

Healthy Liverpool: Gambling with Our Future

Liverpool CCG is proposing a major gamble over hospital provision. They believe that increasing care in the community will reduce demand for hospital care. If fully funded and integrated with NHS hospitals, NHS community care could be good, but it can't reduce pressure on hospitals immediately and there's no evidence yet that it will work here amidst poverty, deprivation, austerity and cuts. "Healthy Liverpool" may mean closures and privatisation.

Hospitals

As the Liverpool Echo reported (26 Aug), CCG Deputy Chair Dr Simon Bowers admits that Healthy Liverpool will lead to hospital closures. He told BBC Panorama

"The new model is funded by moving money around the system, so that inevitably means taking money out of hospitals to spend in the community."

"We will have less hospitals in Liverpool at the end of the Healthy Liverpool programme."

Healthy Liverpool (HL) envisages "two adult emergency centres, one of which would provide Major Trauma services". These services are now a collaboration of Aintree, the Royal, and Walton, which suggests one service will close and one will downgrade to an "emergency centre".

On cancer, HL urges reducing Clatterbridge to an outpatient service, and relocating most cancer surgery to the new Royal.

HL suggests that pregnant women with complex needs be relocated from the Women's, possibly to the Royal; that neonatal care be combined with Alder Hey; and that gynaecology could be relocated, again to the new Royal.

Less need for hospitals?

The CCG expects less need for hospital care. Dr Bowers says, *"Through Healthy Liverpool, we are keeping people healthy before they get ill. If we then have to react when they become unwell, we will react close to them, close to home."*

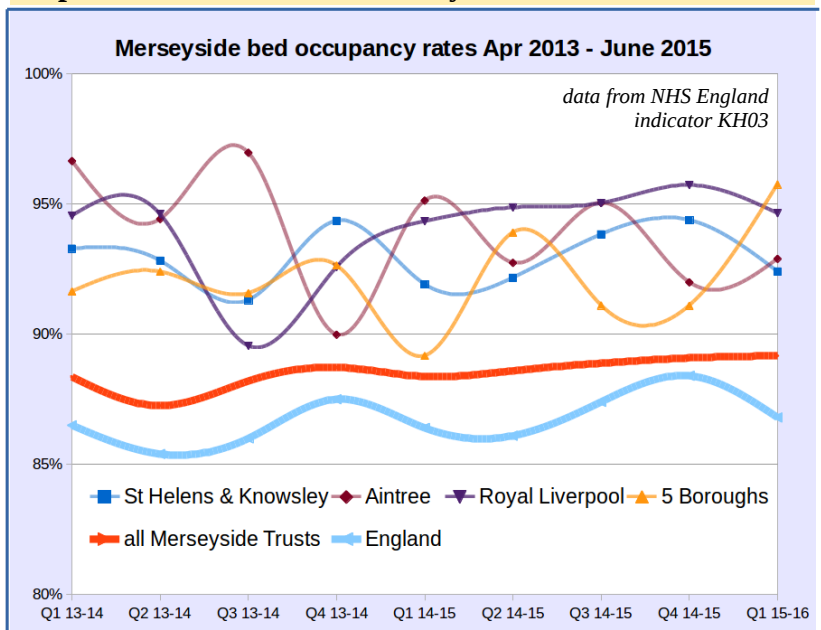
What's the evidence that it will work? A study published in the British Medical Journal and guidance issued by the hospital regulator Monitor and reported in the Health Service Journal in September, pour cold water on claims that community care will immediately reduce demand for hospital services, as assumed by the CCG plan to shift money out of hospitals.

Monitor: Out of hospital care 'no panacea'

As the HSJ reported on 9 Sept., Monitor has warned providers that schemes to move care out of hospital are not guaranteed to reduce costs or demand pressure in the short term.

