Disaster Healthcare in North West London

Discussion paper submitted to Health Campaigns Together by Roger Steer

Disaster Healthcare is raising its ugly head again in NW London. The threat of a future healthcare financial meltdown is being used to justify the undemocratic 'transformation' of the way in which the NHS delivers healthcare, the amount of healthcare that can be expected, and the method of financing that healthcare.

In the past it was left-wing agitators who were accused of being quick to claim a crisis in the NHS, now it seems the NHS's own managers are inclined to draw attention to the prospect of year-end deficits as a sign of a deeper malaise and as a trigger for radical action.

NW London NHS has broadcast the fact that it is heading for over £100m overspend; its reaction is to restrict healthcare "affecting patients, (which) will generate strong views and we will need to make some difficult choices".

This is straight out of the Disaster Healthcare handbook, where every crisis is used as an opportunity to further a neo-liberal health agenda denying care to those that need it and reducing the capacity of the NHS to provide healthcare. We have seen it before, it doesn't work, there is no evidence it can succeed and it should be treated with the contempt it deserves.

The NHS has history

In 2008 David Nicholson, then NHS Chief Executive, described the £20bn challenge of bridging the gap between projected health needs and the resources to meet them. He suggested a radical centralisation of NHS hospital care to bridge the gap. The financial crisis of 2008 and a change of government in 2010 gave these plans further impetus and culminated in proposals to close A&E departments and hospitals in NW London – the Shaping a Healthier Future (SaHF) proposals. It was claimed that the NHS was unsustainable in its current form, its budget heading for massive uncontrolled deficits, and the only hope was to hand over control of the NHS to new unproven ways of 'transforming' the NHS – preventive action, new technology and private sector expertise (new models of care) would somehow enable cutbacks in healthcare capacity, A&E departments and professional staff.

That story did not end well, with the SaHF proposals finally thrown out in March 2019. But almost inevitably NHS managers have come back for a second bite of the cherry. The new story is rebilled as 'Delivering the Long Term Plan' through integrated care systems.

The national NHS Long Term Plan, published in January 2019, was intended to be a useful distraction from the failed Sustainability and Transformation Plans of 2016. However it is no plan at all but just another rehash of the old narrative. There is no resource plan to back it up (with recent announcements of additional funds merely repackaged versions of previous announcements), no capital funding plan, no staffing strategy and no way of dealing with the mounting social care crisis. Yet it repeats the same mantra that salvation lies in 'transformation' and 'integration', rather than in the obvious solution of flexing finances to cope with rising pressures.

NHS England's intention is to evade the Health and Social Care Act 2012, which purported to strengthen local commissioning of services, to create new managed entities remote from democratic scrutiny and control. This would spell the end of local control of commissioning and allow the imposition of swingeing cuts to services under cover of 'patient safety' or 'restoring financial control' by avoiding what is seen as 'the local veto' represented by the requirement for local scrutiny and local support for any significant change to local services.

Are NHS finances out of control?

Financial sustainability is invoked time and time again as the reason for cutting services to the public. In reality the problem the NHS faces is an excess of financial control in the face of burgeoning populations, ageing populations with multi-morbidities, and failures of social care and primary care to cope with the rising demand for services. The proof is the permanent ability of the Department of Health and Social Care to present balanced budgets at year-end, every year, with unerring and uncanny exactitude (give or take a tiny blip in 2017/18 and 2018/19).

Going back further in time the iron grip of the state on healthcare spending is demonstrated over and over. Finances are not out of control. Whatever the service pressures the Department of Health and Social Care always balances its books.

It does this using the full panoply of tactics from the "let's store problems up to be solved another day" book. We all know them: supress salaries and wages, cancel maintenance, delay investments in replacement equipment and buildings, fail to account for the full costs of hidden costs (pensions , clinical negligence), defer training and reduce numbers of trainees etc. All these tactics are short term and counterproductive. It is however misleading to see the problems in the NHS as lack of financial control. The problem is the price of that financial control.

It has been pointed out that many Trusts have had to take out loans totalling £14bn to help meet their cash commitments thus demonstrating lack of control. The reality is that these are being funded from other areas of the NHS and capital budgets. This is not to deny that there are not high and intractable pressures in parts of the NHS but rather it shows the scale of the resources that can be brought to bear from within the NHS to keep the show on the road.

Are NW London NHS finances out of control?

We consider NW London financial performance in relation to the NHS allocation policy intended to provide fair funding for localities, and also in relation to NW London current performance.

NHS allocations

The table below is compiled from recent NHS CCG allocation totals compared to those in previous years, the most recent being July 2019. DfT refers to percentage 'distance from target', where target is a fair allocation of resources based on population need. Three things are clear from the table.

First, the overall London funding position has moved further above target, and will stand at 2% above in 2020/21. Secondly, NW London as a whole has moved from being overfunded, ie having allocations in excess of target, to being close to target, with large over-allocations only in West

London CCG and Central London CCG. There was a shift of 3.1 percentage points between 2018/19 and 2019/20 in NW London or around £118m of total NHS place-based allocations.

Third, Hammersmith & Fulham CCG in particular has moved from being 5% in excess of target in 2016/17 to 2.8% under target allocation in 2019/20. If H&F CCG were to receive its full target allocation it would have an extra £10m per annum[1].

