HEALTH EMERGENCY

Issue No. 66, Autumn 2010. **WHITE PAPER SPECIAL ISSUE**

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White Paper would combine biggest-ever cuts with biggest-ever privatisation

Say NO to ConDem rationing boards!

The ConDem government's White Paper 'Liberating the NHS' makes many controversial proposals, but at its heart are two key factors: the fragmentation and privatisation of the NHS – and £20 billion of spending cuts by 2014.

The scale of these "efficiency savings" guarantees that even while it appears to give GPs greater control over services, the opposite is the case.

With tight budgets and cuts to be made, consortia of GPs established to spend £80 billion in commissioning budgets will inevitably become little more than ***rationing boards***.

Far from improving services they will have to choose which services will be cut and which sections of patients should be excluded from treatment.

To accept this would not be "liberation" for the GPs or their patients: it' would be a capitulation to the ConDem government.

As the debate over the White Paper begins to widen, it's clear that there is a strong and growing opposition to many of its core proposals, even among the group who appear to have most to gain from it.

GP magazine found fewer than one in five of the 300 GPs who responded to an online poll believed that the changes would improve patient experience or the funding of primary care services.

Twice as many (41 percent) feared a fresh "postcode lottery," while 71 percent expected the scrapping of PCTs and SHAs to lead to an increase in private sector involvement in commissioning. 60 percent of responses in a poll on the pro-White Paper National Association of Primary Care website also opposed the government's commissioning plans.

No wonder one of the leading apologists for the scheme, Dr Michael Dixon of the NHS Alliance, has issued a rather desperate appeal for GPs not to turn their backs on the government proposals, claiming that it would be "utterly disastrous" if they did not "embrace the White Paper and make it work".

> If the NHS Alliance, the Royal College of GPs and the BMA, along with the health unions simply took a firm stand against the White Paper, the ConDems would not be able to carry out their plans.

'You've got affordable cancer'

But of course Dr Dixon has got it the wrong way round. The real disaster would be for GPs and their organisations to allow themselves to be cynically used by the government to push through proposals which will have far-reaching and negative consequences for patients as well as for the NHS and its one million employees.

It will also be a disaster for tens of thousands of hospital doctors: the proposals could effectively privatise health provision and reduce England's NHS workforce from almost 1 million to virtually zero by 2014.

Despite these problems, at present the BMA is committed to "engage critically" with consultations on the ConDem plan.

This is a mistake. Indeed if the NHS Alliance, the Royal College of GPs and the BMA, along with the health unions which have already declared themselves against the proposals, simply took a firm stand against the White Paper, and marketisation and privatisation of health care that are implicit in it, the ConDems would not be able to carry out their plans.

Until a few weeks ago the BMA was conducting just such a campaign, now sadly sidelined as they struggle for influence with Mr Lansley.

Perhaps the biggest reason for standing up against these plans, which could effectively transform the NHS into a National Health Market, with no public sector providers, is that there is absolutely no evidence that these expensive, experimental reforms – the biggest-ever privatisation of health care anywhere in the world – could deliver the promised improvements for patients.

It's all looking like a mess waiting to happen.

The cost of implementing the White Paper (upwards of £1.7bn) seems like a classic waste of money much better spent on patient care.

But from the point of view of Andrew Lansley and his Tory colleagues, if it resulted in denationalising the NHS, reversing the great legacy of Nye Bevan, and opening up a new £100 billion market to private companies, it would be seen as money well spent.

SPECIAL APPEAL

Help us campaign to save our NHS!

The NHS faces its biggest-ever threat: a 'double whammy' of massive cuts year by year to 2014, coupled with the White Paper proposals that could wipe out all public sector provision of services.

The ConDem government has no mandate to transform the National Health Service into a national health market. But if there is no public challenge, the White Paper could be forced quickly through Parliament.

Hospital staff have everything to lose and nothing to gain from the proposals which could see tens of thousands of jobs axed, and hundreds of thousands pushed out of the NHS workforce, with new threats to their pay scales and pensions.

