

Health Campaigns Together

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'UNTHINKABLE' brutal planned cuts hidden from us till after election

Three days before the election the *Health Service Journal* leaked the news that NHS England and the regulator NHS Improvement had for months been secretly discussing draconian measures to force down spending to comply with the tightening cash freeze on the NHS. The news reached the mainstream media the day before the election.

NHS managers in debt-ridden trusts and commissioning groups in 14 areas have been told to "think the unthinkable," including "changes which are normally avoided as they are too unpleasant, unpopular or controversial." According to one chief executive, some of the proposals "challenge the value base" of NHS leaders.

But the NHS bosses lacked the bottle to release or even leak these details to the public and to the politicians in time to allow voters to show their reaction to this most serious threat of major cuts. The *HSJ* noted that "There is no expectation of details being made public until after the election."

The secretive working methods of NHS England, combined with a tight reading of the usual pre-election "purdah" restrictions on public sector bodies, also blocked the release during the long 7-week election campaign of damaging information on the declining performance of the NHS and the number of key targets that are being routinely missed.

Again voters were kept in the dark, and effectively deceived as ministers attempted to divert attention away from the gathering crisis in the NHS.

But since the election more details have emerged of the plans that are still being developed as part of NHS England's new "Capped Expenditure Process" to restrict spending to the "control totals" set for each area for 2017/18.

Key suggestions identified by the *HSJ* include:

- Limiting the number of operations carried out by non-NHS providers so the funding stays within the NHS.
- Systematically drawing out waiting times for planned care, including explicit consideration of breach-



INEXCUSABLE: the NHS managers who helped conceal damage done by NHS cash freeze

- Bristol, S Gloucestershire & N Somerset
- Cambridgeshire & Peterborough
- Cheshire (Eastern, Vale Royal & South)
- Cornwall
- Devon
- Morecambe Bay
- Northumbria
- North Central London
- North West London
- South East London
- North Lincolnshire
- Staffordshire
- Surrey & Sussex
- Vale of York, Scarborough & Ryedale

ing NHS constitution standards.

- Stopping NHS funding for some treatments, including extending limits on IVF, adding to lists of "low value" treatments, and seeking to delay or

avoid funding some treatments newly approved by NICE.

- Closing wards and theatres and reducing staffing, while seeking to maintain enough emergency care capacity to deal with winter pressures.

- Closing or downgrading services, with some considering changes to flagship departments like emergency and maternity.

- Selling estate and other "property related transactions".

- Stopping prescriptions for some items, as suggested by NHS Clinical Commissioners earlier this year.

Local managers are reported to be concerned not that the public have been hoodwinked, but that the secrecy during the election period means that the plans have been delayed two months into the financial year, effectively magnifying the scale of the cuts required.

As this newspaper is prepared details have emerged of the proposals in two of the areas covered by the Capped Expenditure process, North

Central London and Cheshire (more inside, page 2).

In Cheshire the *Guardian* obtained a leaked 21-page document detailing proposals including an arbitrary 25% reduction in endoscopy examinations, which could put the lives of patients with early stage cancers at risk.

Shadow Health Secretary Jon Ashworth has condemned the secrecy and unfairness of the proposals, which amount to a 'postcode lottery' for patients. He told the *Guardian* "Now we learn detailed proposals for north London involve shocking restrictions on care quality and access for patients. This weak and unstable Tory government expects NHS bosses to put finances ahead of the best interests of patients."

Health Campaigns Together is keen to mobilise even more determined and united campaigning, not only in each of the 14 areas initially targeted for these cuts, but also across the remaining parts of the country which will soon face similar attacks on the quality and accessibility of health care.

They have no public support, and a weak government can be forced to back down if pressure is applied strongly enough.

We want the capped expenditure process scrapped – and full funding for our NHS in place of years more austerity cuts.

NHS is No. 1 concern for anxious voters

You would not have guessed it from the media election coverage focused on Brexit and other issues, but according to Sky Data the NHS was the number 1 issue in voters' minds on June 8 – well ahead of the economy, immigration and Brexit.

Health Campaigns Together did our bit to ensure the NHS was on the political agenda, distributing over 20,000 of our 8-page election special packed with information to campaigners and trade union activists all over England.

We also backed and publicised the work of the #ourNHS NHS Roadshow which promoted non-party campaigning materials and hard hitting videos and social media, with one video notching up over 10 million hits and social media repeatedly reaching out to more than 100,000 followers.

But it's clear that worries about the gathering crisis in the NHS have now reached wide layers of the population. A BMA survey to be published as we go to press has found that for the first time ever more people are dissatisfied with the NHS (43%) than satisfied (33%), and that 82% of the sample surveyed said they are worried about the future of the NHS, and two thirds expect it to get worse in the next few years.

The crisis and concerns arise from the brutal real terms funding freeze since 2010. The BMA has now resumed its appeals for a change of course.

The TUC will be joining with Health Campaigns Together to make the same point in a series of Happy Birthday NHS events on July 5: now is the time to press a weak and wobbly government for hard cash for #ourNHS.

HAPPY BIRTHDAY

#OUR NHS

#ourNHS BIG BIRTHDAY BASH

Saturday 1 July - Wednesday 5 July

NO CUTS | NO CLOSURES | NO PRIVATISATION

THE PEOPLE'S ASSEMBLY

Building #ourNHS Big Birthday Bash July 1 & July 5 – www.ourNHS.info

Mental health Less talk, more action required

"Once upon a time mental health was a Cinderella service. But these days it feels impossible to continue to call it one, with the increased media attention and high profile proponents transforming it into a national priority."

So says the HSJ's ever-optimistic Joe Gammie: but it's hard to square this glowing account with the harsh reality in many areas of budget cuts, bed shortages and desperate shortages of staff.

The flood of warm words in official government policy pronouncements is not matched at all by the cold facts on the ground. STPs, charged with improving mental health, are in many areas planning more cuts.

Theresa May might have promised 10,000 more staff for mental health during her disastrous election campaign, but this is missing from the Queen's speech and there is no practical way it can be delivered. In would in any case only half fill the 20,000 vacancies which have reduced some local services to crisis point.

The last thing mental health staff need is more gushing words: everybody may be talking about mental health – campaigners need to be demanding ministers and the NHS start doing something about it too.



Seeing red: health visitors on the March 4 #ourNHS demonstration which called for funded, publicly provided social care

Budget's £2bn 'extra' won't resolve crisis in social care

Despite early optimistic projections from NHS England that an extra £2 billion of funding for social care announced in the March budget by Chancellor Philip Hammond could help "free up 2,000-3,000 acute hospital beds," it's increasingly clear that the extra cash does not even make good recent cuts.

NHS Providers chief executive Chris Hopson was quick to point out by early May that social services would still lack resources to prevent the crisis of delayed discharges and pressures on front-line beds that hit the headlines last winter.

The *Health Service Journal* quoted one hospital chief executive who warned: "The first reaction of most councils has been to tell us 'you won't see any difference.'"

Real life in social care is a far cry

from the "integrated," proactive service dreamed of in STPs.

Instead social workers are struggling with heavy caseloads, working longer hours and missing lunch breaks, according to a survey by UNISON and *Community Care* magazine.

More than half the professionals responding (56%) said their caseload is influenced by staff shortages, and austerity is taking its toll on the profession, and on service users. 60% felt that cuts had made an impact on their ability to make a difference.

Almost half of those responding said they finished the day with concerns about their cases; three-quarters (74%) of these said this was due to them being unable to get necessary paperwork completed.

Two-thirds of them said they had not had a lunch break on the day of

the survey: and 64% said they "almost never" take a break at work.

Another UNISON survey, *The Damage: Care in Crisis*, based on a survey of more than 1,000 staff working in homecare, residential support and day services found almost two thirds of those responding had less time to spend with the people they care for because of staff shortages, and a similar number (65%) are working alongside fewer staff than six years ago.

More than a third (36%) said the rationing of supplies such as bed sheets, incontinence pads and wipes, and cutting corners had increased as a result of budget cuts. Some care home residents are not getting access to showers and regular visits to the toilet.

£12.5bn has been cut from local government services, and £5.5bn from social care in England since 2010.

First details emerge of 'capped expenditure process'

[From front page]

The *Guardian*, which broke the news of planned cutbacks in North Central London and Cheshire notes that "The 21-page Cheshire paper repeatedly makes clear that cutting costs in these ways could endanger patient safety".

Nonetheless the Cheshire plans also include scrapping a £900,000 increase to mental health budgets, leaving patients with acute mental health problems dependent on inappropriate care in A&E.

The planned cuts in endoscopies have been condemned by leading cancer specialists as likely to delay the necessary early detection of cancers, which inevitably reduces the possibility of swift action to tackle any tumours detected, and potentially endangers lives.

They note that GPs are encouraged on the one hand to assist early detection by referring patients with as little as a 3% risk of cancer for tests – while the latest cuts make this much more difficult.

The Cheshire cuts run counter to the guidance sent out to commissioners by NHS Improvement, which states that: "Mechanisms will need to be developed to ensure that patient safety is not jeopardised and that urgent cases are not overlooked."

Of course if urgent cases are not detected, they will inevitably be overlooked and patient safety will be jeopardised.

In North Central London a 31-page report seeking to claw back a projected £180m deficit, also leaked to the *Guardian*, makes clear that another series of damaging cuts are being proposed to make savings – by denying patients treatment, extending waiting times for operations and even closing A&E and maternity units.

