TESTIMONY

THE DESTRUCTION OF THE NHS

WHY WE NEED THE NHS BILL NOW

February 2016

Published on behalf of NHS activists
by Calderdale & Kirklees 999 Call for the NHS,
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Presented by National Health activists from across England
at a meeting with the Shadow Health Secretary, Heidi Alexander MP
Thursday 14th January 2016 at 7.15pm
Grimond Room, Portcullis House, London SW1A 2LW

Foreword

Here are testimonies about the destruction of the NHS from 19 "Support the NHS" campaign groups around the country. These testimonies outline the impacts on patients and staff in their areas as the NHS is dismantled; they also critique the national policies and programmes that are driving this destruction.

With one or two exceptions, testimonies are verbatim reports of brief statements by the campaign groups at a meeting with the Shadow Health Secretary, Heidi Alexander MP, on 14 January 2016. We appreciate Heidi Alexander making time to listen to us and to answer our questions honestly, even though they were not the answers we were hoping for.

We think the main positive outcome of the meeting was the powerful evidence from pretty much the length and breadth of England about the damage that the government, and its quango NHS England (aka the NHS Commissioning Board) is wreaking on our NHS; together with sharp critiques of key programmes, policies and institutions that are driving the destruction of the NHS.

The NHS is held in high regard. It not only offers us personal security and care in times of greatest need – when our health is threatened – but is a symbol of a nation standing together to look after all of its people. But its existence cannot be taken for granted and its principles have been under attack almost from its inception by those for whom it is primarily seen as an income stream rather than a public service. Those attacks have grown in strength over the last 30 years.

As closures, down-grades and reconfigurations have taken place across the country, campaign groups have grown, or were newly created, to fight to keep valuable services. Faced with immediate challenges in their communities, campaigners took some while to make the connections that these attacks were widespread, similar in nature and followed patterns of consultation in which all the answers appeared pre-determined. We now see we have real common cause in fighting to stop and reverse the destruction of the NHS.

The cross-party NHS Reinstatement Bill, which has its second reading on 11 March 2016, is vital to the restoration of the NHS as a fully publicly owned, funded and run health service - in line with the wishes of 88% of the public.

We hope that our testimonies will be a useful resource for Support the NHS campaigners everywhere.

Testimonies

Examples of NHS cuts and sell offs in various parts of the country

Problems arising from Hartlepool District General Hospital downgrade

Fighting 4 Hartlepool Hospital

Fighting for Hartlepool Hospital wants to keep the hospital open and bring back services that have been removed, particularly A and E.

Hartlepool Hospital was in the black when it was amalgamated with North Tees Hospital in Stockton, and it now stands underused whilst North Tees is sub-standard structurally, older, more out of date than Hartlepool.

North Tees are overloaded with more patients than they can physically accommodate and it has been updated by taking equipment from Hartlepool. Now £50 million is needed - of which £25 million has been secured - to implement plans to extend and upgrade North Tees.

In contrast services at Hartlepool are being closed and downgraded, including the (closure of) the A and E. There's the closure of the In Vitro Fertilisation unit and potentially the future closure of maternity, the hospital birthing unit could potentially be unviable because of the staffing levels and the fact that people are choosing to go to North Tees.

Plans for the £300 million hospital at Wynyard, which is mid-way between Hartlepool and North Tees, were shelved last year, and points that have been raised at meetings with the Clinical Commissioning Group and Hartlepool Borough Council include ambulance response times, waiting times for patient transfer and the length of waiting time to see a doctor at North Tees.

There is a FOI request to North East Ambulance Service that has not yet been replied to, asking for ambulance response times for Hartlepool and ambulance response times for South Durham. Information from Hartlepool Borough Council and the Chief Executive included Stockton when what was requested were figures for Hartlepool only.

The Intelligent Monitoring Report on North Tees and Hartlepool NHS Foundation Trust from the Care Quality Commission shows elevated risk of mortality at the Trust. In December 2013, the Trust was one of 13 hospital Trusts named by Dr Foster Intelligence in the hospital guide of that year as having higher than expected mortality indicator scores for the period of April 2012 to March 2013 .

Hartlepool has a population of 94,000 and has no emergency cover or care from 8pm to 8am, all patients are advised to ring 999 or 111 for ambulance, if you attend the One Life Centre part owned by Virgin you will only be seen if it is an accident.

Hartlepool has no bus service after 7pm so journeys are difficult and expensive for non-car families. Should you present at North Tees Hospital and are discharged, you will have to make your own way home to Hartlepool in a taxi at a cost of around £25 for a single journey. So I think that gives us a bit of an indication of what the situation is in Hartlepool.

Downgrading of Dewsbury District Hospital maternity + A&E
Patricia Foley, Dewsbury KONP

Dewsbury may have specific connotations for people – Shannon Mathews, suicide bombers, favoured marching ground for the English Defence League - and now it's losing its hospital services too. Sited in North Kirklees, with the Wakefield hospitals - Pinderfields & Pontefract - it comes under the Mid Yorkshire Hospitals Trust.

Complex orthopaedics, gynaecology and general surgery have been cut; colorectal surgery, Intensive & High Dependency care - cut; coronary care (in what has been described as the nation's 'heart attack capital') - cut.

Services for half a million patients are being centralised at Pinderfields - the least accessible hospital for patients from North Kirklees (18 miles from where I live). This is undermining the viability of Dewsbury District Hospital & overwhelming Pinderfields.

MATERNITY
It's a deprived area & high risk pregnancies predominate. The answer? Close consultant led maternity & paediatric services – open a mid-wife led unit with 6 beds, allow pregnant women & their visitors to struggle to over-crowded Pinderfields – (which will have 6 more cases per bed per year).

Dewsbury has a high birth rate – 79 per 1000 - set against a national average of 63 & Wakefield's 65; it has low birth weights @ 99 per 1000 - 81 nationally & 76 in Wakefield; but chillingly, infant mortality in Dewsbury @8.9 is more than double the national figure of 4.1 with Wakefield @5.2.

So why aren't the specialist services in Dewsbury where they are needed – instead of 15 miles away?

A&E
In 2012, Dewsbury was ranked as one of the mostly highly rated A+E Departments in the country. In 2013 Trust attendances at A&E increased by 9% (the highest growth in N of England); emergency admissions increased by 10% - (second highest in North of England).

Yet, Dewsbury A&E is being downgraded to a minor injuries & assessment unit, in favour of centralising A&E at Pinderfield. The result? Increased journey times, cutting into 'the Golden hour' & resulting in cases like that of a 90 year old who was advised to get a further bus to Pinderfield. To get a shard of glass removed from his finger.

PFI
No viable patient centred case has been made for all this – this was why the plans were submitted to the Secretary of State for review.But Jeremy Hunt approved them, leaving the Trust's two £311m index-linked PFI hospitals intact, at Dewsbury's expense.

With annual deficits of £10.5m, the future is uncertain – 2 Dewsbury District Hospital buildings are to be sold off via PropCo & there will be more cuts to Dewsbury District Hospital, as the only hospital in the Trust without a PFI debt.

The Dewsbury District Hospital downgrade doesn't stand up clinically, whilst socially it's a disaster – health inequalities exacerbate other inequalities & undermine social cohesion - & how can a higher volume of services centralised in one place improve health outcomes ?

Delays & restrictions to patient care
Calderdale & Kirklees 999 Call for the NHS

These are just a couple of examples of cuts to Calderdale NHS services.
These aren't people's real names, but their stories are.

Speech and Language therapy and autism support

When Alex's 3 year old son Jake was referred to Speech and language at Calderdale Royal Hospital, she was told that if she'd pay for private sessions Jake could access therapy earlier.

Alex said no to private S&L therapy sessions.

After 10 months and 2 S&L therapists' assessments at nursery, a S&L therapist gave the nursery and the parents some tasks to do, wrote to the consultant paediatrician that Jake needed a complex communications assessment, and told Alex that Jake would wait a year for this.

In the meantime, the S&L therapist would check in on Jake on a 6 month basis unless he's making no progress and then she'd see what to do.

So at the earliest Jake has to wait 20 months for the complex communications assessment, which is basically to assess for autism.

This delay has made Alex stressed and unwell. Jake is struggling without the support he needs. The other day he fell downstairs and had to have his head glued together.

The whole Calderdale art therapy service is being cut for "cost improvement"

The mental health trust is shutting down the whole art therapy programme in Calderdale at the end of March. Last November the Trust told me it had no plans to shut the art therapy programme in Hebden Bridge.

I'd asked the Trust because a service user, Anne, had been trying and failing for months to get a straight answer from the Trust managers about when the service would be moving to Halifax, which is what service users were told in early 2014.

Now the entire service is being withdrawn.

This is the first time the mental health trust has decided to cut an entire service for so-called "cost improvement" - until now, it's only cheese pared services. The Union is challenging this strongly as a dangerous precedent.

Meanwhile, Anne has been anxious and stressed for a year. This has worsened her symptoms and she recently had a blackout in the street and knocked out her front teeth.

Anne said,

> *"I'm gutted. My therapist and I agree that I have around another 18 months of work to do and then I'm finished - or if my treatment ends now I'm likely to remain as I am, having blackouts and other symptoms (such as IBS) which mean I'll not be employable due to long periods when I'm off sick. Working with the therapist has meant I've been able to withdraw off medication and have not been hospitalised with somatic pain for around 5 years. Previously I was a regular inpatient on general wards for pain management due to acute bouts of IBS and also under consultants for migraines as well as being prescribed medication for anxiety and depression. Working with the therapist has saved thousands of pounds for the NHS and many hospital hours, so I dispute that cutting this service is a cost effective measure."*

TESTIMONY

THE DESTRUCTION OF THE NHS

Fragmentation of Public Health services and lack of democratic accountability for the NHS

North Kirklees Support the NHS

Public Health

Since the Health & Social Care Act 2012, some Public Health in England has been devolved to local authorities. In 2015/16, cuts to public health funding meant a £1.6m cut in the case of Kirklees, with more cuts to come. The public health budget was not ring fenced.

The hand over of some public health service commissioning to councils has fragmented public health services.

For example, savings by investment in contraception - a public health service commissioned by the council - are not felt by the council, but by the Clinical Commissioning Group (CCG), which commissions abortion services. So where's the incentive for the council to invest? Yet the cost saving to the total health budget, by avoiding terminations, is huge.

The effective treatment of gonorrhoea has been compromised by online prescribing by 7 pharmacy chains [(1)]. The disease causes severe inflammation, possible sterility and is passed from mother to baby in the womb. Suboptimal treatment must be avoided.

Antibiotic resistant strains of gonorrhoea have been located in Leeds. With internet sites like Tindr, they are likely to be spreading fast. Although symptoms are unpleasant, not everyone has them. 50% women and most men with the disease don't know they're infected. Rigorous tracing of contacts is vital.

Resistance has been hastened by online pharmacies, offering prescriptions for oral treatment without the necessary accompanying injection, and without stressing the importance of tracing contacts. (7 online pharmacies in March 2015 BBC)

Spectrum Healthcare (Private) won the Genito Urinary Medicine (GUM) contract in Barnsley. Genito Urinary Medicine Consultants treat Sexually Transmitted Infections. Spectrum reviewed all staff contracts and started staff cuts after the 45 day TUPE contractual obligations ended.

