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Privatisation

**Private sector profits as NHS crumbles** Companies are steadily making gains in the health service as it struggles to cope. Caroline Price investigates in Pulse Oct 2016

Pulse has learned major healthcare companies are seeing profits more than double, uniformly citing the pressures on the NHS as the driver for increased activity. But the companies benefiting are not the usual suspects, like Virgin Care and Care UK who rely on winning contracts to run large parts of the NHS. Instead, it’s those companies offering an alternative to the decrepit NHS that are cashing in. Private hospitals are capitalising on the underfunding of the NHS by expanding their services, focusing on areas subject to rationing drives or long waiting lists *such as cataract treatment and hernia repair.*

A recent survey of private healthcare industry leaders concluded the 'self-pay' market could grow by 10-15% a year over the next three years. Tellingly, it singled out falling confidence in the NHS among the public as a major driver of business. Meanwhile, figures obtained by Pulse under the Freedom of Information Act reveal many CCGs are expanding the use of the private sector to reduce waiting lists, with commissioning of care from private hospitals growing by 18% between 2013/4 and 2015/16.

And GPs in one area were recently asked to encourage their patients to use their private health insurance if they have it. The reason? CCGs’ desperation to make savings. The policy was a success, of sorts. NHS Mid Essex CCG reported GP referrals to private providers increased by 6%, perhaps providing a measure of relief to stretched NHS services.

But this short-term gain provided a window on the future direction of the health service - one where the NHS is shrinking, while private healthcare continues to expand. And general practice services themselves are next in line for the private sector; in the past year a raft of private GP outfits have burst onto the scene, with many explicitly citing the crisis in general practice to promote their self-pay services. They include app developers, who match up patients and GPs offering private sessions, and others who offer the chance to speak to GPs over a video link.

Larger private providers are also showing interest in general practice. GP leaders say the Government is undermining the NHS in favour of the private sector through 'scandalous' underfunding, and 'sleepwalking' us towards a US-style health insurance system.

And private companies own figures seem to back this up.

- **BMA health care** doubled its profits in 2015 from 8m to £16.7m. This was largely due to 13.5% rise in NHS caseload and 3.5% rise in self pay caseload.
- **Spire reported 30% revenue increase**, from £674m to £885m, between 2011 and 2015 and a 20% increase in patient discharges.
- **Nuffield Health reported a 15% increase in hospital revenue** between 2013 and 2015, from £457m to £525m and a 37% incease in procedures since 2013 from 149,900 to 206,000.
- **Circle’s revenue** is up 32% in 2014 and 15% in 2015.

Interestingly Care UK and Virgin Care which rely on delivering contracts to deliver services in the community have seen revenues fall while United Care pulled out of an £800m contract in Cambridgeshire after just eight months, complaining the arrangement was financially unsustainable.

The companies booming are the ones taking advantage of long waiting lists at NHS providers. There has been an 18% overall increase in the amount spent by the NHs care delivered at private hospitals over the last three years.

At the same time trusts across England saw a 14% increase in income from private patients between 2012/13 and 2015/16.
Former Tory Health Secretary profits whilst businessmen leech £262m a year from OUR NHS  by Tom Roberts In Evolve Politics 26th October 2016 http://evolvepolitics.com/former-tory-health-secretary-profits-whilst-businessmen-leech-millions-nhs/

Using a Tory loophole, millionaire businessmen have taken £262million a year out of the NHS. This money, equivalent to 7000 junior doctors, has been stripped from the NHS to become private profit. And guess who’s being paid to advise on drug pricing? Former Health Secretary Andrew Lansley!

The startling figures came to light after a seemingly bewildered Jeremy Hunt called in the Competition and Markets Authority (CMA) after it emerged that 32 drugs had seen price hikes of up to 1000% in 5 years. A further 196 have seen their prices doubled. In the most extreme case hydrocortisone tablets, a common allergy medicine, have risen by 12500% – from 70p in 2008 to £85 today. That’s what I call inflation.

The greedy “entrepreneurs” exemplify the worst kinds of vulture capitalists. They buy up exclusive marketing rights to off-patent medicines and then hike the prices. All they need to do is re-brand the product with its generic name, as generic products have no NHS price controls whilst named products do. This obvious loophole can then be exploited to raise the price of medicines to record highs.

Following on from his successful privatisation by stealth, Lansley is now paid to advise three pharmaceutical companies. One of which, Roche, has attracted criticism for its own pricing. Roche’s £90,000 price tag for its breast cancer drug has left it unaffordable on the NHS. Of course it bears reminding that Lansley was hired to advise on how to price such medicines. It’s a good wheeze if you can get it – hand people the keys to someone else’s car with one hand whilst helping to fence it with the other. Oddly, Mr Lansley’s advisory period ended shortly before the scrounging pharma companies were turned down by the NHS. Perhaps his pricing advice isn’t so sound after all.

Virgin wins contracts worth £65m  2 November, 2016 By Lawrence Dunhill, Health Service Journal

Virgin Care has been awarded two five year contracts to provide community and urgent care services for a clinical commissioning group in Lancashire.

West Lancashire CCG launched a tender process for the services after the Care Quality Commission raised concerns about Southport and Ormskirk Hospitals Trust, the incumbent provider (SOHT). The community services contracts are worth £45m over five years

Private firm Optum, Lancashire Care Foundation Trust and Bridgewater Community Healthcare FT were also shortlisted for further discussions about the community services contract, which was previously advertised as being worth £45m over five years.

Optum and Virgin Care were the only bidders shortlisted for the urgent care services contract, including GP out of hours provision and a walk-in centre in Skelmersdale, for a contract worth around £20m over five years. Virgin Care will start delivering the services in April.

Neighbouring Southport and Formby CCG has also recently tendered its community services, which were also run by Southport and Ormskirk Hospital Trust. This contract has been awarded to Lancashire Care FT.

GPs award potential £700m contract to Virgin Care Adrian O’Dowd in the BMJ  14.11.16

GPs on a clinical commissioning group and local councillors have awarded a contract that could be worth £700m (£810m; $880m) to the private health company Virgin Care to run or oversee 200 types of NHS and social care services to people in Bath and northeast Somerset.
The decision, announced last week, has provoked concern over what is thought will be one of the largest handovers of public services to a private firm to operate when the new arrangements begin in April next year. Bath and North East Somerset Clinical Commissioning Group (CCG) and Bath and North East Somerset Council announced on 10 November that they had awarded a seven year contract to Virgin Care. The contract, worth £70m a year, has the option to extend for a further three years, meaning that it could be worth a total of £700m between 2017 and 2027.

The decision was made, said the CCG, after extensive consultation with service users, members of the public, and health and care professionals.

Under the agreement, Virgin Care will deliver some services directly, as part of a mental health collaboration, and will subcontract some services from other providers. The services include community health and care services such as diabetes nursing, physiotherapists, speech and language therapy, independent living services, and district nurses, together with mental health services, public health nursing, the NHS Health Checks programme, and dementia support.

A spokesman for the CCG said that there was no intention for Virgin Care to take over running GP services but that it wanted community services to work with general practices through specific locality hubs that align with the area’s 26 practices, allowing for closer collaboration.

The other serious bid for the contract was from a local consortium led by Sirona Care and Health, a not for profit company, which bid in partnership with local NHS trusts and charities.

Concern was voiced by Chaand Nagpaul, chair of the BMA’s General Practitioners Committee, who told The BMJ, “The BMA believes that services should be delivered by NHS providers who have the experience, expertise, and commitment to the values of the NHS necessary to provide patients with the most effective and safe care. “Past history has shown that private sector companies take over contracts with little understanding of or connection to NHS structures and have a mindset that is driven by a desire to make a profit, which can lead to a focus on providing services at the lowest possible cost.”

Jonathan Ashworth, Labour’s shadow health secretary, criticised the decision, saying, “Under the Tories hospitals are facing financial crisis while patient care suffers, yet all the Tories offer is further cuts and outsourcing to private companies like Virgin.”

**Government quietly privatises the NHS's in-house agency staff provider**

**The private sector will be offered a majority stake in NHS Professionals**

Jon Stone Political Correspondent The Independent, 19.11.16

The staffing agency will be sold off with the aim of creating a 'profitable business model' Rui Vieira/PA

The Government is to privatise the NHS’s in-house, publicly-owned provider of agency staff, ministers have announced.

NHS Professionals, the health service’s main staffing agency, provides 90,000 health workers to around a quarter of NHS trusts, covering two million shifts a year.

In a written statement issued on Thursday as most MPs headed back to their constituencies, the Government announced it would sell off a majority stake in the organisation to the private sector with the aim of “creating a profitable business model”.

Labour says the sell-off amounts to further privatisation of a key part of the health service, while the Government claims the private sector will help provide new investment.

It is understood that the Government could invest public funds in the organisation directly through the Treasury but has chosen to use the private sector instead.

“Following market analysis and a thorough appraisal of a business case, the Department’s preferred option is to create a joint venture partnership to bring in the necessary investment and expertise to the business and give the Company greater operational autonomy,” health minister Philip Dunne said in the statement.
“The Department will sell a majority shareholding so that the Company is run and controlled by the new partner, which will carry the majority of the finance and operating risks of the business. “Contractual mechanisms will be used to ensure that the dual aims of creating a profitable business model whilst meeting the needs of NHS customers - delivering savings and a high quality service - are correctly aligned and fully agreed upon.”

