



THE DARZI REPORT: the critical gaps

A critical review of Professor Sir Ara Darzi's report on London's health services: A Framework for Action



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LHE reponse to Darzi

The Darzi Report: the critical gaps

EXECUTIVE SUMMARY

Professor Darzi's 124-page report addresses some long-standing and important weaknesses in health and health care in the capital, and offers some fresh ideas. At first sight it appears to present a detailed strategy to address chronic inequalities in healthcare provision.

It deserves to be taken seriously in proposing some radical changes and seeking genuine modernisation to deliver improved health and social care provision across Greater London. However it leaves many important questions unanswered and also embodies a number of serious weaknesses and inconsistencies which need to be drawn out and discussed.

Nevertheless the gaps and unclarity in sections of the Darzi report raise the danger that it could be used at local level as a device to force through cuts. Its emphasis on the end of the era of the District General Hospital, for example, has been seized upon by local NHS managers seeking to force through controversial cash-driven plans to downgrade DGHs (notably the management of Trusts and PCTs in South East London, who have invoked the Darzi report as justification for their plans for downsizing and cutbacks at Queen Mary's Hospital, Sidcup, with proposals for a 'consultation' to begin next month).

And Darzi's call for more "elective centres" has also been latched onto by Kingston Hospital Trust as a pretext for privatising its entire elective surgical service – the management of which they want to hand over lock stock and barrel to a private company in order to compete more aggressively with other London hospitals for a share of the healthcare "market".

London Health Emergency has been the most consistent and proactive in exposing and challenging these and similar plans, publicising leaked documents to reveal the secretive manoeuvres of local managers desperate to hit cash targets, and working with trade unions and local campaigners to mobilise in defence of threatened local services. We have 24 years of history campaigning against cutbacks in services, and we will continue to oppose any attempt to downgrade or close services without improved and alternative services being put in their place.

NHS London has argued that, while discussions proceed on the Darzi report, no hospitals or services will be named for downgrading or closure in the capital until the end of the year. Given the clear evidence that this policy is being ignored by local Trusts and PCTs it is vital that the SHA intervenes strongly and immediately to impose this moratorium if the wider debate is not to be pre-empted by short-term cash-driven cuts, and key services handed over to the private sector.

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Central to Darzi's plans is the replacement of London's current network of district general hospitals with a combination of relatively few new centres of specialist excellence coupled with an undefined number of "major acute" hospitals, "local hospitals" and "elective centres".

Only "major acute" hospitals would offer treatment for emergency admissions (more than 600,000 in 2005-6, of which over 500,000 were through A&E departments), so the decision to downgrade any significant number of DGHs to "local hospitals" would need to be accompanied by substantial investment to expand the bed capacity and staff of the remaining "major acute hospitals". There is no such detail in the Darzi report, which leaves completely vague the question of how many there should be of each type of hospital, where they should be, and how patients (and relatives) would be expected to get there and back.

Many traditional A&E services would be replaced with a combination of improved out of hours services, and a number of "urgent care centres," some of which may be downsized A&E units, others based in new "Polyclinics"; 150 polyclinics are proposed, at an estimated annual cost of £3.1 billion.

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

- there is no road-map towards implementation,
- the costings do not appear to be realistic,
- one key group of staff (GPs) have yet to be convinced of the merits of the central proposals,
- and too many real and pressing problems are wished away or simply ignored.

In this context there is a real danger that whatever its merits the Darzi Report and discussions about it will be utilised primarily as a smokescreen behind which local NHS managers will press through unpopular cutbacks in services – cutbacks that will reduce access to front-line care for many who most need it and who find it most difficult to travel longer distances for care – the elderly, the poor, and people from minority ethnic communities.

The missing links

1. Cash questions: the context of London's NHS

Despite the battles to balance the books in London's hospitals mental health services and Primary Care Trusts in the last 12 months, the financial situation is not even mentioned in passing in the Darzi Report.

Indeed fears that the plans are cash-driven and seeking cuts are underlined by the fact that the report goes on to argue (on the basis of some highly doubtful projections) that the package of proposals could save a total of £1.5 billion per year from a rising health budget by 2016.

Services in various parts of London are already under imminent threat of reduction or closure.

2. System questions

Professor Darzi accepts the market-style reorganisation that has taken place since the NHS Plan in 2000, arguing that "Commissioning is potentially a very powerful lever for driving change". "Commissioning" is the current term to describe the purchaser/provider split first introduced into the NHS under Margaret Thatcher's "internal market" reforms in the 1990s, and which has also brought the complex and expensive system of "payment by results" which means that NHS Trusts are now only funded per case on a fixed tariff for the work they do. As a consequence of payment by results, the proposal to move 50% of A&E and 60% of outpatient work out of hospitals would also remove more than £500m from London hospital

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Trust budgets, while many of the associated costs and responsibilities would remain in the hospital sector. Darzi does not discuss these issues, far less demonstrate the viability of the new profile of services he proposes.

Ministers have to choose between further marketisation of the NHS or the type of planned framework of services proposed by Professor Darzi: they cannot have both.

3. No section on older patients

One of the long-running problems facing NHS services in London has centred on the long-term care of frail older patients. The so-called “community care” reforms have left responsibility for long-term care in the hands of local government, not the NHS, while the provision of nursing homes and many residential home places has become the preserve of the private sector, along with a handful of not-for-profit and voluntary organisations. Most of London (with a couple of notable exceptions) has always had well below the national average provision of care home places for frail older people.

For many years social service budgets have also been under pressure, and one consequence of this has been a continual tightening of the system of “eligibility criteria” for social care, alongside a sharp increase in charges for services such as day hospitals and home care. This collapse of social service support across much of the capital represents a major challenge to the NHS.

4. No section on transport, travel times and access

Transport around London, with its snail-paced traffic and congestion and its high-cost public transport running from the periphery in to the centre but with few links around outer London, has been a long-standing headache for NHS provision and planning.

The issue of the location of the new services is one which will shape many people’s reaction to Darzi’s plans. Questions such as “how many local and major acute hospitals?” coupled with “where will they be?” will be among the first from almost anyone reading the report.

5. Missing partners

It is conspicuous that among the varied organisations and institutions listed when Darzi turns to partnership working, the trade unions and professional organisations of NHS staff are not included.

125,000 staff in London’s hospitals face an uncertain future: many face the prospect of being transferred to very different patterns of work in polyclinics or in the community: it is not at all clear whether or not those working in polyclinics would be directly employed by the Primary Care Trusts, or some other form of NHS management structure. PCTs have been urged by government to divest themselves of direct responsibility for providing services..

Primary care staff are historically among the least-well organised in trade unions, and there is a real issue in ensuring that all sections of staff in the polyclinics are properly represented and able to negotiate satisfactory terms and conditions.

There is also a wider issue: the total absence of any democratic mechanism of accountability for London’s NHS. The new London Strategic Health Authority, NHS London, with a budget of £10.1 billion, is an appointed quango with no system of accountability to Londoners at all.

What mandate has NHS London to force through the Darzi report or any other changes?

What opportunity do Londoners have to elect those who shape their health services and remove those who take decisions that lack popular support?

London Health Emergency has suggested that the report could be put to a referendum timed to coincide with next year’s GLA and mayoral elections: that is only one possibility, but the issue of democratic accountability will not go away until some mechanism is introduced.

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What will happen to London's hospitals?

Professor Darzi is a specialist hospital doctor, and the message that has come most clearly from his report is the argument that the days of London's District General Hospitals are numbered, while the days of specialist hospitals are here.

Some DGHs should be scaled up to "major acute" hospitals, possibly becoming one of seven (why seven?) "hyper-acute hospitals" and an elite handful might be linked up with Universities in Academic Health Science Centres.

However the DGHs which are not chosen to fit these categories would be effectively downgraded to "local hospitals" with restricted range of services, and an "urgent care centre" in place of an A&E unit.

Darzi does not identify any hospitals for development as specialist centres: nor does he finger those that he believes should be downgraded to "local hospitals", although we have already pointed out several hospitals already facing the prospect of downgrading from DGH and the loss of A&E services.

With no details on the number, capacity or geographical location of any of the hospitals he is proposing, it is also difficult to link Darzi's proposals on hospital care with his professed wish to remedy health inequalities and make services more accessible for ethnic minorities and the poor.

And while the report itself dodges the hard questions on hospital care, the general suggestions are being cynically milked by local NHS managers as the basis to argue for downgrading services to save money.

London Health Emergency remains unconvinced that it will be possible to deliver comprehensive and accessible health care to a growing and ageing London population with less than the existing provision of hospital services.

We will continue to press for a more detailed and concrete discussion: and we will continue to oppose cash-driven cuts that reduce access to care without any compensating improvements for local people.

Polyclinics: the case examined

The report suggests a network of 150 "polyclinics" to serve the capital's 7.5 million population: on closer examination a polyclinic appears to be a combination of a super-sized health centre, a minor injuries unit, a small-scale outpatients department and a base for community health services.