Every cutback that is accepted will just encourage desperate employers to come back for more.

It really is do or die for those of us who want to defend the NHS as a public service, and who value the staff who deliver services.

To build a successful campaign requires resources, publicity, time and effort: and until there is a broad popular campaign established with the support of the main health unions, much of the work will fall to organisations like London Health Emergency.

But right now, we don't have the resources to cope.

We need help to keep the issue in the media, and work with local campaigners to get the message across in meetings, protests and local publicity. Just producing and distributing this newspaper has cost £2000.

We urge any readers or supporting organisations that can do so to make a donation, as large as you can afford, to ensure we have the resources to keep on fighting to scupper Lansley's White Paper, keep our NHS intact … and keep it public.

■ **You can donate by cheque (to 'LHE'), or online at www.healthemergency.org.uk**

● **website:** www.healthemergency.org.uk ● **email:** healthemergency@gmail.com ● **snailmail:** BCM London Health Emergency, London WC1N 3XX

McKinsey's: over-paid, over-rated, over here!

One bizarre side-effect of the Con-Dem coalition government was the publication of two documents which the New Labour government had stubbornly refused to allow into the public domain.

Both are the result of work by US management consultants McKinsey's, and address the issue of the drive for 'efficiency savings' (aka cuts) in the NHS to bridge a predicted £20 billion gap between a frozen budget and rising pressures by 2016-17.

The first (smaller) document is a national survey, elements of which leaked into the public domain last summer, and which was immediately publicly disavowed by Labour ministers, who insisted that it was not government policy and would not be implemented.

Nevertheless it soon became clear that despite the government's view, a number of Strategic Health Authorities *were* seeking to adopt a number of the proposals, not least in the rapid reduction of the NHS workforce – by as much as 10% -- as a way to save money.

NHS London's secret

The second document became even more shrouded in secrecy: commissioned by NHS London, it was a special version of the original with more detailed facts and figures on the London context.

For 6 months or more campaigners and health unions attempted to use the Freedom of Information Act to force NHS London's secretive bureaucracy to allow proper public scrutiny of plans which were quite obviously controversial.

When this second document – all 159 pages of it – was finally published, the reason for NHS London's reluctance to allow it out became immediately transparent.

Firstly, contrary to expectations, the document is not so much a 'report' as a ramshackle collection of (sometimes quite smart-looking) Powerpoint-style slides, each containing a series of statistics and assertions, but with little if any connecting explanation, evaluation or discussion of the proposal.

If this type of report were presented as an undergraduate research project at a university it would be rejected for inadequate use of supporting evidence and references, the lack of any clear structure or approach, and the lack of any coherent or collected conclusions.

Nonetheless this document contains many of the seed ideas around which PCTs across London, grouped into five secretive "sectors," have been meeting behind closed doors to plan the cutbacks.

Closures

Here are the proposals for "levers to reduce costs of care" including "reduced double running costs through a single point of access to urgent care" (in other words the rundown and closure of A&E units in London).

The document goes on to claim that more savings could also be had from "increasing scale, efficiency and quality from centralisation" of other hospital services (i.e. more closures).

Other "levers" to cut costs include reducing costs of clinical staff, using nurses and health professionals to replace doctors, and reduced costs of overheads (suggesting that the rollout of polyclinics could bring an 80% cut in clerical and admin staff working for GPs).

The report also discusses at some length the "decommissioning of some services" – effectively imposing a system of rationing access to treatment for conditions such as varicose veins, hernia and even joint replacements, leaving patients in pain with the "choice" of going private or going without.

No analysis

Time and again the ideas proposed in the McKinsey document are simply thrown in without any serious analysis of possible down-sides and problems, and without any discussion of the systems changes that would be needed to achieve the desired result.

In almost none of the examples is there even a costing of the likely investment required to make the change happen, let alone a balance sheet to show how any significant savings could result.

The McKinsey document is also confirmed as the central inspiration for those NHS managers who want to switch as many as 60% of A&E patients, and 50% of outpatients away from hospital facilities and into 'polyclinics' or other as yet non-existent facilities in primary care.