The minister said that the Government would retain a non-majority shareholding in the organisation to stop it from deviating from its original purpose.

**Why Cambridgeshire £800m contract collapsed** (summary from BMJ by John Puntis)

A landmark £800m (£930m; $1bn) contract to provide older people’s and adult community services collapsed just months into operation because of the “grossly irresponsible” actions of NHS commissioners and the service provider, an influential committee of MPs has concluded. In a damning report, the House of Commons Public Accounts Committee said that services for patients would suffer as a result of the failed deal between Cambridgeshire and Peterborough Clinical Commissioning Group and Uniting Care Partnership, a partnership between Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. The deal, which was one of the largest outsourcing deals ever signed by the NHS, began in April 2015 but was terminated after just eight months after the parties failed to reach agreement on contract costs.

The report also noted that the CCG and the two trusts had been forced to share an additional burden of £16m incurred from the contract’s failure, which weakened the financial positions of all three organisations and reduced the money now available for services to the region’s patients. The Labour MP Meg Hillier, chair of the Public Accounts Committee, said, “It beggars belief that a contract of such vital importance to patients should be handled with such incompetence. The deal went ahead without parties agreeing on what would be provided and at what price—a failure of business acumen that would

**The ghost of Christmas yet to come?** (Looking at the USA : summary from John Puntis from 3 different articles in BMJ 18.11.16)

Roughly a fifth of insured US patients who obtained care at a hospital that was in their health plan’s network were potentially exposed to substantial “surprise bills” because they received treatment from emergency room staff who came from outside the network, a new study has found. Hospital physicians typically compete on the basis of quality and price to be included in health insurance plan networks, but many in-network hospitals contract out their emergency department care to groups of independent physicians who may or may not be in their patients’ networks. As a result, patients who go to an in-network hospital for emergency care may receive an unexpected “balance” bill to cover fees charged by these out-of-network physicians that their health insurance plan will not cover.

Using the differences in the fees charged, the researchers estimated that the patients who were cared for by out-of-network physicians could, on average, have faced a surprise bill totalling $622.55 (£500; €580). Many patients faced substantially higher bills, including one patient who faced a potential bill of nearly $20 000. The researchers wrote that such surprise bills can be a substantial burden to many patients, noting that one federal study found that nearly half of Americans were not able to cover an unexpected $400 expense without either selling assets or borrowing money.

For 45 years, the US healthcare system has been accurately characterized as the most expensive among nations in the Organization for Economic Cooperation and Development (OECD), as mediocre regarding quality and effectiveness, as inadequate in that it left nearly 50 million Americans uninsured, and as substandard in core outcomes such as infant mortality and life expectancy. In short, the only category at which Americans seemed to excel was in spending the most money. Between 2005 and 2008, many sectors in American society became vocal in calling for comprehensive healthcare reform to address failings in access, quality, cost, and outcomes. Between January 2009 and March 2010, new President Barack Obama worked with hefty Democratic majorities in the US Senate and House of Representatives to fashion comprehensive reform to tackle these deficiencies, signing the Affordable Care Act on 23 March 2010. By fall 2016, more than 20 million formerly uninsured Americans had obtained affordable coverage, and many millions more had won protections from now prohibited insurance practices such as rating consumers based on medical history; the percentage of uninsured Americans is now estimated at below 9%, the lowest ever. Since the
election Republican leaders, including Trump, have emphasized their determination to “repeal and replace” the ACA as rapidly as possible.

US adults are more likely to skip care because of cost, to struggle to afford basic necessities, and to have poorer health than adults living in 10 other high income countries, a survey has found. The Commonwealth Fund conducted the survey, which was based on interviews with nearly 27,000 adults in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The results were published on 16 November 2016 in the journal Health Affairs. “The United Kingdom was the only country where low-income adults were not significantly more likely than the rest of the population to report cost-related problems,” the authors wrote.

**Trust seeks to terminate £200m contract**  
Health Service Journal  
by Shaun Lintern

Nottingham University Hospitals Trust will look to terminate a five year, £200m estates and facilities contract with Carillion amid concerns over poor standards.

A leaked email from the chief executive of Nottingham University Hospitals Trust Peter Homa, seen by HSJ, confirms the trust is looking to agree “a managed exit” from their contract with the support services firm Carillon after months of warnings from the trust.

In October, HSJ reported that nurses at the East Midlands trust were cleaning ward areas after Carillion staff had finished their work. There have also been complaints over overflowing bins and rats spotted in food preparation areas. There have also been complaints about a shortage of linen, the availability of equipment and portering services.

Carillion was awarded the five year contract to run the trust’s estates and facilities services in April 2014 after a competitive tendering process. Around 1,500 staff transferred to the company following award of the contract.

Services provided by Carillion include cleaning, catering, laundry and linen, car parking and security. The trust warned the company in July that unless there were improvements it would terminate the contract and last month the board agreed there had been “insufficient progress”.

In an email to staff, trust chief executive Peter Homa said: “NUH and Carillion are now exploring a managed end to the Carillion contract.” Estates and facilities staff will remain employed by Carillion until such time as future arrangements are agreed by both parties, which we anticipate to be January 2017.

**Funding / Underfunding the NHS**

**Trust execs tell peers that NHS needs more funding (at last!)**  
summary from British Medical Journal by John Puntis Nov. 16

Chief executives at three large acute trusts gave a blunt message about their perceived underfunding of the health service during a three hour evidence session of the House of Lords NHS sustainability committee on 15 November. The NHS was approaching a “crossroads,” said Michael Deegan, chief executive at Central Manchester University Hospitals NHS Foundation Trust, giving evidence during the session for the committee’s inquiry into the NHS’s long term sustainability. “Our view is that the current path that we are on is taking us rapidly towards an unsustainable position,” said Deegan, also a member of the Shelford Group, which represents 10 of England’s leading NHS academic healthcare organisations. “On a national level, our most fundamental concern is how much, as a country, we are willing to invest in health and social care,” he said. “It's abundantly clear that there is not enough resource for the service to meet the legitimate demands of the patients and communities we serve.”
The reduced growth rate of investment in the NHS since 2010 and a similar pattern predicted until 2020 meant that the NHS was falling behind the ever growing demands made on it, he warned. Asked by peers to quantify the extra money needed, Deegan said, “The OBR [Office for Budget Responsibility] estimates seem to suggest that, if we were to return to a level of 4% growth per annum, which looks like a sensible level to take on board the level of demand pressures on the NHS, technology, and innovation, that would be appropriate for the foreseeable future.”

(The Shelford Group does not include Leeds THT and is comprised of: University Hospitals Birmingham NHS Foundation Trust, University College London Hospitals NHS Foundation Trust (UCLH), Sheffield Teaching Hospitals NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust (OUH) Newcastle-Upon-Tyne Hospitals NHS Foundation Trust, King’s College Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust, Guy’s and St Thomas’ NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust (CUH)

**NHS will not deliver improvements without extra cash, MPs tell Chancellor** by Adrian O’Dowd, BMJ 31.10.16

The NHS in England will not be able to deliver the expected transformation as set out in the NHS Five Year Forward View without more money, MPs have told the Chancellor, Philip Hammond.

MPs on the parliamentary health committee took the unusual step of writing directly to the Chancellor on 31 October with a public letter that set out their concerns over pressures on the NHS, even before they published a report from their inquiry into the state of NHS finances.

“We write as members of the health committee to express our concern that the extent of this pressure is not sufficiently recognised by the government,” they said in the letter, saying that they needed to alert the Chancellor to the severity of the situation before he finalised his autumn statement, which will be delivered next month. The current deficit of NHS trusts and foundation trusts was a billion pounds higher than the official £2.45 billion (£2.72bn; $2.98bn) recorded by the government, they said.

The committee also said that the government’s continued use of the figure of an additional £10bn for health spending up to 2020-21 was wrong and risked giving a false impression that the NHS was awash with cash. The more accurate figure for increased funding was £4.5 billion between 2015-16 and 2020-21.

A lot of the increase in funding was being made from reductions in areas of health spending that fell outside NHS England’s budget, such as the public health grant to local authorities, and education and training funded through Health Education England. “The reality of taking such a substantial portion of the additional money granted to the NHS from other areas of health spending is that this puts at risk the achievement of the Five Year Forward View,” they wrote.

The most pressing issue, however, was cuts to spending on social care in recent years, said the MPs, who warned that witnesses during their inquiry had been clear that these reductions were “having a serious impact” on the NHS. “The fragility of the adult social care market is now beginning to impact both on the people who rely on these services and on the performance of NHS care,” said the letter.

Health think tanks generally welcomed the letter and its warnings. Richard Murray, director of policy at the King’s Fund, said: “It is no longer credible to argue that the NHS can continue to meet demand for services and deliver current standards of care at the same time as staying within its budget.”