The document admits: "We recognise that these choices may be difficult for a number of reasons [because they include] ... options that impact on quality of care [and] options that would be difficult to implement."



Questions over fire risk in PFI hospitals

As this issue of *Health Campaigns Together* goes to press safety checks are under way in NHS hospitals throughout England, following the tragically-preventable disastrous fire at Grenfell Tower in west London.

However before these latest checks even begin, ministers and NHS chiefs should already know that a number of the newest hospitals, built under the costly Private Finance Initiative, have already been flagged as fire hazards – with some still to complete remedial work to tackle identified risks.

Five years ago one of the first wave of relatively small PFI hospitals, the £64m Hereford County Hospital was subject to an enforcement notice having failed a safety test. The county's fire safety manager said that the building had a number of "hidden structural deficiencies".

Unsafe

Two years ago the first-ever PFI hospital to open, Carlisle's Cumberland Infirmary, was also one of the first PFI hospitals to be branded as unsafe by an independent expert's report, and described as "one of Carlisle's biggest fire risks" by the local Fire

Brigades Union.

The hospital was served with an enforcement notice demanding immediate action: but work to address the problem of flaws in fire-proofing materials was expected to cost £14m – over 20% of the initial cost of the hospital – and take up to 18 months to complete.

The local News & Star newspaper obtained a copy of the 92-page report under Freedom of Information laws, which revealed

- a catalogue of problems including poorly-fitting fire doors, gaping holes and gaps in seals in sometimes incomplete fire walls which could allow smoke to spread;
- a wall in the special care baby

unit sealed with foam which was not adequately fire resistant,

- a defective fire alarm system
- and a failure by the PFI consortium which owns and maintains the building to ensure its staff were testing fire detection and alarm systems.

Costly flaws

Last summer there were further revelations of inadequate fire protection at larger and much more expensive PFI hospitals including Coventry's £380m University Hospital (where one source told the *Sun* that the flaws in fire protection were so serious that "if this was any building other than a hospital, it would have been closed down").

On top of this came problems identified at the £169m Walsall Manor Hospital, the £312m Royal Derby, and the £326m King's Mill Hospital in Mansfield. The estimated costs of remedial work across these four hospitals was estimated at £47m.

Peterborough's £289m City Hospital was also served with an enforcement notice last summer demanding the

building be "made safe:" the fire service noted that no progress had been made despite raising concerns a year earlier.

As with the other PFI hospitals, the trust delivering services had no control over the fabric of the building which is owned and maintained by the PFI consortium.

When interviewed for the UNISON pamphlet *The PFI Experience: Voices from the Frontline* in 2003, staff in many first wave PFI hospitals complained strongly about what they saw as poor quality buildings, slipshod building techniques and sub-standard materials, all in the drive to reduce costs and therefore maximise the profits to be scooped up by the PFI consortium.

It will therefore be a surprise if many more PFI hospitals are not added to the growing list of tower blocks and other buildings where public safety is at risk from inadequate fire safety.

Campaigners must press for answers before lives are at stake.

■ *The PFI Experience: Voices from the Frontline* is still available to download: http://www.healthemergency.org.uk/pdf/PFI_experience.pdf



Early PFI with all the faults: Carlisle's Cumberland Infirmary

61%

of type 1 A&E cases seen in 4 hours in Hillingdon Hospital in 2016/17

95%

target for all A&E patients to be admitted or discharged

£330mThe real terms **cut in value** of NHS funding to 2020 according to NHS Clinical Commissioners. Real value of frozen NHS funding will fall as costs rise through inflation and rising population.**650**

fewer GP practices since NHS England founded in 2013

900

average increase in numbers of patients on GP lists

560,000A&E patients waiting over 4 hours for a bed **2016/17****58,000**A&E patients waiting over 4 hours for a bed **2006/7****577,195**

bed days lost as a result of delayed discharges between December 2016–February 2017

22%

increase in delays over 2 years

NO MANDATE for NHS cuts, closures, or privatisation

Theresa May's Conservatives are clinging on to power as the largest party despite losing vital seats and their majority in the Commons, but it's very clear from the polls and the voting that they have not won a mandate to drive through more cuts, closures and privatisation of the NHS.

May wanted the election campaign to focus on Brexit and securing a "strong and stable" majority for her policy of austerity and her plans to further cut welfare and impose charges for social care.

But the opinion polls consistently showed the public put the state of the NHS as their top concern, well above Brexit and immigration.

Nowhere is there the slightest evidence that any electorate has been persuaded to support the closure of local hospitals as part of vaguely-defined "reconfiguration" of services or 'new models of care'.

Nor is there any sound reason why people should support these cynical plans – whether these be the 44 Sustainability and Transformation Plans (STPs) for carving up England's NHS or the pre-existing and ongoing plans in many areas to downsize, downgrade or close down acute or community hospitals and beds.

Lack of evidence

These plans have emerged in very different areas of the country, but all have one thing in common – a complete lack of credible evidence that the "new models of care" and alternative "out of hospital" services can either replace existing services or save money.

Across the country STPs have also been drawn up assuming ready availability of capital to develop new services and expand some existing hospitals to serve as centres while others are downsized or closed.

But the reality is that there is next to no capital available. The reason is simple: the 7-year virtual freeze on real terms NHS budgets imposed since 2010 has driven trusts into the red and forced repeated raids on the



limited pool of capital available to help cover revenue deficits, while the bill for backlog maintenance in England's NHS has risen to £5 billion.

Now plans have been hatched up to sell off "under-used" and "surplus" NHS property assets, and borrow new money from the private sector to fund the changes – and bail out trusts in the red.

Long term damage

Once these assets are gone, they are gone – and once long-term private finance contracts are signed, as we have already seen with over 100 disastrous PFI hospital contracts, the NHS is saddled with escalating costs for 30 years at a time.

These plans make sense to the construction industry, investors and speculators, but not for the NHS, which needs public sector investment, not the permanent freeze imposed since 2010.

And it's clear that there is no public acceptance of plans that have either been bulldozed through by unelected NHS bureaucrats in the teeth of local opposition or, in the case of the STPs, drawn up in secret, with no public consultation, and often with little if any support from supposed "partners" in local government.

We have seen thousands marching against the threat of cuts in places

that have not seen anything similar in recent years – Essex, Canterbury, Devon: these concerns will not fade away as long as the threat hangs over local services.

In Canterbury, the threat has increased, as emergency medical services at Kent & Canterbury hospital have closed "temporarily" on June 17, leaving seriously ill patients to travel upwards of 16 extra miles for treatment. No date has been given for this cutback to be reversed: but with the East Kent Hospital Trust's beds already 94% full, it's clear the loss of these services at Canterbury will pile pressure onto Ashford and Margate.

Similar problems can be found wherever there is a planned downgrade or closure: in Mid Yorkshire Hospitals and in Leicestershire desperate managers have had to admit that the planned cuts can't work and reopen beds that have closed.

The STPs are not sustainable, not affordable, and not coherent as plans.

Worse, the election period suppressed information on the draconian new cuts being proposed in 14 areas covered by NHS Improvement's "capped expenditure process" – cuts which involve rationing and excluding NHS treatment.



Local MPs know the government lacks a majority in parliament and any mandate to close or downgrade local services. Some, in places like Bedford, Canterbury, Lincoln and Peterborough have just won their seats as a result of championing local concerns over the NHS.

MPs under pressure

Some sitting Tory MPs, even in safe seats, are also painfully aware of the pressure to be seen to defend the NHS against cuts, such as Torridge and West Devon MP Geoffrey Cox, who promised a hustings meeting he would chain himself to the railings of Barnstaple Hospital and resign the Tory whip if the hospital's A&E is "ever threatened".

The uncertain period, with the

possibility of another election within months or a year or so, and the recent evidence of very large swings by voters (such as Canterbury) putting even substantial majorities at risk, can help campaigners put all MPs under pressure to speak up and lobby for local services or stand discredited.

We need to take this chance to maximise the pressure on local and national politicians to resist cuts and press for an end to the freeze on NHS budgets and the cap on NHS pay.

Now is not the time to relent in the fight: we have a great deal of NHS still to defend, and we have a political situation that gives us great leverage to defend it and make the case for the changes we really need rather than the half-baked carve-up proposed by NHS England.



Fighting on: campaigners fighting for Kent & Canterbury Hospital lobby parliament after the election (see p4)



RCN launches a summer of protests

Josie Irwin, Head of Employment Relations Department, Royal College of Nursing

This summer, thousands of Royal College of Nursing members across the UK are protesting to scrap the cap on NHS pay.

It follows an unprecedented poll of RCN members in which 91% of 52,000 respondents working in the NHS said they'd take industrial action to end the pay cap.

It's no surprise nursing staff feel so strongly about this issue. The continuing pay cap for NHS staff is unfair and devalues both nurses and nursing. Since 2010, the cost of living has increased by 22%, which means nursing staff have been dealt a real-terms pay cut of 14%.

Not only does the pay cap deter people from joining the profession, it also means that many experienced

staff are being left with no option but to leave. Right now, there is a shortage of nurses across the UK. In England alone, 1 in 9 nursing posts are unfilled. Current staff are stretched to the limit and patients are not receiving the care they deserve.

The summer of protest will send a message to the new Government that enough is enough.

Planned activity includes local protests to coincide with NHS pay day, and postcards which RCN members can send to their MP.

