

INTO THE RED ZONE

A **Keep Our NHS Public** Briefing Note for MPs, councillors and health campaigners in England in the aftermath of the June 2017 election

1) A new situation – with dangers, but new scope for campaigners

The government's misleading barrage of waffle over mental health – with a pitiful allocation of funding equivalent to just £300m a year to 2020 now required somehow to cover thousands of additional nurses and therapists at a minimum cost of £1.25 billion per year¹ – can't hide one stark fact. The staffing "increases" proposed by Jeremy Hunt would not even replace the 6,000-plus mental health nursing posts axed since 2010².

The threats to local services have not receded with Theresa May's loss of her party's previous slim majority in the Commons. The cash constraints are as tight as they were before the election, the millionaire Chancellor has set his face against any relaxation of austerity – other than the £1 billion to buy the support of the DUP in Parliament – and refused to countenance a pay increase above 1% for NHS and other public sector staff whose pay has been frozen or below inflation for seven straight years, suggesting that they are 'overpaid' on the basis of supposedly "generous" pensions.

As a result all the hospitals and services that were at risk prior to the election are still potentially at risk now.

Nobody should be fooled by the cynical attempts of Jeremy Hunt and NHS England to use the recent report of the US Commonwealth Fund to claim that the NHS is the best in the world¹. They know that the performance of our NHS is increasingly being hampered by the seven years of frozen budgets already imposed, and that they are planning years more of standstill funding.

The results are clear: patients and their relatives all over the country are finding many services and treatments no longer covered, services "centralised" at greater distance, staff in hospitals and community services working under greater pressure, waiting times lengthening, and threats of closures of beds, wards, services and whole hospitals.

The trusts' organisation NHS Providers is warning that without an immediate injection of extra cash (and a commitment from local authorities to spend the limited and belated increases in their social care budgets on provision that will facilitate swifter discharge of

¹ See Explanatory note on this at the end of this report.

patients and hospital bed closures), there could be yet another winter of growing crisis in the NHS to match or exceed the dramatic problems that hit headlines last winter³.

In particular NHS Providers' head of analysis Philippa Hentsch points out that on their recent survey:

"92% of trusts reported that they expect there to be a lack of capacity in primary care, 91% in social care and 80% in mental health services. [...] Only one in four trusts said they had a specific commitment that the extra social care funding would help reduce NHS delayed transfers of care (known as 'DTC'). For community and mental health trusts, the figure is one in 10.

"This pattern is concerning given that although hospital trusts understandably account for the highest number of DTCs, it is in mental health and community services where the rate of delayed transfers has been increasing at a faster rate."⁴

As the resource constraints tighten like a straitjacket around the NHS, the pressure grows on managers to comply with new plans to sell-off historic NHS assets and borrow yet again to fund new buildings and investment in services through the costly and wasteful Private Finance Initiative.

2) Unstable government – uncertain MPs

While these threats are real, the conditions have never been more favourable to those lobbying and campaigning in defence of local services.

As this crisis looms, the government is quite obviously weakened by the loss of its majority, and the uncertainty, coupled with the open conflicts within the Conservative Party over Brexit, public sector pay and some of the consequences of austerity mean that there could be an election called or forced at short notice at almost any time.

As a result, no local MP can feel secure that they will not in the immediate future be held to account over their failure to fight hard and openly to defend local services where they are threatened. Indeed after the loss of seats such as Canterbury (with a 20% swing reinforced by concerns over the future of the Kent & Canterbury Hospital) and even the seemingly impregnable stronghold of Kensington and Chelsea, few Tory MPs can feel that their majority would survive their failure to oppose a major hospital closure on their patch, especially where existing hospitals are already so tightly stretched and in some cases overwhelmed by demand at peak times.

This makes it a crucial and ideal time to intensify the local lobbying of all elected politicians – MPs and councillors – demanding that they take a stand in defence of local services, and against the enforced rapid sell-off of "surplus" NHS property to meet short term financial objectives. Campaigners should be targeting not only key marginals in the last election but even MPs in "safe seats".

One area which confirms this is South Essex, where controversial plans to downgrade two A&E departments in Southend and Chelmsford's Broomfield Hospital have been effectively dropped after sustained pressure from campaigners clearly made an impact on local politicians: the Tories held on to seats in June, but have clearly pushed behind the scenes to get the plan dropped.⁵

Exerting real pressure means demanding Tory MPs go much further than raising timid questions or making ineffectual speeches to a largely empty chamber in odd moments in parliament. They must be forced to use their potential power to endanger the government majority in Parliament.

Councillors too, from all parties, must be forced by local campaigners to make use of what remaining legal powers they have through Health and Wellbeing Boards to hold local NHS managers to account, and Scrutiny Committees (which retain the right to delay controversial plans pending a ruling from the Secretary of State) invoking their full powers to block damaging cuts.

Labour and Lib Dem MPs as well as Tories need to be pressed to play an active role in challenging cutbacks that threaten local access to care, and ensuring that there are no potentially damaging concessions made to the half-baked plans that are being drawn up in the hopes of securing swift financial savings.