John Appleby, chief economist at the Nuffield Trust said: “The health secretary himself has admitted that the NHS is facing one of the most difficult periods in its history, and social care is widely acknowledged to be on its knees.”

**Government must be clearer in its claims about NHS funding, says statistics watchdog**

Gareth Iacobucci in BMJ 24.11.16

The UK government must be clearer and more precise in its claims about NHS and healthcare funding, the UK Statistics Authority has said.
The watchdog, which oversees the government’s use of official statistics, examined a repeated claim by the prime minister, Theresa May, that the government had provided £10bn (€11.75bn; $12.4bn) in extra funding for the health service. This followed complaints from the BMA and the Labour Party that this figure, which has also been used by the health secretary, Jeremy Hunt, was misleading. The government’s use of the £10bn figure has been hotly disputed by healthcare think tanks and the House of Commons Health Committee, on the grounds that it refers to the money allocated to NHS England rather than to total health spending. Although funding to NHS England has increased, the Department of Health’s wider budget—which funds areas such as public health, medical education, and training—was cut by around 25% this year.

NB see https://www.kingsfund.org.uk/blog/2016/11/health-service-brink-priority-corridors-power article by Chief Exec Chris Ham which says the Kings Fund view is that the £10bn or £8bn the Govt is supposed to be putting into the health Service is actually 4.5bn

**Patient care is at risk from lack of new funds in autumn statement, healthcare leaders warn** Gareth Iacobucci BMJ 24.11.16

The government’s failure to commit new funding to the NHS and social care in its autumn statement will put the care of patients at risk, health and social care leaders have warned. The government was strongly urged to revisit its 2015 spending review pledges for health and social care because of the severe pressures across the service. But the chancellor of the exchequer, Philip Hammond, ignored the calls and repeated the increasingly discredited claim that the government had already committed £10bn (€11.7bn; $12.4bn) extra funding for the NHS by 2020. Jane Dacre, the President of the Royal College of Physicians said that the failure to acknowledge the current pressures on the NHS was “alarming.” “Our NHS is underfunded, underdoctored, and overstretched, and today’s lack of additional funding will only exacerbate the grave situation we face. The pressures put patient safety and recovery at risk every day of the week. Patients are facing longer waits for treatment, and the number of patients stuck in hospital because of delays in being discharged has increased by 80% in the past five years. This is clearly not sustainable.”

Gary Porter, chairman of the Local Government Association, said, “Councils, the NHS, charities, and care providers have been clear about the desperate need for the chancellor to take action to tackle the funding crisis in social care. It is unacceptable that this has not been addressed in the autumn statement. Extra council tax raising powers will not bring in enough money to alleviate the pressure on social care.” The health think tanks the Health Foundation, the King’s Fund, and the Nuffield Trust issued a joint call ahead of the statement calling for social care to be prioritised, said that vulnerable older people would suffer from the decision not to invest extra money into the crisis hit sector.

**Why talking about an 'NHS tax' isn't brave at all** Dave Byrne in Open Democracy 7.11.16

Norman Lamb, Liz Kendall, and Alan Milburn want the NHS to turn to various less progressive forms of taxation for its funding. Such proposals have a shoddy history.

![Image](How should we pay for the NHS?)

Last month, a cross-party coalition floated the idea of a hypothecated tax, a tax devoted to a specific purpose, as a way of funding the NHS. People like the NHS and would be willing to pay more tax if the tax was devoted to that purpose, so the argument goes. This proposal does the rounds from time to time. Often this special “NHS tax” is
linked to National Insurance (NI), which after all already meets a proportion of health costs, and appears to be a tax that is already hypothecated towards benefits and health.

The coalition behind the current proposals is fronted by LibDem Norman Lamb, who told this Autumn’s LibDem conference: “let’s look at the case for a dedicated health and care tax, shown on your pay packet”. Lamb is joined by fellow former Coalition Health Minister, Tory Dr Dan Poulter. Completing the ‘cross-party’ coalition is Liz Kendall, former shadow health secretary and failed Blairite Labour leadership candidate.

The links between hypothecated taxes and National Insurance are deeply concerning. NI is now widely recognised as just another form of income tax levied on some but not all income, and thus, deeply regressive. In particular, unlike income tax, NI is not paid on pensions, payments from tenants, income from trusts, or income above a certain ceiling.

And there are other forms of less progressive taxation being explored by ‘cross-party’ groups including right wing Labourites. Only this week, former Blairite health minister Alan Milburn and his new employer, PWC, have suggested that local governments should have more powers to raise council tax to pay for healthcare – another deeply regressive tax.

Why do politicians flirt with regressive taxes to fund the NHS? It’s perhaps instructive to look at the history.

Where does the money currently come from to pay for the NHS in the UK? The answer is from tax obviously but is it from National Insurance or general taxation? In fact about 18% of the costs of the NHS are borne by National Insurance Contributions – some £21 billion of the £118 billion the NHS cost in 2015-16.

Why? After all, Nye Bevan recommended “general taxation” as the way to fund the NHS and specifically rejected the idea of an NHS paid for mostly through National Insurance. In ‘In Place of Fear’ Bevan wrote that using a “contributory” system like National Insurance to fund healthcare would prove too complicated and unfair, calling it a “peculiarly unsuitable” approach. But despite that – and despite its markedly regressive character - governments of all colours have seen National Insurance Contributions as a useful tax source.

When sickness benefit was introduced by the Liberal government in 1912 it included a right to treatment by GPs for insured workers ‘on the panel’. Every insured worker was on the panel of a GP – the origin of our current GP system. The original motive for this was supposedly to get the worker back to health and back to work. Given the ineffectiveness of most curative interventions at that time its real benefit was being “signed off work” by the medical practitioner. That gave sick workers time to recover and get an income whilst doing so. In the interwar years, coverage was extended from the worker to the worker’s family. So when the NHS was established by the post-war Labour government in response to Beveridge’s proposals, part of the cost of the NHS was picked up by NI contributions.

But for most of the post-war period the primary purpose of the National Insurance scheme remained the funding of unemployment, sickness and especially retirement benefits. Originally workers paid a flat rate contribution in return for flat rate benefits, but from the 1960s time there was a shift towards earnings related contributions and earnings related benefits, though Thatcher scrapped the latter in favour of returning to flat rate benefits.

Like income tax, National Insurance is levied on those who earn incomes but not on other incomes – and thus, like income tax, it is easily avoided by the rich who can convert earned income into capital gains and so on. But it is far more regressive than income tax. People start paying National Insurance at a lower threshold of income than for income tax. And for many years it was not paid at all on earned income over a ceiling. It’s now levied at just 2% on income over a ceiling, as opposed to 12% up to that threshold.

Despite (or perhaps because) of its tendency to hit the poor harder than the rich, NI has been regarded as a useful ‘stealth tax’ since the 1960s.

The correct solution is to fold NI into general income tax. This would be politically difficult, given the impact this would have on affluent pensioners who not only do not pay NI on their pensions but do not even pay NI on earned
income once they are over 65. Actually it would be easy to take a lot of pensioners out of this liability by raising the income threshold for income tax itself.

We need to redistribute. And of course any tax policy ‘going forward’ has to get after tax avoidance and hit it very hard. There is one proper way to pay for the NHS (and indeed social care) and that is through a progressive tax system treating all taxes as part of that system, not through silly games with a very dodgy history.

**Services at breaking point & inequalities widening because of lack of funds and staffing**

**NHS cancer testing service 'at breaking point' BBC 23.11.16**

Pathology departments in NHS hospitals around the UK are struggling to cope with rising requests for cancer tests, Cancer Research UK has warned.

Without more staff to meet the demand, long waits for test results could become the norm, says the charity. One in two of us will have cancer at some point, and getting it diagnosed early is vital.

The government says it is investing in cancer services, which includes having the right number and mix of staff.

According to the report:
- Year on year, requests for pathology services have been increasing, but staffing levels are not increasing fast enough to keep up.
- Of 36 laboratories that responded to a survey about staffing, 20 had at least one (full-time equivalent) vacancy among consultant staff.
- Of these 20 laboratories, 13 had had these vacancies for six months or longer.
- A significant chunk of the workforce is nearing retirement age and there are not enough new graduates to fill the void.

Cancer Research UK says that in the next five to 10 years there will be a shortage of consultants across all areas of pathology.

It says the same problem applies to other cancer diagnosis services such as scans and endoscopies.

Prof Manuel Salto-Tellez, a Cancer Research UK pathology expert, said: "We need to act now before this situation gets worse. It's vital that patients are diagnosed at an early stage when treatment is more likely to be successful and pathology plays a crucial role in this. "The number of cancer cases diagnosed each year is set to rise and the already stretched pathology services won't cope unless we ensure more people are trained and employed in pathology. We must also make sure that existing staff have the support they need to do their job."

There were around 352,000 new cancer diagnoses in the UK in 2013. Cancer Research UK estimates this will rise to 500,000 a year by 2035.

A Department of Health spokesperson said: "Early and fast diagnosis is crucial in improving patient outcomes and experience. Getting pathology test results to patients quickly is a key part of this. That's why we have invested over £2.5bn on efficient and robust pathology services across the NHS."

