SAVE LEWISHAM HOSPITAL CAMPAIGN CONFERENCE AND DISCUSSION
NHS in Crisis
Why is our NHS under threat and what can we do to defend it?
Goldsmiths College Saturday 5 December 2015

THE THREAT TO COMMUNITY SERVICES IN LEWISHAM

Brian Fisher and Tony O'Sullivan

- **Austerity is hitting the poor, the disabled, those with mental health difficulties and other vulnerable groups and even kills people**
- **When combined with cutting the welfare state, austerity kills**
- **Under government cuts, our welfare state could become a skeleton service**
- **Community care *(health and social care)* has been slashed over the last five years from the significant expansion which took place in 1999-2010, following the Thatcher/Major Tory years 1979-1997**
- **Community services for older people are reducing to unsafe levels**
- **Community services for children, including child protection ('safeguarding children'), are threatened by government NHS and council cuts**
- **Funding for CAMHS (Child and Adolescent Mental Health Services) suffered a devastating cut of 27% in one year, and despite a hasty injection of government funds, has not returned to previous levels**
- **Local health commissioning managers [see below – OHSEL] hope to invest in community care – but at the same time are due to save £1.1billion annually by 2018/19**

The Save Lewisham Hospital Campaign wants to see:

- **Investment in community services for safer, better services closer to home**
- **All health service plans open to public scrutiny**
- **No cuts to our hospital services – the hospital at the centre of our community is the key to the safety of pathways delivering community-based care:**
- **Changes to services to improve care, i.e. not for purely financial reasons**
- **Support for the council where it is fighting cuts to vulnerable community services**

What is 'Community Care'?

Community care is any service provided outside of the hospital. This includes general practice, (primary health care), social care and all the NHS services delivered in the community, including pathways into and out of hospital.

GPs, district nurses, children's nurses, health visitors, school nurses, therapists, counselling and mental health services, child development and disability services, safeguarding children and vulnerable adults, adoption and fostering services for adults with learning and other disabilities, home care, day centres and residential homes, sexual health services, voluntary

sector support services, community pharmacies, the 111 service and the London Ambulance Service and many more.

Community care is vital for safe and effective care at home and between hospital and home.

Community care is the often invisible but vital web of support – most vital for the vulnerable in our society – delivering care between hospital, community and council services, often in our own homes. It provides a complex support network of personal care, advice, treatments and therapy: the oil that helps the NHS work more smoothly and the glue that holds the health and care system together.

We are more familiar with and understand better what hospitals do; and we are more readily fearful and angry when our local hospital is threatened. It is harder to recognise threats to a wide network of services which embrace and support vulnerable and sometimes silent populations in the community. It is less obvious what to protest about and to whom.

Austerity means attacks on wages, benefits and living standards and cuts to the welfare state. This combination is toxic and dangerous. It kills vulnerable people

- Since May 2010, under the Coalition Government:
    - Councils have had a 40 per cent cut to their government grant
    - 350,000 full-time staff have been lost
    - 150,000 fewer people now receive adult social care

- Lewisham Council's 'General Fund' which pays for our local services has been cut already from £391m in 2010 to £270m today (a cut of 31%).

- Further savage cuts have been signposted by Osborne. Government's 'direct support grant' to fund local authority services in Lewisham is plummeting – from £208.1million in 2013 to £138.3million in 2017 (34% reduction) – to *ZERO* by 2020, according to Osborne's Comprehensive Spending Review.[1] The differential assault on less wealthy, working class Labour areas is thinly disguised.

- The National Audit Office says: "Need for care is rising while public spending is falling, and there is unmet need." *['Unmet need' means people are at risk from neglect of their essential health and social necessities]*

- The voluntary sector has been slashed and faces new cuts of about 25%

- 1000 extra deaths from suicide and an additional 30-40,000 suicide attempts are estimated to have occurred during this period of economic crisis. [2]

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

[2] http://www.theguardian.com/society/2015/nov/12/austerity-a-factor-in-rising-suicide-rate-among-uk-men-study

Some of the effects on community care facing our Lewisham population right now and into the future

1. **Staff are increasingly stretched and are working harder and longer hours *(typically unpaid).*** Despite these challenges, most users still receive a good quality service delivered by caring and attentive staff who listen and involve them in decisions about their care.

