HEALTH EMERGENCY

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Jess Hurd: reportdigital.co.uk

Fight back for NHS - before it's gone!

By April this year, the NHS we have known will have been swept away by the Tory Health & Social Care Act. Local and relatively accountable public bodies – Primary Care Trusts and Strategic Health Authorities – will have been scrapped.

In their place will be a new, experimental system which claims to put GPs in charge through 'Clinical Commissioning Groups', but in fact hands local control over to private management consultants and a new, bureaucratic NHS Commissioning Board.

Planning is to be replaced by a competitive market. Existing NHS hospitals and services will increasingly be cut back to make room for new private sector providers that depend upon NHS contracts. These companies will pick and choose which services they see as profitable, and leave the rest – emergencies, complex cases, chronic illness, most mental health – to what's left of the public sector.

The new CCGs will be dominated by government demands for £20 billion "cost savings" by 2015: they will not be so much commissioners as rationers of care, deciding only which hospitals and services to close, which treatments and drugs to exclude, which patients should be treated as second class.

One area they will not be encouraged to cut is spending on Private Finance Initiative contracts that are milking billions from the NHS in over-priced deals for new hospitals. It's clear that while everything else is cut, PFI is being left intact whatever the cost, with generous subsidies to satisfy private shareholders.

We already know NHS managers' response is to press for more cuts in hospital care: the New Year message from Mike Farrar, chief executive of the NHS Confederation warns politicians not to support local campaigns to stop hospital closures.

Hospitals under pressure

But despite all the so-called think tanks and desperate NHS managers like Mr Farrar arguing for closures of A&E units, beds and whole hospitals, official figures show serious pressures on existing services.

Since 2001, A&E attendances in England have increased by 60%, and routine hospital admissions and emergency admissions by 35%. In London emergency admissions are up by 51% and routine admissions by 60%. **Yet numbers of general and acute beds have been cut by 22%, with more cuts to come.**

Reports from the Dr Foster and the King's Fund have warned that hospitals are "full to bursting" and that 2013 might mark the turning point as spending cuts leave inadequate capacity.

Plans to "reconfigure," "centralise" or "downsize" hospitals rest on vague promises of community services for which no plans or resources exist, and wildly over-optimistic and unproven assumptions. There is no actual evidence these policies might work.

Nor will any NHS cash savings be reinvested in health care: instead we have seen the first £3 billion snatched back by George Osborne and the Treasury … to spend on tax cuts for the rich and big business.

So 2013 is a testing year. As people have found in Lewisham, where a local hospital faces fast-track closure, we have to fight for services if we want to keep them . We also have to challenge privatisation and the carve up of the NHS budget by grasping private firms.

We can't guarantee any of these fights will succeed: but we can be sure that if we do nothing we will see our NHS broken up, with some services closed down and others parcelled out to profiteers.

Nye Bevan said in 1948 that the NHS would live for as long as there were people ready to fight for it. 2013 is the time for everyone to respond to that call.

INSIDE

London fights back

Furious local campaigners have been hitting the streets and piling pressure on local politicians across London, with A&E services, beds, services and staff under threat in a series of cost cutting plans.

In South East London the attack has been swift and sudden, flowing from the decision of Health Secretary Jeremy Hunt to invoke the draconian "unsustainable provider regime" set up by Labour.

The first guinea pig in this experiment is the chronically indebted South London Healthcare Trust, which has been dragged into crisis by two unaffordable PFI contracts, for Queen Elizabeth Hospital in Woolwich and Princess Royal University Hospital in Orpington.

The Trust Special Administrator, appointed in July, swiftly drew up a brutal package of proposals which included the dismembering of the neighbouring Lewisham Hospital Trust, which is not connected with South London Healthcare, not in debt, and delivering high quality services.

Under the plan Lewisham would lose its A&E, maternity, paediatrics, and emergency and complex surgery and medicine: more than half its site would be closed down and sold off. Vague plans for a new elective care centre lack any plausibility, and are included only as a smokescreen for the cutbacks.

Also under the cosh would be the remaining services at the already depleted Queen Mary's Hospital in Sidcup, which would also be largely closed, and most of the site sold off.

South London Healthcare would be split up, with QEH merged with Lewisham, and PRUH taken over by King's College Hospital: it would face a massive drive for "efficiency savings" with the loss of 140 doctors, hundreds of nurses and other health professionals, and outsourcing of services.

The only things to remain intact would be the PFI contracts: SLHT's £207m accumulated debts would be written off, and the new trusts would be given an increasing annual subsidy for the next 20 years to help pay the private speculators and maintain their profit stream.

As with NHS NW London, the assumption is that a majority (in Lewisham a staggering 77%) of A&E attendances could be handled "in the community" or by an Urgent Care Centre – an assumption rejected completely by hard-hitting letters from Lewisham's A&E and critical care consultants.

In fact a minimum of 30,000 emergency admissions and complex cases a year would no longer be able to access care locally in Lewisham but would need to travel to surrounding hospitals – where beds and capacity are already stretched to the limit.

Angry meetings and protests against these proposals have centred on Lewisham, where 90 consultants have published detailed rebuttals of the administrator's proposals for their own specialist services. Over 10,000 joined a march in pouring rain at the end of November, and hundreds have been turning out to each meeting and lobby called by campaigners.

Phillip Wolmuth www.reportdigital.co.uk

North West London

In West London four of the nine A&E units face closure – each of them delivering services to deprived local populations.

Ealing Hospital, serving the diverse and deprived Southall area, and offering tailor-made services to meet local needs, would face the loss of almost all its acute services if its A&E closes.

The other A&Es targeted under NHS North West London's preferred option are Charing Cross, Hammersmith and Central Middlesex, a PFI hospital that has been progressively stripped of its specialist services.

The closures are part of a much larger strategy that would cut beds not only in the hospitals that lose their A&E but also in all the hospitals that are supposed to take the extra workload of serious cases and emergency admissions when the other units close.

