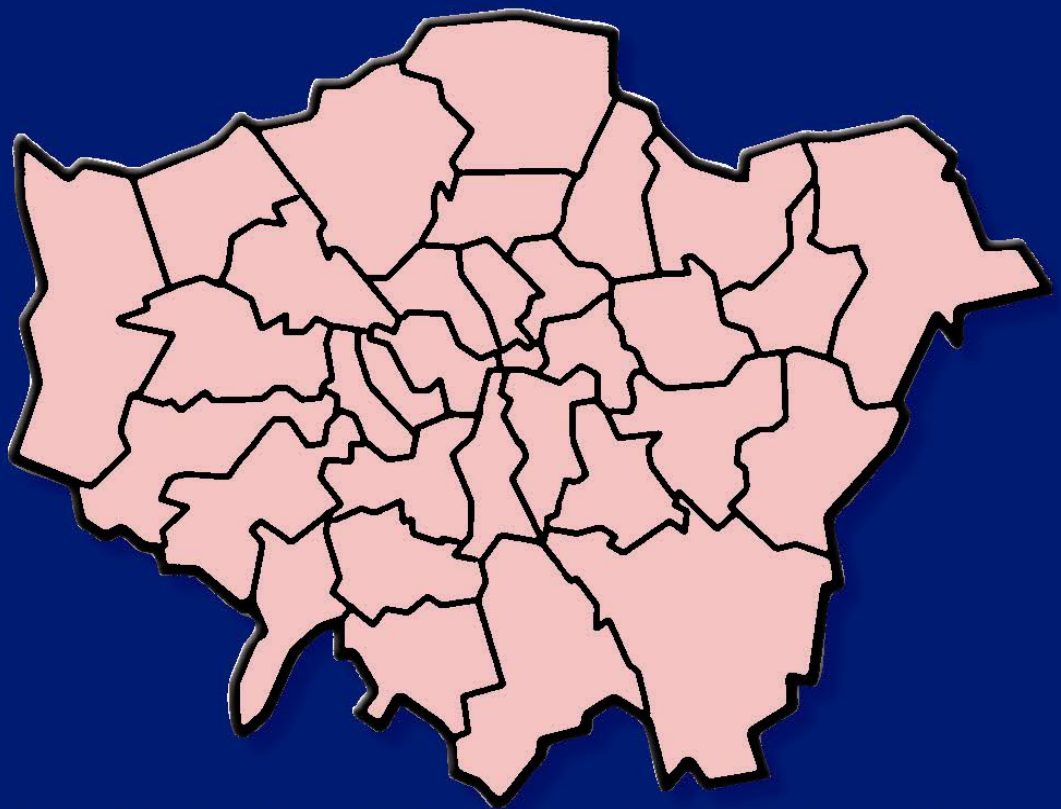
London's NHS

ON THE BRINK



A health check on NHS commissioners and providers as the NHS heads for its biggest-ever spending squeeze

BMA

London's NHS : On the Brink

London's health services are headed towards a major financial and organisational crisis.

The apparently calm exterior in many areas reflects either a delayed reaction to problems, or a delayed recognition of the scale of the problems that have to be faced by most Primary Care Trusts, NHS Trusts and Foundation Trusts in the stormy financial period ahead. Far-reaching changes in the system of care and the biggest-ever squeeze on health budgets could lead to record numbers of beds and hospitals closing.

That much seems beyond dispute from the combination of four factors:

- The new government squeeze on public spending, raising the pressure on PCTs and Trusts to balance the books this year and address potential deficits before further requirement to make cuts from 2010 when growth slows, followed by the predicted freeze on NHS spending from 2011.
- The specific policies proposed to tackle this large-scale financial squeeze, coupled with Lord Darzi's plans[1] to centralise specialist services and downgrade most other London hospitals, seem certain to undermine the viability of many District General Hospitals. Primary Care Trusts, as later sections of this report will show, are seeking to solve their financial problems by crudely dumping the problem onto providers, creating an impossible situation in some financially challenged Trusts.
- The secret discussions, plans and briefings that have been organised by NHS London[2],
- and the published papers and reports of London's Trusts and PCTs, many of which can already see plans for this year and the future going badly wrong.

The base case assumption by NHS London is that from 2011 there will be 0% real growth. The best case assumption is 0.75% real growth, but the worst case looks at a real terms reduction in spending of 2.5% until 2014, from when 0.5% growth may resume. Against these grim predictions of static or falling real income, NHS London is also projecting a growth in activity ranging between 1.5% (low) to a high of 5.5%, with a base case assumption of 4%[3].

Given the scale of this problem, which NHS London has estimated as more than £5 billion real terms cuts by 2017[4], PCTs and Trusts are being pressed to begin cutbacks now, rather than wait until later. But the full brunt of the cuts being proposed will not take effect until the first year of whichever government wins the next election: the crisis will last for a whole parliamentary term, raising the question of whether political leaders will be willing to pay the potential electoral price of implementing these policies.

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[1] Healthcare for London (2007) *A Framework for Action*, NHS London

[2] See for example the detailed account in the *Health Service Journal* (Sept 10 2009: 6-7) of a major report and briefing of PCTs by NHS London based on research by McKinsey's. However requests, including one by this author, for release of this report under the Freedom of Information Act have been refused by NHS London (see http://www.london.nhs.uk/webfiles/FOI/November%202009%20disclog/L378%20Response.pdf)

[3] Healthcare for London (2009) Affordability Assumptions offered as guidance for PCTs in Strategic Planning, available http://www.london.nhs.uk/publications/tools-and-resources/commissioning--2009-10-strategic-plans-and-world-class-commissioning-assurance-process

[4] *HSJ* Sept 10 2009, page 7

Of course the wider problem is not unique to London. The whole NHS faces a cash squeeze after eight years of very substantial year-on year growth in spending. The pressure begins to intensify from next financial year, and seems set to continue at least until 2017 as public spending and health care are made to pay the staggering price of government intervention to bail out the failed banks. There is a stark contrast between the largesse shown by ministers to failed bankers, with a continued, apparently limitless flow of tens of billions of taxpayers' money in handouts to enable them to ride out tough times, compared with the tight fisted and rigid moves to rein in much smaller levels of overspending by Trusts and PCTs delivering vital services and dealing with public demands for health care.

But a cash squeeze on England's NHS means a heavy squeeze on London's NHS: London has 14.8% of the English population[5], and its PCTs will receive allocations of £13.2 billion this year to commission services: that's 16.5% of England's PCT budgets[6] (see Appendix 3).

This slightly inflated share of spending partly reflects historical factors such as the concentration of demand for certain treatments, the historic concentration of teaching hospitals and tertiary specialist hospitals in the capital, and the inflated cost of delivering services in London. Average spending per head on London's population is lower than North East England, Scotland and Wales, but above the England average[7].

A proportional reduction will mean that a sixth of any national cutback will fall on London, and PCTs and Trusts which in many cases are already confronting substantial deficits this financial year face an even stiffer test of their ability to scale down spending while leaving vital services intact.

Measuring the cuts

There have been various estimates of the real terms financial impact of the expected freeze on NHS budgets from 2011 at a time of rising demand for health services and continued rising costs for drugs, supplies and buildings. The NHS Confederation in June argued that the NHS would face real terms cuts of £8-£10 billion in the three years from 2011, but also quoted NHS Chief Executive David Nicholson arguing that the reduction could be as much as £20 billion [8].
A study by the King's Fund and the Institute for Fiscal studies in September put the real terms cutback at between £20billion and £40bn by 2017[9].

The ubiquitous management consultants McKinsey, a US-based company which has itself become a major beneficiary of numerous profitable consultancy contracts as a result of government "reform" efforts in the NHS, have included hard-hitting proposals for 137,000 job

[5] ONS (2009) Final Mid-2007 Population Estimates, at http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

[6] Department of Health 2009-10 PCT revenue allocations, at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091447.pdf

[7] Department of Health *Departmental Report 2009*, page 224.

[8] NHS Confederation (2009) *Dealing with the Downturn* (Paper 4, June)

[9] Appleby J, Crawford R, Emmerson C (2009) *How cold will it be? Prospects for NHS funding: 2011-2017*, The Kings Fund, London

losses and a squeeze on front-line providers in their suggestions on how the NHS could cut spending by £20 billion[10]. Axing medical school places and scrapping the government's cherished if belated efforts to improve stroke care are also singled out by McKinsey as potential ways to make savings, although the rapid growth of bureaucracy – including lavish spending by PCTs on management consultants – appears to go unnoticed in their high-profile report.

Tribal Newchurch, another consultancy firm that has done well from NHS contracts but is also connected to one of the new private providers seeking a share of NHS spending, has proposed that the £20 billion saving could best be achieved by delivering more services to patients in their own homes rather than in hospital, cutting hospital workers' jobs but "multiskilling" other staff to deliver care in the community[11].

Exactly how this would replace hospital care while saving money is not explained.

NHS London

NHS London has been among the most proactive Strategic Health Authorities in responding to this grim financial scenario. In June, according to the *Health Service Journal*, it circulated to PCTs a report incorporating material from McKinsey outlining the likely scale of the spending gap from 2011.

However this document has been withheld from publication, with only a few of its key points leaked through the *HSJ*, and a potted summary of the conclusions published by NHS London as "affordability assumptions" in delivering Healthcare for London.

Indeed despite the predictably heavy McKinsey focus on slashing back hospitals and NHS secondary care providers, there is little evidence from Board papers that the full report has been seen, let alone discussed by the very NHS Trusts or Foundation Trusts which are likely to be first in the firing line.
According to the *HSJ* version, which has not been contested by NHS London, the still-secret report assumes London PCTs will face a funding gap in the capital of £5.1 billion by 2017. The authors predict that even if the tariff paid to providers for treatment can be reduced by 3-4 percent a year PCTs would still be £2 billion short of balancing their books (although of course such a measure would enable PCTs to foist the main brunt of the crisis onto the Trusts and Foundation Trusts). The hospitals, too, apparently could face an additional funding gap of £2.9bn-£3.4bn.

In response to this, NHS London proposes a massive run-down of the capital's hospital services, alongside a full-scale switch to the use of polyclinics and GP practices to deliver care. London's hospitals could face "a drop of up to 72 percent in their workload and up to 42 percent in their annual income by 2016-17" according to the article by Sally Gainsbury (HSJ September 10).
The *HSJ* article also reports the NHS London view that the package of measures including switching care to polyclinics could mean axing a third of hospital beds, while acute and trauma care would be "centralised at selected acute hospitals" and many existing hospitals would by implication be downgraded, run down or closed.

[10] Gainsbury S (2009) McKinsey exposes hard choices to save £20bn *Health Service Journal* September 10:12-13

[11] Gainsbury S (2009) Shift hospital care out of hospital urges Tribal *Health Service Journal* September 10, page 8: Tribal is connected with private sector health care provider Care UK.

Interestingly NHS London appears to hold the view that these highly controversial changes – based on a document which it still will not publish to the wider London public, and has refused to release under Freedom of Information requests – "have been widely consulted on".

NHS London "affordability assumptions" (based on McKinsey figures)

NHSL Proposal	Comment
Base case 0% growth, best case +0.75%, worst case -2.5% growth until 2013/14	All of these assume 2.5% inflation plus other pressures increasing demand.
Base case assumption 4% growth in activity (1.5%-5.5%)	Hospital contracts already over-performing this year, with Trusts complaining of under-contracting by PCTs
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%, appointment times (GP consultations) 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 polysystem"	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 : 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

Secretive sectors

In fact not only have these plans and discussions been hidden so far from the London public, but the discussions on them have also been largely hidden from London's 31 Primary Care Trusts, the bodies which are supposedly responsible for commissioning services for their local resident population. Instead NHS London has set up six new "sector" organisations (covering SE, SW, NW, N Central, Inner NE and Outer NE London PCTs), and these bodies

have also been meeting in secret and drawing up plans based on the unpublished (and therefore unquestioned) assumptions[12].

Few details of these sector plans have been revealed, although the North Central sector has reported to its five PCTs that it is working on a scenario that suggests a funding gap for the sector of £600m-£900m by 2017 – between 27% and 40% of the combined 2009-10 North Central budget[13].

No other sector has allowed any of its projections to appear in the public arena, although applying similar percentage shares of any projected shortfall would suggest that if North Central faces a shortfall of £600-£900m, the total gap is likely to be £3.5-£5.3 billion, so the sector shares could be:

- North West could be £840m-£1,270m.
- ONEL and INEL could each be £385-£580m.
- SE London could be £735m-£1,110m.
- SW London could be £560m-£850m.