Yet the document also reveals how strange this obsession with running down A&E services has become, since the total London spend on existing A&E units is just 5% of the hospital budget and 2.65% of the total cost of London's NHS, so even a big proportional saving would not amount to much.

And there are no big savings to be made: in 2007-8 London's A&E units treated almost 4 million patients – at an average cost of just £79 each: it is hard to see how switching services to new premises could save very much from this, and of course there has been new research evidence to show that it would not be safe to switch anything like 60% of A&E cases into primary care.

Instead savings are sought in all kinds of unhelpful and unlikely areas: we are told that there should be a reduction in numbers of patients referred for outpatient care – despite the fact that 18 out of 31 London PCTs are already referring fewer than the national average. Nowhere is there a discussion of the possible impact on patient care of being denied specialist outpatient treatment.

Sick ideas

Sickness rates in London's hospital staff are the second lowest in England and below the national average – but McKinsey's claim that more money could be saved if fewer staff got sick: they don't tell us how, and appear to have no detailed analysis of the causes of sickness absence.

The London document argues for "possible but challenging" targets to save £2.4 billion through acute sector productivity, but this turns out to require a massive 21-37% increase in productivity by nurses, a 9-43% increase in doctors' productivity and a massive 34-42% saving on overhead costs: but it offers no practical ways in which these savings might be made.

McKinsey's appear to regard *all* paperwork, *all* admin, and even discussion with other nurses as outside the nurse's proper role, but they do not suggest who else should do these roles instead of nurses.

McKinsey's also prove to be the source of the suggestion that very large sums of money could be saved in primary care by slashing the average time allocated to patient appointments with GPs – by one third, from 12 minutes per patient to just 8.

This could 'save' a massive £570m, argues the slide, but it offers no discussion of the possible impact on patient care or patient satisfaction, let alone the job satisfaction of GPs: the Royal College of General Practitioners is currently campaigning for *longer* consultation times.

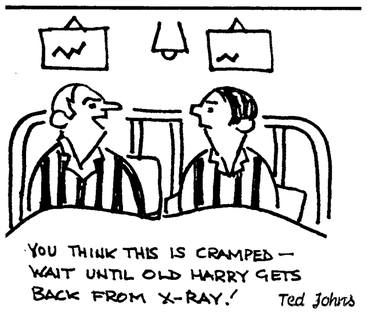
The document also claims that the same level of community services could be delivered by 11-15% fewer staff, if district nurse productivity could just be increased. Once again we are given no clues on how this should be done.

There are more examples – a long and shapeless list – but time and again the same gaps and evasions recur.

It seems clear that a lot of money has been wasted on these reports. Any money spent on them was wasted, because the total silence on exactly how any of the proposals are to be implemented means that they are as useful as a chocolate fireguard.

But as the ConDem coalition cranks up the heat, demanding £20 billion of NHS cutbacks – by 2014 – these proposals are the only ones on the table.

So even though the ideas are ill-judged, inconsistent and impractical, this does not mean that they will necessarily be discarded. Watch out for a McKinsey-style cutback near you!



What they are saying about the White Paper

Carillion, which has contracts for PFI hospitals and outsourcing was "excited", Virgin-owned private healthcare provider Assura Medical's chief executive was "enthusiastic".

Healthinvestor magazine has also eagerly embraced the white paper, which it argues "offers the private sector a raft of opportunities in the healthcare market by enabling patients to achieve greater choice and control over their treatment and care through access to any willing provider".

Pulse magazine, responding to FAQs warns that: "The White Paper will lead to huge new opportunities for private companies, with firms such as UnitedHealth, Tribal, Bupa and Harmoni already offering to run commissioning and accountancy services and back-office functions for GP consortiums."

The NHS Alliance welcomed the white paper as a "unique opportunity for frontline GPs", and Dr Michael Dixon of the Alliance has issued a rather desperate appeal for GPs not to turn their backs on the government proposals, claiming that it would be "utterly disastrous" if they did not "embrace the white paper and make it work."