Lack of democratic accountability for the NHS

The public believe CCGs to be secretive and opaque. [(2)]

It was not public knowledge that North Kirklees CCG was in line to be 'lead commissioner' for the untested, experimental West Yorkshire Urgent & Emergency Care Vanguard until it was chosen for a pilot.

The Vanguard Board, for areas of 11 CCGs, will be 2 arms lengths away from patients and not transparent or accountable to them. Its complex web of different providers including NHS, private and charity, plus subcontracting from all or any of those, provides a useful smokescreen for fraud and profiteering.

The recent conviction of an NHS England employee, for conspiracy to defraud Leeds and York Mental Health Trust, shows how easy it is. (3)

Concurrent with the experimental Vanguard is the proposal to knock down Huddersfield Royal Infirmary, sell off the land and replace it with a new small planned care hospital with an urgent care centre. This means the loss of Huddersfields A&E, along with the transformation of Halifax A&E into a Keogh-style Emergency Centre.

The downgrade of Dewsbury A&E and District Hospital was approved, in spite of Kirklees and Wakefield council's Joint Health Scrutiny Committee's recommendation that it was *'not in the best interests of the local population*' (4).

Two local CCGs recently awarded £5m worth of the Huddersfield half of 'community services' away from Calderdale and Huddersfield NHS Foundation Trust (CHFT), to private Locala. The contract award was messy and delayed and CHFT appealed unsuccessfully to Monitor against the CCGs' decision.

Locala has effectively split apart the nursing teams and clinical therapists who were delivering the services. Previously the teams had covered the whole of Huddersfield and Halifax areas. The disruption to about 30 areas of services, is compromising patients.

The award was decided on points. There was one point difference between the NHS and the private bidder. The public has no way of knowing if lobbying amongst 'friends' to set the points parameters to favour one bidder, occurred or not. Re-jigging the weightings would have changed the decision completely.

Nothing is given its name. In stage-managed meetings in public, entities are referred to in code, eg 'Phase 2 partner', and information is hidden behind 'Commercial confidentiality'.

NHS England offloading commissioning of Primary Care to CCGs is a concept riddled with conflicts of interest (5), as if the formation of federations of GP practices had not caused enough already.

The removal of 'commissioning' ie the purchaser/provider split and 'profit motive', through the NHS Bill, will solve these problems at a stroke. The return of Public Health responsibility to the NHS, as it is in Scotland and Wales will engender an integrated approach to disease management and control.

Notes

With the Health and Social Care Act 2012, Directors of Public Health lost their independence. They are jointly employed by the councils and Public Health England. Cash-strapped councils are offering less money plus more responsibility and therefore the posts are being deskilled as better qualified people are not attracted to them. Councils can stop them speaking about problems in their area.

Info sources

1) Gonorrhoea

- http://www.bbc.co.uk/news/health-31649099 pharmacy treatment of gonorrhoea March 2015
- http://www.bbc.co.uk/news/health-35153794
- http://www.bbc.co.uk/news/health-34269315

http://www.ncbi.nlm.nih.gov/pubmed/18724573

For profit healthcare provides inferior care at inflated prices after 40 years of experience in the US

2) Secretive CCGs

NHS Citizen Assembly ExCel London, Nov 2015) http://bit.ly/NHSCABlog Attendee oral testament

3) Opportunities for fraud

NHS England employee found guilty of fraud

- http://www.yorkshireeveningpost.co.uk/news/latest-news/top-stories/four-to-be-sentenced-over-3m-nhs-fraud-plan-1-7596129
- http://www.freepressseries.co.uk/news/14111474.Gwent_man_guilty_of_part_in_plot_to_defraud___3_million_from_NHS/?ref=rss
- http://www.belfasttelegraph.co.uk/news/uk/four-are-found-guilty-of-plotting-to-defraud-nhs-of-3m-34240860.html

4) Hospital downgrade- Cuts to local hospital provision

- http://www.yorkshirepost.co.uk/news/mid-yorkshire-hospitals-trust-to-bring-forward-plans-to-centralise-a-e-services-to-this-year-1-7652283

5) Conflicts of interest

North Kirklees CCG and GP federations: Curo Health Limited is a Federation of all 29 GP practices within the North Kirklees area (exactly the same coverage as NHS North Kirklees Clinical Commissioning Group). An explanation of Curo Health is in the web page of the Dementia Action Alliance, which the NKCCG also funds.

Dementia Action Alliance

- www.dementiaaction.org.uk/members_and.../3722-curo_health_limited
- https://www.opendemocracy.net/ournhs/jenny-shepherd/politicians-should-have-duty-of-candour-about-nhs-too

Conflict of interest fears as Hunt appoints NHS adviser with big private healthcare interests

- www.energyroyd.org.uk/archives/11177

Marketization of substance misuse services at Brighton & Hove & impact on NHS staff

Sussex Defend the NHS

The fate of Substance Misuse services (SMS) over the last decade - particularly since the Health and Social Care Act 2012 - strongly reflects what is happening elsewhere in the NHS, particularly in mental health services.

We feel it is no understatement to say (echoing Clare Gerada's prescient statement from 2012) that - in the absences of any intervention or a halt being called - we are witnessing the

> *"extinction"* of NHS-based Substance Misuse Services *"with a full-on uni-directional shift from the NHS to the voluntary sector".*

Our experience of the consequences for SMS staff in Brighton and Hove reflects what is happening in the wider NHS, as services are hived off from the NHS at an ever-accelerating rate.

According to Collective Voice[1] (a collaboration of providers of drug and alcohol treatment and recovery services) as best as can be judged from inadequate data, last year local authorities spent about £820m on drug and alcohol services: 30% of the total public health budget. Collective Voice estimated that of this, £277m is spent in the NHS , £376m by third sector organisations, with the rest run by private companies. Many of the third sector organisations have grown hugely in recent years. For instance Crime Reduction Initiatives (CRI), who were a partner in the previous Brighton and Hove contract, have a turnover of £141m and run all the SMS services in the Birmingham.

SMS: The Brighton story

Discussions began in 2013 around the service being re-tendered. It had been largely provided by the local mental health trust, and some services by a third sector organisation CRI.

This community service, and the inpatient detox beds, had won awards and accolades for the great service they provided.

Despite this, there was very little consultation with staff over the tendering process and then it emerged that the preferred bidder was neither of the local providers but a consortium of another third sector organisation Cranstoun and another NHS provider – Surrey Borders NHS (Obviously not local to Brighton!)

This time the 3rd sector organisation was the main partner and the NHS trust a small player so that the (few remaining) NHS workers could be TUPE'd [2].

There was great opposition to this proposal by the service workers and Sussex Defend the NHS. There was also opposition from some of the local councillors on the Health and Wellbeing Board .

However, the contract was awarded to Cranstouns. No surprises, the contract was cheaper and supposedly working to a new care model (which the award winning service team was supposedly not able to provide and wasn't consulted on).

This new service has proved a disaster for clients and staff. It has at times been unsafe with no staff to write prescriptions and no channels of safe communication between Surrey and Brighton. The staff have had to move into inferior buildings, there has been decreased engagement by clients with attendant consequences – for instance over the needle exchange which has moved. We also learn that the service is already over spent.

And this week we hear of a final terrible consequence of this fragmented service, the internal market and the rising power of 3rd sector organisations in their take over of HNS service.

This is the closure of a ward at the local hospital run by the mental health trust that was for inpatient substance misuse detox. This service has been a vital component of previous SMS contracts but not this one. So now, there are no in patient detox beds in Brighton and Hove. Instead, clients will have to go to Islington in London, accessing beds owned by, guess who Cranstoun.

Impact on staff

16 staff have left and only 2 have been replaced – a huge reduction in the qualified nursing staff for such a vital service for vulnerable clients. This has also meant the loss to the NHS and this needy client group of years and years of specialist knowledge. The staff who ran the inpatient beds may have been redeployed but they are not able to use their specialist skills.

Several roles with in the community service have been reorganised and down graded.

What we want to emphasise:

1)That these 'take overs' of NHS services by 3rd sector organisations or 3rd sector/NHS partnerships are not acceptable. This outsourcing is harmful to clients and staff. It invariably leads to a fragmentation and deterioration of service, as we have seen in Brighton.

2)The loss of local inpatient beds for detox and dual diagnosis clients is also unacceptable. As one local commentator put it – really going back to the Victorian era of sending people away 'over the border'.

3)That Health and Well Being boards appear to be moving quickly away from the publicly accountable bodies they should be.

Notes

[1] Information from Collective Voice is here downloadable here: http://www.collectivevoice.org.uk/wp-content/uploads/2015/11/Briefing-ahead-of-the-Spending-Review.pdf

[2] TUPE: - See Glossary

The Primary Care disaster
Gaynor Lloyd, Brent Keep Our NHS Public

(This runs well over the 3 minutes allotted to each group at the 14th January meeting, so includes a lot of material that there was not time to deliver at the meeting. It ends on p 27.)

GPs in primary care are at the centre of the NHS.

But funding for general practice has fallen in real terms compared to secondary care - even though the government is pressing for treatment to move out of hospital.

There is a national picture of GP burnout, early retirement, exponential rise in GPs wishing to go to Australia or Canada, and a fall in applications for training places. There is a shortage of GPs in my area, Brent.

I shall outline how Brent in NW London has suffered from being part of the NW London “Shaping a Healthier Future” hospital reconfiguration, which has been commissioned with the involvement of local GPs on the Clinical Commissioning Group (CCG) who have demonstrated clear conflicts of interest.

Shaping a Healther Future (SaHF) is a project to reconfigure the major hospital provision in N W London; its first "casualties" were the A&E closures at Hammersmith and Central Middlesex.

It also requires the transfer of hospital services into the community, with an opportunity for contracting that feeds the development of large scale GP “locality companies” and furthers the destruction of the concept of GP practices that operate as family doctors

Commission calls for total halt to Shaping a Healthier Future scheme

Following the catastrophic local effects of the A&E closure at Hammersmith and central Middlesex, 3 local authorities commissioned Michael Mansfield QC to carry out an enquiry. Its results are damning – suggesting a total halt for re-examination – but the NHS is ignoring its existence. We do not know if the local authorities will follow up – if a judicial review is to take place, then the interval of time is worrying.

SaHF's reclassification of some hospitals, the closure of parts of others (and the sell off of sites) was meant to be preceded by the provision of "care closer to home" - an attempt to set up out of hospital services in the community.

In the event, with 8 CCGs’ fragmented control over what was to be pushed out of hospital, it's hard to see what alternative community provision was put in place - still less if it's effective in patient care.

And don't ask about the money! On top of the costs of procurement, there was apparently nil regard for the effect on the income of the local provider trusts. CCG's seemed oblivious to the link between their anticipated Quality Innovation Prevention and Productivity (efficiency) savings and the commensurate slides in the income of the local Trusts.

Not to mention loss of staff in the "decommissioned" services...

GPs' conflict of interest

But let me try to stick to Brent and another pernicious side effect from the out of hospital strategy: the role of CCG's as commissioners of those services - and the opportunity for GP's banded together in various configurations to bid for them. The opposite of a purchaser/ provider split really - though not one we should necessarily welcome.

The Royal College of General Practitioners were concerned from the time that CCGs were set up under the Health & Social Care Act 2012, that GP's commissioning services for their area would create a potential conflict of interest, and that even the perception that some GPs may be commissioning services on the basis of advantage to their pockets could damage their reputation with patients. That concern is justified in our case.