In NW London, NHS Brent has projected a need to make savings of £60m in the four years to 2014[14], although it is not clear if this is in response to the grim NHS London forecasts, or merely a response to local projections, with worse to come.

In a foretaste of the way we can expect these sectors to operate, an early proposal from the sector team in Outer North East London was announced to the press at the end of October without any prior discussion with the most affected PCT (NHS Redbridge) – despite the fact that the PCT's own Chief executive is heading the ONEL project[15]. It centred on the axing of A&E services at King George Hospital in Ilford, and sharing the diverted caseload between the already inundated Queen's Hospital in Romford, Whipps Cross Hospital, and the new Loxford polyclinic – leaving open the question of where emergency admissions from Redbridge will find treatment. The plan triggered howls of anger from both local Redbridge MPs and from Redbridge councillors, and the tide of anger appears to have kept on growing, according to the Ilford Recorder, leading to the planned consultation being pushed back from its target date.
The viability of this plan is further questioned by the most recent figures from NHS Redbridge, which show that the Barking, Havering and Redbridge Trust, which runs hospital services at King George's and at Queen's, is currently running 26% above its planned levels of A&E caseload from Redbridge residents. Its emergency admissions are also 12.6% above plan, with almost 10,000 emergency admissions from Redbridge residents in the first four months of the year[16]. Without a very substantial investment in increased beds and facilities at both Queen's and Whipps Cross, axing services at King George's would mean this caseload would simply swamp the available services for miles around, and subject patients to longer delays and journeys for treatment.

[12] NHS London (2009) Commissioning Regime 2009-10 (July 2009) sets out the role of the Sectors and their chief executives.

[13] See NHS Camden Board paper *North Central London Service and Organisation Review,* September 2009

[14] NHS Brent Board Paper *Medium Term Financial Strategy 2009/10-2013/14 and WCC Financial Assessment*, July 2009

[15] *Ilford Recorder* (2009) Doomed! Recorder uncovers new plot by London health chiefs of axe A&E, front page October 15.

[16] NHS Redbridge *Finance Report Period 4* (Redbridge Primary Care Trust budget 2009/10), October 2009

Darzi plan

Like the Loxford polyclinic, which PCT bosses claim has treated up to 200 Redbridge patients over an 8-week period who might otherwise have gone to a hospital A&E (less than 2% of the comparative King George's A&E caseload) many of the NHS London plans and assumptions can be seen to flow from the 2007 report *Healthcare for London: A Framework for Action* by Sir Ara (later Lord) Darzi, and from the assumptions it rested on.

Among the central policy themes in Darzi's report (written long before the crash of the banking system and the current squeeze on public spending) were:

- The objective of reducing health care costs by £1.5 billion per year.
- The establishment of a network of 150 "polyclinics" to deliver enhanced primary care services and take over many of the functions currently delivered in hospitals, including minor injuries/urgent care services currently delivered via A&E.
- The concentration of trauma and stroke services in a few specialist centres.
- The differentiation between "local hospitals", elective centres, major acute hospitals, specialist hospitals and Academic Health Science centres.

One strength of Darzi's approach in this report and subsequent proposals has been his stress on tackling inequalities and the need to develop more pre-emptive and proactive measures to improve health and seek to reduce pressures on health care, although these positive aspirations do not connect clearly with his more controversial proposals. Centralising enhanced primary care services in larger polyclinics may be argued to make sense in some contexts, but if this involves longer and more awkward and expensive journeys for some of the more frail and deprived local population who are better served by local GP practices, the benefit and commitment to equality of access is more questionable.

But among the major weaknesses of Darzi's 2007 report, and the 50-page Technical Paper which accompanied it, setting out some of the rationale and assumptions behind the proposals, were that:

- It failed to discuss the financial context of health care in London, which even then faced serious problems, especially in a few key areas.
- In particular Darzi failed to address the financial implications of transferring services to polyclinics for hospitals whose revenue flows through the government's "Payment By Results" system: moving 50% of A&E and 60% of outpatient work out of hospitals would on Darzi's figures strip over £1 billion from hospital budgets[17], but not reduce their costs by anything like as much.
- The proposals were often based on false and implausible assumptions or statistics which were inaccurate or out of date[18].
- There was no section addressing care for older people, or the pressures on social care providers which have not enjoyed the budget increases enjoyed by the NHS in recent years.
- The plans did not address the costs, delays and logistical problems of transport in London.
- The report explicitly accepted the marketisation and fragmentation of London's NHS that has been accelerated by reforms since 2000, but appeared also to assume that collective decisions can somehow be reached on the selection of certain hospitals as "major acute" and the downgrading of other popular DGHs to the status of "local hospitals".

[17] Healthcare for London (2007) *A Framework for Action: Technical Paper,* page 23.

[18] All of the caseload figures and many others in Darzi's report and Technical Paper were based on 2005-6 data.

- The plans for Polyclinics, outlined in more detail in the Technical Paper, rested on implausible assumptions on caseload, costs and management. Each polyclinic would be expected to handle a massive 226,000 primary care consultations a year, equivalent to 620 cases a day, 7 days a week[19]. Darzi's projections would require each polyclinic to have a staff of at least 20 GPs and another 69 health professionals: an operation on this scale would need far more than the rudimentary management resources proposed in the Technical Paper.

The reason for revisiting these issues here is that it has become clear that Lord Darzi's 2007 plans and their assumptions are at the heart of the latest proposals flowing from NHS London to address the financial squeeze.

The whole NHS London concept of substituting untried "polysystems" for existing hospital services, large scale "decommissioning" of allegedly unnecessary and ineffective hospital treatment, and scaling down hospital services centres on the Darzi proposals, few of which have been publicly discussed in any detail since the report first appeared two years ago.

The handful of sketchy proposals from Darzi's plan that were put to a public consultation by NHS London eventually scraped a wafer-thin 51% support in the spring of 2008, on a pitiful response of fewer than 4,000 Londoners from an electorate of 5 million [20].

And while this "mandate" has since been brandished by NHS London as an endorsement for its subsequent proposals, they have not been so keen to acknowledge the unanimous and heavily critical response to the Darzi Report by the Joint Overview and Scrutiny Committee representing London's boroughs (April 2008)[21].

Any concerns which the Boroughs and the wider London public may have had back then over the generalisations and abstractions of the initial Darzi Report are now likely to be multiplied and intensified now, as more specific proposals to reconfigure, downsize, or centralise local services finally reach the public arena after the secretive debates at sector and NHS London level.

Other London issues

- **Challenged Trusts**

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[19] Healthcare for London (2007) *A Framework for Action: Technical Paper*, page 25-27

[20] Healthcare for London (2008) 'Consulting the Capital consultation shows support for key proposals', Press release 6 May, available at: http://www.healthcareforlondon.nhs.uk/healthcare-for-london-consulting-the-capital-consultation-shows-support-for-key-proposals The figures from the consultation showed that just 932 people had registered support for the idea that "almost all GP practices in London should be part of a polyclinic, either networked or same-site," while slightly more, 966 people, had said that they "tend to agree" with the nebulous idea. This endorsement from 0.033893 per cent of the greater London electorate was presented by NHS London as 51 per cent – of the 3,760 responses which answered the question. The *Guardian* duly headlined "'Public in favour of polyclinic scheme for London,' says NHS" (http://www.guardian.co.uk/society/2008/may/06/nhs.health). By contrast, the *Health Service Journal* (May 8 2008) more prudently headlined "Polyclinics 'pie in the sky,' finds capital consultation."

[21] Joint Overview & Scrutiny Committee (JOSC) to review 'Healthcare for London' (2008) *Final Report*, April 2008 (A joint authority health scrutiny committee comprising all of the London Boroughs and the City of London, Essex and Surrey County Councils), http://www.hackney.gov.uk/joint-overview-and-scrutiny-committee-to-review-healthcare-for-london.pdf

Nine London Trusts and NHS Hillingdon appear on an inglorious lists of Trusts singled out nationally as financially challenged: this includes one Trust (South London Healthcare) formed from merging three previously challenged Trusts (Bromley, Queen Elizabeth and Queen Mary's) into one big one.

The current list incorporates:

- Barking Havering and Redbridge University Hospitals NHS Trust.
- Barnet & Chase Farm Hospitals NHS Trust.
- NHS Hillingdon.
- Lewisham Hospital NHS Trust.
- Newham University Hospital NHS Trust.
- North West London Hospitals NHS Trust.
- St George's Healthcare NHS Trust.
- South London Healthcare NHS Trust.
- West Middlesex University Hospital NHS Trust.
- Whipps Cross University Hospital NHS Trust.[22]

Some of these have balance sheets which appear more favourable than might be expected – on the strength of substantial long-term loans which require regular repayment: others like South London Healthcare carry huge cumulative debts that are reported.

The challenged Trusts themselves are scattered in every corner of the capital – from north to south, west to east. Most, with the exception of Newham, are in relatively outer parts of the capital, in areas often ignored by previous reports and plans for London such as the King's Fund[23] and Tomlinson[24] reports of the 1990s.

What these challenged Trusts have in common is an even greater vulnerability to the financial pressures taking shape in the new situation, with the prospect of tariff reductions, diversion of caseload to primary care and limits on elective referrals compounding the already massive problems they have in seeking to balance the books and pay off debts.

- **PFI**

Other factors are also driving towards tough decisions in London's NHS. The capital has a number of hospitals built or under construction under extremely expensive Private Finance Initiative contracts, carrying hefty "unitary charge" payments for decades to come. London's 20 PFI hospital schemes will build new facilities costing £2.6 billion – almost a quarter of the £11 billion national total . But the repayments over the lifetime of the contracts will total £16.7 billion – averaging more than six times the basic cost of the buildings. Even allowing for the fact that some of the schemes include the supply of non-clinical support services, this is an extravagant cost, and it has left some Trusts in serious financial difficulties (see Appendix 2[25]).

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[22] NHS London (2009) Challenged Trust Board update, Board Paper October 2009, http://www.london.nhs.uk/webfiles/board/09%20Meeting%207%20Oct/4.3%20Enc%20H%20CTB%20briefing.doc

[23] Kings Fund (1992) *London Health Care 2010*, London, King's Fund

[24] Tomlinson B (1992) *Report of the Inquiry into London's Health Service, Medical Education and research*, London, HMSO

[25] London figures and totals extracted from HM Treasury (2009) *PFI signed projects list*, available http://www.hm-treasury.gov.uk/d/pfi_signed_projects_list.xls

Queen's Hospital in Romford, for example, cost £238m to build, but is set to cost £2.28 billion by the end of the contract in 2042 – more than nine times the cost of the hospital. The index-linked unitary charge is £43.5 million this year, according to Department of Health spreadsheets, but is set to rise above £90m in the final three years. These annual increases in PFI costs are part of a legally binding contract, and take effect regardless of the income and pressures on the Trust, and this will be especially onerous in the next few years of generalised squeeze on NHS funding.

The Barking Havering and Redbridge Trust, which runs the hospital, is currently carrying £105m in cumulative deficits[26]. And the Trust has never been able to afford to open or staff the whole costly building. Indeed, despite regular and prolonged Red Alerts at Queen's, management in September signed a contract to rent out a ward that had been closed since April to private US hospital chain HCI[27]. (Romford Recorder 22 September).

Costly PFI schemes are also at the centre of the financial nightmare in South East London, where two Trusts with PFI hospitals, Queen Elizabeth Hospital and Bromley Hospitals, have been merged, along with Queen Mary's Hospital Sidcup, into a single South London Healthcare Trust, with combined cumulative debts totalling close to £200 million[28].

Treasury figures[25] show that Bromley's Princess Royal University Hospital is set to cost £788m for a building which cost £118m, and QEH was one of the cheaper first wave hospitals at £96m, but will cost a massive £798m by 2030 when the contract ends – more than 8 times the initial investment.

As the new combined Trust hunts for ways to cut back spending and balance its books, it is Queen Mary's, with only a minor PFI scheme on site, which has been singled out as the main sacrificial victim, as the cheapest site to impose cuts. It faces a rundown of its busy A&E and other acute services despite the lack of investment to expand QEH or PRUH to take the increased caseload [29].

