People's Inquiry into London's NHS

SECOND REPORT

Supported by Unite the union, London and Eastern region

London's NHS Into the Unknown

The People's Inquiry

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Foreword

The London and Eastern region of Unite is once again extremely proud to sponsor this second report by the People's Inquiry into London's NHS.

We realised 18 months ago that if we were to fully understand what the Tory-led coalition government has been doing to our health service, it was essential to piece together a picture of what was happening London-wide. That's why we first established the Inquiry.

Since this time, its findings have been vindicated. In particular the report's call for a new body with strategic overview of London's fragmented health services was echoed by Lord Darzi's London Health Commission.

But any Inquiry can only offer a snapshot of the situation at the time. Things are moving fast. Now, with a crucial general election imminent, we need an up-to-date picture of events to inform our members, election candidates supported by Unite, campaigners and all those interested in making the NHS a major electoral issue in the capital – and ensuring that whichever government takes the reins after May 7, that it comes under immediate pressure to start putting things right.

Since the first report was published we have seen a deepening divide between London's 32 Clinical Commissioning Groups (CCGs)– which hold the budgets for healthcare – and the hospitals, mental health and community health service trusts which deliver frontline services.

This report shows that while almost all CCGs are running surpluses, almost all of the hospital trusts, which have no voice on health spending, face rapidly growing deficits. It addresses the implications of Acident and Emergency (A&E) closures, the growing gaps in social care and the failure to develop long-promised services in the community and "closer to home". It also explores the growing pressures on GPs, which threaten the future of primary care services.

While almost every politician and NHS manager talks about "integrating health and social care", we can see that the Health and Social Care Act 2012 has further fragmented London's health services, sets organisations in conflict and competition with each other, leaving patients caught in the middle.

Trusts have been driven deep into the red as costly agency staff are used to cover vacancies that have been exacerbated by miserly NHS pay awards and intensified pressure on frontline staff as senior managers try for a fifth year to deliver more care for less.

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. But its healthcare is now run on a piecemeal borough by borough basis, with world class hospitals required to compete with each other rather than work together with community services, GPs and social care.

Our hope is that this report will bring some sense to the debate raging on the future of our NHS. Those pushing for further cuts and more commissioning need to consider this evidence and think again.

I would like to thank our eminent panel members who once again gave up so much of their time and energy to ensure that we have a report that shows what is going wrong with our NHS, and, crucially begins to spell out what needs to be done to put it back together again.

As Bevan said, "the NHS will survive as long as folk have the faith to fight for it." Unite has faith. Our union represents tens of thousands of NHS workers in the capital; but more than that, our members from all walks of life rely on the service that they fund through the taxes they pay.

Many of our members have also been heavily involved in campaigns to defend the NHS across the capital; fighting privatisation, cuts and closures and raising concerns about quality of services and patient safety.

The challenge is now for Unite, with London's Labour movement and all those who value the NHS to take up these recommendations, and redouble the fight right up to and beyond the election for policies which will put our NHS back together again.

Peter Kavanagh
Unite Regional Secretary
London and Eastern region
Unite the union

Foreword

The original People's Inquiry report into London's healthcare, sponsored by Unite and published a year ago in March 2014 came as a wake-up call.

It certainly came as a wake-up call to me, and to the members of the panel, who gave their time, so generously, to listen to hours of testimony.

The follow-up review, summed up in the new report we have just finished, has deepened our concerns. Hours of evidence from 20 well-placed witnesses once again revealed the lack of strategic overview of healthcare in London, and showed how the chaos of the Lansley reforms are still leaving their mark and causing difficulties for health planners and others.

We are once again grateful to all the experts, managers and front line staff who took the time and trouble to come and share their experiences, facts, and concerns. And we thank Unite, the union which has once again unselfishly supported our Inquiry, allowing the panel, as before, speak to anyone and ask them what questions we chose, as well as shape our own recommendations to follow on the previous report.

The impact on the NHS of the current prolonged period of austerity left us deeply troubled and the uncertainties brought about by the impending election have only served to make matters worse. Just as we were going to print the decision to devolve health spending and planning in Manchester has cast a shadow over what the future of London's healthcare might look like if the same approach were to be adopted.

A ray of optimism: the Five Year Forward View, that we did not have time to consider in detail, may, in my view, provide a vehicle for local healthcare to be planned locally and for services to be shaped around the needs of the communities they serve. Time will tell.

However we found little evidence that the Better Care Fund, which has been seen as a way forward for health and social care would make anything better in London. There was a total absence of evidence that anything substantial would come out of it.

We were disappointed once again to find almost no evidence of the work of local Health and Wellbeing Boards, or Health Watch organisations. We made clear in our original report there was little evidence of local engagement – a situation that has not improved.

This is not a good time in the history of London's NHS. It's not clear how long these problems will persist. That said, once again we salute the men and women who plan our health services and work at the frontline to deliver them.

Our thanks and admiration go to them all.

Roy Lilley, Chair,
People's Inquiry,
March 10 2015.

Executive Summary

London's NHS – Into the Unknown

Our first report, London's NHS at the Crossroads, was published in March 2014: it was a wide-ranging report covering a variety of issues in London's NHS, the background to the current situation, and the impact of the Health & Social Care Act (H&SCA), then in its first year.

We are delighted to note that our report has been received by the London Health Commission, established by the Mayor of London and chaired by Lord Darzi, and informed some of its 62 recommendations, especially in echoing our concerns over the lack of strategic overview and leadership in London's NHS. We know our first Inquiry report has also been read, and in at least one case cited as an authoritative source, by NHS bodies in London. Our warning that the freeze on NHS funding was not sustainable has also been confirmed by policy changes from both of the larger parties.

But events and policies – both at national and at a more local, London level – have developed rapidly. In the run-up to a potentially crucial election we believe it is useful to establish a new benchmark on the state of play in the capital's NHS and the scale of the issues to be addressed by whichever party takes charge after the election.

London Overview

In just five years the NHS in England has gone from surplus to deficit, with the threat of worse to come. Three quarters of acute trusts can't balance their books, with total deficits likely to exceed £1 billion for 2014-15. In addition NHS England's London area team has projected as a potential gap in the capital of £4 billion or more by 2019.

National projections show London's population climbing to almost 9.4 million, and growing significantly faster than the rest of England across all ages with the exception of the oldest. Numbers of over-65s living in the capital are expected to increase by almost 19% in the ten years to 2021. This is especially important, since London, now has the highest rate of emergency admissions in England for people aged 65 and above.

London's NHS cash squeeze

Clinical Commissioning Groups (CCGs) in London are collectively expecting a combined surplus of £159 million by the end of March, but Trusts face almost the opposite situation, forecasting a combined deficit of £267 million at year end. Just FOUR of London's 19 acute trusts are in balance or surplus on their latest figures – and many of the nine which still cling to the hope of reaching balance or surplus by end of year are expecting to dig deep into contingency reserves and one-off measures to do so.

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

Commissioners band together

The planning of London's healthcare in these straitened times is a peculiar hybrid of local level proposals drawn up by individual CCGs, alongside new attempts at "Collaborative Commissioning." The 32 CCGs have again been divided into the same five "clusters" as PCTs were grouped in under NHS London (North West, North Central, North East, South East and South West).

Known targets for "efficiency savings", London health economy 2015-19	
North West London (CCGs only)	£365m
North Central London	£490m
North East London	£943m
South East London (incl only 1 provider)	£639m
South West London	£570m
KNOWN TOTAL	£3,007m

(Data from CCG and trust Board papers 2014-15)

Table 1

In other words we are seeing a combination of the new structures born from the Health & Social Care Act with older concepts of more strategic planning and organisation, except the new 'Collaborative' structures now have regard only to collaboration between the commissioners – largely disregarding the much bigger and more intractable financial problems facing their provider trusts.

London-wide target for efficiency savings

The targets identified in table 1 add up to £3 billion: however missing figures for providers whose targets are not included are likely to bring the total close to the £4 billion figure identified by NHS England. However CCG plans for "efficiency savings" turn out to be almost entirely made up of targets to reduce activity – and failing on almost every count to deliver.

The Inquiry Panel was impressed by the positive possibilities that would be opened up by switching the focus from the narrow concerns and balance sheets of individual NHS organisations – commissioners and providers – to address the wider health economy.

There is no benefit in CCGs stacking up surpluses on the one side of the divide if this is achieved at a cost of equivalent or larger deficits for local providers, or cost-saving measures by providers which result in diluted skill mix and reduced quality of care, or the rationalisation of services – or even refusal to treat "excess" emergency patients above the arbitrary quota of 2009 caseload who can only be treated at a financial loss.

We will therefore be recommending that the new unit of planning should be the **local health economy**, combining both commissioners and the various NHS providers.

The acute providers strike back

NHS Providers, a group of the most powerful of the trusts , accounting for three quarters of acute services, lodged formal objections to the tariff drawn up by NHS England and Monitor for 2015-16. This is the first coordinated resistance from NHS senior managers to a major policy – not only since the current system was introduced as part of the Health & Social Care Act – but for many years in the NHS.

The teaching hospitals and specialist hospitals also objected to the proposal in the tariff to "cap" payments for specialist services at 2014-15 levels: many of these trusts are heavily dependent on income from specialist services, which have been commissioned by NHS England.

Ambulance services

London Ambulance Service NHS Trust's performance has weakened further against target response times, not least because of growing delays for ambulance crews seeking to hand over patients at London's busy A&E units. Further evidence heard by the panel shows that the weaknesses in the LAS performance are themselves also symptoms of much wider problems in the NHS and social care in England.

Mental Health

The funding system for forensic specialist beds, which we heard last time was a problem, is still unresolved, although the problem has been postponed. Child and Adolescent Mental Health Services (CAMHS), too, remain a problem: a national shortage of beds means children in distress have to be transported hundreds of miles, or kept in police custody. Again the problem is down to NHS England, which commissions these services.

On adult mental health beds, however there has been some progress – no thanks to the commissioners, but to trusts taking it on themselves.

There has so far been no review of the resources available for mental health, and many commissioners continue to ignore government pleas to give 'equality of esteem' to mental health, and are squeezing down mental health budgets.

Primary Care

General practice undertakes 90% of first patient contacts in the NHS, but does so for just 7.3% of London's healthcare budget of £15.1 billion. As the Royal College of General Practitioners has repeatedly pointed out, spending on general practice has actually fallen in real terms as well as a percentage of total NHS spending since 2010.

The pressures have grown to the point that there are increasingly severe problems in recruiting doctors to train as GPs, and GPs to apply for London posts. Dr Michelle Drage told the Inquiry Panel of "an absolute pressure cooker going on

every day in GPs' surgeries. You can't access community nursing services because they don't exist […] Ditto district nurses, social services and mental health."

Dr Clare Gerada, working with NHS England, has been leading discussions on a *Strategic Commissioning Framework for Primary Care Transformation in London*, outlining a case for increased investment – equivalent to between £310m - £810m, phased over a number of years. Lord Darzi's London Health Commission also proposed £1 billion capital investment to upgrade GP practice premises.

Dr Gerada's new proposal for integrating primary and secondary care health services echoes but goes further than our Inquiry's recommendations 4.1 and 4.2 last year, calling for integration of care inside and outside of hospitals through 'vertical integration' of community services with NHS and foundation trusts. It also has similarities with Simon Stevens' proposal for an alternative model of Primary and Acute Systems.

Social care

Large cuts have hit social care budgets every year since 2010: research shows a 16% cut in real terms to spending on older adults from 2009-2014, leaving 300,000 fewer older adults in England receiving care. The impact of the financial cuts on social care in England since 2010 – after 15 years of growth in budgets for Personal Social Services – are also spelled out in an important new study The Coalition's Record on Adult Social Care, which shows that by 2013/14, 17.4 per cent less was being spent on services for older people than in 2010: "By contrast, the number of people aged 65 and over increased by 10.1 per cent over the same period, including an 8.6 per cent increase in the population aged 85 or over."

The London picture is equally bleak. A study for London Councils at the end of 2013 predicted that even if the boroughs increased the share of spending on social care for older patients, the funding gap in adult social care by 2017/18 would be at least £907 million.

London figures from the Health and Social Care Information Centre show huge variations in the levels of spending on social care for older people and for adults with mental illness. There is an even bigger disparity in provision of domiciliary care. Just under 8,700 older people received direct payments from social services in 2013/14 to buy in support: 14 of the 32 London boroughs each made direct payments to fewer than 200 people.

Eligibility criteria

An overview analysis by the Association of Directors of Adult Social Services (ADASS) has found that eligibility to social care for people assessed as having 'low' to 'moderate' needs has fallen from almost 30% of English councils providing care in 2010 to just over 10% in 2014/15.

Setting the minimum eligibility threshold at the level of there being (in the phrasing of the Care Act) a 'significant risk to any aspect of the adult's well-being' clearly runs in contradiction to the new statutory requirement to offer "preventative services." Moreover if there is no requirement to provide preventive services it makes a nonsense of the many NHS strategic plans which rely on social care as a way to minimise use of hospital services.

The Commons Public Accounts Committee has noted that: "The Department of Health (DH) acknowledges that it does not know whether some preventative services and lower level interventions are making a difference."

At national level and in London a grand strategy for the integration of health and social care, and the further integration of primary and community services – which run as a common thread through almost all policy statements from NHS commissioners – have been advocated and adopted as policy, despite a lack of working examples and evidence, and alongside relentless cuts in resources to meet rising demand in health and social care.

The Better Care Fund

In London the total in the Better Care Fund (BCF) war chest is £844m, made up of £209m from local government and £635m from CCGs. Ambitious targets have been drawn up for the cash savings to be generated (in the form of fewer non-elective hospital admissions, fewer permanent care home admissions, fewer delayed transfers of care, and increased effectiveness of re-ablement and 'other schemes).

For London the hugely ambitious target 'saving' for the NHS at the end of the first full year of the BCF is almost £76m, including savings from a 10.1% reduction in the rate of admission to care homes, a 2.8% reduction in non-elective activity, 1,121 older people remaining at home three months after discharge, and 201 more people supported to live independently.