3) The tightening financial squeeze

Despite all the government rhetoric about giving the NHS an "extra" £8 billion, which has been widely discredited, the Institute for Fiscal Studies (IFS) pointed out the average real terms rise from 2010-2015 was just 0.9% per year compared with the annual 4% real terms cost pressures, with a similarly low real terms increase planned to 2020. As a result: "English DH spending in 2019–20 will be *slightly below 2009–10 levels* after taking into account the growth and ageing of the population"⁶.

NHS Providers in their July 2017 report The State of the Provider Sector states:

"Frontline NHS funding is due to drop from the 3.8% increase in 2016/17 to +1.4% in 2017/18, +0.7% in 2018/19 and +1.3% in 2019/20, providing a significantly greater challenge. While all extra funding is welcome, the government's manifesto commitment of £8bn for the NHS is unlikely to make a significant difference to the degree of extra challenge the NHS will face. As the Nuffield Trust and others have pointed out, **the increase would not keep NHS spending rising in line with the wider economy, and falls far short of keeping up with costs and demand.**"⁷

The Nuffield Trust has projected the need for an increase in budget to the equivalent of at least £150bn in 2017/18 prices by 2022 to restore the historic average rates of growth of NHS spending and deal with rising population and cost pressures. This is at least £18 billion above the level promised by the government and £22bn above existing plans⁸.

As NHS Providers and other analysts have shown in the pre-election period and since, the financial pressures on the NHS at national and local level, which was the key factor in last winter's crisis conditions in acute hospitals, are set to become even more impossible.

One CCG Accountable Officer recently stated **“There are no further savings that can be made without impacting on patient care”**.

NHS Providers drew a similar conclusion before the election with their analysts that to provide the same or better services with declining real terms resources is **“Mission Impossible”**⁹.

All of these problems remain unresolved. The level of savings required threatens to undermine key principles and values, with rationing of care to save money, and more and more operations and treatments excluded from the NHS, forcing patients to pay privately or go without. **According to one chief executive, some of the proposals now being raised “challenge the value base” of NHS leaders.**

Savings on the scale required are politically impossible, whichever body seeks to implement them:

- The 200 or so **Clinical Commissioning Groups** (who are now collectively warning that the real value of their budgets is set to fall by £330m by 2020, while demand rises);
- increasingly desperate **provider trusts** seeking to live within their “control total” deficit as costs rise;
- the **44 “footprint” areas** that have been required to draw up **Sustainability and Transformation Plans (STPs)** most of which are completely implausible;
- or the planned new, tightly cash-limited **“Accountable Care Systems” (ACSs)** – which may be eased into place with generous cash handouts, but will inevitably be squeezed as the financial straitjacket is tightened.

NHS England Chief Executive Simon Stevens has already emphasised that the first requirement of the first eight ACSs will be to **cut demand and balance the books**, or as he puts it, they **“must be involved in more assertively moderating demand growth,”** meet quality targets and **“achieve a single system financial control total.”**¹⁰

The freeze on real terms NHS budgets has driven two thirds of trusts into the red in 2016/17, and forced repeated raids on the limited pool of capital available to help cover revenue deficits. **Meanwhile years of repeated short term cuts, including cuts in capital spending by trusts, mean the bill for backlog maintenance in England's neglected NHS has risen to a scandalous £5 billion**¹¹.

4) Naylor Review threatens massive sale of assets

Now plans have been hatched up in the **Naylor Review** to speed and enforce the sale of “under-used” and “surplus” NHS property assets¹², and through “Project Phoenix” to borrow new money from the private sector to fund developments that are supposed to increase the potential market value of the assets being sold¹³. There is even, alarmingly a suggestion that some of the sale proceeds could be used to help deal with the revenue deficits of NHS trusts – literally selling off the assets to pay the bills.

Once these public assets, built up over decades or even centuries, are gone, they are gone for ever – 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 implemented since 2010.

5) Symptoms of the growing crisis

Lack of beds and A&E consultants

The Royal College of Emergency Medicine has highlighted the need for an extra 5,000 beds to bring occupancy levels of acute beds back down to the target 85%¹⁴. 2,200 more A&E consultants are also needed to deal with the constantly rising caseload¹⁵. Clearly neither of these can be achieved within a cash-strapped NHS.

Bed occupancy has steadily increased year by year while there are now 9,000 fewer acute beds across England’s NHS than 2010. There are ongoing plans in many areas to reduce this further with cuts and closures of whole services and hospitals, including community hospitals which help contain the pressure on front-line acute beds.

The extent to which bed capacity is now inadequate to deal with the extra pressures over the winter period was clearly exposed in the winter of 2016/17, with bed occupancy at record levels, and delays causing what the Red Cross has described as a “humanitarian crisis” in some A&Es.