PFI will also be a major millstone round the neck of Barts & the London NHS Trust, which is in the throes of constructing the largest PFI scheme in the NHS, redeveloping Bart's and building a new Royal London Hospital in Whitechapel. The scheme is costing £1 billion and the 35 years of index-linked payments will start at £96m in 2013 – in the midst of the predicted cash crunch for London's health services.

The capital's PFI payments are close to £250m this year, but will rise to more than £400m from 2014, forcing up the overhead costs of the Trusts involved, and squeezing resources for other health services[30]. PFI hospitals with their debts and their inflated and inflexible overhead costs are at a disadvantage under the Payment by Results system already, but this will be even more serious if sustained efforts are made to reduce the tariff price of treatment by 3-4 year after year.

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[26] Barking Havering & Redbridge NHS Trust (2009) Finance Report to September Board meeting

[27] *Romford Recorder* (2009) Cancer Centre for hospital: for private patients, September 25:page 18

[28] Davis A (2009) Services cut as hospitals merge with £200m debts, *Evening Standard* March 2, http://www.thisislondon.co.uk/standard/article-23655985-services-cut-as-hospitals-merge-with-200m-debts.do

[29] Lister J (2007) Under the Knife, http://www.healthemergency.org.uk/workingwu/Undertheknife.pdf

[30] London figures and totals extracted from HM Treasury (2009) *PFI signed projects list*, available http://www.hm-treasury.gov.uk/d/pfi_signed_projects_list.xls

- **Rising caseload**

While NHS London looks to axe a third of hospital beds, across most of the capital, PCTs and Trust boards report continuing ***increases*** in numbers of patients seeking A&E treatment, and rising numbers of emergency admissions. Indeed caseload is expected to continue to increase throughout the period of budget restraint (see later sections).

London has 24 acute Trusts and 5 foundations delivering acute hospital care, plus 3 specialist hospital Trusts.

After a rapid reduction in hospital bed numbers in the 1980s and early 1990s, London has seen total bed numbers and general and acute beds diminish more slowly than the rest of England in the last four years (2005-9)[31]. However this has been mainly due to an increase last year in the number of acute beds to 16,868 (now slightly higher than the 2005 figure) as a correction to previous excessive closures, compared with a national reduction of 7.9% over four years. Nonetheless a number of London hospital Trusts are now warning that acute bed occupancy levels are close to 100% and consistently higher than the target 85% level (see Appendix 4).

On geriatric beds, closures in the capital have generally outstripped the England average, with London losing 25.5% of geriatric beds since 2005 compared with 21.9% in England.

Official figures show 3.7 million attendances at A&E facilities in London in 2008-9, 20.1% of the England total: these figures reflect London's much higher levels of social mobility and numbers of residents temporarily or continually unregistered with GPs, including asylum seekers, refugees, new migrants and new arrivals in the capital. All of these groups, along with others lacking access to out of hours primary care, are more likely to make use of A&E as a substitute for GP services. This pattern of use of A&E has long been a feature of inner London and of other inner city areas (see Appendix 5)[32].

In recent years the A&E figures have also begun to include specific detail on attendances at the various minor injury and similar units established in the capital since the mid-1990s. These people, many of whom may in future be suitable for treatment in "polyclinics", are self-selected as minor cases, and accounted for almost 18% of "A&E" attendances in London last year. If these figures are subtracted, London hospitals' front line A&E units saw 3.1 million first attenders, equivalent to 17.2% of the national figure.

By contrast with the disproportionately higher number of A&E attenders, the capital's hospitals handled just 612,553 emergency admissions in 2007-8, a smaller proportion of total admissions than previous years, and a lower proportion of total admissions (35%) than

[31] Bed figures here and elsewhere in document extracted from Department of Health 'Beds Open Overnight in England', 2008-9 and 2004-5, available from http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781

[32] Figures on A&E attendance extracted from Department of Health statistics: Archive: A&E attenders, available http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_087973

the English average (43.5%)[33]. This seems to suggest that London's hospital doctors are if anything less ready to admit patients as emergencies than their colleagues elsewhere in the country. (Appendix 1)

However the use of emergency services still shows a continual upward trend almost two decades after the first governmental commitment to switch more of these services from hospitals to a "primary care-led NHS". Indeed this continued increase in A&E attendances has occurred despite the increased complexity and higher unit costs of new systems which deliver the most minor treatment through standalone minor injury units, which sacrifice any of the efficiencies that could have been achieved by establishing a more rational "triage" system, ensuring primary care facilities are situated on site alongside mainstream A&E units.

NHS management continue to focus their energies on the still unresolved problem of redirecting local people from centres they know and trust to new centres they may not view as appropriate.

However elective treatments are also on the increase in most areas of London, and all of the projections from NHS London assume a continued year on year increase in demand for the next 8-9 years; both elective and emergency caseloads in many areas are running well above projected and contracted levels, forcing many Primary Care Trusts into deficit.

This is why a number of PCTs have begun to look to various forms of "demand management" or "referral management", which in some case will seek to limit hospital caseload by intervening to re-route a GP referral to some other form of treatment[34]. This of course runs counter to the concept of "patient choice".

Any measures to cut back on hospital treatment and rationalise or centralise hospital services have to take account of the views and wishes of patients and the wider public, the political pressures on ministers, MPs, and councillors as elected politicians, who (unlike appointed PCT, SHA and Trust directors) can pay an electoral price for unpopular policies forced through at the expense of local services.

But any plan for cuts must also take account of the objective situation of London's NHS: this includes the continued heavy and increasing use of the existing services, and the logistical problems of switching large numbers of emergency patients to more remote locations involving longer journey times, especially on London's heavily congested road network.

- **Mental health**

After a prolonged process of reorganisations and mergers, London now has three mental health Trusts together with 6 mental health Foundation Trusts.

The capital spends a higher amount per head on mental health than other English regions and several London PCTs spend substantially more on these services than the Department of Health average of 13% of Hospital and Community Health Services budgets[35]: NHS Westminster for example spends 24%[36]. In many areas services have been transformed and

[33] Figures calculated from Hospital Episode Statistics, available at: http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=209

[34] See below, and also *Pulse* November 7 2008 PCTs planning huge expansion in referral schemes, http:// www.pulsetoday.co.uk/ story.asp ?sectioncode=23& storycode=4121081& c=2

[35] NHS Confederation (2008) *The NHS handbook*, page 163, NHS Confed, London.

[36] NHS Westminster (2009) *Corporate Finance Report*, September, Annex A

improved, but there is still a need to provide for high quality inpatient treatment for those who require it.

However in the last four years, the capital has lost 21% of its NHS mental health beds. This compares with a reduction of just 15.5% in England, and comes despite a long history of under-provision of NHS acute and medium secure beds, especially in more deprived areas of the capital, which left many London Trusts heavily dependent upon private sector placements, often many miles from the inner city areas where patients live (Appendix 4).

Mental health bed occupancy levels have been increasing north and south of the Thames: in Haringey several wards at St Ann's hospital have been close to 100% occupied according to the Barnet Enfield and Haringey Mental Health Trust[37].

Private mental health facilities now cost the NHS as a whole more than £860m a year for inpatient care alone, with 25% of all beds in private hands.[38] A very large share of the patients using these beds will be from London. Some Trusts which managed to wean themselves off private providers have slid back into this as a means to deliver care in the short term.

South London and Maudsley Foundation Trust (SLaM), one of the Trusts which worked most energetically in recent years to bring inpatient care back in-house and cut the use of private beds, has recently been paradoxically closing its own beds and contracting to use private sector beds – even while its own occupancy levels increase[39].

A look at the figures shows that occupancy levels of SLaM's mental health beds have increased sharply since 2006, from 81.3 percent to 94 percent last year – an unacceptably high level that inevitably creates periodic shortages and crises. This is despite the fact that SLaM has bucked the trend of the rest of London –and actually *increased* its own bed numbers by almost 15 percent in the last three years[40] .

- **Staff shortages/agency costs**

The Board papers analysed in this report show unexpected higher levels of referral and emergency treatment and the high levels of bed occupancy have caused financial problems for Trusts which have had to bring in more agency staff than planned, incurring higher costs.

Some Trusts report that the costs of additional staff have effectively negated any financial benefit of additional patients paid for through Payment by Results.

- **Private beds losing money**

London's NHS, especially specialist and teaching hospitals, have historically offered a disproportionately large number of NHS "pay beds"; in 2005 Laing & Buisson figures showed London Trusts with 508 private beds, over 40% of the UK total of 1249[41], and more than three times the number of pay beds in any other region. In more recent years Foundation

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[37] Barnet Enfield and Haringey Mental Health Trust, *Performance and Risk Report* 21 September 2009.

[38] Laing & Buisson (2009)' Independent mental health sector grows to record size', Press release December 11 available http://www.laingbuisson.co.uk/Portals/1/PressReleases/MentalHealth2009.pdf

[39] UNISON South London & Maudsley (2009) False economy, *Union Eyes* (front page), Autumn 2009.

[40] Department of Health 'Beds Open Overnight in England', 2008-9 etc, available from http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781

[41] Laing & Buisson (2005) *Healthcare Market Review 2005-6,* Laing & Buisson, london

Trusts have explored ways to circumvent the "cap" on the scale of private medicine to be operated.

However recent figures from a number of London Trusts suggest a resurgence of the age-old problem of private patients – whether home-grown or from overseas – leaving without paying the bill, while the economic downturn has depressed demand for both private hospital beds and NHS pay beds. As Board papers in this report show, some Trusts are now recording significant shortfalls against projected private patient income, and this will further compound the problems of some NHS providers.

Around the capital

All of these factors mean that London's NHS goes into this crisis under pressure and in many cases already carrying or projecting hefty deficits this year. Their Board papers show that at least 18 of the 31 PCTs are already predicting overspending this year totalling over £170m, and as a result most of those which are projecting break-even (and some predicting a surplus) are doing so by relying on use of reserves and contingency funds to cover additional unplanned costs.

Several NHS Trusts, in addition to Barking Havering and Redbridge and South London Healthcare are facing substantial and worrying deficits, mitigated only slightly if at all by higher than planned numbers of patients requiring treatment.

This report will look at NHS London and sector by sector at the published information on PCT and Trust finances to assemble a snapshot of health care in the capital as the storm strikes, and explain why London is "on the brink" of major problems.

NHS London itself threw the spotlight on the growing financial problems of PCTs and Trusts in its October Finance Report, which indicated that the capital as a whole was £52m worse off than planned, with the problems focused on "over-performance on acute contracts" piling pressures on PCTs "with little apparent compensation in trust bottom lines", not least through shortfalls in many Cost Improvement Plans[42].

One additional problem for Trusts and PCTs running a deficit is that many had been hoping to take advantage of an NHS London plan to clear away historic debts for those Trusts and PCTs which manage to get themselves into balance this year[43]. For those that fail therefore, there is the potential 'triple whammy' of this year's losses, the continued burden of past debts, and the concerns over how they can face the future pressures.

According to NHS London Trusts are forecasting a £23m deficit by the end of the financial year: but they were almost £42m in the red by Month 5. PCTs were forecasting a £96m surplus, just £4m below the original plan, but were £43m below target at month 5. NHSL's reading of this position can be seen as optimistic, and based on the most optimistic projections from Trusts, which were on average achieving just 78% of their planned savings, but hoping to push this up to 95% by end of year. More than a third of PCTs were reporting significant variations from plan in their finances, but many of those projecting a break-even would only be able to achieve this through "immediate mitigating actions".

[42] NHS London (2009) October Board papers: Enc G: Finance, available http://www.london.nhs.uk/publications/board-papers/board-meeting-7-october-2009

[43] NHS London (2008) December Board paper: Proposal for a medium term financial strategy for London, available http://www.london.nhs.uk/webfiles/board/08%20Meeting%2022%20Dec/paper%209%20E%20MTFS.pdf

NHS London's six sectors

In March 2009 NHS London announced the formation of six Sectors covering PCTs in the various areas of the capital, and named their lead chief executives. The Press release publicising this new arrangement tried to argue that this would not cut across the role of Primary Care Trusts, but spelled out the extensive brief that would be handled at Sector level:

> "The introduction of the sectors will create larger commissioning entities which will ensure that there is greater leverage, consistency, economies of scale and expertise when entering into commissioning agreements. Also, in 2009/10 the SHA will task the six sectors to take on full responsibilities for acute performance management." [44]

The significance of this arrangement is becoming clearer now that it is obvious that extensive discussions are taking place in these closed committees, using information that is not open to public scrutiny, and that plans and proposals arising from these sectors will be effectively imposed upon local PCTs, as seems already to be taking place with the plans to axe services in Redbridge.