Challenging discrimination, bullying and gagging of whistleblowers

Almost two years after the publication of the Francis Report, despite the warm words from government and opposition for its 200-plus recommendations many of them have yet to be given any legal teeth.

In the latest NHS staff survey only 68% of staff reported that they would themselves feel secure raising concerns over unsafe clinical practice. Just 29% of staff now believe there are enough staff in their department for them to do their jobs properly.

Another major study by Sir Robert Francis, on the treatment of whistleblowers, warns that a "climate of fear" pervades the NHS: 19,000 NHS staff responded to his survey, many of them convinced that speaking out about poor care would be a risk to their jobs and future prospects in the NHS.

Alongside bullying and intimidation is the problem of discrimination and exclusion. Roger Kline told the panel that while London has 41% of its directly employed NHS staff from black and minority ethnic backgrounds, of the 40 trusts, only one had a Black, Minority Ethnic (BME) chair, none had a BME chief executive, and 17 of the 40 had no BME members on the board.

Reconfiguration – the lack of evidence for London plans

All of the published plans for downsizing and downgrading hospitals and reconfiguration of services in NE, NW, SE and SW London – and elsewhere in England, rest on the same largely unproven assumptions that large numbers of seriously ill people can be kept out of hospital by services in the community or from primary care – and that such provision can save money compared to existing services. Advocates of these policies do so largely in defiance of the evidence.

Recommendation 1: The NHS needs a clear commitment to increased real terms funding.

1. 1 WE AGAIN 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 ARE SCEPTICAL about the ability of the NHS to sustain the much higher levels of increased productivity, year on year, that are assumed by the Five Year Forward View, given the current levels of stress on staff.

1.3 WE CONGRATULATE NHS Providers for having been willing to challenge a tariff which threatened to force damaging cuts in frontline services, and urge these senior managers to remain committed above all to the integrity and quality of their services to patients.

Recommendation 2: Reinstate strategic overview

2.1 WE AGAIN RECOMMEND the establishment of a new type of London Strategic Health Authority, which does not simply replicate the old NHS London but encompasses a democratic element, through involvement of the London boroughs which are responsible for social care.

2.2 We recommend that – whether at London-wide level, or in the smaller "sub-regional" groups that the NHS should move beyond the requirement for commissioners and providers each to balance their books to the development of a balanced local health economy. This would create a new framework for cooperation and collaboration.

2.3 WE RECOMMEND that a new London Strategic Authority formed along the lines of 2.2 should break from the secretive model of the London Area Team, and make a practice from the beginning of meeting in public session, publishing its board papers, and promoting active engagement with communities, patients and health staff as well as commissioners and providers from all sectors – acute, mental health, community and primary care, social care and public health.

Recommendation 3: Tackle system failure: integrate care in and outside hospital

3.1 WE RECOMMEND that until and unless there is firm evidence for change and actual services have been established in the community that are demonstrably reducing hospital demand, then there should be no further closures of A+Es and hospital beds.

3.2 WE RECOMMEND London's CCGs take note of the spectacular failures of Serco in community and primary care services, from which they have now withdrawn, and Circle's high profile failure to manage a small district general hospital. We therefore AGAIN RECOMMEND CCGs to look to other more successful models rather than put community health services and other important services out to competitive tender.

3.3 WE RECOMMEND an alternative approach, integrating community services with existing NHS and foundation trusts where this has not already happened, as part of a renewed initiative to establish joint working between the NHS and borough social service departments.

3.4 WE NOTE and RECOMMEND London's commissioners and providers to take note also of the proposals from Clare Gerada for integration of primary care with acute service and community health trusts, to mutual benefit.

3.5 WE RECOMMEND serious and urgent attention needs to be paid to the recruitment, training and organisation of appropriate staff to deliver the community-based services which almost every future plan and strategy for the NHS requires. This again could be something to be coordinated by a strategic London-wide body working with Health Education England.

Recommendation 4: Swift reversal of aspects of the Health and Social Care Act

4.1 WE RECOMMEND a full debate on the necessary steps to repeal or reverse the damaging clauses of the Act and its associated regulations; cut the bureaucratic costs of management consultancy, competitive tendering and other trappings of the "market;" free the NHS and its local bodies from the tentacles of competition law and the Competition and Markets Authority, and establish the explicit duty of the Secretary of State to provide a universal, publicly provided service.

Recommendation 5: Improve the quality and accessibility of primary care

5.1 WE RECOMMEND an immediate halt to any further erosion of the share of NHS spending allocated to general practice. We need instead a phased increase of funding for primary care in London, as proposed in NHS England's Strategic Commissioning Framework.

Recommendation 6: Further investment needed in ambulance services

6.1 WE RECOMMEND that, pending the outcome of a review, all further downgrades and closures of A&E be put on hold until such time as LAS resources are expanded to meet the additional pressures. LAS urgently needs more staff, investment in the ambulance fleet, and a rethink of the working patterns of 12-hour shifts that appear to put intolerable strain on staff and create a further problem in retention of trained paramedics.

6.3 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, and for such costs to be factored into the business case of any proposed changes.

Recommendation 7: Midwifery staffing levels and maternity units

7.1 WE AGAIN RECOMMEND a full review of plans to use the issue of 7/7 working and 168-hours per week consultant cover as a pretext to further centralise obstetric and paediatric services, especially since international comparisons indicate the UK system may be excessively centralised already. We remain unconvinced that centralisation is an appropriate response to problems of achieving compliance with the European Working Time Directive, or in allowing women genuine choice on how and where to have their baby.

Recommendation 8: Improve communication and management relations with staff, and provide adequate protection for whistleblowers

8.1 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 anywhere such measures have not been developed or proved unresponsive.

8.2 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.

8.3 WE NOTE that the proposal by Sir Robert Francis that trusts each appoint their own Whistleblowing Guardian is unlikely to be effective or overcome strong staff anxiety regarding the safe raising of concerns. WE THEREFORE RECOMMEND that each health economy should have a Guardian's office, appointed independently by the Department of Health.

8.3 In line with the 2013 Francis Report, WE RECOMMEND that where, for lack of funds, services cannot be sustained to ensure safe and acceptable quality of patient care, the NHS management concerned should make it clear to commissioners, politicians and the public that these services will be closed unless more funding is provided.

Recommendation 9: Independent review of the evidence base for the clinical case for reconfiguration

9.1 AGAIN, AND WITH ADDED URGENCY, 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 10: Health & Wellbeing Boards

So far Health & Wellbeing Boards (HWBs), created by the Health & Social Care Act, but in the control of local boroughs, have not taken advantage of the flexibility they could have to develop as powerful, inclusive local bodies holding NHS and social care services to account across London.

10.1 WE AGAIN RECOMMEND this inclusive, outward-looking approach as a necessary step to ensure HWBs are best equipped to play a leading role in shaping services.

People's Inquiry

March 2015


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London's NHS plunges Into the Unknown

Introduction: why we have gathered more information

Our first report, London's NHS at the Crossroads, was published in March 2014: it was a wide-ranging report covering a variety of issues in London's NHS, the background to the current situation, and the impact of the Health & Social Care Act, then in its first year. The five public sessions held by the Panel – covering all five sub-regional sectors in which Primary care Trusts had been "clustered" by NHS London – drew in more detail on local changes and issues, and the views of campaigners.

From this we drew up 18 main recommendations, some of which involved more than one specific proposal. While matters have changed and moved on over the past year, the main framework of concerns and key issues has stood up well. Our first five recommendations, called for:

- a break from the planned 5-year real terms funding freeze of the NHS;
- the reinstatement of London-wide strategic overview and leadership;
- the need for transparency and accountability;
- integration of services in place of fragmentation and competition imposed on CCGs by the Health & Social Care Act
- and "swift reversal" of key sections of the H&SC Act.

These very issues, together with some of the topics covered by our other 13 recommendations, have been at the centre of debates and developments in London and across the country in the past year.

We are delighted to note that our report, has been received by the London Health Commission, established by the Mayor of London and chaired by Lord Darzi, and informed some of its 62 recommendations, especially in echoing our concerns over the lack of strategic overview and leadership in London's NHS. We know our first Inquiry report has also been read, and in at least one case cited as an authoritative source, by NHS bodies in London.

But events and policies – both at national and at a more local, London level – have developed rapidly. In the run-up to a potentially crucial election, in which different proposals are being made by the two main parties in contention for government, we believe it is useful to establish a new benchmark on the state of play in the capital's NHS and the scale of the issues to be addressed by whichever party takes charge after the election.

With the limited time available to deliver our follow-up report, we have inevitably heard less this time from the many campaigners in the five sub-regional sectors of London, and focused more on assembling authoritative evidence from health professionals, commissioners, local government, academics and organisations representing health workers.

The 20 witnesses we have interviewed, and the additional written reports we have received, have confirmed and deepened our understanding, and followed through on the discussions we began in the Autumn of 2013.

Rather than write a completely new report restating what we have already said, this follow-up aims to examine those aspects of the situation that have changed or emerged since the beginning of 2014, examine which recommendations, if any, we might seek to revise or update, and which additional recommendations we might choose to add.

This report therefore begins with an overview focused on changes and new debates that have taken shape since the early spring of 2014, before going on to revisit, update and add to our 18 recommendations.

London Overview

Finances: will there be an end to the spending freeze?

In just five years the NHS in England has gone from surplus to deficit, with the threat of worse to come. Three quarters of acute trusts can't balance their books, with total deficits likely to exceed £1 billion for 2014-15[1]. The same has happened in London, which after almost five hard years of "efficiency savings" and cuts is once again being confronted with the need to impose even more drastic "efficiency savings" to bridge what NHS England's London area team has projected as a potential gap of £4 billion[2] or more by 2019.

Most of these "savings" need to be generated by acute trusts and foundation trusts. Policies supposed to divert a growing number of patients away from A&E and hospital care have not worked[2], or in many cases have not been implemented, and this has left most London acute providers in deficit in 2014/15 as they face rising need for their service, and the prospect of diminishing budgets while demand rises in the next five years. The new tighter spending limits also require hard-pressed mental health and community trusts, along with GPs and primary care, to deliver ever more services for the same (or less) money.

Amid a non-stop stream of negative headlines on the consequences of the spending squeeze that has effectively frozen the value of NHS spending since 2010 – with shortages of beds, missed performance targets, struggling ambulance services, and hospital trusts and foundation trusts facing mounting deficits and soaring bills for temporary staff to fill growing numbers of vacancies – politicians appear to have had only a very limited rethink.

Population change in English regions by age group, 2011 to 2021

Region	Population (thousands)		Percentage population change by age group			
	mid-2011	mid-2021	All ages	0-15	16-64	65 and over
North East	2,596	2,724	4.9	7.9	-0.7	22.7
North West	7,056	7,364	4.4	9.0	-1.1	20.3
Yorkshire and The Humber	5,288	5,657	7.0	9.3	2.4	22.2
East Midlands	4,537	4,928	8.6	11.7	2.8	27.2
West Midlands	5,609	5,989	6.8	10.3	1.8	21.3
East	5,862	6,458	10.2	14.9	4.2	26.6
London	8,204	9,371	14.2	19.0	12.1	18.7
South East	8,653	9,453	9.3	12.8	3.5	26.5
South West	5,301	5,743	8.3	12.9	1.8	25.3
England	**53,107**	**57,688**	**8.6**	**12.6**	**3.7**	**23.6**

Source: ONS Interim 2011-based, Subnational Population Projections for England
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/index.html

Table 2

[1]Health Foundation press release February 20: http://www.health.org.uk/news-and-events/press/nhs-acute-deficit-rises-to-860m-the-health-foundation-s-response-to-monitor-s-q3-report

[2]NHS England (2013) London: A Call To Action, available http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/ldn-cta.pdf

All major parties have at least tacitly recognised that George Osborne's plan to maintain the budget freeze for another five years from 2015 is not sustainable. Even by 2016, on Osborne's original plans, NHS spending would have grown less than 1% per year above inflation since 2010, while among the upward pressures on budgets England's population has grown by 3%, and the numbers and proportion of older people with greater health needs has also increased[3]. National projections show London's population climbing to almost 9.4 million, and growing significantly faster than the England across all ages with the exception of the oldest. (See table 2)

However this still implies numbers of over-65s living in the capital are expected to increase by almost 19% in the ten years to 2021 – the same ten years in which the spending freeze is planned, and "efficiency savings" are leading to plans for reduction in frontline services. This is especially important, since London, now has the highest rate of emergency admissions in England for people aged 65 and above[4].

Table 3

NHS England spending	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
NHS (cash)	98,419	100,418	102,844	105,222	109,721	113,035	115,106
NHS (real terms)	106,189	105,588	105,747	107,036	109,721	110,602	110,855
% change		-0.57	0.15	1.22	2.51	0.80	0.23

Source: *Public Expenditure Statistical Analyses 2014* , Tables 1.3, 1.4 (HM Treasury)

The Treasury's own figures show NHS spending will have increased in cash terms by almost £17bn from 2009-2016, but in real terms by just £4.7bn (4.4%). Any further prolongation of the freeze beyond 2015 will reverse the increased spending of the 2000s, and result in a spending gap – widely estimated to be upwards of £30 billion by 2021– between demand and resources in England[5].

A further protracted squeeze would also inevitably bring a series of highly embarrassing service failures and unpopular plans for closures and reconfiguration of hospital services, and could even, as the Conservative Chair of the Health Select Committee has warned, lead to "top-ups and charges" for NHS treatment[6], while lengthening waiting lists and increasing the proportion of people prepared to pay for private healthcare. The freeze on staff pay in the NHS has now meant an agreed real-terms cut in pay for many skilled staff in 2015-16 after below inflation rises since 2010.

A continued freeze would also lead to a stand-off between ministers and the chief executive of NHS England, Simon Stevens, who in late October called for an increase of £8 billion in spending to 2019, to run alongside £22 billion of (as yet unidentified and almost certainly unachievable) "efficiency savings" as a way to bridge the widely accepted £30 billion gap by 2021. All three major parties have stated their general support for the *Five Year Forward View*[7] – although Labour and the Conservatives – the two main contenders for government – have been unwilling to sign up for the funding requested.