The squeeze on beds has run alongside increases in all types of A&E attendances, including the most serious Type 1 cases, many of which require admission to beds.¹⁶ The pressure on beds has been exacerbated by cuts in social care resulting in increasing numbers of delayed transfers of care.

Rising waiting times, cancellations and breaches

Just 68.7 per cent of Trusts are now maintaining the 18 week maximum referral to treatment time standard laid down in the NHS Constitution.

The performance is worsening as the freeze on resources takes stronger effect: numbers waiting are rising also, and have already risen to record levels since 2011.

More and more patients are waiting over a year for treatment: a total of 3.8 million people in England are now on the waiting list for nonurgent operations, up from 2.4million in 2008 – an increase of over 60%.¹⁷

More than 360,000 of them have been on the waiting list for more than 18 weeks, equivalent to one in 10 – and ministers have warned that on present trends that is set to more than double by 2020.

Cancelled elective operations are almost 40% higher than when the spending freeze began in 2010, despite an increased caseload of just 14%. And while the numbers are much smaller, the pressures on the system are also shown by the near 3-fold increase in cancelled operations not performed within 28 days, up from 2,114 in 2010-11 to 6,021 in 2016/17.

Massive staffing vacancies

Obviously one key fact in this growing shortfall in capacity is the estimated 40,000 nursing vacancies, shortages of consultants and doctors, and problems recruiting and retaining GPs to deliver the promised improvements in primary care.

Cumulative impact: red alert

The most recent NHS Providers' member survey shows that

- **only 28% of trusts** have been able to secure a commitment from their local authority that the extra social care funding will be spent in a way that directly reduces DTOCs and frees up NHS capacity, rather than remedy underinvestment and cuts affecting councils' other social care responsibilities
- **only 18% of trusts** believe they have a commitment that will enable them to deliver the NHS mandate requirement of reducing DTOCs to 3.5%.

“Trusts report a lack of capacity across all parts of the health and care system to deal with the expected demand:

- 64% of trusts report a lack of ambulance capacity;
- 71% a lack of acute capacity;
- 76% a lack of community capacity;
- 80% a lack of mental health capacity;
- 91% a lack of social care capacity and
- 92% a lack of primary care capacity.¹⁸

Mental Health – a crisis of under-provision

Another NHS Providers report, *The State of NHS Providers July 2017*, goes on to focus on the **gaps in mental health care**, despite all the government rhetoric.

It notes that **70% of mental health trust chairs/CEOs expect demand for mental health services to increase this year: but they are not getting the funding to match**. Much of the extra mental health funding appears to go to private providers or acute trusts rather than mental health trusts:

“where new mental health funding is flowing, **it is either being targeted at new services or is allocated to non-NHS mental health trusts**. This does nothing to alleviate the growing pressure on core services, many of which are facing significant demand increases”

(...)

“NHS mental health trusts are still paid largely via block contracts which do not take account of rising demand, and **have been asked over each of the last five to seven years to realise significant annual cost improvement programme (CIP) savings of 3 - 6%**. This has had a major impact on the provision of the core services, particularly since the National Audit Office (NAO) pointed out that the costs of improving mental health services may be higher than current estimates.” (p25)

As a result, NHS chief executives report a growing problem of inadequate capacity, especially in services dealing with children (Child & Adolescent Mental Health Services – CAMHS) and liaison with A&E:

“Although two-thirds of trust leaders believe they are managing demand for perinatal, elderly care specialist support and police and crime services, this drops to **less than half managing demand for CAMHS and A&E services**” (p29)

The NHS squeeze of course runs alongside local government cuts, which are also taking their toll on mental health provision:

“Mental health services are commissioned by CCGs, NHS England, council public health functions, other council functions and the third sector. **Across all of these groups mental health trusts saw a decrease in the levels of services commissioned for 2017/18 compared to 2016/17**.

“The most notable change is in the area of council commissioning of all types, where no trusts saw an increase on the previous year, 59% saw a decrease in public health commissioning, and 56% saw a decrease in other types of council commissioning.” (p30)

The NHS Providers survey confirms campaigners’ suspicions that mental health services are effectively sidelined in STP planning processes: **only 11% were confident that their local STP will lead to improvements in access and quality of services**. Over 40% were worried or very worried, while 45% were neutral.

One local leader reported:

“The mental health component of the STP was very good and would support delivery of improved services. **However the required investment is no longer available.**”
(p32)

6) Contradictory signals on “unthinkable” cuts

All the hospitals and services that were at risk prior to the election are still potentially at risk. With no extra money in the pot and the threat of “special measures” to intervene in local health services where deficits are seen as unacceptably high, the pressure to implement these plans is growing.

However, the government exerting huge pressure on NHS England is so lacking in stability that its authority would be endangered by as few as half a dozen Tory MPs rebelling for fear of losing their seats if local hospitals and services are closed.

Challenge the Capped Expenditure Process ...