Some CCG GP members have taken to the commissioning role with enthusiasm: in particular, the opportunity to bid for contracts. Some Brent and Harrow GPs already had "form" in this respect - the company they set up for the provision of out of hours services – Harmoni - was eventually bought out by Care UK, at around £27 million.

Brent's administrative area was organised in to 5 localities. We have some very deprived areas. Prior to the CCG, one of the locality groups of practices - principally in a very deprived area - had already formed a company, which bid for services (like referral management systems) and took over practices outside its immediate commissioning locality.

After CCG's were formed – and in a move which could be seen as protective of services being Local – the other locality groups of GPs formed themselves into companies in order to bid for contracts.

The difficulty is when GPs as commissioners of services are creating policy to tender services, for which they themselves intend to bid - or they formulate and recommend pilot projects for their own locality companies, paid for by the CCG, which then have a competitive advantage when those services are commissioned with those pilots recommend as best practice.

Bungled commissioning of out of hospital services

Brent is certainly not alone amongst the 8 CCGs' GP practices, who all looked for and commissioned out of hospital services alongside the "Shaping a Healthier Future" scheme. But Brent's commissioning of these services has been particularly disastrous.

The commissioning of Shaping a Healthier Future out of hospital services has been bungled from the start. Wave 1 – ophthalmology and cardiology – took literally years longer than anticipated, and is proving much more expensive.

The tendering of community Cardiology had to be aborted on one occasion, and its outcome challenged on final decision: it became apparent after completion of the bid that the CCG had, unawares, de-commissioned a community heart failure service (a service which had won National awards - including for coproduction work with its patients, whereby clinicians and patients together designed a service which works for them all).

Of course these patients were not even consulted about the re-tendered Cardiology service, and Brent had hastily to add the service into the already completed bid.

The local hospital lost income as a result of the transfer of services to the Royal Free; in addition, Healthwatch Brent has referred the resulting service to the Care Quality Commission for numerous failures against its Key Performance Indicators (KPI's).

Healthwatch Brent's referral was based on assiduous research, stemming from information provided by Brent Patient Voice.

(Our questioning of performance led to the CCG setting up a committee, which includes one Brent Patient Voice member, in order to review this with Royal Free. Brent Patient Voice membership of that committee continues but we are concerned that the CQC review is toothless, appearing satisfied by the provision of an action plan . But we ought to keep an open mind.)

Meanwhile, some Brent GP's refer away from the new Cardiology service, back to the old provider.

A total costly farrago. But if this goes on where, serendipitously, some local well-informed patients are following up AND the new provider is an NHS Trust, what hope is there that any CCG out there is carrying out service monitoring at all?

Wave 2 musculoskeletal conditions and gynaecology was eventually abandoned, after the CCG had spent over £730,000 on project management and legal and clinical experts (one of whom was there to promote the lead provider model only really suitable for a Private sector provider).

The gynaecology aspect was based on a pilot conducted by one of the locality companies referred to above; following patient queries, it turned out there was no robust procedure for monitoring the pilot's effectiveness.

However, these locality companies (now called networks) have become embedded in the North West London plan for primary care, in particular in relation to the Whole Systems Integrated Care project.

Again, numerous "pilots" in relation to integrated care have lacked robust measurements as to actual improvement. (Most results seem targeted at being able to create capitated budgets, and projects to form Accountable Care Partnerships - the US model).

Major "reconfiguration" of primary care with no public consultation

Without consultation on such a major reconfiguration, the latest plan for primary care seems to be that a locality 18 – 64 age range will be catered for by the overall network, with the elderly and children within "their" practice's care. Where responsibility for individual patient care will sit with any GP is anyone's guess.

This idea of "mass cover" chimes in with NHS England's new promotion of 30,000 patients lists (with an exception made for rural practices, no doubt as a result of contributions by Sarah Wollaston). Patients generally have no awareness of this.

All of my generation will have had examples of seeing our familiar GP who, knowing us, will pick up on our health issues and at least have a background knowledge of us without having to trawl through the summary notes on the computer in very short appointments. There was a rationale for having a family doctor. No longer.

Of course these kind of changes cannot take place without flexible contracts. My own very personal experience of my very popular excellent GPs, who have served us for over 12 years, is a case in point.

Originally employees of the local Primary Care Trust, then tendered out, after a nine-year patient backed campaign that took advantage of the Labour government's Right to Request legislation, in April 2013 the practice became a social enterprise.

Without warning or consultation or indeed abiding by its own procedures for managing time-limited contracts, 2 1/2 years into the contract NHS England are tendering us out again as part of "Tranche 4" APMS contracts, ignoring vigorous patient complaints, petitions and well attended patient meetings.

APMS contracts were introduced by the New Labour government in 2004, to open up primary care to ‘new providers’. They were used to procure the Labour government’s ill-fated ‘Darzi’ centres across the country. http://www.pulsetoday.co.uk/half-of-darzi-centres-under-review/11045142.article# A 2009 GP Magazine article says:

> *“APMS contracts are the private sector's gateway to providing primary health care to NHS patients.”*

They don’t require a GP practice to be run by medical people, and they are very controllable, time limited and driven by Key Performance Indicators (KPIs).

As if according to the “defund, run down, privatise” plan, after more than 500 GP practices had closed between 2009/10 and 31 August 2014, at an accelerating rate, NHS England - invoking competition law - said it would open up all new GP contracts to bids from the private sector, and only use the time-limited Alternative Provider of Medical Services (APMS) contract, not GMS or PMS contracts.

Following the BMA General Practitioners Committee’s challenge to the legality of this, NHS England watered down its plan - but, as the GPC said at the time, this would only make a difference if NHS England put its revised plan into action.

Re-tendering existing GP practices is directed at large private companies - some of them “locality” companies run by CCG-member GPs

NHS England now says it is bound by competition regulation to tender out our GP service, but its own guidance says this is not true. As a practice patient participation group, we continue to debate the case - but up against an intransigent NHS England, what hope is there?

It is clear this tendering is directed at the larger providers.

The "market engagement event" for this describes the process:

> *"The first three tranches of the programme have resulted in the successful procurement of ten APMS contracts using the standard London contract and methodology. We are about to start Tranche 4 which will offer the greatest number of opportunities to potential providers so far. We would therefore like to offer you a fresh chance to obtain an overview of the programme as a whole, and of the opportunities offered by Tranche 4 in particular."*

We have a list of those who attended the event (our GP's had to be in surgery that Wednesday afternoon) - the potential biddersfor the 16 London practices in Tranche 4 include Virgin, a US based venture capitalist body misleadingly called the Practice Group, the Hurley group which holds various practices across London (with one of its partners recently appointed Head of Primary care services in NHS England - another is Clare Gerada), and one of the locality companies mentioned above.

Bidders for Tranche 4 complete Pre Qualification Questionnaires without saying which practices they want; the bidding process is essentially anonymous - so, even if our GP practice makes it to the next stage, it will not being able to set out its own popularity and success (growing from 5500 to 8500 patients in under 2 1/2 years and holding the local phlebotomy walk-in contract as well as the hub services for the locality for out of hours appointments).

And of course our doctors – already busy and actually seeing patients - will have to spend their time and money from the social enterprise funds in order to undertake all the legal processes as a result of this tendering.

The size of the practice makes it very attractive and our patients feel they have become a juicy commodity to be traded.

If GPs do not get the practice, since at least one of them is not local, that GP will be lost to the area.

This commissioning - part of a joint Clinical Commissioning Group/NHS England commissioning of primary care services – has gone ahead without Brent Clinical Commissioning Group raising any objection to the destabilisation of my practice and other local practices.. Nor have these GPs had any support from their local Local Medical Committee rep, who simply waved them in the direction of the overall London-wide General Medical Council.

I have no idea of the relevance of the fact that the Governing Body majority members (including the LMC member) are from the selfsame locality company that has evinced an interest in bidding - but Royal College of General Practitioner conflict of interest guidance - and their reference to the reputational damage that can follow the perception that some GPs may be commissioning services on the basis of advantage to their pockets - keep wandering unbidden into my mind.

The Integrated Care commissioning minefield

Another Brent commissioning minefield is integrated care, where the locality GP networks are embedded. This is being promoted without any real testing of the basic question:

> *" How will free NHS provision survive, where local authorities' budgets now do not even allow for proper social care funding, where most people requiring social care have to contribute, and that system is being combined with the "free at point of use" NHS?"*

What will be the position of the individual GP here? They already raise concerns about issues such as their role in referring patients to food banks.

The Whole Systems Integrated Care project, as currently drafted, will require patient information to be uploaded onto the so-called integrated care record. Issues such as financial position (social care as above), lifestyle, and compliance with treatment or self-management regimes are to be uploaded.

Local NHS commissioning intentions plans place a huge amount of emphasis on "self-management" and "self care".

At the same time, the press encourages the general populace to wonder why obese people and those who smoke and drink should be entitled to NHS treatment. This challenges the ethical role of GP's.

EU Data Protection Directive "updated" to sidestep privacy and consent issues around patient data sharing

The Commissioners' own Privacy Impact Assessment for Whole Systems Integrated Care reveals that the information required will breach at least 3 principles of data protection. I cannot imagine how the necessary informed patient consent could ever be obtained for this sort of information being uploaded and shared. There would also be obvious dangers to patients, as they are seen by the next member of the "Multi disciplinary team" in an " integrated care package", because the Commissioners acknowledge that they cannot foresee that they will be able to upload information in real time.

However - well-timed to sidestep the need for informed patient consent to the upload and sharing of their confidential data - according to a Local Government Information Unit briefing,

> *"the European Parliament has now ruled to update the 1995 Data Protection Directive to give "greater flexibility" to allow the NHS to share patient data with social care providers. The measures are expected to come into force by 2018."*

So that's all right then. Well, maybe best just to make life uncomfortable for them UNTIL 2018 on data sharing. And consider that TTIP may not be the only reason why a slide out of Europe might not be a bad thing.

Follow the money

The NHS is constantly said to be in financial crisis. Who accounts for the time and resources of GPs in Brent, who no longer see patients but whose practices are "run" by locums while the GPs attend Clinical Commissioning Group committees and Boards? Who accounts for the NHS money that is being expended on tendering processes and on bureaucratic additional structures, on professional consultants which have to be employed to design and work on these additional schemes – for what purpose in terms of improving patient care?

Up to the last Freedom Of Information request, local activists know that for SaHF, £67 million has been spent on management consultants - the same ones featured in the recent disclosure of the overbudget Cabinet office (because civil servants have been replaced by consultants). Another £1.5 million for the period June to October 2015 was noted by our local CCG governing body (having been originally signed off by perhaps one or 2 people as a "single tender waiver").

I suggest someone "follows the money".

TESTIMONY

THE DESTRUCTION OF THE NHS

Keeping Virgin Care out of Bristol children's services and the importance of the NHS Reinstatement Bill

Protect Bristol Community Children's Health Partnership (CCHP)

I'm Mike Campbell speaking on behalf of the campaign to Protect Bristol Community Children's Health Partnership. And those of us here this evening happen to be Labour party members. We represent NHS workers and activists in Bristol who oppose NHS commercialisation.

Together, Protect CCHP and Protect Our NHS are campaigning to keep Bristol children's health services in the NHS. Last year we brought together staff organised in our trade unions, service users, political parties and ordinary members of the public - young and old - to oppose the handing over of these services to private corporations. Our principle aim was to stop Virgin Care taking over these services. A petition supporting this and signed by nearly 7000 people was handed in to our Clinical Commissioning Group in August 2015 following a large public protest in Bristol.