According to the GP magazine *Pulse* (July 13) the proposal amounts to "herding GPs into polyclinics":

"The BMA warned that polyclinics would 'destabilise and fragment' existing GP and hospital services, and GPC acting chair Dr Laurence Buckman said they were reminiscent of something from communist Soviet Union. 'This review does not bode well.'

"Dr Tony Stanton, joint chief executive of London-wide LMCs, said it would 'destroy the very bedrock of British general practice' if most surgeries were relocated to polyclinics.

It is not clear from Darzi's report whether the Polyclinics would be run with an overall management employing staff including dozens of salaried GPs, or whether the Polyclinics would effectively operate as gigantic health centres, drawing together a large number of local GP practices under a common roof, with shared support services.

Polyclinics versus A&E?

Attempts to switch patient care away from hospital A&E departments included "Minor Injury Units" in the 1990s – often as a transitional step towards closing a full-scale A&E. Darzi's version is "urgent care centres" attached to polyclinics as well as hospitals. However, Minor

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Injury Units showed themselves to be less than popular with many patients and relatively expensive to run, delivering questionable value for money.

Nor are by any means all A&E attenders “inappropriate”: Darzi’s own figures in the technical paper (page 15) shows that over 40% were “major” episodes and another 581,000 were fractures, showing almost 60% of the total had good reason to come to a hospital for treatment rather than a minor injury unit.

What services would be included?

Darzi’s report appears to propose that each polyclinic should offer supporting services including Minor procedures, Urgent care and Diagnostics (pathology and radiology). However the report and the “Technical Paper” offer very few hard facts to show that the cost and space implications of these and other services such as physiotherapy have been taken on board.

Size and cost of polyclinics

According to the “technical paper”, each polyclinic would employ an average of around 90 medical and nursing staff, including 35 GPs and 3-4 consultants, be located in rented accommodation, and run on a budget of around £21m a year. 150 polyclinics would need to enlist a total of over 5,200 GPs to full-time work – slightly more than the current complement of GPs in London.

Inadequate investment in top-quality management and experienced and qualified secretarial and clerical staff would be a short-sighted economy: but it seems obvious from the figures that Professor Darzi has seriously underestimated the numbers of non-clinical staff that would be needed to ensure that the new polyclinics work as they should.

His projected total “administrative overhead” would leave just £326,000 for IT services, admin and clerical staff and management to run a £20m a year operation, equivalent to just 13 clerical staff on £25,000 a year – nowhere near the level of managerial and support staff that will be needed.

In addition, the sheer scale and complexity of the buildings required, plus the fact that any integrated X-ray facility, for example, would need to be housed in a lead-lined room, must raise genuine doubts over the possibility of securing anything like the number of ready-made premises that Darzi proposes, and point to the probability of substantial capital costs to convert buildings.

What services should switch from hospitals, and why?

While there may be some synergy to be generated by organising and basing community care services alongside primary care, big questions need to be asked about the sense in switching a range of outpatient clinics from their established and relatively well-resourced base in hospitals, to 150 different polyclinics serving much smaller numbers of patients.

The average polyclinic is also projected (technical report page 25) to carry out just 336 “minor elective surgical procedures” a year: – that’s just 6.5 per week, and especially if the work is shared out it is nowhere near enough to enable medical staff to develop specialist skills. Worse, the average polyclinic is expected to carry out just 19 “emergency surgery procedures” a year. If as Professor Darzi argues, “The days of the district general hospital seeking to provide all services to a high enough standard are over” (page 71) why should general physicians in polyclinics now be expected to deliver adequate standards of treatments which until now have always been provided by specialist surgical staff in hospital?

Why not a pilot?

The logical answer to many of these questions would be to press for a full-scale pilot project launching a polyclinic on the Darzi model in one of the areas of greatest health need in the

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capital. Issues of accommodation, recruitment and staff costs, organisation and management could all be tested out and a realistic estimate made of the costs of rolling out the full scheme.

A prevailing air of unreality

The Darzi Report contains some very interesting ideas: but it never escapes an overwhelming air of unreality, summed up in a number of passages.

Preventative care (p72-73)

Health promotion campaigns have shown time and again that they require a long-term and consistent input, and that achieving long-term change is difficult or impossible where the patient concerned has not accepted the need for change. Professor Darzi offers no evidence that such tactics have been successful in changing the established, often socially-rooted behaviour of people unwilling to change or engage with services. This seems to be a sure-fire formula for failure and demoralisation.

Travel problems wished away

Darzi's report, as we have discussed, omits a number of thorny problems to be confronted if health care is to be modernised and improved in the capital. One of the most stubborn of these problems is the issue of transport.

Community care appointments are assumed to flow seamlessly from one to the other, without any mention of the grinding, stop-start journeys and the frustrating hunt for parking spaces that will punctuate the day of any community-based staff doing home visits.

Misleading examples

The air of unreality continues in a couple of the examples brought forward by Darzi to support his case for change..

One example is the reference to the growing numbers of specialist hospitals in the USA, which flows from the drive for profit among the largely private providers in the costly and bureaucratic US health care system.

Dodgy figures and projections

While there are many missing details, and costs appear to have been understated, there are also some very dubious statistics at the centre of the Darzi plans, which raise further questions over their viability.

1. The estimated figures offered by Darzi on the numbers of community care consultations vary by a factor of four – between 2,088,000 and 8,147,000. Darzi has consistently used the higher figure as the basis for all his calculations, which may be an unsafe assumption.
2. The assumption that use of primary care will increase over the next ten years by 75% to more than 48 million consultations a year assumes a rapid and complete culture-shift by London's population to accept the new system – while in practice not even the GPs who are supposed to deliver the service have yet been convinced.
3. Conversely, a very substantial 8% growth in London's population is projected to require not more, but 6% fewer hospital beds – despite increasing numbers of older residents who on current systems require additional hospital care.
4. Darzi assumes that 50% of a much higher A&E caseload (increased by a massive and maybe questionable 67% to 6.4 million attenders per year by 2016) can be switched to polyclinics and "urgent treatment centres". Given past experience in seeking to divert A&E attendances, this projection remains open to doubt.

Conclusion

This extended analysis of the Darzi report has been developed as a basis to extend and deepen the discussion on serious proposals which may well be rolled out beyond London as the Professor, now a health minister, works on a similar review of the NHS in England.

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London Health Emergency has long experience on these questions. We have campaigned for the past 24 years alongside all kinds of organisations – local councils, Community Health Councils, trade unions, community campaigns and organisations, local councillors and MPs to defend and improve health services in the capital and throughout the country, and to resist privatisation and costly, bureaucratic market-style policies.

If there is to be a serious debate on Darzi’s proposals, the threat of “stealth cuts” taking place before the discussion is complete needs to be lifted. LHE has written to NHS London to urge it to intervene and enforced a moratorium on further cutbacks and closures at least until the end of the year.

We in turn have been approached by NHS London and have agreed to enter into discussions to clarify the SHA’s intentions and feed back our concerns over potential problems with the Darzi report.

We believe there may be some merit in the proposal for Polyclinics as centres delivering enhanced primary care and community services – but we are not convinced of the wisdom or cost-effectiveness of switching large volumes of hospital outpatient and A&E services to 150 relatively small units. And any large-scale reorganisation of primary care has to get over the obvious hurdle of convincing and winning the engagement and support of the capital’s GPs.

We strongly suggest that if the SHE wishes to proceed further with the Darzi proposals, the immediate focus should be on establishing a single fully-functioning pilot polyclinic in one of the more deprived areas of inner London. This would offer a means to demonstrate the effectiveness and actual costs of this model of care, its impact on neighbouring hospitals and other services, its running costs and start-up costs, and the availability of suitable premises for rent in the capital.

We further suggest that any more detailed discussion over specialist hospitals, major acute hospitals and local hospitals can only usefully take place around much more specific proposals on how many of each are proposed, their capacity, their location, the financial resources required, and the logistical implications for local patients.

LHE is not opposed to modern methods or to change: but we are opposed to cash-driven change dressed up as clinical need, and to “reconfiguration” as a pretext for reduced local access to care.

Until and unless we are convinced that a new system will improve services and raise the quality of patient care, we will continue to work with local campaigners and trade union activists to defend the existing services which are well-established and delivering high volumes of treatment.

**John Lister
for London Health Emergency
August 8 2007**

Darzi report: the critical gaps

A critical review of Professor Sir Ara Darzi's report on London's health services *A Framework for Action*

**By Dr John Lister
Information Director, London Health Emergency**

Professor Darzi's 124-page report was launched on 11 July 2007. It addresses some long-standing and important weaknesses in health and health care in the capital, and offers some fresh ideas. Indeed at first sight it appears to present a detailed strategy to address chronic inequalities in healthcare provision.

