their local councils has been siphoned off, and apparently used to pay other council bills instead.

Financing London's NHS commissioners

London's CCGs began life in 2013-14 with budget allocations totalling £9.7 billion (15.4% of the England total). This is significantly less than the £15 billion combined commissioning budgets of PCTs in London in 2012-13, before the new structure was established. This is because the newly-created NHS England through its London "region" LATs now holds budgets for primary care and specialist services adding up to around £4 billion.

According to the NHS CCG Programme Budget Allocations 2014/15 & 2015/16⁶, London's CCG allocations are set to increase by 3.1% to £10 billion in 2014-15, and by 2.6% to £10.3 billion in 2015-16, along with a Better Care Fund allocation of £170 million which will be put into pooled budgets to commission "integrated" social care: this money, which has effectively been top-sliced from what would have been CCG allocations, can only be spent with the permission of the local Health & Wellbeing Board.

In other words from 2013-14 allocations are rising in cash terms by slightly more than the 2.5% average inflation rate for 2013. However this overstates the generosity of the allocation. Although general price inflation fell to 1.9% in January, historically the costs of the mix of goods and services which the NHS has to buy run *1% higher than general inflation*, suggesting that the actual value of commissioning budgets is frozen or falling in real terms. In addition cost pressures from an ageing society and new treatments and technology, along with additional pay costs also impact on NHS resources: this is commonly estimated by Darzi, McKinsey and others to add up to 4% upward pressure on NHS budgets each year.

This is the key factor behind the pressure for the NHS to make cost savings of £20 billion from 2010-2015, at the rate of at least of 4% per year, an unprecedented rate for year-on-year savings. For

many provider trusts the actual target is even higher. The prospects of continued flatline or falling real terms funding imply even larger cost savings of up to £30 billion would be required between 2015-21 to deal with the likely caseload and demand on the budget allocation projected by George Osborne: the gap between resources and demands on London's NHS alone has been estimated at £4 billion by 2021, while the England figure could be as high as £30 billion.

London's health services

Primary care

In 2010 there were 43,000 GPs in the UK of whom 36,500 were in England. London's 5,390 GPs represent just under 15% of the English total. This total is the result of an increase in the GP workforce between 2006 and 2010, with the biggest increase taking place in London, which grew by over 10%, adding 520 GPs. As a result London's population now has 1 GP per 1,576 people, compared with a national norm of 1 GP per 1,441.

Historically London's GPs tend to be in smaller practices, with a larger number of single-handed practices. Three quarters of London GP practices have fewer than 8,000 patients on their list. In almost half the London boroughs more than 20% of GP practices are single-handed. London's GP workforce also tends to be older, with well above the national average of GPs aged over 60 and nearing retirement: in more than a quarter of London boroughs more than 20% of GPs are over 60.

Over the last 10 years the number of doctors across the UK has increased by 29% (from 135,000 in 2003 to 174,500 in 2012), but while numbers of hospital doctors have increased rapidly and consultants by 41%, GP numbers have risen by much less, just 16%. The Centre for Workforce Intelligence has called for a boost to GP training numbers to 3,250 by 2015. The Royal College of General Practitioners (RCGP) calculates that an extra 16,000 GPs are needed in England by 2021⁷ to sustain services and improve primary care services as the population ages. London's local medical committees in a report in September 2013 called for an £1 billion investment to improve services in the capital⁸

Hospitals and secondary care

London's hospital trusts admitted 2.3 million patients in 2012/13, 15.4% of the England total.

Despite incessant plans and promises to reduce numbers of hospital admissions and divert patients into alternative community-based services, the numbers requiring hospital care are stable or rising. Statistics show that in this, as with many other issues, London is not an exception to the rule in England as a whole.

Nor does London make higher than average use of emergency admissions: around one third (33.7%) of London's hospital admissions were emergencies in 2012-13 – slightly lower than the 35% emergency admissions across England. Emergency admissions calculated for London's own

population averaged 91 per 1,000 compared with 101 per 1,000 in England as a whole, even if no account is taken of London's 1 million commuters and visitors ^a.

	England		London	
	Admissions	Emergency admissions	Admissions	Emergency admissions
2009-10	14,537,712	5,177,887	2,239,975	745,154
2011-12	15,019,396	5,242,839	2,341,318	765,319
2012-13	15,145,633	5,336,043	2,309,556	775,108
% total change 2009-13	4.2	3.1	3.1	4.0

Worryingly, however, over half the admissions to mental health trusts in the capital were emergencies, indicating a real need to invest in crisis support but also a real pressure on beds that leaves little scope to give more support to any but the most urgent and critical cases.

London's mental health beds averaged over 91% occupancy, higher than the 88% England average: but we know that acute beds (which are important to ensure minimal delays in admitting the most seriously ill patients) are in short supply, with growing numbers of placements in often distant private sector beds.

Back in 2010 the Care Quality Commission (CQC) expressed concern at the excessive levels of occupancy of the majority of beds on acute mental health wards, with well over half the 486 acute wards in England running at or above 100% occupancy levels, and 35 reported to be running at levels above 125%. Less than a third of wards were running with less than 90% occupancy.

Since then the cash constraints at national level, applying more severely in London, have caused continuing problems in access to mental health acute beds, and a growing problem of severely ill and distressed patients in need of inpatient care being transported sometimes hundreds of miles to remote NHS or private sector hospitals.

Marginal role of private sector

London's hospitals provided 7.9 million bed days in 2012-13, 16.3% of the England total: almost all of this was delivered directly by the NHS. Private sector hospitals in London working on contract to the NHS handled fewer than 20,000 admissions – less than one percent of London's NHS hospital caseload. Three quarters of these were day cases, a much higher percentage than the proportion in NHS hospitals, where – partly because of the sheer number of emergencies, which the private hospitals do not treat – just under one third of total NHS admissions were day cases, and, because of the more complex case mix, around half the non-emergency admissions were day cases.

^a All of the non emergency admissions in these figures include day cases which are not actually admitted.

However there has been more extensive privatisation of provision in some parts of the NHS: pathology services in all of the hospitals in north London have been privatised, along with significant sections of pathology services south of the river. Many hospitals' non-clinical support services, of course (such as cleaning, catering, laundry, portering and security) have been privatised in London and elsewhere in England since the 1980s. Private sector ambulances, initially used only for low-cost, low value non-urgent Patient Transport Services, are increasingly becoming a factor in emergency services, making up between 8-11% of ambulances arriving at Hillingdon Hospital⁹.

Private sector diagnostic services gained a foothold under Labour's expansion of diagnostic and treatment centres in the mid 2000s, and from the same period some private companies have played a role in the delivery of primary care, with some contracts for whole practices and in other areas Harmoni or other providers taking over out of hours services.

However there have been continuing debates over the quality and value for money of many these services, and our Inquiry has heard of the recent successful campaign by Hackney GPs to take their OOH service back from Harmoni.

And while A&E departments remain an exclusively NHS preserve, a few Urgent Care Centres have also been contracted out in London and elsewhere, which less than successful results: the CQC was recently critical of the potentially dangerous lack of training of reception staff in Croydon's UCC, run by Virgin¹⁰: the centre was also failing to hit target waiting times.

Where London is quite different from some other areas of England is in the very limited level to which community health care services have been outsourced to the for-profit private sector: in Bromley and in Kingston community services have been controversially transferred to social enterprises led by the previous management of the NHS service. Elsewhere in London the norm is that most community health services have been 'vertically integrated' with local acute or mental health trusts, or taken over by one of the capital's community health trusts.

It remains to be seen how many CCGs will submit to pressure under the Health and Social Care Act to break up existing community contracts and put them out to tender, with the possibility of a fragmentation of services and a lack of accountability and coordination. Wandsworth CCG seems so far to be an outlier in its commitment to press ahead with this process, regardless of the views of local patients and the public.

Has London got too many beds?

London's hospitals have slightly higher than its proportional share of hospital beds in total compared with England, although running at higher levels of occupancy. But the capital has proportionally fewer general and acute beds that deal with day to day urgent and waiting list cases and older patients.

The faster increase in the birth rate in London has been one factor keeping numbers of maternity beds higher than in England as a whole, and increased concentrations of mental illness keep the pressure on the higher numbers of mental health beds.

Available beds in hospitals Oct-Dec 2013

	Total	General & Acute	Maternity	Mental Illness
England	135,530	104,320	7,644	21,931
London	22,387	15,984	1,446	4,883
London as percent of England	16.5	15.3	18.9	22.3
London bed occupancy/England	higher	higher	higher	higher

The pressures on London's hospitals can also be seen in the slower rate of reduction in bed numbers compared with England as a whole, while occupancy levels are higher for all beds but the diminished NHS Learning Disability service.

It's also worth remembering that just over 1,000 of "London" general and acute beds are in fact in specialist hospitals, which treat a regional and national catchment, so they are not specifically provided for Londoners, and many of these beds may not in fact be available for use by London patients at all.

Bed closure rates compared, England and London

	England			London		
	Bed numbers		% change	Bed numbers		% change
Type of beds	2007	2013	2007-2013	2007	2013	2007-2013
General & acute	122,374	104,320	-14.7	18,159	15,984	-12.0
Mental health	26,929	21,931	-18.6	5,842	4,883	-16.4
Total beds	160,891	135,530	-15.8	25,580	22,387	-12.5

In the baseline scenario for growth mapped out by Healthcare for London in the Technical Paper that accompanied Lord Darzi's report in 2007, and which assumed population growth from 7.6 million in 2006 to 8.2 million in 2016, hospitals across London were expected to need "around 17,500 beds" by 2016^b.

As we know, these plans for provision were scaled sharply downwards in the aftermath of the banking crash. 2010 marked the end of the ten-year increased investment in the NHS, and triggered the so-called Nicholson challenge of making £20 billion savings by 2014. The rather more rapid than expected growth in London's population that was taking place was largely ignored, and in place of

^b It seems clear that this refers to general and acute beds, not the grand total of all types

the growth outlined in Darzi's proposals, NHS London began to call for a third of London's beds to close.

London now already has 100,000 more residents than expected by 2015, but 1,500 beds fewer than Darzi's team had projected would be needed. Even more beds set to close in reconfiguration plans in NW London and elsewhere – and there is no prospect of any extra beds opening in the medium term or more distant future.

Perhaps surprisingly, figures seem to indicate that the existing acute bed complement is somehow managing to absorb the additional caseload. However the service is clearly under growing strain, and there is still no evidence to show that a substantial reduction in bed numbers is possible from now without creating a widespread dislocation of services, with a potential knock-on impact across the capital.

The unfortunate aftermath of the closure late last year of A&E services at Chase Farm Hospital in Enfield, triggering confusion, delays and problems at both Barnet General Hospital and at North Middlesex Hospital¹¹ gives a glimpse of what might happen if bed closures were to be implemented more widely and on a larger scale.

Community health services in London

NHS London's Integrated Strategic Plan 2010-15, published in January 2010, just months before the coalition government took office, warned that urgent action was needed to bridge a potential "funding shortfall of between £3.8 billion and £5.1 billion per year on a recurrent basis" by 2016 – figures strikingly similar to the projections of NHS England's London region looking forward from 2013.

Surprisingly, the biggest savings were seen as coming not from hospitals, but from proposals for squeezing down the costs of delivering services in the community, to generate savings of £800 million to £2 billion.

NHS London also hoped to save money by reducing hospital services, claiming that: "£400 to £500 million a year could be saved by providing more care in the community and less in hospitals". Sadly no evidence to support this key assertion was produced.

Nonetheless this same assumption has emerged at the centre of all of the reconfiguration plans that have been developed, even though there are pitifully few concrete proposals on exactly how community services can be both expanded to handle additional patients displaced from hospitals and simultaneously shrunk in cost to make the savings required by NHS London.

One of the more advanced reconfiguration plans, the Shaping a Healthier Future (SAHF) project in North West London, part of which has now been endorsed by the Independent Reconfiguration Panel, allocated just 14 of almost 2,700 pages of decision-making business case to any discussion of community services. It remains desperately short of any detailed plans on what services should

replace the two A&E units and related services it plans to close at Central Middlesex and Hammersmith Hospitals in the summer of 2014.

Indeed the SAHF documents were so short of convincing plans to fill the gap that would be left by closure of the existing hospitals in Ealing and Charing Cross and their replacement by small cottage hospital-style clinics that the Independent Reconfiguration Panel declared itself unconvinced – and called for a halt to both closures until more work had been done and more public engagement had taken place¹².

In South East London the Trust Special Administrator (TSA) was unable to cite anything more concrete to support his proposals for reduced hospital care than a document expressing the “aspirations” of clinicians to deliver more services in the community.

In North East London, plans to close the vast majority of the beds at King George’s Hospital in Ilford have not been coupled with any proposals for community based services, but are justified on assumptions of increased productivity and throughput of beds at the neighbouring Queen’s Hospital – currently in special measures.

In fact the future of community services is uncertain. Health visitor numbers in the capital have significantly increased in the last two years as a result of the Health Visitor Implementation Plan (HVIP) – after the health visiting workforce had fallen by one fifth in the decade to 2011. Subsequent growth since then should see an increase of over 50% of staff in post by 2015.

But new targets from Health Education England propose that just over 1,000 health visitors are to be trained in the whole of England in 2014-15, 62% below the previous intake.

District nurse numbers have also been in decline – even as the emphasis on community based health care has increased in the last few years. In London, there were 100 places available for District Nurse education, but just five places were filled¹³. Registered district nurse staffing has declined steadily in recent years whilst the skill mix has been diluted. Without these staff in place it’s hard to see how services can be expanded and improved.

However the pressure for cost savings has been driving towards reducing district nurse numbers, and downbanding them to lower pay scales. In March 2013 Hounslow and Richmond Community Healthcare Trust attempted to cut 63 district nurse posts, as it tried to make £2.7 million savings¹⁴.

Community services still appear to be central to hopes of reducing hospital caseload. But they are still largely discussed as an abstraction: in practice they remain as a fragmented mixture of services, many of them in London provided by the acute or mental health trusts with which they have been integrated. However integration is potentially at risk from two directions.

On the one hand, community health, family health – and services such as sexual health, and public health, which leads work on preventive measures and health education, are being transferred to local government, which has some advantages, but makes coordination and integration more difficult in the present system.

On the other hand, the Health and Social Care Act has intensified pressure on CCGs in London to follow many CCGs in the home counties and the rest of England, and put community services, possibly lumped together into pathways of care, out to competitive tender, where the likes of Virgin, Serco and Optum, the rebranded UnitedHealth, are seeking to bid, despite evidence of early contract failures and little sign that any private company is yet making significant profits from community health services.

Social care in London

The latest national figures from the Health & Social Care Information Centre at the end of 2013¹⁵ showed that as a result of continual year on year reductions in spending, far fewer adults are receiving help from social services than when the Healthcare for London plans were first drawn up. Numbers receiving care are down 9% from 2011-12 and a massive 25% down on 2007-8.

The one growth area has been in the increased numbers of service users and carers who are being left to sort out their own needs. Numbers of service users receiving self-directed support rose 16% to 600,000, around a quarter of whom received a direct payment. Over 100,000 carers also received self-directed support for their needs, up by almost a third. Three quarters of carers received a direct payment.

These changes may suit some individuals, but they also reflect the continued reduction of the social care workforce and the support they have been able to offer, increasingly denying patients and carers any choice, and leaving those in need of support increasingly having to fend for themselves.

For those needing social care in London, there is the question of availability of suitable services. In 2010, the Care Quality Commission (CQC) found that London had one of the most serious problems in access to care home places for older people with dementia: with just 33.7 places per 100 population of people over 65 with dementia, the capital had less than two thirds of the provision of the North East, and substantially less than every region except the South West.

The shortage of nursing home places, especially in London, is a clear example of market failure, the failure of supply to grow in line with demand, in a sector which is entirely dominated by private and voluntary providers, with no public sector provision. Historically London has been a less profitable place to provide long term care, because overhead costs such as property prices are higher, as well as higher average wages – so it has always been the case that fewer places have been available to London boroughs. The capital has fewer care home places per 1,000 population than any English region.

But social care is also facing a massive financial squeeze, after years of increasingly tight and reducing social service budgets. Between March 2011 and March 2014 £2.68 billion will have been saved by adult social care in England, equivalent to 20% of the budget, according to forecasts by the Association of Directors of Adult Social Services¹⁶ – figures broadly confirmed and underlined by the more recent Age UK report Care in Crisis.