Even without such rebellions, sensitivities are such that the leaked information that 14 areas would be subjected to a new rigorous regime entitled the **Capped Expenditure Process (CEP)**,¹⁹ developed behind closed doors by NHS England in the “purdah” period before the election, which requires senior managers to “think the unthinkable,” including “changes which are normally avoided as they are too unpleasant, unpopular or controversial,” produced an outcry.

The CEP would impact in some core Tory heartland areas. Revelations that some of the more reckless cuts – such as arbitrary reduction in Cheshire in the number of endoscopy tests, potentially putting cancer patients at risk, restricting access to a range of elective operations and even to angiogram and angioplasty procedures for potential heart attack patients in Surrey and Sussex – was met by near-universal popular opposition. It also brought condemnation from the Tory chair of the Commons Health Committee, Sarah Wollaston, who tellingly told the Guardian²⁰:

“I don't think that these extra cuts are reasonable. You can't justify £500m to the DUP while taking another £500m out of the English NHS.”

Faced with this pressure, within a couple of weeks the regulator NHS Improvement was forced to step in and dilute the process. NHSI announced a series of regulations contradicting the purpose of the CEP approach, and effectively restricting what cuts could be made, while describing the CEP plans as merely “proposals”.

Rather than risk further anger by riding roughshod over legal requirements to consult on local closures and effectively tearing up the (already widely compromised) guarantees offered by the NHS Constitution, NHSI has stipulated:

“Firstly, provider board assurance, on a self-assessment basis, must take place so that the consequences of proposed trust CEP plans are fully considered and will safeguard patient safety and quality.

“Secondly, providers need to ensure that CEP plans are consistent with constitutional rights for RTT (the 18 week referral to treatment standard) and patient choice.

“Thirdly, where CEP service reconfiguration proposals trigger the NHS’ public consultation duties, these will need to be followed. In addition, providers should also ensure that patients and staff are engaged throughout the planning and implementation stages of CEP.”²¹

This rapid climbdown has been accompanied by a reduction in the target for savings from the CEP, from the original £470m to a still daunting £250m. The retreat on CEPs echoes the earlier retreat by NHS England from some of the key objectives of the 44 Sustainability and Transformation Plans (STPs) that NHS England had rubber stamped at the end of last year.

... and oppose the STPs

Just a few months later, NHSE’s March document *Next Steps on the NHS Five Year Forward View*²² imposed a “fifth new test” to be met by any STP plans to close beds as part of their reconfiguration plans:

“From 1 April 2017, NHS organisations will also have to show that proposals for significant hospital bed closures, requiring formal public consultation, can meet **one of three common sense conditions:**

- That sufficient **alternative provision**, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- That **specific new treatments or therapies**, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or
- Where a hospital has been using beds less efficiently than the national average, **that it has a credible plan to improve performance without affecting patient care** (for example in line with the Getting it Right First Time programme).” (p35, emphasis added)

It’s pretty clear from the poorly developed STPs, which lack both implementation plans and any serious evidence to support their key assumptions²³ that **any one of these new conditions, if seriously applied, should be sufficient to bring almost all of the major reconfiguration and bed closure plans to a grinding halt.**

But it's also clear that NHS England, as the nearest equivalent to a direct representative of government in the disjointed and fragmented NHS since Andrew Lansley's 2012 Health & Social Care Act came into force, is seeking to keep the appearance of clean hands and avoid any blame for any of the disastrous cutbacks in access to local services and revived reconfigurations that are threatened.

Half of the STP areas propose to implement cutbacks, and others to revive previous planned reconfigurations which had been tactically omitted from their STPs. Others have pulled back from spelling out similar plans and aspirations, even while insisting enormous sums need to be generated in "savings to bridge claimed "do nothing" deficits.

7) STPs – some on the offensive while others retreat

Reality of NHS crisis hits home

Since the STPs were published, proposed swingeing cuts in acute bed numbers in **Leicestershire** have been reined in after the high-profile chaos and delays during last winter. In **North Devon**, an acute services review which was expected to begin the downgrade of North Devon Hospital in Barnstaple, and which had helped trigger a massive campaign across the northern part of the county, has been published: it now proposes to keep all of the main existing hospital services on the site.

Campaigning works!

Now **South Essex**, which has both an STP and all the trappings of a "success regime," has also joined the retreat, abandoning plans to downgrade **A&E services in Southend and Chelmsford's Broomfield Hospital** and centre services in **Basildon**.

These retreats can be traced to the impact of political pressures, successful campaigning, damaged public image and the objective pressures of local demand for services.

They are also evidence that the STPs are financially driven, not serious attempts at planning and integrating services, or in any way accountable or reliably responsive to local communities.

But it is increasingly clear that STPs and the "boards" seeking to implement them lack not only any popular acceptance or mandate from the public but also **any legal powers to impose cuts, closures or changes** – and that they remain politically weak²⁴.

Challenge to STP legal status

The legal status of STPs as bodies that can compel local trusts or CCGs to take decisions contrary to their local interests has been called sharply into question by the stance of **City & Hackney CCG**, which has insisted upon its statutory right and obligation to address the issues of its local population. It has stated that it will not allow itself to be subordinated to the six other CCGs in North East London, which are proposing a de facto merger with just a single Accountable Officer for all seven.