Northwick Park and West Middlesex, which are supposed to handle Ealing's caseload, are set to lose 32% and 34% of their beds, raising questions over the viability of West Middlesex, a PFI hospital facing 20 more years of rising costs.

Chelsea and Westminster Hospital, whose management actively campaigned for the closure of Charing Cross to maximise their own revenue, would lose a staggering 36% of its beds, in cuts which would affect every hospital and reduce bed numbers across NW London by an average of 28%.

None of these details were included in the bland consultation document, which claimed the support of NW London GPs for this false prospectus, despite having only involved the heads of the new CCGs and the vocal opposition of many local GPs who recognised the dangers of the plan.

Campaigners have also forced NHS NW London bosses to admit that despite the bluff and bluster in their consultation document, there are no concrete plans in place to expand community health services to take over from hospital-based care.

In fact community health services are also to be cut, losing revenue and staffing, as is mental health. In total the plan would axe 5,600 jobs – two thirds of them clinical staff.

Protests against these cuts included a 5,000-strong march through Southall, angry meetings and two public debates in which NHS NW London attempted to persuade local people to accept the cuts.

Ealing's Labour council has supported the campaign, and Hammersmith council have commissioned a detailed critique of the plan by a former NHS boss. Local MPs in Ealing and Hammersmith have all so far opposed the cutbacks.

Will they fight as hard in 2013?

King George's, Chase Farm & St Helier battle on against cutbacks

In North East London the campaign continues against the rundown and closure of A&E and most inpatient services at King George's Hospital and part of a plan to bail out the PFI-encumbered Barking Havering and Redbridge Trust.

BHR, facing a cumulative debt close to £200 million, is set to miss targets to reduce its deficit this year to £39m – falling short by a massive 16%.

And its board papers show the Trust is failing to deliver on A&E and other targets largely because of a lack of beds at the PFI-funded Queen's Hospital, Romford, triggering repeated 'Black Alerts'.

Yet plans to close most of the services at King George's Hospital in Ilford are still pressing ahead.

Maternity services at King George's are set to close in March, meaning that expectant mothers in Redbridge will have to travel to use already crowded services at Whipps Cross, or to the doubtful quality services at Queen's Hospital Romford, which were last summer criticised by the Care Quality Commission.

Chase Farm

In North London, the fight to save A&E and services at Chase Farm Hospital also continues as the Barnet and Chase Farm trust seeks a 'merger' in which it would effectively be taken over by the Royal Free Hospital Trust in Hampstead.

St Helier

And in South West London a solid campaign has challenged fresh moves to close A&E and other services at St Helier Hospital in Carshalton.

The rationalisation plan has run into a new crisis after plans to break up the Epsom & St Helier Hospital Trust collapsed because Ashford & St Peter's Hospital Trust pulled out of plans to take over Epsom.

As a result the proposed consultation that would have driven through the St Helier closure has been stalled, and once again local health chiefs are back to the drawing board.

Bolton deserves better than 'Healthier Together'

With a shortfall in funding of £38m, 500 redundancies are threatened, many compulsory, at Royal Bolton Hospital, with another 1700 staff to be dismissed and re-engaged on worse terms and conditions.

The whole range of health staff are affected: nurses, doctors, admin, technical, therapy and estates staff.

An £8m bridging loan was needed to enable the Foundation Trust to pay wages and bills to the end of December. Monitor has sent in a hit squad of "turnaround" accountants.

The Save Bolton A&E campaign believe that this makes the closure of Bolton hospital more likely: by reducing the quality of care by drastic cuts, management can then say it is not fit to use.

Review

A recent paper from NHS Greater Manchester, 'Healthier Together', introduces a review of primary, community and hospital services, including A&E departments, and the impact on social care, throughout Greater Manchester.

It says a district general hospital in every town and several in cities is no longer "financially sustainable" and is a model "designed to meet the needs of the last century". And that as several Trusts in Greater Manchester are facing "challenging financial difficulties" the issue must be addressed.

Their suggestion is not to call for adequate funding, but to replace local general hospitals with a network of care provided by local GPs backed up by regional 'super-hospitals', leaving people to travel much further for hospital treatment.

They talk of 25% of current admissions being inappropriate, and look to expanding care in community, with "a reduction in dependency and increasing self reliance" which will almost certainly involve cuts in beds when closures and amalgamations take place despite waiting lists growing.

Five hospitals

When the paper went to NHS Greater Manchester Board in October, they discussed having just 5 hospitals in Greater Manchester, for a population of 2.7 million spread over 500 square miles.

Until recently there were 12 hospitals. But they are going fast.

Rochdale now has no A&E. Once the A&E closed, bed closures followed. Now there is just a walk in centre, out-patients and some diagnostics. People have to travel miles to other hospitals.

Bury is being downgraded, and **Trafford** is under direct threat of closure. Official insistence that no firm decision has been made have not deterred campaigners. They know that once a decision is made it is much harder to reverse.

Campaigns have now been launched in **Bolton** and **Wigan** to save their A+E and hospitals. Within 11 weeks 26,000 have signed petitions and 500 attended a rally in Bolton on 1st December.

● ***www.saveboltonaccidentandemergency.org.uk***

Fighting to save Trafford General

Since April 2012 Trafford General Hospital has been managed by Central Manchester Foundation Trust, having failed to get its own Foundation Trust status. Maternity and some children's services were closed in 2010.

Now all emergency, intensive care and acute admissions could go from April 2013 – including the A&E department – leaving only non-urgent elective and day cases, as it becomes an 'orthopaedic centre of excellence'.

But as Save Trafford General campaigner Jo Harding says: "far from ensuring a 'viable and vibrant future', as Commissioners claim, these cuts threaten the whole hospital".

The consultation process was flawed: not all households received the documents, promised meetings with local groups did not happen.