Social care leaders have been the first to admit that savings on this scale could not all flow from efficiency measures: much of the money according to ADASS has been saved by “providing different, more cost effective packages of care” or by reduced levels of care.

One in three directors of social services surveyed in 2013 admitted the savings meant that fewer people could access services: almost half had made savings by freezing the fees they pay to care homes, creating potential financial problems for providers. One in five directors expected the quality of life of service users would worsen, and half expected future cutbacks to include cuts in personal budgets paid to service users and their carers.

As a result of years of cutbacks so far 87% of councils have now restricted eligibility for social care to service users with “substantial” or even more severe needs. This means that those who do receive care tend to be relatively more expensive to support: so a 25% reduction in the number of people supported to live at home in the five years to 2012 brought only a 5% reduction in actual spending.

40% of social service directors now predict a high risk they will have to save money by moving activity to cheaper settings.

According to the Audit Commission, a reducing share of adult social care spending is now allocated to older patients, with more going instead to learning disabilities and mental health. Average spending per resident aged 65 and over was 13% lower in 2012 than in 2010. The percentage cut in spending per head appears even higher because budgets are reducing as numbers of older people increase. The 2013 spending round will lead to a further 10% cut in overall council budgets in 2015/16¹⁷.

All of these problems have an especially serious impact on London, where resources are stretched and costs of care home placements and supporting people at home are higher than the England average. London also has a high proportion of over 65s living alone, which is a factor likely to push up social care spending.

With these pressures and this grim scenario, described by the Association of Directors of Adult Social Services as “a bleak outlook getting bleaker”, it seems most improbable that ambitious plans to support more potential NHS patients in the community, discharge them more swiftly and reduce pressure on A&E and other admissions can be achieved.

How we got here: a short history of plans for London's NHS since 2007

Lord Darzi's plan 2007

In July 2007 Gordon Brown had just taken over as Prime Minister and the NHS was in the midst of ten straight years of above inflation increases in budget. It was another year before the British economy was ambushed by the collapse of the banking sector when, as he then was, Professor Sir Ara Darzi's 124-page report *A Framework for Action* was published.

Darzi's report had some real strengths. Even though it made the extravagant promise of saving £1.5 billion in the longer term through more effective services, it was a plan for growth and development of healthcare. It focused strongly on health inequalities and contained no specific proposals for rationalisation of hospital services. It set out to address some long-standing and important weaknesses in health and healthcare in the capital, offering some fresh ideas for radical changes and genuine modernisation to deliver improved health and social care provision across Greater London. Unlike many proposals before and since, Darzi accepted that to reorganise hospital services it was first necessary to put together an improved system of primary care and community services.

Some of the problems associated with the plan were not necessarily Darzi's fault. Its emphasis on the "end of the era of the district general hospital", was seized upon by local NHS managers (most notably in South East London) who were seeking to force through controversial cash-driven plans to downgrade hospitals without putting in place the other changes spelled out in Darzi's proposals.

NHS London promised that, while discussions proceeded on the Darzi report, no hospitals or services would be named for downgrading or closure in the capital until the end of the year. However this policy was ignored by some local trusts and PCTs.

Central to Darzi's plans was the replacement of London's current network of district general hospitals with a combination of relatively few new centres of specialist excellence, coupled with an undefined number of "major acute" hospitals, along with local hospitals and elective centres. Only major acute hospitals would offer treatment for emergency admissions, so the decision to downgrade any significant number of DGHs to local hospitals would need to be accompanied by substantial investment to expand the bed capacity and staff of the remaining major acute hospitals.

However there was no such detail in the Darzi report, which left completely vague the question of how many of each type of hospital there should be, where they should be, and how patients (and relatives) would be expected to get there and back. Many traditional A&E services were to be replaced with a combination of improved out of hours services, and a number of urgent care centres, some of which could be downsized A&E units, others based in new polyclinics; 150 polyclinics were proposed, at an estimated annual cost of £3.1 billion.

Too many factors were missing from the Darzi report for it to be the finished article:

- there was no road-map towards implementation,
- the costings did not appear to be realistic,
- and too many real and pressing problems were wished away or simply ignored.

The plan also triggered the hostility of GPs, although this was in part their reaction against more modern and effective ways of working.

Since then, the polysystem plans have been largely abandoned: but the other cutbacks have only been partially reduced. Darzi had relied heavily on McKinsey figures, which in turn appeared to be based on little more than wishful thinking, and this left a lot of questions unanswered, not least on

how hospitals across the capital were expected to remain financially viable while suffering a massive loss of income as services were switched away from them. The total cost in lost revenue, if all of the proposed shift of A&E and outpatient care had been carried through could have been up to £1 billion in total, creating chaos in hospital finances ^c.

However Darzi, as Health Minister, famously also made famous “five pledges” to reassure an anxious public in 2008 – of which the most important were the final three:

**“Change will always be to the benefit of patients,
Change will be clinically driven,
All change will be locally-led,
You will be involved,
You will see the difference first. Existing services will not be withdrawn until new and better services are available.”^d**

Unfortunately these worthy sentiments were not carried through in practice. Changes were driven top downwards from the centre by NHS London, and imposed at local level through the five sector committees of PCTs that met in secret, and which were in no way accountable to local people. From 2008 as the banking crash destabilised public sector finances, and made it clear that the ten years of NHS budget increases would be coming to a halt in 2010, these sector committees, later formalised as clusters of PCTs running as collective commissioning bodies, drew up plans which went from Darzi’s generalities to much less acceptable specific proposals for reconfiguration of hospitals and services.

2009-2012: NHS London in the driving seat

From the time it published the Darzi report in 2007 to its abolition in April 2013, NHS London set the pace of change in the capital’s NHS:

- setting out explicit strategic planning guidelines,
- establishing a new layer of management, ‘Healthcare for London’ (since abolished),
- and spelling out in more graphic detail the shape of the health service it wanted to see established across the capital.

However NHS London initially set a far larger target for spending cuts per head in London than any other Strategic Health Authority, expecting London with just 15% of the population to shoulder a quarter of all the cuts and efficiency savings in England^e. From the beginning there were serious

^c Lister (2010) London’s NHS On The Brink (BMA London)

^d Department of Health (2008) Press Release: Lord Darzi sets out tough rules for changes in the NHS (May 9).

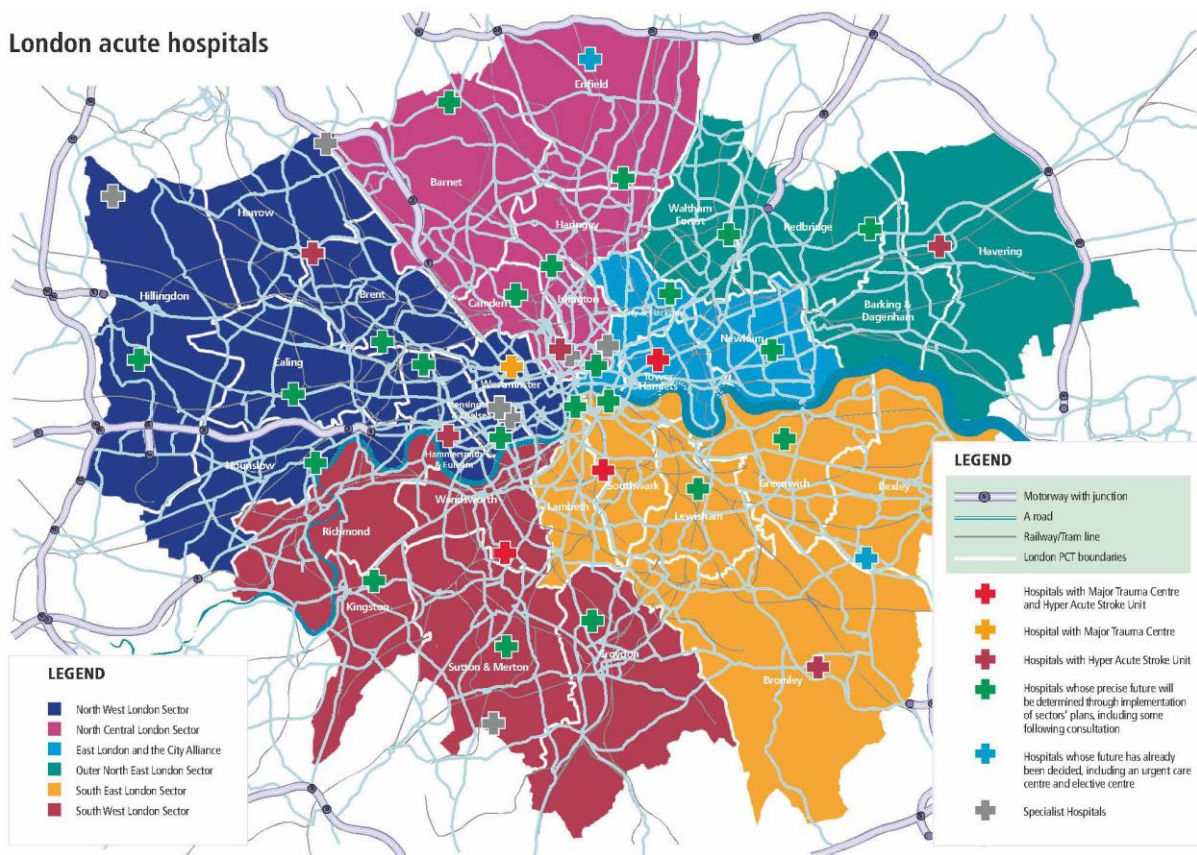
^e Research by London Health Emergency using SHA websites and information from the Birmingham Mail showed in February that the “efficiency savings” targets adopted were: South West £2 billion; South Central £1.3 billion; South East Coast £1.6 billion; West Midlands £2.4 billion; East Midlands £0.8 billion; North West £2 billion; and correctly estimated East of England at £2 billion (since confirmed). London’s £5.1 billion target equates to £673 per head of population, much

grounds for concern, not only at the quality of the evidence to support NHS London's plans, and those which have followed from them, but also the secretive way in which the local plans were hatched.

NHS London spent £114 million on management consultants in 2009-10¹⁸ – including a major report from McKinsey suggesting that they cut 6,000 beds, 1,200 nurses, 600 GPs and 6,000 administrative staff. However right up to the 2010 election they consistently refused to publish this core document underpinning many of their assumptions, even though they had previously told the media of their 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 were included. Their acute bed closure target was equivalent to around a dozen medium-sized district general hospitals.

In this context the plans formulated by the five PCT clusters set out what were ostensibly clinically led proposals for hospital reconfiguration and centralisation of services, making use of many of the core assertions and statistics that had featured in the (McKinsey-researched) *Technical Paper* on the Darzi Report and the (as then still unpublished) McKinsey plans for £20 billion savings.

London acute hospitals



NHS London's map showing hospitals whose future were in doubt as a pattern of green crosses, and the two doomed hospitals as blue crosses

higher than the next largest, West Midlands (£450) and the England average of £393. (LHE Press Release February 10 at www.healthemergency.org.uk).

2010: hospitals in limbo

Just before the last general election, as NHS London itself graphically demonstrated in its colourful map, the future of more than half of London's 40 acute and specialist hospitals hung in the balance as the capital's NHS chiefs drew up plans for reconfiguration – most of which are now tucked away in obscure archives of the British Library – or available via the People's Inquiry website www.peoplesinquiry.org^f.

It's interesting to remember that as the Labour government was backing NHS London to drive through these changes, David Cameron and Andrew Lansley had been opportunistically doing the rounds of threatened hospitals, promising a 'moratorium' on the closure of A&E and maternity units, and that specific hospitals – several of them in London – would be saved.

The moratorium was duly imposed by Lansley in the summer of 2010, and ended in October with a Lansley speech at Chase Farm Hospital, one of those he had promised to save. Immediately after this the first decisive steps were taken to run down Queen Mary's Hospital, Sidcup, another one of those Conservatives had promised to save if elected.

A map of the capital in NHS London's *Integrated Strategic Plan 2010-2015*^g (see above) showed 23 hospital sites where the future was undecided, and two whose future *had* been decided, and which were set to lose most of 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 seven specialist hospitals.

London carved into five sectors or clusters

The five sectors of London (North West, North Central, North East, South West and South East), which had been set up to devise more detailed strategic proposals, outlined plans for cuts (efficiency savings) totalling £2.6-£3.4 billion by 2016/17. The total proposed cutback represented between 19% and 24% of the £13.9 billion allocated to London's PCTs for 2010/11^h.

PCT clusters produced a series of 'commissioning intentions' which were aimed to enable them to maintain financial balance as commissioners up to 2014 - but at the expense of passing the problems

^f Three out of five "sector" plans for health care were still officially under wraps in mid-April 2010 – although the North West London sector plan had 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. The one for South East London appeared to remain incomplete, although an "Executive Summary" had been published. Now available via the Peoples Inquiry website <http://www.peoplesinquiry.org/archive.php>

^g "Integrated Strategic Plan 2010-2015", First State Report, (Healthcare for London) NHS London January 2010, Now available via the Peoples Inquiry website <http://www.peoplesinquiry.org/archive.php>

^h Department of Health 2009-10 PCT revenue allocations, at Now available via the Peoples Inquiry website <http://www.peoplesinquiry.org/archive.php>

on to the providers. They resulted in £692 million of pressure on the 18 acute NHS trusts together with another £309 million of net tariff deflation (paying trusts progressively less each year for the same work).

It was scarcely surprising in this context that local campaigners were unconvinced by assurances that the pressing need for financial savings was not the real driving force behind the plans, or the repeated claims that the plans were in fact being led by clinicians rather than – as it seemed to those on the receiving end – by accountants and management consultants.

The main outlines of the proposals that have dominated debates in the last four years had therefore been largely set out in early 2010. Indeed in North East London, according to the Commissioning Support Unit (CSUs), the business case developed back in December 2010, and now only available for those who are patient enough to trawl through obscure archives on the British Library website (or access our archive of documents at www.peoplesinquiry.org), is still the working document informing the process of reconfiguration. This is despite the fact that almost all the statistics have now been overtaken by events, and two of the NHS trusts discussed (Whipps Cross and Newham) no longer exist, having been sucked in to the financially-troubled giant of Barts Health.

Since the abolition of NHS London in April 2013 essentially these same schemes, minus the commitment to establish polyclinics, but with increasingly clear focus on rationalising hospital services, have been foisted on to the new networks of CCGs that have wound up with responsibility for reshaping services in each geographical sector of London.

However, while selective extracts of some of his proposals have been cannibalised to develop local proposals, Darzi's five pledges to reassure local people have never been implemented. As a result, the various consultation processes have consistently been seen by campaigners as no more than a cynical exercise, offering local communities a heavily one-sided analysis, limited options and a series of leading questions, while offering no serious replies to any searching questions, and taking no account of alternative views.

NHS London “affordability assumptions” (based on McKinsey figures)	
NHSL Proposal 2010 ¹⁹	Critical Comment
Tariff reduction of 2.2% or more on prices paid to Trusts under Payment by Results	Many trusts already facing higher added costs from increased caseload (agency costs etc). Trusts with PFI contracts will be hit especially hard by tariff reductions.
Non-acute services to reduce staff utilisation by 66%, GP appointment times by 33% and prescribing costs by 10-15%.	No evidence to demonstrate that these cuts are possible, or could be implemented without damaging quality of patient care.
GPs to be paid on fee for service basis £50 per consultation to cover extended hours and out of hours cover	Have GPs agreed to this? Has this even been discussed? What will happen to existing PCT contracts for out of hours cover?
55% of outpatient services and 60% of A&E activity to shift to polysystems	Assumption (but no evidence) that this will be achievable and will lower costs without undermining efficiency and effectiveness of A&E and outpatient services. Cash-driven, not based on quality

Aim to prevent 10% of emergency admissions for complex Long Term Conditions and 30% of non-complex (40% of admissions).	Where do these figures come from? No evidence presented to support this proposal or show it to be possible.
Prevent 10% of emergency medical costs through early detection and counselling in polystem	Again no evidence or explanation of how this might be achieved or by whom. No estimate of the staff required at primary care level.
Decommission 7% of elective procedures, 30% of outpatient appointments, 10% of A&E activity and 10-15% of diagnostics	Nothing to indicate how these arbitrary figures have been decided, by whom, or on what evidence

*Source (left hand column) : NHS London Strategic Planning Guidance
Appendix 1: HfL affordability assumptions*

The Strategy to save cash

NHS London set out a series of proposals to improve the affordability of the NHS, based on McKinsey's highly contentious – and largely evidence-free – 2009 plans to improve “productivity”.