City & Hackney CCG's letter in response to the STP (rebranded as the 'East London Health and Care Partnership,' covering 20 organisations in NE London) insists that the agreement between providers and commissioners **"does not create any new legal entity, and each organisation remains sovereign"**.²⁵

The CCG makes clear the new partnership board must "talk to" individual CCG boards and adds **"the governance at STP level needs to reflect the fact that organisations cannot be bound by majority vote"**.

The legal advice to the CCG is very clear, and has implications for the status of all STPs. STPs have been established by NHS England as a way around the damaging fragmentation of the Health & Social Care Act, whilst leaving the Act itself and the various accountabilities and obligations intact. **Conservative Party manifesto proposals to amend the law to facilitate such new structures can no longer be implemented given the government's loss of majority.**

So the CCG's solicitors are amplifying a very pertinent point when they state:

"Since the Partnership Board is formed through a **collaboration it cannot have the status of a unitary board and cannot bind any of its members (the participating organisations) against their will.** Whilst members of the Partnership Board may signal their agreement or disagreement to each proposal at any meeting, **this does not represent a vote in which the majority binds the minority (who object) to accept the proposal; no vote of the Partnership Board can have that effect.**

"In respect of Partnership Board members participating in decisions, we assume that neither the Chair nor the Executive Lead are present at meetings to represent any of the participating organisations and if that is the case they will have no authority from any of those organisations so cannot participate in any 'decisions' made by the board. "

8) Are there positive points to STPs?

The fundamental task of STPs is to drive through changes and cash savings which would not be achievable through the CCGs alone as commissioners, in the hope that enough savings can be made for the NHS to function within a completely inadequate financial limit by 2020.

In other words, the potentially positive and progressive move towards more strategic and wider planning of services in place of the fragmentation imposed by the 2012 Health & Social Care Act is coupled with the development of regressive plans that threaten to reduce local access to services, and an STP structure that is completely lacking in transparency or accountability to any of the local communities within its footprint.

This means that the potential for positive results is completely outweighed by the negative context and trajectory of STPs.

The apparently progressive and positive rhetoric about improving public health to reduce demand on NHS services is completely at odds with actual policies on the ground, the government's continued cuts in public health budgets, cuts in local government spending, and the cash freeze that prevents any serious expansion of primary care and community health services.

Action on social determinants of health also runs up against the cuts in benefits, the housing crisis, the proliferation of low-paid jobs, and all of the worsening problems affecting the poorest in society who suffer the worst chronic health problems.

Those who want to campaign for positive public health measures, or for an end to the fragmentation of services under the divisive, destructive and wasteful competitive market system erected by the 2012 Act need to do so by fighting to reverse that Act, roll back the outsourcing and privatisation of services, and reinstate the NHS as an integrated, publicly owned, publicly provided service, with new, enhanced levels of accountability to local people.

While the 44 footprint areas could in theory be reconstituted as new area health authorities, the STP plans that have been developed are not a stepping stone in that direction but a roadblock, and the STP structures lack any democracy, transparency or accountability.

9) Accountable Care Systems

NHS England has repeatedly advocated that STPs should develop into US-style Accountable Care Systems, in which all of the commissioners and providers in an area receiving a cash-limited budget to commission and deliver a defined range of services and outcomes for a defined local population.

The first eight Accountable Care Systems²⁶ have now reportedly signed a Memorandum of Understanding – the text of which has not been revealed.

The HSJ speculates (on the basis of previous drafts of the MoU) that the document requires each ACS to commit to working in line with the objectives set by NHS England.

In other words while posing as local bodies, they in fact strengthen central control.

The HSJ presumes that the NHS England objectives (which also have not been published)-impose "stringent quality, finance and governance demands", and require each ACS to be seen to be "**more assertively moderating demand growth**", as well as meeting quality targets and achieving a "single system financial control total"²⁷.

This latter requirement means that within ACS areas, any deficit arising in any one organisation can be balanced by surpluses in other organisation: nobody wants to talk of the possibility that the deficits are too large to be managed within the ACS, or that all the organisations are in deficit as a result of inadequate funding.

ACs as proposed in England are a development from the American model of the Accountable Care Organisations. There, the providers step forward to take the risk of providing a defined range of services for a defined population and with a capped, defined budget – effectively shouldering the risk which would normally be dealt with by insurers. This in turn was a reinvention of the Health Maintenance Organisations (HMOs) that had a limited level of success containing runaway health care costs in the USA in the 1990s by effectively limiting the range of hospitals and services its members could access, but again offering a defined group of insured patients a defined range of services at a fixed price.