2. **Services are diminishing**. Healthwatch and the Save Lewisham Hospital Campaign investigated community care in detail. We found:
   - Difficulties accessing services, resulting from a reduction in community care provision,
   - Poor co-ordination of services and continuity of care,
   - Confusion about where to access services and how to find them

3. **General Practice**
   Despite its apparent commitment to 'community-based care', the Government has cut the proportion of NHS funding going to general practice, now down to only 7%. Yet 90% of patient contacts take place in general practice. Government undermining of primary care and GPs has done real damage and left a workforce with severely damaged morale. 40% of GP vacancies nationally are not being filled. Whilst many people still praise wonderful care from their family doctor, others experience real difficulty particularly in getting appointments:

   > *"If the children are ill you need an appointment on the day … not always easy. I can get here at 8am and there may not be any appointments left. I've had to go to A&E in many cases."*

   GP practices usually offer enough time. Doctors often go beyond the allotted 10 minutes and patients value this immensely from the GP or nurse:

   > *"My particular doctor allows me time to explain myself, others don't."*
   > *"Lovely, there's no rush with the nurse, nothing's done before she talks to me."*

4. **Nursery provision for disabled children**
   It is harder and harder to get nursery provision for children under 3years. Disabled children, e.g. children with autism or cerebral palsy, used to get free or subsidised good nursery provision. There community therapy teams could work with Early Years staff and parents to enable early intervention. This is much more difficult now unless parents buy their provision.

5. **Mental health services,**
   Mental health services are vital to our lives and were an early casualty of austerity. Services have been overstretched for years, with gross underfunding and neglect. We all now recognise that mental and physical health overlap, influencing each other but services rarely seem to reflect that. With services in crisis, and inpatient beds disgracefully scarce, some additional

funding has been allocated by the Government for those with 'complex needs', though there are always strings attached.

Many people who can access IAPT services (Improving Access to Psychological Therapies) really value the improvement to their health and wellbeing, but access needs to be improved dramatically. Healthwatch heard many examples of patients not being adequately prepared for discharge from their IAPT therapy course, leaving many feeling very isolated without support.

> *"Very long waiting times for cognitive behaviour therapy. More counselling services [are] needed."*

> *"Access to counselling is too long – this leads to symptoms worsening and can lead to complete breakdown."*

The majority of people who got to IAPT really valued this service and the improvement in their health and wellbeing.

> *"Best thing that happened to me was I was given counselling. The worst was when I was an inpatient – I did not get the care and attention I needed. The nurses did not have time to sit and talk to me. Kept in isolation for too long."*

Waiting times for CAMHS (Child & Adolescent Mental Health Services for young people) have grown significantly since **large cuts of 27% in 2010/11.** Recent hasty injection of government funds has not returned services to previous levels. There is also a lack of awareness amongst young people and their families as to where and how to access additional support outside of CAMHS services. We are pleased to hear that a new triage system has been introduced so that those young people most at risk can be given priority.

6. People with Learning Disabilities and complex health needs

Adults with learning disability or high dependency needs for physical and other reasons are severely affected by cuts. Cuts result in adults with significant disability having reduced day care options and reduced respite care. It means that increasing numbers of people are likely to be reliant more and more on their increasingly elderly parents, and both have less access to respite care. Carers cannot take holidays so easily, leading to exhaustion and the adults who need these life opportunities have less access to them.

> *"The changes and cuts to day care are life-changing for my son who has learning disabilities."*

After years of lobbying by parents of young people with autism for support as they make the transition to becoming adults, a service was commissioned in Lewisham, run by the Burgess Autistic Trust. The service was helping to transform the experience of young people and their families at transition, with a variety of courses and services, including supported leisure, counselling and mentoring. However, recently the team of eight people (four full time) has been slashed to two – one full-time and one part-time. It is hard for families to see their hard-won gains being taken away.

7. District nursing

District nurses visit patients in our homes: for long term conditions, post-discharge from hospital, treating and dressing leg ulcers, giving injections (e.g. antibiotics), dressing wounds and numerous other aspects of care. The service needs substantial improvement if we are serious about improving community care**. *It needs more nurses, with the experience and range of skills to work in home settings*,** if we want people cared for safely, in larger numbers, with fewer admissions, over longer periods.
Recruitment and retention of staff has been a problem. *Nurse training nationally has reduced by 4000 training places* since the Coalition Government came to power in 2010 and there are now severe shortfalls in available nurses. We understand that some senior nursing positions have remained vacant and lower grades (reflecting less experience) have been recruited. Overall the quality of nursing remains good. However, problems exist that cannot be ignored. If the vision of excellent community-based care taking up some of the demand currently met by hospitals is to be realised in practice, these problems must be recognised and addressed.