**Government must not shy away from bold action on public health, says MP**

Matthew Limb in BMJ 22.11.16

A leading Conservative MP Sarah Wollaston, who chairs the health select committee, said that people wanted to see tougher measures being introduced that could significantly improve public health. In September the health committee published a report warning that health inequalities were set to widen after £200m (£233m; $248m) cuts to local authorities’ public health budgets. On becoming prime minister in July 2016, Theresa May said that reducing health inequalities would be a top priority and pledged to fight the “burning injustice” that people born poor will die on average nine years earlier than others.
Michael Marmot, who is director of the UCL Institute of Health Equity, warned how badly many working families would be affected over the next five years by tax and benefit changes planned by the government. “If you want the ‘just about managing’ to manage a bit better and their health to get better as a result, don’t reduce their living standards,” ....The national living wage won’t guarantee the minimum income standard, which families with children need for a healthy life; it’s not enough. The evidence across Europe is that the more generous countries are with their welfare spending, the better their health and the narrower their health inequalities.”

**Sustainability and Transformation Plans**

**NHS Sustainability & Transformation Plans (STPs) Don’t Slash, Trash and Privatise our NHS!**

A Briefing prepared by campaigners from NE London STP area – November 2016

**Introduction**

STPs are driven by a combination of NHS underfunding, new budget cuts, and the Government’s determination to shift the NHS from a clinically-driven service towards US-style models that fit more readily with private insurance-based and corporate-managed healthcare. These changes will have a devastating impact on the NHS and on services and healthcare for local people.

‘Everyone will submit an STP because they have to, but it means there is a lot of blue sky thinking, and then a lot of lies in the system about the financial position, benefits that will be delivered - it is just a construct, not a reality.’ Julia Simon, until Sept 2016, Head of NHSE Commissioning Policy Unit.

**How STPs will affect the NHS**

A Health Service Journal poll of leaders of England’s 209 Clinical Commissioning Groups has revealed the extent of “service changes likely or planned” over the next 18 months:

- 52% would be closing or downgrading community hospitals
- 46% were planning an overall reduction in in-patient beds
- 44% intend to centralise elective services
- 31% would be closing or downgrading A and E
- 30% intend to close an urgent care centre or similar provision
- 23% are planning an overall reduction in acute services staff
- 23% intend to stop in-patient paediatrics in one or more hospitals
- 21% would be reducing consultant-led maternity provision

**Funding**

- £22bn cuts to be imposed through 44 STPs across England by 2020-21
- No growth in services despite sharply rising costs, population numbers and rising health needs – means a devastating decline in what’s available to individuals. These are CUTS, masked by deliberately ambiguous and vacuous language designed to mislead and manipulate the public.

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- **UK spending on healthcare is significantly below the average of major European economies**. If the UK were to increase its spend to 10.7% of GDP, this would equate to an extra £15bn pa.

### Lack of evidence to support NHS England’s Five Year Forward View (5-YFV) ‘new models’

- The NHS has a proud track record of evidence-based practice. This is all but abandoned in the 5-YFV.
- The ‘new models of care’ are cost-driven. We campaigners don’t oppose changes to services – but changes need to be driven by combination of clinical need & requirement for good patient access. Service changes need to be rigorously assessed against these criteria.
- STP changes are being imposed with no such assessment, and lack of valid, peer-reviewed research evidence-base. Anecdotes claiming success are routinely substituted for valid evidence that also takes account of a wider picture. Examples include:
  - decisions to focus services on specific outcomes often take no account of the impact on patients with multiple conditions who may lose co-ordinated care.
  - Arguments about the need to centralize highly complex specialized care are misused to justify closure of units offering excellent care for routine conditions. Often no account has been taken of increased risks of extended blue-light journeys to A&E or difficulties for patients and visitors facing of longer journeys.

### The New Models of Care for the NHS mean:

- Fewer sites for NHS services – people will have to travel further for healthcare. We can’t assume a reduction in locations is acceptable without full analysis of travel implications for local patients and visitors - especially the impact on elderly or disabled relatives and families with children.
- Specialist hubs: some specialist focus is needed for complex and rare conditions – but not for routine health issues where local services and accessibility / travel are more important. Local clinicians could access specialist advice if needed via good NHS networks.
- Selling off the NHS family silver/estate. A one-off boost for treasury finance, with few or no guarantees for local funding. When it’s gone -much of it handed over to private housing - it’s gone forever.
- No new capital money – so rely on PF2 - Many of the new models of care require different, potentially larger premises than currently available. We fear a repeat of disastrous consequences of PFI.
- Reliance on enhanced self care, Skype apps and unproven technology to avoid hospital admission and clinical care amounts to magical thinking! And relies heavily on unpaid family carers (mainly women).
- The most vulnerable and socially excluded patients and families & women will be hardest hit.
- Restructuring of the NHS involves less clinical, more corporate management. Ripe for privatisation.
- Data-sharing. We are very concerned about proposals to share confidential medical data across a range of health and social care providers, leading to major potential for confidentiality breaches.

### Downgrading professional staffing

- Development of new roles such as Physician Assistant/ Associate (PA) (just 2-years’ training) are part of a general move to reduce costs while de-professionalising (dumbing down) the NHS and heightening management control.
- These changes have a poor evidence base, often reporting ‘acceptability’ rather than outcomes. Evidence for success is often anecdotal and much of the ‘research’ would not meet professional standards or peer-review requirements.
- Proposals to engage PAs rather than experienced (yet cheaper) nurses have been justified by ‘too many professional limits’ placed by professional bodies on nurses!
- There is no mandatory registration for PAs, raising major concerns about regulation.
• There is robust (and unsurprising) evidence that PAs are less effective than doctors at diagnosis
• BMA warnings that PAs are not a substitute for fully trained doctors are likely to be ignored
• Concerns that PAs will not recognize important signs that a fully trained doctor would spot
• Pressure to grant PAs independent prescribing powers will lead to enhanced risk to patient safety and increased risk that PAs will be used to substitute for, rather than support, doctors.
• Concerns that GP receptionists may in future be triaging patients and directing them to PAs who will miss more subtle indications
• Concerns that patients directed to PAs are more likely to be elderly, vulnerable, speakers with poor English etc – while articulate middle class patients will be able to get GP appointments
• Similar concerns apply to other proposed new roles, substituting minimally trained staff for professional clinicians, nurses, pharmacy and professions allied to medicine throughout the NHS.
• As the Nuffield Trust puts it ‘…… In the future, care will be supplied predominantly by nonmedical staff, with patients playing a much more active role in their own care. Medical staff will act as master diagnosticians and clinical decision-makers’.

Implications for community care services
• Local Councils have already presided over 30% cuts in adult social care, with over 400,000 fewer people receiving social care services since 2010, and those in receipt getting fewer hours. We have not heard councils explaining these cuts and protesting loudly and very publicly about them.
• Local councils have outsourced the future of the social care sector to large financialised businesses which want to be paid more for doing the same (with no questions asked about their accounting and finance decisions). These businesses manoeuvre politically to reduce risk and avoid consequences, while threatening to hand back vulnerable residents when they go bust.
• We are concerned that Councils will preside over a similar demise of our NHS.
• Fewer hospital beds, and early discharge mean more pressure on GPs, primary care and community care services. The changes will mean repeated tightening of eligibility criteria and more people excluded.
• Social care staff increasingly required to take on tasks previously done by NHS professional staff. Safety risks and extra burden on family carers – predominantly women - and vulnerable patients have not been evaluated.
• “There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true.”

A better future for the NHS: the risks and The NHS Bill
• Our health service is being re-modelled in a way that will be ripe for wholesale privatization and insurance-based care, leaving a low quality rump NHS for those who cannot afford private insurance.
• We are very concerned that this is the Government’s plan for future healthcare.
• At least £4.5bn per year is wasted on simply managing the NHS market, and more on private profit
• Procurement Rules mean that any marketized service is prey to international healthcare corporates.
• There IS an alternative to this wholesale devastation. We want out Councils to support the NHS Bill that will reinstate a publicly funded, publicly provided, accountable NHS. This Labour private members’ Bill, drafted by Professor Allyson Pollock and barrister Peter Roderick, is supported by Labour, the Greens and the SNP, and will receive a second reading in Parliament on 24th February 2017.

What we want from CCGs and councils
We understand and accept that CCGs and Councils are required to manage sharply diminishing resources – but we ALSO expect our political representatives, together with other councils, to explain and shout from the rooftops to protest the devastating impact of these cuts and service changes to local people, and campaign forcefully for the NHS Bill.

The NHS will last as long as there are folk left with the faith to fight for it. Aneurin Bevan, 1948
NHS England is criticised for lack of transparency on service closures

NHS England is facing growing criticism over its stewardship of the 44 sustainability and transformation plans (STPs) that are proposing service closures and other changes to health and social care services across the country. Local representatives from the NHS and local authorities have been drawing up plans since December 2015, when NHS England set them a deadline of 21 October 2016 to submit draft proposals to meet the triple aim of improving health, improving care, and saving money.

Friction has emerged since this deadline after four local councils opted to publish their local plans in draft form before they had been approved by NHS England and the regulator NHS Improvement, as they were concerned about the lack of transparency in the process.