In a summary note to their "care closer to home" toolkit, Monitor says: "Our findings caution against expecting too much from a shift away from hospital settings; this is no panacea. Developing schemes to move healthcare closer to home should sit alongside work on other solutions, such as improving internal processes and decision systems within acute hospitals."

So why do the CCG think they can take money out of hospitals now to fund community schemes? →



Local hospitals are already full to the brim. The chart shows how Merseyside compares with the national rates and safe level for bed occupancy, the percentage of available beds which are occupied by patients.

Bed occupancy rates above 85% can increase the risk of harm, including hospital-acquired infections like MRSA and *Clostridium difficile*. The rate for all hospitals in England is now above 85%, and the rate across 12 Trusts on Merseyside is even higher. It is well over 90% for St Helens & Knowsley, and the 5 Boroughs partnership (mental health). For Aintree and the Royal, bed occupancy is around 95%. The new Royal will have fewer beds, causing even greater pressures.

If patients are discharged too early, they come back with recurrent problems. If the Healthy Liverpool plan starts closing hospital wards, or relocating patients into hospitals which are already full, the crisis will escalate.

Monitor used computer modelling to forecast the costs of four types of out of hospital care:

- telehealth, providing remote support and triaging through a videolink;
- reablement, which helps patients with complex needs recover at home;
- enhanced step-up care, where adults can be treated in community day case settings; and
- rapid response and early supported discharge, where patients recovering from inpatient stays are treated at home.

All four strategies are part of the CCG's plans.

Case management does not reduce demand

Research published in the BMJ in 2012 examined strategies for reducing emergency admissions by case-management of high risk patients. The lead author, Martin Rowland, has 20 years experience researching GP referrals to hospital.

“Most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population rather than in a small group

of high risk people... To manage this [high-risk] 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.”

Some interventions result in increased numbers of emergency admissions. Three trials of interventions had to be abandoned because of increased deaths among the patients involved.

Lifestyle

The CCG banks on changing lifestyles (more exercise, less tobacco and alcohol, reduce obesity) to improve health. Even if lifestyles change, the effects will take years, and people are already ill. Bad housing and pollution are not lifestyle choices.

Community privatisation

No community dermatology service has reduced referrals to hospital units. In Nottingham, the privatised dermatology service run by Circle and staffed by locums, was described by their CCG's external review as an 'unmitigated disaster'. There is no longer an in-patient service, or any specialist registrars, or any medical student teaching.

Treasury prescriptions?

While doctors are not allowed to prescribe new drugs until their effectiveness and safety have been proved, Liverpool CCG proposes to gamble our health with major cuts to hospital provision, in the hope that community care will reduce hospital demand.

We have no reason to believe that Liverpool CCG has the time and the funds to provide such a full community care service that it could conceivably justify cutting hospital services. Once a hospital service or a whole hospital goes, it's gone for good. Care in the community can only work if it is integrated with hospital care and if both are provided by the NHS as a universal, comprehensive service, free at the point of use, funded by taxation, publicly provided and publicly accountable. Otherwise, it's an enticing marketing tool to sell the systematic underfunding and closure of NHS services and their replacement by co-payments, health insurance and private facilities.

For example, recall checks for chronic illness may become less frequent or the number of infertility treatments may decrease. It may become harder to get hip/knee replacements, operations for cataracts, hernias and varicose veins. The number or duration of visits from carers or day centre opening hours may be reduced. Residential homes and day-care centres may close. Integrating health and social care may result in charges, as social care is means tested.

There's no convincing evidence that community care reduces pressure on hospitals, certainly not in the short term. On Merseyside, amidst poverty, deprivation, austerity and cuts – it may not work at all. The safe and sane strategy is to carry out pilot studies while retaining hospital provision, evaluate them, publish the findings and the data, consider the impact of any reconfiguration plan and bring forward proposals for public debate. Otherwise, the CCG just has a wish list, ditching evidence-based medicine in favour of prescriptions from the Treasury.



<https://you.38degrees.org.uk/petitions/save-liverpool-women-s-hospital>