Doubts over benefits

There is significant doubt as to whether HMOs actually reduced any costs,²⁸ and they were eventually overtaken by other insurance schemes. The ACOs that have emerged more recently in the US also have had mixed levels of success in containing and dealing with risk – some have made savings, which result in profit for the provider, while others have made losses which have been refunded through the public funds of Medicare.^{29 30}

In fact both the profitable and unprofitable ACOs in the US are vastly better funded per head of population than the NHS³¹ – leaving little room for doubt that the ACs proposed for England are a means of imposing cutbacks in the availability and provision of health services to meet the specified, inadequate budget.

The nearest equivalent to ACs that has already been tried – with spectacular lack of success – is the use of “lead provider” contracts, which have been chaotic failures in Cambridgeshire and Peterborough and in Staffordshire. This model also reinforces fears that in some cases ACs may be a stepping stone to the introduction of private health insurers – although the lack of likely profit might be enough to keep them at bay.

However, ACs too can appear in principle to offer a potentially progressive form of organisation in contrast to the fragmentation of the NHS: compare Scotland and Wales now, where health care has been removed from the market, and local health boards have cash limited budgets to provide a full range of services to a local population.

The difference is stark between reality and the claim that ACs will “effectively abolish the annual transactional, contractual, purchaser/provider negotiations” and “free up local administrative costs” from contracting, to “reinvest” elsewhere.

In truth, ACs are emerging from the secretive processes and bodies behind STPs **and are not replacing, but being superimposed above a costly and wasteful market system, established in the 2012 Health & Social Care Act.**

The legality of an AC allocating a long-term monopoly contract to one or more NHS providers (or indeed to any other provider) could yet be challenged in the courts by aggrieved private providers angry at missing potential profit.

And despite their name, ACSs are effectively run as business, and lack any transparency or accountability to local people. The strict segmentation of the NHS into local cash limited areas also effectively ends the core principle that the NHS is a *national* organisation sharing risk across the whole population and allowing resources to be targeted nationally to match local needs.

We will always need some form of local and area planning for health care, with guideline budgets on what they can spend: but any step forward from the current fragmented and disjointed service must start from the reinstatement of the NHS, the abolition of the wasteful market system that has delivered no benefits, services that have been outsourced brought back in house – and the development of a publicly accountable, locally responsive service.

That’s why health campaigners press for the abolition of the divisive, costly and bureaucratic competitive market system, and not a half-way house of establishing the NHS as a “preferred provider” among other providers, and subject to the same transaction costs.

10) Election 2017 – new pressure points

There has never been a time when it has been more urgent and important to raise demands on local politicians.

As the page 3 headline in *Health Campaigns Together #7* insists³², Theresa May has no mandate to pursue any further cuts, privatisation or reorganisation of the NHS in England: her flimsy majority is propped up by votes of Northern Irish extremists, who have no right to decide on English health services.

Many of the Tory MPs who limped home in the June election with drastically reduced majorities are painfully aware that their seats could be at risk if they are seen to be fighting hard to save local services threatened by reconfiguration or STPs – and undermined by the continued freeze on the NHS budget.

The importance of lobbying local government to persuade them to use the powers that elected councils still have in relation to health is underlined by recent developments:

- the Hackney development,
- the strong stance taken in West London by Hammersmith and Ealing councils in refusing to sign up to an STP that threatened to implement the closure of acute services at Charing Cross and Ealing hospitals,
- and more recently the decision of the joint scrutiny panel of Calderdale & Kirklees councils to use their powers to enforce a status quo and refer the planned downgrade and downsizing of Huddersfield Royal Infirmary to the Secretary of State for Health (Jeremy Hunt) and the Independent Reconfiguration Panel.³³

The new situation makes it more important than ever to challenge councillors to stand up for local people and in defence of local access to health services, using the powers and resources they still have, to hold local NHS managers to account; to ask MPs to do the same nationally; and to force a standstill in controversial changes pending review.

John Lister
July 31 2017

Explanatory note: the Commonwealth Fund league table comparing health systems

The Commonwealth Fund³⁴ is a US foundation which has the stated charitable aim of improving access to healthcare for America's poor and excluded groups. However, it has not endorsed the widespread calls for a 'single payer', tax-funded, non-profit system in the USA to replace the chaos and extravagant waste of the private sector-dominated system that still leaves so many with little if any actual coverage.

'Mirror, Mirror'³⁵, their occasional "comparative survey" of health care systems in the US and ten other leading developed economies, is pretty obviously an exercise to demonstrate the poor performance of US healthcare, despite the much larger share of GDP allocated to health in the US.

This obviously has a useful purpose, but it is a limited approach that does not deal with all aspects of a complicated comparison. The US system is so expensive, wasteful and disastrous in its exclusions and inequalities that it's easy to ensure it comes last on any measures that include these factors.

However this year, and in 2014 when the last such survey was published, the UK came out as the overall best of the 11 countries. This has once again allowed the government to claim the findings as an endorsement of their policies, and evidence that all is well despite the cash squeeze and all of the evidence of crisis.