The RCN has also recruited more than 500 pay champions who will ensure the campaign reaches every RCN member. The network of champions will share campaign information with family, friends and colleagues.

This summer, nursing staff are standing together to make a difference. The Government must scrap the cap. To get involved, please visit:

www.rcn.org.uk/scrapthecap



Consultants add authority to fight against A&E downgrades

A leading local A&E consultant and clinical director at Southend Hospital has added her weight to the campaign against plans to downgrade A&E services in Southend and Chelmsford, to concentrate all major emergency services at Basildon, (12 miles away from Southend and 17 miles from Chelmsford on often congested roads).

Dr. Caroline Howard, the Clinical Director of Southend A&E and also Clinical Director for Medicine at Southend Hospital was asked at a special meeting of Rochford Council to give her opinion on the proposals.

She said she was attending in her capacity as Lead A&E Consultant and also speaking on behalf of her coun-

terparts and both Broomfield and Basildon, and that she DOES NOT AGREE with the proposals for having just one specialist A&E. The longer you have to travel, she argued, the more likely you are to die.

Dr. Howard went on: "As a Clinician, I need to do the best for my patients and this is NOT the best outcome for them".

This was not what the directors of the "Success Regime" drawing up proposals for Mid and South Essex (the same area as the STP) wanted to hear, and predictably Dr. Fenton, Clinical Director from the Success Regime and Tom Abell, Success Regime's Chief Transformation Officer disagreed with Dr. Howard's informed opinion.

They insisted that the proposal to have only one specialist A&E was the way forward.

But Dr Howard is by no means alone in arguing that the downgrading of Southend and Chelmsford would be a major blow to services. Dr Joseph O'Brien, a consultant gastroenterologist at Southend Hospital, told the *Echo* in the run-up to the election that he believes proposals put forward by the Mid and South Essex Success Regime could have "dire consequences" for residents.

Dr O'Brien warned that the downgrade would spell the "beginning of the end" for Southend Hospital as doctors and nurses will not want to work there.

He said: "There are sound medical reasons why this proposal is ill judged and potentially hazardous."

"Downgrading the A&E department is the death knell for a hospital. Emergency medical and surgical admissions are its life blood, allowing the development of experience and expertise."

"Doctors and nurses will not consider Southend Hospital in future for lack of training opportunities."

Smokescreen

And rejecting the arguments put forward by the Success Regime he also warned that:

"The proposal to downgrade Southend A&E is couched in language that acts as a smokescreen. The general public have had little information regarding the significance and dangers of this proposed move."

A vocal Save Southend A&E campaign is demanding Southend retains a FULL 24/7 Emergency Care facility in our large town hosting an International airport, University, thriving tourist industry and waterfront.

The campaign has also linked up with Chelmsford campaigners and with Basildon, where there are also concerns that the hospital will be unable to cope with the increased demand if the other two A&Es are downgraded.

<https://savesouthend.co.uk/>

In the front line – Lincoln, Bedford, Peterborough, Canterbury

Where hospital fears cost MPs their seats

Among the many high profile parliamentary seats that unexpectedly changed hands on June 8, some of the more conspicuous setbacks for the government were in Lincoln, Peterborough, Bedford – and the 20% swing that saw the incumbent MP in Canterbury replaced by a Labour MP for the first time ever.

What do these four seats have in common? In each of them the future of local hospitals and access to health care is in doubt as a result of STP or other plans.

In Lincolnshire, one of the country's largest, most sparsely populated and least traversable counties, long-standing plans to scale down hospital services threaten local services.

As a result it is one of the 44 STPs which has struggled to secure any semblance of endorsement from the County Council: Leader Cllr Martin Hill said: "As local councillors, we're standing up for our three main hospital sites. Residents will always need emergency care, and we must have

appropriate 24-hour services at the current locations - Boston, Grantham and Lincoln."

The STP is explicitly based on reconfiguration (centralisation) of services, aiming without any clear plan for truly massive reductions in caseload by 2020 – 27.5% fewer A&E attendances, 10% fewer emergency admissions, a 12% cut in elective admissions and a 21% cut in outpatient

of MP in Bedford, which has been lumped together with Milton Keynes and Luton in an STP area which has already undergone years of 'reviews' of acute services in which the future of Bedford Hospital has always been the most uncertain (although Milton Keynes, where the Foundation Trust has also chronic deficits could also be at risk) Luton is upwards of 18 miles away from both.

Bedford's Mayor has long been a vocal critic of the plans which have remained at centre stage with the STP and clearly helped ease out the sitting MP from a relatively marginal seat.

In Peterborough the continued problems of the City Hospital's increasingly unaffordable PFI payments, have recently been combined with pressure on the limited numbers of beds available – and the pre-STP plans for a "merger" of the Foundation Trust with the struggling Hinchingsbrooke Hospital in Huntingdon 25 miles away – and the prospect of further pressure on Peterborough's

beds if services are "centralised".

But of course Canterbury is the clearest example of the NHS cuts as a major liability for a sitting MP: the future of its Kent & Canterbury Hospital has been thrown into doubt by staff shortages and the Kent & Medway STP seeking to axe 300 beds.

In the run-up to the election there were rumours that the East Kent Hospitals Trust, which also runs acute hospitals in Margate and Ashford would begin to run down and close services in Canterbury.

Within days of the election the rumours were proved accurate, with the announcement that patients requiring emergency medical care would "temporarily" be taken directly by ambulance to our hospitals in Margate or Ashford – up to 18 miles away. There is no end of this in sight.

Pressed by a strong local campaign, the local MP protested too little and too late to save his job.

● Campaign for Health in East Kent (CHEK) <https://www.facebook.com/groups/chek999/>



Plan to turn NHS asset-base into debt

A new version of the disastrously expensive Private Finance Initiative seems likely to emerge in an NHS that has been starved of capital and maintenance budgets and seen its capital allocations plundered year by year since 2014 to cover running costs and deficits.

The massive sell-off of NHS land assets proposed in Sir Robert Naylor's recent report on NHS estates seems likely to be coupled with a big expansion of NHS borrowing and debt through "Project Phoenix," which is being developed in the hopes of generating billions in property sales.

Naylor says his aims are to release £2bn worth of assets for reinvestment and supply land for 26,000 new homes.

He proposes to bribe and bully reluctant NHS trusts to sell off their assets with no guarantee that the capital would be returned to them by offering a Treasury hand-out that would potentially double the value of each sale – and by threatening to withhold any capital funding to trusts that refuse orders to sell off "surplus" land.

Regional PPPs

Six regional Public Private Partnerships will be created under the plan to upgrade and develop and then dispose of assets that are 'no longer required' or deemed 'not fit for purpose'.

This could of course include hospitals that face downgrade or closure as a result of local STP proposals for reconfiguration and centralisation of services.

Business case have apparently been submitted to the Department of Health for several major deals with private firms to unlock capital funds worth £5.7bn by selling NHS land and property.

Shared profit

Under the PPP deals it seems the profit from sales would be shared between the NHS and the private partners – though how the cash would be split has yet to be revealed, and the extent to which the NHS would need to borrow capital has not been disclosed.

The *HSJ* reports that, according to one source the arrangements could involve using private funding to con-

vert, renovate or demolish existing buildings, or secure planning permission. This would maximise the price for the sale.

The project requires Treasury sign-off before tenders for the partnerships are published in the Official Journal of the European Union. The *HSJ* reports:

"HSJ understands an announcement unveiling Project Phoenix had been anticipated for shortly after the general election after the Conservative manifesto pledged "the most ambitious programme of investment in buildings and technology the NHS has ever seen".

Sir Robert, the former chief executive of University College London Hospitals Foundation Trust, has



claimed that up to £5.7bn could be generated if trusts "maximise the value of land and buildings" before putting them on the market.

However it also estimates that the NHS backlog of maintenance that has been skimmed or avoided to cut spending now adds up to a massive £5 billion.

So there would be little if any net gain to the NHS if the remaining buildings are brought up to standard – but a prospect of 30 years or more of payments to service the debts run up under Project Phoenix.

This seem more like plunging the NHS into the flames rather than it emerging from them.

Without the raids on capital budget and similar tricks, the NHS deficit would have reached **£3.5bn** by the end of 2015-16, according to one estimate presented to the Commons Public Accounts Committee.



Devon campaigning rewarded by review findings

Mass campaigning seems at least for the time being to have secured a continuation of services at all four main hospitals in Devon – including the North Devon Hospital in Barnstaple which was felt to be most at risk of downgrade or loss of services.

Clinicians have announced the results of a review into acute hospital services which has looked at a range of services in hospitals in Exeter, Plymouth, Torquay and Barnstaple since late 2016.

The review was undertaken because doctors said key acute hospital services were likely to become unsustainable in future due to difficulty recruiting key clinical staff, large increases in demand for services – and difficulty meeting national service standards – but it also took place as part of the "Success regime" seeking to deal with deficits in North East and West Devon, and the STP.

Services such as stroke, maternity, paediatrics and neonatal care and urgent and emergency care were included in the first stage of the review. Other services will be reviewed in a later second stage.

Announcing the results of the first stage, clinicians said that all four acute hospitals in Devon, would continue with A&E, emergency stroke services and maternity services. This would be acknowledged by stronger collaboration between clinical teams and new networking and workforce solutions.