And Trafford should not be treated in isolation: no services should be closed while Greater Manchester hospitals and A&Es are reviewed.

Manchester's Health Scrutiny Committee agrees, demanding that unless **Wythenshawe Hospital** in South Manchester gets another £11million to cope with Trafford patients, plans to close Trafford A&E must be abandoned.

The community campaign, by holding public meetings, running street stalls, organising protests, gained wide local publicity and won support across the political spectrum.

From a demonstration in July 2012 – over 1,000 people filed past the hospital in the biggest public demonstration ever in Trafford – to the delivery of a petition to the PM in October and a candlelit vigil when the public consultation closed, the campaign has united local people demanding that Trafford should not lose any more services.

They have launched another petition to save the birthplace of the NHS - ***http://you.38degrees.org.uk/petitions/save-a-e*** and are pressing NHS decision makers on four conditions that might bring a reprieve:

- difficulties in transport;
- lack of capacity nearby;
- the risk of increasing health inequalities for certain deprived areas;
- and concerns about people with mental health problems who need an urgent 'place of safety' at night.

More information at ***www.savetraffordgeneral.com***

No local campaign?

Trades councils, pensioners, union activists could set up a local CUTS WATCH website to monitor and publicise cutbacks as they take shape. Or join Keep Our NHS Public ***www.keepournhspublic.com***

Admin & clerical staff from Mid Yorkshire Hospitals in the first of their strikes as they fight on against downgrading.

More A&E cuts to bail out PFI

Mid Yorkshire Hospitals Trust, weighed down by the costs of the £330m PFI project for two new hospitals (the main one Pinderfields in Wakefield), has embarked on desperate cost-cutting in an effort to manage its rising deficit.

The cutbacks have focused on scaling down the A&E and other services at the Trust's other two main hospitals, the PFI-funded Pontefract hospital, and Dewsbury.

The plans to axe Dewsbury's A&E brought an immediate angry reaction from local people, and a campaign reaching out to the communities that depend upon the hospital.

200 people braved the first cold day of the winter to support a march from the hospital and protest in the city centre on October 27, and the campaign won support from the local press, which helps put pressure on to local MPs and councillors.

A petition with over 5,000 signatures also helped force back the formal consultation on the A&E closure from the original target of January to March, or maybe even later.

Other cuts include the downgrading of admin and clerical staff, with some at risk of losing up to £2000 a year. UNISON members hit back with four days of solid strike action, and the threat of even more prolonged stoppages if the downgrading is not dropped.

Liverpool PFI: all systems going nowhere

PFI Protest at Royal Liverpool, 6th December 2012. Photo: John Usher

Liverpool needs a new hospital – so why has there been a vigorous campaign against the plan to build one? Because it's a Private Finance Initiative (PFI) scheme.

Two years on from the original approval for the Royal & Broadgreen, it's still far from 'All Systems Go' for this wretched plan.

The Department of Health and the Treasury have yet to approve the current version. The preferred bidder has not been named.

The final contract has still not been negotiated or approved.

In Nov 2010 Joe Anderson (then Leader of Liverpool City Council) told BBC Radio Merseyside

"I know it doesn't provide Value for Money now or in the future, but it's the only game in town".

Since then PFI has wrecked NHS finances from Whiston & St Helens to Kent, passing through Wakefield, Peterborough, Nottinghamshire, and South London.

This devastation pushed the Coalition Government to promise a £1.5bn bailout of the 7 worst schemes – money not from their pockets, of course, but from front-line patient care.

Two of the companies vying for 'preferred bidder' status in Liverpool are Carillion and Horizon (Interserve). Neither has a good track record. Interserve has two of the 7 bailout PFIs and Carillion has one, and three of the 22 where PFI is affecting Foundation Trust status.

In March 2012, Monitor blocked Foundation Trust status for the Royal due to "insufficient evidence to demonstrate that the Trust would be viable with the PFI".

Massive cuts would be needed to fund the scheme, which would cost £500m more than public finance.

The Royal has to find £8.5m 'efficiencies' beyond the 4% annual savings imposed by the Dept of Health.

Hospital Trusts around the country are proving that there is an alternative to PFI, using public finance, pension funds investments and local council loans.

So campaigners ask, why is the Royal ploughing on with a flawed plan which threatens their health service with another PFI debt crisis? They demand that other financing options should be explored.

Following the Chancellor's announcement that PFI is to be replaced by 'PF2' for financing infrastructure projects, the Merseyside campaigners ask whether the Royal is continuing with the old, discredited, PFI scheme, or drawing up a new PF2 plan which could prove to be more expensive with yet more delays.

And will that be subject to a new round of public consultation and scrutiny by NHS Merseyside and Liverpool City Council?

Coalition Against PFI, c/o Keep Our NHS Public c/o News from Nowhere, 96 Bold St L1 4HY or email ***keepournhspublicmerseyside@yahoo.com***

Eastern plan for more PFI fiascos

In the East of England, according to optimistic Treasury figures which seem to understate the costs, three large hospital projects with a capital cost of £642 million are now complete: (Norfolk & Norwich, Peterborough and Chelmsford).

They are set to cost a staggering £4.25 billion by the time the last payments are made in Chelmsford and Peterborough in 2043.

Even at 6% interest a mortgage would have brought a total cost for the same three hospitals of less than £1.3 billion over just 25 years, and much lower, predictable payments.

This would have left the Trusts much greater flexibility in shaping services around local needs and changing pressures.

Instead Norfolk & Norwich Trust, one of the first wave of PFI hospitals, is one of the most expensive compared with original cost, coming in at almost ten times the initial capital investment.

But the cost of payments on the £310m Peterborough PFI – a PFI signed off by the Trust despite receiving two letters from the regulator Monitor warning them not to go ahead – is the key factor threatening the very survival of that Trust, which is running an annual deficit slightly larger than the £40m-plus annual "unitary charge" for the PFI contract – equivalent to 20% of the Trust's total income.