[3]Charlesworth A (2015) Briefing: NHS Finances – the challenge all political parties need to face, Health Foundation, http://www.health.org.uk/publications/nhs-finances-the-challenge-all-political-parties-need-to-face/

[4]Wittenberg R., Sharpin L., McCormick, B., Hurst, J (2014) Understanding emergency hospital admissions of older people, Centre for Health Service Economics & Organisation, Report 6, December, available http://www.chseo.org.uk/downloads/report6-emergencyadmissions.pdf

[5]Charlesworth (2015, as above:8)) also estimates that a continued freeze, even if coupled with productivity increases averaging 50% higher than the recent average of 1.5%, would result in a cash gap in England of £48 billion by 2030/31. The gap would be even larger if lower increases in productivity are achieved.

[6]http://www.newstatesman.com/politics/2014/07/sarah-wollaston-people-are-very-abusive-mps-undermining-throwing-insults-you

[7]http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

London Acute Trusts	Latest YTD surplus/ deficit £m (Feb 2015)	Forecast end of year £m
Barking Havering & Redbridge	-32.20	-38.00
Barts Health	-70.90	-93.00
Chelsea & Westminster	0.00	2.20
Croydon Health Services	-21.50	-23.40
Epsom & St Helier	-3.00	0.00
Guy's & St Thomas's	2.60	3.00
Hillingdon hospital	-10.90	-1.60
Homerton	-1.75	2.00
Imperial College Healthcare	5.90	11.19
King's College	-34.90	-42.50
Kingston	0.00	2.20
Lewisham & Greenwich	-8.70	-8.50
London NW Hospitals	-47.40	-68.00
North Middlesex	-1.70	-2.50
Royal Free Hospital	-6.70	0.06
St George's Healthcare	-0.50	2.70
UCLH	-11.70	-13.00
The Whittington Hospital	-6.20	-7.40
West Middlesex Hospital	-3.50	7.90
Totals London acute Trusts	-253.1	-266.7

Table 4

At its 2014 conference, in advance of Simon Stevens' report, Labour was the first to break from the planned long-term freeze, when Ed Miliband proposed to raise an extra £2.5 billion per year for a "Time to Care" Fund[8], to employ more doctors, nurses and health professionals. – although this may not be available until 2017. The Lib Dems subsequently promised an extra £1 billion in 2016 and another £1 billion in 2017, although they have more recently promised to allocate the full £8 billion requested if they make it back into government[9].

In response for the Conservatives, George Osborne proposed an extra £1.95 billion to be added to NHS core funding next year (2015-16). He described this as a "down payment" on the 5 year Forward View plan, although it turns out much of this money is not new, but rebadged money already in the NHS, and most of it is to be spent not on new services but on propping up existing services[10].

What's clear from all of these craftily-worded proposals and promises is that they all now begin from an acceptance that a further freeze is not sustainable.

It's also clear that the scale of the financial problems already besetting NHS and foundation trusts are far greater than previously acknowledged, and that things are getting worse as pressures on A&E services in particular continue to intensify. These pressures have by no means reduced, despite over 20 years of policies aimed at reducing dependence on hospital services and redirecting patients to alternative services in the community or primary care.

London's NHS cash squeeze

Snapshot surveys of London's acute hospital trusts and commissioners for this Inquiry conducted in December, and again in February reveal a deepening divide between the situation of the 32 Clinical Commissioning Groups – the vast majority of which are in surplus or in balance, with just three forecasting a deficit at the end of the year – and the 19 NHS and foundation acute hospital trusts (a number of which have been forced into mergers by the impact of the financial squeeze and the pressures under the H&SC Act for them to become foundation trusts).

[8]http://www.theguardian.com/politics/blog/live/2014/sep/23/labour-conference-ed-milibands-speech-with-reaction-and-analysis-politics-live-bog

[9]http://www.theguardian.com/politics/2015/jan/05/nick-clegg-promises-nhs-8-billion-lib-dems-government-may-general-election

[10](£) http://www.hsj.co.uk/news/hsj-live/hsj-live-30112014-details-of-chancellors-nhs-spending-boost-revealed/5077296.article#.VODqhI1ybxk

While the most recent figures available show CCGs collectively expecting a combined surplus of £159 million by the end of March, the Trusts face almost the opposite situation. They are currently facing combined deficits of £253 million, and forecasting a combined deficit of £267 million at year end. Just FOUR of London's 19 acute trusts are in balance or surplus on their latest figures – and many of the nine which still cling to the hope of reaching balance or surplus by end of year are expecting to dig deep into contingency reserves and one-off measures to do so.

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

The soaring numbers of attendances at a declining number of A&E departments result in financial penalties not on the CCGs – which have largely failed to deliver the long-promised alternative services in "the community" or primary care – but on the hospital trusts, which can't turn patients away, but suffer the consequences of treating them, both in pressure on staff, but also heavy blows to their financial balance sheets. Not only do trusts have to treat any "excess" emergency patients above 2009 levels for just 30% of the standard tariff payment, but they are often required to bring in additional staff, many of them more costly agency staff, and sometimes even open additional beds to deal with this growing caseload.

When trusts fail to cope, and breach waiting time and other targets, or fill their beds with emergencies and have to cancel elective admissions, they are further penalised for these shortcomings, and can find themselves being placed in special measures. Unlike the CCGs, there is nowhere for the Trust to pass the buck.

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

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

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

Commissioners band together

The planning of London's healthcare in these straitened times is a peculiar hybrid of local level proposals drawn up by individual CCGs, alongside new attempts at "Collaborative Commissioning" in which the 32 CCGs have again been divided into the same geographical groups as the five "clusters" of PCTs that were formed under NHS London (North West, North Central, North East, South East and South West). A London-wide liaison of CCGs has been formed as the London Clinical Commissioning Council. However its ability to coordinate the CCGs appears to be severely limited.

Table 5

	Latest YTD surplus/ deficit £m (February 2015)	Forecast end of year £m
Barking & Dagenham	3.20	4.85
Barnet	-7.00	-20.70
Bexley	1.20	0.10
Brent	5.90	9.50
Bromley	2.70	4.95
Camden	*1.20*	*3.40*
Central London	7.60	11.20
City & Hackney	18.00	34.00
Croydon	-11.80	-14.70
Ealing	5.90	8.70
Enfield	-13.50	-19.00
Greenwich	4.90	7.30
Hammersmith & Fulham	7.20	11.85
Haringey	-1.40	0.10
Harrow	*-0.85*	*2.90*
Havering	1.90	3.10
Hillingdon	0.00	0.70
Hounslow	3.20	4.20
Islington	*3.20*	*6.50*
Kingston	1.40	2.00
Lambeth	4.40	5.90
Lewisham	2.80	3.80
Merton	1.60	2.70
Newham	9.00	12.95
Redbridge	1.30	3.00
Richmond	4.50	7.00
Southwark	3.50	5.97
Sutton	1.50	2.60
Tower Hamlets	7.90	11.90
Waltham Forest	3.70	8.10
Wandsworth	5.50	7.30
West London	7.80	27.10
Total surpluses	**86.45**	159.27

All figures from CCG Governing Body board papers Feb 15 2015

In other words we are seeing a combination of the new structures born from the Health & Social Care Act with older concepts of more strategic planning and organisation, with one important difference: the new 'Collaborative' structures now have regard only to collaboration between the commissioners – and largely disregard the much bigger and more intractable financial problems facing their provider trusts.

One of the first 5-year Strategy documents developed, by the link up of 6 CCGs in **South West London** (Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth) admits from the outset that the key factor in this (as with every previous) plan is financial pressure.

The 'Introduction' from the CCG Chairs admits (page 3) that "we are facing a potential crisis" and "we [the CCGs] have to address a gap of around £210m a year by the end of 2018/19"[11]. The Strategy also admits that acute hospital services in SW London are expected to shoulder the lion's share of these CCG savings – £127m (two thirds) of the total. Worse, the commissioners note that these provider trusts also have their *own* further massive savings target of £360m between them by 2019 – a quarter of their current cost base.

This means "cost improvements" (cuts) of close to 5% per year must be made by SW London trusts, year after year, with no prospect of reprieve as long as the general freeze on NHS spending remains in place. In other words the hospitals (Kingston, St George's, St Helier and Croydon) face a combined target of almost half a billion pounds (£487m) in "savings" to be generated in just five years.

As part of this huge shake-up, SW London CCGs also plan to switch £85 million from hospital budgets to the "Better Care Fund," which is due to be implemented from April 2015. This is supposed to be an "enabler of integration across providers" but seems more like a straight transfer of resources from struggling hospitals to prop up social care, which has been slashed to the bone and beyond by four years of local government cuts.

Known targets for "efficiency savings", London health economy 2015-19	
North West London (CCGs only)	**£365m**
North Central London	**£490m**
North East London	**£943m**
South East London (incl only 1 provider)	**£639m**
South West London	**£570m**
KNOWN TOTAL	**£3,007m**

(Data from CCG and trust Board papers 2014-15)

Table 6

London-wide financial squeeze

In **South East London** it appears that only the CCG "savings" have so far been estimated – at £308m by 2019[12]: £162m of this is to be QIPP savings, £125m of which is to land on acute trusts. On top of this NHS England plans to "save" (i.e. cut) specialised services which "face a reduction of approximately 6-7% in 2014-15, and further cutbacks in later years" – with especially serious consequences for King's College Hospital and Guy's & St Thomas foundation trusts. King's, which was merged with Princess Royal University Hospital (PRUH) in Orpington as part of the break-up of the bankrupt South London Healthcare Trust, with diasastrous consequences for its budget, has been subjected to a Monitor investigation of services at the PRUH, and a 32-strong "turnaround team" from PwC to tackle its projected £40m deficit.

Again in SE London we find that over and above these commissioner-driven cutbacks, driven by commissioners constrained by cash limits, additional savings targets are being imposed on SE London trusts. These targets are identified separately in trust documents. For just one trust, Guy's & St Thomas, the additional target is £331m savings over just five years.

[11]http://www.swlccgs.nhs.uk/wp-content/uploads/2014/06/SWL-5-year-strategic-plan.pdf

[12]http://www.savelewishamhospital.com/wp-content/uploads/2012/12/SEL-Strategy-20-June-2014.pdf

In **North West London** CCGs have estimated their combined 5-year target for savings at £365m – with a similar, if not larger, additional target for the provider trusts[13].

In **North East London**, CCGs are discussing a Decision Making Business Case for a system of Intermediate Care, which starts from the assumption that the combined challenge to commissioners (£249m) and trusts (£694m) add up to a massive £943m according to NHS England's London area team[14].

In **North Central London** (Barnet, Camden, Enfield, Haringey and Islington), the threatened funding gap is £490m over the five years to 2019.

The targets identified here add up to £3 billion: the missing figures for providers whose targets are not included are likely to bring the total close to the £4 billion figure identified by NHS England.

An idea of the scale of the problems facing providers can be judged from the board papers of a hitherto successful foundation trust, Central and North West London (CNWL). It notes projections of substantial growth in population of older adults, working age adults and children in its London catchment areas, but points out that:

> **"There is increased demand as demonstrated. This is not matched nor projected to be matched in commissioning budgets. … The risk for CNWL is that the system redesign will be slower than growth in demand, with continuing over-use of services and impact on patient experience."**[15]

The strategy warns trust board of "an affordability gap that needs to be met in CNWL's planning" … "sustaining high quality services in the current financial climate is challenging." The forecast budgets look forward grimly to a year-by-year reduction in trust income, falling by 8% from £425m in 2014/15 to £391m in 2018/19 – to be met by cuts in the workforce (pay bill to fall 7.7%) and non-pay items, but reducing the foundation from a £5.7m surplus in 2014/15 to a £1m loss in 2018/19.

On the other side of the purchaser/provider divide in the newly fragmented NHS, there is the far from atypical example of Redbridge CCG, which in its January 2015 board papers reported on its performance in pursuit of the QIPP savings targets. These "efficiency" targets turn out to be almost entirely made up of targets to reduce activity – and failing on almost every count to deliver.

- The scheme was reported to be failing to achieve the "planned reduction" of Community Diagnostics, instead commissioning an extra 2,189 episodes.
- The plan to reduce use of Musculoskeletal services had also failed, with activity "significantly higher than plan since Month 1" and increased referrals for Orthopaedics and Rheumatology – by GPs.
- Planned "demand management" of outpatients had failed to deliver on financial or activity targets, so the CCG has decided to dump the problem onto the local trust, by refusing to pay for additional activity – even though it is generated by GPs.
- The same pattern can be seen in Cardiac Diagnostics and in Pathology (where GPs had requested more than double the planned numbers of tests in Month 6).

[13]http://www.centrallondonccg.nhs.uk/media/11252/A5.1%20NWL%20Five%20Year%20Strategic%20Plan%20Draft%20v1.0,%20CLCCG%20GB%20Meeting%2014.05.2014.pdf

[14]Letter from Anne Rainsberry, NHS England London regional Director, to NEL CCGs, 19 December 2014, available http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Downloads/news-and-publications/Governing-body-papers/27%20January%202015/BD%20CCG%20Governing%20Body%2027%20Jan%202015%20Combined.pdf

[15]http://www.cnwl.nhs.uk/wp-content/uploads/CNWL_Strategic_Plan_2014-19.pdf

- On medicines management the CCG had achieved just 20% of its massive target of £2.5m savings. One reason is that the plan combined seeking £1m of savings through a "prescribing incentive scheme" (half of which seems to have been delivered), with a bigger "stretch target" of £1.5m – to be saved through "unidentified" means. Clearly Redbridge GPs were unable to comprehend this bizarre approach by the CCG – of which allegedly they are in charge[16].

In other words inexperienced CCG boards like Redbridge are drawing up plans without reference to, communication with, or visible support from the dozens of GPs in the area, who have continued to respond to patients' clinical needs rather than the sketchy and optimistic plans and balance sheets drawn up in the offices of the CCG.