It deserves to be taken seriously in proposing some radical changes and seeking genuine modernisation to deliver improved health and social care provision across Greater London. However it leaves many important questions unanswered and also embodies a number of serious weaknesses and inconsistencies which need to be drawn out and discussed.

It would be a mistake to read the report simply as a recipe for cutbacks (which are nowhere proposed: the word 'closure' does not appear, and Alan Johnson has assured the Commons Health Committee that the report should not lead to hospital closures) or for wholesale privatisation.

True, Darzi does not, as campaigners would wish, reject any further privatisation or private ownership of services or facilities delivering NHS-funded treatment: he even raises the possibility that some polyclinics, for example might be owned and run privately by GPs. However insofar as it contains specific proposals and examples, his report only singles out examples of good practice in **NHS** treatment centres and units, and the main focus of the report is on the development of the NHS as a public service.

Nevertheless the gaps and unclarity in sections of the Darzi report raise the danger that it could be used at local level as a device to force through cuts. Its emphasis on the end of the era of the District General Hospital, for example, has been seized upon by local NHS managers seeking to force through controversial cash-driven plans to downgrade DGHs (notably the management of Trusts and PCTs in South East London, who have invoked the Darzi report as justification for their plans for downsizing and cutbacks at Queen Mary's Hospital, Sidcup, with proposals for a 'consultation' to begin next month).

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And Darzi's call for more "elective centres" has also been latched onto by Kingston Hospital Trust as a pretext for privatising its entire elective surgical service – the management of which they want to hand over lock stock and barrel to a private company in order to compete more aggressively with other London hospitals for a share of the healthcare "market".

London Health Emergency has been the most consistent and proactive in exposing and challenging these and similar plans, publicising leaked documents to reveal the secretive manoeuvres of local managers desperate to hit cash targets, and working with trade unions and local campaigners to mobilise in defence of threatened local services. We have 24 years of history campaigning against cutbacks in services, and we will continue to oppose any attempt to downgrade or close services without improved and alternative services being put in their place.

NHS London has argued that, while discussions proceed on the Darzi report, no hospitals or services will be named for downgrading or closure in the capital until the end of the year. Given the clear evidence that this policy is being ignored by local Trusts and PCTs it is vital that the SHA intervenes strongly and immediately to impose this moratorium if the wider debate is not to be pre-empted by short-term cash-driven cuts, and key services handed over to the private sector.

Central to Darzi's plans is the replacement of London's current network of 32 district general hospitals with a combination of relatively few new centres of specialist excellence coupled with an undefined number of "major acute" hospitals, "local hospitals" and "elective centres". Only "major acute" hospitals would offer treatment for emergency admissions (more than 600,000 in 2005-6, of which over 500,000 came in through A&E departments), leaving London's acute beds working at full stretch – so the decision to downgrade any significant number of DGHs to "local hospitals" would need to be accompanied by substantial investment to expand the bed capacity and staff of the remaining "major acute hospitals".

There is no such detail in the Darzi report, which as we will show leaves completely vague the question of how many there should be of each type of hospital, where they should be, and how patients (and relatives) would be expected to get there and back.

Darzi also proposes to replace many traditional A&E services with a combination of improved out of hours services, and a number of "urgent care centres," some of which may be downsized A&E units, others based in new "Polyclinics"; 150 polyclinics are proposed, at an estimated annual cost of £3.1 billion. Each polyclinic would cover a catchment population of around 50,000 and be staffed by up to 90 clinical professionals including 35 GPs, with consultants and nursing and professional staff, in addition to admin and clerical staff. This would bring a root and branch reorganisation of most primary care services in the capital.

The report also proposes improved workforce planning and training, and closer working with the GLA and Mayor's Office, although these sections of the report carry little or no detail.

In addition there are positive proposals for improving mental health services, maternity services, palliative and terminal care, and health promotion. These all begin from uncontroversial aspirations, although each of them poses unanswered practical questions on resources, staffing and the wider policy framework of today's NHS.

While many of the ideas put forward appear exciting and interesting, and the report is framed by Darzi's declared commitment to the NHS as a predominantly public service, there is an

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underlying lack of evidence and a problem of credibility. Too many factors are missing from the Darzi report for it to be the finished article:

- there is no road-map towards implementation,
- the costings do not appear to be realistic,
- one key group of staff (GPs) have yet to be convinced of the merits of the central proposals,
- and too many real and pressing problems are wished away or simply ignored.

In this context there is a real danger that whatever its merits the Darzi Report and discussions about it will be utilised primarily as a smokescreen behind which local NHS managers will press through unpopular cutbacks in services that will reduce access to front-line care for many who most need it and who find it most difficult to travel longer distances for care – the elderly, the poor, and people from minority ethnic communities.

The missing links

I. Cash questions: the context of London's NHS

There has been no secret over the battles to balance the books in London's hospitals and Primary Care Trusts in the last 12 months. Many people seeing another report proposing the downgrading of some hospitals and the focus on fewer more specialised units would see this as a way to cut spending. Yet the financial situation is not even mentioned in passing in the Darzi Report.

Indeed fears that the plans are cash-driven and seeking cuts are underlined by the fact that the report goes on to argue (on the basis of some highly doubtful projections) that the package of proposals could save a total of £1.5 billion per year from a rising health budget by 2016. Since there are few hard facts on which to base this assessment, and many of the projections in Darzi's Technical Paper appear to underestimate actual costs, it seems unlikely that anything like this level of savings could be achieved. However it is a ready-made argument for those who wish to believe that the report as a whole is simply a recipe for cuts and closures.

The issue of finance is of course not simply an academic one. Darzi's Report was finalised in the spring and summer of 2007: all of the reports from NHS London confirm that this period was one of severe financial pressures on a large number of London Primary Care Trusts and front-line NHS Trusts. The previous autumn an official survey had found 90% of London's Trusts facing financial problems. Even the most recent financial projections from NHS London (June 2007) show almost a third (9) of London's 31 PCTs still facing substantial deficits totalling £153 million at the end of the financial year, with five of them facing shortfalls in excess of £10m and Hillingdon PCT a massive £52m.

And despite frantic efforts to balance the books, another nine NHS hospital Trusts also faced a projected total of £66m in unresolved deficits at the end of the year.

These cash pressures have been driving local processes of rationalisation and "reconfiguration" of hospital services – which have been proceeding regardless of the Darzi report. For example Darzi refers on page 27 to

“the impressive new health care facilities such as the Brent Emergency Care and Diagnostic Centre at Park Royal”

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However we already know that trauma cases are being diverted away from this modern A&E unit at Central Middlesex Hospital in advance of a widely-predicted further downgrading of this, the A&E unit closest to Wembley stadium. The cutbacks are driven in part by the massive cash shortfall of Brent PCT – which is also undermining a range of other local services – and partly by the efforts of NW London Hospitals Trust to tackle a £24m deficit.

We also know that the cash crisis faced by the Barking Havering & Brentwood Trust, compounded by the soaring costs of the new £238 million PFI-funded Queens Hospital in Romford, which carries an annual unitary charge of £36m index-linked, is forcing the pace towards the rundown and closure of A&E and other acute services at King George's Hospital, Ilford – a hospital barely 15 years old. Here, too, trauma cases are already being diverted – to Queens. King George's is one of the hospitals most likely to be accessible for any emergencies during the 2012 Olympics.

In north London, a consultation has already opened in which both “options” would involve the closure of A&E services at Enfield's Chase Farm Hospital: the document was discussed by NHS London at its June meeting, just days before the Darzi Report was published. The rationalisation process in Barnet and Chase Farm hospitals is driven by the chronic financial crisis of that hospital Trust (£11m in the red last year) and compounded by the deficit in Enfield PCT.

In SW London the run-down of services at Epsom Hospital by the cash-strapped Epsom-St Helier Hospital Trust has run alongside the scrapping of plans for a new PFI-funded “Critical Care Hospital” which has now been deemed “unaffordable”, along with plans for a supporting network of “local hospitals”.

The Trust has been forging ahead with plans to close maternity services at Epsom, and has also tried in the recent past to hive off its highly successful NHS elective treatment centre (the South West London Elective Orthopaedic Centre, SWLEOC), based on the Epsom site, to the private sector. Professor Darzi (page 99) explicitly praises SWLEOC – but appears unaware that only the activities of local campaigners prevented its handover to a US-based private operator.

In SE London an ongoing secretive debate has been taking place between senior NHS managers in 6 PCTs, 4 DGHs, 2 teaching hospitals and 2 mental health trusts over how to tackle the deficits of four ‘financially challenged’ DGHs. Repeated leaks have confirmed that Queen Mary's Hospital, Sidcup, faces a massive reduction in services, primarily because its immediate neighbouring Trusts (Bromley, Lewisham, Queen Elizabeth Hospital Woolwich) have just completed large and expensive PFI-funded projects which would be extremely costly to cancel.