Many of these proposals and assumptions were clearly at the centre of plans that were drawn up by the five sectors and by local PCTs: but some (such as the proposal for a 66% reduction in non-acute services staff, a cut in GP appointment times and an across the board cut in prescribing costs) appear to have been quietly put on the back burner by PCTs, who actually expected they would have to deliver local services and were therefore slightly more alive to some of the practicalities than the top bureaucrats of NHS London and their management consultants.

Community services cutbacks

It was not just hospitals, hospital beds, and the staff posts attached to these services that were potentially at the centre of the drive for up to £5.1 billion worth of efficiency savings and productivity increases in the capital.

Community services, including mental health, topped the list as the biggest single target for potential savings in NHS London's 2010 *Integrated Strategic Plan*, and also faced a drastic new drive to cut costs, including putting services out to tender.

NHS London's *Integrated Strategy* argued that five interventions could between them save up to £3.1 billion. Many of these consist of delivering less care, or seeking to bury the identifiable costs of delivering hospital services in a general heading of community or primary care.

The proposed interventions were:

- Reducing the cost of services delivered in the community
- Providing more care in the community and less in hospitals
- Stopping clinical interventions which NHS London argues “have little or no benefit to those receiving them” – including ‘some joint replacements’ (although no more detail is offered)
- Proactive care for people with long-term conditions, reducing the need for hospital admissions

- Prevention to reduce the risk of ill-healthⁱ (ISP: 3-4)

In practice the evidence for cost savings from developing GP and community out of hospital initiatives is very limited. Recent research published in 2012²⁰ surveying all out of hospital initiatives failed to demonstrate savings.

Primary care

Primary care too initially faced a wholesale reorganisation, with Darzi's plan for a network of polyclinics, or the lower budget and possibly less controversial notion of polysystems, which were expected to work around existing facilities and premises. These new enlarged health centres were intended not only to shake up existing GP services, but were also supposed to take over many services currently delivered by hospital trusts.

However as the resistance of many GPs to the proposals became clear, and the resource constraints grew more pressing, the focus on reorganising primary care became increasingly less prominent – and attention turned much more to driving the hospital reconfiguration process.

2011 – moves towards consultation

From the middle of 2011 more of the sector plans were firmed up, and project teams established between the PCTs involved. In South West London the Better Services, Better Value project was launched in May 2011. In the autumn of 2011 the PCTs in North West London planned the timetable for the launch and consultation on their far-reaching reconfiguration of hospital services which was entitled Shaping a Healthier Future.

In North Central London, after a mass local campaign supported by all parties had secured the future of the Whittington Hospital in the run-up to the 2010 election, attention was focused primarily on downgrading Chase Farm Hospital and closing its A&E.

In North East London, the December 2010 Business Case (see above, page 25) remained at the centre of plans to close A&E and most acute services and beds at King George Hospital, Ilford, as part of the plan for savings and to stabilise the desperate financial plight of the Barking Havering & Redbridge Hospitals trust, which was weighed down by the hefty payments on its £240 million PFI hospital, Queen's Hospital in Romford.

2012: questions over viability

In the spring of 2012 the country's most expensive PFI hospital, the £650 million Royal London, which with the redevelopment of Barts Hospital is part of a £1 billion PFI project, and set to cost in excess of £6 billion, opened its doors, and posed the Barts Health Trust, now enlarged to include

ⁱ Which some PCTs seem to have rather naively interpreted as enabling almost instant results from long-term preventive policies

Whipps Cross and Newham Hospitals, with a growing financial problem in raising the huge legally binding “unitary charge” payments.

Shortly before this, NHS London had commissioned a document from McKinsey²¹ analysing the financial and clinical viability of the capital’s 18 NHS acute hospital trusts. The ‘SAFE’ document (Sustainable and Financially Effective) came up with the grim conclusion that only two trusts, the Royal Free Hospital (which has subsequently become a foundation trust) north of the Thames and St George’s south of the river could hope to remain financially viable if they achieved “productivity opportunities equal to their top quartile peers”.

Eight other trusts – interestingly including Lewisham Hospital, Barnet and Chase Farm and Ealing, each of which has faced threats of downgrades or closures – were seen to be more risky prospects, with a severe warning over the future of Imperial College Healthcare, which runs Charing Cross, Hammersmith and St Mary’s Hospitals in North West London.

But more worrying still, eight more trusts, five of which were seen as hampered by large PFI schemes with unitary charges “above £10 million” were dismissed by McKinsey as “not financially viable with productivity increases alone”.

These trusts at risk were (going clockwise around London from North West): West Middlesex, North West London Hospitals, North Middlesex, Whipps Cross, Newham, Barking Havering & Redbridge, South London Healthcare and Epsom & St Helier.

The North West London consultation, now clearly proposing to close four A&Es and effectively close all but a skeleton service at Ealing and Charing Cross Hospitals was opening up. Soon after this, in the summer of 2012 Andrew Lansley, as Secretary of State announced that the Unsustainable Provider Regime was to be invoked, and a Trust Special Administrator (TSA) appointed – with far-reaching powers and little obligation to consult local views – to tackle the chronic deficits and financial instability of the South London Healthcare Trust in South East London.

South London Healthcare had been formed as a 3-way merger largely as a result of the unresolved financial problems of two of its major hospitals (Queen Elizabeth in Woolwich and Princess Royal University Hospital in Orpington) each of which had increasingly unsustainable PFI contracts.

The earlier *A Picture of Health* project and a laborious 6-borough consultation exercise had already tried to move towards the run-down and closure of the third hospital drawn into the merger, Queen Mary’s Sidcup – but failed to win significant support for its closure, even from people in boroughs several miles away. The value of Queen Mary’s to the merger was that it had land and building assets that were not subject to PFI.

It was only when the TSA published his recommendations in the autumn of 2012 that it became clear that he had resorted to downgrading and cutting services at the neighbouring Lewisham Hospital Trust as part of his costly package to reorganise services.

This was seen as palpably unjust, and triggered the biggest campaign in defence of a local hospital in London since the Edgware Hospital campaign in the 1990s, and, with its second court victory

challenging the lawfulness of the decision of Health Secretary Jeremy Hunt to endorse the TSA's proposals, Save Lewisham Hospital became the most successful defence campaign in recent years.

The scale of the Lewisham resistance inspired campaigners across London, and the willingness of Lewisham's Labour council to commission a critique of the plans and back legal action to reverse them appears to have helped encourage and inspire Ealing's Labour council on the other side of the capital to support the campaign in defence of North West London's threatened hospital services.

Since April 2013

NHS London, the old Strategic Health Authority, has since the implementation of the Health and Social Care Act been replaced by THREE Local Area Teams (LATs) of NHS England, which have no websites, and do not meet in public, or publish their board papers. The North East London LAT is not even based in London, listing its headquarters as the NHS England base in Leeds!

The pretence of a single London body is maintained by the fact that these three teams are represented in public by a new Director of NHS England (London), Dr Anne Rainsberry.

Dr Rainsberry was herself previously an architect of the highly controversial Shaping a Healthier Future plan for rationalisation and reconfiguration of services in North West London.

In the Autumn of 2013 NHS England's 'London Region' published a dire warning that without far deeper cuts than contemplated up to now, the capital's NHS could plunge £4 billion into the red by 2020. *London – a call to action* is a 36-page, rather curiously designed document, publicly launched by NHS England's regional medical director Dr Andy Mitchell, who earlier played a key advisory role in drawing up the Trust Special Administrator's draconian proposals for cutbacks at Lewisham Hospital.

Dr Mitchell told *The Times* that the scale of the cash crisis was so great that hospitals would not be able to afford to staff hospitals safely, and that the only answer was a far-reaching reorganisation of services to close **half** of the capital's A&E units, along with maternity units and paediatric departments, to concentrate services in fewer sites.

This would imply substantial additional closures over and above the A&E units that were already known to be under threat. It also raised the question of the ability of the new 'super-centres' to cope with the increased flow of patients, and whether the necessary capital investment would be available to expand them to the capacity that would be required.

More significantly, it was an argument that very openly begins **NOT** from clinical criteria and objectives, but from the financial pressures and shortages of resources, making clear that the final result has to be reduced spending at all costs.

Meanwhile Jeremy Hunt has responded to his embarrassing double defeat in court by seeking to add a controversial Clause 118 (now 119) to the Care Bill, giving even more sweeping powers to a Trust Special Administrator to reorganise a whole local health economy rather than simply the trust judged to be failing. Although this new legislation would in theory open up Lewisham and almost any

other hospital anywhere near a failing trust to the danger of imposed downsizing or closure, it's clear that the very existence of this clause is testimony to the failure of the proponents of reconfiguration schemes to win any significant public support for their plans.

For the government to begin repeatedly to invoke clause 119 and the unsustainable provider regime would amount to a declaration of widespread failures of hospitals under the government of the day. The claim is that the process will be time limited, transparent and only be used in specific circumstances, and be subject to public consultation is belied by the rushed nature of the exercise, the lack of effective engagement and community access to detailed evidence and documentation, and by the cursory and limited ability to challenge the public consultation document. Already with the passing of the clause there is evidence that commissioners are preparing to exploit this procedure to achieve reconfiguration not possible through standard planning procedures.

CCGs take over the sector plans

Despite Dr Mitchell's efforts and the years of work since 2010, however, most of the plans for reconfiguration and rationalisation of services in London appear to be in some disarray in the spring of 2014. Further initiatives later this year are complicated by the next general election now rapidly approaching bringing sharply increased political sensitivity over anything smacking of hospital closures.

The Better Services Better Value (BSBV) project in **South West London** had developed an extensive – though never completed – Business Case that proposed the closure of two A&E units, almost certainly at Epsom and St Helier Hospitals, and reorganisation of services across the patch. It has finally been abandoned and wound up, after GPs in the Epsom Hospital catchment voted strongly in two ballots to reject it being closed or downgraded.

Interestingly the initial mobilisation of GP opposition was led by Chris Grayling, the Conservative MP and Justice Secretary: but his unofficial ballot was followed by a firm rejection of the plans by 75% of GPs in a follow-up official ballot.

BSBV had stressed that it planned to deliver health services from all five existing hospital sites (but possible scenarios included options with no inpatient care and most of the buildings unused at either Epsom or St Helier, and another scenario would have seen each hospital reduced to fewer than 150 beds).

The long-running saga of attempted reorganisation in SW London therefore enters a new phase, in which a new project is being initiated jointly by Monitor, NHS England and the NHS Trust Development Authority (TDA) to “help groups of commissioners and providers work together to develop integrated five-year plans that effectively address the particular local challenges they face”.

It seems clear that if the intention is to press ahead with any plan similar to BSBV, Epsom Hospital needs to be detached from St Helier: however previous efforts to push through a merger of Epsom with Ashford and St Peter's have failed, and will not be helped by the increasing complexity of competition law and involvement of the Office of Fair Trading.

And while Epsom is protected by senior Conservative MPs, St Helier has also been defended by Sutton's Lib Dem council, Merton's Labour council and local Lib Dem and Labour MPs as well as an active trade union and Labour Party campaign.

This is not predictable nimbyism however but a reflection of the difficulties encountered by BSBV in constructing a viable business case. It appeared that even after cuts in services and jobs the extra costs of extensions to existing acute sites would eliminate any savings from the new proposed configuration, while at the same time it exposed the safety and continuation of services to grave risks. It crucially depended upon the great unknown: whether primary and community care would be successful in reducing demand for acute services and generating real savings.

South East London poses perhaps the biggest problem: the strategy that had eventually been drawn up for reconfiguring services was effectively superseded by the crisis of South London Healthcare, and the TSA's plans for reconfiguration of services have been seriously disrupted by the victory of the Lewisham Hospital campaign. The costly bail-out of the PFI hospital contracts at Queen Elizabeth Hospital and Princess Royal University Hospital is pressing ahead, but the measures that were supposed to help defray the expense by closing and selling off two thirds of the Lewisham site have ground to a halt.

South London Healthcare has, however been dismembered, with Princess Royal University Hospital taken over by King's College Hospital, Queen Elizabeth Hospital having been forced into a merger led by Lewisham Hospital Trust, and the residual services and buildings at Queen Mary's are now in the custody of Oxleas Foundation Trust.

Predictably the closure of A&E services at Queen Mary's has posed capacity problems at Darent Park Hospital and at Queen Elizabeth Hospital Woolwich and Lewisham.

In **North East London** a continuing campaign by all three major parties in Redbridge is still resisting the 2010 plans to close A&E, maternity and other services at King George Hospital in Ilford, although this has now been complicated by questions over quality and capacity issues at Queen's Hospital in Romford, which is currently in special measures (its financial woes, and those of the Barking Havering & Redbridge Trust which runs both hospitals, have been worsened by the excess costs of the £240m PFI-financed Queens Hospital, which opened in 2006).

Another PFI-driven headache in North East London is the deepening financial problems of the giant Barts Health Trust which has been seeking to make savings of £77 million in 2013-14, and faces repeated years of increasingly stiff savings targets to cover the huge costs of the PFI project that has rebuilt the Royal London and modernised Barts at a cost of £1 billion, and now requires the trust to make inflated unitary charge payments running at £115m a year and rising each year to the late 2030s. One consequence has been an attempt to cut Band 6 nursing posts and to effectively dilute the skill mix of services, especially at Whipps Cross Hospital and Newham.

In **North Central London**, where the long-delayed and hotly-disputed closure of A&E and services at Chase Farm Hospital was eventually carried through in November, some 15 years after it had first been proposed, but only after facing a last-ditch legal challenge by Enfield council. Soon afterwards

came a tragic case of a child who died as a result of his parents mistakenly taking him to the Urgent Care Centre at Chase Farm, and the subsequent delays traversing the awkward journey to Barnet General.

NHS managers and ministers have time and again insisted that the large majority (70% or more) of patients using A&E services would still be able to use the reduced services of Urgent Care Centres: sadly most parents and patients are not always able to tell whether they or their child is part of the 70% or part of the 30% who require the full services of an A&E.

There have been further problems into 2014 with long delays and lack of adequate capacity at Barnet General, which was supposed to take a smaller share of the caseload from Chase Farm, and North Middlesex, which was supposed to deal with more.

The situation since the closure seems to bear out the concerns of those campaigners who argued that the promised services to replace Chase Farm had not all been put in place.

And things have gone far from perfectly in North West London, where Ealing council failed to secure a Judicial Review ruling against the proposals from Shaping a Healthier Future to close the existing Ealing and Charing Cross hospitals and replace them with an enlarged clinic treating mainly outpatients and Urgent Care Centres in place of A&E, and close two more A&E units at Central Middlesex Hospital.

Foundation trusts and the Trust Development Authority

Another major factor affecting London's hospitals is the requirement under the H&SC Act for NHS Trusts to become Foundation Trusts: the capital still has a relatively large number of NHS Trusts many of which, as McKinsey's told NHS London in February 2012, lack the means to satisfy the financial viability criteria used by Monitor to guarantee survival in their present form in a new role as a foundation trust. Paradoxically this is because there is more competition within London – which is the objective being pursued by the government, but a risk factor for commercial survival.

A 2013 Summer Report by the Trust Development Authority (TDA) has found that the financial standing and services of 13 London trusts raise material issues or require further investigation. Of these 11 were already facing deficits and falling behind plan^j, while another six, including the London Ambulance Service, raise emerging concerns.

There are concerns over their clinical viability, too: a *Health Service Journal* article, using more recent data than the TDA, pointed to many London trusts, especially those with the Type 1 A&E units that deal with the full range of emergencies, already falling behind performance targets and showing the kind of reduced performance not normally seen until the increasing winter pressures in December²².