Communication between CCGs and GPs at the frontline has of course been made more difficult by the fact that – thanks to the Health & Social Care Act, CCGs have not so far had any direct role in commissioning GP services, which has remained in the hands of NHS England. One of Simon Stevens' first proposals on taking over as Chief Executive was to offer CCGs a chance to co-commission more primary care services.

Even if the spending constraints are lifted after the election, it seems clear from the experience of the new, fractious healthcare "market" so far that without some serious intervention to prevent this destructive polarisation between commissioners and providers, more and more short-sighted and ill-conceived plans will be drawn up by CCGs and their advisors, undermining the financial and clinical viability of existing NHS providers, with serious consequences for patients and access to care.

The implications of these conflicts of interest for patient care were illustrated for the panel in evidence from Dr Tony O'Sullivan, a Lewisham Hospital consultant paediatrician who described meetings of trust representatives with Bexley CCG commissioners, who were demanding a 20% cut in costs before even discussing further on a new contract for children's services[17].

> "Children's Services have been put out to tender by Bexley [CCG]. […]
>
> "They have under-invested in children's services for quite some time, but their starting point in tendering children's services was that they would expect anyone applying for this to cut 20% from the budget, and over the next 5 years to absorb 4%-ish flat-rate NHS inflation costs.
>
> "In my mind that was about a 40% cut that we were expected to put in a tender for, and the other twist is that they are expecting the cut to be differentially at the hospital end, rather than the community.
>
> "So when it comes to children it's just not possible to put a package together that is safe or good. That includes everything from safeguarding, to children's centres, to disability, to child protection, to the acute reception in the A&E. It covered all of that.
>
> "On the other hand if we don't bid, are we laying the NHS open to a private bid from someone who comes in gung-ho and says 'we can do this'?"

The Inquiry Panel was impressed by the positive possibilities that would be opened up by switching the focus from the narrow concerns and balance sheets of individual NHS organisations – commissioners and providers – to address the wider health economy.

[16]http://www.redbridgeccg.nhs.uk/Downloads/News-and-publications/Governing-body-meetings/30%20January%202015/Redbridge%20CCG%20Governing%20Body%20Papers%2030%20Jan%202015%20-%20combined.pdf

[17]http://www.peoplesinquiry.org/pdf/Tony%20Sullivan%2011%20Dec%20TS%20draft.pdf

There is no benefit in CCGs stacking up surpluses on the one side of the divide if this is achieved at a cost of equivalent or larger *deficits* for local providers, or cost-saving measures by providers which result in diluted skill mix and reduced quality of care, or the rationalisation of services – or even refusal to treat "excess" emergency patients above the arbitrary quota of 2009 caseload who can only be treated at a financial loss.

Moreover there is no obvious sense in grouping CCGs together to draw up "strategic" plans which take no account of the consequences of these plans for local providers.

We will therefore be recommending that the new unit of planning should be the **local health economy**, combining both commissioners and the various NHS providers. This would break down the barriers erected by the Health and Social Care Act, and move back towards the wider development of planning for populations and health need. This in turn opens up new possibilities for the integration of primary, secondary and community health services – and the development of seamless care.

If commissioners are really serious about establishing new model of care, they need to take note of the point made to our Inquiry by Ealing Hospital consultant Dr Gurjinder Sandhu, who had explained why in some cases hospitals are reluctant to discharge patients without proper support back to the housing and social conditions that made them ill in the first place:

> **"If the community is going to be treated as a virtual ward, then you need to staff it as a ward".**[18]

Dr Sandhu was among a number of hospital consultants who expressed to us their frustration at being unable, as they would prefer, to discharge patients for lack of proper services from community healthcare or primary care teams, and the widespread restrictions on access to social care.

One witness who has specialist knowledge of these services, Anne Drinkell, formerly a community matron in Hammersmith & Fulham, told the panel of the lack of resources to maintain these services in her area as the needs of the patients they care for increase:

> "I also wanted to give a background about funding reductions. Because compared with some London boroughs, we haven't got a very big elderly population but our elderly population tend to live on their own. We've got more vulnerable adults than you would expect. On the whole our elderly population have less unpaid care and support from family. So people are a bit more isolated. That's quite a significant challenge. At the same time, like everywhere else, social services funding is being dropped and eligibility criteria are being raised.
>
> "One positive thing I would like to say is that in April the local borough are going to drop care charges, so that nobody will have to pay for care. I think that will be really significant in terms of uptakes because I personally know many people who didn't want to get into the means-testing thing and were very reticent about picking up care.
>
> "In Hammersmith & Fulham the NHS are just halving the number of continuing care nurses. These are the people who work out packages of care for our most vulnerable people – the patients for whom the NHS are going to pay most of the tab, because their needs are so health related.
>
> "The skills people need to work out those packages are massive. For example, somebody was telling me recently that for the first time they had somebody home with a full ventilator. So we are talking organising the package of care for somebody who amongst their other needs, needs people who can look after a ventilator 24/7."[19]

[18]http://www.peoplesinquiry.org/pdf/Dr%20Gurjinder%20Sandhu%20(GS)%20consultant%20in%20acute%20medicine,%20Ealing%20Hospital%2016%20Dec.pdf

[19]http://www.peoplesinquiry.org/pdf/Anne%20Drinkell%20campaigner%20&%20retired%20community%20matron,%20West%20London%2016%20Dec.pdf

The acute providers strike back

Acute hospital trusts have found themselves caught in a cleft stick, faced as they are with a reducing tariff, commissioner policies seeking to restrict and reduce the numbers of patients they treat and penalise them for "excess" care on the one hand, and the heavy costs of sustaining emergency services and the additional nursing staff – often from high-cost agencies – required to address issues raised in the Francis Report on the Mid Staffordshire hospitals scandal.

Under these conditions it is perhaps not surprising that NHS Providers, a group of the most powerful of the trusts, accounting for three quarters of acute services, should have finally hit back, and lodged formal objections to the tariff drawn up by NHS England and Monitor for 2015-16[20]. This is the first coordinated resistance from NHS senior managers to a major policy – not only since the current system was introduced as part of the Health & Social Care Act – but for many years in the NHS.

The trust boards – including more than half of foundation trusts as well as many major NHS trusts – were angered by the real terms cut in prices of 3.8% embodied in the proposed tariff, which many trusts see as impossible to achieve after four years of frozen funding have already left a majority of trusts facing deficits. Even the Trust Development Authority warned that the 3.8% cut had gone too far[21]. The teaching hospitals and specialist hospitals also objected to the proposal in the tariff to "cap" payments for specialist services at 2014-15 levels: many of these trusts are heavily dependent on income from specialist services, which have been commissioned by NHS England.

The objectors also complain that the tariff takes insufficient account of the levels of inflation they face, and the increased cost pressures from recruiting additional nursing staff.

The new tariff does contain one partial concession, reducing the "fines" on trusts which treat too many emergency cases to 50% of the tariff for "excess" caseload above 2009-10, in place of the punitive 70% deduction that has applied up to now: but for many trusts, seeing CCGs retaining millions of pounds that should be paid to the trusts for work they have done is still a major frustration. This is especially the case when the CCGs fail – as most clearly have – to use the money to put any alternative services in place to reduce the excess A&E demand.

Concessions from NHS England

In response to the concerns raised by the trusts, NHS England's enlarged team of spin doctors[22] put out unhelpful statements dismissing the objections as a small number of over-large, powerful acute trusts throwing their weight around and demanding extra cash – money that would have to be taken from smaller trusts, mental health, primary care and community services[23]. However NHS England's Chief Executive, Simon Stevens, took a more conciliatory line[24] – pointedly ignoring the system laid down in the Health & Social Care Act which stipulates that a tariff settlement disputed by more than half the trusts should either be redrafted, with new proposals opened up for consultation, or be referred to the protracted machinations of the Competition and Markets Authority.

[20]Donnelly L (2015) Chaos ahead as hospital chiefs veto NHS funding plan, Daily telegraph January 29, available http://www.telegraph.co.uk/news/health/news/11378381/Chaos-ahead-as-hospital-chiefs-veto-NHS-funding-plan.html

[21]Dowler C (2015) Austerity has stretched the tariff's credibility to breaking point, HSJ, (£) http://www.hsj.co.uk/comment/leader/austerity-has-stretched-the-tariffs-credibility-to-breaking-point/5081772.article

[22]Donnelly L (2015) NHS 'spin bill' soars as crisis grows, Daily Telegraph January 30, http://www.telegraph.co.uk/news/nhs/11378553/NHS-spin-bill-soars-as-crisis-grows.html

[23]Dowler C (2015) op cit.

[24]West D (2015) Exclusive: Stevens moves to sidestep pricing rules after provider revolt, HSJ, (£)http://www.hsj.co.uk/news/finance/exclusive-stevens-moves-to-sidestep-pricing-rules-after-provider-revolt/5081982.article

NHS England offered instead an alternative tariff that would be binding on CCGs, but "voluntary" for providers: it has been analysed by the *Health Service Journal* as offering concessions worth up to £500 million, leaving the majority of trusts better-off[25]. Trusts were given just two weeks to decide whether to accept this concession, which would take effect from April 1 but has some unattractive strings attached, or for the whole matter to be referred to the Competition and Markets Authority, with the certainty only that a verdict from them would take months.

While it is not within the brief of our Inquiry to predict or to follow the twists and turns of this complex negotiation process, it is a clear illustration of the way in which the Health and Social Care Act has now polarised the split between purchasers and providers at a time of the tightest-ever financial straitjacket on the NHS. As the HSJ's Crispin Dowler argues[12], the deficits of many acute trusts across the country at times of CCG surpluses "suggest financial risk is not balanced evenly between these providers and commissioners".

Stevens' eagerness to find a compromise and to break down this division is a natural corollary of the *Five Year Forward View* proposals for greater integration of primary, secondary and community health services, which Lansley's Act has made more difficult.

Vertical integration into 'Primary and Acute Care Systems[26]' runs quite counter to the Act's logic (and Section 75 regulations demanding that more and more services are broken off and put out to competitive tender) – but is also much less conceivable under conditions where the commissioners, reflecting only the views of primary care, are forced into continual conflict with the various other NHS providers.

Ambulance services

Our first report discussed the performance problems of the London Ambulance Service NHS Trust, and made recommendations which are still valid. The performance has weakened further against target response times, not least because of growing delays for ambulance crews seeking to hand over patients at London's busy A&E units[27].

However further evidence heard by the panel this time showed clearly that the weaknesses in the LAS performance are themselves also symptoms of much wider problems in the NHS and social care in England. Vacancy rates for ambulance crews have been growing as weary and demoralised paramedics face exhausting 12-hour shifts, often without a break, sitting in ambulances which, when not actively out on a call, are now positioned miles away from ambulance stations, at strategic points proposed by management consultants for swifter responses: these can be car parks, flyovers, intersections – cold, deserted, comfortless and isolating for staff[28].

The panel was shocked to learn that far from speaking out and challenging the inadequate funding and intolerable pressures on her staff, the LAS chief executive Ann Radmore very publicly left the trust at the point of peak press criticism of its falling performance[29]. We are also critical that NHS England should have chosen this juncture to offer her a new job further from the problems of front line services.

[25]McLellan A (2015) £500m risk transfer will not end the search for financial stability, HSJ, (£) http://www.hsj.co.uk/comment/leader/500m-risk-transfer-will-not-end-the-search-for-financial-stability/5082452.article

[26]Stevens S (2014) Five Year Forward View, http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[27]Lydall R (2014) London ambulance crisis: number of emergency crews queueing for 30 minutes outside A&E quadruples in two years, Evening Standard, December 18.

[28]http://www.peoplesinquiry.org.uk/pdf/Malcolm%20Alexander%2011%20Dec.pdf

[29]Barnes S (2015) Ambulance service chief quits to work for NHS England, HSJ January 20, (£) http://www.hsj.co.uk/hsj-local/ambulance-trusts/ambulance-service-chief-quits-to-work-for-nhs-england/5078358.article?blocktitle=News&contentID=8805

London Ambulance Service (LAS) trust board papers report the trust losing an average of 26 paramedics a week, and struggling to fill 400 vacancies, travelling as far afield as Australia and Eastern Europe to recruit staff. All over the country ambulance staff do an extremely stressful job, rushing sick patients through congested roads to a reduced number of A&Es – only to queue up behind other ambulances outside hospitals with no beds spare or room to keep patients who need to be admitted.

In London the problems have been exacerbated by the closures since 2010 of four A&E units – Queen Mary's Sidcup, Chase Farm Hospital, Hammersmith Hospital and Central Middlesex. This leaves ambulances with longer journeys, and longer waits to hand over patients to struggling A&E staff when the limited remaining number of acute beds are full.

Low pay is also a problem. Qualified paramedics are paid on Band 5, which ranges from £21,478 to £27,901, plus London weighting: the real value of this salary has been eroded by at least 16% since 2010 by a pay freeze or below inflation increases. The response to recent strike action, challenging Jeremy Hunt's refusal to agree the Pay Review Body's recommendation of a 1% increase for all NHS staff, drew an especially strong response from LAS staff.

It's clear that the problems with ambulance performance and A&E services in London (and elsewhere) are the product of the wider dislocation of health care under the crushing pressure of five years of frozen spending as population, costs and pressures increase.

Without increased funding and resources including improved community health services and social care to support older patients discharged from hospital, and primary care services developed to help keep more from needing hospital care, NHS A&E units and hospitals will remain "gridlocked" with patients they cannot safely discharge, while more urgent cases wait for admission, and ambulances queue in the car parks.

Mental health

Mental health was a substantial concern in our first report. Subsequent press coverage and the evidence from Dr Martin Baggaley, Medical Director of South London & Maudsley Foundation Trust make clear that the problems we identified then have not been resolved, although SLaM itself has succeeded in reducing the numbers of distant placements of patients in private beds.