Sector	PCTs covered	Total Budget 2009-10	Budget as % London	Equivalent share of £5.1 billion real terms cuts
North West London	Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, Westminster	£3,212m	24%	£1,224m
North Central London	Barnet, Camden, Enfield, Haringey, Islington	£2,255m	17%	£867m
Outer North East London	Barking & Dagenham, Havering, Redbridge, Waltham Forest	£1,437m	11%	£561m
Inner North East London	City & Hackney, Newham, Tower Hamlets	£1,429m	11%	£561m
South East London	Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark	£2,769m	21%	£1,071m
South West London	Croydon, Kingston, Richmond, Sutton & Merton, Wandsworth	£2,119m	16%	£816m

(All figures calculated from Department of Health 2009-10 PCT revenue allocations, at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091447.pdf)

[44] NHS London (2009) 'NHS London announces sector chief executive appointments', Press release March 24, available http://www.london.nhs.uk/news-and-health-issues/press-releases/2009-press-releases/nhs-london-announces-sector-chief-executive-appointments

NW London

According to a March 2009 document drawn up by the NW London Commissioning Partnership, the eight PCTs in the sector "currently spend 7% more than other PCTs in London on acute care". The aim of the Partnership, which will cover 35% of the budgets of the PCTs, was to spend "up to 15% less than their current average", suggesting a cuts target of almost £170m[45].

The NHS London projections, according to the summary by NHS Kensington & Chelsea, suggest a resources gap for NW London of between £190m and £520m by 2016-17, but even this assumes reductions in tariff for acute services – which would pass a very large problem on to NHS Trusts[46].

Brent, Harrow and Barnet are among the boroughs most affected by the continued crisis of the NW London Hospitals Trust which has run high levels of deficit in previous years and began 2009-10 projecting a £12m shortfall at the end of the year[47].

However NWLHT is already running behind even this plan, with overspending at £8.8m in month 6, and containment of further losses dependent upon a £17m savings plan.

The Trust's problem is not lack of work: the October Board papers show NWLH's emergency admissions are up 5% overall, with a 12% increase from Harrow, elective admissions are 2% above plan, and A&E is booming with an 8% over-performance overall, including a massive 27% increase from Harrow. However private patient income is £674,000 below plan, and the high vacancy rate, two thirds of which are for nursing jobs, has meant vital jobs are being expensively filled by agency and bank staff.

- NHS Brent (Budget £501m)

The July PCT Board heard that the overspend had reached £3.2m but was forecast to reach £8m by the end of the year, with a potential for acute care overperformance as high as £14m, mainly at NW London Hospitals and the Royal Free Hospital. NWLH was over target on both elective and non elective admissions[48]. The October meeting was told that the PCT acute overspend could now reach as high as £16.2m, but that the impact of this would be reduced by slippage on investment of £9m and a recovery plan which should generate £4m[49].

However the Medium Term Recovery Plan for Brent seeks savings totalling between £45m and £105m by 2014. A paper presented to the June Board meeting argues the need to "save recurrently £60m (approx) over the three year period 2011/12-2013-14 … (equivalent to an

[45] North West London Commissioning Partnership (2009) Full Business Case: Part 1 The Manifesto, (June 2009) available: http://www.hillingdon.nhs.uk/uploads/boardreports/July%2009%20Board%20Papers/09%20-%20NWL%20Commissioning%20Partnership%20FBC%20Appendix%201Final.pdf

[46] NHS Kensington & Chelsea (2009) Medium Term Financial Strategy – modelling the implications of likely funding gaps from 2011 onwards, September 29 Board papers

[47] North West London Hospitals Trust (2009) Report of the Director of Finance, Period 6, 2009/10, October Board papers

[48] NHS Brent (2009) Minutes of July 30 meeting, October Board papers

[49] NHS Brent (2009) Finance and Performance report October 1, October Board papers

average of £20m per annum)". The PCT was recommended to spread these very large cuts over 4 years rather than concentrate them over three, beginning next year with a £10m cut[50].

- NHS Ealing (Budget £546m)

The September Board meeting was told of concerns over possible overspending on acute services (acute Trusts were over-performing) and on GP prescribing, and the PCT was acting to prevent either service over-performing any further. A balanced budget was still predicted[51].

Ealing Hospital Trust, almost uniquely in London, has been underperforming against its contract with NHS Ealing, to the tune of almost £1.9m by the end of August, with under-performance on General medicine, General surgery and a 35% shortfall in obstetrics and gynaecology[52]. The Trust is also faced with rising bills for agency staff, but more worrying for Trust finance managers is that they have been receiving around 2,000 queries from NHS Ealing each month on payments claimed, which generates a huge workload for the Trust, and uncertainty over revenue. Nonetheless the Trust in September was still predicting a break-even for the end of this year.

- NHS Hammersmith & Fulham (Budget £326m)

The most recent sketchy financial report (September 2009) contains little information other than a complaint at the poor quality data supplied by Imperial and Chelsea and Westminster Trusts. The Imperial contract appears to be under-performing, while Chelsea and Westminster was costing more than projected.

The NHS London report shows the PCT marginally below break-even at month 5, and projecting a surplus of £10.5m – the fourth largest in the capital[53].

- NHS Harrow (Budget £313m)

August minutes from the September PCT Board meeting show a massive 32% over-performance in the A&E services at North West London Hospitals Trust, of which Harrow's share is just 3%. The PCT is facing a £2.5m over-performance from NWLHT, and the September Board papers report a "very high level of risk" that they will miss their target of a £1m surplus[54].

To hit the budget would require the PCT to realise its full savings target of £9.5m and generate an additional £2.5m of savings. But they are £2m short so far on the savings targets, while over-performance by providers has already reached £5m by month 4, threatening a possible overspend by the end of the year of £15m.

[50] NHS Brent (2009) Medium Term Financial Strategy 2009/10-2013/14, October Board papers

[51] NHS Ealing (2009) Minutes of September 17 meeting, Board papers October.

[52] Ealing Hospital Trust (2009) Director of Finance's Report, September Board meeting

[53] NHS London (2009) October Board papers: Enc G: Finance, available http://www.london.nhs.uk/publications/board-papers/board-meeting-7-october-2009

[54] NHS Harrow (2009) Finance report month 4, September Board papers

- NHS Hillingdon (Budget £379m)

This financially challenged PCT has historically set records for the scale of its deficits, and sadly the minutes of the July Board meeting confirm that it is again facing the prospect of overspending, due to over-performance of acute providers to the tune of £1.5m at the end of June.

The end of year projection outlined in the September Finance report is a £2.7m overspend, even though the actual figures to the end of month 4 show the deficit already at £3.4m (6%) and rising, mainly on services provided by Hillingdon Hospital. A&E caseload was up by 9% above plan and there had been a sustained increase in referrals, especially for orthopaedics.

Hillingdon Hospital Trust reported in September that its income was above target by £3m to date, a 7.5% increase on last year, with year-end forecast growth of £8.8m. Elective admissions were up 11.2%, non-elective by 7.9% and A&E attendances were a massive 18.8% above target[55].

At the end of October *Pulse* magazine reported astonishing moves instigated by KPMG to bring NHS Hillingdon back into financial balance, including the replacement of the chair of the PEC. The sitting chair Dr Chris Jowett has resigned, and the PEC "effectively dissolved" according to *Pulse*.

The PCT is apparently moving to establish a new regime, scrapping the previous referral management system and instituting an even tougher management of GP referrals. Pulse reports that all 49 GP practices in the borough are now threatening to withdraw from Practice Based Commissioning[56].

- NHS Hounslow (Budget £363m)

The Board's October papers show that Hounslow PCT was £5.6m overspent against its target surplus of £9.8m but was forecasting break-even by the end of the year[57].
The root of the problem is once again over-performance on acute sector contracts, led by the West Middlesex University Hospital Trust with an over-performance of £5.3m, and Imperial Hospitals Trust over performing by £2.7m, along with slippage in the PCT's planned savings. In total Hounslow expects to end the year with an £11,5m overspend on acute services, which it hopes to balance with savings, describing this as "very challenging".

One particular problem in seeking to pursue the NHS London strategy of switching services out of hospitals is the plight of the PFI-funded West Middlesex Hospital, a Challenged Trust, which cost just £60m to build, but which faces another 25 years of payments towards the total cost of £515m. The PCT refers to the Trust as having a large historic debt, losing money, having a PFI "with years to go" and facing a threat to its viability. The historic debt is £17m, and the Trust in July was discussing borrowing the money to make a repayment of £5.1m this year [58].

Like many financially struggling Trusts, West Middlesex is facing a tide of additional work: it is over-performing to the tune of £7.7m for Hounslow and £2.3m for Ealing, and non-elective

[55] Hillingdon Hospital Trust (2009) Financial Report For September 2009, October Board papers Appendix F
[56] *Pulse* (2009) GP leaders ousted following private firm's report, October 30, available http:/ / www.pulsetoday.co.uk/ story.asp ?sectioncode=23& storycode=4124113& c=2

[57] NHS Hounslow (2009) Finance and activity report, in October Board papers

[58] West Middlesex University Hospital Trust (2009) July minutes at September Board meeting, available http://www.west-middlesex-hospital.nhs.uk/about-us/organisation/board-meetings/?category=12

caseloads are up almost 25% year on year. But this has brought the need to open extra beds, incurring additional staffing costs. The West Mid Trust Board in July reported bed occupancy levels running close to 100%, pointing out that Winter Resilience plans require this to be reduced to 80%[57].

The Trust is attempting to hold this year's deficit to no more than £4.5m, although this requires achievement of a cost saving target of £4.25m.

- NHS Kensington & Chelsea (Budget £337m)

NHS Kensington & Chelsea is forecasting a surplus, but one dependent upon using reserves to cover overspending on acute services over-performance running at 8%, forecast to cost an extra £2.4m. Imperial Hospitals A&E attendances were 30% above planned levels. There are also overspends on community and Learning Disabilities. The September Trust Board was told that a 1.2% cut in real terms resources for the PCT in 2011-2014 with a 3.5% increase in elective activity could create a spending gap of £80 million[59].

The Medium Term Financial Strategy outlines a gloomy scenario in which the PCT at a "best case" would receive 0% real growth to 2017, a "likely case" equivalent to a 2.3% real terms reduction in income, and a worst case in which below inflation increases impose a massive 20% reduction in resources over a five-year period. The results "range from a surplus of £9m to a deficit of £80m".

Imperial College Healthcare Trust Board in September heard a Finance report that it was overspent by £2.3m at the end of August, but still predicting a £12m surplus by the end of the year, with income running ahead of plan.

- NHS Westminster (Budget £488m)

NHS Westminster is still projecting an on-target surplus of £11m, even though its service level agreements were shown in the September Board Papers to be running £6.4m above target – the largest component of which was Imperial College Healthcare trust[60].
The Chelsea and Westminster Foundation Trust has taken full advantage of its "freedom" to meet in secret and publish little or no data on its finances. It has been one of the most eager FTs to explore ways of challenging and circumventing the "cap" on private patient income, especially on its maternity services[61].

North Central London

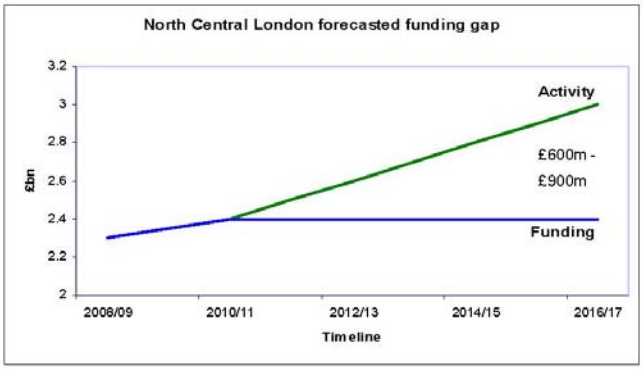
The Sector team covering this part of London has passed on to every PCT a graphical representation of the forecast spending "gap" ranging from £600m-£900m, and several PCTs have incorporated this in their own Board papers, along with initial discussions on how some of them may be affected by the coming cutbacks[62].