^j Barking Havering & Redbridge University Hospitals, Barnet & Chase Farm Hospitals, Barts Health, Croydon Health Services, Ealing Hospital, Epsom & St Helier University Hospitals, Kingston Hospital, Lewisham Healthcare, North West London Hospitals, South London Healthcare, West Middlesex University Hospital - see TDA report http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA_summer_report_FINAL.pdf

The scale of the problem was underlined by the abrupt closure of the new flagship Royal London Hospital to admissions for two days as beds ran out well before any possible winter crisis – in September 2013.

Primary care: no clear consensus

With all of the focus on reconfiguring hospital services and developing community health services to take the strain there is a danger that the need to improve the consistency and quality of primary care services has once more been forced into a subordinate position.

GPs allegedly control 80% of the NHS commissioning budget as a result of the Health and Social Care Act. In practice, we have heard, and evidence suggests that only a minority of GPs participate at all in the decision-making processes of their local CCGs: and one area they are not allowed to decide on or commission for themselves is the primary care service they work in.

They have consistently lost out in terms of resources while being apparently feted by the governing parties. According to RCGP research, between 2005/06 and 2011/12 the overall British NHS budget grew by 18% in real terms, but – despite a growing population and spiralling health costs – funding for general practice FELL by 8.3% in real terms. Calculations show that this is not simply limited growth in spending, but indicates a real terms reduction of £1.3 billion between 2005/06, when 10.7% (£9.5bn) of the British NHS budget was spent on general practice, and 2011/12, when this share had fallen by over two percentage points to 8.4% (£8.8bn) – all calculated in 2012 money²³.

NHS funding for general practice has dwindled to an all-time low as a share of NHS spending²⁴. Far from being in charge, most GPs feel they are being bombarded with tasks and targets making their job harder and their working hours longer, but that little is being done to invest in their services or ensure that gaps in resources are addressed.

Meanwhile demand for primary care has been rising: the number of general practice consultations increased by 75% between 1995 and 2009, resulting in a 40% increase in clinical workload of over 40 per cent when compared to 1998²⁵.

The controversial but substantial effort initiated following the review of London's NHS in 2007 by Lord Ara Darzi – a hospital doctor – focused on primary care, and proposed the development of expanded health centres – polyclinics – few of which in the end were established. Darzi's proposals were strongly contested by many GPs: but it did at least indicate that there was at that time a clear London-wide attempt to enhance the quality of primary care services, and increase investment.

Many GPs will feel it is time for a sustained effort to improve primary care, not as another means to remove care from hospitals, but as a way to improve the quality of care delivered at the first contact, the detection rate for cancers and treatable disease.

We note the evidence given to the Panel by Dr Clare Gerada, Board Chair, Transforming Primary Care in London. She argued for the federation of GP practices into larger-scale extended providers, and in particular an effort to reduce the numbers of single and two-handed GP practices by grouping

them together with others, enabling their patients to access a variety of enhanced facilities and services. This policy has also been echoed and developed by the King's Fund: but we know it to be controversial with many London GPs.

A brief snapshot of the financial situation in London's NHS Trusts and CCGs in 2014

The paradox in all the dire projections of financial gloom is that London healthcare has made a consistent surplus for several years and the latest projection is for a surplus of £664m by the end of March 2014²⁶.

This hardly reflects an NHS out of control. Given the other pressures facing the NHS, it once more displays an overriding priority given by its managers for achieving financial targets ahead of other targets. CCGs are now required to keep back a substantial 3.5% of their £10 billion commissioning budgets as surpluses or contingencies: this seems to run the risk of leaving money unspent while NHS providers cope with rising pressures and deficits. Already in excess of £3 billion of unspent NHS allocation has been clawed back by the Treasury since 2010, with a further surplus apparently set for a similar fate in 2013-14.

A brief survey of CCG Board papers for this Report in February shows 26 projecting a break-even or surplus, with surpluses as high as £29m in West London, £27m in City & Hackney, £16.9m in Central London (Westminster) and £13m in Tower Hamlets. The surpluses add up to £182m.

But against this picture of comfortable surplus, the other six CCGs are braced for deficits totalling £71m, with Barnet topping the list with almost £21m, followed by Croydon at £19m.

Moreover while the style of reporting varies, and not all data can be exactly compared, it's clear that many of the surpluses are reduced and the deficits compounded by a consistent pattern of over performance on acute hospital contracts – i.e. hospitals treating more patients than they had been contracted to provide. On this swift survey the total excess cost adds up to £116 million. To cover this and other higher than expected costs, many CCGs already admit making use of some, or in some cases all of their reserves and contingency funds: in other words the apparent projections are not a full picture of the pressures they face.

From the provider side, the easiest trusts to analyse are the NHS Trusts, which are monitored by the Trust Development Agency. Ten of the 22 trusts in London are projecting deficits by the end of the year adding up to £168 million, while twelve are expecting break even or surpluses totalling £47m.

Some of the most eye-watering deficits (Barts £50m, Barking, Havering and Redbridge £23.5m, and South London Healthcare £19.9m) can be seen as linked with disastrous costs of PFI contracts. To some extent this is also true of North West London Hospitals, which includes Central Middlesex Hospital, perhaps the first substantive sized PFI hospital to face a major cutback as part of the NW London reconfiguration.

While the scale of the problem and the hugely unfavourable future prospect of continuing flatline funding raises questions over whether any of these indebted trusts can ever achieve foundation status, it is harder to monitor the financial health or otherwise of some of the capital's foundation trusts which choose not to publish their board papers and financial reports.

While some foundation trusts have clearly been treating well above contracted numbers of patients, and appear to be profiting from this, others are not so well placed in the new, constrained NHS marketplace. It's clear that mental health trusts are facing pressure as a result of an even heavier squeeze on their budgets by commissioners, both through tariff reductions and disinvestment from services, sometimes on an obviously short-sighted basis.

Recommendations from the People's Inquiry into London's NHS

We have published the fullest possible edited transcript of all the evidence we received in seven public hearings and many of the written submissions to the People's Inquiry at www.peoplesinquiry.org. It is impossible for a summary to do justice to the wealth of experience and information we have seen and heard. We are very grateful to all the individuals and organisations that took the time and trouble to give evidence to the Inquiry, which has added depth and variety to the published evidence available on the issues.

The report above seeks to provide a context for the evidence we have heard, and to fill in additional information where required. We found that running through the various very different public hearings there were a number of common themes that emerged, and dominant issues that are shaping the situation for healthcare in London.

The Panel agrees from all of the available evidence that the present trajectory, if unchanged could lead to increasing strains on front-line services and commissioning budgets, primary care, mental health and community health sectors.

Our conclusions have therefore been developed into a series of recommendations for policies and actions that might avert more serious and damaging problems, halt the inherent slide towards costly and unproductive fragmentation and competition opened up by the Health and Social Care Act – and the consequent diversion of commissioners' scarce management resources – and move towards a more efficient and effective collaboration and integration of health care and social care in the capital.

We recognise that these proposals will be controversial in various circles – contradicting the pro-market logic of the current coalition government's reforms and the previous government's experiments with market forces and use of private providers.

Our proposals are likely to be dismissed by coalition parties, committed as they are to maintaining the current and planned flatline funding of the NHS to 2021 as part of the public sector cuts which

are their chosen way of deficit reduction. But our recommendations will quite likely also cause concern for Labour's economics team, who have so far studiously avoided any commitment to increase NHS or other public sector budgets if they are elected in 2015.

We have heard many reasons to question the evidence behind some of the core proposals of the now disbanded London Strategic Health Authority's healthcare for London project, which still inform most of the current reconfiguration projects in the five sectors of London. Patients, politicians and health professionals have told us that these proposals paid insufficient if any heed to the social needs of a rapidly growing and diverse population, or to the (often ignored but substantial) logistical problems for many patients and their visitors – especially those on low incomes – travelling to alternative secondary services by public transport.

There are also strong concerns from mental health professionals and campaigners that the focus has been exclusively on reorganising acute hospital services, with little attention paid to the implications for mental healthcare, as commissioners impose disproportionately large savings targets on mental health, and the capital has found itself once again in a serious shortage of beds for those patients requiring hospital care.

We have evidence which questions the practicality of achieving the reconfiguration plans in full, and in particular the aspiration for a very substantial expansion of community health services in the context of the developing financial pressures, the lack of concrete plans or visible political commitment to implement them, and the uneven and still under-developed primary care services in many areas.

In every part of London we have heard an overwhelming sense of frustration at the lack, or inadequacy, of channels for public engagement with many commissioners and provider trusts. We have seen little evidence of public or professional confidence in the official box-ticking consultation processes. There is equally little evidence that commissioners or providers give serious consideration or in some cases respond at all to issues and doubts raised during consultation exercises.

Nor does it seem there is any real public awareness of, or confidence in the effectiveness of the new bodies established by the Health and Social Care Act to represent local views and give a limited degree of local accountability of NHS commissioners and providers. Health Watch, despite the efforts and good intentions of some working within the local groups, appears to be uneven and largely ineffective, with little if any public profile – and virtually no involvement in the issues that have galvanised the most active public interest in the last year. And in only one of our hearings (North Central London) was there a report indicating any impact or role for Health & Wellbeing Boards.

This by no means indicates that London boroughs are uninterested in the developments in local health services. In the last few years a number of local authorities have taken the lead in responding to local concerns by commissioning external advice and support and providing a basis for challenging the assumptions and plans of the NHS. Notable examples have been Lewisham council but also Merton and Sutton have responded vigorously in SW London and Ealing, Islington and Waltham Forest similarly. Local authorities have duties to scrutinise and approve NHS plans and an increased

onus is being placed on them with the creation of Health and Well-being Boards, although it is not clear that they are being given the power to fully fulfil this extra responsibility.

The People's Inquiry recommendations seek to address these issues, drawing from the evidence we have heard, and the expertise and views of our Panel.

Obviously many of these issues also apply to other areas outside London, and some clearly require national-level action – in some cases legislation, in others a change of policy – for a lasting solution. However the concentration of population and health services in Europe's biggest city mean that the scale of the problems and urgency of resolving them are especially demanding in London, and the Panel will work with Unite and all those who agree with our proposals to lobby for their adoption and implementation.

Recommendation 1: Review the spending constraints that threaten the future of services

While we recognise that there have never been unlimited funds available to expand the NHS, the Panel is agreed in the view that the current government's claim to have ringfenced NHS funding with tiny percentage annual real terms increases that are falling behind the actual level of rising costs and service pressures is a fatuous argument. At a time when BBC and other news outlets are proclaiming the imminent end to the recession, and an economy once again growing, it seems that NHS allocations are locked in a time-warp of recession and austerity for another six years.

In fact after almost a decade of growth in spending designed to put British health budgets on a par with the European average and redress decades of historic underinvestment (identified in the Wanless Report) the most recent OECD figures show that spending on health care in the UK has been falling as a share of Gross Domestic Product (GDP) each year since the peak of 2009. The UK now stands as only 15th highest spender either in health spend per head of population, or as a share of GDP. This puts us below not only the chronically wasteful US, but also Netherlands, France, Germany, Denmark, Switzerland, Austria, Belgium, New Zealand, Portugal, Japan and Sweden.

In reality near-flatline funding is resulting in practice in a continually tighter financial constraint each year for the NHS, which in some areas takes the form of outright cuts. This is compounded by the undercounting of the population of London which has only recently been recognised as actually housing a million more people, in often overcrowded and therefore unhealthy conditions, than recognised in official funding calculations. Given the lag between population growth and funding growth this means that London's healthcare has suffered particular pressures.

Although the tariff system supposedly takes account of local London cost pressures it is not clear that it is keeping up with the surge in rentals and transport costs in London.

The tariff payments for care provided by trusts are reducing year by year, with a 20% larger reduction in tariff now planned for mental health services compared with acute hospitals. According to the Foundation Trust Network, tariff payments in A&E services in many trusts are now at or below the costs of providing the services, while excess caseload above contracted levels is paid at an even

lower punitive rate of just 30% of the tariff price, while often requiring additional staff, beds and even wards – ensuring that the service runs at a loss.

In addition to this financial pressure, trusts which lack the capacity to get patients off emergency ambulance trolleys and into A&E face penalty payments of £200 each time this process exceeds 30 minutes and £1,000 if they take more than an hour. There are also heavy financial costs where patients are readmitted soon after discharge where this is deemed avoidable – since hospitals are not paid anything for the treatment delivered to a readmitted patient.

According to a recent Channel 4 report, almost £1 billion in penalty payments or reduced payments has been taken from trusts since 2010, with no clear indication of where this money has gone to. Five major London trusts– Imperial College Healthcare, Barking Havering & Redbridge University Hospitals, Barts Health, St George's Healthcare and University College London Hospitals – feature among the biggest losers under this system, which gives the commissioners no financial incentive to put in place the much-promised expanded and enhanced community services that are supposed to reduce the levels of demand for A&E services.

The cash squeeze on providers has been further compounded by the increasing requirement on commissioners to retain reserves from their cash allocations, and the claw-back of over £4 billion in NHS surpluses by the Treasury since 2010, despite clear commitments from ministers that cost savings would be ploughed back into patient care²⁷.

The situation is set to get worse. Evidence from the Nuffield Trust and the forecast from NHS England's London office make clear that, without a change of policy, London's NHS alone faces a widening gap between demand and resources that could rise to £4 billion by 2021.

In the Panel's view a funding squeeze this severe would put the very viability and sustainability of key services in question. This is not just a London problem. The situation in England, of course, is similar: the shortfall by 2021 appears to be £28-£30 billion. The figure could be even higher if, under pressure from other spending departments, the government after 2015 ceases to ringfence NHS spending, and decides instead to include the NHS in the substantial further 10.5% cuts in public spending outlined by Chancellor George Osborne for 2016-19.

As Anita Charlesworth of the Nuffield Trust, which came up with the £28 billion projection, told the Panel in a special briefing, NHS England has also done its calculations of what it thought the resource gap would be, and estimated it to be slightly higher – around £30 billion.

The Institute of Fiscal Studies (IFS) in February 2014 calculated that with the national population growing by an estimated 3.5 million between 2010 and 2018, and growing numbers of the more dependent over-65s in the population, the impact of the squeeze would be that age-adjusted health spending per person would effectively fall by 2019 to a level 9% lower than in 2010.

The real problem is that no viable plans have been put forward to preserve existing services with such constraints on the resources available. Monitor brought in McKinsey to have a look at how much the NHS might save from potential productivity measures. Starting from the same £30 billion

gap, McKinsey claimed that it could point to possible savings of between £10.6 billion and £18 billion, if all of its – often controversial – proposals were implemented. Since these savings fall far short of closing the gap, McKinsey also suggested that the NHS should make even bigger savings from the NHS payroll bill, and also sell off every spare bit of estate in a one-off effort to save the other £12 billion.

However, there are huge uncertainties over whether many of the supposed productivity and efficiency savings are even possible.

- Up to £6 billion has been claimed as the possible saving to be made from moving services out of hospitals and into alternative settings – but the evidence for any savings is slim.
- Another £6 billion has been quoted as the sum that might be saved by better management of chronic disease in the community – but this in turn remains to be tested, and the evidence is not clear. In any case such savings and the new system to generate them depend on as yet purely notional changes in primary care and expansions in community-based services and use of new technology: even if the schemes are sound, they require time – and extra investment.
- The one-off sale of NHS estates proposed by McKinsey could well run into the obstacle of long-standing Treasury opposition to the conversion of capital into revenue.
- Many analysts, including the government's own Office of Budget Responsibility, are questioning whether the pay freeze – that has already taken such a heavy toll on the value of NHS pay with standstill or below inflation increases for the last four years – can be prolonged any further without consequential damage.

Another question mark over the sustainability of a service moulded in this way around the quest for cash savings centres on the fact that all of the payroll cuts and staff productivity savings involve reducing staff ratios. Cuts in staff bring a very likely – but little discussed in this context – negative impact on quality. This raises serious problems in the post-Francis report/post-Keogh world in the NHS, where quality and safety concerns have been raised to new levels: among other new targets, acute hospitals are to be required to publish its staffing levels each month.

However, all the McKinsey proposals are based on levelling hospital staffing down to the lowest possible ratios, despite the fact that, as Anita Charlesworth told the Panel, trusts with the lowest ratios are increasingly facing quality issues.

The Panel are convinced that the levels of financial restraint proposed for the next 6-7 years are **unsustainable** without serious damage to the quality and availability of NHS services, both in London and in England as a whole. There is no locally-based funding of the NHS, which has always drawn its resources from general taxation – and therefore no specifically London answer.