Dr Baggaley told us that the funding system for forensic specialist beds, which we heard last time was a problem, is still unresolved, although the problem has been postponed.

> "There are still problems with it. It is still being commissioned by NHS England, and still at the moment they appear to be offering a price that we think is unrealistic. Essentially every bed we have is costing us more to run than they are paying, and they don't seem to be showing any sign of common sense.
>
> "What's frustrating is that the costs to the country have gone up, because what we did have previously was quite an innovative, effective service which was moving people through the system fairly quickly, so that they were then stepping down to often better care at a lower price.
>
> "But they have now just moved on to saying 'No, to do that would cause more intensive treatment, it would cost more' – so now they are just offering really a very low price. You can't do much with it in terms of quality care, so it means people are staying much longer, so it doesn't save money – that's frustrating.
>
> "What we are hoping is that the commissioning of these services will perhaps be returned again locally. This makes more sense really because you can be much more innovative if you've got local commissioning rather than centralised national commissioning."

Child and Adolescent Mental Health Services (CAMHS), too, are a problem in London as they are elsewhere, with a national shortage of beds meaning children in distress have to be transported even hundreds of miles, or kept in police custody. Again the problem is down to NHS England, which commissions these services. Dr Baggaley told us:

"Obviously what we've got to try to do is benchmark it and make sure we are not being ridiculously expensive. We don't want to gold plate the service. But you've got to provide decent quality services, and it is frustrating. It's the lack of flexibility really.

> "I think part of the problem is I don't think NHS England really understand it particularly. There's a big steep learning curve for them: fair enough. But I just don't think they understand what they are doing."

On adult mental health beds, however there has been some progress – no thanks to the commissioners, but to trusts taking it on themselves:

> "There have been some improvements. We've been trying to do our best to reduce our private sector usage. We have managed to achieve that. What we did was we – at our own cost – opened up some overspill beds ourselves. We effectively opened an extra 26 beds I think. Because (a) we could do it more cheaply than the private sector and (b) it is was much more efficient rather than sending people off to West Sussex or somewhere where you had to transport people, and it was very hard for carers and friends to visit etc. We've done that, and got things under control."

However the growing financial pressures are also being felt in mental health.

> "We've done our best to try to manage with what we've got, and I think the system is working reasonably well at the moment. The trouble is all our plans suggest that to make the figures add up, from next April we've got to start taking roughly a ward out every 6 months, about 30 beds a year for about 3 years.
>
> "We've invested in the community team. That's not unreasonable. One of the things that might improve quality is if people get better care outside, and they are kept well, it will stop them breaking down.
>
> "Two-thirds of our admissions are people we know. If we can only keep them well, they would be happier outside hospitals. Most people don't particularly want to come in.
>
> "That's a positive thing. What I am slightly less confident of is whether we will deliver sufficiently. Theoretically it looks good. It's better than simply cutting: it's good to actually invest it in better services. There is always this slight worry I have that we still end up with too few beds and people rushing. There is a point where the system is quite delicately balanced, it's quite easy for it to tip into complete chaos."

There has so far been no review of the resources available for mental health, and many commissioners continue to ignore government pleas to give 'equality of esteem' to mental health, and are squeezing down mental health budgets. Yet somehow, against all odds all but two of London's mental health trusts are for now managing to keep their heads above water and contain the cost pressures they face: this cannot carry on for ever.

Primary Care

As we are often reminded, general practice undertakes 90% of first patient contacts in the NHS, but does so for just 7.3% of London's healthcare budget of £15.1 billion.[30] As the Royal College of General Practitioners has repeatedly pointed out, spending on general practice has actually fallen in real terms as well as a percentage of total NHS spending since 2010.

In London, the latest figures from Health & Social Care Information Centre (HSCIC) show payments to London GP practices averaging just £137 per patient, only fractionally higher than the England average despite inflated costs of operating in the capital: indeed GPs covered by eight of the 21 "Local Area Teams" in England had more generous funding of GP services[31]. The same figures also show that London's population has risen to 9 million by 2013 – far higher than most other estimates, while numbers of GPs nationally have remained almost unchanged since 2010.

Our Inquiry heard strong evidence a year ago and equally strong evidence again to show the pressures, stress and long hours worked by most GPs to deal with what appears to be an increasing workload of patient care, paperwork and, for those that try to manage both, responsibilities for commissioning health services locally[32]. In addition to these general pressures, GPs in areas where A&E services have been closed or downgraded face a potential rise in workload, while some GP practices in deprived areas have had to fight to protect the Minimum Practice Income Guarantee which shores up the finances of their practice – and which NHS England has been trying to cut.

The pressures have grown to the point that there are increasingly severe problems in recruiting doctors to train as GPs, and GPs to apply for London posts. As Dr Michelle Drage told the Inquiry Panel:

> "There are no services to support GPs any more, and A&E and hospitals are full, and turning things around quicker.
>
> "So you have an absolute pressure cooker going on every day in GPs' surgeries. You can't access community nursing services because they don't exist, because no organisation is providing them in a really solid way. Ditto district nurses, social services and mental health. You're very lucky if you can get access to all the investigations you need to keep people away from outpatients because they cater for the secondary care sector. […]
>
> "We have very few people coming in to vacancies in practices. You used to find 80 doctors applying, 80 trainees applying for one vacancy: now you are likely to get one between two practices."[33]

Recognising the scale of the problem, Dr Clare Gerada, working with NHS England, has been leading discussions on a *Strategic Commissioning Framework for Primary Care Transformation in London*[33], outlining a case for increased investment in general practice – equivalent to between 2% and 5.5% of London's total health spending (£310m - £810m), phased over a number of years. This would be recurrent revenue spending, and would therefore come in addition to the proposals from Lord Darzi's London Health Commission (in its report Better Health for London) for £1 billion capital investment to upgrade GP practice premises.

However the new Strategic Commissioning Framework stresses that its proposals for reorganising primary care and establishing much closer working links with community health and hospital services, is not dependent upon the erection of shiny new premises:

[30]The combined budgets of London's CCGs and relevant spending by NHS London on primary care and specialist services.

[31]Available from HSCIC http://www.hscic.gov.uk/catalogue/PUB16847/nhspaymentsgp-13-14-anx.xlsx

[32]See transcripts of evidence from Dr Ron Singer, Dr Michelle Drage and Dr Onkar Sahota at http://www.peoplesinquiry.org/index.php

[33]http://www.peoplesinquiry.org/pdf/Michelle%20Drage%2011%20Dec%20TS%20draft.pdf

> "The specification in this Framework does not rely on estate changes, but there are a number of practices in London for which premises solutions are now urgently needed. The estates section of this document outlines some of the findings of the LHC report, and its recommendation for approximately £1 billion to be invested in general practice estates over the next five years." (p13)

The Framework sets out a proposed New Deal for General Practice, which aims to:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken
- Provide new funding through schemes such as the Challenge Fund to support new ways of working.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding of what pharmacies and on-line resources can help them deal with.

All of these objectives are completely consistent with the recommendations set out in our first People's Inquiry report London's NHS at the Crossroads. The Framework goes further, responding positively to the proposal for primary care-led 'Multispecialty Community Providers', set out in the Five Year Forward View.

> "These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable them to: provide a wider range of services including diagnostics; share infrastructure, expertise and specialists e.g. for mental health or children; create career paths; train and learn together." (p17)

However in conversation for our second Inquiry, Dr Gerada has made it clear that she does not see the MCPs as the model for the future: instead she is eager to see movement towards a much more ambitious integration – of primary care with hospital trusts.

> "What we have been trying to do is to look at how we can truly achieve integration, we call it vertical integration but let's call it shared working. The multi-professional community trusts (because that's really what the Multispecialty Community Providers are) won't move things on at all, because they're still going to fossilise divisions between primary care and hospitals. […]
>
> […] "One example of what we could be doing is my practice, where we want to integrate fully with our local acute trust. […]

Dr Gerada's new proposal for integrating primary and secondary care services echoes but goes further than our Inquiry's recommendations 4.1 and 4.2 calling for integration of care inside and outside of hospitals, in the form of vertical integration of community services with NHS and foundation trusts. It also has similarities with Simon Stevens' proposal for an alternative model of Primary and Acute Systems.

[34]This document is often referred to, but hard to find; however a full version is included in the January Board papers of Southwark CCG, at http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/governing-body/Governing%20Body%20Meeting%20Papers/CCG%20Governing%20Body%2022%20January%202015v2.PDF

The proposal to bring GP services into a close working relationship with secondary care would also fit well with our panel's new recommendation of reorganising services as a local health economy, breaking down the divide between primary care commissioners and trusts as providers. Clare Gerada also argues this approach would draw GPs – up to 55% of whom are already salaried GPs rather than old-style independent contractors – much more closely into the NHS. However she realises her plans are a leap ahead of what many of her GP colleagues will immediately accept:

> "Of course many of my profession would be against this. And I know that if the transformation of services is to be achieved then it will raise issues such as contracts, pensions, buildings, leaseholds – a number of things which are not insurmountable.
>
> "But why should we not go further and have a single commissioning organisation for the whole of London? Or at very least a strategic commissioning overview? […] There is a chief pharmacist to London but there's no chief GP. Why not?"

Dr Gerada argues that the way forward is through integrating hospitals not with social care, but with primary care and community health services that could provide healthcare to patients at home. Such a bold step would, she believes, start "movement towards integration and reshaping services".

Social care

Large cuts have hit social care budgets every year since 2010: research shows a 16% cut in real terms to services for older adults from 2009-2014, leaving 300,000 fewer older adults receiving care[35,36]. The scale of these cuts, with the prospect of deeper cuts to come in social care prompted leaders of the Local Government Association to join forces with the NHS Confederation and health professional bodies and jointly sign a letter to the Observer early in 2015 warning of the dangers to patients if more cuts continue in health and social care:

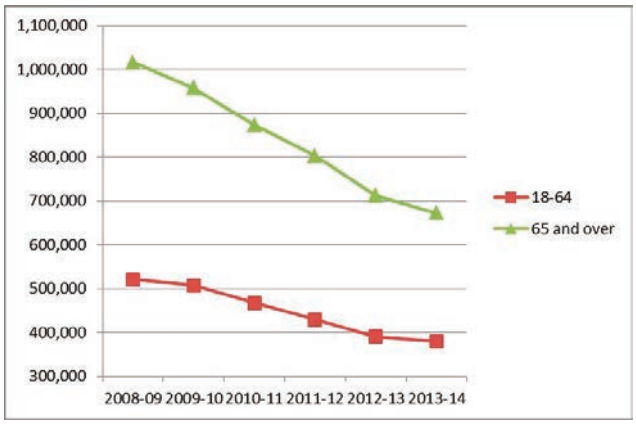

Table 7

> "Councils work incredibly hard with health partners to ease the growing strain on the NHS. But putting extra investment into the NHS without easing the pressure on council budgets is not the solution.
>
> "Without adequate funding for care, the NHS will continue to be forced to pick up the pieces from a social care system that is not resourced to meet demands, which will be increasingly unable to keep people out of hospitals. "This would be a disaster for the health service and those left languishing in hospital beds instead of being cared for in their own homes and communities."[37]

[35]http://www.qualitywatch.org.uk/blog/another-year-cuts-social-care

[36]Thorlby R (2015) Fact or Fiction? Social care cuts are to blame for the 'crisis' in hospital emergency departments, Nuffield Trust, available http://www.nuffieldtrust.org.uk/blog/fact-or-fiction-social-care-cuts-are-blame-crisis-hospital-emergency-departments

[37]'Spending cuts have left the NHS and social care in crisis' Observer Letters, January 2015, http://www.theguardian.com/global/2015/jan/25/letters-what-puts-young-people-off-voting

The impact of the financial cuts on social care nationally in England – following 15 years of growth in budgets for Personal Social Services – are also spelled out in an important new study The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015:

> "Overall spending is projected to have fallen by 13.4 per cent over the Government's five years in office. Already by 2013/14, 17.4 per cent less was being spent on services for older people. By contrast, the number of people aged 65 and over increased by 10.1 per cent over the same period, including an 8.6 per cent increase in the population aged 85 or over." (page 5)[38]

The researchers showed that the shrinking budget at a time of growing population inevitably means care is being given to fewer people who need it:

> "The number of people receiving publicly-commissioned adult social care services fell by one quarter between 2009/10 and 2013/14 from 1.7 million to below 1.3 million." (page 5)

This is especially hitting those who according to many NHS plans for reconfiguring services, should be supported to live at home, and avoid the need for hospital admissions:

> "Care at home and other community-based services were hit especially hard, resulting in an average 8 per cent reduction in the number of users each year."

Even though spending on these important services is falling, the Local Government Association[39] (LGA) has warned that social care is absorbing a rising proportion of the dwindling resources available to councils. The LGA estimate that spending on other council services in England will drop by 66 per cent in cash terms by the end of the decade, from £24.5 billion in 2010-11 to £8.4 billion in 2019/20 to accommodate the rising costs of adult care.

Two thirds of councils in England reduced the number of staff in their adult social service departments between 2013 and 2014, according to the latest Health & Social Care Information Centre (HSCIC) data[40]. In September 2014 there were 10,000 fewer jobs in adult social services in councils in England than in September 2013, and a reduction of over 18% from 159,400 in 2011.

NAO analysis[41] shows that

> "Around three quarters of the reduction in local authority spending has been through reducing the amount of service provided. Volumes of care have fallen across all types of care service."

A consequence of this reduction and inadequate resources is, according to the NAO that:

> "In 2012-13 patients spent 833,000 days longer in hospital than necessary because of delayed transfers of care"

The London picture is equally bleak. A study for London Councils at the end of 2013 predicted that even if the boroughs increased the share of spending on social care for older patients from the current 33% of council spending (£2.8 billion) the funding gap in adult social care in London by 2017/18 would be at least £907 million[42].