The heat on NHS England intensified after a survey of clinical commissioning groups by the Health Service Journal (cited in the Daily Telegraph 31.10.16) showed that almost half of STP areas planned to reduce the number of inpatient hospital beds and a third planned to close or downgrade a local emergency department.

Tajek Hassan, president of the Royal College of Emergency Medicine, said the mooted closures of emergency departments would be “potentially catastrophic and will put lives at risk.” He said, “The hospital bed base is already one of the lowest per head in the Western world, and to reduce bed numbers and close more emergency departments will not only add to the pressure but undoubtedly compromise safety in those that remain open.”

and a useful article from 2014 re evidence:

Preventing hospital admission: we need evidence based policy rather than “policy based evidence” BMJ 23.9.14 by David Oliver, visiting professor of medicine for older people, City University, former national clinical director for older people at the Department of Health

Politicians push for evidence that supports whatever initiative they back, but formal evaluation often shows such initiatives to have failed, writes former older people czar David Oliver

In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals. But the size and speed of these reductions were not informed by any credible peer reviewed evidence—they rarely are.

Recent reviews by the Universities of Cardiff and Bristol on admission prevention and by the health think tank the Nuffield Trust on new models of service in the community, found that the big and rapid reductions were illusory, once the findings had been peer reviewed and control data taken into account.

Similar annual projections have been made for at least a decade. Yet although we have lost about one third of acute and emergency hospital beds in England in the past 25 years, emergency admissions have risen by 37% in the past decade. This farcical game represents a triumph of management consultancy over evidence, and of hope over experience. Local plans are based on how much money commissioners need to “save” on acute activity rather than any realistic expectation of service delivery. Savings are rarely made just by shifting the setting of care even if community alternatives to hospital are available, effective, …

Advice from David Mowatt, Parliamentary Undersecretary for Health re whether Councils have to sign off STPs in Hansard records of Parliamentary process 15.11.16.

“David Mowatt:Parliamentray Under Secretary State for Health
I give my hon. Friend the categorical assurance that if local authorities and the NHS managers doing the planning work have not engaged properly, the plan will not be considered to be complete. That does not mean that every local authority has a veto on its STP.”

Re-organisation – the next chapter: What NHS England isn’t telling you, and more indispensable weekly insight for commissioners, by Dave West. in Health Service Journal 16.11.16

There are five big factors in play:

1. There’s a renewed backing (as highlighted by the recent Alan Milburn/PwC report) for another run at decluttering the NHS quangos, particularly NHS England and NHS Improvement, to ease the horrendous barriers in the system to decision making and to help establish clear direction.

2. The imperative to make further big cuts in management costs.

3. Desire to get more of the good people in commissioning, planning, oversight and regulation working on transformation instead of feeding the beast with reporting templates; or, as Simon Stevens described it last week, getting them off the “rear-view mirror, it’s all gone tits up agenda”.

4. A number of these factors mean the next chapter is not just about binding the quangos’ regional and local teams closer together – instead, the reshaping of clinical commissioning groups and commissioning support units is part of the same process, and probably moving the boundaries between all of these.

5. The fairly urgent need to clarify the next steps for STP leadership, governance and management.

These things will shape the new chapter. It’s likely, and very wise, that Mr Stevens’ preference for structural diversity – “horses for courses” – will hold fast. Some areas will benefit from a firmer hand and some won’t.

What will be the key characteristics and dilemmas?

1. Full time/dedicated leadership for STPs and building teams/structures and governance around them. Having a full time STP lead seems to have worked well in Devon (Angela Pedder) and Essex (Anita Donley). This is raised in the King’s Fund STP report this week. STPs won’t become legal entities but firming them up; giving them staff “seconded” from other organisations; merging CCG management, contracting and governance into bigger patches, creates a virtual structure that all these things can be hung on. New, wider commissioning structures also mean CSUs are very much in the mix – there is potential to bring their teams into these STP level structures, and reduce the contracting/transactional workload.

2. Moving or embedding staff from national bodies to independent regional/subregional structures as in Manchester.

3. A structure designed to achieve big improvements in primary and community care. This is the main aim of all STPs and has become the big theme for the Five Yer Forward View project. Would driving it at STP level help? Perhaps relevant expertise/capacity could be built up, and a new structure would be liberated from the GP conflicts of interest which have often hampered CCGs’ efforts.

However, conversely, NHS England local teams did little better as primary care commissioners; the STP will be further from the ground; and, in some cases, alienating constituent CCGs will further damage the chances of winning round GPs. Many areas, given the choice, would therefore opt for CCG/borough level units leading delivery rather than STPs.

The Commissioner’s reading list

The King’s Fund’s big report on STPs – on the process so far
Watching Wallonia – or stopping individual orgs from blocking STPs, by Chris Ham
The varied progress of the 44 STPs is captured in an insightful report from the King’s Fund that focuses on the process of their establishment (January to July 2016). Interviews with senior staff in four geographically diverse STPs show that although some progress has been achieved in a very short time, there are serious threats to success. The first is that those entrusted with the task, although talented, have no formal authority. They depend on persuasion to bring about changes that have proved intractable for decades. This is exacerbated by lack of resources. There is no additional budget so local leaders have to cram their STP work into already highly pressurised jobs. In addition, leaders feel there is insufficient know-how, both locally and at the centre, on how to shift from a formally competitive system to a collaborative one. And the government’s requirement for local health economies to achieve financial balance jeopardises local initiatives, as has been seen with the integrated care pioneers.

The report also raises concerns about participation. Acute hospitals continue to dominate, encouraged by their financial difficulties; local authority involvement is variable, despite its strategic importance; GPs participate as secondary care commissioners rather than primary care providers; and the public has largely been excluded until plans are well developed. Finally, transformation to a collaborative culture of governance struggles against the persistence of competitive requirements.

Despite attempts to change, the national governance framework remains oriented to the performance of individual provider organisations rather than places. Tension is perceived between NHS Improvement’s and the Care Quality Commission’s focus on provider performance, and NHS England’s requirement for STPs to consider system-wide performance. Locally, this leads to relational difficulties—for example, acute providers are expected to emerge from bruising contract discussions with clinical commissioning groups and then sit down with the same groups to collaborate on place based planning.

Royal college leaders warned that some health professionals working on sustainability and transformation plans (STP) are “blinded” to long term change because of the severity of current financial problems among hospital trusts. The STP are aiming to look to the medium and long term future, but they are being distracted by shoring up the acute sector deficit, which is a real distraction from what they really need to be doing—fulfilling the aims of planning for the future. We need to see social care as the funding priority above healthcare because of its dire position after six consecutive years of cuts to local authority budgets by central government. Some social care members of STP saw the health budget as a way of sorting out their financial problems.

A&E, cancer and maternity units to close in major NHS overhaul

Hospital beds are set to disappear, pregnant women will face long trips to give birth and a string of A&E units will be downgraded or even closed altogether as part of controversial NHS plans to reorganise healthcare in England. A Guardian analysis of the 24 NHS regional plans that have now been published – more than half the total of 44 – has found that health service chiefs plan to push through an unprecedented centralisation of key hospital services across England.

Dozens of England’s 163 acute hospitals look likely to have services, including cancer, trauma and stroke care, removed as a result of the plans, which are at the heart of the new funding package for the NHS. The thinking behind the changes is that some NHS services can be rationalised and managed more efficiently, helping improve patient care, tackling understaffing and helping the NHS save £22bn by 2020 as part of the wider financial settlement agreed for the current parliament.
Prof Sir Bruce Keogh, the NHS’s medical director, and clinical leaders involved in drawing up the plans argue that centralising some types of medical care benefits patients and improves their chances of a good outcome because doctors deal with more cases of certain ailments.

Many of the plans make clear that widespread staff shortages are another key driver. They hope that by concentrating sometimes scarce medical personnel in fewer places they can ensure consultant presence more often than otherwise and so help realise Hunt’s ambition of a more 24/7 NHS.

However, local resistance is building up as details emerge. Campaigners in Cumbria, for example, are warning that patients will die, including mothers and babies, if they have to travel 40 miles from Whitehaven to Carlisle for care – a journey that can take up to two hours depending on the time of day, weather and traffic levels, they say. “Centralisation of services won’t work in Cumbria,” said Annette Robson, a campaigner from the We Need West Cumberland Hospital Group. The hospital’s A&E unit is set to be downgraded, with more serious urgent and emergency cases having to go to Carlisle for treatment.

“We are not asking for specialist services. We are asking for basic provision of a 24/7 A&E and a consultant-led maternity unit in Whitehaven,” she said. “If they go, there is no doubt that lives, including those of mothers and babies, will be lost on the 40-plus mile journey to Carlisle from Whitehaven.”

Many of the published plans give few details of their exact implications. But those that do make clear that several thousand beds in acute district general hospitals are likely to be cut. They include 535 in Derbyshire and 400 each in Devon and West Yorkshire and 30% of all beds in hospitals in Bristol, North Somerset and South Gloucestershire.