Other key recommendations in-

clude:

- 24/7 urgent and emergency care services (including A&E) should continue to operate at four main acute hospitals – the Royal Devon and Exeter Hospital, North Devon District Hospital, Derriford Hospital and Torbay Hospital.

- First-line emergency response for people experiencing symptoms of a stroke will be retained at all four hospitals. This will include rapid stroke assessment, diagnostics and thrombolysis. These services will be supported by 'Acute Stroke Units' (ASUs) at all four sites, and will ensure rapid intervention and aftercare for those with a stroke.

- Trusts will work towards clinical best practice to improve outcomes for stroke patients by developing two specialist 'Hyperacute Stroke Units' (HASUs) in Exeter and Plymouth where patients will receive 3 or more days of intensive treatment for their stroke immediately following emergency treatment, following which they will return home or to their local ASU.

- Retaining consultant-led maternity services at all four main hospital sites is proposed. These specialist units have access to 24/7 clinical care and the specialist services to provide more intensive care when that is needed.

Ian Crawford, a spokesperson for SOHS in Northern Devon said, "The recommendations to retain acute services at North Devon District Hos-



In Exeter campaigners' success in Exeter in keeping the city centre Walk-in-Centre open was celebrated when the staff received a good CQC assessment and invited the "Friends of the Walk-in-Centre" to celebrate with them (picture above). The Friends was an initiative that came out of the KONP campaign to save the centre.

pital (NDDH) would not have been forthcoming without the challenge from North Devon residents who demonstrated in Barnstaple Square last October, in their thousands, and at subsequent public meetings organised by SOHS, showing public support against any removal of local NHS services.

"With regard to local MPs who may try to take credit for these recommendations, it is public support for the local NHS which has so far protected these acute services at NDDH.

"We need to maintain that support to retain all the health services in Northern Devon and that includes community hospitals and beds which

are still under threat from the NHS England's Sustainability & Transformation Plan (STP) which still calls for £550M cuts to Devon's health Budget".

■ **However the future of 71 community hospital beds threatened with closure in South Devon remains in the balance, after the County Council's Health Scrutiny Committee voted to wait another month before referring the issue to the Secretary of State for decision.**

While it's possible they have been given a hint of extra funding to avert the cuts, campaigners need to stay vigilant.

NHS FOR SALE

by JACKY DAVIS, JOHN LISTER and DAVID WRIGLEY.

Myths, Lies & Deception
Jacky Davis, John Lister, David Wrigley

Foreword by HARRY SMITH.
Introduction by Martin McKee
'Essential reading in the battle to save the NHS before private companies bleed it dry' – Ken Loach

All proceeds to Keep Our NHS Public. Order online at <https://keepournhspublic.com/shop/books/>

6 Discussion: STPs and ACOs

Detailed report shows STPs lack legitimacy, evidence and capital

Three vital weaknesses o

A new report published by London South Bank University, is the first to present a detailed critical view of all 44 STPs.

In late 2016, 44 geographic areas of England published Sustainability and Transformation Plans setting out how health and care will be delivered within their local areas in the period to 2020/21.

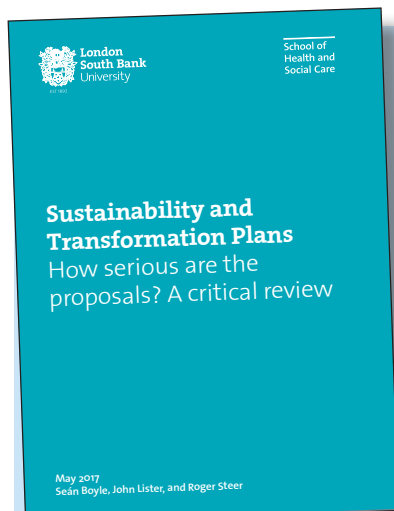
The plans appear to have subsequently stalled in some areas, but were intended by NHS England to bring about a radical transformation of the health care system across the country.

The new 84-page report, by Sean Boyle, John Lister and Roger Steer, reviews all 44 STPs based on a detailed examination of the content of each one, and provides a critique of both the process and content of those STPs.

Because the whole report is so extensive, we present here a few extracts from the summary.

The STPs result from NHS England's *Five Year Forward View* and the subsequent NHS England directive that tasked all NHS organisations to form coherent geographic areas for the purpose of coming together to achieve three aims:

- to implement the Five Year Forward View;
- to restore and maintain financial balance; and,
- to deliver core access and quality



The full document can be downloaded free of charge at <https://www.lsbu.ac.uk/about-us/news/critical-review-44-stps-nhs>. Each of the 44 studies of the individual STPs is also published online at <https://sites.google.com/view/lsbu-hsc-stp-may-2017/home>

standards for patients.

The LSBU report notes, among many other issues:

Public participation and accountability

"There is a lack of clarity around the authority of STPs, their partnership arrangements, and their own role. This leads to a further lack of clarity about the public's role in the plans. Some

STPs rely on public engagement and consultation on parts of their plans, others have developed their plans with some representation from the public.

But overall it is unclear, given STP partners' own accountability to their local populations, how the STPs themselves are to be held accountable to their 'footprint' population, and there is a danger of a distance emerging between the decision-makers and the public."

Role and Governance

"It is hard to determine from the STP documentation how the STP Board operates and where accountability and responsibility actually lie:

- Who makes the decisions, and how?
- What level of delegation is there when individuals are acting for an organisation?
- To what extent is it possible for the decisions of an STP to override those of constituent bodies?"

Needs analysis

"Thirty-one of the 44 STPs offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population.

Eleven make partial reference to needs analysis, but only two (Nottinghamshire and North East London) appear to take serious account of such information."

Impact on equality

"Only five STPs mention the issue of the potential impact of their plans on equality, and the extent to which the proposals may impact on vulnerable groups.

The absence of any concern to identify and act upon local health inequalities is compounded in many STPs by a failure to take account of the impact of the expanded geographical area that is covered by the Plan – ignoring the difficult issues of access to services and transport problems if services are relocated."

Social care

"It is significant that none of the 44 STPs carries any detailed discussion of proposals to address what in most areas are very significant projected 'gaps' in the funding of social care by 2020/21."

Providing a business case:

"Our financial evaluation looked at Economic Case, Affordability, Deliverability and Risk Analysis and revealed particular systemic weaknesses. We have not identified one STP that is as yet capable of demonstrating readiness for implementation.

None of the STPs provide a complete risk analysis. Most were wholly inadequate, some non-existent at this stage and those that did provide an analysis were a testament to the extent of risks, uncertainty and the

£14.35 billion
total of capital funding bids in 44 STPs
£1.82 billion
Largest STP capital bid – from NW London

attendant difficulties attached to the STP process and content."

Workforce

"Two thirds of the STPs (30/44) have no detailed Workforce Plan to ensure an adequate workforce will be in place to implement the policies and new services outlined within them.

As they stand, there appear to be contradictions in the plans between requirements for changed services and the workforce to deliver these, and radical plans to downsize or redis-



Stevens reveals first eight "Accountable Care Systems"

NHS England chief executive Simon Stevens has named the first eight Accountable Care Systems, and promised that the changes will end "the fragmented system that passes people from pillar to post".

The plan is for STPs to evolve into ACSs, and eventually into more formally structured and wider-reaching ACOs.

The ACSs are intended to bring together providers and commissioners to help break down barriers between primary, secondary and social care: but they will initially be controlling only a small share of the total budget: there is no extra money on the table.

According to the regulator the eight areas have "indicative potential to control around £450m of funding" between them, over four years, in exchange for taking on "accountability" for improving population health.

The first eight STPs/parts of STPs to become ACSs will be:

- Frimley Health;
- South Yorkshire and Bassetlaw;
- Nottinghamshire;
- Blackpool and Fylde Coast;
- Dorset;
- Luton, Milton Keynes and Bedfordshire;
- West Berkshire; and
- Buckinghamshire.

ACOs – neither accou

There is also a growing body of evidence questioning the wisdom of another key project from the *Five Year Forward View*, which has since been further promoted by Simon Stevens and in a number of STPs: Accountable Care Organisations (or "partnerships").

These are stated in the Forward View to be modelled on US schemes, many of which grew under Obamacare, with commercial hospital providers and private insurers at their core.

In theory an ACO provider accepts a contract based on a fixed capitation-based fee to cover all of the designated health care issues for a local population, and deliver an agreed range of outcomes.

The track record so far of similar large scale contracts in England has been less than successful. The ACO notion of a fixed, capitated payment is complicated by the fact that in almost every instance commissioners have seen the new structures as a way to make substantial savings.

However if there is insufficient money in the contract to deliver adequate care, even NHS providers will be unable to continue.

This is what happened in the ambitious Cambridgeshire & Peterborough £700m "lead provider" contract to take on the risks of providing the full range of services to the whole local popula-



tion of older people on a fixed budget that was so low most of the private bids were withdrawn before the final stage of tendering.

As a result the contract was eventually tendered out to a consortium of two local foundation trusts.

As predicted, the 5-year contract collapsed, sooner than some expected, within just 8 months – for lack of adequate funding.

Now, after a prolonged hiatus, and many months of efforts to get it off

the ground, a similar – even more controversial – lead provider contract to organise cancer services for much of Staffordshire has also been abandoned – before the contract was even signed.

The CCGs concerned now say that the company they shortlisted and had named as preferred provider "couldn't convince us they could deliver with the resources available. They couldn't meet the required evaluation criteria."