NHS England has claimed it as vindication of the Five Year Forward View, even though the bulk of the data used dates back to 2014 or beyond, before Simon Stevens took over as Chief Executive and the Forward View was even written:

"This international research is a welcome reminder of the fundamental strengths of the NHS, and a call to arms in support of the NHS Forward View practical plan to improve cancer, mental health and other outcomes of care."³⁶ [NHS England]

While the NHS and its values of course need defending against claims from the right that it should be replaced by US-style private insurance, it's important to recognise two vital weaknesses in the Commonwealth Fund's findings.

The first is that all of the comparisons are based not on clinical data, but on government-published statistics, compiled by the OECD and bodies of the WHO, and almost inevitably out of date and raising questions of strict comparability – and surveys of doctors and patients. The Fund itself admits that their work consists of:

“comparative survey research. Since 1998, The Commonwealth Fund, in collaboration with international partners, has supported **surveys of patients and primary care physicians in advanced countries**, collecting information for a standardized set of metrics on health system performance.”

The second weakness, which is not addressed by NHS England, is that on one crucial question the NHS once again, as in 2014, comes near the bottom of the league of 11 countries – the issue of health outcomes. As the *Guardian*'s Denis Campbell and Nick Watt summed up in 2014:

“The only serious black mark against the NHS was its poor record on keeping people alive.”³⁷

This of course is a very serious question. But the Commonwealth Fund offers little if any real guidance on what factors have led to the UK performing so badly in this key area. One obvious explanation is that health outcomes are strongly linked to poverty, inequality, and education, and where these factors are unfavourable it may confound outcomes even of the very best healthcare system.

Nonetheless it's reasonable to assume that the chronic lack of serious investment (and now systematic cuts in spending) on public health measures and health education contribute to the poorer health, diet and lifestyle choices and levels of obesity, which can in turn lead to ill-health, and mean patients present too late in the onset of health problems and are in a worse state to receive treatment.

And lack of significant investment in primary health care (and problems of access as services are centralised) are almost certainly a factor in late detection of health problems.

Now the Nuffield Trust Chief Executive Nigel Edwards has added to the debate by suggesting that the repeated reorganisation and disruption of the healthcare system through ill-judged 'reforms' may also have played a role:

“the claim that the influence of Government on health in parts of the UK is malign does seem plausible. In recent years, the English NHS has undoubtedly had more reorganisation and restructuring than any health system in Europe – even those subject to some of the most rigorous austerity regimes post 2008.

“For example, there have been six reorganisations of commissioning authorities in the NHS in the last 20 years. Regional structures, workforce planning and community services have had similar amounts of often destructive tinkering. [...]

“A second difference might be the extent to which managerialism as opposed to professionalism is the main paradigm for how the English system is run.”

This final point is a useful counter to those who might draw the conclusion from the first two paragraphs that any further reorganisation – to reverse the fragmentation and dislocation imposed on England’s NHS by the disastrous 2012 Act – should be avoided.

The competitive market that has been created in healthcare in England is the driving force behind the replacement of professionalism by managerialism, which in turn is noted by Edwards as a factor in the poor outcomes and performance of the NHS.

A reform to reverse that process, scrap the market and restore professionalism, is essential to restore the integrity and values of the NHS. The NHS Reinstatement Bill, supported by a growing number of Labour MPs, offers a coherent approach to this, aiming to restore the NHS in its pre-Thatcher form, before the “internal market” and contracting out of support services³⁸.

It is perhaps striking in this regard that the latest planned privatisation of services in England is the **outsourcing of NHS Professionals**, established a few years ago as the NHS’s own answer to the use of costly agency staff. The planned sell-off neither saves money nor offers any improvement in efficiency – it is purely driven by the ideology of neoliberalism³⁹.

The campaign against this, which began with an initiative by We Own It⁴⁰, and now been backed by the **Labour Party** calling for an inquiry⁴¹, is another important fight for the values and principles of the NHS.

¹ <https://www.theguardian.com/society/2017/jul/31/mental-health-sector-gives-mixed-response-to-13bn-plan-for-better-services>

² <https://www.theguardian.com/society/2016/nov/01/number-mental-health-nurses-nhs-drops-sixth-tories>

³ <https://nhsproviders.org/media/3218/winter-warning-managing-risk-in-health-and-care-this-winter.pdf>

⁴ <http://www.nationalhealthexecutive.com/Comment/time-to-heed-the-winter-warning-from-the-frontline>

⁵ http://www.echo-news.co.uk/news/15421662.NHS_U_turn_on_A_E_plans_for_Southend/?ref=mrb&lp=9

⁶ <http://election2017.ifs.org.uk/article/uk-health-spending>

⁷ <https://nhsproviders.org/resource-library/reports/the-state-of-the-nhs-provider-sector>

⁸ <https://www.nuffieldtrust.org.uk/files/2017-05/nhs-funding-choices-web-final.pdf>

⁹ <https://nhsproviders.org/media/2727/mission-impossible-report.pdf>

¹⁰ <https://www.hsj.co.uk/commissioning/exclusive-accountable-care-systems-will-make-pathway-for-stps-to-follow/7020001.article>