As staff we oppose the fragmentation of the NHS. We think Labour should oppose this too. And further health service fragmentation under devolution plans means the end of a truly NATIONAL health service. We oppose the provision of clinical services being undertaken by companies whose bottom-line is to make profit. The values that underpin the operations of private companies undermine those that operate within public service – especially around pay, and conditions ofservice, going that extra mile.

We are public servants. We are not, and do not want to be, employed by private companies. There's also something ethically wrong in public services being run by companies who avoid tax. Like Virgin Care Limited.

If everyone avoided tax, then there would be no universal health service. And we see no evidence that private companies like Virgin somehow deliver better quality, more equal services than the public sector. In October Bristol Clinical Commissioning Group announced that the interim one-year contact to provide these services from this April would be delivered by a local NHS trust and partner social enterprise organisations. Not Virgin Care.

But this is only a temporary victory. We still need to ensure that Virgin Care does not win the big prize – the 5/6 year contract from April 2017. We now know that Riverside - a specialist mental health unit for young people - will not be handed over to one of the leading contenders for the contract, the Huntercombe Group . This is a division of the financially crisis-ridden, tax avoiding Four Seasons Healthcare (FSHC). Though they will have a consultancy role.

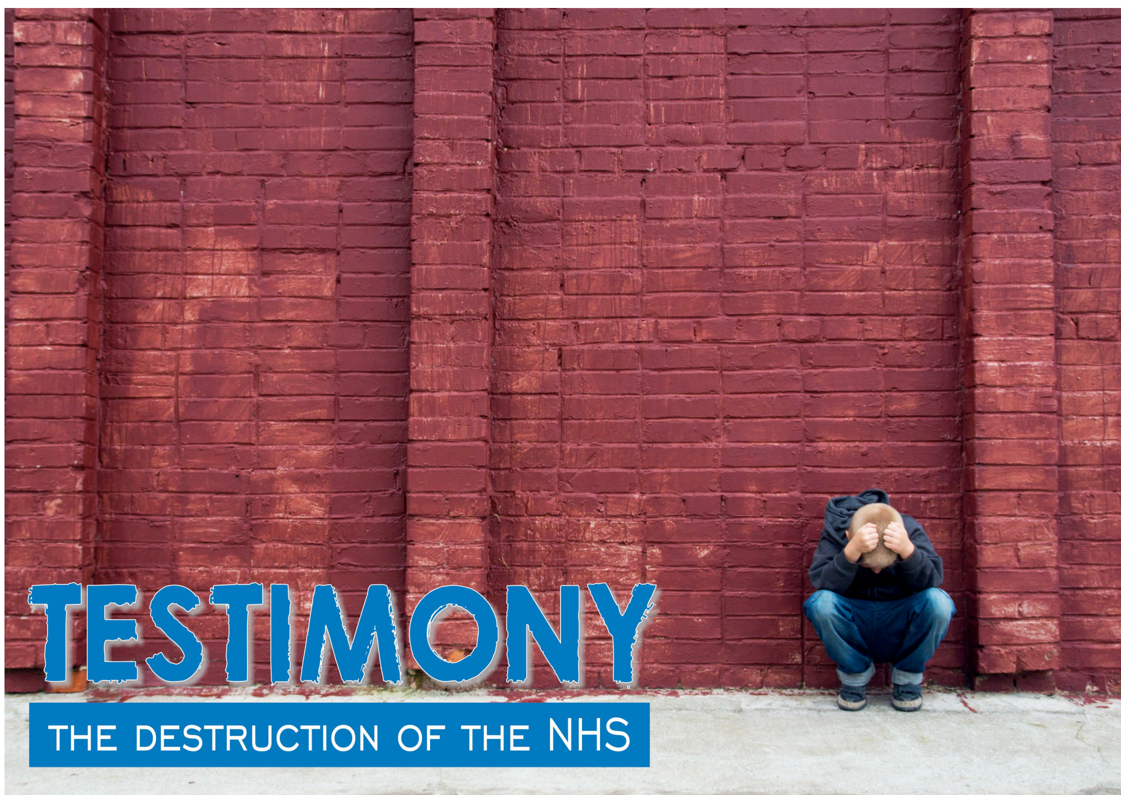
What staff, patients, the public of Bristol want is - for all such services to be publicly owned, publicly accountable within a properly resourced NHS. But we also know that staff can't repeat this fight every time. As campaigners, we are exhausted too! Even if every time a service in England is recommissioned there are people prepared to fight for it, they won't always win.

And what we also know is that sometimes there won't even be a fight. Privatisation by stealth is happening all over the country. Right next to us in Wiltshire, Virgin Care have

won a massive contract for delivering services just like ours and no one even noticed. And yesterday they won a Kent contract to run Sheppey and Sittingbourne hospitals.

And so it's imperative that Labour commits... to supporting the NHS Reinstatement Bill, to proper resourcing for a national health service, equal to the percentage of GDP of similar western European economies, paid for from taxation. And opposes the Devolution Bill, an extremely risky proposition that will lead to a two-tier health system, with charging for services, just as it has in local authority social care.

Thank you for listening.



NHS Staffing issues

NHS staff and training

Colin Hutchinson, Calderdale 38 Degrees

I want to concentrate on the worsening crisis in manpower which is one of the main factors driving unwelcome changes locally and nationally.

I was a Consultant Ophthalmologist, until my recent retirement, working at Calderdale and Huddersfield NHS Foundation Trust, which is based on two District General Hospitals – one in Halifax and one in Huddersfield, serving a population of about half a million.

I was also Clinical Director for Ear Nose and Throat, Ophthalmology and Maxillo-Facial Services for ten years and Lead Clinician for Skin Cancer Services for six years, so one of my main responsibilities was the development of the clinical teams to deliver safe, effective and comprehensive services. This is becoming harder and harder to achieve, due to the lack of available trained staff to recruit from.

· Accident and Emergency Services are likely to be lost from either Halifax or Huddersfield – one of the main reasons is the inability to recruit enough Consultants in Emergency Medicine, Anaesthetics and Paediatrics to maintain safe staffing rotas – they just aren't out there.

· The Dermatology Department has been run with skeleton staffing for more than ten years, which is why we have had an Ophthalmologist leading the Skin Cancer Team. Nationally there are about 200 vacancies for Consultant Dermatologists. The response of Health Education England is to increase training numbers by four next year! There has been no collection of data on numbers of vacant posts for doctors in the NHS since 2010, "To reduce the burden of bureaucracy on providers"!

· Our Maxillo-facial Service is based at Bradford Royal Infirmary. 50% of the Consultants in the Department are leaving, with little prospect of replacement, which will make that service unviable.

· For twenty years, our Ophthalmology Department has been able to offer treatment for almost all eye diseases, and we have had highly trained staff able to do this. Since commissioning has been divided into "Specialised" and "Non-specialised", and many of the treatments that we have been performing have now been classified as "Specialised", they will not be available locally, and we will be unable to recruit bright and enthusiastic surgeons, who have worked hard to develop these skills. The decision as to which treatments to remove from District General Hospitals is not based on any outcome data, but on the opinion of a panel.

· The lottery of the annual round of contracting adds to the difficulties. It takes years to build up good clinical teams, but they can be destroyed at a stroke and cannot easily be put back together. Private companies are skilled and well-resourced in bidding for contracts, but often much less adept at delivering a high quality service. Potential candidates will be less willing to relocate their families if they are uncertain whether the team they are joining will continue.

· We are constantly being told that services are being reduced in hospitals, but being built up in the community; but skilled staff are still required in the community. Where are they? There has been only a 0.6% increase in nursing staff in the community since 1998. Even more worryingly, there has been a 40% drop in the number of qualified District Nurses. A third of those remaining are over 50 years, yet very few District Nurses are being trained to replace them – only 5 qualified in the whole of London in 2013.

· Clerical staff are essential in ensuring that we get the greatest productivity out of highly paid medical staff, but large numbers of them are being "let go". For example, Consultants' Secretaries provide a vital point of human contact between patients and the baffling complexities of the health system. They have intimate knowledge of the clinical teams in which they work. Removal of such staff to generic call centres means much more expensive Consultant time spent administering their case load, and less in actually treating patients.

The fragmentation of the NHS into financially autonomous bodies, competing, rather than co-operating with one another; the instabilities caused by the market in health services; and the lack of an effective national commitment to the training and development of sufficient clinical and supporting staff pose one of the greatest dangers to the survival of the NHS in this country.

Urgent action is required now.

Undervaluing NHS workers, leading to low morale and problems with recruitment and retention etc.

Severn Junior Doctors Pressure Group

As a medical student I am frequently inspired by the positive impact healthcare professionals can have on a patient's life. However with increasing frequency I am being advised by my clinical mentors, who are senior clinicians, to leave Medicine. Come 2020 changes to the registration of junior doctors mean that they will no longer be required to work in the NHS. The combination of these issues is only going to compound the current staffing shortages. I believe this sentiment is shared among other allied healthcare professionals and unless addressed will only further risk compromising patient care.

From our time shadowing hospital staff, I'm sure we're aware that morale appears to be at an all time low. From my experience as a junior doctor, some of the biggest causes are concern about patient safety and feeling unable to meet minimum standards due to time pressures or poorly designed targets. We would like it to be made easier to highlight these concerns, safe in the knowledge that Trusts would be supported in addressing these, rather than penalised. Most importantly we would like political parties to engage sincerely with front line staff to discuss how best to value them.

With increasing frequency doctors are choosing to gain clinical experience abroad. Out of my year of about 40 doctors who are at the stage of applying to a specialty, less than half seem to have applied. The rest are mainly looking abroad. Those choosing to return to the NHS are often faced with many barriers. For example GPs can have to sit two expensive exams and undergo at least three months of retraining, during which time they are unemployed. This is despite having worked in similar health care systems abroad. In contrast these high clinical standards are not always visibly maintained, for example amongst some locum doctors. This imbalance is unsustainable if we are to maintain high standards of patient care.

All of the issues we have discussed above are independent of the current junior doctor contract crisis. As representatives of junior doctors we would like to thank you for the support of yourself and your party to date. However further clarification is needed of Labour's position on the junior doctors crisis following recent publications. Labour have the opportunity to distance themselves from the current government's stance on health and align themselves with the public support for the NHS and junior doctors. Labour have maintained the high ground on healthcare and unless further support is given to the protection of the NHS and its workforce, Labour risk losing this advantage over the Conservative party.

Simon Stevens
And his Five Year Forward View

Vanguard schemes: Patients will suffer
National Pensioners Convention & Civil Service Pensioners Alliance

(This is a rewritten, longer version of the statement delivered at the meeting.)

Vanguard[1], even with capable, competent and inspiring leadership, and with hard working dedicated staff, is not working for the majority in the way the "headlines" say it is.

It sounds sensible, ethical, and inspiring; there will be articulate patients happy to tell you how their care has improved, not knowing they are a lucky minority. National Pensioner Convention members are already telling us that patients are paying a heavy price.

Vanguard is like pasting Osborne and Little wallpaper on a crumbling unstable wall.

