Sections from initial Panel Briefing, prepared by John Lister.

London's NHS cash squeeze

The first People's Inquiry report, London's NHS at the Crossroads, highlighted the impossibly large targets for savings by Trusts and CCGs as a result of the coalition government's real terms freeze on health spending. Despite some last minute panic adjustments to funding for winter pressures, this problems remains at the centre of the crisis in London's NHS.

A snapshot survey for this Inquiry of London's acute hospital trusts and CCGs in early December 2014 reveals **a stark divide** between the 32 CCGs – the vast majority of which are in surplus or in balance, with just three forecasting a deficit at the end of the year – and the 19 NHS and Foundation Trusts (a number of which have been forced into mergers by the impact of the financial squeeze and the pressures under the HSC Act for them to become foundation trusts).

While the CCGs collectively expect a combined surplus of £155 million by the end of March, the Trusts face almost the opposite situation. They are currently facing combined deficits of £185 million, and forecasting a combined deficit of £156 million at year end. Just four acute trusts are in balance or surplus on their latest figures – and many of the 12 which still hope to reach balance or surplus by end of year are expecting to dig deep into contingency reserves and one-off measures to do so.

The impact of the Health & Social Care Act appears to have been to deepen the divide between CCGs, in which only primary care has any effective voice, and the NHS provider trusts, which now have even less input into decision-making, and are seen by CCGs as a way to pass on financial problems.

The soaring numbers of attendances at a declining number of A&E departments are an occasion not for financial penalties on the CCGs – which have largely failed to deliver the long-promised alternative services in "the community" or primary care – but on the hospital trusts which suffer the consequences.

Not only do trusts have to treat "excess" patients above 2009 levels for just 30% of the standard tariff payment, but they are often required to hire new staff, many of them more costly agency staff, and even open additional beds to deal with the growing caseload. When they fail to cope, and breach waiting time and other targets, or fill their beds with emergencies and have to cancel elective admissions, they are further penalised for these shortcomings, and can find themselves being laced in special measures. There is nowhere for the Trust to pass the buck.

Waltham Forest CCG makes clear the counterposition of CCGs and acute trusts by adding in potential penalty payments and withheld payments to Barts Health as their "upside" projection, with the "downside" showing fewer penalties. There appears to be no significant disincentive to deter CCGs from simply dumping financial problems and the consequences of their failure onto the trusts.

However at least one CCG has recognised the potential problems of heaping too many fines and penalties onto already financially challenged trusts. Tower Hamlets CCG is concerned for the future of Barts Health:

> "Barts Health has suffered from particularly severe problems in delivering the national requirements, and as a result of the fines levied through the contract are high, forecast to be in the region of £4m for THCCG and £20m as a whole …
>
> "Barts has a planned financial deficit in the region of £43m but is reporting significant risk that the final outturn position will be substantially worse than this. By imposing the contractual fines, THCCG needs to balance the benefits of applying contractual measures designed to penalise poor clinical care with the obvious impact on the Trust's finances, and the potential adverse consequential impact on its operational capacity.
>
> "In light of this, CCG executives are discussing with the Trust how a jointly agreed plan may be able to deliver the quality improvements required."
>
> THCCG Governing Body papers November 2014, page 60

Duty of candour

The first People's Inquiry Report recommended that NHS senior managers should be subject to a 'duty of candour' about the situation they face. This has sadly not borne fruit, although it is interesting to note that in the Board papers of some NHS and Foundation Trusts it is now possible to read more accurate descriptions of the problems.

Harrow CCG is a rare exception to the general rule of silence on the situation among commissioners, in response to a local survey of patients which found that seven of their top ten priorities related to improved access. It also notes that the Independent Reconfiguration Panel report on the reconfiguration of NW London hospital services "requires GP practices in NW London to move towards a 'seven day' model of care to support the agreed changes to acute services."

The CCG responds by pointing out:

> "It is financially unsustainable for every GP practice in NW London to operate 8am-8pm, 7 days a week and this is not an expectation for GPs in Harrow.
>
> "There are not enough GPs and nurses in NW London for every GP practice to operate 8am-8pm, 7 days a week.
>
> "Likely that increasing the number of appointments would cater for unmet need instead of redistributing existing demand.")
>
> (Harrow CCG Commissioning Intentions 2015-16, p 23)

It is useful to get this outspoken statement of reality to counterweigh the suggestion that somehow reducing hospital services and switching the resources to primary care and community services would somehow open up a new era of unlimited personal 24/7 care by multidisciplinary teams of health professionals.