The Chelmsford Trust is also financially struggling, facing chronic deficits following the construction of a PFI-funded wing at Broomfield Hospital.

But no lessons seem to have been learned from these costly mistakes: egged on by George Osborne's plan for a "PF2" cosmetic remodelling of the original failed PFI formula, new schemes are still being drawn up in east of England for two more costly new hospital projects with dodgy prospects – a new Papworth Hospital at £200m-plus and a £320m new super hospital for Watford.

Not so magic Circle

The deal that gave private equity-backed Circle Health the contract to manage Hinchingbrooke Hospital in Huntingdon has been under fire from the National Audit Office and the Commons Public Accounts Committee.

But the abrupt departure of Circle's talkative founder and chief executive Ali Parsa, with a £400,000 pay-off, and a change of style at Hinchingbrooke under his successor seem to suggest that maybe the firm won't be sticking around to find out if they can eventually make any profits from the ten-year deal.

Circle's plans for savings of £311m over ten years and up to 20% job losses over three years have been revealed.

Deficits have topped £4m six months after Circle took over, and the company – which has never made a profit – gets nothing until the hospital is in surplus. Significantly, if deficits reach £5m they could decide to cut their losses and walk away.

Don't bet against the contract coming up for grabs again before 2013 is out.

Make healthcare your business!
Pile up profits from sickness!

HOSPITAL MILLIONS

Playing instructions

1. Set up the game. Copy the money to create a bank. Cut out the four playing tokens, one for each player. Cut out the 28 £ contract tokens, to be held by the Banker until purchased by players (4x7, each colour coded to match playing tokens). (***Additional copyable artwork for the banknotes and contract tokens can be downloaded from www.healthemergency.org.uk***)

2. Hand out money to each player. At the start of the game each player will have £1.5 million, with a mix of large and smaller notes. Roll the dice to see who goes first. The player with the lowest number is the banker: highest number will start the game.

3. Starting from the New Financial Year, each player in turn will roll a dice and advance that number of spaces.

4. Depending on which space you happen to land on, you may buy up any of the unsold contracts, or have to pay a fee to the owner as stipulated. A player who has already bought a contract and lands again on his own square may invest in another contract at the same price, to raise extra fees from others who land on it.

5. If a player manages to purchase all four PFI contracts, the fees for other players landing on those squares are doubled.

6. A player landing on Community Care or Triage squares must throw a dice to discover the result , from the matrix on the centre of the board.

7. During the course of the game, you are entitled to collect £500,000 each time you pass the New Financial Year.

8. Once you cannot pay the amount owed to the bank or another player and cannot negotiate a loan from any other player, you are considered bankrupt. If landing on another player's property causes your bankruptcy, you must give that player everything you have left.

9. Once a player has gone bankrupt, the game is over. The surviving player or the one with the largest assets in cash and contracts is the ***Hospital Millionaire***.

£10,000	£100,000
£50,000	£200,000
£1 million	£100,000

New Financial Year
Speculation starts HERE

Pricey Water Closet Consultancy
£500,000
Fee: £10,000 x throw of 1 dice per contract

PATHOLOGY SERVICES
£200,000
Fee £40,000 per contract

BACK OFFICE & CALL CENTRES
£200,000
Fee £40,000 per contract

PFI
£1,000,000
Fee £200,000 x throw of 2 dice

CLEANING SERVICES
£200,000
Fee £60,000 per contract

Community Health Services
£500,000
Fee £100,000 per contract

Triage
Throw a dice to learn your outcome

GP OUT OF HOURS SERVICES
£100,000
Fee £10,000 per contract

You are approved by Monitor as a "Qualified Provider". Throw a six to purchase any available contract

KING'S FUND consultancy
£800,000
Fee: £10,000 x throw of 2 dice

Medium Secure mental health
£400,000
Fee £80,000 per contract

PFI
£1,000,000
Fee £200,000 x throw of 2 dice

Community Care
Throw a dice to get your multidisciplinary assessment

Secretarial Services
£100,000
Fee £20,000 per contract

You are bought up by an **Offshore** hedge fund Go to New Financial Year

McKimouse management consultancy
£1,000,000
Fee £300,000 x throw of 1 dice

Private Wing
£150,000
Fee £30,000 per contract

Surgical implants & prostheses
£800,000
Fee £100,000 per contract

PFI
£1,000,000
Fee £200,000 x throw of 2 dice

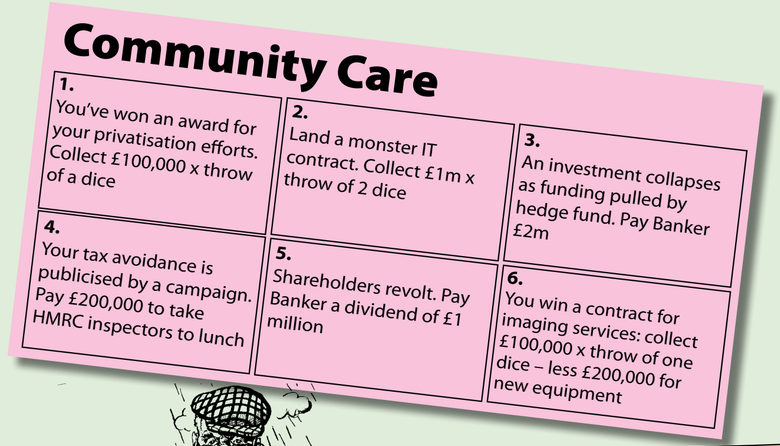
COSMETIC SURGERY
£750,000
Fee £150,000 per contract