[59] NHS Kensington & Chelsea (2009) Medium Term Financial Strategy – modelling the implications of likely funding gaps from 2011 onwards, September 29 Board papers

[60] NHS Westminster (2009) Integrated Performance Report (Appendix A), September Board papers

[61] *Financial Times* (2007) NHS Trusts set up deals to avoid private income caps, 20 August, available http:/ / www.ft.com/ cms/ s/ 0/ eaee2e76- 4eb4- 11dc- 85e7- 0000779fd2ac.html

[62] NHS Camden (2009) North Central London Service and Organisation Review, September Board papers



But the North Central sector itself seems to be relatively low profile, lacking even a rudimentary public face in the form of a website or any gestures towards engagement with the public.

Several North Central PCTs already seem to have their hands full with serious problems of overspending and rising demand for services this year, and this may have diverted some of their attention from the bigger problems coming down the line.

- NHS Barnet (Budget £ 529m)

The PCT reported at its July meeting that it was overspent by £2.9m and could face a £7.9m overspend at end of year, but this would be dealt with using reserves and contingency money. The key factor was a £2.2m overspend on services from the Royal Free. Continuing care services were also overspending by £1.3m. The PCT was also underachieving on savings targets and underspending on intermediate care[63].

The Finance report described the new Payment by Results tariff as a "risk" to a balanced budget. There were also concerns that ambulance response times were deteriorating in the area, and key cancer targets were not being met.

Barnet & Chase Farm Trust, one of the capital's challenged Trusts, is already beginning to detect problems this year, with its income reported at the September Board meeting to be £2.2m below target (despite increased caseload in emergencies and outpatients) while expenditure was £1.4m above target. The Trust was then still forecasting an end of year surplus of £3m, but this is clearly a risky forecast[64].

- NHS Camden (Budget £454m)

The September meeting of the PCT heard dire warnings that unless commissioning of services is changes NC London could face an £800m shortfall in implementing the Healthcare for London proposals. The PCT itself was projecting a break even this year, although the Finance Report warned that UCLH was on course to over provide by £7.8m, having already reached £2.4m in month 4[65].

The PCT has been among the most energetic privatisers, having recently contracted out community physiotherapy services to a company based in Northumberland[66]. All three GP

[63] NHS Barnet (2009) Minutes of July meeting, September Board papers

[64] Barnet and Chase Farm Hospitals Trust (2009) Integrated Performance report, September Board papers

[65] NHS Camden (2009) Financial Position, Month 5, September Board papers

[66] *Camden New Journal* (2009) Physio services are taken over by private firm (by Tom Foot), August 13

practices controversially privatised, with contracts handed to United Health are all shown in the Performance report as under-achieving on access, with Brunswick medical Centre also underperforming on other measures[64].

- NHS Enfield (Budget £437m)

The September Board meeting was told that the PCT was already £10.9m overspent, and estimating a full year shortfall of £24.2m: this is significantly different from the bland "break-even" forecast reported in the NHS London October finance report[67].

The PCT deficit is explained as the outcome of overspending on acute services, rising from £4.8m in Month 4 to £6.5m in Month 5, and estimated to hit £14.1m in the full year, with the failure of cost saving and "better value" schemes to deliver expected savings.

- NHS Haringey (Budget £424m)

The September Financial Report talks of a "challenging" financial situation and forecasts a £1.6m deficit by end of year, despite month 5 figures which show a £2m overspend in a single month and a £4m overspend on acute services by month 4. With overspending on acute services predicted to end the year at between £9.8m and £11.25m, the PCT's hopes of a smaller deficit hinge on the use of £12m of contingency funds.

An Executive Report to the September Board Meeting also reveals that the PCT faces an additional risk in the form of the new Clinicenta contract, which requires the PCT to pay out £1.5m in the first year and a total of £10m over five years regardless of the level of services delivered.

The paper setting out the business case for the relatively modest £144m PFI funded reconfiguration of North Middlesex University Hospital appears to have been deleted from the published papers, but an Excel spreadsheet appendix has been left[68], indicating the level of uncertainty for this project as a result of the Barnet Enfield and Haringey clinical strategy. It shows that while use of hospital services including outpatients, A&E and emergency admissions is projected to rise year by year, generating almost £15m a year additional income for the Trust towards the £20m a year unitary charge, the clinical strategy could cut each of these areas, leaving a reduction of income of almost £34m a year from that total.

The 34-year PFI contract, of course, is not flexible or linked to the Trust's income or ability to pay, so the reconfiguration of services by the PCTs could leave this provider with a major financial headache.

- NHS Islington (Budget £412m)

Having originally planned to deliver a £3.4m surplus, Islington PCT is facing a "significant increase in over-performance" on its mental health and community services as well as acute care. The spending on services at UCLH in August was "almost double the average of previous months", with increases in maternity, general medicine, elective and non-elective, and A&E.

[67] NHS Enfield (2009) Finance Report to 31 August 2009, in September Board papers

[68] Available http://www.haringey.nhs.uk/listening_to_you/public_meetings/search_results.asp?frmdate=30+September+2009 (Agenda item 12)

The September papers warned that this over-performance could reach £5.8m by year end. Other Trusts were also over-performing, by £1.4m, and the PCT was looking to use reserves to help balance the books[69].

Whittington Hospital Trust breaks with the London-wide pattern by reporting a reduction in activity in outpatients and elective services, although there has been a slower reduction in pay costs, leaving a £1.4m deficit by the time of the July Board meeting, rising to £2.2m by September.

High vacancy rates have led the Trust into a 50% increase in agency spending in August compared with August last year[70].

Outer NE London

This sector appears at face value to be one of the more outward facing and high profile bodies, boasting involvement in the North East London website (www.healthfornel.nhs.uk) and even presentations inviting public involvement.

But the first controversial announcement, for the rundown and closure of A&E services at King George Hospital in Redbridge, has exposed the extent to which even this sector has been conducting its decision-making and discussions in secret.

The sector contains two of London's challenged Trusts (Whipps Cross and Barking Havering and Redbridge), with another (Newham) in the neighbouring Inner NE London sector, and BHRT's problems have been compounded by recent findings of the Care Quality Commission branding it uniquely as the weakest Trust in the country[71].

Sadly it seems that the energetic plans to reduce hospital services being hatched up by NHS Havering could further undermine the future of this multiply-challenged Trust, potentially posing huge long-term problems for access to health care.

- NHS Barking & Dagenham (Budget £301m)

The Finance Report to the September Board covers only the period to the end of July, and projects a surplus of almost £8m at year end: however this rests on the assumption that the PCT is successful in ensuring that other commissioners share the larger portion of the risk from the Barking Havering & Redbridge Trust. The previous financial report had warned that the Trust was assuming unaffordable levels of income, which could have resulted in additional costs to the PCT of £5.7m this year.

The solution of this problem on behalf of the PCT comes at the expense of intensifying the financial problems in its principal provider of acute services, both at King George Hospital, Ilford and Queen's Hospital in Romford.

- NHS Havering (Budget £376m)

According to the Chief Executive's report to the October Board meeting, Havering PCT has moved from "high risk to potential deficit", largely driven by the over-performance of Barking

[69] NHS Islington (2009) Finance Report Month 5, September Board papers

[70] Whittington Hospital Trust (2009) Financial position August 2009 (September Board papers) and equivalent earlier reports

[71] *Romford Recorder* (2009) 'Health Trust worst in the country – again', front page October 16

Havering and Redbridge Trust, leading to an overspend of £5.5m by the end of September, and an end of year forecast of a deficit of up to £12m.

BHRT is of course one of the capital's "challenged trusts" – and its financial planning assumes more income from Havering PCT (£10m) than the PCT believes is affordable.

Havering has the largest elderly population in London, and one that is increasing in numbers, with a projected 23% increase in ages 65+ by 2023 and a 49% increase in over 85s. These older people are currently among the large and rising numbers attending A&E. The borough also expects an increase in mental health conditions of old age, with incidence of dementia among over 65s predicted to increase by 32% by 2025, and depression by 28%[72].

Havering, echoing ONEL, is basing its longer term projections on McKinsey's assumption that "between 50-60% of activity will be moved [from hospital settings] within the first two years" and around 40% of outpatient activity will be axed (The Case for Change page 22).

The PCT wants 4 polyclinics delivering a range of services across the borough by 2012, with the assertion that there will be "significant saving over a five year period, dependent on successful implementation of a range of services" – but the PCT offers no explanation or evidence to show how this will be cheaper or more effective than existing care pathways.

Without showing that primary and community services are more efficient or productive than hospitals Havering echoes ONEL and McKinsey determination to:

> " Review efficiency and productivity in high impact areas to shift activity from acute to Primary Care and Community Settings, and to identify any early gains." (The Case for Change page 23).

- Redbridge (Budget £365m)

According to the September Finance report, A&E activity at Barking Havering and Redbridge Trust was running 26% above planned levels, with emergency admissions 12.6% above plan – an extra cost of £2m to date.

A&E activity at Whipps Cross was also 8% above planned levels. GP referrals were running at the highest levels ever recorded, and with the BHRT activity already £5.3m above plan by September there was a real risk that the PCT would do even worse than the projected £3.5m overspend.

> "The trusts have now submitted claims at month 4 which are almost £25m more than the agreed budget, these claims are currently being contested." (Finance Report September 2009 page 3)
>
> "However, the upper level of risk identified is £30.9m. There is, therefore, an additional £20.63m risk that the Executive Team are managing through the turnaround programme. In practice it is unlikely that all the financial risks will go in the PCT's favour or all against it. We have therefore advised NHSL that there is a potential we could miss our control total by £10m and instead of carrying forward a £7.5m reserve we operate at a £2.5m deficit." (Finance report September 2009, p11)

[72] NHS Havering (2009) The Case For Change, available http://www.haveringpct.nhs.uk/docimages/384.ppt

Another concern for the PCT was that the controversial contract with the ISTC at King George Hospital was running at 58% of plan, effectively paying for services that were not being used.

- NHS Waltham Forest (Budget £395m)

The Board's September minutes note that the £42m above target spending on acute contracts by PCTs in London had not been matched by any corresponding surpluses among the main Trusts.

Waltham Forest is projecting a worst case £6.6m deficit at the end of the year, although spending at Whipps Cross Hospital could overshoot target by £7.6m. Some £4.4m of under spending on other services could limit the level of the PCT's end of year shortfall.

The financial state of play at Whipps Cross Hospital Trust is obscured by the decision of its Trust board to meet mostly in secret, and publish no papers: the most recent published agenda dates back to May 2009.

Inner NE London

Inner NE London includes a challenged Trust (Newham) and potentially one of the biggest financial headaches anywhere in the NHS as the £1 billion Bart's and London PFI hospital scheme takes shape, lining up for completion in the midst of one of the worst-ever spending squeezes.

With such vast investment over a whole generation in a massive new hospital, bringing massive legally binding costs to the Trust which need to be covered by the local health economy, it will be even harder for INEL PCTs to implement the NHS London strategy of withdrawing services from hospitals and reproviding through polyclinics and primary care.

The three boroughs have consistently numbered among the most deprived in the country, and the prospect of cutting back on health services in the East End to pay even more billions to bail out the bankers appears especially perverse in this context.

- NHS City & Hackney (Budget £472m)

The PCT registered a surplus of £12.9m last year, and was £2.5m underspent by Month 2 this year, but has scaled down its investment plan to ensure it has resources to balance the books, having noted the risk from the new Payment by Results tariff[73].

- NHS Newham (Budget £510m)

NHS Newham shares the capital-wide pressures from over-performance of acute providers. Its new Urgent Care Centre had had the perverse effect of triggering an increase in admissions rather than reducing the numbers attending hospital. The July minutes quote the PCT Chair suggesting disinvestment may be required to control spending.

Despite the overspending of £3.5m by month 3, predicted to reach £8.8m by year end – the vast majority of this (£8.1m) with Newham University Hospital, Newham was still predicting a surplus of £3m "providing it takes a number of actions to generate savings from reserves, demand management measures and a detailed review of budgets".

[73] NHS City & Hackney (2009) Finance report and Minutes of July meeting, both from September Board papers

There has also been a significant increase in the rate of growth in Emergency activity at NUHT, and the PCT is pressing the Trust to look into the reasons and seek ways of limiting this growth in demand. The July Board meeting was warned that :

> "It would be a huge challenge to achieve the 4-hour A&E target while reducing emergency admissions. Primary Care Practitioners, Practice based Commissioners and the Corporate PCT would all have to be involved. The Clinical Reference Group was looking at the issue as a matter of urgency.[74]"

Newham University Hospital Trust, a challenged Trust, has brought forward a cumulative deficit of £3.5m but notched up another shortfall of £1.4m in the first three months of this year. One factor is the high levels of agency staff required to fill vacant posts[75].