With the Transatlantic Trade and Investment Partnership (TTIP) and the new fears around the Deregulation Act, it is like doing this when you know you have the house sale in the bag. This new Act apparently requires that business should be promoted as a priority over health - although lawyers are still checking out exactly what the Deregulation Act means, since the Tories slid in new measures without going through the Parliamentary scrutiny process.

Like NHS Devolution, none of Vanguard's supposed savings and improvements are evidence - based. They seem to rely more on a hope that demand will decrease in key areas, such as GP visits, prescriptions, outpatient visits, average length of hospital stay, non-elective inpatients and A&E attendance.

The 2015 King's Fund report *'Making change possible: a Transformation Fund for the NHS'*[2] is an example of how radical proposals are made in the absence of evidence to support them.

Vanguard trumpets some laudable aims. Patients think it is what they would like, but it's not what most will get. There is not enough funding, and not enough experienced medical staff to deliver this "vision".

In the longer term it is set up to enable privatisation, and to enable the less scrupulous to operate without scrutiny or accountability. Partners supposedly integrating with NHS services are either not interested, or are eyeing up the funding to plug their own gaps.

What most Local Authorities, private companies and the big charities know and are expert at, is outsourcing. How to win contracts as opposed to delivering high quality sustainable services.

With current legislation, and the privatisation agenda behind the current quango decisions, privatisation - or outsourcing as it is otherwise known - seems to be the only game in town, even when the NHS and Local Authorities s would like to keep services within the NHS.

Quotes from the Coal Face

This is what National Pensioner Convention members are reporting on what NHS staff, patients and carers from all over England are saying:

End of Life:
We are passionate about giving a good service, but there are not enough specialists, not enough nurses, no spare capacity to train. Patients will suffer.

Mental Health:
NHS: people are beginning to take more notice
Carer: My daughter is being pushed to independence as they don't have the capacity to treat her now. As a result, she tried to commit suicide – no counselling, just sent back home for us to try to pick up the pieces.

Integration:
NHS: How can we integrate when would - be partners won't answer emails, seldom come to meetings and when they do, push their own agenda without listening, and refuse to change or compromise.

Public Health:
Local Authorities don't understand public health and have little time to listen.Local Authorities have some good staff, and some bad ones, but in the end what they, especially the managers, know is to offload work as cheaply as possible, or stop services without understanding the consequences longer term.

Public Health services are seen by many Local Authorities as a chance to sell what were NHS assets like buildings and land. Once under LA control they are earmarked for "development" i.e. to build executive housing estates, or a new supermarket, even if it's bad for patients and results in a more expensive service (or no service at all). The business agenda seems to trump everything.

Local Authorities/Charities:

Councillors are fighting to get new services to their area to win votes, regardless of where those services are really needed.

Members have reported that charities know they will get better results from the better areas, and are often under LA influence to do so (see above), so they are piloting in the more affluent areas, where there is already a good support network, and good services. Deprived areas are losing out both ways. PS it is no longer OK to refer to these experiments as "pilots".

Local authorities are starting to look at charging the frail elderly to be picked up when they fall, so even more ambulances likely to be called out for simple falls requiring lifting, if older people cannot pay.

Members report that small charities who work for the public good are losing out to the big, more business influenced ones, who know how to tender for contracts and can afford to.

Attendance Allowance is being considered for devolution to Local Authorities many of whom are unable to support people who were on severe disablement allowance (now

stopped but sort of devolved in that Local Authorities are intended to pay out if this support is needed – seems a mess with government blaming Local Authorities and Local Authorities blaming government) and for social care. Postcode lottery?

Hospitals and Care Homes

Staff from both are reporting patients being bounced back and forth between two underfunded and understaffed and increasingly undertrained systems. Workers know patients are badly served, and sometimes neglected to the point of abuse.

Patients are turning up undernourished with hypothermia and dehydrated at hospitals at a time beds are being cut. Beds are being purchased for discharged patients in care homes while there are not enough places for other people who need them, and care in the community has been cut.

Hospital at home is only good with sufficient funding, trained staff and for simple cases.

Hospices are seeing their funding cut, medical capacity in communities is limited, so people are dying in agony, while family carers are trying to work as medical staff, and paid carers are still sending end of life patients into hospitals to die.

Yes, private tests are quicker for a few - what happens when they have to deal with the bulk of the population as the NHS have given up doing them, though?

Self-Care/Management

It is a worthwhile enhancement not a magic cure. No matter how fit we try to make the population this message is likely to reach mainly the educated middle class. The more disadvantaged people are, the less likely they are to practice self-care as research has shown (for good reasons).

In the last 3 years of life almost everyone requires expensive and intensive input from health and care to achieve a good end. For the disadvantaged this might be 15 years earlier than their better off counterparts. It still means that the most expensive 3 years in health and care terms will not shrink unless the birth rate goes down, and the population decreases. It looks like England will need the same funding and services or more for the foreseeable future.

Technology

It is helpful and is another enhancement, but only in its place and with good security. Try talking to a screen or phone when you are sick and scared, have dementia, or are not tech savvy. A caring and knowledgeable fellow human to hold your hand and reassure will always be needed.

Pilots

As I said before there is now no such thing as a pilot. I can only conjecture that running pilots might provide an evidence base for not going ahead with the Vanguard and Devo plans, and thus ammunition for those opposing them.

It may be privatisation overall has failed too soon for their aims, and is beginning to draw too much public attention to these aims, as currently emphasis is being firmly put on financial management rather than outsourcing (in public I mean, not what is actually happening).

The privatisation plan is too entrenched, and too cunning for this to be anything like a real set back, and straws in the wind indicate that Devo is now a preferred method for delivering the agenda. Blame can then be firmly laid on Local Authorities and the public who voted for the councillors, even while Osborne holds all the power and the purse strings. Think Devo Manc and the 10 billion pounds promised - now down to 6 billion. LAs are saying they know all this but would still prefer to steer their own ship – by doing so they are taking the blame and enabling the government and chancellor to get away with the destruction of a truly national NHS.

Funding

There is now more talk, and lobbying (House of Lords anyway) around paying to access the NHS. This has been shown by studies to be counterproductive (as people turn up at a free A&E rather than pay to see a doctor (France)), and to drive inequality as the better off "worried well" will increasingly use the service they pay for, while the sick and poor can't afford the access they need.
In the US this often amounts to demands for unnecessary procedures, operations, and increasing use medications or alternatives without any evidence base as to their efficacy, but simply on the grounds that patients are clients, and as customers they know best (and are more profitable).

Notes

[1] Vanguard - a bunch of schemes across the country that are being given extra funding from NHS England to accelerate the implementation of NHS England's Five Year Forward View. Vanguard schemes are fast-tracking the alignment of their local NHS organisations with American private health insurance company care models, working practices and contracting methods. This involves a merger of the NHS with Local Authorities' means-tested, privatised social care and leisure services, and co-locations and collaborative working with job centres - for instance GPs coaching patients to get them back to work - and other government agencies.

Links

[2] King's Fund report 'Making change possible: a Transformation Fund for the NHS'
http://www.health.org.uk/sites/default/files/MakingChangePossibleATransformationFundForTheNHS.pdf
(download)

Wirral Vanguard & Accountable Care Organisations
Kevin Donovan, Defend Our NHS

Most local residents learned that Wirral was a Vanguard via the local free sheet headline:

> “Private sector plays major role in 'new model' health care for Wirral”.

The news item on 8th April 2015 came as a surprise to many, including those who take a close interest in health developments and politics locally and otherwise.

It was based on a press release from the Wirral Health and Wellbeing Board, whose chair is the Labour leader of Wirral Council, Councillor Phil Davies. He welcomed the successful outcome of the Integrated Primary and Acute Care Systems Vanguard bid, saying the aim is:

> " to bring home care, community nursing, GP services and hospitals together for the first time since 1948."

On 15th April 2015, we sent Phil Davies a list of questions about the bid (1). He hasn't replied.

The Wirral Vanguard project budget does not appear to be specified (although we are willing to be corrected). However in a 6th May 2015 article on Vanguard schemes, the Health Service Journal reported:

> “HSJ understands that NHS England has now committed the funding to a number of projects, but not all of it will be spent implementing the new care models, while some will go to schemes unconnected to the Forward View.”

Who is involved?

The local partners are Wirral Metropolitan Borough Council and all local NHS bodies, including "a set of collaborative consortia" of Wirral GPs. (2)

The Kings Fund is an external partner (described as the Wirral Partnership's "critical friend").

External partners also include a US-controlled IT corporation and a US Accountable Care Organisation:

· Cerner UK Ltd (“cornerstone partner in the delivery of informatics solutions and promotion population health management”)
· Advocate Physician Partners ACO, (USA) (“cornerstone partner in the delivery of modelled Accountable Care Organisation deployment and learning”)

Campaigners find this terrifying (3) – and not just because of the amount of management gobbledegook. But NHS bodies and the Labour council have welcomed it with open arms. Why?

> "ACO pacts like the one that Advocate has just signed with Blue Cross look like the proverbial game-changer on payments that health plans have been looking for. Instead of seeing large provider groups expand and simply demand higher payments for fee-for-service unit costs, leveraging their size for bigger payment deals, providers and payers together can focus on reining in the cost of care and sharing the rewards."

As far as we are concerned the confluence of devolution, Vanguard and US corporations - all enthusistically welcomed by local Labour councils - and the existing presence of intruders like Virgin Care is a formula for the further dismantling of the NHS and the entry of corporations and insurance companies.

Notes

1) Here is that list of questions to the leader of the Labour council, amended and augmented but the originals still unanswered:

- What public consultation took place - not just about the notion of integrated health and social care (which can seem uncontentious), but about this particular model AND the specific partners who were awarded the contract?
- Why was it necessary to initiate this new project – when what seems to be a similar model was already being developed as part of the Vision 2018 strategy?
- How much is the budget?
- How much of the budget will be paid to the external partners?
- How much will be spent on trips to or from the USA?
- Who are the "GPs [who] have been engaged and have expressed strong commitment to advance their current work in integrated care by developing and implementing this plan."?
- Cerner does have a long standing relationship with Wirral University Hospital NHS Foundation Trust, but was any thought given to previous controversy including http://ukcampaign4change.com/2013/09/26/hospital-chiefs-plan-high-risk-go-live-in-secret/ and the overstatement of the benefits of technology?
- Why has Wirral granted major US and/or US-owned corporations enhanced entry to our local health services - especially one representing the ACO model? Surely this and "testing of a capitated budget approach" are the logical precursors to a health insurance scheme?
- Suspicion grows with the involvement of the King's Fund and its advocacy of Simon Stevens' approaches to health funding. See for example: http://joh.sagepub.com/content/42/3/539.full.pdf+html
- What can we expect, noting analysis of what's proposed for Manchester, about the direction of our health and social care services http://t.co/hEpwk4OvBe? How do local initiatives like this contribute to a national health service? Wirral obviously has problems as detailed so well by the JSNA, but the involvement of US corporations will make many patients nervous about the approach to solving them.
- Just what could local professionals and patients and genuine community organisations not achieve, which requires this new approach?

2) Local partners are:

· Wirral University Hospital NHS Foundation Trust ("cornerstone partner in the delivery of home facing specialist acute care")

· Cheshire and Wirral Partnership NHS Foundation Trust ("cornerstone partner in the delivery of integrated mental health services")

· Wirral Community NHS Trust ("cornerstone partner in the delivery of integrated community services")

· Wirral Clinical Commissioning Group ("cornerstone partner in the delivery of reformed commissioning, contracting and payment models and GP member lead organisation")

· GPs on the Wirral who "are currently represented through a set of collaborative consortia. In the development of this bid a number of GPs have been engaged and have expressed strong commitment to advance their current work in integrated care by developing and implementing this plan."