1. 1 WE RECOMMEND that the planned allocations of funding to the NHS are revised significantly upwards at the first available opportunity, returning to real terms increases each year which at least match the increased cost and demand pressures on NHS providers.

We recognise that in the current financial and political climate this proposal will be controversial with all the main political parties. We don't have any specific proposal on how this extra money could be raised by the government, but we understand – not least from the size of surpluses refunded to the Treasury in recent years and the very substantial reserves which are held by commissioners and Foundation Trusts - that there is sufficient resource already in the system to enable a strategic uplift to spending in the sectors facing most pressure.

We note research that shows that any extra spending on healthcare is economically beneficial with not only a high local multiplier effect but a low level of import penetration making investment in healthcare one of the most effective ways of boosting the economy²⁸.

Further support for additional spending is provided by comparison with spending in other comparable countries, where spending on healthcare is around 2% more in GDP terms and much more in than that in the USA²⁹.

In the longer term we would argue that additional funding for the NHS should be raised through progressive taxation rather than flat rate taxes that fall most heavily on those with low incomes. Panel members have discussed possibilities including a hypothecated increase in income tax, which does appear to enjoy some measure of public support.

The amounts raised in tax and the decisions on how to allocate these funds are inevitably political decisions for the party in government to decide. However it is important that politicians are made fully aware of the consequences of the decisions they take and take responsibility for those consequences. The Panel strongly believes that it's not the job of local commissioners or NHS trust directors to mount a political defence of cash constraints that impede their ability to maintain services, or to pretend that unpopular changes and service reductions are driven by clinical concerns when in fact they are a response to financial pressures imposed upon them.

1.2 WE RECOMMEND that, in line with the findings of the Francis Report and with our general call for more transparency and accountability, all NHS senior managers should be subject to a duty of candour about the situation they face and required to speak out openly where they face unacceptable choices driven by resource constraints. This would put the duty to explain back onto the politicians and ministers; they alone must be required to justify their priorities and decisions to the electorate.

1.3 WE RECOMMEND a review should take place of the funding formula and tariffs paid for care in London. For years it has been alleged London was overprovided but it is not clear whether funding or tariffs recognise the actual population, the additional population treated in London and the additional costs faced by Londoners.

Recommendation 2: Reinstate strategic overview

Time and again in each of the hearings the Panel has heard evidence of the need to restore some form of strategic oversight of London's 32 CCGs, and establish a body that would enable commissioners in adjacent CCGs to cooperate wherever appropriate and jointly plan and commission services to match the wider needs of their populations.

The CCGs themselves have been limited in their legal powers to work together by the framework of legislation: belated changes made to the Act during the public hearings of the Inquiry have been required to facilitate organised cooperation and joint decision-making. However the Health and Social Care Act imposes no obligation on CCGs to work with their neighbours, which can result in different levels of care being commissioned by adjacent CCGs, leading to unequal treatment of patients on the same ward – for example in the level of follow-up support for new mothers breast-feeding.

The Panel agrees with those witnesses who have told us that London needs a strategic planning and enabling body. It also needs a body which is able to carry through the role previously fulfilled by NHS London; of intervening where necessary to pool risk, shift funds, and maintain stability of local services under especially severe financial pressure. This would clearly require a policy shift at national level to create a more flexible method of allocating resources. It is not clear to us that the tariff system can be relied upon to meet the essential costs of services. It seems it may result in some trusts generating large cash surpluses while others struggle through no fault of their own. There needs to be an element of judgement, flexibility and local discretion reintroduced into the funding of healthcare.

It's clear that, as former NHS London chief executive Dame Ruth Carnall told Panel members, one reason Strategic Health Authorities were abolished by the Health and Social Care Act was because they were seen by Andrew Lansley as a natural obstacle to the free play of market forces and competition. But there seems to be little evidence that increased competition can deliver either cost savings or improved clinical care. Ruth, who is now advising London mayor Boris Johnson, told Panel members that Lansley had even initially opposed the centralisation of stroke services in London – a measure now universally cited as an example of the merits of centralising specialist care – on the basis that it interfered with the market: only the weight of clinical opinion succeeded in forcing the policy through.

2.1 WE THEREFORE RECOMMEND the creation of a new type of London Strategic Health Authority, on a model which does not replicate the former structure of NHS London, but one which encompasses a democratic element, possibly with involvement of the GLA, London boroughs and CCGs. Once again London is not a special case on this issue: we also feel that similar new-style SHAs with democratic input should be established to cover natural regional populations elsewhere in England.

Panel members felt that useful lessons could potentially be learned from a closer study of the effective integrated organisations that have been established in the devolved administrations in

Scotland after the Scottish Parliament scrapped the division between purchaser and provider, as well as linking health and social care in Health Boards.

2.2 WE RECOMMEND the strategic body that primarily relates to London and its various needs should take over the commissioning of primary care in the capital from the remote control of NHS England and its three London local area teams (LATs), which appear to have little if any accountability to or, interaction with Londoners.

Recommendation 3: Transparency and accountability

With some honourable exceptions, the general sentiment in our hearings was that many of the CCGs across London have very poor levels of engagement with local communities and elected politicians. Questions have been raised by many over the level of actual engagement of GPs with CCG boards, and the level of explicit support that exists among GPs for some of the policies and plans that have been endorsed by CCGs.

The most glaring gap in credibility was revealed by the ballot of GPs in Surrey Downs, which was initiated by Chris Grayling MP, the Justice Secretary, and later confirmed by a further official ballot. It showed 75% of GPs opposed to the plans for hospital reconfiguration drawn up by the Better Services Better Value project in SW London, which the CCG and its predecessor PCT had previously gone along with because they saw it as proposing only the closure or a significant reduction and downgrading of services at St Helier Hospital, but not their own local Epsom Hospital³⁰.

Similar doubts have been raised by limited unofficial ballots of GPs in Sutton showing opposition to any loss of services at St Helier Hospital, as endorsed by their CCG. In North West London, as we were told by Dr Mark Spencer of Shaping a Healthier Future, a ballot of GPs in Ealing also revealed a majority against the plans to remove services from Ealing Hospital. The plan was nevertheless signed off by their CCG – only to subsequently be found wanting by the Independent Reconfiguration Panel.

Questions have also been raised in hearings over the extent of potential and actual conflicts of interest of GPs on CCG boards who are also shareholders or directors in private sector companies seeking NHS contracts.

Over and above the level of GPs' awareness, engagement and active support for proposals which also potentially involve substantial changes in their own workload, there are questions about where policy-making and commissioning plans are being developed, and by whom. There is little clarity over the role played by the three Commissioning Support Units (CSUs) that cover Greater London, which appear to have no public profile, don't meet in public, and do not appear to be subject to the Freedom of Information Act.

Concerns over the quality of the work done by CSUs for CCGs in NW London were explicitly raised by commissioners and providers: for example in evidence to the Panel by Dr Mark Spencer, who said he wanted the CSU dissolved and the services brought back in-house to CCGs, and by Central and North West London Foundation Trust finance director Trevor Shipman, who argued for all of the CSUs to be wound up and the money given to CCGs to develop their own support. UCLH chief executive Sir

Robert Naylor also told us he was dissatisfied with the commissioning arrangements established by the Act. The risk of failure by the South London CSU is prominent among the concerns raised in Lewisham CCG's board assurance framework.

The picture is more confused by the proposal to merge the South London and NW London CSUs in a strategic alliance with Kent and Medway CSU, and by NHS England's changing long term plans for CSUs, which are not now expected to be taken over by private companies, but to become free-standing social enterprises by 2016. It does not seem from the evidence heard by the Panel as if the NHS England plan fits with the concerns of either CCGs or healthcare providers.

At the London-wide level there is equally little information available to Londoners on the structure, role and activities of NHS England's three local area teams, in relation to their London region office, which is taking decisions – some of them controversial, – on commissioning of primary care, district nursing and specialist services. This organisation also appears to have no system of meetings, and no public profile: so even though they may in theory be subject to the Freedom of Information Act on some questions there is no way at present of obtaining enough information about them to frame a pertinent question.

With CCGs everywhere now subject to Section 75 of the Health and Social Care Act and therefore under pressure to put an increasing range of services out to competitive tender, the level of transparency is likely to reduce still further as various papers and specifications, and the evaluation process are shrouded in "commercial confidentiality". Any services which are as a result contracted out to the private sector or to social enterprises will – at least for the present – also cease to be in any way accountable to local people or subject to Freedom of Information requests, although we note that Social Enterprise UK is campaigning for legislative changes to open up all independent providers delivering publicly-funded services to be subject to the FOI Act.

The Panel notes the argument that to subject private companies to the FOI Act puts them at a competitive disadvantage: but we also note that where private and public sector providers are in competition for publicly-funded contracts on what is said to be a "level playing field," the same requirements for openness and transparency should apply to all those competing. Acceptance of the FOI Act should therefore be a standard requirement of any private company or social enterprise seeking NHS contracts.

This lack of transparency does nothing to enhance public confidence in NHS decision-making, especially when the decisions turn out to be themselves controversial.

3.1 WE RECOMMEND that all bodies taking and shaping decisions over NHS provision and commissioning should be public bodies, and required to hold regular and well-publicised meetings in public, and to publish its board papers and policy discussions. These bodies and all organisations delivering publicly-funded care and services should also be subject to Freedom of Information legislation.

3.2 WE RECOMMEND that commissioners make use of the powers they already have within the procurement process to stipulate that acceptance that they will be accountable under the FOI Act

should be a standard requirement for any private company or social enterprise seeking NHS contracts.

3.3 WE RECOMMEND that any limited business secrecy at the time of negotiation of contracts with public, private or social enterprise providers should be followed by the prompt publication of the eventual contract as agreed, along with relevant supporting information.

3.4 WE RECOMMEND the use of open book contracting as the basis for contracting to help avoid accusations of overcharging.

Recommendation 4: Integration of care in and outside hospital

Much of the frustration reported in our public hearings across London results from the evident lack of a viable infrastructure of integrated services to support patients discharged from hospital, and averting unnecessary admissions to hospital of patients who need a package of care at home that exceeds the capacity of routine primary care services.

The Panel has heard no convincing evidence that substituting community based health care for hospital-based care would necessarily save substantial amounts of money or even necessarily facilitate the closure of NHS beds – not least because demand for healthcare, especially among older people, continues to increase and London's population is set to rise. However, we are convinced that nevertheless there are clinical and social benefits to minimising levels of hospitalisation wherever possible and keeping hospital stays as short as possible and that this should be the long-term objective for future sustainable services.

The fundamental stumbling block to developing services along these lines is the continued organisational separation of health and social care, coupled with NHS cash constraints (worsened by the top-slicing of additional money for social care), limited capacity in primary care to undertake any additional responsibilities, and continuing council cutbacks in social care budgets. This is even more of a problem when, in a growing number of areas outside London, councils' search for cash savings has led to the outsourcing of social care to private providers.

The Panel has been recommended by Ruth Carnall to study the positive results of a number of relatively limited pilot schemes for developing care outside hospital that have been funded in North West London. However, although they look interesting, these appear to be largely run and organised within the NHS with additional designated funding and to be very much clinically led with specifically NHS objectives. This falls short of the level of integration we would like to see and is not yet on the scale required to underpin any wider restructuring of services.

Ruth Carnall told Panel members her own preferred solution would be the integration of services into 5, 6 or 7 large integrated care organisations, led by large secondary care trusts like Imperial or UCLH – but she admitted that this was “anti-competitive”, and that Monitor would not approve. She went on however to argue that in this instance London is a special case, because the relatively short distances between providers makes it possible to argue that there is some choice and competition in any borough.

The Panel feels that any policy that starts not from the efficient delivery of integrated services to meet patient needs, but from an ideological insistence on the need above all for competition, is unlikely to make best use of limited resources or result in constructive collaboration and the development of genuinely integrated pathways of care.

This is also borne out by the evidence we have heard from successful providers such as UCLH chief executive Sir Robert Naylor, and Central and North West London Foundation Trust finance director Trevor Shipman that more cooperation and integration and less competition would benefit the development of sustainable, high quality services.

4.1 WE RECOMMEND a halt to the costly and complex extension of competition and piecemeal tendering of NHS community services – especially given the problems already being faced in some areas by private providers such as Serco and Virgin in delivering community services of acceptable quality at a profit.

4.2 WE RECOMMEND an alternative route of integration of community services with existing NHS and Foundation Trusts where this has not already happened, as part of a renewed initiative to establish joint working with NHS and borough social service departments. This type of arrangement, if properly designed, with trusts being given appropriate incentives for outcomes and adequate investment in community services and links with primary care, would better facilitate supportive discharge and give genuine incentives to secondary care to reduce admissions.

4.3 WE RECOMMEND the maintenance of incentives for trusts to continue to have short waiting times and recognise that a return to waiting lists to regulate supply and demand is not acceptable.

Recommendation 5: Swift reversal of aspects of the Health and Social Care Act

Evidence we have heard confirms the view that the Health and Social Care Act, which took effect from April 2013 has created a more complex structure for London's NHS, and one which is less accountable to Londoners. It increased the number of decision-making organisations in London, while removing the body responsible for strategic overview and planning.

With so many additional decision-making bodies, the expected savings in terms of management cannot be realised, and the new structure also lacks **any** clear decision-making process. Contrary to the impression given with the establishment of CCGs, the Act has brought greater centralisation of control into the hands of NHS England, Monitor and the Trust Development Authority. And this in turn has reinforced the divide between commissioners and providers.

The separation of Public Health from the NHS, located as it now is in the sphere of local government, has also been shown by Trevor Shipman to be a problem, for example in the commissioning of sexual health services.

“The whole basis of sexual health services, in order to prevent ongoing diseases, to prevent it getting worse, is that we see the patient if they choose to see us, and we continue to treat them: that applies in and out of London. What we see is local authorities have a different approach to financing these things, and these are interfering in clinical care, and we have raised this with Public Health England.”

Trevor Shipman also pointed to problems in commissioning mental health services by Clinical Support Units which lack proper public health data on levels of local need, while much of the expertise in designing and delivering mental health is now held by London's mental health trusts – which have no voice in commissioning.

Another perverse but predictable outcome of the Health and Social Care Act in London, in particular, has been for a considerable number of Foundation Trusts to take advantage of the very large increase in the proportion of its income FTs are now permitted to generate from private medicine. The cap was lifted from Foundation Trusts which had previously been limited to the percentage of total turnover they made from private sources when their foundation status was achieved.

Now FTs are permitted to raise up to half its turnover from non-NHS contracts and private patients. There appears to be little evidence that this expansion of facilities and care for the minority with health insurance or the money to pay for treatment generates any benefit to the majority of NHS patients. Instead, at a time of stringent NHS resource restraint, the focus of management time on the generation of increased income from private care would seem to represent a diversion from the improvement of quality of frontline NHS services for which budgets are frozen and only a declining tariff is paid.

In addition Section 75 of the Act specifically aims to create a competitive market in health care. The subsequent hotly contested regulations that were adopted in April 2013 now effectively compel 211 CCGs each to put an estimated 60 to 600 contracts for services out to competitive tender, with all the associated substantial drain on management energies, expertise and very substantial additional financial cost. In London the danger is that this could lead to fragmenting existing integrated services as well as increased bureaucratic costs that detract from resources for frontline care.

The Panel has been struck by the conspicuous lack of enthusiasm for this new competitive market, even among Foundation Trusts, which have so far been successful in securing substantial contracts: there has been no presentation to us of any positive benefits to the NHS from all this additional bureaucracy and management effort. Asked her view on the benefits of competition, Ruth Carnall told Panel members that a degree of competition between NHS trusts and Foundation Trusts can sometimes encourage higher quality – but offered no examples of benefit from private sector competition with NHS providers.

Experience outside London where large community health contracts have been awarded to private providers has been mixed at best, with negative impact on the development of other related NHS services, and questions over the quality and viability of the privately delivered care.

For these and other reasons it's become clear to the Panel that many of the proposals that might be brought forward for the improvement, integration and greater efficiency of services in London run into the obstacle of the new Act.

5.1 WE RECOMMEND the obligations to competition imposed by the Act be repealed at the first available opportunity, along with steps to restore the explicit duty of the Secretary of State to provide a universal service, as proposed in Lord Owen's short Bill.