Affordability of the new system also seems to be an issue in Northumberland, where the flagship ACO proposal was due to go live this April.

It has now been shelved for an indefinite period because of major deficits in the budget of Northumberland CCG, which were apparently partly covered up as a result of pressure from NHS England.

As a 'vanguard' project, the Northumberland ACO had received substantial extra funding from NHS England since 2015, and the HSJ's Daily Insight column raised the obvious question: "Its deteriorating financial position also raises important questions about whether there is enough money in the local system to set up an ACO which doesn't fall over the instant it goes live."

In similar fashion another showpiece of integration of health services and social care, the Torbay and South Devon Integrated Care Organisation

f STPs exposed

tribute the workforce, or to do both."

Reconfiguration of acute services

"In many cases the STPs have built on previously proposed rationalisation and reconfiguration of acute hospital services in their areas, often extended so as to speed up the process of seeking cash savings, with the resultant reduction in local access to health care.

Reductions in acute bed numbers and numbers of A&E departments are

present in over 50% of published STPs.

Given the tightening financial pressures on the NHS and social care; the lack of capital to fund investment in new facilities, hubs and equipment; the sparseness of financial plans; the weakness or absence of serious workforce plans; the failure to provide analysis of the specific health needs of the growing populations within the 44 STP areas; and the lack of specific intelligence on the impact of any proposed new models of care within the STPs:

there is little reason to believe that these ambitious reductions in demand and pressure on acute services will be achieved in the timescale proposed."

Evidence

"We suggest that there is a need for the evidence base supporting the case for change to be substantiated through independent academic review, before launching into plans for widespread 'transformation'."

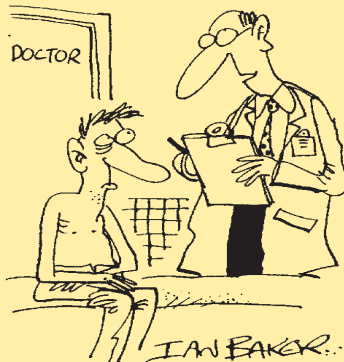
Ministers ditch new laws planned to bolster STPs

NHS England chief executive Simon Stevens has repeatedly claimed that the STPs, and within them especially the new Accountable Care Organisations will "abolish the purchaser/provider split" – the competitive market entrenched by Andrew Lansley's Health and Social care Act in 2012.

But the legality of this has yet to be tested.

Getting trusts to collaborate rather than compete for contracts, and commissioners to collaborate with providers seems like a sensible thing – but runs counter to the law, and some CCGs are still carving up services to put out to competitive tender, with Virgin and other companies picking up more business.

The ill-fated Tory Manifesto hint-



"I'd like to see you again next week for a post-mortem"

But these proposals, like so many others, have been dropped in the Queen's speech, and the Manifesto scrubbed from the Conservative Party website, making it clear that no new laws are coming soon.

As a result, according to some of the advice of legal firms specialising in NHS matters, it seems the STP process is open to legal challenge.

Councils or campaigners may wish to challenge specific plans, or even question in court the right of STPs, which have no legal status, to take decisions and force changes.

Alternatively, private companies seeking access to what they hope might be potentially profitable contracts may bring in the lawyers if they see these taken over by new ACOs on long-term contracts.

ed at new legislation to entrench the STPs, override some of the competition requirements of the Act, and effectively strip CCGs of control.

untable nor caring

was set up in October 2015.

The plan was for the Integrated Care Organisation's mission to pool health and social care budgets and run the services from under one roof – effectively the Multi Specialty Community provider (MCP) model as set out in the *Five Year Forward View* and many STPs.

However the scheme which was supposed to save millions of pounds by creating and testing the first combined health and social care trust has been running a £12m deficit in its first year.

Torbay and South Devon NHS Foundation Trust has told the two councils involved that it is withdrawing from a 'risk-sharing' agreement, which splits

liabilities for unexpected costs, and Torbay Council has been warned that the organisation presents a 'substantial financial risk' to the local authority.

So it seems the ACOs can only maintain any level of integration if funded significantly more generously than local commissioners believe they can afford.

US ACOs brought public sector losses

£6,500

average spend per head of American ACOs that lost money

£7,700

average spend per head of US ACOs that retained a surplus

£2,057

average per capita spend per patient in England's NHS, before planned reductions

It's not just a British issue. ACOs in the US have proved to be far from free of problems or a guaranteed profit stream.

The cost savings they were originally expected to deliver have not always come at all, and any savings have only come at a price.

Harvard academic Ashish Jha, crunching the numbers published by the CMS (Centers for Medicare and Medicaid) in August 2016 for the first four years of ACOs involved in the Medicare Shared Service Program found just over half (203) of the 392 that reported delivered savings totalling \$1.5 billion, while 48% (189) showed losses totalling \$1.1 billion, leaving a total saving of \$429m.

Even these 'savings' turn out to be

largely illusory, since the CMS was forced to pay out a higher sum to the ACOs, which take a share of any savings, but do not carry any of the costs for losses – leaving Medicare and Medicaid with a net loss of \$216m.

All this is on the basis of dramatically higher spending per person in the USA than in the UK.

Even the loser ACOs received a generous \$9,601 (£6,500) per person covered per year, while those making profits secured an even larger \$10,580 (£7,700).

These figures are respectively more than 3 and more than 4 times higher than the average £2057 spent per patient per year in England's NHS – a figure which many STPs explicitly seek to further reduce.



STPs in legal limbo: Enter the lawyers

As it comes to the difficult question of trying to implement the proposals in STPs, often in the teeth of bitter local opposition, NHS managers are now beginning to wonder about the legality of STPs and the potential Accountable Care Organisations they are hoping to establish. Legal firm Hempsons has produced some briefing material which underlines these concerns.

In their *Fit for the future* briefing on June 17 they set out an "NHS legislation wish list", and note in particular the problems created by Andrew Lansley's health and Social Care Act:

"The current health and social care legislative framework is a brick wall that STPs and ACSs run into when they try to share decision making and join up services. It is designed for an inherently non-integrated, competitive quasi-market."

[...]

"The section 75 partnership regulations (NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No. 617) provide limited ability for a CCG to share its commissioning functions with a local authority."

"NHS foundation trusts simply cannot share decision making. NHS trusts are hamstrung by limited powers to invest in corporate bodies."

In response to this, Hempsons argue the need for new legislation:

"What might be some legislative changes that would enable the NHS and local authorities to integrate services and develop and implement STPs and ACSs? We suggest some below."

"Some may be more controversial than others, but they all recognise the reality that the NHS (steered by NHS England and NHS Improvement) is in many ways already reversing out of a competitive quasi-market back to a centrally directed system where the purchaser-provider split is abolished and foundation trust autonomy offers few if any benefits."

The Hempsons *Seven Steps to accountable care* pamphlet, produced jointly with NHS Providers, again stresses that STPs have no legal status or powers:

"Key considerations that should be taken into account by STP partners leading on the evolution to accountable care are:

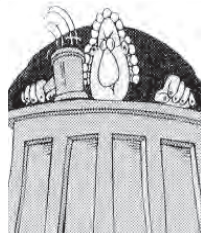
- STPs currently have no powers to make decisions: their recommendations need to leave partners with real choices on whether to accept the recommendation

- they are not legal entities; this makes it difficult to hold them accountable, so STP leaderships need to take care to refer back to partner organisations and respect the unique role of boards and well as the liabilities and duties of directors

- STPs are not board-led organisations and will not have a NED [non executive director] majority or built in NED challenge. [...]

- there is a system-wide imperative to make swift progress and a seeming unanimity as to the way forward; in these circumstances leaderships need to guard against group-think

- the transition from STP to ACS to ACO is clearly difficult to achieve in the current legislative framework. Clarity and simplicity in decision-making are therefore preferable to complexity."





Save Our Hospitals Hammersmith & Charing Cross (KONP Affiliated group)



Merril Hammer

Over the last 5 years Save Our Hospitals: Hammersmith and Charing Cross have been fighting plans to downgrade Charing Cross Hospital from a major acute hospital to little more than a glorified Urgent Care Centre, with a huge loss of beds, consultants, and its A&E.

Hammersmith and Fulham Council joined the fight to keep the hospital open. This year, with the council tax bill, they delivered posters saying Save Charing Cross Hospital to all residents asking that they be put in windows.

Health bosses, under attack for years from campaigners, were clearly rattled by this. They wrote to the council leader, Stephen Cowan, threatening to raise a formal complaint to the Department for Communities and Local Government, claiming that the council was going beyond their remit, wasting taxpayers' money and upsetting NHS staff and patients by claiming the hospital was still going to close.

Later, Julian Bell, leader of Ealing Council, received a similar threatening letter about council funds being used to fight the closure of Ealing Hospital. It is no coincidence that both councils are in the same STP footprint (NW London) nor that both councils were the first to refuse to sign up to the STP.

Health bosses claim the hospitals are not closing despite the significant downgrading. As Stephen

Cowan has pointed out in an even more recent letter to all residents: "It's like demolishing someone's house only to tell them they have in fact not lost their house because the new garden shed they've been given will henceforth be known as a 'local house'."

During the general election, the Tories reprinted the CCG/Imperial letter to Cllr Cowan after it was published on Imperial Healthcare Trust's website, and used it as part of their election campaign claiming the council, and by implication campaigners, were lying about the threat to the hospital.