> *"Different nurse every time. Didn't know who was going to come."*
>
> *"They didn't turn up at all, the call centre had no knowledge of when they were going to arrive or call back."*

The district nurse sometimes is the only person the housebound patient sees in a day. When patients feel that nurses are 'in and out as soon as possible' it leaves people feeling unhappy with the experience.

One patient commented that being bed bound left her in an extremely vulnerable position and felt her overall experience of care had been humiliating. ***We have to do better than this!***

8. Sexual Health services

In this key area for young people addressing important needs such as contraception, safe-sex, sexually-transmitted disease and well woman's health, two clinics in Lewisham have become nurse-led (Sydenham and Downham). This is the first time ever that there have not been doctors at these clinics and over the last few years opening hours have been cut for all the clinics. The trust argues that there has been a centralisation of services at the Waldron Health Centre's clinic and that they are putting in the resources there, but there have been real cuts and many nurses have left the service because of the changes.

9. Health visitors, school nurses, family nurse partnerships

At present there have been no cuts in health visiting, school nursing or family nurse partnerships apart from bearing their 'share' of the Trust savings which are taken from the budget each year.

The threat to health visitor, family nurse partnerships (working with young, vulnerable parents) and school nursing will be felt in the coming year as these services are now funded by public health through the Council, which is facing huge government cuts. As well as the effects on users of these services, it feels unsafe and stressful for staff working with vulnerable children with so few support services and high social care thresholds

10. Hospital discharge

When a patient is discharged from hospital to continue their care at home, safe and effective community based care must be there to support them. Getting someone out of hospital at all

costs when social care and community nursing cannot offer safe continuity to that person's care is the opposite of integrated care.

We found that discharge practices can be unsafe.[3]

We found a need for improvement in:

- Awareness of discharge procedures
- Consistency of discharge planning
- Communication between multi-disciplinary agencies
- Family, friends or carers being involved in the discharge process
- Reducing long waits for those waiting to be discharged

"I was left to travel home with my belongings spilling out of plastic bags, while wearing pyjamas and with no money and/or means to travel. I was fortunate that a friendly stranger helped me out. Travel should have been provided … It should be provided for ALL vulnerable patients."

Local Authority cuts

Lewisham has worked hard on better integration between hospital, primary care and social services but the last few years have damaged the pathways. *And there is more to come.* **Here below are some proposed local authority cuts 2016-18,** still to be debated by the council.

SERVICES UNDER THREAT	INTENDED SAVINGS
Provision of care and support services, including mental health	£1,800,000
Reduced care packages, mainly for the elderly	£1,100,000
Health Protection	£23,000 over 2 years
Obesity/Physical Activity	£23,000 over 2 years
Health Inequalities	£100,000 over 2 years
Sexual health services	£500,000 over 2 years
Youth services	£300,000 over 2 years
Adults with learning disability	Information not available yet

The future of services in Lewisham: Our Healthier South East London

It is in this context that **Our Healthier South East London** (OHSEL), bringing together six South East London Clinical Commissioning Groups, is planning health services across the whole area. One of their key aims is to boost community services. However well-intentioned this may sound, the devil is in the detail and in the context.

OHSEL says that community services must be significantly boosted in order to safely manage the increasing need for acute care and long term conditions, which would otherwise need hundreds of

[3] http://www.healthwatchlewisham.co.uk/sites/default/files/discharge_report_.pdf

additional acute hospital beds. **And yet the projected annual health funding for SE London has to be reduced by an annual £1.1billion by 2019/20.** This is the SE London proportion of the £22bn reduction in NHS funding requirement nationally by 2019/20 agreed between Simon Stevens, NHS England's chief executive and Jeremy Hunt.

Most senior NHS executives[4] and thinktanks[5] now agree this is not possible, especially with no protection for social care. It comes after years of 'efficiency savings'.