We note the Labour Party's public commitment to reverse the Act, and urge Labour to explain in more detail how much they would reverse, how and how soon.

But we put the proposal forward for consideration by ALL parties, including the coalition parties which unwisely implemented the Act with no electoral mandate, and against the opposition of health professionals and health unions.

Recommendation 6: Repeal Clause 119 of the Care Bill and reconsider the TSA Failure regime

We are concerned at the powers of the Trust Special administrator to override the normal planning processes of the NHS. It is not clear to us that the TSA regime is required and its early use does not inspire confidence. Its use to identify scapegoat trusts fails to uncover the systemic problems and can lead to hasty and ill-considered pseudo-solutions to deep seated problems. We would prefer to see increased local flexibility and powers to address genuine local problems.

We also note the effort by ministers to add a clause 118 (now renumbered 119) to the otherwise unrelated Care Bill, with the clear aim of extending the potential powers of a Trust Special administrator to reorganise health services in an entire health economy rather than simply, as the current unsustainable provider regime allows, stepping in to reorganise a failing trust.

The Panel has been convinced that even with the addition of a limited commitment to consultation, clause 119 would effectively give draconian powers to an administrator that would mean no hospital could feel secure from potential intervention if any neighbouring trust ran into difficulty.

Despite its many flaws, which have subsequently been exposed by the independent report for Lewisham council and by campaigners and consultants at Lewisham Hospital, the proposal by the Trust Special administrator for the reorganisation of South London Healthcare Trust, including the very substantial cutbacks in services and closures of buildings at the neighbouring Lewisham Hospital Trust, would have been driven through unchanged and without the possibility of legal challenge had clause 119 been in place.

It is a clause that would open up a fast-track for the implementation of bad policy almost anywhere in the vicinity of a "failing hospital" without any local public support or engagement. Although we have heard Ruth Carnall's view that clause 119 will not be used to supplant the normal reconfiguration process in most places – because its widespread use would imply a prior decision by

the government of the day that many hospitals were failing – we still feel that it stands as a threat, and offers no constructive way forward.

6.1 WE THEREFORE RECOMMEND that there should be reconsideration of the TSA regime and at the very least this clause is rejected, or, if it is passed in the next few months by the House of Commons, that it should be swiftly repealed by whichever government takes over in 2015. We don't accept that rushed and top-down processes can ever secure serious local acceptance of controversial proposals.

To address the longer-term problem of securing public endorsement of the need for some reconfiguration of health services,

6.2 WE RECOMMEND a London-wide needs assessment and analysis of patient flows and existing resources, to be drawn up without delay for the new Strategic Health Authority at the earliest possible opportunity, by a panel including public health experts, commissioners, providers and local authorities. The assessment should specifically include areas of service that have commonly been overlooked or ignored by reconfiguration proposals – such as healthcare for children, and mental healthcare for adults, children and adolescents and older people.

This assessment should then serve as the basis for community planning of integrated health care services in the various geographical localities in London, within available resources. The full proposals, objectives, resource implications and action plan would then be put to a thorough and inclusive consultation including the health staff involved and their trade union and professional bodies, local communities and patient groups, elected politicians (while the more detailed discussions, which are hard to debate in a large public forum, might also involve citizens' juries or similar methods of assessing representative views).

We are clear that any satisfactory consultation must comply with the Gunning principles^k in particular allowing people to be involved in shaping proposals from the early stages, and with regard to any subsequent additional safeguards in the NHS Constitution. Those leading the consultation must be required to demonstrate how they have taken account of questions raised, reasoned critiques, calls for supporting evidence and alternative points of view.

^k The Gunning (or Sedley) principles were propounded by Mr. Stephen Sedley QC and adopted by Mr. Justice Hodgson in *R v. Brent London Borough Council, ex parte Gunning* (1985) 84 LGR 168 at 169. They were subsequently approved by the Court of Appeal. The Gunning principles are that:

- (i) consultation must take place when the proposal is still at a formative stage;
- (ii) sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
- (iii) adequate time must be given for consideration and response; and
- (iv) the product of consultation must be conscientiously taken into account.

Recommendation 7: A renewed initiative to improve the quality and accessibility of primary care

The Panel heard from a number of speakers on the mounting pressures on GPs and the uneven and often unsatisfactory quality of primary care services across London. As GPs remind us, 90% of NHS patient contacts are conducted by GPs, and patients are living longer, with many older patients routinely visiting their doctor with multiple, complex conditions.

Ministers tell us that as a result of the Health and Social Care Act, GPs control 80% of the NHS commissioning budget. Yet the RCGP and BMA point out that NHS funding for general practice has fallen by more than a fifth since 2004-5, and has dwindled to an all-time low. Far from being visibly in charge, most GPs have for some time found themselves more often told what to do – and how – in the development of local services.

The controversial but substantial effort initiated following the review of London's NHS in 2007 by Professor Ara Darzi – a hospital doctor – focused on primary care, and proposed the development of expanded health centres – polyclinics – few of which in the end were established. Darzi's proposals were strongly contested by many GPs, but did at least indicate that there was at that time a clear London-wide attempt to enhance the quality of primary care services, and increase investment.

However the abolition of NHS London as a Strategic Health Authority, and the absence of any equivalent body able to drive such a project right across the capital have also brought a virtual halt to substantial investment and initiatives to improve primary care.

We note the evidence given to the Panel by Dr Clare Gerada, who is currently conducting a separate inquiry into the development of primary care in London, and stressed the case for the federation of GP practices into larger-scale extended providers, and in particular an effort to reduce the numbers of single and two-handed GP practices by grouping them together with others, enabling their patients to access a variety of enhanced facilities and services. This policy has also been echoed and developed by the King's Fund.

Dr Anne Rainsberry of NHS England's London office also told the Panel that about 40% of GP practices in London are single or two-handed practices, and that "For a single or double handed practice trying to deal with relentless rise in demand is challenging." Dr Rainsberry told us how GPs themselves are "engaging in conversation on how to transform primary care" in London. She said "We are keen to work with GPs to look to how we can support them to provide the care they want to deliver."

However, this may prove difficult given the attitude to such a large number of smaller practices, in which the GPs may well feel themselves to be not so much supported as under threat. We also note the lack of evidence to demonstrate that – in a sector of healthcare marked by seriously uneven quality – care from smaller practices is consistently poorer than that in larger group practices. NHS England's *General Practice Call to Action* argues that London practices lag behind the rest of the country in measures of quality and patient satisfaction – although it admits some practices in

deprived boroughs (where the concentration of smaller practices tends to be higher) achieve excellent clinical outcomes and patient satisfaction.

Worryingly, GP cancer referrals are lower in London than the rest of England, with late diagnosis being a key factor in poorer cancer survival rates. Twenty-three of the lowest 25 boroughs for breast screening coverage are in London. No clear link has been shown between this worrying issue and smaller practices.

NHS England also stresses that there is a GP shortage: “nationally 16,000 more GPs will be needed than are currently available by 2021.” The problem is especially serious in London, where one in six London GPs are over 60 years old, compared with one in ten nationally. London also has a significant nurse shortage, and premises are also an issue, despite previous efforts to improve the situation across the capital. According to NHS England “a thorough diagnostic of one London region found 30 per cent of practices to be operating from substandard premises – the proportion elsewhere is likely to be similar”.

NHS England continues: “In the face of a £4 billion funding gap in London, transferring resources to primary care will need to be matched with ambitious changes in the configuration of services and improved integration. Whilst there have been incremental uplifts to general practice funding over time, funding growth has been relatively flat in recent years.” In fact analysis by the Nuffield Trust (2013) shows a real terms decline in investment into general practice from 2010-2012.

With resources limited and falling behind increased demand on primary care, the Panel does not accept that priorities for its development should be predominantly shaped around attempts to transfer services from hospitals. Rather the development of primary care and the development of alternative ways of supporting patients outside hospital is a precondition for the viability of any subsequent plans for reconfiguration of other services.

None of the plans to reduce dependence on hospitals, support more vulnerable patients in their own homes, coordinate more effectively with community services, and develop a real infrastructure of district nursing, mental health and primary care and accessible therapy services can be satisfactorily carried through without further investment and organisational focus on primary care.

We, therefore, strongly argue the need to improve primary care in London. But we also question whether it can be satisfactorily achieved while decisions on commissioning of primary care are in the hands of NHS England, and not controlled by any strategic London body.

7.1 WE RECOMMEND that an investment programme in primary care is reinstated as a priority of a new Strategic Health Authority for London, linked with the needs assessment we propose in recommendation 6.2. We note that part of this must involve realising long-standing promises and aspirations to ensure all GP practices in London are able to make use of modern, accessible local facilities in a health centre.

Logically this requires an expanded workforce, and so,

7.2 WE RECOMMEND a further initiative to expand the workforce of GPs for the future by those planning medical education through Health Education England in conjunction with the three Local Education and Training Boards that cover London.

Recommendation 8: Review the allocation of resources for mental health services

The public session on South-East London, held in Lewisham, heard the medical director of the South London and Maudsley trust Dr Martin Baggaley speak of his concerns, which he had earlier expressed publicly to the news media, over the growing shortage of mental health beds in London, and the growing waste of public money in purchasing less effective care for NHS patients in private psychiatric hospitals.

Dr Baggaley was not the only person to speak to us of their concerns over the resource constraints on mental health care, which is now largely delivered in the community, but which also requires access to beds when necessary for patients needing more intensive support. We note the (as yet unsuccessful) campaign over several years by mental health trusts for mental health care to be subject to the same type of targets for maximum waiting times as apply to the acute sector. While acute services now have to be delivered within 18 weeks, waiting times for some Child and Adolescent Mental Health Services are now 18 months, with young people having to travel huge distances to access appropriate beds, and even in some cases face treatment on adult wards.

Resources are not just a problem with in-patient services: targets for improved access to talking therapies for mental health care have also been missed in primary care. Concerns have also been expressed about the negative impact on mental health services of the Francis effect driving a recruitment of additional nurses for acute hospitals – while numbers of nurses in community health services have reduced.

New figures have emerged since our public hearings showing not only a second successive year in which national level spending on mental health services has declined after 10 successive years of growth – figures which the government has now decided should no longer be routinely collected – but also that mental health trusts face a 20% larger annual reduction in the tariff price to be paid for treatment in NHS hospitals than acute trusts.

Another indication of the extent to which mental health in the capital has effectively lost out to acute services on resources can be seen in the way that various reconfiguration plans have ignored their potential impact on mental health provision, and largely omit any serious discussion on mental health services. In the case of the proposals for Lewisham Hospital, the South London and Maudsley Trust was among those to express concerns because of the implications for the future of the mental health services delivered by the Ladywell Unit on the Lewisham site, which had not been addressed in the TSA proposals.

The government has just published a substantial new policy document Closing The Gap setting out priorities for essential change in mental health. But it appears from the current situation in London

that efforts to close the gap need to start with challenging the priorities that prevail in CCGs and in NHS England. This again requires leadership on a London-wide level, along with new initiatives to improve public awareness of mental ill-health and attitudes to it.

8.1 WE RECOMMEND a moratorium on any further service reductions in mental health, pending a rapid, full-scale review of the resources available and the pressures on all sectors of mental health services and provision in London, to be followed by swift action to respond to the gaps and shortfalls and resources that are identified.

Recommendation 9: A review of the tariff set by NHS England for specialist forensic mental health services, focused on cost per stay and effectiveness of care rather than cost per day

Speakers from the South London and Maudsley Trust also told the Panel of the threat to their hitherto successful specialist forensic services, and potentially to other key specialist mental health services resulting from inappropriate decisions by NHS England, the body which has now taken over the commissioning of specialist services in the capital, a job once done by NHS London.

They pointed out that NHS England has fixed a tariff price for forensic services, based on a daily rate which is below the SLaM's cost of delivering the services in south-east London, but which is based on a service model that results in much less effective services, and much longer average length of stay. This new model favours ineffective private providers.

In other words, what appear to be more expensive services turn out to be better value and lower in cost per episode, because patients are in hospital for shorter stays, and less likely to be subsequently readmitted.

9.1 WE RECOMMEND as a matter of urgency that NHS England, and its London regional office review its flawed tariff for forensic and other specialist mental health services in the light of an overview of the average cost per episode and the effectiveness of treatment, and revise its tariff accordingly.

Recommendation 10: Breathe life into the organisations that are supposed to represent local patients and communities giving HEALTH WATCH bodies the statutory powers that were previously held by Community Health Councils

The Panel was pleased to hear from two speakers active in local Health Watch organisations, but also noted the general lack of response from Health Watch organisations in the rest of London to our appeal to participate in the Inquiry, and the consistent absence of any Health Watch voice or visible involvement in any other local campaigning around issues of public concern such as hospital reconfiguration and other issues.

The two speakers themselves expressed some frustration at the slow progress in developing the network of Health Watch organisations, the lack of profile, and the lack of organisational strength

and statutory powers for Health Watch. This is especially noticeable in comparison with the much greater powers, local legitimacy and roots in local communities which were previously enjoyed by most Community Health Councils (CHCs) – the original organisations that were established in the 1970s to represent local communities and patients, but abolished by Alan Milburn in 2003.

Since 2003 a succession of poorly understood, poorly publicised, poorly supported and often poorly organised and led organisational structures have been established by successive government reforms to take the place of some of the work that was previously done by CHCs. There seems to be little confidence anywhere that Health Watch can ever achieve any of the energy, impact and focus that were previously a feature of the best and most active CHCs. So poor have Health Watch been at sticking up for local patients and themselves that in their first year a quarter of the funding that was supposed to be passed on through local councils has been top-sliced - effectively cut from Health Watch budgets with barely a whimper of protest.

As they stand, local Health Watch groups, established under the Health and Social Care Act, with local groups acting as subordinates to Health Watch England – and Health Watch England subordinate to the Care Quality Commission – seem doomed to remain as toothless and largely irrelevant organisations left on the sidelines as the public and local communities campaign on issues that concern them.

10.1 WE RECOMMEND that Health Watch England is closed down, and local Health Watch bodies are separated from the CQC and modelled on the old CHCs. They should link up with local community organisations, pensioners groups and other community organisations, and be given the statutory powers to inspect hospital and community services, to object to changes which lack public acceptance, and to force a decision on contested changes from the Secretary of State.

Recommendation 11: Councils must take the opportunity opened up by the Act to make underachieving and narrow Health & Wellbeing Boards genuine platforms for the planning and scrutiny of public health, health and social care in each borough

The Panel heard a number of passing references to Health and Well-Being Boards (HWBs), the local government-led bodies established by the Health and Social Care Act, but few of these references gave any clue as to the activities and local composition of the Boards. There was no feeling that HWBs were playing a significant or influential role either on public health issues (now in the orbit of local government) or in scrutinising plans for other health services in the locality.

This may be down to the timidity of local councils, or because they have their own agenda dominated by the need for large scale and continuing cuts in their own services imposed by central government. Whatever the reason, few HWBs appear to have made any effort to draw in wider participation or establish any real independent role. Yet the Act gives wide discretion to councils on how many people should sit on each board, how often and how publicly it should meet, and how it should interact with local health providers and the wider local public.

There is therefore scope for boroughs which wish to do so to develop HWBs as forums in which local concerned members of the public discuss and examine the health services provided to local people, and – with Health Oversight and Scrutiny Committees – call local health providers and commissioners to account. HWBs are chaired by the leader of the council and have a mix of elected members and senior officers, including the chair of the CCG on them. They have limited powers to participate in the strategic commissioning plans of the CCG. They could do much more, and the local authority should raise its voice as leader of its local community in ensuring that this is at the heart of the commissioning plan. But few do so because their attention is elsewhere, reducing HWBs to a low level technical discussion rather than a high level political strategy discussion. As the only directly elected voice currently in the mix, they should do more.

There have been suggestions that HWBs might under a future government be merged with CCGs to create new, more representative commissioning bodies. Even if this policy is adopted it is important to break from the largely passive role and bureaucratic composition of most HWBs. They offer an opportunity for councils to press their case for particular services to be developed, or for reconsideration of plans for reconfiguration or other controversial changes affecting their boroughs.

Unless such potential avenues for dialogue and questioning local policies are developed, frustrated local communities challenging proposals they feel put services at risk will be left only with the option of taking to the streets with placards and banners in protest rather than have any way of entering more constructive dialogue and debate.