· Wirral Metropolitan Borough Council ("cornerstone partner in the delivery of integrated social care services and reformed commissioning, contracting and payment models").

3) Why is this terrifying? To quote from the project bid:

"The application also leverages the existing partnership arrangements Cerner have with Advocate Physician Partners (APP) who will provide their ten year experience of bringing together more than 4,500 physicians from primary and secondary care backgrounds who are committed to improving health care quality, safety and outcomes for patients across Chicago and Central Illinois. Formed as PACS-style care management alliance between independent GPs and Advocate Health Care hospital system, APP is a leader in population health management and has garnered wide-spread international recognition for its innovative clinical integration program. The comprehensive approach coordinates patient care across the continuum—ensuring care is delivered at the right place and at the right time. This results in more efficiency, improved health outcomes and significant cost savings for patients. We will seek learnings [sic] and advisory support for successfully setting up and managing our new care models."

"Our model will catalyse a new model of integrated care on that is already being piloted through our 'Vision 2018' health economy collaboration programme, supported by a technology enabled population health model. It will entail testing of a capitated [sic] budget approach for target population segments across primary and acute care, but with support from mental health and community providers. This will have the dual focus of reducing health inequalities while achieving costs savings through [sic] and reduced inefficiency and duplication."

Conflict of interest issue
Simon Stevens' previous employment by United Health
Steven Carne 999 Call for the NHS

I'm sure most of us in this room know who Simon Stevens is and have feelings about his position as Chief Executive of NHS England. For the majority of the general public, and NHS Staff because they are too busy looking after patients and are not informed from above, Simon Stevens is an unknown entity.

In 2014, Gail Cartmail, Assistant General Secretary of Unite, said that Simon Stevens,

> "despite his low profile is possibly the most important person in England."

I leave that with you. But as far as I and my colleagues at 999 Call for the NHS are concerned - given all that has been highlighted here by so many voices from around the country - Simon Stevens is possibly the most dangerous man in the NHS.

In tracing his history it is interesting to note the relevance of recent events and developments in NHS England. He began his career in the North East - in Northumberland he was General Manager of Mental Health; his hometurf has recently become the first victim of Vanguard completion.

There is little point in tracing his full CV tonight but it is worth noting that recently at a UK Health Conference, held before his employment as CEO of NHS England, his biography read:

> *"Simon Stevens' responsibilities include leading United Health's strategy for, and engagement with, national health reform, ensuring its businesses are positioned for changes in the market and regulatory environment".*

This could almost perfectly describe Simon Stevens activity since becoming Chief Executive of NHS England.

Unite the Union has called for a full investigation into Simon Stevens' ability to manage our public health service, given that his main driving skills in reform have been developed in the USA's profit-driven health insurance model of health provision.

Through its position as a potential lead provider of privatised Commissioning Support Units from April 2016, United Health's subsidiary Optum will play a major role in managing and forming strategy for our Public Health Service. So is there not now a case to ask :

> *"Is Simon Stevens able to make decisions the best interests of a public health service, with so many attachments to one of the world's largest global health corporations?"*

In 2014 Simon Stevens was welcomed by all parties, including the Labour Party. Now in 2016 can the Labour Party, given the evidence presented tonight, still support the current Chief Executive of NHS England?

And when talking to the public, we have to ask the question:

> *"Why is an expert in private health insurance and profit-driven medical care the boss of our public National Health Service?"*

5 Year Forward View
Deborah Harrington 999 Call for the NHS

Simon Stevens' 5 Year Forward View (5YFV) is the machine which is driving all the changes. We are seeing across the country 'new models of care' and 'new models of working'. Where campaign groups' statements have referred to down-banding of staff, having to travel 25 miles to your nearest A&E, losing consultant led midwife units, seeing essential mental health units closing down – this is part and parcel of the 5YFV.

The themes that you find in the full 5YFV document are the same as the ones Jeremy Hunt constantly refers to – the 24/7 NHS and a constant exhortation to change if the NHS is to remain 'sustainable'.

Part of Jeremy Hunt's response is that it is not sustainable to stay as we are in the face of the huge financial challenge the service faces. But that financial challenge is the result of the so-called funding gap – the difference between what the service needs to function properly and what it has been given. That gap is the result of the NHS being consistently underfunded since 2010. It needs roughly 3.8% a year and is getting less than 1% a year. This is catastrophic considering that we do indeed have a growing population and therefore increased health needs – but the resources to cope have been removed.

The 5YFV says there is a health and wellbeing gap, a care and quality gap and a funding and efficiency gap which have to be dealt with.

The health and wellbeing gap is about issues that have been raised such as care in the community and bed discharges being held up because there is nowhere safe to go. The model is supposed to be that we are all going to look after our health better, we are not going to be obese, we are not going to have diabetes, we are not going to have heart attacks because we are all going to eat more healthily and live better!

The 'new models of care', that are removing the care that people need, are happening now – but our health hasn't improved yet. Public health strategies aren't new but they have had their funding cut. How can we be serious about prevention, serious about health strategies when a huge amount of the resources needed to actually make that happen have been removed?

The 5YFV says we need to:

> *'match the funding with wide ranging and sometimes controversial system efficiencies'.*

When the chair of the Clinical Commissioning Group in Walthamstow was asked how GP practices are going to cope with a 30% decrease in GP numbers he replied that 30% of the people don't need to see a GP anyway. Gaps can be filled with the U.S. style physician assistants or nurse practitioners. He also wants to see an increase in the number of volunteers in the community. A whole range of things will be brought in which are about de-skilling, de-funding, de-professionalising, reducing services and these are the 'new models of working'.

That's the new NHS that the 5 Year Forward View is creating.

Whistle blowing, doctor-patient relationship & New Public Management

Dr Bob Gill, Save our Hospitals South East London

I am Dr Bob Gill. I have been a doctor in the NHS for over 22 years. There has been a lot of interesting detail presented here today but we need to ask ourselves:

How has so much damage to the NHS been done with so little public awareness?

A transformation of the NHS over the past 20 to 30 years, carried out by all main political parties, has repurposed the NHS from a service to provide healthcare for the public into something like a corporate model. The small medical leadership has been hollowed out and replaced by a bloated, corrupt management structure which keeps control of bad information and keeps control on people who dare to reveal this information. This was devised and is known as New Public Management and is a key instrument of destroying all public services - not just the NHS.

What used to be the case was that doctors' and patients' interests were aligned. If the patient got better you had no financial incentive to make sure that didn't happen; but now the alignment is being skewed.

Conflicts are being introduced as a routine consequence of mushrooming targets, and the target culture which enjoyed a free run for 13 years under the New Labour government.

This causes perversion of behaviour, endemic gaming of statistics: I know in Brighton targets are being fraudulently achieved, people are being put under so much pressure that they lie.

I had junior colleagues report to me that they are coming under immense pressure to do the wrong thing. A paediatric registrar was resuscitating a young child close to the point of death. He was told to leave that child because somebody down the road was going to breach the 4 hour target.

These are the sort of cases that are happening and are happening now.

In general practice we have had Quality and Outcomes Framework (QOF), Health Checks and Dementia screening.

QOF target payments encourage overmedicalisation and prescribing. The GP faces financial loss if they chose not to comply. As an example: treating elderly diabetic patients to strict targets puts them at risk of hypoglycaemia and falls. Reaching the target will harm some patients.

Conflicts arise such that a GP undertakes dementia screening to get paid £50, although the screening has no clinical value and may stigmatise patients.

A lot of this is not evidence based. What are we doing it for? Particularly when money for useful activity is not available?

In effect, GPs are being paid to data mine for the private insurance industry. Your premiums will be decided on the information I have collected on your behalf. In order to maintain surgery finances that's what I have to do.

Coming closer to home there's a case now that is becoming public of a Dr Chris Day who worked for Lewisham and Greenwich Trust who when he went to his annual review of performance made a protected disclosure and found his career ruined, because that's how the NHS keeps a lid on bad patient experience and significant damage.

What we have got to look forward to now is the further privatisation of Commissioning Support. It's bad enough to get information out with public scrutiny - but once more and more work is hidden behind commercial confidentiality, the game will be over.

South East London NHS issues - mostly arising from imposition of 5 Year Forward View

Frances Hook, Greenwich KONP

Lewisham & Greenwich NHS Trust is working towards being a Foundation Trust. What is the Shadow Health Secretary's opinion on this?

What is her view of "Our Healthier SE London" - part of Simon Stevens' national 5YFV - and of the Pan London devolution plan for Health ?

The document for the Our Healthier South East London (OHSEL) plan had a 2011 graph, showing that of 11 comparably wealthy OECD countries, the UK's NHS came out top- so why change the NHS?

But the OHSEL document highlighted that we were the 10th out of 11th as the most unhealthy living, Why mislead the SE London population?

The graph also showed the US health care system came 11th out of the OECD countries - so why does the 5 Year Forward View want the NHS to adopt its "care models" and workforce make up and practices?

We also asked the Shadow Health Secretary what her position was on 'Personal Health Budgets'.

Heidi Alexander MP gave no answers to our questions.

Notes

A 2103 report from the US National Research Council and the US Institute of Medicine, U.S. Health in International Perspective: Shorter Lives, Poorer Health, found that US citizens' health and life expectancy were poor compared to other similarly wealthy countries.

The report noted that the U.S. has a large uninsured population compared to other countries with comparable economies, and more limited access to primary care. This is disturbing, given the adoption of US primary care models in the NHS, as proposed in Simon Stevens' 5 Year Forward View and currently being imposed in NW London, Hartlepool and North Tees, Dewsbury & Wakefield, Calderdale & Kirklees, and the Wirral - as reported in campaigners' testimonies at this meeting.

Here is the link to the downloadable (PDF) report, US Health in International Perspective: Shorter Lives, Poorer Health:http://www.nap.edu/catalog/13497/us-health-in-international-perspective-shorter-lives-poorer-health

Private Finance Initiative (PFI)
Joan Stewart, Oxford Keep Our NHS Public

We have heard from colleagues here today - from all over the country - about abuse of the NHS.

I want to focus on another abuse. That of PFI - and its equally toxic offspring - PF2. Both are scandalous abuses of public money. Money that is ending up in tax havens. Money that is not being invested in the NHS, but is being diverted from where, as we have already heard, it is sorely needed.

There are £11.6 billion's worth of PFI NHS schemes in England, which will cost us £80bn over the life time of their contracts, and averaging 7 times their capital costs. Of the many eye-watering figures that caught my attention, one startling set is for a PFI project at Newham University Hospital that had an initial capital value of £35m, which in 2013 had already made £131m in repayments, and still has another £606m to go. Let's remember what the initial capital value for this project was: £35m. And the total cost will be: £737m. Yes, £737m - amounting to a final total repayment that is 21 times the initial capital value! And this is just one of many such schemes (scams!).

Some trusts are having to fork out a far higher share of their budget on these extortionate schemes. For example, Sherwood Forest NHS Foundation Trust is having to allocate 16% of its revenue on PFI repayments for a project that had a capital value of £326 million, but which will eventually have cost it £2.4 billion. Other distressed trusts are also appealing for a government subsidy to ease their deficits.