Community care needs massive investment, hospitals are at 95-100% bed occupancy, nursing rotas have to rely on agency staff and social care is being decimated. Even in Simon Stevens' own view, in his *Five Year Forward View,* there are key barriers to making such savings possible:

> *The need to take effective action on prevention (e.g. obesity and diabetes);*
> *The need to invest in new care models;*
> *Most importantly: the sustaining of social care services; and*
> *Improving efficiency through big investment in the wider systems such as IT.*

Even more importantly, the evidence that better community services will *reduce* the need for hospital services is very weak. With investment, good community services deliver good care but do not significantly reduce the need for hospital inpatient capacity. (See Appendix)

There are suggestions that OHSEL also wants to cut some hospital services. This is dangerous and short-sighted. The UK has the fewest beds per head of any advanced country – and the beds are so overused that they can pose safety risks.

We continue to expect of OHSEL that is shares all its plans with local people, as it is legally bound to do.

What we want for Lewisham

Community based care has to be safe care. It has to be able to support people with significant health needs to live their lives successfully in the community, with as good a quality of life as possible. It means people having access to good health care, and good social, educational and leisure opportunities. It means good access to facilities and services at home and in the community and it means that disabled or ill people can use that access.

Families and carers need to know what services are out there. They have to physically be able to access them. Carers must be protected from exhaustion. It means good, safe primary and community health care and good locally available inpatient hospital care when needed, linking effectively with Social Services.

Good communications are needed across the whole of health and social care. And it means health, social care, education and training, and voluntary sector services all working together.

Good community care also will support communities to help themselves.

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[4] http://www.theguardian.com/commentisfree/2015/nov/08/nhs-chairman-funding-crisis-collapse
[5] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/kings-fund-spending-review-submission-sep-2015.pdf

Join the Campaign in fighting for:

- **Investment in community services for safer, better services closer to home**
- **Halting of cuts to services for vulnerable communities**
- **All OHSEL plans to be open to public scrutiny**
- **Maintained and improved hospital services**
- **Support for changes to services only when there is reliable evidence that shows they are likely to improve care**
- **Help us to fight against cuts and for improved community services by letting us know about cuts.**
  Contact savelewishamhospital@yahoo.com

Brian Fisher and Tony O'Sullivan **December 2015**

Appendix
SOME REFERENCES ON COMMUNITY BASED CARE and ADMISSION AVOIDANCE and INTEGRATED CARE/ OUT OF HOSPITAL CARE

Overview on proposition that there are alternatives that can replace hospital care
NHS For Sale: Myths, Lies & Deception. Jacky Davis, John Lister, David Wrigley. 2015 pp 44-47- Are alternatives any cheaper? Do they even work? [references in book] http://keepournhspublic.com/ Monitor. Moving healthcare closer to home: a summary **It is difficult to cut costs across a local health economy in the short run** Although schemes can help hospitals avoid future capital spending, it is difficult for local health economies to save costs in the short run through community-based schemes. Three of the four schemes we modelled did not break even within five years. This is because: • Schemes can take up to three years to set up, recruit and become sufficiently credible to attract referrals. So providers and commissioners should not expect immediate impacts. • Even when schemes are cheaper per patient, it may be difficult for the local health economy to realise any savings. A local scheme (or schemes) will only lead to health economy-wide savings if it consistently diverts enough patients from local acute hospitals to allow them to close bed bays or wards. The cost saving is then only realised if providers and commissioners have the will to close down capacity that is freed up. In the context of rising demand for acute care, commissioners and providers will need to be entirely confident that community-based schemes can safely absorb expected extra demand before they will feel justified in closing acute capacity. However, community-based schemes will help commissioners and providers to avoid or delay future capital spending whether acute capacity is closed or not. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459400/moving_healthcare_closer_to_home_summary.pdf
Is there evidence for community based care reducing hospital admissions safely?
David Oliver. Preventing hospital admission: we need evidence based policy rather than "policy based evidence". BMJ September 2014; http://www.bmj.com/content/349/bmj.g5538 *"In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals.1 But the size and speed of these reductions were not informed by any credible peer reviewed evidence—they rarely are.* *Recent reviews by the Universities of Cardiff and Bristol on admission prevention and by the health think tank the Nuffield Trust on new models of service in the community, found that the big and rapid reductions were illusory, once the findings had been peer reviewed and control data taken into account."* [other references in article]