Independent Sector Treatment Centre
£400,000
Fee £80,000 per contract

Triage
Throw a dice to learn your outcome

Primary Care contract
£300,000
Fee £60,000 per contract

A&E
Throw double 6, or pay **£200,000** to move to private wing



Community Care

1. You've won an award for your privatisation efforts. Collect £100,000 x throw of a dice	**2.** Land a monster IT contract. Collect £1m x throw of 2 dice	**3.** An investment collapses as funding pulled by hedge fund. Pay Banker £2m
4. Your tax avoidance is publicised by a campaign. Pay £200,000 to take HMRC inspectors to lunch	**5.** Shareholders revolt. Pay Banker a dividend of £1 million	**6.** You win a contract for imaging services: collect £100,000 x throw of one dice – less £200,000 for new equipment

Triage

1 Your think tank wins hedge fund backing. Collect £500,000 and advance to **King's Fund**.	**2** Rebrand an old drug as a new product. Collect £2m	**3** Your cheap cosmetic prostheses are found to be faulty. Collapse your company and relaunch under a similar name to dodge payout. Pay Banker £500,000
4 Cash in on a flu epidemic, taking the chance to market your ineffective medicine. Collect £3m	**5** Rushed to A&E. Do not collect any fees until discharged	**6** Unexpected Quality Inspection reveals your poor standards. Pay Bank £1m to continue regardless

Private clinic with NHS contract
£250,000
Fee £50,000 per contract

Community Care
Throw a dice to get your multidisciplinary assessment

PFI
£1,000,000
Fee £200,000 x throw of 2 dice

Commissioning Support Services
£150,000
Fee £30,000 per contract

Physiotherapy Services
£200,000
Fee £40,000 per contract

Dodgy practices: primary care for sale in Merseyside

A murky saga lies behind the proposed transfer of 22 GP practices in Merseyside to SSP Health, a company run by 2 GPs from Wigan.

In the late 2000s, the Department of Health authorised private health, consultancy and insurance firms to pick up lucrative contracts advising PCTs on buying healthcare.

Tribal Consulting got a £4.5m 3-year contract for Ashton, Leigh and Wigan PCT, including practice based commissioning, and shaping supply, demand and utilisation management.

In a glossy pamphlet on their project with Tribal, the PCT highlighted 'Risk Stratification' using a system based on studies of insurance claims, used by major US healthcare providers and commercial insurers.

Dr Balwinder Duper appeared in this. Dr Duper, Clinical Lead of Atherleigh consortium, was quoted in a similar publication by Capita in January 2012.

By then Capita had swallowed most of Tribal Consulting's health consultancy, to provide support services to GP commissioning consortia.

Dr Duper is the Medical Director of SSP Health, founded in 2007 by Dr Shikha Pitalia (an enthusiastic supporter of Lansley's Health Bill) and her husband Dr Sanjay Pitalia, who own all the shares. Sanjay Pitalia is a director of 23 active companies, including property development and private medicine.

Controlling these surgeries, SSP Health will have a powerful voice on the Liverpool, South Sefton, and Southport & Formby CCGs. The link to Capita could strengthen Capita's influence on CCG commissioning decisions.

Ten of the Liverpool practices had GPs directly employed by Liverpool Community Health, an NHS organisation staffed by NHS employees.

Why were the surgeries put out to tender, without public consultation? Responding to a Freedom of Information request in September 2011, Liverpool PCT said there would be no public consultation "as there is no material change specified in the tender for the services currently provided."

However, in January 2012, the PCT aborted the tender process, and changed the specifications so that GPs would do work previously done by Practice Nurses.

This material change to the service should have required public consultation and also affected the financial basis of the tender.

Liverpool Community Health withdrew from bidding in June, and said that removing practice nurses "means the quality of care to patients would diminish" and the moves were simply "unsafe."

Accusing Liverpool PCT of breaking its procedures on consultation, health campaigners say the PCT must reverse the decision and begin the process again, consulting the public before inviting any tenders.

In a further twist, the Office of Fair Trading is investigating whether the transfer may contravene the merger provisions of the Enterprise Act 2002, and "may be expected to result in a substantial lessening of competition within any market in the UK."

And NHS Merseyside has revealed that the transfer is subject to settlement of contractual terms and approval by the Cooperation and Competition panel. The deal is not yet final.

Private sector dominates new list of "qualified" providers

As the clock ticks down to the roll-out of the market in healthcare that will replace the NHS from April it is increasingly clear that – far from putting GPs in control – the main aim of the government was to open up NHS budgets to "any qualified provider".

And a survey in December by Pulse magazine has found that more private sector providers than NHS organisations have so far been approved for the register of "Qualified Providers".

Established NHS providers seem set to be heavily outnumbered.

Official Department of Health figures show 38 of the 87 "qualified" providers are from the private sector compared to 26 from the NHS. The remaining 23 are made up from 19 'third sector' organisations, and four social enterprises.

PCTs were told to select three community or mental health services to be tendered out under Any Qualified Provider by September 2012, and as a result 30 types of community healthcare services will be provided by 400 provider outlets across the country, according to Pulse.

However GPs and CCGs are NOT compelled to put services out to tender, or to open them up to Any Qualified Provider.

This is made very clear in the NHS Commissioning Board's own 'Briefing on Procurement of healthcare (clinical) services' published in September 2012.

It states that there are three options for procuring services:

- any qualified provider (AQP), which gives GPs no control whatever, and no guarantees of quality, as "patients will decide which providers to be referred to";
- competitive tendering, which does allow GPs to assess rival bids from NHS and other providers and to choose the most suitable;
- or "appoint a specific provider or group of providers without competition (Single Tender Action)".

Of the three, the worst in every respect is AQP, which prevents any scrutiny of quality or planning of services, undermining existing providers and creating potential gaps in care.

It is more urgent than ever for campaigners, health unions the BMA and the Royal College of GPs to remind CCGs that they have been told they have a choice, and they should clearly choose now, in advance, to reject AQP.