South-west London will also see its bed capacity shrink considerably when one of St George’s (1,038 beds), Kingston (520 beds), Croydon (443 beds), Epsom (374 beds) or St Helier (525 beds) hospitals lose all their acute services, because the plans for that area say that five acute hospitals cannot be sustained.

The plans are the vehicles for implementing locally the *NHS Five Year Forward View*, NHS England chief executive Simon Stevens’s blueprint for transforming services to cope with the growing demand for care while also delivering the £22bn of savings he has pledged to find by 2020.

Jeremy Hunt, the health secretary, has backed them, but stressed that potentially unpopular decisions will be taken by local NHS and council leaders, and not by ministers. Theresa May is said to have recently told Stevens to ensure that hospital closure plans did not become a big issue in newspapers.

Conservative MP Dr Daniel Poulter, who was a health minister until May 2015, said he feared the real potential of the plans to improve the quality of care could be lost because the need to make savings will become a top priority.

Mounting protests could coalesce into a political challenge for the government, he added. “Given that the NHS is often seen through the prism of hospital services changes and closures in marginal seats, the political consequences of how the plans are being forced to operate will soon be all too apparent,” Poulter said.

The exact number of bed losses will increase substantially as a result of plans in most of the 44 areas to provide a wide range of specialist medical services at many fewer sites than at present. The areas involved include parts of Somerset, Cheshire and Merseyside, Bedford, Luton and Milton Keynes. None of the 24 plans spells out who will be the winners and losers from the reorganisation.

Several hospitals face being “gutted” of key services, say critics. For example, Bedford hospital will lose its A&E and consultant-led maternity units and the ability to undertake most emergency surgery.

Similarly, plans to change utterly the role of Barnstaple hospital in Devon have already prompted a 4,000-strong protest march. Chester MP Chris Matheson has started a campaign to stop the closure of the city’s Countess of Chester hospital, which is at risk because of a mooted merger with two others.

Many hundreds of beds in community hospitals are also set to go, despite the key role they play in rehabilitating mainly elderly patients – for example, those who have had surgery or a fall. Devon plans to
close four community hospitals altogether, as does Dorset (three) and Leicester, Leicestershire and Rutland (two).

All the proposals in the plans will be put out to public consultation, so may be changed as a result of opposition. But Stevens and other senior NHS bosses have made clear that a radical transformation in how the NHS functions is needed.

NHS England says that a huge increase in care outside hospitals, including in patients’ homes, and much greater efforts to keep people healthier for longer, will reduce the need for beds in hospital.

A&E units at hospitals in Macclesfield, Milton Keynes, Teesside and Hinchingbrooke in Cambridgeshire are all likely to be downgraded.

Maternity care at the Horton hospital in Banbury, Oxfordshire, is likely to be supervised in future only by midwives, not doctors. Centralisation of childbirth units is also set to lead to downgrading at Yeovil hospital in Somerset, and also at as yet unidentified hospitals in Surrey, Birmingham and Solihull and Leicester, Leicestershire and Rutland, among others. “Despite the flannel and platitudes these STPs are NHS England’s way of forcing local health bosses to make cuts, since genuine savings on this scale cannot be delivered,” said Dr John Lister, a health policy expert and co-ordinator of the Health Campaigns Together group.

But Prof Chris Ham, chief executive of the King’s Fund, said STP-driven downgrades of certain services were in effect painful medicine that the NHS had to take to ensure it survives. “The public may be understandably concerned about travelling further to access A&E care. But in many cases that will be a price worth paying for a higher standard of care, and the same would apply to maternity services. Overall this is a painful process that the NHS has to go through,” added Ham.

An NHS England spokesman defended the plans as necessary modernisation. “Our NHS has constantly adapted to improve services for patients, taking advantage of new opportunities and making common sense changes in areas that really matter to patients – making it easier to see a GP, providing more specialist services in people’s homes, speeding up cancer diagnosis and offering help faster to people with mental illness.

“We are talking about steady incremental improvement, not a big bang, tackling things doctors and nurses have been telling us for years. By continuing to adapt to a changing world, the NHS will be able to secure a better service for future generations”.

A labour view:

**Questions Need To Be Asked About Jeremy Hunt’s New NHS Reorganisation**

02/12/2016 in the Huffington Post  Justin Madders  Labour MP for Ellesmere Port and Neston

A new NHS reorganisation, carried out behind closed doors is now upon us, as I first warned in May, in the form of Sustainability and Transformation Plans (STPs).

The principle of the STP process could have made a significant contribution to the challenges the NHS faces. Labour is not opposed to the idea of a more localised strategic oversight of the NHS and the health sector, mainly because this is what we used to have in the form of Strategic Health Authorities before they were scrapped by the Tories as part of their last disastrous reorganisation.

Nobody would object to the idea of partners from across the sector in local areas working together to transform and improve services but the process has been fundamentally flawed from day one. It has been mired in secrecy and hijacked as a vehicle to attempt impossible levels of “savings” to cover up the reality of a chronic funding crisis engulfing the health and social care sector. The simple fact is that it is not possible to improve health and social care services when health professionals are fighting a losing battle to
keep the show on the road due to six years of chronic underfunding. You cannot build a conservatory on a house which is teetering on the brink of collapse due to unstable foundations. The shocking lack of measures to address this systemic underfunding in the Autumn statement wilfully fails to acknowledge the current crisis which manifests itself in the worst collective set of performance figures the NHS has ever seen.

We do not intend to oppose an individual STP if it can be genuinely shown to deliver an improved patient experience over the five years of its existence and to that end we have devised a series of tests, grouped under five convenient headings which will determine our response to each STP.

We know some STP leads have admitted that “the financial component is a strong driver” to their STP so have made the financial aspects the first area of consideration although we are concerned that this is taking priority over clinical and patient need. We will be asking if the STP is able to demonstrate what actual savings will accrue from individual parts of the plan that aim to reconfigure, centralise, integrate or close services? We will ask does the plan increase fragmentation of services through reliance on other providers? Does the plan provide funding for both transformation of services and the delivery of financial sustainability and has funding for the capital requirements and programme management of the plan been identified and secured?

If the STP can show a credible and deliverable financial plan we then need to ask what that will mean for the patients. Does the plan improve access to GP and other NHS services for patients? Does the plan contribute to the delivery of Jeremy Hunt’s vision for a 7 day NHS? What about prevention? What are the risks associated with anticipated reductions in bed numbers? We anticipate this being one of the most difficult areas for STP’s to satisfy given what we already know about closures and downgrades that seem to be financially rather than clinically driven.

We will then be asking if the plans can tackle the crisis in social care and mental health. Does the plan improve integration between health and social care? Is parity of esteem achieved? Does access and entitlement to social care improve and will the plan reduce the number of days lost to delayed transfers of care? Where does the plan leave the health service at the end of five years? Does it put it in a good position to tackle the well-known demographic changes over the next 20 to 30 years?

If the plans are to succeed they must have genuine local support across the various sectors which will be responsible for carrying out the plan. Have the local authorities been involved signed off the STP? How does it align with other priorities and the strategic needs assessment? Have GPs, CCGs and social care commissioners been closely involved in developing, evaluating and financially analysing emerging proposals?

Finally we will be asking if there has been genuine involvement and engagement in the development of the plan. Labour strongly believes the voice of patients must be heard in these decisions. Past changes to services have only succeeded where patients have had buy-in to the proposals, so we would expect consultations on these plans to include not only patients groups but also the voluntary sector, staff representatives, care providers, elected representatives, care professionals and of course the general public. Are there open and transparent accountability arrangements in place? Will the public and other key stakeholders have the opportunity to influence the plan at an early stage and is there sufficient information for engagement with stakeholders to consider a range of options? The Government have repeatedly said there are existing rules in place for changes to existing services but STP’s as a whole but the Government have maintained that STP’s as a whole have “no legal status” which means it may be difficult to challenge plans as a whole.
Dear Mr Mackey,

Re. Consolidation of back office and pathology services

Pathology forms part of almost all patient pathways, so anything that affects pathology will inevitably have an impact on primary care, emergency medicine, acute medical care and surgery, to name but a few. There is evidence that at times of financial constraints, investment in pathology can save money elsewhere in the system. We believe the focus should be on demand optimisation – ensuring that services are used appropriately to inform patient care – rather than relying on efficiencies of scale to deliver savings. Treating pathology as a silo and attempting to force through hastily-planned mergers is likely to lead to destabilisation that will undermine clinical services and cost more than any savings made. In addition, at a time when there are already workforce shortfalls in many parts of the country, the effect on staff morale may precipitate collapse of the system.

The recent letters from NHS Improvement demanding plans for consolidation of ‘back office and pathology’ services within days are, in our opinion, a mistake and a backward step. Forcing a single solution on such a diverse range of services will inevitably result in failure, with associated expense, compromised quality and reduction in staff morale. It is vital that we learn from the examples of consolidated services – both those that have failed as well as the celebrated successes.

Empath, a pathology partnership between University Hospitals of Leicester NHS Trusts and Nottingham University Hospitals, was established in 2012. Despite following recommendations set out in Lord Carter’s 2008 report, the initiative has not realised the degree of consolidation or efficiency savings predicted. The Board of Empath was disbanded in 2015 and a new board is being established, with a new Strategic Outline Case – effectively starting again.