- NHS Tower Hamlets (Budget £447m)

This PCT is still predicting a £10.25m surplus despite levels of overspending at the Bart's and London Trust. Tower Hamlets apparently has sufficient reserves to ride through these pressures for 2009-10: it is not so clear how it may fare in the even tougher times ahead[76].

Meanwhile September Board papers from Barts & the London Hospitals Trust predict an end of year over-performance of £9.2m … but a surplus of just £4.5m, well short of the original target of £12.1m[77].

South East London

The situation in outer SE London is dominated by the plight of South London Healthcare Trust, the crisis-driven merger of three financially challenged Trusts, Queen Elizabeth Hospital, Bromley Hospitals and Queen Mary's Hospital Sidcup. The Trust began life with almost £200m of historic debts, fuelled in part by the costly PFI-funded Queen Elizabeth Hospital (£799m for a building costing £96m) and Princess Royal University Hospital (£788m for a hospital costing £118m) which have resulted in high and inflexible overheads, and inadequate bed numbers made further problematic at QEH by the financial problems forcing long-term ward closures.

The financial crisis in these two Trusts, and the high costs of terminating the PFI contracts, have meant that attention has turned to Queen Mary's as the easiest and cheapest source of substantial cuts in services and spending.

The SLH Trust's July minutes report the Trust struggling to hold the deficit this year within the agreed limit of £29.7m by the end of the year:

> "This was extremely challenging, representing savings of around 7% on the Trust's budget. At present the Trust believed it was around £10m short of this target."

In fact the September papers reveal the Trust £23m in the red by the end of August and forecasting a £47m deficit this year, with the Finance report admitting: "after five months all

[74] NHS Newham (2009) July meeting minutes (p8) in September Board papers

[75] Newham University Hospital Trust (2009) July minutes (September Board paper)

[76] NHS Tower Hamlets (2009) Finance Report for period ending July 31, page 12 (September Board papers)

[77] Barts & the London Trust (2009) Finance report (September Board papers).

sites are in a position which is worse than planned". Emergency caseload is up 7%, elective up 6% and A&E up 10% with an extra 10,400 attendances above plan.

To make matters worse, NHS Bexley had successfully challenged some claims for payment, and NHS Bromley had challenged and effectively refused to pay for thousands of follow-up outpatient appointments, each PCT solving their problems by effectively widening the financial gap at the Trust.

This increased caseload was piling on pressure on staffing, with soaring costs for bank and agency staff to cover vacancies, with almost half of this problem located at QEH:

> "Pay on substantive staff is £8.4 m (7%) below budget, reflecting over 400 wte vacancies and there is £2.3m within budgets for bank and locums. However this is offset by expenditure to date of £6.9 m on agency staff and £10m on bank and locums.
>
> "As previously reported, the significant variance is at QEH where agency, bank and locum expenditure totals £7.8 m to date (46% of the Trust total) and is offset by only £1.8m arising from vacancies and £1m in specific budget, giving an adverse pay variance of £5m."

Efficiency savings plans had delivered just £4.4m against a target of £23m.

The proposals to reduce Trust deficits also shed an interesting light on the strategic document A Picture of Health, which SE London PCT managers and NHS London always been strenuously argued was based purely on quality of care and access. SLH in September make clear that it is in essence a cash-cutting programme to "right-size" health services and balance the books. After a preliminary paragraph outlining the massive scale of the financial challenge to the Trust, the SLHT Finance Report continues:

> "Following the principles of A Picture of Health we need to decide where specialties will move/consolidate on single sites. There must be acceleration of the project to "right-size" the Trust in a way that allows it to be viable whilst our capacity must be used effectively." (Finance report September 2009)

In inner SE London there are also pressures on the Guy's and St Thomas's Foundation Trust, which unlike many Foundations publishes its Finance reports and admitted in September to a £2m loss in the first four months of the year, against a planned £6.7m surplus. It revealed that the Trust as a whole was forecasting a £2.5m deficit at year end, a long way adrift of its target of a £20m surplus[78].

Guy's and St Thomas's are implementing a £16m savings plan, imposing a 2% target on all departments.

King's Foundation Trust has also published minutes showing income and expenditure running £849,000 below plan because of the impact of agency costs and inflation on clinical supplies[79].

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[78] Guys and St Thomas' Foundation Trust (2009) Financial Report for the four months to 31st July 2009

[79] Kings College Hospital Foundation Trust (2009) Minutes of July 28 Board of Directors meeting, available http://www.kch.nhs.uk/about/foundation-trust/board-of-directors/boardofdirectors-meetings/?assetdet=9344&esctl264010_assetdet=9345

On mental health services, South London and Maudsley Foundation Trust reported in October that it is running a higher surplus than planned, but that deficits are building up in Adult services, older adults and addictions, requiring contingency funds to cover these losses. Another pressure is the use of private sector beds, averaging 16 to the end of August, costing the Trust £1.5m. Ward nursing budgets were also overspent[80].

- NHS Bexley (Budget £321m)

The PCT is carrying a £10.7m debt which has to be repaid over the next two years[81]. The September Board meeting heard that the PCT was still predicting break even on this year's budget, although overperformance on acute services and mental health had already totalled £6.7m[82].

The PCT is rolling out four new polyclinics, at Sidcup, Crayford, Bexley and Welling, making reference to the consultation on the A Picture of Health rationalisation proposals. The rundown of A&E and acute services at Queen Mary's Hospital, Sidcup, downgrading it from District General Hospital to an outpatient and rehab unit continues, with faster than expected reduction of maternity caseload, and mothers diverted to Queen Elizabeth Hospital or to Dartford [83].

- NHS Bromley (Budget £466m)

The PCT September papers report a "small underspend" (£9,000) to the end of August, but warn that overspends at South London Healthcare, Guy's & St Thomas's and King's could wipe out the planned investment programme. Princess Royal University Hospital and QEH are both over-performing, with a possible £6.7m overspend by the end of the year, most of this down to PRUH[84]. The PCT in July heard of concerns over the high number of GP referrals for elective treatment[85].

Bromley has become one of the first PCTs in the country to opt to outsource its community services to a new, untested Social Enterprise, Bromley Healthcare. In deciding to switch to this experimental model, the PCT will be transferring existing staff out of the NHS and into a new contract, raising serious questions over pay scales, pensions, terms and conditions and the terms and conditions that will be available to any new entrant staff. Opting for this line meant discarding a strong bid from the neighbouring Oxleas Foundation Trust, which had won the community contract in Bexley and would have offered continuity of NHS employment to staff[86].

[80] South London & Maudsley Foundation Trust (2009) Finance report to September (October Board papers)

[81] NHS Bexley (2009) Medium Term Financial Strategy (January 2009)

[82] NHS Bexley (2009) Finance report (September papers)

[83] NHS Bexley (2009) Minutes of July Board meeting

[84] NHS Bromley (2009) Finance Report for September Board meeting

[85] NHS Bromley (2009) July minutes for September Board meeting

[86] NHS Bromley (2009) Minutes of June meeting. see also NHS Bromley Press release June 26 "Bromley PCT takes next steps decision on community health services"

- NHS Greenwich (Budget £424m)

The Finance report to the September Board meeting revealed £2.4m overspending, the bulk of which was down to £3.1m increased demand for acute services, especially at the local Queen Elizabeth Hospital, mitigated slightly by some underspends elsewhere. The PCT has reserves to cover this level of overspending, but the paper with the end of year projections has not been published.

- NHS Lambeth (Budget £580m)

Lambeth's September Board papers predict a £1m underspend by end of year, but concede that the risks to this include the current level of overspending on acute services, which is projected to reach £9.2m but on a worst case could reach £13.2m. Higher than expected acute caseload has been handled by Guy's & St Thomas's, King's and St George's hospitals, with emergency pressures across all providers and increased levels of elective work[87].

As a result the projected year-end figure ranges from a best case £6.2m surplus to a worst case £9.1m deficit.

- NHS Lewisham (Budget £485m)

October Board papers show Lewisham had already overspent by £5.2m on acute services by the end of month 5, and is forecasting an overspend of £13.5m-£15m. Over £9m of the target savings have yet to be identified, and the September Board discussed a range of last-ditch measures including postponing some activity to next year[88]. The October Finance report focuses on in-year savings including "demand management" and predicts a best case financial outturn deficit of £8.7m after spending reserves, and a worst case of £10.35m. Most acute providers were running at above planned levels including Lewisham Hospital, King's and Guy's & St Thomas's.

- NHS Southwark (Budget £493m)

The PCT has been concerned with overspending on acute and other services at month 5 totalling £7.3m, with acute services accounting for £6.2m. King's Healthcare Foundation Trust is heading for an end of year over-performance of between £4.5m and £8.4m, while Guy's and St Thomas's are set to exceed targets by between £3.5m and £4.8m. Southwark's best case overall year end projection is a surplus £1.7m, and the worst case is a deficit of £11.4m[89].

The PCT is focused solely on hospital over-spending, and seems less concerned by evidence that Primary Care services are also running above target, showing a greater percentage overspend than acute care.

This inconsistency may be explained by the fact that the PCT's "System Wide Sustainability Project" seeks to divert up to £6m worth of activity from hospitals to primary care this year

[87] NHS Lambeth (2009) Financial report to September Board meeting

[88] NHS Lewisham (2009) Minutes of September Board meeting (October Board papers)

[89] NHS Southwark (2009) Month 5 Finance Report, in September Board papers

and £12m next year – despite the lack of any firm evidence that this would reduce costs on the level required, or any clear plan of how it is to be achieved[90].

Even without any actual details this is the most specific and ambitious spending reduction programme published for action this year by a London PCT. The Project is seen as the means to rein in spending, and makes no pretence at being anything other than a plan to cut costs:

> "Over the last 4 years Southwark NHS has invested £15 million which is an increase of 15% in real terms for the provision of acute hospital services. We currently spend approximately £120.5m. However acute activity continues to increase leading to significantly higher levels of over performance against planned activity in the contract. Currently in 09/10 over performance from our two acute hospitals is in the region of £13m.
> "In the current economic climate and the overall increase in both costs and activity in the KCHFT it was recognised that this level of investment was unsustainable and that both provider and commissioners would have to do things differently to live within the financial envelope for acute services." (System Wide Sustainability Report page 3)

The plan includes:

- Shifting activity (including 20% of outpatient clinics by 2011 and 35% by 2016) from acute hospitals to "lower cost settings in primary and community care. … This will include negotiation of some consultant-run clinics from community and primary care settings, delivering care at lower tariff".
- "Improved long term condition case management by primary care and community services".

In neither case are the potential costs and inefficiencies of the new system discussed or evaluated in financial or human resource terms: the assumption seems to be that primary care and community services offer a low cost or no-cost solution, with no problems in absorbing this additional workload.

The document goes on to outline complex plans for "meet and greet nurses" to stand in the doorway of King's College Hospital "in order to divert appropriate patients to primary care services" (security implications for staff encountering an angry reaction are not mentioned), along with paying "a reduced tariff for patients seen by GPs in A&E" and establishing an "urgent care service on the Denmark Hill site", followed by a "rationalisation" of urgent care locations. It is not clear which of these is the main policy, or how effective any of them may prove in practice: nor is there any costing of providing these additional services for people with the least serious health issues compared with the cost of a triage system and primary care provision in King's A&E.

The September Board meeting heard of concerns over A&E waiting times in the two main providers, King's and Guys & St Thomas's, which are just over the 98% target and "not high enough to give confidence that it will be possible to maintain performance above 98% for the whole year"[91]. There are also concerns at poor local performance by the London Ambulance Service, which has been at 73.5% for Category A response within 8 minutes (compared to the 75% standard) and second lowest in the country and 84.5% for Category B response within 19 minutes (compared to the 95% standard) and lowest in the country, as at week ending 23 August. The latter target cannot now be achieved this year.

[90] NHS Southwark (2009) System Wide Sustainability Progress Report (sept 25) September Board papers

[91] NHS Southwark (2009) Performance Report, in September Board papers

There has been a 3% increase in Category A calls to the LAS (across the whole of London) compared with the same period last year, and a 2% increase in journeys.