A seminar to discuss this issue was held at the King's Fund on July 19, just a week after the Darzi Report was formally published, and it seems that staff are being briefed and the rationalisation process is pressing ahead driven by cash constraints, invoking Darzi's proposals and terminology and exploiting the vagueness on the number and location of major acute hospitals.

Financial pressures are also driving damaging cutbacks in mental health services, including specialist mental health care. Lambeth and Southwark PCTs have imposed cutbacks in spending to balance their books which have forced the South London & Maudsley Foundation Trust to propose cuts including the closure of the trail-blazing Felix Post Unit, internationally known for delivering specialist care for older patients. Strong local opposition

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from the community and service users have helped stall the planned closure, but it remains a threat.

So while Darzi himself may choose not to involve himself over more localised resource issues and decisions on the allocation of new hospital and other services, his proposals for a rational re-think across the capital as a whole are unrealistic unless London's Strategic Health Authority steps in and imposes the moratorium it has promised on localised cutbacks and downgrading.

London Health Emergency has already been actively involved in exposing and challenging each of these cutbacks, working with local trade unionists and campaigners to defend local services. We will not allow debates over the Darzi report to divert from this fight to maintain local services until and unless they are replaced by properly funded and resourced alternative and improved services that ensure access for those who need them.

2. System questions

Professor Darzi accepts the market-style reorganisation that has taken place since the NHS Plan in 2000, despite the fact that these measures have already substantially restricted the ability to plan the type of modernisation and reform he is proposing. He does not show or seek any evidence to support his assumption (page 12) that "Commissioning is potentially a very powerful lever for driving change": nor does he explore any alternative methods to drive change and tackle inequalities in health.

The fact is that "commissioning" is the current term to describe the purchaser/provider split first introduced into the NHS under Margaret Thatcher's "internal market" reforms in the 1990s, which Tony Blair originally promised to sweep away, and which health secretaries since Alan Milburn in 2000 have in practice consolidated and strengthened into a "market" which is no longer "internal" to the NHS. Since 2003 private sector providers have been able to compete with each other for ringfenced contracts to deliver services to the NHS, while NHS Trusts have been excluded from bidding for the work.

"Commissioning" has also brought the complex and expensive system of "payment by results" which means that NHS Trusts are now only funded per case on a fixed tariff for the work they do: Professor Darzi does not seem to have taken on board the extent to which that system now restricts the scope to develop, for example, the two new Trauma Centres which he proposes should be established (page 63) or the new Specialist Hospitals he suggests, or the seven "hyper-acute" hospitals he believes should provide high-tech stroke care and other services for the capital.

Payment by Results means that hospital Trusts cannot afford – and Primary Care Trusts have no mechanism to pay for them – to run spare capacity in the form of empty beds, or gamble on the numbers of severely ill people who might need, for example, treatment in a Trauma Centre. London's sole existing Trauma Centre at the Royal London Hospital handles just under 1,000 cases a year: but most of London's other A&E units each handle only a minuscule number of severe cases: on the basis of these numbers it is most unlikely that local commissioners or the hospital Trusts themselves will feel under any pressure to divert resources to help establish one or more new Trauma centres.

This is just one of many ways in which despite Professor Darzi's acceptance in principle of the commissioning model, in practice most of his proposals require a very different approach – planning, and the allocation of resources on a rational and London-wide basis, not driven by

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arbitrary market forces, cash pressures and competition. Darzi sets out to show that his proposals are a means to remedy long-standing and dramatic inequalities in health: but markets, in which goods and services are effectively traded as cash values or commodities, and in which providers seek to deliver surpluses or profits, are recognised as a poor and ineffective way of delivering equity.

The new NHS financial framework undermines key elements of Darzi's proposals. His suggestion that 50% of existing minor work in A&E departments, for example, could be switched to the new Polyclinics, is discussed in general terms from a clinical point of view – and we may or may not be convinced that the new system would be better. But Darzi does not refer to or explore the financial consequences of this switch for the hospital Trusts themselves, which are severe because under Payment by Results every patient who switches to another provider takes the money with them.

On the figures presented in the Technical Document that accompanies the report, 50% of current levels of A&E attenders last year would equate to 1.7 million people per year, and on the current PBR tariff, switching them to polyclinics would amount to a loss of £136m from hospital budgets. However it must be remembered that the hospitals would not be able to make anything like a corresponding 50% reduction in A&E spending, because those who continued to require hospital A&E care would be the most severe and complex cases, requiring nursing, medical and other professional staff on hand.

In similar fashion, Darzi proposes that 41% of hospital outpatient appointments should be transferred to Polyclinics: this would slice another £330 million from hospital budgets, while a fresh approach to axing “unnecessary” outpatient visits could remove another 20% of existing caseload, and cut hospitals' income by another £160m.

In other words the combined package could switch a very large amount (in excess of £500m) out of the hospital Trust budgets, while many of the associated costs and responsibilities would remain in the hospital sector. Darzi does not discuss these issues, far less demonstrate the viability of the new profile of services he proposes.

Whether or not we accept that there is a clinical case for measures such as ceasing to commission the 20% of appointments Darzi argues to be ineffective, the financial consequences of these changes need to be factored in if a viable service is to be maintained.

Can changes on this scale be made without forcing the closure of hospitals and services which Professor Darzi would prefer to see remaining open and delivering major acute or local hospital services? Is there any mechanism to pump-prime the establishment of new hyper-acute hospitals and specialist units, or deliver the capital investment to launch a wave of polyclinics, in the current regime of Payment by Results?

The answer is no. Not without an intervention that overrides the new competitive market. We can already see with the downgrading and cutbacks discussed above that the hospitals which fall victim of the current fragmented system may be in precisely the geographical location that a rational plan requires services to be available – close to large sporting and other venues, or close to major transport links, etc. A competitive market does not run on the basis of health needs and social equity, it runs on the quest for surpluses and the elimination of services which cannot pay their way.

Ministers have to choose between further marketisation of the NHS or the type of planned framework of services proposed by Professor Darzi: they cannot have both.

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3. No section on older patients

One of the long-running problems facing NHS services in London has centred on the long-term care of frail older patients. The so-called “community care” reforms ushered in as a result of the 1988 Griffiths Report have left responsibility for long-term care in the hands of local government, not the NHS, while the provision of nursing homes and many residential home places has become the preserve of the private sector, along with a handful of not-for-profit and voluntary organisations.

Most of London (with a couple of notable exceptions) has always had well below the national average provision of care home places for frail older people, and this in turn has limited the options for social services departments seeking to carry through their responsibility to work with NHS Trusts and PCTs to facilitate swifter discharge of older patients from hospitals.

For many years social service budgets have also been under pressure, and one consequence of this has been a continual tightening of the system of “eligibility criteria” for social care, alongside a sharp increase in charges for services such as day hospitals and home care.

Perhaps this is one reason why Darzi argues in his report (page 90) for a far greater extension of outreach working by NHS staff from polyclinics:

“NHS staff will be going into people’s homes to keep people out of hospital.”

Darzi also tacitly accepts the gaps left by local boroughs when he suggests that:

“The need for increasing support from social care and the associated costs of this should be considered as part of NHS commissioning with NHS resources being used, where appropriate, to commission social care.” (page 90)

Darzi’s report also talks naively of NHS London working “with its partners”, including the London boroughs, the Greater London Authority and the Mayor’s office: but he does not address the resource constraints and the policies that some of these boroughs have faced and imposed, or the consequences for genuine partnership working.

Throughout England two thirds of councils have now restricted eligibility to social care to virtually exclude all but the bed-bound: and London’s boroughs have been among the meanest in raising charges and imposing ever more draconian eligibility criteria.

Brent and Lewisham have trebled charges for some services; Harrow has slapped a £20 charge on its day centres; London boroughs implementing tighter interpretations of the means test for charges include Harrow, Camden, Islington, Merton and Richmond. Wandsworth has slashed its subsidy on each hour of home care from £3.21 to just 1p, while tightening its eligibility criterion from “moderate” to “substantial”. Redbridge too has increased criteria from “substantial” to “upper substantial”. Yet DoH definitions stipulate that “substantial” means:

“abuse or neglect has occurred or will occur and/or there is, or will be, an inability to carry out the majority of personal care or domestic routines”. (*Public Finance* March 16 2007)

Lambeth has gone even further, and in a meeting in which guards needed to be called in to eject 80 angry protestors, this year pushed through cuts which restricted services to those with “critical” needs – withdrawing support from 750 frail older people, while more than

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doubling hourly charges for home care, increasing meals on wheels costs by 54% and slapping a massive £35 fee on previously free day centre services.

This collapse of social service support across much of the capital represents a major challenge to the NHS. And the absence of a proper infrastructure to support frail older people discharged from hospital is one part of the explanation both for London hospitals' lower rate of day surgery than elsewhere in the country, but also for longer average lengths of stay in hospital. Any attempt to revamp the system without addressing these key questions is likely to run into problems.