The Pathology Partnership (tPP), a joint venture of six trusts in East Anglia established in 2014, aimed to ‘transform and modernise pathology services’, working more efficiently ‘following best practice recommendations set out in the Carter Report on Pathology 2008’. Cambridge University Hospitals, the host of tPP, has recently given notice that it intends to withdraw from tPP, following losses of £15 million last year. CUH stated that ‘tPP was ‘not proving to be the most cost effective way of providing pathology services for CUH.’

The above are just two examples of much-heralded consolidation programmes that failed, despite the best intentions of those involved, adherence to the principles set out in Lord Carter’s report, years of discussions and adequate investment. What hope is there for other services to consolidate at extremely short notice, without consideration of local requirements or the complexity of services?

Pathology is not a single discipline but is made up of twenty diverse specialties. Some, such as haematology and clinical biochemistry, lend themselves to consolidation and efficiency savings, with large labs being able to process millions of blood samples. This relies on joined-up IT, standardised requesting and reporting protocols and good transport infrastructure, the provision of which is patchy or non-existent in many places. Investment in the National Laboratory Medicine Catalogue will help, but will require significant clinical input and investment in IT systems to realise the potential benefits.

Many other pathology specialties do not benefit from consolidation at all. There is increasing evidence that cellular pathology, which is largely reliant on people to make diagnoses and uses relatively little automation, is better provided from smaller, local departments. We are aware of departments that have merged, with no overall change in the number of staff or volume of workload, but resulted in poorer turnaround times and reduced quality. Specialised genetics and molecular pathology services are already largely provided on a regional basis, usually on a larger scale than STPs, which may not provide the best model for reconfiguration of services.

We are collating information from pathology services that have attempted or undergone consolidation, both successful and failed, and plan to issue a document on lessons learnt to aid others considering the same process.

The pathology professionals who deliver, manage and develop services are keen to be involved in maximising efficiency while maintaining high quality services but this takes time, good management, investment in infrastructure and consideration of local demographics and priorities, there is a no one-size-fits-all solution that can be planned in a few days or adequately summarised in two pages.
We encourage you to consider the submissions that trusts will be providing in the next few days in the light of the information above and to involve our organisations where possible to ensure that those with the greatest understanding of pathology services are at the heart of plans for service reconfiguration.

Yours sincerely,
Dr Suzy Lishman Dr Gwyn McCreanor Mr Ian Sturdgess

**East of England Network Collapse : Used as Example to NHS Improvement by Professional Bodies** Jonathan Berg, The Association of Clinical Biochem & lab medicine (ACB) 9.16

Many readers will have received the joint IBMS, RCPath and ACB letter to NHS Improvement commenting on the demand for NHS Acute Trusts to put forward proposals for “back office and Pathology” to produce plans for networking by the end of July.

The letter from the concerned professional groups urged caution when reviewing the ideas that have been sent in such a short timeframe after a few weeks of local deliberation. The letter went on to give examples of networks in difficulty, including the recent high profile East of England Pathology Partnership collapse, with the host laboratory announcing their intention to leave the project.

**Origination of the Pathology Partnership**

The East of England Pathology Partnership came out of the work of Dr Stephen Dunn’s Strategic Projects Team at the East of England Strategic Health Authority. After protracted efforts in tendering and Trusts deciding whether to be part of the network, six Trusts finally joined together as the Pathology Partnership. This was launched in May 2014 and was hosted at Cambridge University Hospital Trust. It incorporated the pathology laboratories of Cambridge, Ipswich, Hinchingbrooke, Colchester and West Suffolk hospitals and East & North Hertfordshire NHS Trust. Legally the Trusts were set up as both owners and customers, under a joint venture arrangement, with differing proportional shareholdings. The shareholding of the Cambridge Trust appears to have been the largest, but it was under 25%, as stated in the Office of Fair Trading report in April 2014.

In July 2014 Capita Healthcare Decisions was awarded a 7 year, £9.7m contract to work, together with CliniSys, to deliver IT system infrastructure to the Partnership. At the time a company press release commented: “By working together, Capita Healthcare Decisions and CliniSys have delivered a solution that embodies the wider NHS aim of doing more with less, enabling the Pathology Partnership to benefit, immediately, from improved efficiencies and availability of services”.

More recently work on new job contracts took place, with staff all coming under the employ of the Cambridge Trust. It is believed that equipment contracts have also been placed.

**Financial Problems Key**

The Pathology Partnership reported a £4.9 million loss in its first year and the 2015/16 figures in July reported as a £15 million deficit. This appears to have been too much for the Cambridge host Trust who, under a new chief executive, are grappling with regaining financial balance. They announced their intention to withdraw from the joint venture at the end of June. They stated that in their view: “the current model is not proving to be the most cost effective way of providing pathology services for the Cambridge Trust. The withdrawal process will take 12 months and is not expected to be complete until July 2017.

The website notes .. “The Partnership was formed in response to changes driven by commissioners and NHS England to transform pathology services and follows the best practice recommendations set out in the Carter Report on Pathology 2008. By consolidating pathology services into a network of laboratories across a wider geographical area, the partnership will deliver significant efficiencies and benefits for patients, hospitals and GP surgeries.”

...... ACB News understands that the five Trusts left in the joint venture are currently undertaking an option appraisal on how to move forward. One option being considered is to revert to each Trust being in direct control of their locality pathology work. However, this is far from easy, with the changes in community pathology service for GPs that have already been made having knock-on effects on long term planning for local laboratory design and size.
STP news update

West Yorks STP and the Leeds Place Plan  (update from Gilda with particular ref to Leeds)

The West Yorkshire STP which is built on the 2 year place-based plans for each of the 6 local authorities involved was finally published on November 10th. You can read the plan and/or public summary here: http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

The plan says that it aims to close a £1.07bn funding gap by 2021. If almost £0.2bn comes from central Govt (which is very unlikely – see funding articles above), WY has to find almost 0.9bn. More than half of this is to come from ‘consolidation’ ie closures across the region, about one third from reducing hospital beds ostensibly by reducing demand through improvements to community care and a big focus on self care and a tenth from sharing commissioning, processes and “back office” functions. Detail on losses is thin but it looks like at least 2 hyper-acute stroke services are in the firing line, the aim is to have a single neurological rehabilitation centre in the region, pathology has been told to shape up or be outsourced and more endoscopy is to be outsourced. A and E is being reconfigured and an unspecified number of hospital beds will be cut. Workforce changes will be brought in to max flexibility and push jobs down the qualification chain with volunteers and family members picking up more of the tab. Plans for joint commissioning between CCGs and between health and social care are moving at pace. In Leeds the three CCGs are increasingly acting as one and are working on plans to move towards accountable care organisations like those in the US which will involve devolving budgets to consortia of commissioners and providers who take responsibility for providing services to a place based slice of the population. (these ACOs will be ripe for plucking by private companies)

Local CCGs have to submit their financial plans to NHS England by 16th December and by 23rd December they must submit their final operational plans and sign off contracts for the next 2 years.

In Leeds the Councillors have made some effort to push back against the imposition of the West Yorkshire plan in that they sent a letter to NHS England on 28th October saying that most councils supported the content of their local plans but couldn’t “endorse the content of the West Yorkshire and Harrogate-wide STP as, while the high level outcomes of the plan have been discussed with various officers of our councils, the submission has not yet been to any formal Council forums or endorsed in any of our planning processes.”

At the special Health and Wellbeing Board meeting on 24th November they declined to accept the CCGs’ joint operational plan on the grounds that the plan they were presented didn’t have enough detail but would consider making a collective e mail decision when these gaps had been filled in.

There was a Joint Scrutiny meeting of chairs and reps from all the West Yorks Scrutiny Boards except Harrogate on 18th November. This expressed concerns around consultation, communication, governance etc and RESOLVED – That a more detailed forward plan around key milestones within the STP be presented to the next meeting of the Joint Committee for discussion. We understand that Harrogate will be invited to attend. This Committee is due to be held at 10am on Jan 23rd in the Civic Hall, Leeds and will be open to the public (so do come if you can!) Campaigners will also be writing to the Chairs of Scrutiny Committees beforehand.

Some Developments round the country  from Keep Our NHS Public Steering Group e mails

In Dorset there is a proposal to close 50% of GP Practices and replace with poly clinics funded by PFI. noted in e mail from Debbie Monkhouse Dorset KONP 28.11.16
Hammersmith and Fulham Council has announced plans for legal action against the NW London STP which aims to close first Ealing then Charing Cross Hospitals. H&F and Ealing Councils are the first to refuse to sign off the STP - action we need replicated across England. In a step forward last Tuesday Hounslow Council passed a motion with all party support to retain acute services at Ealing and CX and a statement was signed by 5 councils including Harrow and Brent condemning the closure plan. The public meeting called by H&F Council this Tuesday (see attachment) is vital in demonstrating the scale of public opposition and highlighting the need to protect local health services. (from KONMP sg e mail 28.11)


Liverpool Mayor, Joe Anderson, Chair of the health and Wellbeing Board leads opposition to the Liverpool STP in the HWB Board Meeting 21.12 from Alex Scott Samuels

“As it stands, this report seeks to be noted, but I want to make it very clear that the proposals within the STP are rejected by the Council and this Board, because it fails to address the key issues facing our residents and their health in the years to come. The STP is damaging to our Health Service and undermines any faith we could have in the Government’s ability to invest in a future for the NHS”

STPs to be paused until / rebooted in January from report on the STP Conf. in Leeds 1.12 by Leonora Everitt,

Jim McKay, Head of NHS Improvement said the STP process is PAUSED for at least a month – until later in January 2017 so that the preparation for winter and the sorting of the 2017-2019 contract can be done. It was suggested that it is not necessary for these contracts to reflect local STPs and, there wasn’t enough time to put the STP in contracts. Also that many of the STPs are not what is needed and there are issues to be sorted, including looking at better more consistent guidance from the two NGHS bodies overseeing the STP process (NHS England & NHS Improvement).