Roland M, Abel G 2012. Reducing emergency admissions: are we on the right track? BMJ 2012;345;e6017, 16 September 2012
http://www.bmj.com/content/345/bmj.e6017 - [further 22 references in article]

"*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 percent of an average general practitioners 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."* [thanks for finding, Greg Dropkin]

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http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf Does investment in the health sector promote or inhibit economic growth?

http://www.hsj.co.uk/Journals/2014/11/18/l/q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf Commission on hospital Care for Frail Older People HSJ and Serco

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S Purdy. Interventions to reduce unplanned hospital admissions. 2012. A series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.
http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/

"***Background:*** *The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA* [unplanned hospital admission]*. Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions."*
"***Conclusions:*** *This review represents one of the most comprehensive sources of evidence on interventions for unplanned hospital admissions. There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, A & E services and continuity of care reduce unplanned admissions."*

[See below for further extracts on individual areas reported on]

Effect of targeted intervention to population 'at risk' of admissions
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf The effect of the British Red Cross 'Support at home service" on hospital utilisation. Nuffield Trust *"We analysed data on hospital use in the six months after referral to Support at Home. The Red Cross group had a 19% higher rate of emergency admissions than the control group. Accident and emergency visits were also similarly higher. Nonemergency admissions, however, were 15% lower in the Red Cross group than in the matched control group. There was no significant difference between the two groups in terms of outpatient attendances."* [extract from executive summary]
On Integrated care
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf The reconfiguration of clinical services: what is the evidence? Kings Fund. Candace Imison http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0005/81266/BP-08-1210-035.pdf
On impact of social care
David Oliver president, British Geriatrics Society, and visiting fellow, King's Fund. We cannot keep ignoring the crisis in social care. BMJ May 2015; http://www.bmj.com/content/350/bmj.h2684

S Purdy (2012) **Interventions to reduce unplanned hospital admissions** which is a series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.
http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/

Executive summary:
*"**Background:** The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA* [unplanned hospital admission]*. Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions."*

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Executive summary of findings under individual categories
Overall **case management** did not have any effect on UHA although we did find three positive heart failure studies in which the interventions involved specialist care from a cardiologist " "specialist clinics for heart failure patients, which included clinic appointments and monitoring over a 12 month period reduced UHA… There was no evidence to suggest that specialist clinics reduced UHA in asthma patients or in older people."

Community interventions: Overall, the evidence is too limited to make definitive conclusions. However, there is a suggestion that visiting acutely at risk populations may result in less UHA e.g. failure to thrive infants, heart failure patients.

Care pathways and guidelines: There is no convincing evidence to make any firm conclusions regarding the effect of these approaches on UHA, although it is important to point out that data are limited for most conditions.

Medication review: no evidence of an effect … in older people, and on those with heart failure or asthma carried out by clinical, community or research pharmacists … the evidence was limited to two studies for asthma patients.

Education & self-management: Cochrane reviews concluded that education with self-management reduced UHA in adults with asthma, and in COPD patients but not in children with asthma. There is weak evidence for the role of education in reducing UHA in heart failure patients.

Exercise & rehabilitation: Cochrane reviews conclude that pulmonary rehabilitation is a highly effective and safe intervention to reduce UHA in patients who have recently suffered an exacerbation of COPD, exercise based cardiac rehabilitation for coronary heart disease is effective in reducing UHA in shorter term studies, therapy based rehabilitation targeted towards stroke patients living at home did not appear to improve UHA and there were limited data on the effect of fall prevention interventions

Telemedicine is implicated in reduced UHA for heart disease, diabetes, hypertension and older people.

Vaccine programs: … the effect of influenza vaccinations on a variety of vulnerable patients. A review on asthma patients reported both asthma-related and all cause hospital admissions. No effects on admissions were reported. A review on seasonal influenza vaccination in people aged over 65 years old looked at non-RCTs. The authors concluded that the available evidence is of poor quality and provides no guidance for outcomes including UHA. A review on health workers who work with the elderly showed no effect on UHA.

Hospital at home: This was a topic covered by a recent Cochrane review of hospital at home following early discharge. Readmission rates were significantly increased for older people with a mixture of conditions allocated to hospital at home services.
We found insufficient evidence (a lack of studies) to make any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of UHA.

Tony O'Sullivan **October 2015**