4. No section on transport, travel times and access

Transport around London, with its snail-paced traffic and congestion and its high-cost public transport running from the periphery in to the centre but with few links around outer London, has been a long-standing headache for NHS provision and planning.

Darzi refers to transport only in the vaguest and most idealistic terms¹. He points out for example that delivering treatment in more patients' homes will involve a more travelling for NHS staff:

“Providing more care at home will have transport implications for NHS and social care staff, who will need to be able to travel quickly and (where travelling by car) park easily.” (page 90)

Who could disagree: but how could this be achieved? The report offers no answers, and the actual policies of the “partner” organisations – tightly restricted, high cost parking, congestion charges, etc – are not even mentioned.

There is no more detail on how patients are supposed to access the new configuration of hospital and other services. We are told that if all 150 polyclinics are built and suitably distributed then most people should be living within 1 or 2 kilometres of a polyclinic (page 95). But of course hospital services are likely to be further away and specialist hospitals even more remote from many parts of London: this may prove to be little problem for those regarded as emergencies and transported by an enhanced London Ambulance Service, but for those travelling for elective appointments or seeking to visit relatives in hospital the problems could be considerable.

The issue of the location of the new services is one which will shape many people's reaction to Darzi's plans. Questions such as “how many local and major acute hospitals?” coupled with “where will they be?” will be among the first from almost anyone reading the report.

Since Professor Darzi has not given any indication of where he would suggest positioning the various local, major acute and specialist hospitals, it is difficult to have any more informed discussion of the transport implications: but it is clear that whenever more concrete proposals emerge the issue of accessibility, especially for those most vulnerable elderly and low income groups, will feature large in the public response.

¹ The only real exception is in discussion of midwifery services, where he admits that “midwives currently spend valuable clinical time travelling between GP practices, women's home and/or hospitals. Instead, most antenatal and some postnatal care should be provided in larger clinics in the community” (page 47). In other words a centralised system rather than the fragmented system Darzi is proposing for other services.

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5. Missing partners

It is conspicuous that among the varied organisations and institutions listed when Darzi turns to partnership working, the trade unions and professional organisations of NHS staff are not included.

Yet Professor Darzi's proposals would shake up the working patterns of tens of thousands of NHS staff – and completely reorganise primary care services. Some of those directly involved in delivering these services may be convinced that the new system is better and happily go along with it: but other groups of staff may need more persuading.

GPs in particular have much at stake in the short and medium term – but also have to be convinced of the plans if they are to be recruited to work in a completely new way in the planned polyclinics, which cannot run without them.

A serious discussion with the BMA and with local medical committees might be seen as one way to work towards a common view, but it rather appears that the Darzi approach is to impose the new plan from top down. It appears that the intervention of a high-profile specialist hospital doctor seeking in this way to force GPs into line has already angered some of the more conservative elements.

Similarly, 125,000 staff in London's hospitals face an uncertain future: large numbers of them face the prospect of being transferred to very different patterns of work in polyclinics or in the community: it is not at all clear whether or not those working in polyclinics would be directly employed by the Primary Care Trusts, or some other form of NHS management structure. PCTs have been urged by government to divest themselves of direct responsibility for providing services..

Darzi raises a general suggestion of improved training, but again there are no specifics, and there will be fears that the new configuration of services will require fewer staff and offer less attractive terms and conditions than the trade unions have so far achieved. Primary care staff are historically among the least-well organised in trade unions, and there is a real issue in ensuring that all sections of staff in the polyclinics are properly represented and able to negotiate satisfactory terms and conditions.

“Community Care” services are also forecast to handle a vast and expanding caseload, raising serious questions over staffing levels and the efficient organisation and management of services, which will become ever more demanding as more care is designated to be delivered at an individual level to patients in their homes.

More midwives are urgently needed to enable local services to offer women the choice of home births, midwife-led units or hospital obstetric department: but there are already shortages of midwifery staff in the existing framework. Again discussions and cooperation with the relevant staff unions seems essential if solutions are to be found.

Another area of concern is in the costings and estimates for the new Polyclinics. While medical, nursing and clinical professional staff are itemised, and their salaries calculated, the non-clinical staff – admin and clerical support staff including the practice managers, receptionists, secretaries, IT support and also the cleaning staff – are lumped vaguely under “administrative overhead” along with the rent. But the very high volumes of activity projected to take place in Polyclinics will place a heavy burden on administration if the end result is not to be long and chaotic queues and frustrated patients and clinical staff.

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One might expect the trade unions representing these groups of staff to be invited to play a constructive role in any genuine debate. Union concerns will centre not simply on jobs and pay, but also professional issues and the anticipated caseload and resulting work pressures on staff in the new system.

But we also might expect to see some discussion of how other organisations representing local communities and sections of the London population, such as pensioners groups might be made part of the discussion and be offered a basis to raise their concerns, doubts and questions.

This in turn raises the wider issue of the total absence of any democratic mechanism of accountability for London's NHS. London's population of 7.6 million is almost that of Wales and Scotland combined: yet while Scotland's NHS is run through a fully-fledged Parliament, and Wales has been able to use its National Assembly to force through progressive changes (free prescriptions) and exclude unwanted market-style "reforms" (foundation Trusts, payment by results) London's Assembly has no voice over health policy at all.

The new London Strategic Health Authority, NHS London, with a budget of £10.1 billion, is an appointed quango with no system of accountability to Londoners at all. Any long-term plans to develop a responsive and accountable health care system for the capital should also address the issue of democracy: what mandate has NHS London to force through the Darzi report or any other changes? What opportunity do Londoners have to elect those who shape their health services and remove those who take decisions that lack popular support?

London Health Emergency has suggested that the report could be put to a referendum timed to coincide with next year's GLA and mayoral elections: that is only one possibility, but the issue of democratic accountability will not go away until some mechanism is introduced.

What will happen to London's hospitals?

Professor Darzi is a specialist hospital doctor, and the message that has come most clearly from his report is the argument that the days of London's District General Hospitals are numbered, while the days of specialist hospitals are here.

Some DGHs should be scaled up to "major acute" hospitals, possibly becoming one of seven (why seven?) "hyper-acute hospitals" and an elite handful might be linked up with Universities in Academic Health Science Centres. However the DGHs which are not chosen to fit these categories would be effectively downgraded to "local hospitals" with restricted range of services, and an "urgent care centre" in place of an A&E unit.

In addition, Darzi talks of developing more "elective centres", citing the model of the NHS-run SW London Elective Orthopaedic Centre (SWLEOC). The recent collapse of plans for a private sector treatment centre based at Queen Mary's Hospital, Sidcup, leaves open the space for a greater expansion of NHS-run elective units, but leaves open the issue of core funding and the problem of an increasingly competitive "market" in which Trusts such as Kingston Hospital are seeking to expand their share at the expense of other London Trusts.

The report, as we have repeatedly underlined, is seriously lacking on detail to fill out its very general suggestions. Darzi does not identify any hospitals for development as specialist centres: nor does he finger those that he believes should be downgraded to "local hospitals",

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although we have already pointed out several hospitals already facing the prospect of downgrading from DGH and the loss of A&E services.

One limiting factor implementing this aspect of the Darzi report is the generally high level of caseload handled by most of London's 32 A&E units, both in terms of attendances and in terms of emergency admissions. Cutbacks and closures in the past have now meant that the closure of any substantial A&E unit would inevitably transfer a very large volume of more serious cases requiring immediate admission to surrounding hospitals, and this could not be done without substantial investment in additional beds and facilities at the receiving hospital. Darzi's Technical Paper does not discuss either capital or revenue funding for additional services along these lines.

With no details on the number, capacity or geographical location of any of the hospitals he is proposing, it is also difficult to link Darzi's proposals on hospital care with his professed wish to remedy health inequalities and make services more accessible for ethnic minorities and the poor.

And while the report itself dodges the hard questions on hospital care, the general suggestions are being cynically milked by local NHS managers as the basis to argue for downgrading services to save money.

London Health Emergency remains unconvinced that it will be possible to deliver comprehensive and accessible health care to a growing and ageing London population with less than the existing provision of hospital services. The possible downgrading of Queen Mary's in Sidcup, for example would leave the whole borough of Bexley with no acute hospital: it might solve the cash problems of the local health economy but only at the expense of prejudicing the health services of large numbers of Londoners.

We will continue to press for a more detailed and concrete discussion: and we will continue to oppose cash-driven cuts that reduce access to care without any compensating improvements for local people.

Polyclinics: the case examined

One new concept stands out from the report: the suggestion of a network of 150 "polyclinics" to serve the capital's 7.5 million population: on closer examination a polyclinic appears to be a combination of a super-sized health centre, a minor injuries unit, a small-scale outpatients department and a base for community health services.