Council funding crisis 'not a reason' to block STPs, warn Stevens and Mackey by Dave West in n HSJ, 12 DECEMBER, 2016 http://tinyurl.com/gpemxce

The fact NHS budgets cannot be used to solve the social care funding crisis “is not a legitimate reason” for failing to press on with STPs, Simon Stevens and Jim Mackay have warned. The chief executives of NHS England and NHS Improvement wrote to sustainability and transformation plan leaders and other NHS and local authority bosses today, giving an update on STPs and contracting for 2017-19.

They also state that:

- Areas which have agreed 2017-19 contracts by the 23 December deadline “within the total resources available to their STP”, will be eligible to take on a “system control total”, as was offered in the September planning guidance.
- NHS England and NHS Improvement will “refine and prioritise” capital bids “over the next eight to 12 weeks”. A new capital framework will be published within two weeks.
- The national vanguard programme funding is “rolling-over… into 2017-18 for a final year”. National new care models funding this year is around £200m, of which around £100m is going to local vanguards. Applications are now open to transformation funding pots for cancer, mental health, learning disabilities and diabetes. The total national transformation funding for 2017-18 or 2018-19 is not clear.
- STPs “are understandably a work in progress”. They must start engagement to turn their “proposals” into “plans”, and also in 2017-18 “become implementation partnerships”. For “a small number” this will mean quickly becoming an “integrated or ‘accountable’ care system [where] providers and commissioners will come together, under
a combined budget and with fully shared resources, to serve a defined population”. For others it will “take the form of forums for shared decision making and performance accountability”.

In an apparent reference to senior local government figures’ complaints about STPs putting too much of their focus on the NHS, and side-lining the social care funding gap, the letter says: “While the NHS spending review settlement nationally was never intended to – and is obviously not able to – offset pressures in local authorities’ budgets, this fact is not a legitimate reason for councils or the NHS to stand in the way of action needed to put local health and care services onto a sustainable footing.”

Council officials and councillors have raised a variety of concerns about STPs. In one case, Birmingham City Council chief executive Mark Rogers, also the area’s STP leader, used an interview with HSJ to criticise NHS England and NHS Improvement for a “sort out the NHS first” attitude.

The letter says: “The best STPs have built strong relationships with local councils, on the basis of shared goals and reciprocity of support.” It also says: “We will also work with STP leaders with the most advanced plans to give you greater direct influence and freedom over how NHS England and NHS Improvement staff and resources – as well as the talent in CCGs, CSUs and other bodies – can be better aligned and deployed in your area to support your STP’s implementation.” The letter does not describe how or when this process will take place.

Mr Stevens and Mr Mackey say the “most immediate task now is to focus on completing the contracting round by 23 December”. They say: “In its autumn statement, the government made explicit its intention that all parts of the NHS must live within the resources that it has allocated.

“Taking the total local funding envelope as the fixed point, the shared task is therefore to ‘reverse engineer’ a pragmatic set of funding decisions between programmes of care and individual services. It is important that this is supported by clear plans that manage cost and risk, not just shift them between organisations.”

Mr Stevens spoke to HSJ last week, setting out the next steps for STPs, and stating that: “The NHS’s budget settlement in the spending review was not intended to, and obviously cannot absorb, all the pressures in the local authorities [and the] financial pressures on their side. That fact should not be used as a reason for individual councillors or NHS bodies taking issue with the broad direction being set out in the STP.”

NHS passport proposals

NHS passport proposals are just more grubby politics from May and Hunt

Kailash Chand 22 November 2016 in Open Democracy

https://opendemocracy.net/ournhs/kailash-chand/nhs-passport-proposals-are-just-more-grubby-politics-from-may-and-hunt

Jeremy Hunt - rather than working to meet the real challenges of the NHS - is playing the politics of distraction during Autumn Statement week. Hunt’s – and Theresa May’s – preferred side show is tough talk about how they are “determined to stamp out abuse of the system”. Hunt’s most senior civil servant, Chris Wormald, suggested this week that every citizen in England would have to show his or her identity to receive health care, including for emergency and primary care, having broken bones reset, pre-admission stays in intensive care, and rides in ambulances.

But as Jonathan Portes of the Institute of Economic Research says, the extent of deliberate health tourism has been “hugely overstated” and is in fact a “very small part of NHS expenditure”. Estimates of the supposed costs of so-called ‘health tourism’ vary from under £35m to more than £500m. These sums might sound substantial, but even the higher figure accounts for less than 0.5% of the overall NHS budget. This is a politically motivated move rather than a response to patient needs and human rights. The government – yet again – is running scared of the tabloid press's ability to set the agenda in social policy.

There are very small numbers of migrants who come here with pre-existing health conditions and find themselves registering with the health service. There is already a system in place for hospitals to recover the cost of treating patients who are ineligible for NHS care. There is absolutely no data or evidence to support the idea of large numbers of overseas visitors coming to the UK specifically to seek out free treatment. If anything, more people are likely to come to work in the NHS.
This proposal is just another in a long line of attempts by government ministers to convince the public that they are “tough on immigration”. But in truth, as BMA Chair Mark Porter told the Today programme this morning, the issue is a “pinprick on top of the actual problems facing the NHS” - and the suggestion of passport control in our hospitals not a “proportionate” response nor one that will solve the NHS’s actual problems.

Doctors’ primary ethical duty is to respond to the needs of their patients. NHS staff should not be required to make judgements on the immigration status of patients or their entitlement to treatment under the regulations. Indeed doctors have already reacted with fury with many vowing to boycott any such plan. Ben White, one of the junior doctors involved in the recent High Court challenge, tweeted “Well, I certainly won’t be asking anyone for their passport before resuscitating them, thanks.”

There are also wider implications of seeking identity proof. Timely treatment keeps people out of hospital, stops the spread of infectious diseases such as tuberculosis, and ultimately saves money in future treatment costs. Denying healthcare to people who need it—including pregnant women, torture survivors, and people with communicable diseases—is simply inhumane and unpragmatic.

This proposal is not really about saving money. It is about deflecting the blame for the NHS crisis away from the real challenges of dealing with an NHS beset by funding cuts, demoralised staff, and privatisation. An health and care system where general practice, A&E, public health and social care are all in crisis. Theresa May’s government needs to abandon their dismantling of the NHS and looking for scapegoats to blame, and focus instead on saving it.

Response from Pete Gillard. Staffordshire KONP quoting Nye Bevan 21.11.16

It might be useful to go back to Nye:

‘One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the Health Service any more than does a British citizen.

‘However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the Free Service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry identification everywhere to prove they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Services for ourselves would end up being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march together.

Thatcher pushed for breakup of welfare state despite NHS pledge

Alan Travis in The Guardian  25.11.16

Margaret Thatcher secretly tried to press ahead with a politically toxic plan to dismantle the welfare state even after a “cabinet riot” and her famous declaration that the “NHS is safe with us”, newly released Treasury documents show.

The plan commissioned by Thatcher and her chancellor Sir Geoffrey Howe included proposals to charge for state schooling, introduce compulsory private health insurance and a system of private medical facilities that “would, of course, mean the end of the National Health Service”.

Some of her cabinet ministers believed they had buried the plan, drawn up by a seconded Treasury official, Alan Bailey, from the Central Policy Review Staff (CPRS), at a special cabinet meeting on 9 September 1982.
Nigel Lawson in his memoirs said the paper of “long-term public spending options” had been buried after what he described as “the nearest thing to a cabinet riot in the history of the Thatcher administration”. In her own memoirs, Thatcher claimed to have been “horrified” by the CPRS paper and insisted that she and her ministers had never seriously considered it.

The CPRS paper had been partially leaked and she was only able to quell the subsequent furore by famously pledging the “NHS is safe with us” at the October 1982 Tory party conference. Downing Street briefed that the toxic plan had been “shelved”.

But Howe’s Treasury private office papers released by the National Archives on Friday confirm that not only had that special cabinet meeting taken place to discuss the plan but that two months later, far from being buried, Thatcher was still secretly trying to press ahead with it.


iii http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce

iv https://www.adass.org.uk/media/4345/key-messages-final.pdf

v http://www.cresc.ac.uk/medialibrary/research/WDTMG%20FINAL%20-%2001-3-2016.pdf