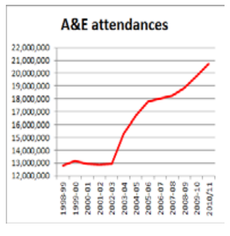
If enough CCGs take a stand, it will encourage others, and maybe even persuade some to change their minds and opt not to proceed with AQP.

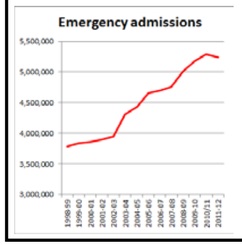
This would begin to restrict the areas where AQP can be implemented.

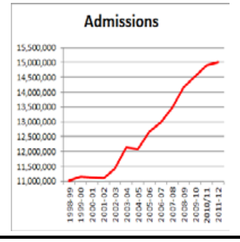
If this triggers a clash with the Commissioning Board, it will be a useful and educational test of strength that will also expose to all GPs and the wider public the extent to which the NHS is being hijacked by the private sector.

However more than one in five CCG board members have financial interests in private healthcare providers, leaving them open to possible conflicts of interest when commissioning services from next April, according to another *Pulse* investigation.

More patients, admissions and emergencies … but fewer beds







Despite all so-called think tanks and desperate NHS managers trying to make the case for closures of A&E units, beds and whole hospitals, rising levels of demand continue to point to serious pressures on existing services.

Reports from the Dr Foster and the King's Fund in recent months have warned that hospitals are "full to bursting" and that 2013 might mark the turning point as spending cuts leave inadequate capacity.

Department of Health figures (left) show a consistent trend of rising A&E attendances, admissions and emergency admissions over the last 13 years, while bed numbers have been cut by 23% in the last decade.

Increases in admissions and emergency admissions have been significantly higher in London than the national average, with admissions rising by 51% and emergency admissions by 60% in the capital since 2001-2, compared with 35% and 35% in England as a whole.

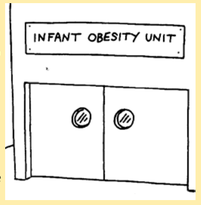
The long-promised replacement of hospital care with community services has still not materialised.

Fears over public health funding

Among the less publicised aspects of the Health & Social Care Act has been the transfer of responsibility for public health – developing policies and initiatives to combat smoking, obesity, alcohol and drug abuse, and promote sexual health – from the NHS to local government, and a new national agency Public Health England.

Local councils have for many years been responsible for social care, which being outside the NHS is not delivered free of charge at point of use, but subject to means-tested charges.

Council funding has also been at the centre of George Osborne's squeeze on public spending, with 27% cuts over three years from 2010, after many years of annual cutbacks which have taken a heavy toll of social care. In many areas this is now available only for those with the most severe needs, leaving everyone else to fend for themselves.



With more cuts still to come, there have been fears over the future of the £2.2 billion to be set aside to fund the new council role in public health. The Association of Directors of Public Health have called for this to be increased by at least £1 billion to ensure resources are adequate to combat health inequalities: but the signs so far are not promising.

A new funding formula seems to work consistently to the benefit of the more prosperous south, and the disadvantage of the poorest. London Mayor Boris Johnson has complained that the formula would represent a loss of £10 per head for over 7 million Londoners.

Birmingham's cabinet member for Health and Wellbeing, Steve Bedser, has also warned that the transition must be properly funded, to prevent growing demand falling foul of reducing resources.

These fears have been compounded by the continued delays in announcing the amount of money that each council will have to spend, or the extent to which some local councils can link up with new local area teams to be run by the NHS Commissioning Board, or with the new Public Health England set-up.

If funding is reduced, some existing public health staff who have been working for PCTs will lose their jobs, leaving gaps in services.

The crucial announcement on how much each council will have to spend, originally due in November, has now been pushed back to early 2013, even though the new arrangements are set to kick in from April.

In some areas, notably London, where a quarter of posts are vacant, there have been problems recruiting Directors of Public Health.

Time to test out EU competition laws

NHS bureaucrats trying to persuade us there is "no alternative" to further fragmentation of the NHS and supplanting our planned, publicly provided services with a new competitive health care market tend to refer to European Competition Law as the ultimate element of compulsion.

There is no escape, runs the argument: once services have been opened up to competition, European law means that the market must continue.

They argue that health care is seen as an "undertaking" just like any commercial or business operation.

But blogger Roy Lilley has raised a serious questions over the extent to which health care has to be included under European law, and in October dug up a ruling from a 2003 legal challenge, in which the European Communities Court of First Instance declared that:

"an organisation which purchases goods ... in order to use them in the context of a different activity, such as one of a purely social nature, does not act as an undertaking simply because it is a purchaser in a given market.

"Whilst an entity may wield very considerable economic power […] it nevertheless remains the case that, if the activity for which that entity purchases goods is not an economic activity, it is not acting as an undertaking for the purposes of Community competition law... "

Hunt: he will be hoping nobody tests out EU competition law

In other words, there is no necessary reason to assume that any attempt to invoke EU competition law to open up parts of the NHS to private sector bids and competition would inevitably succeed.

Rather than running up the white flag and surrendering control over our relatively efficient publicly provided services, creating an expensive bureaucracy of market mechanisms, it would be better to stand firm and resist the privatisers.

Even British competition law has yet to be properly tested in any challenge to privatisation in health care.

So with another 39 community health services lined up for "any qualified provider" from April, the time is ripe for a determined resistance. Which CCG will be bold enough to test the strength of the marketisers – and force the hidden privatisation out into the public arena?

£20 billion opportunity as private firms eye up the NHS

Private sector investors are licking their lips in anticipation of fat profits to be made from the carve up of the NHS under the Health & Social Care Act.

A detailed overview from Catalyst Corporate Finance looks to a "£20 billion opportunity for the private sector", including the homecare and domiciliary sector and care homes, already dominated by private providers.