Whatever campaigners and the wider public may think of this idea, it does not appear to have gone down too well with some of those most centrally involved – the GPs. The method of operation – drawing up a large and complex report without any prior detailed discussion with the key groups of professionals necessary to ensure it can work – has not impressed stubbornly independent GPs who have always resisted moves that might incorporate them as employees into the mainstream NHS.

According to the GP magazine *Pulse* (July 13) the proposal amounts to "herding GPs into polyclinics":

"The Healthcare for London report, written by Professor Sir Ara Darzi, the newly appointed health minister, proposes merging hundreds of GP practices in the capital into a network of so-called 'polyclinics'. SHAs elsewhere in the country are now

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closely studying the controversial new model, which could lead to the relocation of thousands more GPs.

“The new sites would offer extended opening hours and provide up to 50% of outpatient treatment currently carried out in hospitals.

“The BMA warned that polyclinics would 'destabilise and fragment' existing GP and hospital services, and GPC acting chair Dr Laurence Buckman said they were reminiscent of something from communist Soviet Union. 'This review does not bode well.'

“Dr Tony Stanton, joint chief executive of London-wide LMCs, said it would 'destroy the very bedrock of British general practice' if most surgeries were relocated to polyclinics.

“Dr Michael Dixon, chair of the NHS Alliance, also attacked the proposals, adding: 'I don't think it's what patients or GPs want. We need an increased focus on continuity and personal care.'”

One factor driving the hostile response from GPs could be the studied vagueness over how the proposal would be implemented: it is not clear from Darzi's report whether the Polyclinics would be run by PCTs, or free-standing units of the NHS, each run with an overall management employing a staff, including dozens of salaried GPs, or whether the Polyclinics would effectively operate as gigantic health centres, drawing together a large number of local GP practices under a common roof, with shared support services.

The first two of these options would effectively spell the end of the treasured “independent contractor” status granted to GPs as a concession by Aneurin Bevan as he attempted to win them to support the new National Health Service in 1948, and jealously guarded by them ever since. The second option would be a less traumatic change for GPs but would offer different problems in organisation and management.

Polyclinics versus A&E?

Much of the Darzi plan amounts to yet another attempt (after many others have failed) to switch patient care away from hospitals (and especially from A&E) to a variety of alternative venues. In the mid 1990s the fashion was for “Minor Injury Units” – often as a transitional step towards closing a full-scale A&E, and frequently coupled with proposals for more out of hours services to be provided by GPs: Darzi's version is “urgent care centres” attached to polyclinics as well as hospitals. However, as with so many of his proposals, we are not told how many such units are required or where they would be: nor would all of them be open 24 hours.

Minor Injury Units showed themselves to be less than popular with many patients and relatively expensive to run, delivering questionable value for money: the most successful were those that effectively operated as a “triage” unit alongside a functioning A&E. Many of the MIUs located outside of main hospitals had their opening hours swiftly scaled down, while attendances at the remaining A&E units remained stubbornly high and have continued to rise year on year most years since 1992.

Nor are by any means all A&E attenders “inappropriate”: Darzi's own figures in the technical paper (page 15) shows that of 3.5 million A&E attendances in London's hospitals in 2005-6, 1.44 million (over 40%) were “major” episodes, classified as “emergency admissions, trauma”. If another 581,000 fractures are added to this total of appropriate attenders, this means almost 60% of the total had good reason to come to a hospital for treatment rather than a minor injury unit.

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This would seem to undermine Darzi's prediction that as many as 50% of A&E attenders could be diverted to polyclinics. And to achieve anything like such a switch would require a substantial culture shift among the wider public – and that is unlikely to take place unless public confidence can be won.

Unfortunately the severe lack of detail in much of the remainder of the Darzi report does little to convince a sceptical and increasingly cynical public that the plans amount to more than a new rationale for closing their local hospitals.

What services would be included?

Darzi's report appears to propose that each polyclinic should offer supporting services including:

- Minor procedures
- Urgent care
- Diagnostics (pathology and radiology)

However the report and the "Technical Paper" offer very few hard facts to show that the cost and space implications of this have been taken on board. Indeed the costings in the Technical paper focus only on the running costs and supplies, and ignore the capital investment required for each polyclinic and the recruitment of staff – who do not appear to be included either under the clinical establishment or under "administrative overheads".

- To carry out any surgical "minor procedures" requires the designation and investment in a suitable and sterile theatre area, availability of sterile supplies, and raises the question of anaesthetist support.
- It is not at all clear whether the pathology is to be a small self-contained unit on site – which raises questions over facilities and equipment and the availability of sufficient qualified staff – or a phlebotomy and sample-collecting system that will pass on tests to a larger unit at the local hospital. In this case logistics and turn-around times need to be addressed.
- The suggestion of X-ray and other imaging also raises the issue of the availability of sufficient qualified radiographers, the cost of supplying and installing expensive equipment to 150 new units, and the need for a lead-lined room to house any X-ray equipment, along with appropriate electrical supply and fittings. Again the question arises of whether this is a cost-effective and efficient way to use costly equipment and scarce staff, and whether it facilitates the development of specialist skills. An X-ray department servicing an urgent care centre, minor primary care referrals and outpatient clinics is likely to be complicated to administer, requiring its own clerical support, IT and filing arrangements.
- However X-ray services would have to be available if the provision of "Urgent care" is to include the setting of minor fractures. This would also require the availability at all times of a qualified plaster room technician, with suitable space, supplies and facilities.
- There are also doubts over the cost implications and space required for other therapeutic services. Darzi does not itemise physiotherapy, for example, under the activities at each polyclinic. If physiotherapy is to be provided it will require qualified

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staff, clerical support, as well as designated space and equipment. Occupational therapy and speech therapy would also logically be based in polyclinics, and would also require suitable accommodation, space to deliver treatment, and appropriate equipment. The proposed expansion of “talking therapies” and other forms of primary care treatment of mental health problems also have an implication in terms of space, staff and administrative support.

All of these have implications for the financial and clinical viability of the polyclinic, and appear to be costs and spec requirements over and above the “detailed” list drawn up by Darzi’s Technical Paper. The questions need to be asked and answered before it is clear that the proposals represent a viable option for London’s NHS.

Size and cost of polyclinics

According to the “technical paper” that accompanies the main document, each polyclinic would employ an average of around 90 medical and nursing staff, including 35 GPs and 3-4 consultants, be located in rented accommodation, and run on a budget of around £21m a year – a total investment of £3.1 billion annually when all are open.

The scale of the new polyclinics and their substantial projected caseload for primary care services would mean that they would need to enlist a total of over 5,200 GPs to full-time work – slightly more than the current complement of GPs in London.

However the culture of work in polyclinics would be vastly different from most current general practice: Darzi specifies a polyclinic would need a minimum of 43 consulting rooms, while at present almost 500 London GPs are currently working in single-handed practices, and fewer than 300 London GPs are part of large practices with 10 or more doctors.

While there are always a few exceptions to the rule, and one or two GPs have been involved in drawing up the Darzi plan, there is no sign so far that GPs in general will respond positively to proposals which would in many cases lead to a reduced status, a requirement to work in a big team, and a loss of identity and control over standards for smaller but committed practices which have worked for many years to develop and improve their services.

There must also be questions over the quality of the care that a polyclinic could deliver. The projected caseload of each polyclinic is enormous even at the primary care level – with an estimated 226,000 consultations averaging a staggering 620 per day, every day throughout the year. Even with no gaps between patients, and working on Darzi’s estimate of 15 minutes consultation time, this stacks up to 93 hours of GP time and 57 hours of Allied Health Professional time EACH DAY – requiring 13 GPs and 7.5 AHPs to be available even if they did nothing else but process patients. And all of these figures assume that a third of primary care would remain in GP practices outside of the polyclinic itself, and would need to be funded and resourced.

However polyclinics would handle even more than this: an average polyclinic is also expected to deal with 25,000 outpatient appointments a year (480 every week of the year), plus 21,000 “A&E” (“urgent care centre”) cases (57 every day of the year), and 41,000 Community Care episodes – almost 800 per week, over and above home visits.

Activity on this scale, managing and arranging payroll, training and other support for 100 or more staff, and ensuring reliable and punctual operation of a wide range of treatments, consultations and tests, represents a major management challenge.

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Inadequate investment in top-quality management and experienced and qualified secretarial and clerical staff would be a short-sighted economy that would rapidly threaten chaos. It seems obvious from the figures that Professor Darzi has seriously underestimated the numbers of non-clinical staff that would be needed to ensure that the new polyclinics work as they should: his projected total “administrative overhead” is just £1.26m per polyclinic: but it seems that at least £900,000 of this would be rent, leaving just £326,000 for IT services, admin and clerical staff and management to run a £20m a year operation. That would equate to just 13 clerical staff on £25,000 a year – nowhere near the level of managerial and support staff that will be needed.