[38]Burchardt T., Obolenskaya R., Vizard P. (2015) The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015, Social Policy in a Cold Climate Working Paper 17, available http://sticerd.lse.ac.uk/dps/case/spcc/wp17.pdf

[39]Local Government Association (2012) Funding outlook for Councils from 2010/11 to 2019/20 – Preliminary Modelling http://www.local.gov.uk/c/document_library/get_file?uuid=c98405b7-b4a6-4b25-aebf-a63b5bcfa5c1&groupId=10171

[40]http://www.hscic.gov.uk/6031

[41]National Audit Office (2014) Adult Social Care in England: Overview: p34, NAO, available http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

[42]London Councils (2013) 'A case for sustainable funding for adult social care.' http://www.londoncouncils.gov.uk/London%20Councils/1513LCAdultSocialCare6.pdf

This is especially important, because London is an outlier in the south of England, with a far smaller percentage (37%) of home care residents paying for their own care than the South West (53%), South East (55%) and Eastern (50%) regions. Only the North West (36%) and North East (22%) had a smaller share of care home residents paying their own fees, and dependent on council-funded care than in London[43].

The latest available London figures from the HSCIC show huge variations in the levels of spending on social care for older people and for adults with mental illness. There is an even bigger disparity in provision of domiciliary care – with the top six boroughs delivering 90 percent of the London total, each of them ranging between 358,000 (Kensington & Chelsea) and 962,000 hours of care (Greenwich). None of the other 26 boroughs delivered more than 29,000 hours, while Sutton provided the least of all, with just 8,700 hours.

Ministers have encouraged the use of personal budgets (direct payments) for some NHS patients, but the implementation of this policy in social care, where it was first introduced, has up to now been very patchy and limited. A grand total of just under 8,700 older people received direct payments from social services in 2013/14 to buy in support[44]: 14 of the 32 London boroughs each made direct payments to fewer than 200 people, while the most enthusiastic were Enfield and Redbridge, each with over 600 direct payments.

The average size of the weekly payments to older people and adults also varied enormously: 8 boroughs paid out an average of less than £200 per week, with the lowest being Bexley, paying just £62 on average. Most paid above £200, with the most generous being Kingston, where 345 clients received an average of £492 per week. However the statistics on this spending offer no information on what these sums of money are spent on, and whether this represents value for money for the borough or for the client. Nor do they seek to explain why there have been so few payments, or what costs the smaller payments are expected to cover.

In many London boroughs one service that older people cannot spend direct payments on or make use of is the delivery of home meals: eight London boroughs[45] reported spending nothing at all on this, while one spent less than £5,000 providing meals. Nationally one third of UK local authorities have ceased to provide "meals on wheels" for elderly and vulnerable people[46]. This may put them at risk of malnutrition, and tends to mean that older people unable to cook for themselves are obliged in those areas to seek care elsewhere, increasing the numbers using care homes and hospitals. Age UK has estimated that of 2 million older people in England with care-related needs, almost 800,000 receive no support of any kind.

Eligibility criteria

One of the proclaimed advantages of the government's controversial Care Act is that it presents itself as replacing the widely varying local criteria defining who is eligible to access social care services with consistent new criteria. However the new eligibility criteria effectively endorse the decisions that have already been made by many local authorities to exclude any provision of services for people with 'moderate' needs, and only offer any support to those with the higher threshold of 'substantial' needs[47].

[43]Figures from Laing & Buisson, cited by National Audit Office (2014) Adult Social Care in England: Overview: p15, NAO, available http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

[44]Personal Social Services: Expenditure and Unit Costs, England - 2013-14, Provisional Release: Unit Costs by CASSR, from HSCIC.[45]Camden, Islington, Barking & Dagenham, Bexley, Bromley, Enfield, Havering, Newham and Sutton

[46]Butler P (2014) A third of councils cut 'meals on wheels elderly care lifeline, The Guardian, November 11, http://www.theguardian.com/society/patrick-butler-cuts-blog/2014/nov/11/third-councils-cut-meals-on-wheels-social-care

[47]Age UK (2014) Care in Crisis 2014, http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/CIC/Care_in_Crisis_report_2014.pdf?epslanguage=en-GB?dtrk%3Dtrue

An overview analysis by the Association of Directors of Adult Social Services[48] (ADASS) has found (page 14) that eligibility to social care for people assessed as having 'low' to 'moderate' needs has fallen from almost 30% of English councils providing care in 2010 to just over 10% in 2014/15. A study for the Strategic Society Centre and Independent Age at the end of 2014 found that:

> "Broadly speaking, around half of the older population with some level of difficulty with day-to-day activities receives disability benefits, whereas around one in six receive local authority support of some kind – although in many cases, these groups will overlap."[49]

Setting the minimum eligibility threshold at the level of there being (in the phrasing of the Care Act) a 'significant risk to any aspect of the adult's well-being' clearly runs in contradiction to the new statutory requirement to offer "preventative services." Moreover if there is no requirement to provide preventive services to help people cope longer living at home, it makes a nonsense of the many NHS strategic plans which rely on this as a way to minimise use of hospital services.

The lack of any coherent or convincing plan to take account of the levels of need of older people and support them in their own homes has been highlighted by the highly critical report of the Commons Public Accounts Committee last July on Adult Social Care in England. Having taken evidence from the Department of Health and the Department for Communities and Local Government, the all-party committee noted[50]:

> "The Departments **do not know** whether the care system can become more efficient and spend less while continuing to absorb the increasing need for care. […] Local authorities' cost savings have been achieved by paying lower fees to providers, which has led to very low pay for the care workforce, low skill levels within the workforce, and inevitably poorer levels of service to users. […] [emphasis added]
>
> "We are concerned that the Departments **have not fully addressed** the long-term sustainability of the adult social care system, and that its policies to drive change (the Care Act and the Better Care Fund) are not supported with new money and do not acknowledge the scale of the problem. […] The Departments acknowledge that they do not know how local authorities will achieve the required efficiencies, but still believe the ambitious objectives of implementing the Care Act and integrating services are achievable." (p6) [emphasis added]
>
> "The Department of Health acknowledges that it **does not know whether some preventative services and lower level interventions are making a difference**." (p 7) [emphasis added]
>
> "The Department for Communities and Local Government told us that they did not know how local authorities would be able to maintain spending on care for adults and improve outcomes in a situation where needs were increasing but overall public funding was falling." (p12) [emphasis added]

To complete the picture of central government ignorance and indifference to the viability of adult social care services, the PAC found:

> "The Department of Health recognised the need for greater research in these areas, and it acknowledged that **the lack of evidence on what works** and how changes should be implemented was a barrier to integration of health and social care." (p13)

[48]ADASS (2014) Adult social care funding: 2014 state of the nation report, Local Government Association & Association of Directors of Adult Social Services, October 2014, available http://goo.gl/m8krW8

[49]Lloyd J (2014) The Bigger Picture, http://www.independentage.org/media/847199/biggerpicture_policyfinal.pdf

[50]http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/518/518.pdf

In other words at national level and in London a grand strategy for the integration of health and social care, and the further integration of primary and community services – which run as a common thread through almost all policy statements from NHS commissioners – have been advocated and adopted as policy despite a lack of working examples and evidence, and alongside relentless cuts in resources to meet rising demand in health and social care.

A further fundamental problem with implementation of the Care Act, according to the ADASS report at the end of 2014, is that according to an LGA poll of 54 councillors leading adult social services, not one was very confident that its provisions could be implemented in 2015-16, only 6 declared themselves "very confident", while 46 were either "not very confident" or "not at all confident" that the funds would be there[51].

Better Care Fund

Our Inquiry Panel were concerned at the significant absence of information from our various witnesses on either the Care Act or the plans to implement the Better Care Fund from April 2015. By contrast a search through published documents on the internet quickly reveals the scale of the plans that have been drawn up so far, with some remarkably precise projections of seemingly almost instantaneous results.

The coalition government has emphasised that they see this £5.3 billion fund being spent jointly with social care services and in partnership with local authorities and Health & Wellbeing Boards – although 79% of the fund has come from money top-sliced from local CCG budgets.

In London the total in the BCF war chest is £844m, made up of £209m from local government and £635m from CCGs. Ambitious targets have been drawn up for the cash savings to be generated (in the form of reduction in non-elective hospital admissions, reductions in permanent care home admissions reduction in delayed transfers of care, increased effectiveness of reablement and 'other schemes[52].

However just three of London's 33 councils (including City of London) managed to get their Health & Wellbeing Board's BCF plans approved without reservation: 25 were approved "with support", four approved "with conditions" and one – Hillingdon – was among just five English councils whose plans were not approved.

The London plans also differ from the England average. They involve spending less than the average on social care (35% London, 39% England average), mental health (3% London, 6% England) acute services and continuing care, and more than the average on community health services (51% London, 31% England average) and primary care (3% London, 1.7% England average)[44].

For London the target 'saving' for the NHS at the end of the first full year is almost £76m, including the savings from an expected 10.1% reduction in the rate of admission to care homes, a 2.8% reduction in non-elective activity resulting in 15,315 fewer "unnecessary" days spent in hospital, 1,121 older people remaining at home three months after discharge, and 201 more people supported to live independently. These hugely ambitious targets would be challenging to achieve in such a short timescale even at a time of increasing resources and stable structures, but the very opposite is now the case.

[52]NHS England (2014) The Better Care Fund 2015/16 NCAR Results and analysis, available http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf

Moreover ADASS has drawn attention to the fact that an increasing share of the money transferred to social care from the NHS since 2011/12 has been used not to invest in new services but to mitigate the impact of cuts in local government funding on social care provision – 50% of the £930m transferred in England in 2014/15 has been spent in this way. With varying amounts left "unallocated" each year, this has left a minority share to be spent on new services each year so far[53].

The problem is not only that the Better Care Fund is primarily rebadged money taken from the NHS budget, at a time when resources are already stretched, but also that it has to be spent jointly with local councils at a time when social care expenditure and council funding are expected to be further cut each year. The ADASS report warns (p25) of the scale of cuts facing council social care budgets:

> "By the end of the decade our projections show a funding gap of £4.3 billion, or 29.4 percent of net adult social care budgets in 2013/14 (thus slightly more than the NHS funding gap)."

ADASS warns that tensions between the ill-funded "partners" have arisen from NHS concerns that the BCF will not generate sufficient savings from reduced use of hospital care to cover the increased £1.9 billion NHS contribution to the BCF in 2015/16. This has led to demands from the NHS that more than half of the money – £1 billion – must either be generated from reduced emergency admissions, or kept to be spent by the CCGs. And this in turn has created more friction between the "partners".

ADASS recognises that both sides come from a different agenda. NHS commissioners are "wary of the idea of joint or single commissioning," which they believe could lead to a unilateral takeover of commissioning by local government. Councils on the other hand make no secret of the fact that they believe Health and Wellbeing Boards, with "CCGs as equal partners" could be the best model for commissioning both health and social care. This in turn appears to be pretty much the model embraced by the Labour Party's 10-year strategy and speeches by shadow Health Secretary Andy Burnham.

Whatever the ambitions of either side, it appears from the extremely limited information in the public domain – little if any of which appears to have reached the ears of frontline staff in hospitals or in primary care – that there is a danger the Better Care Fund fails to deliver any of the promised results, and results in local battles over limited resources rather than the development of genuine integration of services. The plans that have been published seem to rest at a level of abstraction, with little attempt to produce evidence. According to "financial modelling" for London Councils by Ernst & Young:

> "There is potential for London local authorities to **save between £240 million and £735 million** [a quarter of the entire social care budget in London] from implementing integration in health and social care, alternative delivery models and category management, with additional savings anticipated from increased investment in public health."[54] [emphasis added]

Much of this "modelling" is based on wishful thinking and optimistic forward projections from as yet untested plans, such as the Tri-borough councils (Hammersmith & Fulham, The Royal Borough of Kensington & Chelsea, and Westminster City Council) which in 2012 developed a business case for a project which was "expected" to generate savings of "approximately £50 million per year" primarily driven by "a reduction in acute hospital activity". This plan, despite the fact that no results were to hand, has been taken as the basis for assumptions of what might be achieved in other London boroughs. This is the very opposite of evidence-based policy-making.[46]

[53]ADASS (2014) Adult social care funding: 2014 state of the nation report, Local Government Association & Association of Directors of Adult Social Services, October 2014, available http://goo.gl/m8krW8

[54]London Councils (2013) 'A case for sustainable funding for adult social care.' http://www.londoncouncils.gov.uk/London%20Councils/1513LCAdultSocialCare6.pdf

The reality seems to be very different. The government's cuts in local government and freeze on NHS spending are now combining with the fragmentation and destabilisation of local services driven by the 2012 Health & Social Care Act and creating major obstacles to developing & improving these vital services.

Since the lobbying power appears to have been much more influential in defending NHS resources and services than local government, it seems that the only viable way to move towards the integration of services inside and outside hospitals is through a process of vertical integration, allowing NHS provision of home care, in conjunction with community health services, district nurses and local primary healthcare teams. However, the Manchester proposals announced just as this report was finalised appears to move in the other direction, putting NHS funding into the hands of local authorities.

Challenging discrimination, bullying and gagging of whistleblowers

Almost two years after the publication of the Francis Report[55], despite the warm words from government and opposition for its 200-plus recommendations many of them have yet to be given any legal teeth.

New obligations have been added to the Nursing and Midwifery Council's code of conduct, imposing a 'duty of candour' on professional nursing staff, requiring them to speak out if they witness unethical or unacceptable behaviour.

But many will still fear to do so because they know that they will be harassed, bullied and victimised by management and even staff colleagues if they do. Despite the fine phrases, the protection theoretically afforded to those who flag up failures of care is pitiful, delayed, expensive and uncertain. So many who should be speaking out and helping to change systems and services for the better feel it more prudent to just keep their heads down and hope they don't get caught up in a major incident.

In the latest NHS staff survey, published as this report is completed, only 68% of staff reported that they would themselves feel secure raising concerns over unsafe clinical practice[56]. And with specific reference to the Francis Report on Mid Staffs, where dangerously low staffing levels were a major factor, just 29% of staff now believe there are enough staff in their department for them to do their jobs properly – something they should be raising with managers.