Total place-based allocations[2]	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
	DfT	*DfT*	*DfT*	*DfT*	*DfT*
Brent CCG	-0.6	-0.5	-0.5	-3.6	-3.5
Ealing CCG	-1.8	-1.6	-1.6	-1.6	-1.6
Hounslow CCG	-2.5	-2.3	-2.3	-1.2	-1.1
Hammersmith and Fulham	5.0	4.4	4.3	-2.9	-2.8
Harrow CCG	-3.2	-2.8	-2.8	-0.9	-0.8
Hillingdon CCG	-2.9	-2.5	-2.5	-1.1	-1.0
West London CCG	23.1	21.2	19.4	14.8	14.8
Central London CCG	14.5	12.7	10.3	4.9	5.1
NW London	3.4	3.0	2.5	0.6	0.7
London	**0.9**	**0.7**	**1.3**	**1.6**	**2.0**

In NW London as a whole there is no case for major cutbacks in spending. Only Central London and West London CCGs are considerably above target; the move to pooling budgets in a merged mega CCG would act to mask that fact.

Current performance

NW London NHS finance reports in month 4 of 2019/20 give the financial position of the NWL CCGs as showing a year-to-date deficit of £20.7m, £4.3m worse than plan; but still NWL CCGs forecast they will achieve the deficit plan for the year of £50.9m.

So the basis of letters from the NW London NHS supremo, Mark Easton, claiming to be heading for a £112m deficit at year-end is unclear. No detail has been provided.

[1] The funding position of H&F CCG may be being distorted by the GP at Hand scheme being promoted through a local GP practice in H&F; although we are led to believe that this is not the reason for recent increases in deficits . As the Allocation reflects registered patient populations we would expect the allocation to increase as new patients are recruited, but extra costs would be encountered. The local council is seeking assurances that local residents are not losing out.

[2] The figures for 2016/17, 17/18 and 18/19 are taken from the allocations published in 2016. For 2019/20 and 2020/21 figures are as released in July 2019. See https://www.england.nhs.uk/allocations/

Even if this were true several actions are possible other than to resort to panic measures. For example it should be possible to draw down additional resources from the centre as has been done in many areas across the country.

The reasons for the projected deficits must be fully understood. Finance reports indicate a £50m deficit was planned and so the true variance may be just £60m not over £110m.

Indications from the finance reports are that there is no mystery to the increase in overspending: it is related to an increase in patient activity. GP list sizes have increased by 8%, A&E activity by 6%, non-elective admissions by 10% and elective care by 4%.

Harrow CCG is responsible for more than 60% of any overspend; the resource allocations figures summarised above indicates that surplus resources may lie in Central and West London rather than across NW London as a whole.

What all this points to is a mentality pervasive in the NW London NHS that is blind to rising demand because planning models assumed demand could be reduced and activity would fall. In any case the size of the total health economy in NW London is over £4.5bn, so a surge in spending of £50m still represents just 1% of spending and does not justify ill-considered and urgent action without scrutiny and relevant approval.

Effort should be applied to properly reviewing the needs of the rising population, identifying the reasons for excess spending and targeting resources and action accordingly.

So what is actually happening?

According to the NHS's own figures, population is growing, demand is rising and resources are not keeping up. Shortfalls in primary care and social care are directing more patients to A&E departments and urgent care services.

In the face of ample evidence to explain current spending pressures the Chief Officer of the NW London Collaboration of CCGs has written to colleagues in NW London raising the spectre of "difficult choices".

The only specific things mentioned in the letter are plans to reduce out of area activity (but if patients choose to go to capacity down the road because of difficulties being seen in local premises the answer is improving access to local services, not cutting them); reducing consultant to consultant referrals by 20%; making people pay for over the counter medicines; reducing patient transport; cutting home oxygen costs; reducing enteral feed costs; trying to understand rising emergency care costs (closing cheaper urgent care premises doesn't help); and increasing 'demand management' by letting primary care networks know when the contract is running out (!).

This doesn't sound convincing and the fear lurks that plans to close services at Ealing Hospital and elsewhere will be presented on safety grounds as a means of securing savings not available on agreed rational grounds.

The implications of increased demand on staff are that they are becoming burnt out and are leaving, are proving difficult to recruit and performance standards are slipping. Plans need to be drawn up which address the real problems and these need to be discussed with communities and the staff

charged with implementing them. At present there are no draft plans, no agreed plan and no justification for officers taking urgent action.

So why does the NHS persist in pursuing “transformation”? In part it is wishful thinking. Who wouldn’t want to be able to meet rising demand for healthcare at no extra cost? Unfortunately the claims of snake oil salesmen cannot always be trusted, and neither can politicians induced into this way of thinking by payments, and false promises. An extraordinary number of parliamentarians have direct links with the private healthcare industry. So do more than a third of GPs sitting on CCG Boards.

The alternative of providing more resources and employing more doctors is regarded as unaffordable and politically unacceptable by some politicians. But the UK cannot have its cake and eat it. It cannot be world-beating at lower funding levels in out of date premises. The UK spends about 22.5% less than the top European 15 nations. The numbers of doctors it uses is even less. The answer is therefore obvious.

In addition productivity is linked to investment in modern equipment in modern premises. Without ready access to investment funds the UK will lag behind. In NW London capital investment and increases in resources could improve both output and productivity. Unfortunately capital investment is not affordable financially under current rules and previous plans for capital investment would have led to less staff and resources to meet rising demand.

There have to be changes in both national funding and staffing strategies before a coherent local plan can emerge. Ploughing on with a plan that will make matters worse is the real recipe for disaster.

Healthcare Audit Consultants

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