Currently, unitary charge payments for PFI projects amount to 2% of NHS spending, some £2bn. Not surprisingly, two thirds of A&E closures are in PFI trusts and 10 out of 15 NHS hospitals with the worst deficits have PFI deals. Deficits that are contributing hugely to the record £2bn-plus deficit that trusts are forecast to run up.

So, it is clear that PFI/PF2 is forcing inflated charges and unaffordable financial burdens on the NHS. The results of which are: savage cuts in services, severe losses in front-line staff, and the selling-off of valuable assets. Ultimately, all adversely affecting patient care.

Questions:

- Will Labour accept the evidence that PFI/PF2 hospital projects are appalling value for taxpayers' money, are unaffordable and unsustainable, command excessive interest rates and inflated service charges for private investors, and are contributing to the impoverishment of the NHS?
- What steps will Labour take to secure a fair deal for those NHS trusts already burdened by unaffordable PFI/PF2 debts?
- Will Labour now strongly oppose this toxic form of financing new NHS hospitals?

Glossary of terms and key organisations

A&E - The Health and Social Care Information Centre defines 3 types of Accident & Emergency departments:

- Type 1 is major A&E for life threatening illnesses and accidents - the blue light A&E.
- Type 2 is single speciality major A&E eg Moorfields A&E for eyes
- Type 3 covers a range of services, which can be doctor-led or nurse-led. A defining basic characteristic of a Type 3 department is that it treats minor injuries and illnesses (sprains for example) and that it can be accessed without appointments.

Accountable Care Organisation (ACO) - Also known as a Health Maintenance Organisation, this is an American form of health company that provides managed care (ie care that follows set protocols and pathways) for a private health insurance company. Health Maintenance Organisations (HMOs) were promoted by President Nixon through the HMO Act of 1973, before he resigned in 1974 to escape impeachment for obstruction of justice, abuse of power, and contempt of Congress. John Ehrlichman – later imprisoned for his role in the Watergate scandal – persuaded Nixon that HMOs were the future for American healthcare on the grounds that:

"All the incentives are toward less medical care, because the less care they give them, the more money they make."

ACOs are now being set up to run Vanguard schemes (see *VANGUARD*). Clinical Commissioning Groups describe ACOs as a "new provider form" that will lead Alliance contracts - ie contracts that are held by a Lead Provider, which subcontracts bits out to other "providers" both statutory and third sector. CCGs are calling this NCMs - New Contractual Models.

Alternative Provider Medical Services (APMS) *contract* - a GP contract introduced by the New Labour government to open up GP services to private health companies. It is time-limited, "flexible" about terms and conditions for GPs and other clinical staff and doesn't need to be held by GPs.

British Medical Association (BMA) - The doctors' trade union

Care Quality Commission - A bone of contention for many clinicians, the Care Quality Commission was set up in 2009 to monitor the quality of NHS services. According to Professor Of Public Health, Alysson Pollock, this "stripped out public accountability for the NHS," by moving it to arms-length, market-based inspection and enforcement under both the new Care Quality Commission and Monitor – the economic regulator for the newly-marketised NHS. Until New Labour's meddling, the NHS was directly accountable to the public, since it was under the direct control of the government.

Clinical Commissioning Group (CCG) - Set up by the 2012 Health and Social Care Act, Clinical Commissioning Groups replaced Primary Care Trusts. They plan and buy NHS services for their local authority area and are required to do this according to EU competition law, ie under "market" rules. A key difference between them and Primary Care Trusts is they do not have the same obligation to treat all patients in their geographical area. New secondary legislation ('section 75 regulations') which went through parliament in April 2013, gave statutory powers to Monitor to force Clinical Commissioning Groups to use competition (ie, outsourcing or opening services up to bids from private providers), regardless of considerations of public wishes and with scant regard to quality, compared to price. The regulations appear to breach earlier parliamentary assurances that CCGs would not have to use competition.

Community Services - are NHS services that are provided in people's homes and out of hospital. They include things like district nursing, health visiting, home-based rehabilitation programmes, NHS walk-in centres, specialist diabetes services, educational nutrition and dietetics sessions, school nursing, therapies like physiotherapy, podiatry, speech and language therapy and palliative care.

Curo Health Ltd - is a GP Federation in North Kirklees, West Yorkshire. It was registered with Companies House in January 2014 as a private company limited by shares. Its shareholders are GPs from the 29 GP practices that are also members of the North Kirklees Clinical Commissioning Group Governing Body. In 2014, North Kirklees Clinical Commissioning Group approved Curo Health's request for £0.51m to set up and run a pilot project starting in October 2014, initially for a year, but with a view to running for 3 years, to trial the Care Closer to Home system for over 75 year olds.

Darzi Centre - (aka Independent Sector Treatment Centre). Lord Darzi, a professor of surgery, was brought into the Department of Health by the Brown government in order to advise on " big investment opportunities opening up in primary health care". (Leys & Player, The Plot Against the NHS).

Darzi recommended taking key aspects of secondary care – eg diagnostics, day surgery and management of chronic illnesses – out of NHS hospitals into new GP-led health centres which could be run by for-profit providers, under a new kind of primary care contract – the 'Alternative Provider Medical Services' (APMS) contract (see above). Darzi clinics contracted with private health companies on very expensive terms, to carry out high volume, low complexity, planned care/elective treatments.

Leys and Palmer (p48) report that on average, the Darzi Centres received three times more payment per patient from Primary Care Trusts (PCTs) than ordinary GP practices:

> "PCTs found that they were paying up to £300,000 a year in running costs for some centres which had hardly any patients."
>
> "What was really in prospect was corporate control of both primary care and a large part of existing NHS secondary care…" Leys and Player(p 45)

An investigation in July 2011 showed that one in four Darzi Centres had registered fewer than 500 patients. A Southampton GP, Dr John Glasspool, found via a Freedom of Information request that a Southampton Darzi Centre had registered just 1,220 patients, despite receiving £907,000 in 2011/2. It meant the centre received around £743 per patient per year – more than seven times the average funding for a GP practice.

The Darzi clinics scheme quickly fell through because it was such a costly privatisation rip off and provided such poor health care. By 2011, the Primary Care magazine Pulse was reporting:

> "PCTs have begun paying out undisclosed figures in compensation for the early termination of Darzi centre contracts, as more centres across England close their doors due to financial pressures…
> The investigation shows the centres – rolled out in every PCT under the directive of former Labour health minister Lord Ara Darzi – but branded expensive white elephants by GP leaders – are increasingly being targeted for closure as cash-strapped PCTs try to bring their finances under control.
> Of 68 PCTs to provide information to Pulse on the contractual status of their Darzi centre, more than one in eight (13%) have either terminated their contract or are planning to imminently, with many others renegotiating deals for financial reasons…"

The Vanguard schemes (see below) and NHS England's Five Year Forward View (also see below) aim to resurrect Darzi centres under other names.

Emergency Centre - This is a term now used for an A&E department that provides a full range of acute and emergency care for people with life threatening illnesses and accidents.

Deregulation Act - This new Act apparently requires that business should be promoted as a priority over health - although lawyers are still checking out exactly what the Deregulation Act means, since the Tories slid in new measures without going through the Parliamentary scrutiny process.

Devolution Bill - George Osborne's Cities and Local Government Devolution Bill promises "radical devolution", but this isn't so much what most people understand by the term, but rather what George Osborne wants it to mean: a recipe for continued Westminster control of everything that matters to it, and a mechanism for blaming local government when it can't cope on the limited budgets that central government proposes to devolve to combined authorities.

Behind closed doors and with no democratic discussion or decision, some combined authorities such as Greater Manchester have decided to take on devolved authority for the NHS. They have gained control over the entire annual budget for NHS and social care funding for their region, in order to trial cost-cutting models of care. (See Five Year Forward View, below.)

This NHS "DevoManc" was a deal cooked up between George Osborne and and an unelected Council chief exec, together with the Leader of Manchester City Council. A deal that was signed and sealed behind closed doors, without any public mandate.

It aims to make "transformational changes" to the NHS in Greater Manchester – but without the public consultation that is legally required when there are proposals for significant changes to the NHS in an area.

Greater Manchester (GM) is in the middle of a huge, controversial upheaval to its NHS and social care, along the same lines as the shake ups outlined in the Testimonies on NHS cuts and sell offs (See p6-29, above.) 4 to 5 GM hospitals are to lose their A&Es or other acute services, while both NHS and social care funding has been cut through so-called NHS “efficiency savings” and cuts to local authority funding.

Devolving responsibility for NHS funding and decision making to the GM Combined Authority and the GM NHS organisations means that they – not the Department of Health and the rest of central government – will have to deal with this mess. How convenient for George Osborne. Or whoever replaces him.

Under the Devolution Bill, the Communities Secretary can force a combined authority to adopt an elected mayor and remove a dissenting council from its jurisdiction. And it’s for the Communities Secretary, not local councillors, to determine the length of a mayor’s term of office and when the elections should be held. More info here https://www.opendemocracy.net/laird-ryan/truth-behind-osborne's-devolution-revolution#

The Devolution Bill just shifts control over a region’s budget from a remote government in London to a remote individual – an elected mayor covering the whole of a combined authority area.

Dr Foster Intelligence - A health service data company co-founded by Tim Kelsey (who went on to become National Director for Patients and Information in the NHS), Dr Foster’s NHS data have been subject to considerable criticism, particularly its calculation of hospital death rates.   Info here: http://www.lrb.co.uk/v35/n07/paul-taylor/rigging-the-death-rate

An Open Democracy article raised the question:

> *“If commercialised data jeopardises hospitals futures, do skewed stats become big business?”*

If skewed, commercialised data are used to name and shame hospitals for under-performing, could this lead to public dissatisfaction with NHS hospitals and an exodus of people with money for private insurance and good enough health to qualify for private insurance, to the private healthcare sector?

Dr Foster Intelligence became a joint venture with the Department of Health in a £12m secret deal criticised by the National Audit Office in a 2006 report.

Of the £12m that the Department of Health shelled out, £7.6m was paid directly to Dr Foster LLP   and the rest used for working capital for the joint venture, Dr Foster Intelligence. The Department of Health set up the joint venture without any competitive tendering.

This meant that the deal could have been open to legal challenge - info here: http://www.theregister.co.uk/2007/02/06/nao_criticises_doh/

Five Year Forward View (5YFV) - NHS England's 5 year Plan 2015-2020 is Simon Steven's blueprint for another major top-down NHS reorganisation to deal with a projected £22bn funding shortage by 2020. It aims to cut costs by introducing 'new models of care' and a 'modern workforce' - both based on US private health insurance systems. Where campaign groups' statements have referred to down-banding of staff, having to travel 25 miles to your nearest A&E, losing consultant led maternity units, seeing essential mental health units closing down – this is part and parcel of the 5YFV.

Foundation Trust - Public Health Professor Allysson Pollock explains that Foundation Trusts are:

> *"…a halfway house to privatisation. Foundation trusts have powers to generate up to half their income privately, and can use half their beds and staff for that purpose. They can enter joint ventures with shareholders and corporations, and sell land and buildings and lease them back. In short, they have the power to redesign NHS services for the private sector, or franchise them to big business."*

Until the New Labour government set up NHS Foundation Trusts in 2004, hospital managers had reported to the Secretary of State. In turn, the Secretary of State was accountable to Parliament, so MPs could ask questions about their local hospitals. But once NHS Foundation Trusts were set up, hospitals were no longer accountable to NHS management structures, or to the Secretary of State.