Saga is now the largest provider of domiciliary care in the UK, while other companies such as Four Seasons and Care UK (itself taken over in 2010 by private equity firm Bridgepoint, and which has in turn now taken over the primary care provider Harmoni for £48m) are moving in.

The report points out that the private sector has only a very small share of the £8.3 billion primary care market (where it looks to a possible 40% share) and acute hospital services, where it hopes to carve out 20%.

There are high hopes for more penetration of community health services, for the private sector to grab £2 billion of the available £8-£8.5 billion market by 2020.

The Catalyst report celebrates the landmark £500m 5-year contract scooped up by profit-hungry Virgin Care in Surrey (where it notes staff transferred to Virgin are being allowed to retain access to the NHS pension scheme), its strong chances of another major health and social care contract in Devon (despite a court judgment that the decision to select Virgin was unlawful because the impact on children was not assessed), and Serco's £140m 3-year contract for community health in Suffolk.

But it is also a warning that the same predators are seeking more easy prey in 2013.

We already know that the privatisation of services is a major threat to standards of care.

Within weeks of securing their contract Serco were announcing job cuts in Suffolk.

In September Corporate Watch secured devastating information on the controversial pathology services in Guy's and St Thomas's Hospitals which had been taken over by Serco. Documents released under Freedom of Information legislation showed 400 clinical failures in 2011, and financial failings that brought £5.9m losses and meant the joint venture had to be bailed out by the Trust. The company is seeking to take over 30% of the pathology services market.

A £500m 5-year contract for pathology services has been lined up in the Midlands and East area, as a final gift for the private sector before the fanatically pro-privatisation Strategic Health Authority is scrapped in April.

The challenge for campaigners is to identify threats early and hit back hard with campaigns to shame the CCGs and Health & Wellbeing Boards into dropping any planned privatisation.

Bosses see profits in pathology

CUTBACKS ROUND-UP

Trick questions

Tight fisted managers looking for a pretext to slash nursing pay in Stoke Mandeville Hospital have resorted to absurd "psychometric tests" – in which nursing staff are asked hypothetical questions on how to respond if they were on a sinking ship.

Come to think of it, the question is no so much hypothetical as a disguised way of discussing the plight of the NHS. But those who fail to jump through the right hoops on the questionnaire are finding their salaries cut as they are downbanded.

It's interesting that the controversial new criteria avoid any actual reference to patient care.

Curtains for Kettering?

Kettering General Hospital could lose a massive 515 of its 658 beds under one of the scenarios for cutbacks being floated by health chiefs in an exercise laughingly entitled "Healthier Together".

The project covers a large patch including Luton, Bedford, Milton Keynes, Kettering and Northampton. Of the 14 options drawn up, the favoured option would cut 600 beds across the five hospitals, and reduce Kettering to one of two smaller hospitals with a scaled down A&E, no medicine or critical care and only 30% of its maternity services. The second favourite option would cut 229 of Kettering's beds.

The document outlining the plans was leaked to the local press, while health chiefs continue their debates in secret, refusing to allow any scrutiny until they have completely made up their minds, in advance of a tokenistic 12-week "consultation".

Campaigners in EAST SUSSEX have been protesting against plans to "reconfigure" hospital services in Eastbourne and Hastings, cutting beds, staff and community services to make savings of £104m over 5 years

Tearing the heart out of Hertfordshire

Health care in Hertfordshire is set to face a massive £276m in cuts to slash 17% from spending over the next four years.

Plans to revamp Hemel Hempstead Hospital have been put on the back burner, as commissioners focus again on trying to reduce the numbers of patients referred to hospital – and effectively asking more and more patients to sort themselves out ("manage their own care") as the money runs out.

Obese patients and smokers who refuse to change their lifestyles are already being refused non-emergency operations. There is also the lingering threat of new "care pathways" as a further means to scale down hospital and other services.

Yorkshire

Rotherham Hospital has joined the growing list of Foundation Trust on the crisis list as plans have been hatched up for 750 job losses by 2015 – 20% of the workforce.

Unions have been told that compulsory redundancies are inevitable, as a report from the Trust's chief executive, bizarrely entitled "Creating Certainty in an Uncertain World," warned that it would need to make £50m of savings from its £220m budget.

In North Yorkshire and York, a £10m cuts package that would axe residual minor injury units, close community hospital beds and halt a plan to recruit health visitors was announced in September as PCT chiefs warned they were set to run out of money before March 2013.

Local GP leader Dr Dougie Lumb described the "slash and burn cuts" as "the longest suicide note" to be written by a PCT before they are all abolished in April.

Private growth – at NHS expense

Public funds have been used to spawn a growing private sector, that has focused on creaming off the most profitable elective treatments, leaving all of the rest to the NHS.

This is clear from the findings of a report researched for the Nuffield Trust by the Institute of Fiscal Studies, which investigated the extent to which elective care in certain specialties had been diverted away from their nearest NHS Trust to other providers.

The drop in use of patients' nearest hospital correlated with the expansion of the "independent Sector Treatment Centres" (ISTCs) the controversial private for-profit units set up by New Labour with lavish subsidies and incentives from 2003 onwards, in a determined effort to undermine the existing NHS trusts and create "contestability" and a new market in health care.

The new figures show than by 2010-11 ISTCs had managed to pick up 17% of the NHS funded total of hip replacements, 17% of hernia operations and 6% of gall bladder removals (cholecystectomies).

Of course all of the complex and risky cases have remained with the NHS, as have all of the emergency orthopaedics, and other operations – which the private sector has always wanted to leave to others.

The report fails to address the question of how much actual choice has been in the hands of the patient, and how much their options have been constrained by policies decided by or imposed upon their local Primary Care Trust: most ISTC contracts were negotiated nationally by Department of Health bureaucrats, and PCTs were then obliged to make use of the provision that they were already having to pay for.

