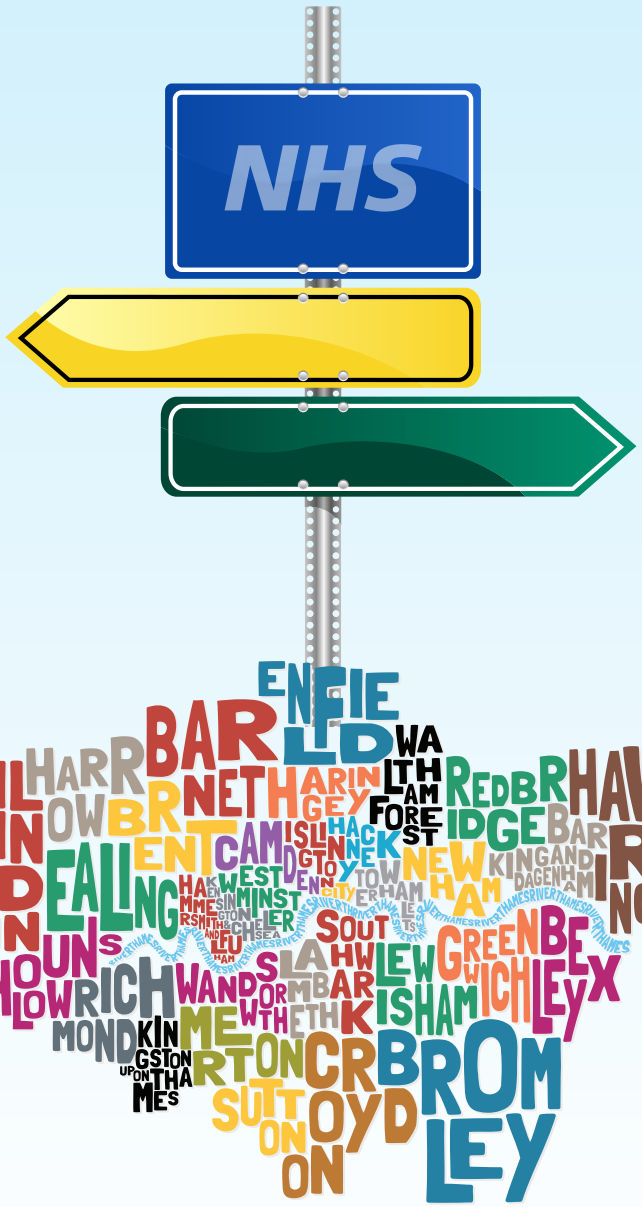
People's Inquiry into London's NHS

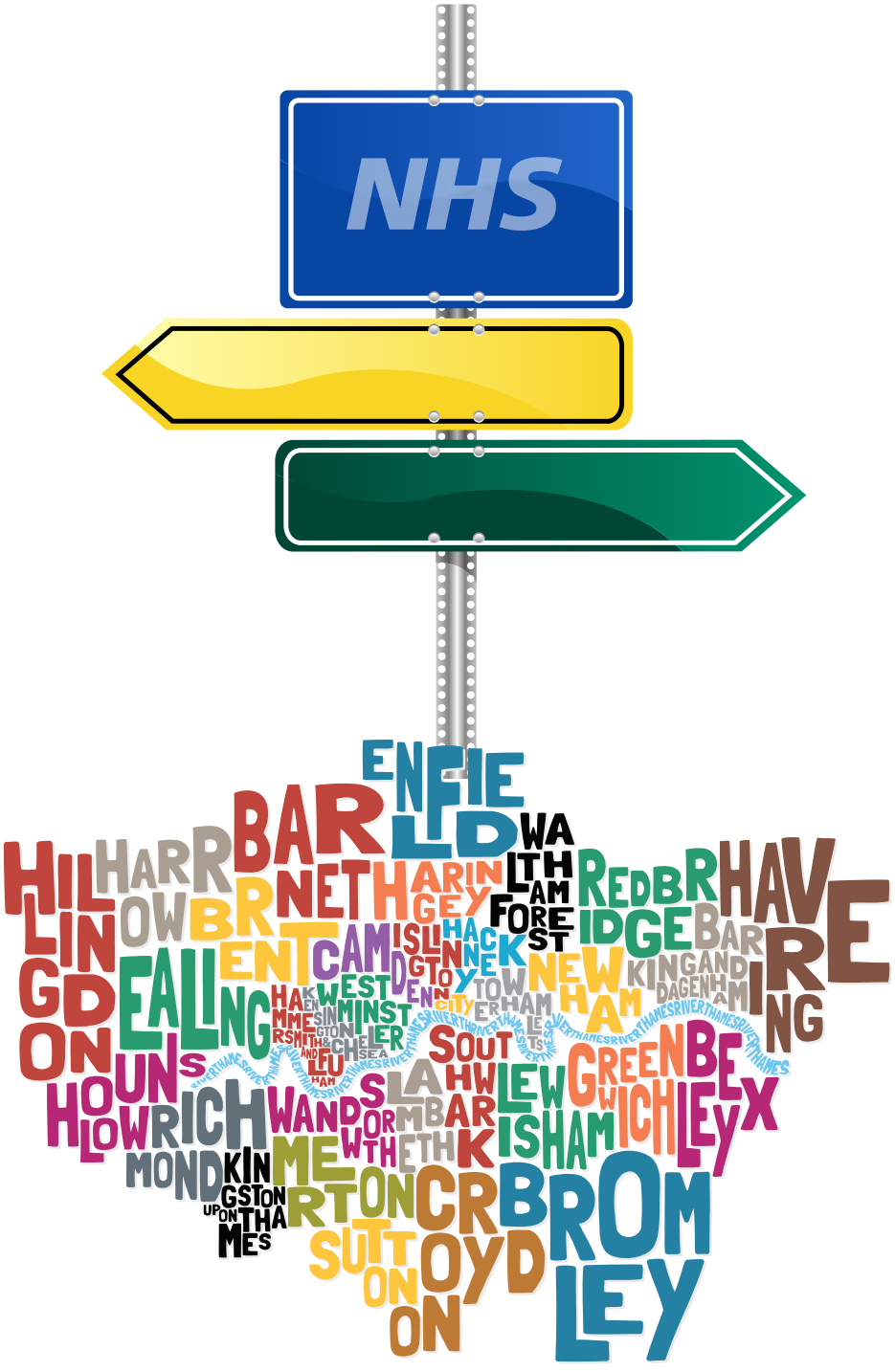
Supported by Unite the union, London and Eastern region

London's NHS at the Crossroads



The People's Inquiry

NHS LONDON


NHS

Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Peter Kavanagh
Unite Regional Secretary
London and Eastern region

Foreword

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

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

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

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

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

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

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

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

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

Roy Lilley
Chair, People's Inquiry into London's NHS

Executive Summary

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

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

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

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

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

The Inquiry

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

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

The Report

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

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

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

London's NHS

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

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

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

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

Finances

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

Services: primary care

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

Hospitals and secondary care

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

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

Private sector

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

Community health services

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

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

Social care

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

Plans for London's NHS since 2007

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

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

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

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

PFI

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

Since April 2013

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

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

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

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

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

Financial snapshot

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

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

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

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

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

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

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

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

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

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

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

Recommendation 2: Reinstate strategic overview

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

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

Recommendation 3: Transparency and accountability

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

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

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

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

Recommendation 4: Integration of care in and outside hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation 16: Policies to avert PFI-driven financial failures

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

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

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

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

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

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

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

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