Before NHS Foundation Trusts were set up, NHS trusts (see below, Trusts) that ran hospitals, mental health, community or ambulance services held their board meetings in public, published board papers and had an obligation to consult on major changes. But NHS Foundation Trusts are run as businesses ('independent Public Benefit Corporations'). Their boards are free to meet in secret, can choose not to publish their board papers and can take big decisions without reference to anyone except Monitor, the national healthcare market regulator. (Info source: NHS SOS, p 26)

The result is that our hospitals and primary care health services (GPs, opticians etc) are now run by secretive NHS Foundation Trusts with no democratic accountability.

All foundation trusts are now licensed by Monitor (the NHS "market" regulator - kind of like Ofgem for the NHS) and this is the main tool it uses to regulate them. The licence incorporates a set of conditions covering financial viability and governance as well as other areas reflecting Monitor's expanded role within the health sector.

Foundation Trust status is a blank cheque for rip off Private Finance Initiative (PFI) schemes (see below, Private Finance Initiative).

Golden Hour - the hour following the onset of a life threatening accident or trauma when there is the greatest likelihood of recovery if appropriate emergency care can be administered.

GP Federation - a company set up by member GP practices, often billed as being a way to respond to the problems the Health and Social Care Act 2012 has caused them and to be able to bid for contracts - which are tendered by the Clinical Commissioning Groups with Governing Bodies made up of GPs from the GP Federation, creating obvious potential conflicts of interest.

Health & Social Care Act 2012 - a massive top down NHS and social care reorganisation with a stealth-privatising agenda, this Act was passed by the Coalition Government with no democratic mandate whatsoever, since it was not in any party's 2010 election manifesto. The 2012 Health & Social Care Act also broke David Cameron's pre-election promise that there would be no top down reorganisation of the NHS under a government led by him. It was the legislative equivalent of a hand-grenade tossed into NHS administrative structures.

The Health and Social Care Act removed the duty of the Secretary of State for Health to provide comprehensive, universal healthcare that is free at the point of need – meaning that the NHS buck no longer stops with the Secretary of State, who has to answer to MPs, and so to the public.

> "…the Health and Social Care Act guarantees that almost every decision on the development and configuration of services is now being taken without any regard to the views of local people, or even in the teeth of popular opposition…with only sketchy, tokenistic attempts to address local concerns over the closure of hospitals and A&Es." (NHS SOS, p 25)

Dr Louise Irvine, chair of Save Lewisham Hospital Campaign, has estimated that the administrative costs of managing the full-blown competitive provider market unleashed by the Health and Social Care Act could rise to over 20% of the NHS budget for England. That would mean that over £15 billion a year would be spent on managing the market – money that has had to be found in addition to the £20 billion over 4 years so-called efficiency savings from 2011-2015.

Health & Wellbeing Board (HWB) - Health & Wellbeing Boards were set up in every local authority from April 2013. They have duties in relation to public health and some (limited) opportunity to influence the decisions of the local clinical commissioning group. (See above, Clinical Commissioning Group.) They also may commission (ie, buy) some health services in their own right, especially where health and social care overlap, or in relation to 'wellbeing' and health advice. They set the 'Health & Wellbeing Strategy' priorities for the health of the local population. This strategy is supposed to guide the plans of the local Clinical Commissioning Group and Health & Wellbeing Boards can in theory challenge and slow down the CCG's plans if they breach the Strategy.

HWBs are to encourage (or even take responsibility for) joint commissioning (joint buying of services by councils and the NHS), and to ensure that all health & social care providers in an area work in an "integrated" manner. (See below, Integrated Care.)Whilst this sounds sensible, and certainly more linked-up working between different parts of the NHS is desirable, it is important for campaigners to make sure that 'integration' (particularly between health and social care) and 'innovation' strengthens, rather than waters down, NHS principles (paid for from universal taxation, non-means tested, publicly run for patients not profit).

Also be aware that councils are under pressure to outsource to the private sector all the services they buy - this trend is accelerating.

Healthwatch - another organisation set up by the 2012 Health and Social Care Act. There is a local Healthwatch for each area covered by a single Clinical Commissioning Group. They are supposed to be the public's "watchdog" for NHS services but they are not allowed to criticise government health policies so they are a bit of a toothless watchdog. They can 'enter and view' NHS organisations like GP practices and hospital wards and this can be useful particularly in countering sensationalist media misrepresentations of what's going on in local NHS services - if the local Healthwatch is so minded.

Integrated Care - You'd think integrated care would simply mean finding ways to link up all the different services patients need https://www.gov.uk/guidance/enabling-integrated-care-in-the-nhs - but it seems there may well be a hidden agenda here.

There is a dearth of evidence for the efficacy of integrated care, and there are anxieties that - given huge central government funding cuts to Local Authorities' social care budgets - the integration of health and social care will mean the plundering of already inadequate NHS budgets to prop up local government services. This is what's happening as a result of the Better Care Fund - the main current vehicle for integrating NHS, social care and other public services.

Social care has been plagued for decades by cuts, outsourcing and piecemeal privatisation of services, leaving many staff on zero hour contracts and service users with 15 minutes sessions of care.
The danger is that under local authority rules, integrated health and social care will mean that there will be means-tested charges for services rather than the NHS principle of services funded from general taxation.

The outcome may be a deregulated, local service – partly privatised, its social care component already 90% privatised – facing a meltdown in local authority finance, competing with other localities for patients and funds, with local pay and conditions for health workers, and all branded as "integrated".

Lack of evidence for the efficacy of integrated care is outlined in various reports:

> *"Current policy is aimed at cutting the number of emergency admissions by providing more, better services outside hospital that can either prevent the need for hospital admission or offer the same care but in different settings. This is a common theme in initiatives for more integrated services, including the government's Better Care Fund. But there is little evidence that this can be achieved."* (Bardsley and others, 2013, cited in a Nuffield Trust briefing (NHS hospitals under pressure: trends in acute activity up to 2022), (p11)

A 2014 Health Service Journal review of the evidence for promoting "integrated care" out of hospital found that:

> *"a close look at the data highlights a dearth of evidence on the impact of integrated care".*

And, reporting on its Commission on Hospital Care for Frail Older People, the Health Service Journal (November 2014) stated:

> "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."

Intelligent Monitoring Report - a report on an NHS organisation by the Care Quality Commission. (See above, Care Quality Commission.) So-called "intelligent monitoring" uses various kinds of statistical analyses to judge the risk that an NHS service may be of poor quality, and to then carry out an inspection and produce a report. The CQC was attacked in 2015 after a whistleblower said it had handed the £1.2 million contract for developing its 'risk based intelligence' approach to prioritising inspections to consultancy firm McKinsey & Co without proper tendering.

NHS England (NHSE) - also known as the NHS Commissioning Board, is a government quango reponsible for commissioning (planning and buying) specialist NHS services in England, according to EU competition law, ie treating the NHS as a market. It was set up under the 2012 Health and Social Care Act. It has a big responsibility for planning NHS services including setting the framework for those that Clinical Commissioning Groups are nominally responsible for planning and buying. Its 5 Year Forward View (2105-2020) is the blueprint for its plans for both specialist and locally-commissioned NHS services (see above)

Private Finance Initiative (PFI) - is a way for corporations to build and run our schools, hospitals, roads and prisons, and rent them to the state. Introduced in the UK by the Tory government under John Major, the claim was that this would enable costs to be cut, while ensuring that public services remained free of charge. After initially disfavouring the scheme while in opposition, two months after the Labour party took office in 1997 the health secretary, Alan Milburn, announced that "when there is a limited amount of public-sector capital available, as there is, it's PFI or bust". From then on, the only money the NHS could rely on for capital projects belonged to the private sector.

NHS Foundation Trust status is a blank cheque for rip off Private Finance Initiative (PFI) schemes that are bleeding the NHS dry. Legislation that makes a Foundation Trust (FT) "irreversible according to the law" serves as a cunning wheeze to take taxpayers' money out of the NHS and into the pockets of vulture funds and tax-avoiding private companies who are bloating themselves on PFI rip offs.

This is how it works. If a FT hospital fails to generate enough income it can be closed, no matter that the public needs it – unless it is a PFI hospital, in which case it will be protected by special measures. These include closing down non - FT hospitals and transferring their services to Foundation Trust Hospitals, which then suck up all the income that comes from delivering those services.

The government is desperate to do this because the Department of Health expects to have to bail out trusts that are unable to repay their PFI repayments over the remaining life of their contracts. The situation is a massive mess, as the House of Commons Committee of Public Accounts reported in 2012-13.

As a result the government is trying to close non-FT hospital and services. Even in 2011-12, when overall, the NHS was performing under budget – returning £2.1bn to the Treasury - the government tried (unsuccessfully) to cut A&E, acute maternity and paediatric services at the successful and much-loved Lewisham Hospital – against massive public opposition, in order to transfer its services to and fund the South London Hospital Trust. This Trust, writes Prof Pollock, includes:

> *"six hungry PFI schemes. PFI currently consumes more than 16% of its income, compared to capital charges of 4% before PFI."*

South London Hospital Trust is one of two London Foundation Trusts which between them have a deficit of over £115m, and the government placed it in special administration in 2012.

Increasingly this pattern of sacrificing non-PFI hospitals to protect bankers' PFI equity and profits is being reproduced across the country - as many of the Testimonies on NHS cuts and sell offs show.

Purchaser/Provider split - the Thatcher government started to turn the NHS into a market system, through creating an "internal market" by splitting the NHS into "purchasers" and "providers".

Third Sector Organisation - a term used to describe the range of organisations that are neither public sector nor straightforwardly private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives. Many corporations have created subsidiary groups and registered them as 3rd Sector Organisations - eg non-profit charities which does raise tax evasion issues. Some charities have also grown financially as they take on a more managerial provider role - MacMillan, Age UK, Altzheimers Society, Diabetes UK, Cancer Research.

Trust - A National Health Service trust is an organisation within the English NHS generally serving either a geographical area or a specialised function - such as an ambulance service. In any particular location there may be several trusts involved in the different aspects of healthcare for a resident. Trusts were established under the National Health Service and Community Care Act 1990 . Confusingly, they're not Trusts in the legal sense, but a type of public sector corporation.

TUPE - Transfer of Undertakings, Protection of Employment: when people's employment is transferred to another company following a merger, outsourcing, privatisation or takeover. Some employment rights are protected but for very short time and often protection is minimal.

Unitary Charge Payments - are the annual payments PFI hospitals must make to the PFI companies that own the hospital and provide its hugely costly housekeeping and maintenance services. This “unitary charge” is made up of:

- Interest on the debt
- Repayment of the debt
- Service charge (housekeeping and maintenance services)

Vanguard - a bunch of schemes across the country that are being given extra funding from NHS England to accelerate the implementation of NHS England's Five Year Forward View. Vanguard schemes are fast-tracking the alignment of their local NHS organisations with American private health insurance company care models, working practices and contracting methods. This involves a merger of the NHS with Local Authorities' means-tested, privatised social care and leisure services, and co-locations and collaborative working with job centres - for instance GPs coaching patients to get them back to work - and other government agencies.

TESTIMONY

THE DESTRUCTION OF THE NHS