Just after the election *Guardian Online* published an article which showed that only 13% of the hospital site would be used for health purposes – the remainder to be sold off to property developers. The now amended article (<http://bit.ly/2sAKYrq>), states both that no closure will go ahead without consultation but also, in direct contradiction, the DoH confirmed that consultation had already taken place in 2012/13 and closure plans will go ahead.

Campaigners believe that threats to the councils and pressure on the media are a sign of how rattled health bosses are in the face of widespread public opposition to their plans and of councils who are standing up for their hospitals.

- Sohhandf:
- sohhandf@gmail.com
- www.saveourhospitals.net

Reports from around the country

Newcastle & North East thriving

KONP North East was "re-kindled" last year and since then has re-established itself as one of the region's most active campaigning groups. John Whalley reports on the group's progress.

It has been a busy time across the country, and up here in the North East is no exception. A good reference point for our activity is at www.konpnortheast.com/news Highlights included:

- 2016 coming to an end with a superb inter-campaign one day workshop with Dr Louise Irvine and Olivia O'Sullivan (of Save Lewisham Hospital Campaign) – the underpinning rationale was around learning from one another by bringing together local health campaign groups (there are seven across the geographically diverse north east) and also avoiding the need to reinvent the wheel (Louise and Olivia were superb in outlining the highs and lows of their campaign experiences in Lewisham).
- An experimental pre-Christmas

"electronic five-wave campaign sequence", in which we provided a structure and timetable for KONPNE members and supporters to sequentially e mail councillors, MPs, CCGs, healthwatch, etc across the seven CCGs which make up our STP footprint.

- North East March and Rally for the NHS in February 2017 – One thousand supporters led by no less than five north east MPs.
- National NHS March and Rally in London – say no more!
- Pre-election NHS focusing and a bespoke Tynedale Health Hustings in Hexham, rural Northumberland: attended by all parliamentary candidates, bar the Conservative candidate who had a prior engagement, and his office felt it to be "inappropriate" to send anyone in his place. He failed to respond when we asked him why....
- 700 people signed our petition at the NHS Roadshow earlier this month, and local parliamentary candidates responded to our three key questions about the NHS (see KONPNE website).

Forthcoming events for NHS birthday week include supporting

Save South Tyneside Hospital Campaign at the Summer Parade (first Saturday), a KONPNE Newcastle Public Lecture and Q&A by Professor Allyson Pollock (Monday), an event involving cake, a huge card and mail-out to Mr J Hunt (Wednesday), and marching alongside Durham KONP at the 133rd Durham Miners' Gala (second Saturday).

We have focused on developing our IT, and now have a full complement of website, Facebook, Twitter, and Mailchimp platforms, so it is good to report that there is no escape.

Our Steering Group is slowly increasing in size, and we feel that our work at KONPNE has also been enhanced through developing relationships with nearby health campaign groups and organisations.

We are very grateful for this interpersonal and inter-group support and friendship – it really has made a huge difference. If we are to move forward in our campaign work, we know that we need to engage with one another, listen, support, and share expertise and resources.

- KONP North East (KONPNE):
- www.konpnortheast.com
- Facebook: NHSPublicNorthEast
- Twitter: KONPNorthEast

Swindon: new group defeat "police" threat

Samantha Wathen

Swindon KONP was only recently formed* (April 2017) by myself and Sarah Newman. It was set up following interest and involvement in the Our NHS/Peoples Assembly/HCT demonstration in London, and in response to our own personal stories connected to the health service.

Since then our group has grown rapidly from 2 to over 50 members. We meet monthly. The group was largely election focused, with the election being called only a few days after we formed.

But it's been eventful. Last month we made the front page of the local paper (*The Swindon Advertiser*), when in *Swindon BID* (the owners of a shopping precinct in the town) threatened us with police action for "leafleting in a public place".

This has now been resolved and we did return unperturbed the following week. The company have since conceded that our right to distribute political leaflets is written in law. This episode helped establish our presence locally to wider sections of the community.

We are lucky enough to be well supported by local political party members of all backgrounds (except Conservative). These include Labour party candidates Mark Dempsey, in North Swindon, who significantly closed the gap with Tory MP Justin Tomlinson; and Sarah Church, who made gains in South Swindon against Tory Robert Buckland.

These party members and oth-

ers supported us by speaking at our #VoteNHS Roadshow on Wednesday 31 May.

This was well attended and covered by local press. Guest speakers were orthopaedic surgeon Mr Rishi Dhir and Consultant Psychiatrist Dr Mona Kamal from People's Assembly. The audience left enthused, informed and ready to spread the #VoteNHS message.

Going forward we hope to respond to local private health contracts and currently have FOI requests pending regarding these. This is particularly pertinent in our area as Virgin Care has a large contract in Swindon, Bath and Wiltshire for over 200 services.

- Swindon KONP:
- Facebook: Keep our NHS Public – Swindon Branch (Group page)
- Twitter: @KONPSwindon

*Joining KONP and setting up a new group is easy. Check the website for details (www.keeppournhspublic.com/join-the-campaign)



Spot the law-breakers?

Thousands at Leeds anniversary



Gilda Petersen

When we failed to defeat the Health and Social Care Bill in 2012, Leeds KONP promised we would take to the streets every anniversary to protest against Government attempts to dismantle our NHS and this year was no exception.

Around 3,000 people from NHS campaign groups across Yorkshire joined with local trade union branches and Trade Councils, political parties, community groups and individuals to make a huge noise against privatisation, cuts, closures and deliberate underfunding of our NHS.

We started with passionate personal stories and poems from health workers, patients and parents of sick children. The brilliant PCS union samba band led us round Leeds centre and provided a great carnival atmosphere. Unite brought their award winning brass band, and jazz and folk musicians kept the rear of the march jumping.

A large contingent from 'Hands off Huddersfield Royal Infirmary' and activists from Dewsbury and Halifax were warmly welcomed when they marched up from Leeds station and we were delighted to welcome 'Save Grantham Hospital' campaigners in their distinctive bright red hoodies.

GMB union members wearing hospital scrubs pushed a bed, people dressed up and brought home

made placards, and CND propelled a giant "NHS not Trident" missile. Members of the public clapped, some joining the march, and we had excellent coverage from local radio, BBC and ITV news. Tracy Brabin, MP in what was Jo Cox's constituency of Batley and Spen, gave a moving and fiery speech to close the rally.

Leeds KONP has had longstanding support from Leeds TUC and constituent unions but this year we have been working hard to move up a gear from support to genuine joint working with the unions and campaign groups across Yorkshire.

We welcome people from round the region to our twice monthly meetings and try to get out and about to support events organised by fellow campaigners across the region, most recently a vigil for mental health in Halifax and a protest in York when Simon Stevens came to give a lecture at the University. Next outings will be to Huddersfield Hands off Our Royal Infirmary's huge party in the park on June 24th and Sheffield's NHS birthday event in July.

Thanks to our trade union support we are able to share resources across Yorkshire. Our snappy postcards with an image on the front and short, punchy copy on the back go down well and a print run of 10-20,000 means we are able to supply to other NHS campaign groups. During the election we targeted our postcards and stall on

marginal constituencies and like to think this made some difference to the results!

We are now meeting regularly with representatives from Yorkshire campaign groups, Unite, GMB and Unison. We hope to expand this to include the RCN and RCM and draw more health workers into our campaign. Apart from trying to rally support for action at hospitals across Yorkshire on the NHS's birthday, we are aiming to organise a large protest meeting in Barnsley about the way NHS staff are being TUPE-ed into specially created organisations where the NHS can save on VAT and they can be employed on second class pay and conditions. What happens in Barnsley today will be happening in Leeds and Bradford tomorrow if they can get away with it.

If you want to join Leeds KONP on July 5th, we will be outside the multi-storey car park near the A&E entrance of Leeds General Infirmary 07.30 – 09.30 am. We have giant birthday cards, banners, balloons, our "NHS cut to the bone" skeletons and specially made birthday bunting. We will take all of it across to St. James site for a second round of protest and celebration from 12-2 pm. All support welcome.

- Leeds KONP: www.leedskeepournhspublic.wordpress.com
- Facebook: Keep Our NHS Public – Leeds
- Twitter: LeedsKONP

Caught in the app trap? New fight, old enemy

Alan Taman, Assistant Editor

Digital health, we are told, is the new frontier for medicine and the NHS. Upheld as the great new hope for making the care of the future accessible to all. With wearable devices and ever-smarter apps, and making huge leaps in the way data is gathered, collated and analysed. "Big data" to save the NHS and help it shift away from all those crumbling, expensive Victorian buildings.

The problem is, it isn't unfolding like that. To date the most prominent developments have not only failed to uphold the principles of the NHS, they are undermining them by offering "pay as you go" functions or threatening privacy.

There are a growing number of apps aimed at taking your money in exchange for "fixed fee" advice. Apps like "Doctaly" offer GP consultations for a fixed fee online. Though if you have a chronic condition, a mental health problem, or can't put up the 25 quid – well, tough. The online GP also does not have access to your records.

On the "big data" front, the most controversial development has been the link between Google's super-processing "artificial intelligence" Deep Mind and several London trusts to analyse patient data. This promises to be groundbreaking in spotting patterns of disease and allowing earlier interventions. But there are worries over handing people's health data to the corporate giant which are largely unaddressed and have not received much public debate. Is our privacy over health going to be eroded through silence?