11.1 WE RECOMMEND that if the HWBs are NOT given a role in shaping local health care as part of revisions to the Act after 2015, then local Health Watch bodies, with the additional powers proposed in Recommendation 10.1, should be merged with their local HWBs.

Fusing together these two organisations gives the opportunity to create a single, clear and authoritative, democratic voice for local people that will monitor and scrutinise local health and social care services and plans for future developments, but also champion patient complaints.

Recommendation 12: Further investment needed in ambulance services, and greater clarity on “pathways” of care

With any potential remodelling of health services that involves patients going further for better treatment, and in the context of current pressures on primary and community care, the capacity of London's highly-stretched ambulance service to cope with rising demand is pivotal.

The Panel heard in one session in central London a detailed account of some of the problems developing in London's ambulance service. Malcolm Alexander, who chairs the Patients' Forum for the London Ambulance Service (LAS) spoke of the increasingly long delays in responding to calls from what are designated category C1 and C2 patients. These people are not regarded as being the most urgent cases, but may have fallen, had an accident or have taken an overdose – and may wait for 2 to 3 hours for an ambulance. The LAS trust's performance for these patients in September 2013 was just 66% for C1 and 59% for C2, against a target of 90% to reach the patient within the required 20-

30 minutes. This seems to suggest that frontline staffing levels and resources of the ambulance service are not keeping pace with the rise in urgent and emergency calls across London.

The Panel was also concerned at the lack of transparency on this issue: if it's clear that because of pressures on the service they are likely to wait significantly longer than the target time, patients left waiting, or those who are waiting with them after making a call on their behalf, should be informed of this by ambulance control, so that they know the situation – and in some cases may be able to make other arrangements. The LAS trust should also make clear to the public the actual situation they face and its consequences for these services.

We also heard of concerns over the misleading rhetoric of pathways of care which conceals the fact that none of these pathways appears to have been clearly established or viably operating. There appeared to be significant problems especially for mental health patients, older patients – and for primary care, which seems to be expected to shoulder most of the responsibility for providing the so-called pathways. For the LAS there is the question of whether it makes sense for a skilled ambulance crew to be waiting hours at a call arranging a package of care for one individual patient rather than on the road responding to emergency calls.

The proposed reconfiguration of hospital services in London serves to highlight the consequences of the effective dismantling of what used to be London Ambulance Service's Patient Transport Service. Thirty years ago these vehicles used to ferry older frail and less mobile patients to and from outpatient appointments: but the service has been scaled right down and in many areas replaced by patchy privatised provision and crew with minimal training.

Many of the quite legitimate concerns raised by witnesses in the various panel meetings centred on the awkward and lengthy journeys that they might face to access alternative hospital services if their local hospital closed. These arguments are often simply brushed aside by those leading reconfiguration, or responded to by highly misleading claimed journey times which take no account of the actual experience of patients and relatives, especially those with mobility problems and reliant on public transport. The problems could more sensibly be addressed through re-establishing a reliable and accessible Patient Transport Service system in the affected areas, given the almost universal failure of promised talks with Transport for London to result in bus services that fit in with changing journeys to hospital.

We find that the current level of performance and structure of LAS Category C services are clearly unsatisfactory, and falling far short of their targets.

12.1 WE RECOMMEND an urgent review of emergency ambulance services to establish the resources needed to meet and sustain target standards, along with a review of the system of pathways of care, to quantify the resources required to make these a reality rather than an empty phrase, or simply another complex task dumped onto already overstretched GPs.

12.2 WE RECOMMEND that there should be an obligation on ambulance control to notify callers well in advance in cases where it's clear that delays are inevitable in the dispatch or arrival of an emergency ambulance.

12.3 WE RECOMMEND an appraisal of the costs, benefits and viability of the expanded network of Patient Transport Services that would be required for LAS to provide reliable services that could enable less mobile patients to travel further for outpatient treatment in the event of hospital reorganisation.

12.4 The unclear status and functioning of pathways of care needs to be clarified to ensure that local services are viable and clearly understood by all of the health professionals involved and explained to patients and carers, along with any implications for them.

Recommendation 13: Respond to Royal College of Midwives concern over staffing levels and maternity units

The Panel heard a very extensive presentation from Royal College of Midwives (RCM) general secretary Cathy Warwick, who in the hearing on November 29 set out the substantial concerns for the levels of staffing and the plans for the future of maternity provision in London. She pointed out that the baby boom has been greatest in London, with a 29% increase in births since 2001, well above the 23% increase in England. And while it's levelling off elsewhere, this is not the case in London.

London has an unusual demographic. Of the total births in London in 2012 57% had mothers who were born overseas, against the U.K. average of 25%. Women in minority ethnic groups especially those from a socially deprived background, have higher rates of complication in pregnancy, there can be specific demands on interpreting needs, and staff need support in giving culturally sensitive care. This is a real pressure in some areas of London.

The number of full-time midwives has increased in London by half since 2001, but the RCM argues that this increase isn't enough, and the workforce not divided evenly or in proportion to needs. As a result, maternity across London has very different ratios of births to midwives from one area to the next, ranging from 37:1 in the least provided area, down to 22:1 in the best.

Even when there has been increased investment in posts, Cathy Warwick argued this doesn't mean the midwives are there to do the work. Vacancy rates have been reduced, but remain high, and services rely on agency staff who are not always properly integrated into the service. London employs more agency midwives than anywhere in England. London women are less likely to know their midwives, less likely to be made aware of their options and less likely to see midwives as often as they'd like to.

In answer to questions Cathy Warwick argued that contracting is largely ineffective. "The new system is a disaster", with no clear control and too many bodies taking decisions. Maternity care needs to be commissioned over a much wider area than CCGs.

The RCM's written submission to the Inquiry argues that the centralisation of maternity services across London is being largely driven by the adoption of a standard of 168 hours a week consultant obstetrician presence on delivery suites ie 24/7. The RCM argue that this may be appropriate where the population using a service is at high risk and the 'available' on call consultant is being called in

frequently. But they also quote Catherine Calderwood, who is NHS England's Clinical Director of Women's Services who told the Commons Public Accounts Committee: "there is no evidence that outcomes are improved with 24/7 resident consultants".

The implementation of 24/7 consultant cover is argued by the RCM to be unaffordable within current spending constraints, without a major consolidation of units. The Panel noted a number of concerns that were raised in the local hearings over the resourcing and accessibility of maternity services if such consolidation does take place.

However, several Panel members also remain unconvinced on the viability and safety of stand-alone midwife-led units, especially in London boroughs where there are relatively few low risk births. Panel members did not feel it was sufficient for many labour wards without 24/7 consultant cover to be covered only by consultant staff on-call for emergencies.

13.1 WE RECOMMEND that the points raised by the RCM, which correspond with other evidence we have heard from campaigners in different parts of London, be the basis for further research to establish the evidence for the clinical safety of stand-alone midwife-led units in the context of the social conditions in London. The RCM, Royal College of Obstetricians and Gynaecologists and service users should be engaged in the development of a new London-wide and nation-wide strategy for safe, accessible and patient-friendly maternity care, and the necessary development of the workforce and training required to make this possible.

13.2 WE RECOMMEND a full review of plans to further centralise obstetric and paediatric services. International comparisons indicate the UK system may be excessively centralised already. We remain unconvinced that centralisation is the appropriate response to problems of achieving compliance with the European Working Time Directive.

Recommendation 14: Post-Francis report staffing levels: the impact of Cost Improvement Programmes

From many of the trade union and campaign representatives the Panel heard widespread concern over downbanding of staff, dilution of skill mix, and pressures on staff – all of which raise questions over the extent to which some of London's NHS employers have taken on board the lessons and recommendations of the Francis Report on Mid Staffordshire Hospitals.

While much of the focus in London reconfiguration has been on consultant staffing levels, a recent European study shows a correlation between better-staffed, more highly-skilled nursing teams and lower mortality rates in hospitals. Comparisons showed that death rates could be 30% lower in the best-staffed wards.

Nurse staffing averages several years ago, when the data was gathered, show an average of almost nine patients per nurse in England, third highest of the countries studied. But this was before the spending freeze, and current staffing levels seem set to worsen. Anita Charlesworth of the Nuffield Trust has pointed out that there has been no analysis of the future staffing implications of the

planned savings that have been assumed from NHS payroll costs in the proposals drawn up by McKinsey and others.

Unite rep Rita Drobner and others have emphasised in their evidence that the growing level of under-staffing of clinical support services, and the downbanding of staff has a hugely negative impact both on morale of staff, but also on the training of new staff with the necessary qualifications. Experienced staff are expected to sign off people as qualified before they are confident that they have achieved the right level and there are problems retaining trainees once they complete their training if they cannot progress upwards through the paybands.

In Barts Health, the trust is seeking £77 million in cost savings, including widespread job losses and requiring many senior Band 6 nurses to reapply for a reduced number of their own jobs. We heard in both open session and in the closed session reports of staff concerns about the regime of bullying, the pressure on whistleblowers, epitomised by Barts' decision to sack UNISON rep Charlotte Monro. We heard Unite officials describe the increased workload of grievance and disciplinary hearings, the increasing pressure on staff with sickness problems, the growing levels of stress on staff and the double burnout of staff who take on the role of union rep, only to find their facility time restricted, and their time off for union work not backfilled, resulting in big backlogs of their own caseload.

All of these reports have emphasised that the pressure behind this increasingly unsympathetic and unresponsive management regime is performance indicators and financial restraints and while it's accepted that some trusts have been more aggressive and more demanding than others, the general picture is one in which staff on frozen pay and falling real incomes are facing rising pressure, while trade unions are finding it hard to defend them.

Unhappy, over-stressed, under-valued staff dealing with aggressive managers who don't want to hear about problems and shortfalls in services are unlikely to deliver the kind of safe, sustainable, high-quality service that people rightly expect. This is also unlikely to emerge from the process of privatisation of clinical support services that has also been reported, in which staff lose their NHS terms and conditions, and services become even less publicly accountable.

In the closed session we heard about one initiative to take on the issue of under-staffing amongst nurses – the 4:1 campaign, which we now hear is being supported both by Unite and by UNISON: it has helped to develop a long-overdue debate over minimum staffing levels.

Several methodologies are already available to be used to calculate appropriate nursing establishments, including:

- Safer Nursing Care Tool (SNCT),
- Nursing Hours per Patient Day (NHPPD),
- Birthrate plus (Midwifery),
- Professional judgement (a consultative method of setting nursing establishments using the expertise and experience of the senior nursing and midwifery team).

It should be noted that these various methodologies generate a range of conclusions. It is accepted that the level and skill mix of staffing needs can vary according to the work done on the ward, the numbers of patients and other pressures.

Clearly some further work is needed to develop a consensus view around which trades unions and professional bodies can unite and press for more substantial guidance.

14.1 WE RECOMMEND that lessons from the Francis Report, not only on understaffing but on the negative consequences of bullying and the obligations on management to speak out when faced by resource constraints that potentially threaten the quality of care be taken on board for all sectors of the NHS.

14.2 WE RECOMMEND that further research be commissioned by the trades unions – and preferably also by NHS managers – on the impact on staff morale, performance, recruitment and retention of downbanding staff to pay grades appropriate for less qualified staff.

14.3 WE RECOMMEND that, whether or not 4:1 is the right level or a universally applicable nursing formula, the establishment of authoritative and appropriate guidelines would be an important step towards accountability and averting further failures as a result of under-staffing in acute hospitals. But an agreed standard is needed. A number of different methodologies have been developed as the basis for guidelines on staffing levels. Much of the published research, including the detailed RCN pamphlet 'guidance on safe nurse staffing levels in the UK', is several years old, and none takes account of the current and likely future resource constraints.

14.4 WE RECOMMEND trades unions and professional bodies should come together to carry out practical and comparative research to establish the basis for firm national norms on staffing levels and skill mix for each category of healthcare provision, and to publicise their findings as widely as possible, and campaign for these to be adopted.

14.5 WE RECOMMEND that equivalent norms should also be developed for mental health, community services, and in allocating district nursing and health visitor caseloads. Such guidelines would add further pressure to the recent government requirement for acute hospitals to publish monthly information on their staffing levels and help to prevent the threatened cash constraint resulting in a collapse in the quality of NHS care.

Recommendation 15: Improve communication and management relations with staff, and provide adequate protection for whistleblowers

The high profile case of Barts Health's sacking of Charlotte Monro was repeatedly referred to by witnesses at our public hearings, along with other grim assessments of the management regime in a number of London trusts. This has confirmed fears that – despite occasional warm words from Jeremy Hunt and calls for a duty of candour since the Francis Report – there is the prospect of intimidation rather than any real support for NHS staff who draw attention to actual and potential gaps and deficiencies in services. There is still no real protection for whistleblowers within the NHS

and no system to call to order managers who victimise whistleblowers on such flimsy pretexts as the spurious allegations against Charlotte Monro.

Sadly, on this issue too, it seems that London is no exception to the wider rule. Even in a surprisingly optimistic speech to the Nuffield Trust to mark the first year since the publication of his 290 recommendations, Robert Francis was obliged to point out problems that still persist.

Francis reports that some trust managers have not learned the right lessons:

It is important that no tolerance is afforded to oppressive managerial behaviour of the sort identified only last week by an employment tribunal in the South West, which victimises staff who raise honestly held concerns. Every such case is hugely damaging to the confidence of other staff who are contemplating raising concerns. It is clear that there is much to do in this area.

Our witnesses, including a number of trade union reps who had the courage to speak out, emphasised Francis' final point: that any victimisation has the impact of damaging the confidence of others who might have spoken out and suppressing the information necessary for service failings to be identified and resolved. This issue has special relevance in London where so many NHS Trusts are facing serious financial pressure and such substantial levels of reconfiguration of services.

Also of relevance to management in some of the most financially challenged London trusts are Robert Francis' latest warnings against cutting back on basic quality of care: he said at the Nuffield Trust event:

To pretend an acceptable level of service can be delivered when it is not possible to do so, is to deceive patients and the public. If sufficient staff are not provided to care for patients in an acceptable fashion then all professionals involved need to make their voice on behalf of patients heard loud and clear.

This does highlight one of the issues raised by our Panel, which is the duty of management and trust directors to speak truth to power and to make clear to commissioners and to politicians where cutbacks and service closures are being imposed as a result of cash constraint or policies made elsewhere. Any obligation of candour needs to apply not just to staff at the frontline, but to the very top of NHS provider organisations – and to GPs whose practice resources are unable to stretch to take on additional caseload imposed upon them by diverting care out of hospitals and into the community.

As this report is completed, the current published guidance from the NHS Social Partnership Forum, *'Speak up for a Healthy NHS'*, dating back to 2010, is clearly being disregarded by employers and has failed to give staff any real confidence that they will not suffer detriment if they raise concerns over standards. We understand that new guidance on how to deal with whistleblowing is being developed between unions and NHS managers in the Social Partnership Forum and is due for publication in April. But without sight of these proposals, the Panel makes its own recommendation.

15.1 WE RECOMMEND commissioners introduce an explicit contractual requirement for trusts and NHS-funded providers to develop partnership working with trade unions which can create constructive ways of addressing concerns on the safety and quality of patient care. This should be coupled with a requirement to protect whistleblowers where such measures have not been developed or proved unresponsive.

15.2 WE RECOMMEND that nursing staff, doctors and other professionals at all levels must be empowered to insist on the high standards set out in their respective professional codes of professional conduct if they are to be held accountable for any failures to do so.

15.3 WE RECOMMEND that NHS management at all levels be also required to adhere to the principles outlined by Francis in his speech at the Nuffield Trust in February 2014 and where services cannot be sustained at safe and acceptable quality of patient care for lack of funds, they should make it clear to commissioners, politicians and the public that these services will be closed unless more funding is provided.

Recommendation 16: Policies to avert PFI-driven financial failures

The Panel has heard of the three extreme examples of the impact on local service stability of costly PFI hospitals – South London Healthcare Trust, Barts Health and Barking Havering and Redbridge University Hospitals Trust (BHRUT). Whipps Cross Hospital has been mentioned as a possible casualty of the Barts PFI, King George Hospital in Redbridge is the most likely victim of the crisis in BHRUT and of course the South London healthcare crisis famously threatened services at Lewisham Hospital as part of an extremely expensive package of measures drawn up by the Trust Special administrator and resulted in the closure of most services at Queen Mary's Sidcup.