The National Association of Primary Care has also said it was "vital that primary care clinicians embrace the new world open heartedly".

The Royal College of General Practitioners declared before the white paper was even published that it was the "right direction of travel": but its chair-elect Clare Gerada said "For most GPs, it's like rabbits in the headlights. There is also a natural disinclination to working with external organisations, for fear of going to the dark side and being part of the privatisation agenda.'

Right wing think tank Civitas warned that the upheaval could disrupt plans to drive through £20 billion in "efficiency savings". Stressed the "scant evidence base" for Lansley's plans, Civitas argued they could set the entire NHS back by at least a year, and "any slight blip will mean one thing for patients: a return to rationing, either by waiting or by reductions in services."

The Conservative Party's Bow Group, the oldest centre-right think tank in Britain, claims key strands of the reforms are unfeasible and risk creating a postcode lottery of healthcare.

The Nuffield Trust has warned that the reforms "will require significant management expertise to implement smoothly," and that "There is a huge risk that this level of reform cannot be implemented without major failure".

The slightly less right wing **Social Market Foundation** condemned the changes as "at best a waste of time, at worst a waste of money", warning that ill-prepared GPs could wind up outgunned and outmanoeuvred by powerful hospital Trusts.

The normally docile **Patients' Association** said that the changes are "a huge experiment without much hard evidence about how they will work in the NHS".

UNISON, the biggest public sector trade union, has taken the government to court challenging moves to implement the proposals before they are even debated in Parliament and while the "consultation" with the public is not yet concluded.

Unite, Britain's biggest union, has also opposed the proposals, and set up a campaign committee.

The BMA's National Council has voted heavily in favour of "critical engagement" with the consultation process, although it has not formally spelled out its reservations or identified any issues which might persuade negotiators to pull out if not resolved.

Former Health Secretary Andy Burnham, trying to kick-start his leadership bid in the Labour Party, has correctly branded the Lansley proposals as "Without doubt the most dangerous threat to the NHS in its 62-year history: a recipe to turn order into chaos, a fair service into a free-for-all, and to let market forces run riot. For patients, it means longer waits in A&E, months on waiting lists and a postcode lottery writ large."

A better policy: the BMA's Hamish Meldrum and BMA activists join a demonstration fighting the marketisation of the NHS

NHS White Paper summed up

The NHS White Paper "Equity and Excellence: Liberating the NHS" is the most radical NHS reform in 62 years since the NHS was formed.

Among its proposals:

'Efficiency savings' of £20 billion are to be generated by 2014.

It aims to abolish the existing commissioning organisations – 152 **Primary Care Trusts** and 10 **Strategic Health Authorities** – and hand the main responsibility for commissioning services with a combined budget of £80 billion to **GPs**.

GPs will be required by their contract to be members of around **500 local "consortiums"** which will be statutory bodies to carry out the responsibilities of commissioning. They will receive a **management allowance** to allow them to buy in support, which may be from former NHS employees or from the private sector.

A new **NHS Commissioning Board** will be established to commission primary care services, specialist care and maternity services. It will oversee the GP consortiums, and have powers to assign GPs to a consortium if they have not already joined one. It will have regional offices, and will employ NHS managers – but it is not known how many.

The 90 plus **NHS Trusts** which are not yet Foundation Trusts **will have to achieve Foundation status**, or become part of a larger Foundation Trust by 2013, when the legal status of NHS Trust will be abolished.

The **"cap"** that limits the proportion of **Foundation Trust** income that can be derived from **private medicine** or contracts with the private sector will be removed. FTs will be given greater freedom to operate as social enterprises, though they "will not be privatised". They will be encouraged to negotiate local variations on national pay and terms and conditions.

GP consortia and the NHS Commissioning Board will buy in health care from **"any willing provider"** – Foundation Trusts, social enterprises or the for-profit private sector. Competition law will apply.