The NHS is far from idle, and has invested a lot of time and effort into looking at how digital health use can best be adapted to suit the NHS. NHS Digital, whose goal is to "improve health and social care in England by making better use of technology, data and information", was given over £250 million for its budget and has over 2,500 staff – and this in times of "austerity". Hardly a trivial player.

But its remit is focused on supplying IT infrastructure and security advice (sore point, lately).

Why is it, then, that privately marketed apps seem to be getting the upper hand (or wherever we end up wearing the new tech) and massively important ethical considerations like privacy are not receiving the attention they need?

Once again, the flawed logic of the market is apparent. As groups like HCT and KONP have stated repeatedly, if you apply the principles of the market-place to healthcare, you do NOT get a "more efficient, leaner, better" service. Which is what ideology of the neoliberal would assume. What you actually get – as shown by rock-solid grounded researchers such as Dorling (*Unequal Health*) and Marmot (*The Health Gap*) – is unfairness, corruption of the

principles the NHS is founded upon, and a preservation and extension of inequality. Inequalities to access, and for outcomes, would worsen.

So far from *freeing* people from the ills of inequality and the inequalities of illness, applying the "new tech" unthinkingly (uncaringly?) with market-led delivery is far more likely to make them worse.

This is much more than ability to pay. The most vulnerable, the least powerful, the most silenced, the most insecure, the least wealthy. None are likely to benefit first, or at all, and certainly not in relation to their need, if the current trends continue to dominate the field, and the NHS continues to be left struggling to defend its principles in this (not so brave) new world, just as it has to struggle "in real life" against Tory cuts, under-funding and hostile ideals.

Digital health has been the subject of research for some time now (with university centres at Oxford, London, Manchester and Aberdeen, for example). Health professional networks, based in social media, are starting to question the way digital health is being allowed to develop.

But unless the political will is found to ensure the new technology is available to all, dependent on need, when it's needed, and in a way that those who need it can *understand and apply for themselves* – a critical characteristic of digital health is the way it could shift the "power of knowledge" to the user/patient – then what could have been one of the greatest shapers for fighting and reducing health inequality could easily become yet another dystopian travesty squandered by the "haves" while the "have nots" struggle on. Meet the new boss, same as the old boss...

The solution in our hands

The technology itself could yield the solution: social media is already a powerful influencer in politics. It has its own perils and emerging discourses that threaten as much as empower (anyone for Trump?). But if people campaign in the virtual and real world to stop the dream souring to the nightmare, then digital health tech for all can be as much a part of the NHS as the real-world ward.

Digital health was science fiction when Asimov coined his "first law of robotics": "No robot shall harm a human or, through inaction, allow a human to come to harm".

"No digital health app or system shall harm anyone or, through denied accessibility, allow anyone to come to harm" might be a good beginning when building principles to fit this sweeping change.

Log on, fight on. The future can be what we make it. Or what others will make of it for us, if we let them.

• healthjournos@gmail.com

Dudley CCG seeks bids for £5bn 15 year MCP contract

Dudley Clinical Commissioning Group has gone several steps further than Manchester down the road of absurdity, seeking tenders for a £5.5 billion contract for multi-speciality community provider – to run for a staggering 15 years.

The CCG's advertisement states:

"The MCP will hold a contract of up to 15 years, under which it will manage a single, whole population budget, "transform access to and delivery of community health and care services", and meet a defined set of outcome and performance measures.

The services to be provided by the MCP include (among others):- • community-based physical health services; • some existing out-patient services; • primary medical services; • urgent care and primary care out of hours services; • adult social care services; • mental health services; • learning Disability Services; • end of life care; • activities currently carried out by the CCG.

This latest wild experiment has been castigated by health management blogger Roy Lilley as a disaster waiting to happen. Lilley, in his usual inimitable style begins:

"Fifteen years ago?

"Frank Sinatra died, Google's first

beta site released, Bill Clinton... err... well, you know. Britney sang; 'Baby one more time'.

The Queen's mum died. A train ploughed off the tracks at Potters Bar. The firefighters went on strike.

Since then, plenty more; not least the world-wide banking crisis and more recently the astonishing general election.

Can you predict the future? No; you can trust your instincts, rely on experience and look at the odds but you can't predict the future.

The CCG at Dudley think they can...

They are so sure, they are willing to plunge the future of their resident's healthcare into a fifteen year, commercial gamble.

They are looking for a multi-community provider to do the job until March 2033.

They are committing £5,445,000,000 of taxpayers' money on a colossal bet that they can predict what is going to happen in the next 15 years, that won't rock their boat, destabilise their plans or worst, unravel them.

It is either the height of management conceit or unforgivable naivety. Management by crossing yer fingers.

The competitions and mergers brigade should kick-in the doors



and shove the daft idea up the CCG's shredder.

[...]

Lilley flags up the huge unanswered question:

"Will they publish a risk register? I challenge them to publish it.

"Risks? How about; staffing, demand, prices, inflation, Brexit, recruitment, training, funding, the cost of money, the markets, politics, demographics, estates, the viability of secondary care, innovation, Apps, operating costs, the weather, public attitudes, government, to say nothing of the outcome of, certainly, three general elections.

And... there is the STP, hopelessly conflicted as CCG members will be in their group. No one will take them seriously again. What price vertical integration now?

What happens when the success-

ful bidder for the contract does what Circle did; when the going got tough at Hinchbrook... they walked.

What about staff? They have no say. No say about being TUPE'd. No say about their future... it's their NHS, too.

And, what about the public? They pay but have no say. No one voted for this.

Make no mistake, the purpose can only be to sell to the lowest bidder."

Campaigners

Lilley speaks for many campaigners when he concludes:

"Whatever it takes, this has to be stopped. NHS institutions, the Secretary of State, Number 10, NHSI, NHSE, the local authority, Healthwatch, the local papers, regional press, the public, you and me.

We have to stop it."

£5.9bn Manchester tender awards contract to ... the current NHS providers

The commissioning of NHS services in the costly, bureaucratic and fragmented competitive market created by Andrew Lansley's Health and Social Care Act continues to get CCGs twirling round and round in ever-more wasteful circles.

The more services are integrated and planned in any strategic way, and the more budgets are squeezed by the ongoing freeze, the less likely it is that the private sector, which (with the bizarre exception of Virgin's loss-making contracts) is only interested in sure fire profits, will see any benefit in bidding for risky and inadequately-funded contracts.

In the devolved powerhouse of Manchester, where fanfares of publicity greeted the launch of a massive an enormous integrated care contract for 'out of hospital' health and care services across the city of Manchester, the 3-month exercise has resulted in a single bid - from a consortium of existing providers.

The Manchester Provider Board is a consortium made up of Manchester City Council, local GP federations, the city's three acute trusts, community service providers and Greater Manchester Mental Health Trust.

The consortium is now the only provider in line for the 10 year contract worth £5.9bn to set up a "local care organisation" to provide all non-acute services across Manchester.

But it's still not a simple matter.

Manchester Health and Care Commissioning will now go through the motions of a 'strategic dialogue' with the bidding consortium, inviting a detailed proposal with the contract to be awarded in early 2018 and go live in April 2018.

How much all this rigmarole is costing in management time, management consultancy, accountants and lawyers has not yet been disclosed.

However it's impossible to avoid the simple fact that the same results could have been achieved more quickly, cheaply and simply by simply discussing what the commissioners wanted and making an agreement with the providers already there on the scene.

At the end of the day it comes down to a very basic issue: is there is enough money in the contract to enable the providers to properly staff and deliver the services?

Or, like Cambridgeshire's famous fiasco on Older people's services, will the NHS trusts be unable to carry the losses – and the giant contract fall over after a few chaotic months?

Private sector keen to cash in on soaring waiting lists

In early April the unlikely source of the *Telegraph* trumpeted a warning that the number of patients waiting longer than 18 weeks for surgery is set to double in the next three years.

Apparently analysis, based on official NHS figures, suggests the total number waiting for operations could reach almost 5 million in 2020 - an increase of almost 2 million since 2015 – and more than double the number waiting in 2008, before the spending freeze was imposed in 2010.

The same analysis shows that on current trends more than 800,000 patients could be waiting more than 18 weeks for treatment in three years - a rise from 360,000 today.

However it emerges that these calculations have been done by a body with an axe to grind – the NHS Partners Network, the outfit which represents private sector providers of NHS care.

While the private hospitals clearly want more patients to be urged to take advantage of a legal right to choose where to have NHS treatment

– including the option private hospitals, it does not completely invalidate the figures, since it's clear from last winter and current performance that the NHS is struggling to survive on the current brutally inadequate cash limits.

In March Simon Stevens, chief executive of NHS England, admitted that times for routine operations were likely to grow longer, as cash-strapped NHS hospitals are obliged to prioritise emergency and cancer care.

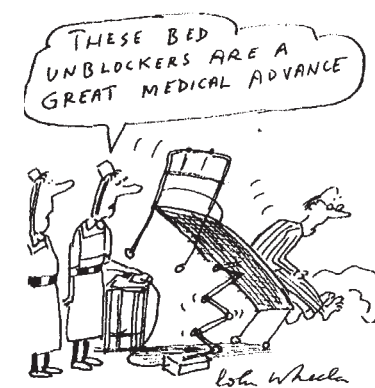
Senior doctors said an NHS target to carry out 92 per cent of non-urgent operations within 18 weeks of referral had been "jettisoned in all but name" as the health service struggles to meet demand.