Roger Steer, an accountant from Healthcare Audit Consultants, which advises local authorities, spoke in our November 8 hearing, and told the Panel that the existence of one or more large PFIs in an area is often a cost driver behind reconfiguration. PFI can be a major financial problem, because the capital costs associated are a lot higher than with non-PFI sites.

The excess costs of PFI and the legally-binding contracts involved mean that the NHS is committed to these PFI hospitals and so NHS managers must look to make savings by closing other hospitals, even if that wasn't what they would do otherwise. This had already happened in South East London, when Queen Mary's Sidcup was closed by South London Healthcare Trust as a result of the excess cost of PFI hospitals in Bromley and Woolwich.

While there are obviously a number of more radical possible solutions – which are unlikely to be implemented by any future government – Roger Steer and others have suggested a workaround solution to the immediate problem, which the Department of Health has chosen to ignore, but which the Panel supports as a basis for immediate government action.

This proposal was well summed up by Roger Steer in our hearing:

The excess costs of PFI can be dealt with by making adjustments in the Payment by Results tariffs. Trusts with PFI schemes have capital costs averaging about 10.2% of turnover but they get paid as if their capital costs were just 5.8% – so every single one of these hospitals has a major hole in their finances. In Bromley the capital costs were 11.3%, in Woolwich it was 10.4%, which meant they were losing £20-£30 million a year, because of the effect of the PFI hospitals.

If you move to a payment system that's adjusted for the actual cost of capital, that would resolve the problem overnight and it would be self-funding in that it would be paid for by those trusts which get a fortuitous saving at the moment. This is one of the reasons why many of the foundation trusts are sitting on surpluses totalling billions of pounds: they have benefited from the way that the payment system works.

Keith Palmer summed it up: "Making the funding of capital charges more cost effective would reduce the deficit of those trusts with high PFI costs at no net cost to the NHS, it would make funding of patient care more equitable, reduce the pressures for reconfiguration across hospital sites, prevent leakage of cash out of the NHS and enable more NHS trusts to become foundation trusts sooner".

16.1 WE RECOMMEND that Payment By Results tariffs for each hospital should be adjusted for the actual costs of their capital at zero net extra cost to the Treasury.

16.2 WE RECOMMEND fresh efforts to find ways to reduce the costs of existing PFI schemes and stem the flow of PFI payments, especially those going to offshore companies in tax havens.

Recommendation 17: Independent review of the evidence base for the clinical case for reconfiguration

The Panel has heard compelling critiques of some of the key elements in the clinical case for reconfiguration and centralisation of hospital services. The Panel heard in our public sessions again and again of the difficulty of getting a focused discussion of these points, some of which expose serious flaws in reconfiguration plans and the lack of evidence for widely quoted claims and figures.

The standard consultation process time and again allows those proposing controversial reconfiguration to avoid, ignore or inadequately respond to questions raised by critics. Even where contested plans go to Judicial Review (JR), no space or place is allowed for discussion of the merits or weaknesses of the arguments, since the JR proceedings are firmly and narrowly focused on the process that has been followed rather than the substance of the proposals.

As a Panel, we don't feel it appropriate to take votes on clinical arguments or on specific reconfiguration proposals which we have not, as a Panel, been able to go into in detail. However on some of the key contested issues at least, it appears to the Panel from what we have heard that the critics have raised a case to answer.

On other issues, where we have heard only partial discussion, we feel the evidence for both sides of the argument needs to be presented, and its appropriateness tested. But there is at present no forum in which this can take place.

17.1 WE RECOMMEND the commissioning of an INDEPENDENT REVIEW of the evidence for the various reconfiguration processes taking place across London by a combined panel of academics representing each side of the argument – and if necessary further research to answer the questions that have been raised. The findings, which will also have implications for many other reconfiguration proposals in England, should be widely published and disseminated to inform evidence-based policy.

The review should among other things explore:

- Evidence on the costs, organisational and practical viability and future financial impact of diverting more hospital care into community based services. We recognise that the specifics of each reconfiguration will be local and not necessarily transferable but we also recognise that many of the arguments used in each of the reconfigurations are generic arguments based on the same assumptions. A much better evidence base needs to be assembled that can convince friends and foes of potential reconfiguration alike.
- The extent to which community services have been shown satisfactorily to replace hospital care and free up hospital beds, and the applicability of schemes implemented elsewhere to the specific context and demographic of London.
- The staffing and training requirement to deliver enhanced provision of community health care across London
- Evidence for the extent to which further centralisation of services in specialist care other than stroke, cardiovascular, and trauma can guarantee to reduce premature mortality – and the potential capital and revenue costs, staffing issues, managerial changes and logistical and access issues that would flow from the closure of more local services.
- Evidence for the actual impact, trust by trust, of the weekend effect or similar variations in mortality rates in London hospitals and possible explanations and solutions.
- Evidence for the argument that failure to reconfigure local services could be the cause of specific numbers of excess deaths.
- Evidence on the protocols for the cases which it is accepted should NOT be treated in an Urgent Care Centre, and on the proportion of current A&E caseload that it is safe or desirable to treat in a standalone Urgent Care Centre.
- Evidence on the viability of a “small, safe A&E” as proposed for Lewisham by Sir Bruce Keogh and Jeremy Hunt, but rejected in the Keogh Review of Emergency Services³¹.

- Evidence of the willingness and capacity of primary care, district nursing and health visiting services in London to take on the additional workload implicit in shifting more NHS treatment out of hospital. This could contribute to the findings of Dr Clare Gerada's project on primary care in the capital.

Recommendation 18: An end to constant cuts in social care budgets, and a review to establish nationally-agreed eligibility criteria for social care support

Any hope of developing viable services to support patients discharged from hospital, living in the community or to help reduce levels of potentially avoidable hospital admission inevitably faces the question of resources for community health and social care.

These are due to come even closer together from 2015, when district nursing services, currently commissioned by NHS England, are transferred – together with health visiting, family nursing and a rag-bag of other services – to local government, which is already responsible for social care. Increasing sums will be top-sliced from the NHS budget to cover these services. But of course council budgets have been subjected to hefty cuts of 28% since 2010 and social service budgets, which have suffered much of the brunt of this, have been cut repeatedly in the preceding years.

This has left a bare-bones social care system that is increasingly restricted only to those with the most serious needs, and heavily reliant on privatised, largely casualised domiciliary support services delivered by staff on the minimum wage and frequently facing zero-hours contracts that do not reimburse them for travelling time.

There are mixed signals over community health services in London.

Health visiting numbers have significantly increased in the last two years as a result of the Health Visitor Implementation Plan (HVIP) which aims to entirely reverse the fall in numbers over the previous decade. The health visiting workforce fell by one fifth in the decade to 2011 to leave just 7,941 FTE, but growth since then should see another 4,200 additional staff in post by 2015. But new plans show numbers training from now on will be significantly lower, with a target of just over 1,000 more health visitors to be trained in England in 2014-15, 62% below the previous intake. A large proportion of this workforce is aged over 50, and to ensure that those retiring are replaced and numbers are maintained there has to be continued growth year by year. To maintain recruitment, inner city health visitors should be on salaries that reflect their additional training and responsibilities – band 7.

London has some of the highest caseloads in the country and the inquiry heard from health visitors in Waltham Forest who have caseloads more than double the recommended safe level. Deprived areas are expected as a result of the Implementation Plan to have significantly smaller caseload than other areas but it was clear from evidence and panel discussion that caseloads in many parts of London remain high. It is planned that significant reductions in caseload will be achieved by 2015.

One concern is what will happen to the increased budgets that underpin this increased staffing once responsibility for commissioning changes post 2015 when health visiting is transferred to the local

authority, especially as overall budgets come under increased pressure. There is assurance from NHS England that these budgets will be ring-fenced for the first two years, but then what happens after that?

However, numbers of school nurses, whose role complements that of health visitors, who are responsible for the 5-19 age group, have flat-lined as the school age population has grown.

District nurse numbers have also been in decline – even as the emphasis on community-based health care and swifter discharge of patients from hospital has increased in the last few years. An increased number of qualified nurses are needed. However, in London there were 100 places available for district nurse education, but just five of the 50 places available were filled in September. The recruitment failure was due to a lack of suitable applicants for the programme and in some cases a failure of the literacy and numeracy assessments. But the Queen's Nursing Institute³² argues that a bigger underlying problem is that district nursing suffers from a lack of profile when nurses are choosing their career pathways, partly because student nurses have little or no exposure to community nursing practice in their training.

There is a consensus that there is a rising need for services as a result of an ageing population and the increasing burden of long term conditions, yet registered district nurse staffing has declined steadily in recent years whilst its skill mix has been diluted. Staffing pressures may well become more serious because the community nurses in general have a higher age profile than the nursing workforce in general, with over one third of community nurses aged 50 and over, compared to one quarter of the acute, elderly and general nursing workforce.

The Panel has discussed the worrying lack of coherence to the fragmented mixture of community health, family health, public health and partially privatised social care services that need to be coordinated and properly trained and experienced to deliver the required mix of care outside hospital. We are not reassured by the fact that these services should increasingly be commissioned and planned by Health & Wellbeing Boards which have up to now made little if any impression, while both NHS and local government budgets face a tightening squeeze on current spending plans until 2021.

18.1 WE RECOMMEND that this interface of health and social care be a main focus of the London-wide needs assessment we called for in Recommendation 6.2, to identify the resources required for the expansion of these services in the capital.

18.2 WE RECOMMEND that this development should include a programme of improved training – and therefore enhanced status – for care workers, who need to be integrated as part of the health and social care team. This means an end to low cost, low value, low quality contracts with private providers whose profits depend upon zero hours contracts, which save money for the employer at the expense of fragmented, unsatisfactory care for service users. As contracts come up for renewal, services involving zero hours contracts should be brought back into the public sector so that scarce staff resources can be used efficiently and services can focus on the needs of the client.

Written by John Lister

For the Peoples Inquiry Panel, March 2014

1 ONS figures October 2013, available: <http://www.ons.gov.uk/ons/rel/regional-trends/region-and-country-profiles/region-and-country-profiles---key-statistics-and-profiles--october-2013/key-statistics-and-profiles---london--october-2013.html>

2 A review of local actions in the former London Spearhead boroughs to reduce health inequalities through key social determinants: employment, housing & income, LHIN, February 2012.

3 Greater London Authority (2014) London Mental Health, The invisible costs of mental ill health, available <https://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf>

4 Department of Health (2013) Investment in mental health in 2011 to 2012: working age adults and older adults <https://www.gov.uk/government/publications/investment-in-mental-health-in-2011-to-2012-working-age-adults-and-older-adults>

5 Ham, C, Edwards N, Brooke B, (2013) Leading health care in London, Time for a radical response, King's Fund London

6 <http://www.england.nhs.uk/wp-content/uploads/2013/12/allocation-summary.pdf>

7 Soteriou M (2013) England heading for 16,000 GP shortfall, RCGP warns. GPonline 15 July <http://www.gponline.com/News/article/1191095/England-heading-16000-GP-shortfall-RCGP-warns/>

⁸ Soteriou M (2013) London primary care needs £1bn funding boost, LMCs warn, GPonline September 17, <http://www.gponline.com/News/article/1212080/London-primary-care-needs-1bn-funding-boost-LMCs-warn/>

⁹ Barnes, S (2014) Increase in private ambulances causes problems for trust, Health Service Journal March 6, £paywalled at <http://www.hsj.co.uk/news/acute-care/increase-in-private-ambulances-causes-problems-for-trust/5068499.article#.Ux4xf43ivxk>

¹⁰ Campbell D (2014) NHS watchdog says Virgin Care-run clinic put patients at risk. Guardian 4 February. http://www.theguardian.com/society/2014/feb/04/nhs-watchdog-virgin-care-croydon-hospital?CMP=tw_t_gu

11 Adams S, (2013) Hospital declares 'internal emergency' and turns away ambulances after it's swamped following A&E closure, Mail Online 15 February <http://www.dailymail.co.uk/news/article-2560270/Hospital-declares-internal-emergency-turns-away-ambulances-swamped-following-A-E-closure.html>

¹² Independent Reconfiguration Panel (2013) Advice on Shaping A Healthier Future proposals for changes to NHS services In North West London <http://www.irpanel.org.uk/lib/doc/000%20lnw%20report%2013.09.13.pdf>

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- ¹³ Queen's Nursing Institute (2013) Report on District Nurse Education in England, Wales and Northern Ireland 2012/13
<http://www.qni.org.uk/docs/Report%20on%20District%20Nurse%20Education%202012-13.pdf>
- ¹⁴ Lintern S (2013) District nursing would be 'decimated' by proposed London cuts. Nursing Times 20 March 20, <http://www.nursingtimes.net/nursing-practice/clinical-zones/management/district-nursing-would-be-decimated-by-proposed-london-cuts/5055325.article>
- ¹⁵ HSCIC (2013) Community Care Statistics, Social Services Activity, England - 2012-13, Final release <http://www.hscic.gov.uk/searchcatalogue?productid=13822&topics=1%2fSocial+care%2fSocial+care+activity&sort=Relevance&size=10&page=1#top>
- ¹⁶ Association of Directors of Adult Social Services (2013) Social care funding: 'a bleak outlook is getting bleaker, 6th May
http://www.adass.org.uk/index.php?option=com_content&id=914&Itemid=489
- ¹⁷ Audit Commission (2013) Social care for older people Using data from the VFM Profiles, July <http://www.audit-commission.gov.uk/2013/07/audit-commission-analyses-cost-of-social-care-for-older-people-in-a-value-for-money-briefing/>
- ¹⁸ <http://www.standard.co.uk/news/nhs-london-splashes-out-114m-on-advisers-6505324.html>
- ¹⁹ Source: 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>
- ²⁰ Purdy S et al. (2012). Interventions to reduce unplanned hospital admission: a series of systematic reviews: final report. Bristol: University of Bristol.
- ²¹ Available at: <http://www.nhshistory.net/safe-report-february-2012.pdf>
- ²² Williams D (2013) Exclusive: London A&Es already struggling before winter pressures begin, Health Service Journal 23 September, £ paywalled at <http://www.hsj.co.uk/news/acute-care/exclusive-london-aes-already-struggling-before-winter-p pressures-begin/5063309.article?blocktitle=News&contentID=8805#.UxtNy43ivxl>
- ²³ RCGP (2013) Press Release: Waiting times for GPs predicted to worsen this winter, as result of emerging £10.2bn funding black hole, 25 November, available <http://www.rcgp.org.uk/news/2013/november/waiting-times-for-gps-predicted-to-worsen-this-winter.aspx>
- ²⁴ Price C (2013) New RCGP chair launches campaign to boost general practice funding

Pulse, 18 November available <http://www.pulsetoday.co.uk/news/finance-and-practice-life-news/-new-rcgp-chair-launches-campaign-to-boost-general-practice-funding/20005095.article#.UxtZAY3ivxk>

²⁵ King's Fund & Nuffield Trust (2013) Securing the future of general practice: new models of primary care, available www.nuffieldtrust.org.uk/publications/securing-future-general-practice

²⁶ See <http://www.england.nhs.uk/wp-content/uploads/2014/01/item8-board-0114.pdf>

²⁷ These figures were calculated in 2013 by Noel Plumridge writing in the *£paywalled Health Service Journal* ("We have been misled over NHS funding", March 19) – available <http://www.hsj.co.uk/comment/columnists/we-have-been-misled-over-nhs-funding/5056109.article>

²⁸ Reeves et al. *Globalization and Health* 2013, 9:43
<http://www.globalizationandhealth.com/content/9/1/43>

²⁹ See OECD (2012), *Health at a Glance: Europe 2012*, OECD Publishing.
<http://dx.doi.org/10.1787/9789264183896-en>

³⁰ Foster A (2013) GP commissioning group quits controversial BSBV hospital reforms, *Sutton Guardian* November 8, available http://www.suttonguardian.co.uk/news/10797051.GP_commissioning_group_quits_controversial_BSBV_hospital_reforms/

³¹ Keogh B (2013) High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report, NHS England, available <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

³² Queens Nursing Institute (2013) *Care in local communities - district nurse vision and model*, Department of Health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-district-nursing-04012013.pdf