Patients must be given free **choice of GP** (not restricted to where they live), **choice of any provider**, choice of **named consultant team**, and choices in **maternity care**, **mental health**, **diagnostic** testing, **long term conditions** and **end of life care**.

Performance targets including waiting times are to be **scrapped** and replaced by "outcome targets".

The Foundation Trust regulator, **Monitor**, is to become an economic regulator for all organisations providing NHS care.

The **public health** and health promotion functions of PCTs are to be taken over by **local government** through new 'health and wellbeing boards', which will also take over the role of councils' oversight and scrutiny of local health services.

The patient voice is also to be changed again: **Local Involvement Networks (LINks)** are to be replaced by new **Healthwatch** groups funded by local government, which will take on additional roles to make them "more like a 'citizen's advice bureau' for health and social care" (DH).

The White Paper is out to consultation until October. Most of its proposals are for swift implementation, and all of the proposals are to be carried through before 2014.

The full text is available: *www.official-documents.gov.uk/document/cm78/7881/7881.pdf*

Just say 'NO': TEN GOOD REASONS to oppose the NHS White Paper

1. Andrew Lansley's "reforms" would bring the biggest privatisation of health care anywhere in the world. It would transform our National Health Service into a competitive National Health Market, in which £100 billion of public money would be used to buy services from privatised providers. Competition and privatisation can force standards down, as happened when hospital cleaning services were privatised in the 1980s.

2. GPs will be compelled to join local commissioning "consortia", each probably including 80-100 GPs. These statutory bodies will take decisions on how the money should be spent. But the White Paper includes the biggest-ever squeeze on NHS funding, with £20 billion of "efficiency savings" required by 2014. So consortia will become **Rationing Boards,** offering GPs and their patients FEWER choices on the work these bodies did will divert GPs from their main role in delivering clinical care. Many consortia will either re-hire redundant PCT staff, or bring in private management consultants: the total level of 'bureaucracy' will be little different from now.

'We're short-staffed – find your own corridor to dump yourself in'

than they have now.

3. A recent poll of GPs suggests fewer than one in five believes the White Paper will improve the patient experience of the NHS. Almost three quarters believe it will increase the role of the private sector in commissioning. If GPs and consultants stood together to oppose it, this "reform" package could not pass.

4. Each PCT area would have 2-3 consortia, each of them taking its own decisions, with no overall planning authority, creating a new "postcode lottery" in which some consortia fund treatments that others will not.

5. PCTs and Strategic Health Authorities will be scrapped, and thousands of skilled and experienced managers and service planners will lose their jobs. But taking over by one – by 2013. Foundations will be removed from the NHS balance sheet. They would all become "social enterprises", and encouraged to tear up national pay scales for their staff, who would no longer be NHS employees. Legal limits on the amount of money Foundations can raise from private medicine are abolished by the White Paper. With NHS funding frozen, this will mean FTs will concentrate on drawing in paying patients from the UK and other countries, and open up a new 2-tier health service.

6. It will be less accountable to local people or to Parliament. Ministers will no longer answer questions or take any responsibility for local health services, which will be "regulated" by Monitor and the Care Quality Commission, neither of which has a successful track record. The new National Health Market would be even less publicly accountable than companies supplying gas or broadband.

7. The White Paper is silent on how consortia could avoid being 'captured' by the biggest and best resourced GP practices, most of which are in wealthy areas. There is no requirement for GP consortia to work with other consortia, or take any wider view beyond their own local catchment population. Contradictory decisions could result in the collapse or withdrawal of some local hospital and mental health services, again reducing choice for patients.

8. Every remaining NHS Trust will be forced to become a Foundation Trust – or be taken over by one – by 2013. Foundations will be removed from the NHS balance sheet. They would all become "social enterprises", and encouraged to tear up national pay scales for their staff, who would no longer be NHS employees. Legal limits on the amount of money Foundations can raise from private medicine are abolished by the White Paper. With NHS funding frozen, this will mean FTs will concentrate on drawing in paying patients from the UK and other countries, and open up a new 2-tier health service.