¹¹ <http://www.fm-world.co.uk/news/fm-industry-news/nhs-property-board-should-be-set-up-to-drive-estates-savings-says-naylor-review/>

¹² <http://www.healthcampaignstogether.com/pdf/Comments%20and%20Questions%20on%20Naylor.pdf>

¹³ <http://www.healthcampaignstogether.com/pdf/HCTNo7.pdf>

¹⁴ <https://healthcaredtimes.co.uk/nhs-needs-5000-more-beds-to-achieve-safe-occupancy/>

¹⁵ <http://www.rcem.ac.uk/docs/Policy/RCEM%20Manifesto%202017.pdf>

¹⁶ <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areas-ae-waiting-times-and-activity-ae-attendances-and-emergency-admissions-2016-17/>

¹⁷ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/06/RTT-Overview-Timeseries-May17-corrected-XLS-85K.xls>

¹⁸ <https://nhsproviders.org/media/3218/winter-warning-managing-risk-in-health-and-care-this-winter.pdf>

¹⁹ 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

The measures proposed as ways to contain spending included:

- 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 breaching 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.

²⁰ Denis Campbell *Guardian* July 14: ‘Revealed-NHS-Cuts-could-target-heart-attack-patients-in-Surrey-And-Sussex’ <https://www.theguardian.com/politics/2017/jul/14/revealed-nhs-cuts-could-target-heart-attack-patients-in-surrey-and-sussex>

²¹ Lawrence Dunhill’s *Health Service Journal* report ‘Savings drive softened after ‘top-down pressure’ complaints’, June 27, <https://www.hsj.co.uk/7019153.article>

²² <https://www.england.nhs.uk/wp-content/uploads/2017/03/next-steps-on-the-nhs-five-year-forward-view.pdf>

²³ For a serious analysis of all 44 STPs, see the London South Bank University study *Sustainability and Transformation Plans: How serious are the proposals? A critical review* by Sean Boyle, John Lister and Roger Steer. Available <http://www.healthcampaignstogether.com/pdf/sustainability-and-transformation-plans-critical-review.pdf>, or the more recent CHPI study <https://chpi.org.uk/wp/wp-content/uploads/2017/06/STPs-5-key-questions-FINAL-2017-06-18-.pdf>.

²⁴ See <http://www.healthcampaignstogether.com/pdf/sustainability-and-transformation-plans-critical-review.pdf> and centre pages of Health Campaigns Together newspaper no. 7 <http://www.healthcampaignstogether.com/pdf/HCTNo7.pdf>

²⁵

<https://www.hsj.co.uk/nhs-city-and-hackney-ccg/commissioners-tell-stp-they-remain-sovereign/7020067.article>

²⁶ Identified as Frimley Health; South Yorkshire and Bassetlaw; Nottinghamshire, Blackpool and Fylde Coast; Dorset; Luton, with Milton Keynes and Bedfordshire; West Berkshire; and Buckinghamshire. <https://www.hsj.co.uk/commissioning/simon-stevens-names-the-first-accountable-care-systems/7018795.article>

²⁷ <https://www.hsj.co.uk/commissioning/exclusive-accountable-care-systems-will-make-pathway-for-stps-to-follow/7020001.article>

²⁸ http://www.pnhp.org/news/2000/march/claim_that_hmos_sav.php

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- ²⁹ Gruessner V. (2016) Two Contrasting Opinions on Accountable Care Organizations, Health Payer Intelligence August 25, available <http://healthpayerintelligence.com/news/two-contrasting-opinions-on-accountable-care-organizations>
- ³⁰ <https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/>
- ³¹ <http://www.healthcampaignstogether.com/pdf/The%20case%20of%20the%20missing%20evidence%20-%20STPs%20and%20Five%20Year%20Forward%20View-2.pdf>
- ³² <http://www.healthcampaignstogether.com/pdf/HCTNo7.pdf>
- ³³ <http://www.examiner.co.uk/news/live-protests-councillors-make-decision-13364271>
- ³⁴ <http://www.commonwealthfund.org/about-us>
- ³⁵ <http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>
- ³⁶ https://www.theguardian.com/society/2017/jul/14/nhs-holds-on-to-top-spot-in-healthcare-survey?CMP=share_btn_fb
- ³⁷ <https://www.theguardian.com/society/2014/jun/17/nhs-health>
- ³⁸ www.nhsbill2015.org
- ³⁹ https://www.theguardian.com/society/2017/jul/27/labour-demands-inquiry-into-privatisation-of-nhs-owned-recruiter?CMP=share_btn_tw
- ⁴⁰ <https://weownit.org.uk/nhsp-no-sale>
- ⁴¹ https://www.theguardian.com/society/2017/jul/27/labour-demands-inquiry-into-privatisation-of-nhs-owned-recruiter?utm_source=esp&utm_medium=Email&utm_campaign=GU+Today+main+NEW+H+categories&utm_term=236910&subid=18785878&CMP=EMCNEWEML661912