The projected salary costs again show a worrying lack of detail in the Darzi proposals. While the cost of employing a full time GP and consultant to a polyclinic is put at £125,000, the projected annual cost of staff nurse/AHP is put at a massive £50,000: while this would resolve any conceivable recruitment problems for the polyclinics, which would find themselves besieged by eager hospital staff keen for a salary rise, it could seriously undermine staffing levels in the hospitals and rides roughshod through the carefully-negotiated Agenda for Change pay structure. By contrast no pay scales or grades are discussed for other clinical and non-clinical support staff.

It seems that the full cost of the plans has been underestimated. But there is another questionable assumption: Darzi’s financial projections exclude any capital costs for building and equipping new polyclinics: instead his figures for “administrative overhead” include an assumed annual lease payment – but this in turn hinges on the availability of 150 sufficient suitable premises for indefinite rent.

However the sheer scale and complexity of the buildings required (43 consulting rooms, space for at least 100 to wait, another 1000 square metres for office and other admin space, circulation space, etc, plus the fact that any integrated X-ray facility, for example, would need to be housed in a lead-lined room) must raise genuine doubts over the possibility of securing anything like the number of ready-made premises that Darzi proposes.

Many of the buildings that might be converted to polyclinic use will require extensive capital investment in refurbishment, partitioning and upgrading, plus equipment costs. These figures seem to have been conveniently omitted from the calculations.

What services should switch from hospitals, and why?

While there may be some synergy to be generated by organising and basing community care services alongside primary care in this way, big questions need to be asked about the sense in switching a range of outpatient clinics from their established and relatively well-resourced base in hospitals, to 150 different polyclinics serving much smaller numbers of patients.

This will consume time of consultants and other medical staff in travelling, and Darzi points out the need for “careful management to ensure they are seeing sufficient volumes of patients” (report page 67:162). Is it economically viable, or a wise use of valuable human resources to fragment services in this way?

And while the daunting workload of primary care and community care services questions the quality of services that the polyclinics would be able to deliver, the extremely small and fragmented caseload for some other services also raise serious doubts over quality.

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The average polyclinic is projected (technical report page 25) to carry out just 336 “minor elective surgical procedures” a year: – that’s just 6.5 per week, and especially if the work is shared out it is nowhere near enough to enable medical staff to develop specialist skills. Worse, the average polyclinic is expected to carry out just 19 “emergency surgery procedures” a year.

Projections for emergency medicine also make it clear that only a handful of patients each week would be receiving treatment at polyclinics, raising the question of whether it would not be safer and better all round to leave these procedures in hospitals where more experienced and specialist staff are on hand, seeing many more cases day by day.

Ironically the Darzi report itself repeatedly stresses the problems of staff seeing too few patients to develop skills:

“There is evidence that specialist units performing larger numbers of cases achieve better results, particularly in more complex work” (page 22:42)

“Hospitals in London are not able to take advantage of the latest advances in medical care, as specialist staff and facilities are spread across too many sites.” (page 24:44)

“A recent meta-analysis in the British Journal of Surgery has found that there is a positive relationship between volumes of specialist surgery and three key outcome indicators (mortality rates, reduced lengths of stay and complication rates)” (Page 70:178)

Indeed Darzi goes on to insist controversially that “The days of the district general hospital seeking to provide all services to a high enough standard are over” (page 71): so why should general physicians in polyclinics now be expected to deliver adequate standards of treatments which until now have always been provided by specialist surgical staff in hospital?

Darzi also proposes but does not give detailed proposals for the provision of diagnostic services at polyclinics – involving both imaging and pathology: however the increased costs involved, both in terms of the provision of sophisticated equipment to another 150 sites across the capital, and the availability of sufficient qualified radiographers and other professional staff to use it safely and reliably, are likely to be enormous.

Existing hospitals in London already face problems in recruiting and retaining radiographers and radiologists as well as laboratory staff – there is a danger that a big expansion of technical facilities would stretch the existing workforce even thinner, resulting in gaps in services.

Why not a pilot?

The logical answer to many of these questions would be to press for a full-scale pilot project launching a polyclinic on the Darzi model in one of the areas of greatest health need in the capital. Issues of accommodation, recruitment and staff costs, organisation and management could all be tested out and a realistic estimate made of the costs of rolling out the full scheme. A pilot project would also give an opportunity to take on and answer the doubts and concerns of GPs and others over the viability of the scheme and create the best basis to convince more GPs to accept the new way of working.

Unfortunately the Darzi scheme jumps from zero into proposing ten polyclinics – and this may prove too much for the BMA and other critics to accept.

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A prevailing air of unreality

The Darzi Report contains some very interesting ideas: but it never escapes an overwhelming air of unreality, summed up in a number of passages.

Preventative care (p72-73)

Nobody can object to efforts to prevent unnecessary hospital admission: but health promotion campaigns have shown time and again that they require a long-term and consistent input, and that achieving long-term change is difficult or impossible where the patient concerned has not accepted the need for change.

So it is quite unrealistic to expect rapid and measurable results from the well-intentioned proposals set out in the Darzi Report, which states that:

“Community healthcare staff (...) should work with public health colleagues to seek out people at high risk of smoking and obesity (e.g. through deprivation indices). They should then provide tailored advice and support to help people to improve their diet, take more exercise and stop smoking. This is likely to require effort to reach out, recall and follow people up who may be reluctant to access services or keep up with the programmes.” (page 72)

Nobody would oppose a campaign to reduce smoking or obesity: but Professor Darzi offers us no evidence that such tactics have been successful in changing the long-standing, often socially-rooted behaviour of people unwilling to change or engage with services. This seems to be a sure-fire formula for failure and demoralisation, which may perhaps be garnished with some self-deception in the form of carefully juggled statistics and “targets” to conceal the actual situation.

Prof Darzi gives no idea of how many staff at what level should be allocated to this work, or how it would be funded and managed. Since the moral exhortations of NHS professionals would be competing with the day to day social conditions which helped generate and maintain unhealthy lifestyles and with the reluctance of the service “users” to get involved, it is hard to know what an appropriate number of staff might be.

Travel problems wished away

Darzi’s report, as we have discussed, omits a number of thorny problems to be confronted if health care is to be modernised and improved in the capital. One of the most stubborn of these problems is the issue of transport.

On page 90, discussing the delivery of services to individual patients at home, the report wishes the whole problem out of existence, offering no actual solution but simply alluding to a world in which travel would be swift and simple:

“NHS and social care staff ... will need to be able to travel quickly and (where travelling by car) park easily.”

Of course neither of these ideal aspirations is currently the case – but nor are the wasted hours or the cost implications of increasing numbers of home visits discussed in the Report or the Technical Paper. Community care appointments are assumed to flow seamlessly from

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one to the other, without any mention of the grinding, stop-start journeys and the frustrating hunt for parking spaces and concerns over security for themselves, their vehicles and any drugs and supplies they may be carrying, that will punctuate the day of any community-based staff doing home visits.

Perhaps this is one area where the “partner organisations”, the Mayor’s Office, the GLA and/or the local boroughs, might be called upon to help out – with a Greater London Health Carers’ Parking Pass, perhaps, or some other means to exempt staff from punitive fines, congestion and parking charges?

Partnerships (p 117)

The section on partnerships, as we have noted above, sadly omits the health unions and professional bodies from the list, but instead identifies partners such as the Mayor’s Office, the GLA and the local boroughs.

This is an easy “partnership” for them, since few, if any demands are directed towards them, and the Report does not even mention the dismal situation of social care in the capital and the progressive exclusion of larger numbers of older people from the limited services that continue.

Other “partners” on Professor Darzi’s list include the voluntary sector (itself also a victim in many areas of the cuts in social care spending inflicted by London boroughs) and the private sector, although we should be pleased that there is little in the way of specific proposals for private provision or privatisation.

It is also notable that the government’s latest attempt to replace the Community Health Councils it abolished a few years ago, the so-called Local Involvement Networks (LINks), are omitted from Professor Darzi’s chosen list of partners. Patients and the wider public are not to be directly involved in this process – other than through the inadequate proxy of their local boroughs.

This is a less than proactive way of building a body of support for plans which will need popular backing if they are to persuade a conservative and unconvinced cohort of GPs to follow new policies.

Misleading examples

The air of unreality continues in a couple of the examples brought forward by Darzi to support his case for change..

One example is the reference to the growing numbers of specialist hospitals in the USA (page 71:186, page 103:52). The problem with this is that the switch to specialist hospitals in the US flows from the drive for profit among the largely private providers in the costly and bureaucratic US health care system.

While general hospitals have a legal obligation to deliver emergency services to those in need, and carry an on-cost of delivering care to uninsured patients who come in through their ERs, specialist hospitals have no ERs, avoid any emergency work, pick the most lucrative specialty services, and are often located well away from the poorest areas.