If we were not sure this was the case, more proof has now been delivered in the form of another major study by Sir Robert Francis, this time on the treatment of whistleblowers.

It warns that a "climate of fear" pervades the NHS: indeed the whole report was delayed by the sheer weight of numbers of the 19,000 NHS staff who responded to his survey, many of them convinced that speaking out about poor care would be a risk to their jobs and future prospects in the NHS. And while health secretary Jeremy Hunt promised to push through a law before the election to protect whistleblowers, the fact is that the top-down bullying culture of the NHS will take more than a piece of legislation to eradicate.

[55]On the disastrous systems failure that led to the collapse of care in Mid Staffordshire Hospitals Foundation Trust in the mid 2000s, available (3 Volumes) http://www.midstaffspublicinquiry.com/report

[56]Hazell W (2015) Third of staff do not feel secure about raising concerns, Nursing Times (£)http://www.nursingtimes.net/nursing-practice/specialisms/occupational-health/third-of-nhs-staff-do-not-feel-secure-about-raising-care-concerns/5082684.article#.VO6yQrnh4-4.twitter. NHS Staff Survey available from http://www.england.nhs.uk/statistics/2015/02/24/the-2014-nhs-staff-survey-in-england

The panel heard Roger Kline, who has specialised in these issues. He underlined the scale of the problems that are still faced by those who speak up:

> "Nursing Times did a survey one year after Francis earlier this year [2014]. Of the people who had raised concerns, 47% of nurses who had raised concerns said they had suffered personally negative consequences as a result of doing so. That seems to be a pretty catastrophic piece of data that nobody seems to spend much time discussing.
>
> "It's not just morally wrong that people are treated badly, but it's bad for patients, and that's what underpins the new initiative that Simon Stevens is supporting in the NHS around a work-force based equality standard."[57]
>
> Roger makes very clear the connection between the way staff are treated, and the quality of treatment they then give to patients, and are willing to uphold:
>
> "Bullying seems to me to be the glue that holds all this together. Twenty two per cent of NHS staff are bullied, 23% last year [24% in the latest staff survey]. It's an incredibly high level of bullying for a caring organisation. But less than half the cases are reported, and the proportion of cases of bullying being reported is falling significantly.
>
> "Bullied staff are less willing to raise concerns. They are going to be less willing to admit mistakes. They are going to work less effectively in teams. They are going to show less discretionary effort, and they are going to show less compassion to patients, because if you are being bullied it's pretty hard to treat with the appropriate care those you look after."

Moreover, says Roger, while bullying may be driven from the most senior levels of the NHS, setting impossible targets and hounding staff who fail to reach them, there is a benefit for the trusts which set out to tackle this and establish new, more inclusive ways of working, inviting and encouraging staff to raise problems so that they can be addressed and the organisation improved.

> "The trusts that have cracked [the problem of bullying] are finding of course they're getting extra discretionary effort, more productivity, lower absenteeism rates from their staff. So at both ends it's wrong."

Roger Kline's other, related focus is on the staff who suffer from other forms of discrimination and exclusion, drawing attention to the "snowy white peaks" of senior management throughout the NHS, and especially in London:

> "London has 41% of its directly employed NHS staff from black and minority ethnic backgrounds. It would be higher if contractors were included. 45% of patients according to the last census (it's probably slightly higher) are from black and minority ethnic backgrounds.
>
> "What I found was of the 40 trusts, only one had a BME chair, none had a BME chief executive, and 17 of the 40 had no BME members on the board. I'm talking about places like the Homerton, the Royal Free, Barnet, Enfield and Haringey Mental Health Trust.
>
> "There has also been a decrease in the proportion of BME board members in recent years. They were not only disproportionately white, they were disproportionally male."

It's clear that when senior management looks and sounds so little like the staff they manage and the communities they are supposed to serve, the organisations which allow this situation to continue are less able to deliver satisfactory services. In each case of bullying, gagging, victimisation of whistleblowers like Charlotte Monro (the union rep whose tribunal case against Barts Health is still

[57]The full transcript of Roger's evidence is available at http://www.peoplesinquiry.org/pdf/Roger%20Kline%20Roger%20Kline%20(RK),%20researcher%20and%20author%2011%20Dec.pdf . His slides are also available from www.peoplesinquiry.org

dragging on some 18 months after she was first disciplined), or exclusive policies that result in largely white, male directors and senior managers – even in trusts with the most diverse workforce – the key to changing things, says Roger Kline is to start from the recognition of the problem:

> "The key is to accept you have a problem, is to look at the data and listen to the staff. So although many trusts would think 'I'd give my right arm for that,' they know they are not there yet."

Questioning the evidence for "reconfiguration" of services

Since our last report, the debate on the potential impact of plans for the reconfiguration of hospital services, and diverting more services into "community", "primary care" and "social care" settings has moved from the academic to the practical. The vigorously contested closure of two small A&E units at Hammersmith and Central Middlesex hospitals took place in September as the first step towards a North West London plan, Shaping a Healthier Future, that also called for the closure of A&E and most inpatient services at Ealing and Charing Cross Hospitals, with a net loss of around 1,000 beds[58].

Concerned boroughs in NW London are now conducting a detailed review of the consequences of these policies so far, and the potential impact if the remainder of the downgrading and closures take place as planned[59].

Despite the constant assurances that alternative services would be in place to deal with the emergency patients who would need to travel elsewhere – to Northwick Park, St Mary's Paddington, West Middlesex or Chelsea & Westminster hospitals – no extra beds or facilities were in fact available, and the closures triggered an immediate slump in performance of emergency services across the whole of North West London, with hospitals as far afield as Hillingdon facing a sharp increase in caseload.

In South East London we have also seen the merger of the once-threatened Lewisham Hospital with Queen Elizabeth Hospital in Greenwich, formerly a component of the now-dismembered South London Healthcare Trust. The merger has served to put the deeply flawed plans of the Trust Special Administrator (TSA) – who had called for the closure of most acute services at Lewisham as part of a costly "rescue" package for South London Healthcare – to the test.

Again the failure has been spectacular. Dr Tony O'Sullivan, a consultant paediatrician at Lewisham & Greenwich Trust told us of a CQC inspection in February 2014:

> "One of the major CQC findings was that the Queen Elizabeth emergency department's acute pathway was not fit for purpose: and the subsidiary finding was that the QE had far too few beds. I think they quoted 75 or 80 beds were needed in order to unjam the log jam of patients pouring into the A&E not being able to be admitted to wards, backing up into the ambulances in the car park, and then fines being imposed for those.
>
> "So, far from the TSA proposal that 450 beds could be lost from the local South East London health economy, the CQC said that as of that moment the local health economy didn't have enough beds."[60]

All of the published plans for downsizing and downgrading hospitals and reconfiguration of services in NE, NW, SE and SW London – and elsewhere in England, rest on the same largely unproven assumptions that large numbers of seriously ill people can be kept out of hospital by services in the community or from primary care – and that such provision can save money compared to existing services.

[58]http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/Onkar%20Sahota,%20London%20Assembly%20Member%20for%20Ealing%20and%20Hillingdon.pdf

[59]http://www.standard.co.uk/news/health/top-barrister-to-investigate-impact-of-ae-closures-on-patient-safety-9895171.html

[60]http://www.peoplesinquiry.org/pdf/Tony%20Sullivan%2011%20Dec%20TS%20draft.pdf

The evidence for cost savings from developing GP and community out of hospital initiatives is very limited. Research published in 2012[61] surveying all out of hospital initiatives failed to demonstrate savings.

Similar findings have been highlighted by the more recent Commission on Hospital Care for Frail Older People, set up by the Health Service Journal and conducted by a group of experts led by the respected Birmingham hospital boss Dame Julie Moore. After surveying the evidence, they concluded it was a "myth" that measures such as the "integration" of health and social care, and improved services in the community would reduce the need for hospitals or bring cash savings for the hospital sector. While better community services were desirable, the report argues that this would only delay rather than avoid the need for hospital stays:

> "The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong."[62]

The Inquiry Panel heard from analysts Seán Boyle and Roger Steer, who emphasised the same points, and drew our attention to more recent literature from various researchers on the evidence, again with similar conclusions[63].

Candace Imison's report from the King's Fund, for example, titled The Reconfiguration of Clinical Services: What is the Evidence? makes similar points:

> "There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand."[64]

That report concludes:

> "The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change."

In particular Imison found that evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking; and evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

A third recent study, this time from the Nuffield Trust, The Effect of the British Red Cross 'Support at Home Service' on Hospital Utilisation[65], was designed to show that better integration of social care and hospital care would reduce demand for acute care. It concluded:

"Our research did not detect lower use of hospitals for the British Red Cross group compared with a matched control group over the longer term. In fact, the evidence suggested that emergency admissions may have been slightly higher in the British Red Cross group.

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[61]Purdy S et al. (2012). Interventions to reduce unplanned hospital admission: a series of systematic reviews: final report. Bristol: University of Bristol, available http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf

[62]Barnes, S. (2014) Integration will not save money, HSJ commission concludes, Health Service Journal, 19 November, 2014 available http://www.hsj.co.uk/news/acute-care/integration-will-not-save-money-hsj-commission-concludes/5076808.article?blocktitle=News&contentID=8805#.VG41vo1ybxk

[63]http://www.peoplesinquiry.org/pdf/Boyle%20and%20Steer%20The%20Peoples%20Inquiry%2011%20Dec%20FINAL.pdf

[64]Imison C, Sonola L, Honeyman M, Ross S (2014) The reconfiguration of clinical services What is the evidence? http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

[65]Georghiou T., Steventon A (2014) Effect of the British Red Cross 'Support at Home' service on hospital utilisation http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf

> "'The results reinforce the challenges around reducing rates of emergency hospital admission. This is a common concern across health services, and one that has proved difficult to convincingly address. In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation.'

A 2012 analytical paper in the BMJ by Professor Martin Roland and Gary Abel[66] went further, to question the received wisdom that hospital admissions could be reduced and costs cut by improving primary care interventions, especially aimed at those of high risk (whose chronic health problems often lead to them being perjoratively dismissed by NHS bureaucrats as "frequent flyers").

Among the bevy of myths dispelled by this study is the illusion that high risk patients account for most admissions, or that case management of such patients could save money:

> "most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population. […]
>
> […] even with the high risk group, the numbers start to cause a problem for any form of case management intervention – 5% of an average general practitioner's list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions."

Roland also points out the difficulties of assessing the effectiveness of those interventions that have taken place because of fluctuations in numbers of admissions even among those at high risk. Some of the interventions that have been piloted, providing case management for high risk groups of patients, have proved not only ineffective, but to result in increased numbers of emergency admissions – possibly because the increased level of care resulted in additional problems being identified. Indeed three trials of interventions have had to be abandoned because of increased deaths among the patients involved. Roland warns that an additional unintended negative consequence could result from GPs feeling under "excessive" pressure not to refer sick patients to hospital.

And Roland criticises the failure of many plans aimed at reducing hospital admissions to consider the role of secondary care, and improved collaboration between GPs and hospital colleagues.

Advocates of these policies do so largely in defiance of the evidence.

[66]Roland, M. Abel, G. (2012) Reducing emergency admissions: are we on the right track? BMJ 2012;345:e6017, 16 September, http://www.bmj.com/content/345/bmj.e6017

Revised recommendations from the People's Inquiry into London's NHS

As with our first Inquiry, many of the issues raised in this report and our recommendations also apply to other areas outside London, and some clearly require national-level action – in some cases legislation, in others a change of policy – for a lasting solution. However the concentration of population and health services in Europe's biggest city mean that the scale of the problems and urgency of resolving them are especially demanding in London, which is our primary focus here.

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.

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

Recommendation 1: The NHS needs a clear commitment to increased real terms funding

Since our first report Simon Stevens as Chief Executive of NHS England has published his Five Year Forward View, which has been welcomed and accepted by all three main political parties. However a key component of Stevens' plan is the call for an additional £8 billion funding in real terms by 2019. Despite limited promises for increased funding, neither of the two larger parties has so far made clear whether they would increase funding on that scale, or how they would pay for it.

The panel also heard the projections forward to 2030 from the Health Foundation[67], who argued that the increased cost of extra government spending to bridge the potential £30 billion gap between resources and spending on services to meet increased needs and cost pressures would still leave Britain well within the average health spending of the 15 wealthiest EU countries as a share of GDP (The UK in 2012 spent 9.3% of GDP on health, compared to the EU15 average of 9.9%).

However the Health Foundation figures assume the achievement of much higher than previous levels of increase in 'productivity – without really defining what "productivity" is. Health care is inherently more labour intensive than other industries, and "efficiency" savings which focus on reducing staff costs are likely to impact negatively on the quality and quantity of services available, and further increase the work pressure on already hard-pressed and relatively low-paid staff. The current plight of hospital trusts, with most of them facing growing deficits, and the pressures on budgets of mental health and community health services mean that there is little if any further scope for savings to be made without serious damage to the quality and availability of NHS services.

In the light of the new figures presented by Simon Stevens and the Health Foundation:

1. 1 WE AGAIN 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 ARE SCEPTICAL about the ability of the NHS to sustain higher levels of increased productivity, year on year, as assumed by the Five Year Forward View, given the current levels of stress on staff. There is a danger that apparent "efficiency savings" will come at the expense of falling quality and effectiveness of services, or increased problems in recruiting and retaining staff.

[67]Charlesworth A (2015) NHS finances, the challenge all parties need to face, Health Foundation Briefing, http://www.health.org.uk/publications/nhs-finances-the-challenge-all-political-parties-need-to-face/

1.3 In line with our previous recommendation that all NHS senior managers should be subject to a DUTY OF CANDOUR about the situation they face, WE CONGRATULATE NHS Providers for having been willing to challenge a tariff which threatened to force damaging cuts in front line services, and urge these senior managers to remain committed above all to the integrity and quality of their services to patients. The duty to explain cuts, closures and downgrading of services should be firmly loaded onto the ministers whose decisions are responsible: they alone must be required to justify their priorities and decisions to the electorate.