9. A competitive healthcare market will make it more difficult for GPs to collaborate with their medical colleagues in hospitals, and for consultants and hospital staff to share best practice. Competition law will apply, and will brand cooperation of this type as "collusion". The split between "purchaser" and "provider" will be widened.

10 All these changes are proposed without a shred of evidence that they will deliver the promised improvements. The last Tory government's experiment with GP Fundholding was an expensive failure in the 1990s, and new figures now show that "practice based commissioning" experiments under New Labour were more expensive than the system they replaced, with high levels of overspending.

How big could £20bn cuts be?

The King's Fund's chief economist John Appleby has recently spelled out the scale of threat to the NHS from the coming cash squeeze.

Arguing in the British Medical Journal (17 August) in favour of protection of the NHS against the general round of cuts affecting most other public services, he argues that if the NHS were not protected it would have to find actual cuts amounting to around 14% of its budget (£18 billion) over the next few years, and suggests five ways it could do this:

30% real pay cut for all staff
Abolish the NHS in London
No drugs
Sack all consultants and general practitioners
Abolish the NHS in Scotland and Wales

A different approach would be "for whole services to close down: no NHS dentistry (£2bn), no community services (£9bn), no ophthalmic services (£0.5bn) – and still another £6.5bn to find".

He sums up: "Fourteen per cent is equivalent to £18bn for the UK NHS. This is not a cut that can be achieved through a bit of salami slicing of everyone's budgets. The NHS would have to think at least on the scale of the suggestions above."

Appleby makes the obvious point that none of these proposals is very appealing.

But the ConDem White paper looks to make £20 billion of 'efficiency savings' by 2014.

So are we going to let them do it?

"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

Evidence-free market-style "reforms" that fragment care, increase costs, and let in private sector

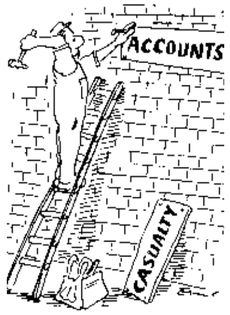
We've been here before!

Bob Dylan once famously sang that "you have to pay to get out of going through all these things twice". George Santayana told us that those who do not learn the lessons of history are doomed to repeat it. Karl Marx said that history repeats itself, "the first time as tragedy, the second time as farce".

Even the NHS Confederation, representing health service employers, recently published a critical study of reorganisations over the last ten years, entitled 'The triumph of hope over experience".

But Andrew Lansley's NHS White Paper is ignoring the lessons of two decades of failed "reforms" and reorganisation – and today's Condem coalition is going far further and faster down the road of privatisation than Margaret Thatcher's radical government ever contemplated.

JOHN LISTER looks back to show the similarities between today's policies and yesterday's costly failures.



What will it cost?

The White Paper will cost at least £1.7 billion to implement, although a recent editorial in the British Medical Journal estimated that the cost could be closer to £3 billion. Running alongside a massive squeeze on NHS budgets aimed at generating 'efficiency savings' of £20 billion by 2014, the reorganisation will also bring a loss of thousands of NHS jobs, many of them managers, but many more admin staff, clerical workers and clinical staff in front lines services.

However this does not mean that there is any guarantee the new policies will actually deliver savings on bureaucracy.

The difference would be that the new bureaucrats may no longer be directly employed by the NHS, or accountable through NHS organisations.

This is because closing down Primary Care Trusts and Strategic Health Authorities is linked with passing on the responsibility for the £100 billion NHS budget to GPs – most of whom lack the expertise, time and resources to take this work over without damaging the level of care they can give to their patients.

So GPs will have to employ staff to administer each of the 500 or GP Consortiums, which will be formed as the new statutory bodies to commission health care at local level. As such they will need responsible officers and management.

The GPs may choose to employ staff who will only recently have lost their jobs in PCTs and SHAs: or they may opt to bring in private sector management consultants, who (scenting profitable work on the way for them) have been among the most prominent supporters of Lansley's White Paper. 71% of GPs in a recent poll said they feared the White Paper would bring a greater private sector involvement in the commissioning process.