The Partners Network claims that on average independent sector providers were able to treat NHS patients just six days quicker than health service providers could manage, at theoretically the "same costs" to the taxpayer – although the cash flows out of the NHS and into private sector profits.

A total of 3.7million people in the UK are now on the waiting list for non-urgent operations, up from 2.4million in 2008.

More than 360,000 of them have been on the waiting list for more than 18 weeks, equivalent to one in 10.

As our Election Special pointed out, NHS-funded elective patients, for whom there are no NHS beds, now ac-



count for 40% of the revenue of private hospital chains BMI and Spire – filling otherwise empty private beds and lining ever-greedy private wallets.

BMA links cuts and privatisation

This year's BMA Annual Representatives Meeting has passed a motion accusing the government of deliberately creating the crisis in the health service to push through privatisation.

The motion, proposed by GPC chair and BMA chair-elect Dr Chaand Nagpaul, argued that the crisis in NHS hospitals had been 'consciously created' by the government 'in order to accelerate its transformation plans for private sector takeover'.

He said: "The government speaks of new investment but in the same breath asks us to make £3 of efficiency savings for every £1 spent.

Dr Nagpaul referred to a warning from the government's former safety expert Don Berwick that 'austerity has gone too far and that it's not possible to run the NHS on current funding'.

New officers elected at busy first HCT AGM

Delegates from over fifty affiliated organisations were present at the first Health Campaigns Together Annual General Meeting, generously hosted by Unite the union in London on April 22.

The busy meeting took reports on what had been achieved since HCT was founded in the autumn of 2015 and launched its public profile with a successful conference in January 2016. The most conspicuous success has of course been the work with the People's Assembly to build the huge #ourNHS demonstration in London on March 4, backed by over a dozen national trade unions in addition to the continued support of Unite.

However the AGM also discussed what could be done to ensure the NHS was high on the political agenda in the long run-up to the June 8 general election.

It was agreed that HCT would remain a non-party political campaign, but highlight the impact on the NHS of the seven years of frozen funding since 2010, and the damaging impact of the Health & Social Care Act and privatisation in a special Election issue of our newspaper (still available online).

Another decision was to support the work of the NHS Roadshow which had swiftly assembled up to 70 volunteer activists – many of them junior doctors and health professionals – as soon as the election was announced. HCT printed thousands of the easy-read Fact Sheets designed for distribution as well as downloading from the HCT and Roadshow websites. They are still relevant and available free of charge via the HCT website.

The first formal elections saw Keith Venables take office as Secretary and two new co-chairs elected – Merrill Hammer from Save Our Hospitals Charing Cross and Hammersmith, and Dr Louise Irvine from the Save Lewisham Hospital campaign (who went on to stand once more against Jeremy Hunt in the election, taking 20% of the vote). Vice chair is Mike Forster of the Hands off HRI campaign in Huddersfield. John Lister remains as Treasurer and editor of the newspaper.

HCT welcomes joint work wherever possible with local campaigns that have not yet joined us.

We invite any affiliation from local and national trade union organisations, Labour Parties and other political parties committed to defending the NHS and its principles, at www.healthcampaignstogether.com/joinus.php



UNISON votes to affiliate

Health Campaigns Together is delighted to hear that the national delegate conference of UNISON, the largest public sector union, has with the support of its National Executive Committee backed a Composite motion calling for affiliation to HCT:

The relevant section reads:

"Conference agrees to affiliate to 'Health Campaigns Together' which organised the massive demo in defence of the NHS on 4 March 2017 and calls on the National Executive Council to initiate national action to protect the Health Service.

Conference believes that the huge size of the national demonstration in defence of the NHS in March this year that was mostly built by local campaigns and the number of local demonstrations around the country shows the potential for a serious fight to defend the NHS.

"We believe that the unions should be doing more to build that fight."

The composite goes on to outline a series of ways in which UNISON can further boost the work it is already doing in many areas to support and build local campaigns against cuts, for full funding of the NHS and for the lifting of the pay cap on NHS staff and defending NHS jobs.

It calls on the UNISON NEC to ask the TUC to call a national demonstration in defence of the NHS.

Prior to this HCT has developed increasingly strong links with UNISON, with a number of health and local gov-

ernment branches affiliating to us directly and subscribing to our quarterly newspaper or the Election Special.

This has increased in the run-up to and after the March 4 demonstration.

And while we welcome UNISON's decision to affiliate at national level, and hopefully work more closely with HCT, we are also keen that health and other branches of UNISON should affiliate at local level as well, so that we can help to develop strong local campaigning involving NHS staff as well as campaigners in the community, and maximise the pressure we can bring to bear on NHS managers, councillors and MPs in the stormy days ahead.

Affiliation is easy and is best done online at <http://www.healthcampaignstogether.com/joinus.php> with payment where possible by bank transfer, and where necessary by cheque.

Branch members can easily be kept informed if branches also subscribe to this newspaper and distribute copies in workplaces and through meetings.

And UNISON branches, regions or national bodies wanting to show support and maybe publicise local issues of concern, or local campaigns are welcome to send us in articles, photos, cuttings or documents you want covered in the next paper, or help resource the campaign by taking out paid adverts in future issues of Health Campaigns Together, again online at <http://www.healthcampaignstogether.com/advertise.php>

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an alliance of organisations. That's why we're asking organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning.

WE WELCOME SUPPORT FROM:

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local and national NHS CAMPAIGNS opposing cuts, privatisation and PFI
- pressure groups defending specific services and the NHS,
- pensioners' organisations
- political parties – national, regional or local

The guideline scale of annual contributions we are seeking is:

- **£500** for a national trade union,
- **£300** for a smaller national, or regional trade union organisation
- **£50** minimum from other supporting organisations.

NB If any of these amounts is an obstacle to supporting Health Campaigns Together, please **contact us** to discuss.

■ **Pay us direct ONLINE – or with PayPal if you have a credit card or PayPal account at <http://www.healthcampaignstogether.com/joinus.php>**

■ **For organisations unable to make payments online, cheques should be made out to Health Campaigns Together, and sent c/o 28 Washbourne Rd Leamington Spa CV31 2LD.**

We have decided to produce Health Campaigns Together newspaper **QUARTERLY** in 2017.

It is still **FREE ONLINE**, but to sustain print publication we need to charge for bundles of the printed newspaper: **Cost PER ISSUE** (inc post & packing)

■ 10 copies £10 (£5 + £5 P&P)

■ 50 copies £25 (£15 + £10 P&P)

■ 100 copies £35 (£20 + £15 P&P)

■ 500 copies £70 (£40 + £30 P&P)

For intermediate quantities – see <http://www.healthcampaignstogether.com/newspaper.php>.

Bundles of papers will only be sent on receipt of payment, and a full postal address



Contact us at healthcampaignstogether@gmail.com. www.healthcampaignstogether.com

Health Campaigns Together

Supported by Keep Our NHS Public & London Health Emergency ● No. 7 Summer 2017 ● FREE

Happy 69th BIRTHDAY

On July 5 1948 a unique experiment began – with the launch of the first universal health care system for the whole population to be open to all, free at point of use, offering a comprehensive range of acute and primary care services and treatment, and funded through general taxation.

The legislation for it had been driven through Parliament in 1946 against consistent, aggressive opposition by the Conservative Party, by Health Minister Aneurin (Nye) Bevan (pictured right with a nurse).

Unlike insurance based systems with their rules over entitlement to cover, their various funds and separation of funding from provision of care, the new NHS was a health care system available without prior qualifying period, to support people 'from cradle to grave', on the basis of clinical need, not ability to pay.

It covered all aspects of health care providing free GP services, and free dental treatment including false teeth, spectacles, drugs and other necessary supplies.

The National Health Service was hugely popular, and swiftly revealed the huge extent of pent-up unmet need arising from the previous sham-bolic "mixed economy" of health care comprising private care, together with charitable, and municipal hospitals.

The fact that demand for many of these services levelled off after the initial backlog had been met disproves all those who claim that health spending is a "bottomless pit" and those who argue that services provided free inevitably create unlimited demand.

The new opportunity for previously separate municipal hospitals to group together with other local charitable and teaching hospitals created new possibilities for developing joint working by clinicians, a national



Health Campaigns Together is delighted to be celebrating the 69th Birthday of the NHS jointly with the TUC and other health unions.

While marking the continued skill, dedication and hard work of 1.3 million NHS staff we note the threat currently posed to the quality and accessibility of key services as a result of funding constraints.

So together with the health unions we call for:

- no cuts or cash-driven closures
- fair pay for all NHS staff
- a fully funded, publicly owned and provided National Health Service

training and career structure for hospital doctors, and research and development to lay the basis for modern medicine.

As a result the difference was not simply the replacement of various insurance schemes covering specific

groups of population with a single payer system (as demanded now by progressive campaigners in the USA): it broke completely away from the concept of insurance to establish health care as a citizen's right.

And by nationalising the entire

network of hospitals and bringing them together in a common system, the NHS also created the awareness that it's OUR NHS, belonging to the people, and not a private enterprise.

All these founding principles are now at risk: that's why each year it

becomes more important to both celebrate the continuity of the NHS values and traditions, and to warn that if we cease to fight for it, we can lose it.

As Bevan said "The NHS will live on as long as there are folk with faith to fight for it". That's us. Join us!



and many more to come!