Recommendation 2: Reinstate strategic overview

WE WELCOME the support given by Lord Darzi's London Health Commission to the call for a strategic overview, although we agree with those witnesses who warned that the creation of a new post of Health Commissioner, focused primarily on public health issues and answerable to the Mayor, would not address the need for leadership and overview in London's NHS. We note the relatively poor performance of the Mayor of London on the public health issues for which he is currently responsible, such as air quality

WE ALSO note the various new forms of collaboration that have been established by CCGs, establishing five sub-regional groupings across the capital to develop strategic plans, and the London Clinical Commissioning Council. All of these represent a recognition of the need for neighbouring organisations to work together despite the Act, which separates them from each other.

However all of these groupings relate only to each other as commissioners, and not to providers, unlike the Strategic Health Authorities which took responsibility for the whole health economy.

2.1 WE AGAIN RECOMMEND the reinstatement of a new type of London Strategic Health Authority, which does not simply replicate the old NHS London but encompasses a democratic element, through involvement of the London Boroughs which are responsible for social care[68].

2.2 We recommend that – whether at London-wide level, or in the smaller "sub-regional" groups that the NHS should move beyond the requirement for commissioners and providers each to balance their books to the development of a balanced local health economy. This would begin to break down the divisions created by the purchaser/commissioner-provider split which has become so pronounced, with providers lacking any input into the development of strategic plans. This would create a new framework for cooperation and collaboration.

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[68]Our report is being finalised as news emerges for the first time – and with little if any prior discussion among NHS managers, health workers, clinicians or the wider public – of the plan to devolve control over £6 billion of NHS budgets for health care in Greater Manchester to local government, advised by CCGs. It's already clear from the Health Service Journal analysis that many more details of this proposal remain to be resolved before this plan is due to be implemented in 2016.

However our panel has repeatedly heard evidence and engaged in discussions in which the need for a London-wide strategic body with overview of health services across the capital has been central. London has by various estimates 8-9 million population, as large as Wales and Scotland combined, both of which have control over their own NHS – and 3-4 times larger than Greater Manchester. If any devolution is on offer in England, surely the capital should also be considered as a candidate for such powers.

That said, it is clear from the discussions around the Better Care Fund and the deepening problems of a growing cash gap in social care as well as NHS budgets that simply merging the two inadequate budgets, without having established any wider cooperation and integration between health and social care, is unlikely to succeed, and there are concerns that taking the NHS under the control of local government could open healthcare up to charges similar (or higher) than those in place for social care.

When we again discussed strategic leadership in London, our panel specifically rejected any notion that the NHS in London and its £20 billion-plus combined health and social care budget should be "controlled by the Mayor" – whether that be the present incumbent or another of different political persuasion: by the same token it would represent a serious problem if health services across Greater Manchester could be in any way controlled by an elected Mayor, overriding any existing local control and accountability.

There seems to have been no consultation over the Manchester proposals, either with the CCGs which are allegedly in control of local services, or with the wider electorate, public and patients. The deal appears to have been done over the heads of local people: it has already been widely criticised including by Andy Burnham, so could even yet be scrapped before it begins if Labour wins the coming election.

2.3 WE WERE SURPRISED and disappointed that the London Area Team of NHS England, who participated in our first Inquiry did not respond this time to our invitation to tell us how they have progressed. We note that while last time few witnesses had positive things to say about the London Area Team, this year people have been even more critical , consistently pointing to the lack of London-wide leadership. Having heard from the London Clinical Commissioning Council, an organisation representing the capital's CCGs, the panel were not convinced that this has or is ever likely to have the power or influence of a strategic NHS authority responsible for the capital's health economy, rather than a commissioners' body.

WE RECOMMEND that a new London Strategic Authority formed along the lines of 2.2 should break from the secretive model of the London Area Team, and make a practice from the beginning of meeting in public session, publishing its board papers, and promoting active engagement with communities, patients and health staff as well as commissioners and providers from all sectors – acute, mental health, community and primary care, social care and public health.

Recommendation 3: Tackle system failure: integrate care in and outside hospital

The NHS has been expensively and extensively restructured since the 2012 Health & Social Care Act to encourage competition and bids from "any qualified provider" for services. This top-down reorganisation, coupled with the spending freeze has resulted in an NHS where commissioners are time and again at loggerheads with providers, hospital doctors can't discharge patients for lack of social care or community based health services, GPs can't cope with the extra caseload dumped onto primary care by hospital cutbacks, ambulances face lengthening journeys and delays handing over emergency patients – and CCGs with no reference to their GP colleagues or local communities implement far-reaching policies that undermine the viability of local trusts.

Across London "strategy" documents are being drawn up by commissioners that impose impossible efficiency targets on providers, and seek to reorganise services on assumptions that lack evidence and properly developed alternatives to hospital care.

The literature is now growing to show that some of these models have not, do not and will not deliver the promised results. Meanwhile hospital trusts are being unfairly penalised for things that are not their fault or within their control.

Underlying the situation is social care which has budgets cut to the bone, offering increasingly restricted access other than for the most extreme levels of need, and facing more cuts to come. The Better Care Fund is not new money, but money sliced off NHS budgets. This has already worsened the problems on pressurised hospitals, and there is little overt sign that either the NHS or social care are ready to implement new systems from April.

The fragmented system is becoming increasingly dysfunctional. We recommend government action at the earliest possible point to ensure that in each council the funding of social care is sufficient to meet basic needs, without which a properly-functioning NHS is impossible.

3.1 WE RECOMMEND that until and unless there is firm evidence for change and actual services in the community that are demonstrably reducing hospital demand, then there should be no further closures of A+Es and hospital beds.

3.2 WE RECOMMEND London's CCGs take note of the spectacular failures of Serco in community and primary care services, from which they have now withdrawn, and Circle's high profile failure to manage a small district general hospital. These failures are not one-off problems, but an indication of the inability of the private sector to deliver acceptable quality health services and make a profit from today's NHS. We therefore AGAIN RECOMMEND CCGs to look to other more successful models rather than put community health services and other important services out to competitive tender.

3.3 WE RECOMMEND an alternative route, of integrating community services with existing NHS and foundation trusts where this has not already happened, as part of a renewed initiative to establish joint working between the 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.

3.4 WE NOTE and RECOMMEND London's commissioners and providers to take note also of the proposals from Clare Gerada for integration of primary care with acute service and community health trusts, to mutual benefit. The provision of healthcare in community settings and in patients' own homes under the direction of the NHS may prove a more reliable system than the ever dwindling, often poor quality and minimal service delivered by private contractors for hard-pressed social services[69].

3.5 WE RECOMMEND serious and urgent attention needs to be paid to the recruitment, training and organisation of appropriate staff to deliver the community-based services which almost every future plan and strategy for the NHS requires. This again could be something to be coordinated by a strategic London-wide body working with Health Education England.

Recommendation 4: Swift reversal of aspects of the Health and Social Care Act

We note:

- the increased level of criticism of the Health & Social Care Act, its costs, inefficiencies and the fragmentation of NHS planning.
- the rapid expansion by some leading foundation trusts in London of private wings and facilities designed to take advantage of the increased limit on income from private patients.
- that the Five Year Forward View largely ignores the structures and competition clauses within the Act
- the Private Members' Bill from London MP Clive Efford which sets out proposals for a limited repeal of the Act
- the draft Bill drawn up by Professor Allyson Pollock, barrister Peter Roderick and Lord David Owen for the complete reversal of the Act and the "reinstatement of the NHS".

4.1 WE RECOMMEND a full debate on the necessary steps to repeal or reverse the damaging clauses of the Act and their associated regulations; cut the bureaucratic costs of management consultancy, competitive tendering and other trappings of the "market;" free the NHS and its local bodies from the tentacles of competition law and the Competition and Markets Authority, and establish the explicit duty of the Secretary of State to provide a universal, publicly provided service.

[69]Charlesworth A (2015) NHS finances, the challenge all parties need to face, Health Foundation Briefing, http://www.health.org.uk/publications/nhs-finances-the-challenge-all-political-parties-need-to-face/

Recommendation 5: Improve the quality and accessibility of primary care

In our first Inquiry report, we recommended that an investment programme in primary care should be reinstated as a priority, and that part of this must involve capital investment to ensure all GP practices in London are enabled to make use of modern, accessible local facilities in health centres.

Since then there has been a recommendation for a £1 billion investment in new premises, which we welcome. But spending on primary care is still a diminishing share of the NHS budget, and the pressures on primary care are obstructing the necessary recruitment of new GPs and the retention of those in post.

5.1 WE RECOMMEND an immediate halt to any further erosion of the share of NHS spending allocated to general practice, along with the phased increase of funding for primary care in London, as proposed in NHS England's Strategic Commissioning Framework.

Recommendation 6: Further investment needed in ambulance services

The London Ambulance Service (LAS) is suffering some the most intense scrutiny and critical press coverage it has experienced since the 1980s, as the service takes the blame for under-resourced hospital emergency care and a failure to deliver promised alternative services in primary and community care.

Things have got visibly worse since we called a year ago for an urgent review of emergency ambulance services to establish the resources needed to meet and sustain target standards. The closure, and threatened further closures of A&E units in London makes this review even more essential, since each downgrade and closure of an A&E serves to lengthen journeys and delays in handing over patients, and thus pull down LAS performance against target response times.

LAS senior management must be willing when necessary to warn publicly when the consequence of local cutbacks put fresh strain on an already under-resourced service.

6.1 WE RECOMMEND that, pending the outcome of a review, all further downgrades and closures of A&E be put on hold until such time as LAS resources are expanded to meet the additional pressures. LAS urgently needs more staff, investment in the ambulance fleet, and a rethink of the working patterns of 12-hour shifts that appear to put intolerable strain on staff and create a further problem in retention of trained paramedics.

6.3 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, and for such costs to be factored into the business case of any proposed changes.

Recommendation 7: Midwifery staffing levels and maternity units

WE CONGRATULATE the Royal College of Midwives on achieving close to its target levels of midwife staffing in London, and continuing the campaign for safe, modern, patient-centred models of treatment.

Last year we called for further evidence to show the clinical safety of stand-alone midwife-led units in the context of the social conditions in London. The further evidence given this time to the panel satisfies us that the model is safe, although we are still concerned that such models may be used in a cynical way by trusts or commissioners not primarily as a way of improving maternity care, but as part of an argument for downgrading or closing more hospitals.

7.1 WE AGAIN RECOMMEND a full review of plans to use the issue of 7/7 working and 168-hours per week consultant cover as a pretext to further centralise obstetric and paediatric services. International comparisons indicate the UK system may be excessively centralised already. We remain unconvinced that centralisation is an appropriate response to problems of achieving compliance with the European Working Time Directive, or in allowing women genuine choice on how and where to have their baby.

Recommendation 8: Improve communication and management relations with staff, and provide adequate protection for whistleblowers

In the light of the latest report by Sir Robert Francis on the treatment of staff who raise concerns over the quality of patient care, we note a depressing lack of progress in protecting "whistleblowers" from harassment and victimisation by management.

8.1 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 anywhere such measures have not been developed or proved unresponsive.

8.2 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.

8.3 WE NOTE that the proposal by Sir Robert Francis that trusts each appoint their own Whistleblowing Guardian is unlikely to be effective or overcome strong staff anxiety regarding the safe raising of concerns. WE THEREFORE RECOMMEND that each health economy should have a Guardian's office, appointed independently by the Department of Health.

8.3 In line with the 2013 Francis Report, WE RECOMMEND that where, for lack of funds, services cannot be sustained to ensure safe and acceptable quality of patient care, the NHS management concerned should make it clear to commissioners, politicians and the public that these services will be closed unless more funding is provided.

Recommendation 9: Independent review of the evidence base for the clinical case for reconfiguration

Our inqury panel has heard accounts of the disastrous consequences of the closure in NW London of two A&E units without having put in place adequate alternative services and capacity in neighbouring hospitals or on the community. In SE London, too, services are struggling to cope, even after the plans to axe hundreds of beds have been overturned.

It is important to note that more studies have recently been published, from the King's Fund, the Nuffield Trust and the Health Service Journal's Commission on Hospital Care for Frail Older People, all of which question the validity of key assumptions on which London's main reconfigurations have been proposed. The Panel has also heard that fears that commissioners and NHS Trusts in NW London are nonetheless determined to press ahead with further ill-prepared closures, of maternity at Ealing Hospital, and of acute services at Charing Cross and Ealing hospitals, disregarding the lessons of the first cutbacks, and ignoring the findings and recommendations of the Independent Reconfiguration Panel report in the autumn of 2013.

9.1 AGAIN, AND WITH ADDED URGENCY, 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 10: Health & Wellbeing Boards

We note the results of the last local elections in Hammersmith and Fulham and see the over-turning of the previous high profile Conservative administration as an indication that people wish, and have the right to, vote on health strategy. However the structures established by the Health & Social Care Act leave no real avenues for this to happen on a day to day basis.

This situation could be changed. So far Health & Wellbeing Boards, bodies created by the Health & Social Care Act, but in the control of local boroughs, have not taken advantage of the flexibility they could have to develop as powerful, inclusive local bodies holding NHS and social care services to account across London. WE AGAIN RECOMMEND this inclusive, outward-looking approach as a necessary step to ensure HWBs are best equipped to play a leading role in shaping services.

HWBs with a more developed role in local commissioning of services are included in the Ten Year Plan for the NHS issued in 2015 by the Labour Party. However there is only one fleeting reference to HWBs in the recent Memorandum of Understanding setting out the plans by Chancellor George Osborne, along with NHS England, to devolve £6bn of health funding to the Greater Manchester Combined Authority. This will set up a project board entirely consisting of local government, NHS and central government bureaucrats, along with council and CCG leaders who have not made any attempt to consult those they are supposed to represent before signing up in support.

If bold steps were to be taken by London boroughs, powerful expanded Health and Well-being Boards, bringing councillors together with local campaigners, communities and service users could play a much more active and effective role in shaping the strategic future of public health, health care and social care in the capital.

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