"Choice" by patients and GPs is further limited by the proliferation of "referral management centres" which now second-guess the decisions taken by GPs, and routinely send back referral letters if the bureaucrats at the centre feel there is a cheaper option.

- **ISTCs did 12,000 hip operations in 2010-11: but the NHS handles 856,000 operations on "bones & joints" that year.**
- **In total the NHS dealt with 9.8 million elective admissions and 5.2 million emergencies.**
- **0% of emergencies are treated by the private sector.**

Mental health care takes a kicking

Mental health budgets in England have been cut for the first time in ten years as austerity reaches into every corner of the NHS. But the hardest hit have been the services for people with the most serious and chronic needs: spending on "talking therapies" for less demanding cases is actually increased (doubled in the last three years).

As the cuts have been drawn up, community services, allegedly the intended focus for more mental health care, have been increasingly dismantled – some of them further undermined by the uncertainties from the roll-out of "personal health budgets" which have been driven through despite the widespread concerns of NHS managers and professionals, and the evidence of failure of similar policies in the Netherlands.

The cuts have come at a time when an independent commission investigating the treatment of Schizophrenia has condemned catastrophic shortfalls in treatment, with too many patients spending too long on "demoralised and dysfunctional" hospital wards.

But people trying to live in the community with serious and enduring mental health problems have also found their lives made more miserable by the government onslaught on disability benefits, which involves an 'assessment' in which unsympathetic employees of private profiteers Atos seeking to deny 80% of claimants their benefits ask hostile and inappropriate questions which are especially stressful for people with mental illness.

Social care services, such as they were, are also being cut to ribbons by desperate councils facing year on year cutbacks in budget imposed by George Osborne. Among the cuts of

"A lousy trillion? Call me when you're ready to talk some real money."

most impact on mental health care are those in employment centres and day centres: but there have also been cuts in home support, crisis services and other support services without which many struggle to survive in the community.

Cuts hit clinical staff

The squeeze on mental health services is epitomised by the brutal cutbacks proposed by the Norfolk & Suffolk NHS Foundation Trust which seek to axe 21% of jobs in the next four years, most of them clinical staff.

86 beds are to be cut, while 33 consultant psychiatrists (a third of the total), 60 percent of staff grade doctors, and over 200 full time equivalent Band 6 nursing and therapy staff and another 34 Band 5s are also to lose their jobs, under the cost-cutting plans "designed to protect healthcare services over the next four years".

Since many of these staff are women working part time hours, the full time equivalents are likely to involve much larger numbers of staff.

Trust chief executive Aidan Thom- as insists the plans were drawn up by clinicians, but it's clear that every section of front line staff is taking a hit: only secure (forensic), drug and alcohol services, Wellbeing Services in Norfolk and Suffolk and Continuing Care in Norfolk and Waveney are so far unaffected, but will face their own round of cuts in later announcements.

By contrast to the attrition of professionals there is to be a small increase in numbers of Band 3 health care assistants – as skilled nursing jobs are replaced by cheaper, less qualified staff.

Bob Blizzard, the former Waveney MP, told local reporters he was concerned that so many acute inpatient beds were being cut after he had campaigned so hard when he was in office to get the number of beds increased. Half the 40 beds are to be axed in Great Yarmouth and Waveney, with an increase in 'alternative admission beds' – whole two substance misuse beds are to be moved to the west of Norfolk.

He said: "In-patient beds are already over subscribed. Staff have given me examples of patients sent to out of area beds, of patients accommodated in expensive private beds at £500 plus per day, of the existence of a waiting list for in-patient beds, of cases where new patients have been accommodated in the beds of patients out on leave (who may need to return urgently) - contrary to clinical advice.

"It's hard to see how we can make do with fewer in-patient beds, when we already have a shortage."

Community mental health teams have already been cut in Waveney, in advance of the new plans which place more reliance on community care.

From April GPs will now take the blame for cash-driven cuts in hospital services

GPs forced by Act into rationing role

The rationing of health care began under Labour, but has been institutionalised by the coalition and its Health & Social Care Bill, which makes GPs on Clinical Commissioning Groups into the new rationing boards, deciding which services to deny their patients to balance the books.

A Freedom of Information request by the Labour Party last autumn revealed that nearly half of all PCTs in England had restricted which treatments they would fund: 16 were restricting cataract operations, 24 tonsillectomy and 21 were restricting surgery for varicose veins.

125 treatments had either been restricted or had been stopped completely since 2010.

Removing all these treatments from the list available through the NHS also helps to slash the apparent waiting lists, allowing them to boast that fewer are waiting: but it confronts patients with a brutal choice – pay privately, or go without.

A list of treatments with allegedly "limited clinical benefit" was drawn up by McKinsey for Labour ministers in 2009: it included hip and knee replacement, cataract, hernia and varicose veins operations. The list was disavowed by Labour and publicised by Andrew Lansley on taking office, but is now the working list for PCTs all over England as they line up to hand over the rationing decisions to GPs.

But it seems as if a fair number of PCTs will be passing over deficits as an inherited problem for the new CCGs: and the range of issues on which CCGs will have genuine control is dwindling fast.

The NHS Commissioning Board is planning to keep firm control over the commissioning of £12 billion worth of specialist services – a far larger allocation than in previous years.

This is just one way in which local area teams from the National Commissioning Board will hog-tie CCGs.

CCGs will also be strongly steered from the beginning by "Commissioning Support Units" of management consultants, some of them former PCT staff. CCGs which open up services to Any Qualified Provider will also be surrendering any commissioning role in relation to these, leaving patients to pick their provider (see page 6.)

To make matters worse CCGs have been press-ganged into signing up for rigid constitutions which include gagging clauses, powers to expel practices, and other provisions which many will find unacceptable.

And *Pulse* magazine has revealed that these documents can be imposed as a requirement of authorisation of a CCG even if none of the local GPs has signed them.

So it's quite clear who's really in charge – and it's not the GPs.

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