South West London

This sector is unusual in that even in its opening summary of the situation, the Whole System Development Project makes clear the limited scope for a radical approach:

> "Using the population estimates from Healthcare for London reference documents it can be seen that there is not a surfeit of hospitals in SW London. This project takes as a working assumption that there will be healthcare facilities in the same locations as currently exist for the foreseeable future."[92]

The document explains that SW London contains "one major acute Trust, three local hospitals and one specialist hospital [The Royal Marsden]". The major acute Trust is a challenged Trust (St George's) but the "three local hospitals" (Kingston, Epsom/St Helier and Mayday) may feel threatened by this low-key assessment of their role.

Indeed Kingston Hospital Trust has just opted to postpone a bid for Foundation Trust status, noting the lack of encouragement and support for its proposals from the Primary Care Trust and the longer-term uncertainty flowing from the Whole System Development Project[93].

The Project is to be run by McKinsey's, who have secured a £1.3m contract from the sector's PCTs to add to the other extensive and lucrative work with PCTs in SW London[94].

- NHS Croydon (Budget £527m)

Minutes of the July PCT meeting reveal an alarming 14% under-performance by community health services, incurring the risk of penalties. The PCT overall is forecasting a £5.4m surplus, but in May the Finance report noted that the added costs of the flu epidemic and of the new Payment by results tariff are "preventing any developments that were not on the list for prioritisation".

Mayday Hospital Trust reported in September that it was £900,000 below plan, and now predicting break-even at the end of the year in place of the original target surplus of £400,000. However it is another Trust facing high costs from use of agency staff, and it is clear that while income is running above plan, costs have gone up by at least as much, so in October the Trust as a whole had fallen further behind its plan, and slipped behind also on its £5.7m cost improvement plan[95].

- NHS Kingston (Budget £249m)

Kingston PCT had no financial report at its September Board meeting, but brief details from the other papers show an overspend of £2m on acute services, of which Kingston Hospital Trust accounts for £796,000. The PCT expects to cover this with reserves and under-spending on primary care.

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[92] Whole System Development Project (2009) Project initiation Document, May 14, available http://www.wandsworth-pct.nhs.uk/bdrep/BR2890_Attach%2010%20-%20WSD%20PID%20v1%200.pdf

[93] Health Service Journal (2009) Foundation bid deferred, November 6 http://www.hsj.co.uk/5008209.article

[94] NHS Richmond (2009) Joint Committee of South West London PCTs Delegation Arrangements & Consultancy Contract, in September Board papers (Attachment D)

[95] Mayday Hospital NHS Trust (2009) Executive Performance Report 2009/10 Period Ending Month 6

NHS Kingston has been one of the most eager to hive off its provider service to a "social enterprise", in which staff no longer be NHS employees[96].

The PCT has also moved rapidly towards the establishment of a polyclinic on the Surbiton Hospital site, spending another £500,000 on management consultants to oversee the redevelopment of the site, after a report from the ubiquitous McKinsey's claimed that the £15m plan was sound[97].

However the Board meeting in June noted that the polyclinic programme could have far-reaching impact on the financial viability of Kingston Hospital as "the local acute Trust"[98].
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Kingston Hospital Trust Board heard in September that it was running a £1m surplus and predicting an end of year surplus of £1.9m. However it has been struggling with staff shortages, with a 29% vacancy rate for health care assistants in acute medicine and emergency departments, and has the highest percentage spend of any hospital in London on temporary staff[99].

- NHS Richmond (Budget £ 267m)

Richmond PCT seems to have handed over much of its management and strategic thinking to a succession of contracts with McKinsey's, and the most recent Board papers also discuss awarding a further £1.3m contract to McKinsey's for the SW sector, to outline a "Whole System Development Project" – the sort of task that NHS directors and senior managers might have been expected to take on.

NHS Richmond has been employing the US consultancy to do "sector landscape work" and a "sustainable future" project. The AD Acute & Specialist Commissioning reported at the July meeting that he was waiting for the outcome of McKinsey's work before moving ahead on Demand Management. In addition the PCT has recruited a Director of Transformation … to "bring the workstream [and other additional new recruits] together""[100].

The PCT September Financial report showed overspending of £4.7m on acute commissioning by month 5 and £5.1m overall, but the forecast is still for a slight underspend at the year's end.

- NHS Sutton & Merton (Budget £583m)

Very high levels of over-performance at local Trusts have resulted in Sutton & Merton projecting a likely £14.3m overspend by the end of the year: this could yet prove to be over-optimistic, given that the overspend by month 5 was already £9.6m. Again the key factor is acute services, with Epsom/St Helier Trust exceeding contracted levels by £3.5m and St George's by £3.9m. The PCT's initial plans relied very heavily on use of reserves and

[96] NHS Kingston (2009) PCT Provider Services Separation Progress Report, (September Board papers)

[97] This is Local London (2009)'£500,000 on consultants for Surbiton Hospital polyclinic', January 22, http://www.thisislocallondon.co.uk/whereilive/southlondon/surrey/4065208.print/

[98] NHS Kingston (2009) Minutes of an Extraordinary Board meeting August 11

[99] NHS Kingston (2009) Performance report to September Board meeting

[100] NHS Richmond (2009) Minutes of July meeting, (September Board papers)

contingencies to counter over-spending, and also incorporated £2m savings from "demand management"[101].

Strangely the Epsom/St Helier Trust Board in July heard that income was running £1m below plan, and the Trust was overspent by £1.5m. However the longer-term security of the Trust has been improved by the prospect of securing public money for the long-awaited rebuild of St Helier Hospital after a succession of ill-judged schemes hinging on Private Finance Initiative came to nothing[102].

- NHS Wandsworth (Budget £489m)

Its July minutes show that Wandsworth PCT, which originally aimed for a £6.3m surplus, now plans to use £6m of reserves to cover an overspend of £5.5m, the lion's share of this being at St George's hospital, where emergency care is running well above plan.

Non-acute services are also forecast to overspend by £2.2m, mostly as a result of higher costs for placements, home care and forensic mental health services.

St George's Hospital trust demonstrates the contradictions of the situation, with predicted income running £5.5m above plan, but expenditure also up by £4.7m. The latest end of year projection is for a £4.5m surplus, but the Trust faces a "Challenge Programme" target of £52m in the year, and has been falling behind on payments[103].

The Trust has been hit by a £400,000 shortfall in income from private and overseas patients.

Conclusions

This snapshot survey of published Board papers reinforces the notion that as early as half way through this financial year problems have been building, both for purchasers/commissioners, whose budgets are facing greater than expected strain, but also for providers, whose extra income for additional caseload, when they can persuade PCTs to pay up, is often insufficient to cover the extra costs they are grappling with.

We have to recall that this is a year of GROWTH in NHS spending, the last full year of the successive years of above-inflation increases, and that problems already visible will intensify from 2010 even if they won't yet have reached the scale of the most draconian NHS London projections and plans for the years from 2011.

Secrecy

It is clear that both NHS London and the PCTs recognise that few of their plans to scale back spending are going to attract much – if any – public support: and in many areas they have been discussing plans at PCT and sector level in secret.

NHS London has refused to publish the full McKinsey report on which they have based their guidance to PCTs. This ensures that Londoners, and other analysts have

[101] NHS Sutton & Merton (2009) Finance report to September Board meeting

[102] Epsom & St Helier University Hospitals Trust (2009) Financial report for the month of July (in September Board papers)

[103] St George's Healthcare Trust (2009) Financial Performance Report month 5 in September Board papers.

no opportunity to scrutinise McKinsey's methods, evidence or findings – all of which must be open to question.

But the six sector teams have also kept their discussions under wraps, leaving the London public largely disenfranchised[104]. As we have now seen with the ONEL plans to run down King George Hospital in Redbridge, the result is that a controversial plan, is released like a bombshell to an unsuspecting public, and elected political leaders and campaigners have to begin a rearguard action to defend popular and busy local services.

The total lack of transparency is underlined in this case by the fact that the ONEL lead is the chief executive of NHS Redbridge – and yet the PCT board appears to have had as little advance warning and discussion on this plan as anyone else in the Borough.

The sector teams are clearly seen as a way to by-pass local opposition and discussion at PCT level, issuing ready-made policies as a fait accompli. But the angry reaction by local people in Redbridge also shows that this may not work out exactly the way NHS London intended, and the latent public opposition to cuts in core hospital services remains very powerful, even in apparently conservative boroughs in outer London.

A key focus for those campaigning to defend London's services must therefore centre on full disclosure and public debate on all of these policies and on the assumptions and projections on which they are based. This is vital to give Londoners a real chance to campaign not only against cuts they oppose at local level but to take a wider view of the framework which is dictating cutbacks across the NHS.

Darzi plan for London: the unanswered questions

Another conclusion from this survey is that Lord Darzi's proposals from 2007 are alive and well … at least in the thinking in boardrooms of NHS London and PCTs: but the issues that undermined Darzi's approach two years ago are still weaknesses now.

There may be a degree of popular acceptance of the idea of polyclinics, especially in areas where primary care has historically been poor, where they can be seen to meet patients' needs and can be positioned to be accessible to the population they serve. But there will be little if any support for polyclinics if they become perceived as a back-door way to close popular local hospitals, and if the imposition of polyclinics becomes a "one size fits all" formula to be imposed right across London. Darzi's Technical Document did not properly cost out either the capital cost or the revenue costs and staffing requirements for polyclinics. Darzi's proposal for a few specialist units and a network of specialist hospitals to centralise stroke and trauma care (which together represent less than 5 percent of London's A&E caseload) have both won acceptance: but few of those who were consulted and endorsed these ideas would have realised that this could also be the basis for downgrading their District General Hospital to a "local hospital" with limited services, as is already beginning to happen.

Nor did Darzi's 2007 proposals address the financial consequences for hospital trusts which lose activity (A&E minor cases and outpatients) to polyclinics, and therefore lose large chunks of their revenue under the "Payment by results" system. And no evidence has been produced to show that it is cost-effective or clinically desirable to switch outpatient and other services to smaller primary care settings.

[104] Nor will many people in NW London be greatly enlightened by the place-holder text, cod Latin and empty spaces on the sector website http://www.nwlcp.nhs.uk/inovem/inovem.ti/system/text/home

Nor does the basic infrastructure of primary care services and staffing exist to ensure that anything like the target numbers of patients can be switched in the short term from hospitals to primary care. We have yet to see a costed plan with proper timetable for the training of staff and management structure to deliver many of these services from primary care.

All of these are extremely important issues, because as we have seen from this round-up many London hospital Trusts are already struggling to stay afloat and meet demand. But they are all too aware that many of the minor cases that might be diverted elsewhere will cost the Trusts money in lost "payment by results" income, but do little to reduce their operating costs.

Undermining Trusts

The final conclusion brings these points together: this survey of London's NHS raises serious questions about the long term viability of many of the capital's acute hospitals in a complex and contradictory market.

For the hospitals, the challenge is to juggle a whole series of pressures in the context of a frozen – but in real terms reducing – budget:

- The planned switch of patient care to primary and community settings.
- Rigid targets for waiting times and other measures of performance.
- The cream-skimming of routine, uncomplicated surgical cases by "independent sector treatment centres", with the money flowing out of the NHS, while the NHS picks up all the complicated and risky and expensive cases.
- 'Patient choice' allowing patients to choose elective treatment in private hospitals, with the money following the patient … out of the NHS.
- Overhead costs bloated for several Trusts by costly PFI deals in which index-linked unitary charge payments will increase every year : hence paying for London's £2.6 billion worth of new hospitals will cost more than six times as much – £16.6 billion.
- Tariff reductions year on year for Trusts if McKinsey/NHS London approach is adopted, regardless of rising costs faced by the Trusts themselves: no equivalent squeeze on PCTs, which are increasing layers of bureaucracy and spending millions on management consultants.
- Staff shortages, resulting in heavy agency bills to fill vacancies for vital posts … delivering services for which tariffs are to be arbitrarily reduced.
- Demand management, aimed at reducing use of hospitals.
- Referral management, aimed at reducing use of hospitals.

The bottom line from each of these changes is that the NHS Trusts remain solely responsible for delivering ALL emergency care, ALL complex, risky and costly care, and most care for patients with chronic conditions, but with budgets constantly eroded by the pressures listed above.

This is a form of 'market' which is systematically biased against NHS providers but which allows the private sector to select which profitable areas it will offer, at preferential rates.