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Analysing the rapid expansion of specialist hospitals and raising the question of whether they are simply “cream-skimming” the most profitable cases, leaving many of the problems for other general hospitals to pick up, Kelley Devers and colleagues in 2003 pointed out that:

“In addition to quality and cost concerns, consumers' access to other basic services may decrease if the same volume is spread across more hospitals.

“By drawing the most profitable services and patients away from general hospitals, specialty hospitals could undermine general hospitals' ability to cross-subsidize services that are not profitable.

“For example, general hospitals may curtail emergency services, close burn or psychiatric units or provide less community outreach and fewer prevention services.”²

Just because it is seen as profitable in the competitive and hard-nosed US system to switch to specialist hospitals does not mean that it necessarily makes sense for the NHS in London.

Professor Darzi also cites the example of the Polikum polyclinic in Berlin which handles a caseload similar to that of the polyclinics proposed in London. Darzi refers to the fact that it provides “over 250,000 outpatient contacts a year”. Interestingly he also mentions that it employs 45 doctors – rather more than he is proposing for the London polyclinics. Sadly he does not give us the running costs of the polyclinic, which may offer some guide as to likely costs here.

However what Professor Darzi does not mention is that in Germany there is a historic legal separation between outpatient services (traditionally delivered by consultants in their treatment rooms) and hospital services: hospitals have never been allowed to provide outpatient treatment. So the break in delivery is nowhere near so dramatic in Germany as it would be for British hospitals to lose the payment by results funding for up to 60% of their outpatient caseload.

Nor does Professor Darzi point out that Germany spends a far higher share of its national wealth (GDP) on health than the UK: in fact Germany's social health insurance system is second only to the USA in its health costs, spending almost 11% of GDP, and delivering a system which as a result has no waiting lists and a surplus of hospital beds.

We may have much to learn from other countries in the way we deliver health care, but on some issues the key issue is a simple one of resources and political commitment to develop and improve services.

Dodgy figures and projections

While there are many missing details, and costs appear to have been understated, there are also some very dubious statistics at the centre of the Darzi plans, which raise further questions over their viability.

1. There appear to be no reliable data on the numbers of community care consultations currently taking place in London. The estimated figures offered by Darzi in the Technical Paper (page 4) vary by a factor of four – between 2,088,000 and 8,147,000. This is an astonishingly wide spread, but instead of seeking a reliable number, or opting to use an

2 Devers K, Brewster L, Ginsburg PB (2003) Specialty Hospitals: Focused Factories or Cream Skimmers? Issue Brief No. 62 April, Centre for Studying Health Systems Change, Washington, <http://www.hschange.org/CONTENT/552/?words=specialist+hospital>

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average of the two, Darzi has consistently used the higher figure as the basis for all his calculations: and from this high point he then projects a further 52% increase over the next ten years – to more than 12 million a year.

There is a real possibility that all of these numbers are much too high, and that capacity will needlessly be allocated.

2. There is a similar assumption that use of primary care will increase exponentially over the next ten years – expanding by 75% to more than 48 million consultations a year. This is linked with the assumed transfer of a growing volume of work from hospitals to primary care, but it does also assume a relatively rapid and complete culture-shift by London's population to accept the new system – while in practice not even the GPs who are supposed to deliver the service have yet been convinced.

3. Conversely, a very substantial 8% growth in London's population is projected to require not more, but 6% fewer hospital beds – despite increasing numbers of older residents who on current systems require additional hospital care. Darzi does not define where these bedreductions should be: but the figures on projected population growth (page 30) show 17 boroughs in which population is projected to rise by more than 10%.

It would seem to be logical to ensure that hospital services and bed numbers are at least maintained in these areas, if not expanded: and in general hospital services should also be maintained intact until the expected impact of the new system begins to show a measureable effect in under-used beds and services.

4. London's hospitals had a current caseload of 3.5 million A&E attendances (2005-6), of which 1.44 million (over 40%) were "major" episodes, classified as "emergency admissions, trauma", with another 581,000 fractures accounting for almost 60% of the total. However Darzi still assumes that 50% of a much higher A&E caseload (increased by a massive – and maybe questionable – 67% to 6.4 million attenders per year by 2016) can be switched to polyclinics and "urgent treatment centres". Given current statistics and past experience in seeking to divert A&E attendances, this projection remains open to doubt.

5. The conspicuous silence over the financial impact of the Darzi proposals on London's hospitals leaves open the question of how many hospitals will remain open either as major acute, local or specialist hospitals, and how many will be forced to close. Not discussing the financial implications does not prevent them having an impact on health services. Making no proposals on where services should be does not ensure that existing services are safe or that future services will be geared and located appropriately to the health needs of those with greatest health problems.

CONCLUSION

This extended analysis of the Darzi report has been developed as a basis to widen and deepen the discussion on serious proposals which may well be rolled out beyond London as the Professor, now a health minister, works on a similar review of the NHS in England.

We think it is important that the potential problems implicit in the proposals are discussed openly and resolved before potentially costly and embarrassing mistakes are made: we also know that it will not be possible to persuade a sceptical London public to accept a scheme unless it can be shown to be viable and carrying informed support.

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London Health Emergency has long experience on these questions. We have campaigned for the past 24 years alongside all kinds of organisations – local councils, Community Health Councils, trade unions, community campaigns and organisations, local councillors and MPs to defend and improve health services in the capital and resist privatisation and costly, bureaucratic market-style policies.

We have consistently campaigned for a service adequately funded, accessible and equitably provided, targeting health needs and tackling the sharp inequalities in health: we have researched for and campaigned with trade unions for improvements in mental health and to expose gaps in care for older people and the consequences of the so-called “community care” reforms in effectively privatising long-term care in London and beyond.

We were still engaged in this campaigning effort when Professor Darzi put forward his report which outlines some interesting future proposals for reshaping the future. We were immediately concerned that the Report fails to locate the proposals in today’s situation, and offers no credible route map for implementation. His report does not outline any specific call for either cutbacks and closures or for privatisation, but in the current context many will conclude that these are the “hidden agenda” behind the talk of tackling inequalities in health, improving mental health services and developing partnerships with local government, and promising to cut spending by £1.5 billion over 10 years.

The report has been published at a time that as many as nine local hospitals in the capital face a threat of downgrading or closure of services including A&E, and when cash pressures are shaping policies and decisions at PCT and Trust Board level. In discussing the provision of primary care, community care and hospital services only in the most general terms, with no specifics on numbers or location of services, Darzi has added a new dimension but not resolved the doubts and fears of many local people and NHS staff.

If there is to be a serious debate on Darzi’s proposals the threat of “stealth cuts” taking place before the discussion is complete needs to be lifted. That’s why LHE has written to NHS London to urge it to intervene and enforced a moratorium on further cutbacks and closures at least until the end of the year.

We in turn have been approached by NHS London and have agreed to enter into discussions to clarify the SHA’s intentions and we will take the opportunity to feed back our concerns over potential problems with the Darzi report.

We believe there may be some merit in the proposal for Polyclinics as centres delivering enhanced primary care and community services, although any large-scale reorganisation of primary care has to get over the obvious hurdle of convincing and winning the engagement and support of the capital’s GPs.

However we are not convinced of the wisdom or cost-effectiveness of switching large volumes of hospital outpatient and A&E services to 150 relatively small units, at the expense of destabilising popular local hospitals.

We strongly suggest that if the SHE wishes to proceed further with the Darzi proposals the immediate focus should therefore be on establishing a single fully-functioning pilot polyclinic in one of the more deprived areas of inner London. This would offer a means to demonstrate the effectiveness and actual costs of this model of care, its impact on neighbouring hospitals and other services, its running costs and start-up costs, and the availability of suitable premises for rent in the capital.

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We further suggest that any more detailed discussion over specialist hospitals, major acute hospitals and local hospitals can only usefully take place around much more specific proposals on how many of each are proposed, their capacity, their location, the financial resources required, and the logistical implications for local patients.

We have spelled out many other concerns in this response: above all, we are concerned that Londoners should enjoy ready access to modern, well-staffed and properly-resourced hospital services: and that any new system designed to divert patients to alternative types of care is tested and developed to demonstrate its effectiveness before any plans are implemented to run down and close existing NHS services.

That's our bottom line. LHE is not opposed to modern methods or to change: but we are opposed to cash-driven change dressed up as clinical need, and to "reconfiguration" as a pretext for reduced local access to care. Until and unless we are convinced that a new system will improve services and raise the quality of patient care, we will continue to work with local campaigners and trade union activists to defend the existing services which are well-established and delivering high volumes of treatment.

Professor Darzi may have identified some better ways forward. If he and NHS London can answer some of these questions convincingly we may yet be persuaded that this is the case: and if the promised moratorium is imposed, we will see evidence that the discussion is taking place in good faith.

Dr John Lister
London Health Emergency, August 8 2007