Forgotten pledges

While still a minister, Lord Darzi in 2008 – apparently seeking to reassure a sceptical public – rather rashly promised five guarantees on the changes he and the government were proposing.

- "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".[105]

Darzi may have moved on from his brief ministerial career, but his London policies are still very much at the centre of policies flowing from NHS London and the PCTs. The current state of play in the capital suggests this might be a good time to revive Darzi's five pledges, and challenge NHS London, the six Sector teams and the PCTs to explain just how their proposals – which are clearly now driven first and foremost by cash concerns, and lack evidence (or public support) behind them – fit with these principles.

The BMA's Eight Principles for a public NHS

In response to our concerns about the current and potential damage of market reforms, the BMA in London and nationally is calling for an NHS that:

- Provides high quality, comprehensive healthcare for all, free at the point of use.
- Is publicly funded through central taxes, publicly provided and publicly accountable.
- Significantly reduces commercial involvement.
- Uses public money for quality healthcare, not profits for shareholders.
- Cares for patients through co-operation, not competition.
- Is led by medical professionals working in partnership with patients and the public.
- Seeks value for money but puts the care of patients before financial targets.
- Is fully committed to training future generations of medical professionals.

Researched and drafted for BMA London Region by
John Lister, November 2009

[105] Department of Health (2008) Lord Darzi sets out tough rules for changes in the NHS, May 9, available http://nds.coi.gov.uk/clientmicrosite/Content/Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=366998&SubjectId=36

Appendix 1

London Hospital Admissions

	Admissions	Emergency	Waiting List	Emergency As % Admissions
2004-5	1,495,567	**565,574**	505,399	**37.8**
2005-6	1,608,597	**603,843**	538,955	**37.5**
2006-7	1,722,457	**622,761**	559,458	**36.2**
2007-8	1,737,865	**612,553**	599,497	**35.2**
Increase 2004-2008 (%)	**16.2**	**8.3**	**18.6**	**-**
England totals 2007-2008	11,031,000	4,795,000	-	**43.5**
London as % England 2007-2008	15.8	12.8	-	-

Source : Figures calculated from Hospital Episode Statistics for each year, available at: http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=209.

Appendix 2

London NHS PFI schemes (source: HM Treasury website)

Commissioning Body	Project Name	Date Of Financial Close	Total Capital Value (£M)	Years Of Contract (Operational Phase Only)	Total Payments (£M)
Barking, Havering & Redbridge NHS Trust	Oldchurch hospital in Romford	Jan-04	**238.00**	36.00	**2,277.5**
Barnet and Chase Farm Hospitals NHS Trust	NHS Treatment Centre	Feb-99	**54.30**	30.00	**622.36**
Barts & the London NHS Trust	Acute site rationalisation	Apr-06	**1,000.00**	35.00	**5,295.08**
Brent PCT	Willesden	Dec-02	**21.00**	30.00	**124.55**
Bromley Hospitals NHS Trust	Farnborough Hospital	Nov-98	**117.90**	30.00	**787.97**
East London & the City Mental Health NHS Trust	Mental Health services reprovision at Newham	Sep-00	**14.50**	30.00	**63.29**
King's College Hospital NHS Trust	New block	Dec-99	**75.50**	35.00	**727.32**
Kingston Hospital NHS Trust	Kingston Hospital	Nov-04	**27.60**	30.00	**337.59**
Newham Healthcare NHS Trust	Newham General Hospital	Jan-04	**52.10**	30.00	**491.93**
North East London Mental Health NHS Trust	Goodmayes Hospital	Jul-00	**10.80**	30.00	**50.58**
North Middlesex Hospitals NHS Trust	Reconfiguration of Acute Hospital services	Jul-07	**144.00**	34.00	**1,037.53**
North West London Hospitals NHS Trust	Central Middlesex Hospital	Nov-03	**69.30**	30.00	**298.61**
Queen Elizabeth Hospital NHS Trust	Greenwich	Jul-98	**96.10**	30.00	**780.49**
Queen Mary's Hospital Sidcup NHS Trust / Oxleas NHS Trust	Joint procurement to reprovide mental health services	Dec-98	**21.00**	30.00	**132.47**
St George's Healthcare NHS Trust	Neurological & cardiac units	Mar-00	**46.10**	32.00	**319.25**
The Lewisham Hospital NHS Trust	University Hospital	Jul-04	**72.00**	32.00	**268.45**
The Whittington NHS Trust	Redevelopment of Acute Hospital services	Oct-02	**31.90**	30.00	**158.47**
University College London Hospitals NHS Trust	University College Hospital	Jul-00	**422.00**	32.00	**1,926.01**
Wandsworth PCT	Queen Mary's, Roehampton	May-04	**75.40**	30.00	**466.68**
West Middlesex University Hospital NHS Trust	New District General Hospital	Jan-01	**60.00**	32.65	**515.28**
LONDON TOTALS			**2,649.50**		**16,681.39**

London figures and totals extracted from HM Treasury (2009) *PFI signed projects list*, available http://www.hm-treasury.gov.uk/d/pfi_signed_projects_list.xls

Appendix 3
London PCT allocations and shares of spending

PCT	2009-10 Allocation £000s	Population (000)	Spend Per Head (£)	Spend As % London	Spend Per Head As % London Average
Barking and Dagenham PCT	**301,080**	166.9	**1,804.0**	2.3	**103.1**
Barnet PCT	**528,745**	329.7	**1,603.7**	4.0	**91.6**
Bexley Care Trust	**321,350**	222.1	**1,446.9**	2.4	**82.7**
Brent Teaching PCT	**501,538**	270.0	**1,857.5**	3.8	**106.1**
Bromley PCT	**466,265**	300.7	**1,550.6**	3.5	**88.6**
Camden PCT	**453,989**	231.9	**1,957.7**	3.4	**111.9**
City & Hackney	**472,222**	217.6	**2,170.1**	3.6	**124.0**
Croydon	**526,752**	339.5	**1,551.6**	4.0	**88.7**
Ealing	**545,775**	305.3	**1,787.7**	4.1	**102.1**
Enfield	**436,718**	285.1	**1,531.8**	3.3	**87.5**
Greenwich Teaching PCT	**424,160**	223.1	**1,901.2**	3.2	**108.6**
Hammersmith and Fulham PCT	**326,448**	172.5	**1,892.5**	2.5	**108.1**
Haringey Teaching PCT	**424,321**	224.7	**1,888.4**	3.2	**107.9**
Harrow PCT	**313,370**	214.6	**1,460.3**	2.4	**83.4**
Havering PCT	**376,447**	228.4	**1,648.2**	2.8	**94.2**
Hillingdon PCT	**379,496**	250.7	**1,513.7**	2.9	**86.5**
Hounslow PCT	**362,964**	220.6	**1,645.3**	2.7	**94.0**
Islington PCT	**412,126**	187.8	**2,194.5**	3.1	**125.4**
Kensington and Chelsea PCT	**337,424**	178.6	**1,889.3**	2.5	**108.0**
Kingston PCT	**249,459**	157.9	**1,579.9**	1.9	**90.3**
Lambeth PCT	**580,017**	273.2	**2,123.0**	4.4	**121.3**
Lewisham PCT	**484,939**	258.5	**1,876.0**	3.7	**107.2**
Newham PCT	**510,371**	249.6	**2,044.8**	3.9	**116.8**
Redbridge PCT	**365,515**	254.4	**1,436.8**	2.8	**82.1**
Richmond PCT	**267,442**	180.0	**1,485.8**	2.0	**84.9**
Southwark PCT	**492,748**	274.4	**1,795.7**	3.7	**102.6**
Sutton and Merton PCT	**583,188**	385.2	**1,514.0**	4.4	**86.5**
Tower Hamlets PCT	**447,591**	215.3	**2,078.9**	3.4	**118.8**
Waltham Forest PCT	**395,510**	222.3	**1,779.2**	3.0	**101.7**
Wandsworth PCT	**488,965**	281.8	**1,735.1**	3.7	**99.1**
Westminster PCT	**447,789**	234.1	**1,912.8**	3.4	**109.3**
London total	**13,224,724**	**7,556.5**	**1,750.1**	-	-
England	**80,030,703**	-	-	-	-

Population figures from ONS (2009) Final Mid-2007 Population Estimates, at http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

PCT allocations from Department of Health 2009-10 PCT revenue allocations, at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091447.pdf

Appendix 4

Hospital bed numbers in London and England 2005-9

Year	Name	Total	General & Acute		Acute	Geriatric	Mental Illness	Maternity
		(Available)	(Available)		(Available)	(Available)	(Available)	(Available)
2004-5	England	180,966	136,184		109,544	26,641	31,286	9,081
	London	**29,013**	**20,912**		**16,676**	**4,236**	**6,233**	**1,539**
2005-6	England	175,436	132,826		108,134	24,692	29,802	8,881
	London	**27,930**	**20,305**		**16,357**	**3,948**	**5,775**	**1,557**
2006-7	England	167,019	126,976		104,079	22,897	27,914	8,643
	London	**26,523**	**19,003**		**15,654**	**3,349**	**5,713**	**1,539**
2007-8	England	160,297	121,780		101,080	20,700	26,929	8,441
	London	**24,926**	**17,506**		**14,669**	**2,836**	**5,842**	**1,488**
2008-9	England	159,386	121,688		100,892	20,796	26,430	8,386
	London	**26,540**	**20,025**		**16,868**	**3,157**	**4,922**	**1,535**
% change 2004-9	England	-11.9	-10.6		-7.9	-21.9	-15.5	-7.7
% change 2004-9	**London**	**-8.5**	**-4.2**		**1.2**	**-25.5**	**-21.0**	**-0.3**

Bed figures here and elsewhere in document extracted from Department of Health 'Beds Open Overnight in England', 2008-9 and 2004-5, available from
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781

Appendix 5

First attendances at London Accident and Emergency services 2008-9

Barking and Dagenham Primary Care Trust	**54,622**
Barking, Havering and Redbridge Hospitals NHS Trust	**177,625**
Barnet and Chase Farm Hospitals NHS Trust	**150,072**
Barnet Primary Care Trust	**78,570**
Barts and The London NHS Trust	**119,453**
Bromley Hospitals NHS Trust	**84,162**
Chelsea and Westminster Hospital NHS Foundation Trust	**97,574**
City and Hackney Teaching Primary Care Trust	**10,415**
Ealing Hospital NHS Trust	**98,324**
Epsom and St Helier University Hospitals NHS Trust	**129,786**

Guy's and St Thomas' NHS Foundation Trust	**144,627**
Hammersmith and Fulham Primary Care Trust	**14,058**
Haringey Teaching Primary Care Trust	**36,640**
Havering Primary Care Trust	**37,176**
Hillingdon Primary Care Trust	**30,512**
Homerton University Hospital NHS Foundation Trust	**108,868**
Imperial College Healthcare NHS Trust	**208,057**
Kensington and Chelsea Primary Care Trust	**14,620**
King's College Hospital NHS Foundation Trust	**135,476**
Kingston Hospital NHS Trust	**100,540**
Mayday Healthcare NHS Trust	**151,768**
Moorfields Eye Hospital NHS Foundation Trust	**64,487**
Newham Primary Care Trust	**39,637**
Newham University Hospital NHS Trust	**88,496**
North Middlesex University Hospital NHS Trust	**107,902**
North West London Hospitals NHS Trust	**207,819**
Queen Elizabeth Hospital NHS Trust	**98,224**
Queen Mary's Sidcup NHS Trust	**80,273**
Redbridge Primary Care Trust	**33,688**
Richmond and Twickenham Primary Care Trust	**46,786**
Royal Free Hampstead NHS Trust	**77,308**
St George's Healthcare NHS Trust	**133,430**
The Hillingdon Hospital NHS Trust	**96,030**
The Lewisham Hospital NHS Trust	**126,564**
The Whittington Hospital NHS Trust	**86,991**
Tower Hamlets Primary Care Trust	**43,108**
University College London Hospitals NHS Foundation Trust	**93,558**
Waltham Forest Primary Care Trust	**45,147**
Wandsworth Primary Care Trust	**45,241**
West Middlesex University Hospital NHS Trust	**90,291**
Westminster Primary Care Trust	**27,556**
Whipps Cross University Hospital NHS Trust	**92,947**
Total	**3,708,428**
Hospital A&E total	**3,150,652**
PCT units total	**557,776**

Figures on A&E attendance extracted from Department of Health statistics: Archive: A&E attenders, available http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_087973.