60% of those responding to a poll on the website of the strongly pro-White Paper National Association of Primary Care were opposed to the government's commissioning plans – that the NAPC is vociferously supporting.

Commissioning Board

In addition to the local commissioners the new NHS Commissioning Board will need to keep a watching brief on every GP consortium, and on the individual practices from which the Board will be commissioning primary care services, in addition to its other role of commissioning specialist care and maternity services.

This means, at least in the view of some experts, that the new Board will need to be big, with its own managerial structure, regional offices and directorates, and is likely to recruit senior staff from Strategic Health Authorities and PCTs.

But there will inevitably also be additional bureaucracy at the level of NHS Trusts and Foundation Trusts, since each Trust will be dealing with a far larger number of commissioning bodies, and negotiating with them. In the new competitive health market Foundation Trusts will require more marketing and commercial staff, who do not contribute to health care, but enable the Trust to compete with social enterprise and private providers.

So how much if anything will be saved from bureaucracy in real terms is open to considerable doubt.

High cost of markets

We already know that markets are more expensive as a way of administering the NHS than the previous integrated structure prior to 1990.

Earlier this year the Commons select committee revealed that the NHS was alreaday spending a staggering 14% of its budget – £15.4 billion per year – on management and administration: this compares with 8% in 1991-92, and 11% in 1995-96 as the costs of Margaret Thatcher's controversial 'internal market' reforms began to grow.

Numbers of senior managers have risen by a staggering 91% since 1995, more than double the 35% increase in the total of doctors and nurses.

More recent changes towards a more open market system have pushed costs even higher: recent figures show that even a limited roll-out of Practice-Based Commissioning, a precursor to the White Paper proposals, cost around twice as much in increased costs as it appeared to generate in savings, even as a voluntary scheme. The PBC practices overspent their budgets by an average of 2.5 percent, equivalent to a massive £2 billion overspend if applied to the whole £80 billion commissioning budget.

When GP Fundholders held on to funds

However we also know that the previous Conservative experiment in delegating commissioning to GPs was an expensive failure.

By 1994, just a couple of years into the GP Fundholding scheme, NHS chief Executive Alan Langlands was complaining that GPs faced a "paper overload," and the BMA was complaining that doctors were being turned into a "demoralised and demotivated workforce". Millions had been spent offering GPs £16,500 lump sums as a non-refundable down payment for expressing an interest in the scheme, and millions more on £30,000 start-up payments for those who signed up.

Of course some GP Fundholders did very nicely in holding on to funds: figures obtained by Alan Milburn MP showed just 585 fundholders had retained a total of £28 million in 1993-4 – an average of £47,000 for each practice. In NE Thames region fundholders held on to £1 for every £6 allocated, equivalent to £77,000 per doctor.

Admin costs were also high, since Trusts had to deal with a rapidly rising number of small-scale purchasers of health services, at an extra cost estimated in 1997 as at least £1m on average per Trust – or £500m a year.

The fragmentation of the NHS and the consequent bureaucratic costs appear to be very similar in each case: under the new White Paper each PCT will be replaced by on average three or four consortia, each of which will need managers and have to negotiate its own deals and contracts.

Fundholding = 2-tier NHS

What were the results of fundholding for patients? Even Andrew Lansley now admits that fundholding led to a "two-tier NHS".

By 1994 almost half of the 173 hospitals surveyed by the BMA were offering preferential services to fundholders' patients, with 41 of them promising fast track admission while other NHS patients were left to wait even longer.

We are now assured of course that GP consortia would be very different, because all GPs would be compelled to be members of a consortium, whereas fundholding was only open to the largest GP practices.

Lawrence Buckman, chair of the BMA's GP Committee insists that "This is definitely not the son of fundholding. … if it looked like fundholding mark 2 I would not be interested in it."

Buckman has focused on the fact that consortiums and GP practices will not be able to retain unspent surpluses: but they are likely to face potential penalties for overspending, which could potentially skew the clinical judgement of some GPs.

Many GPs already fear that the fragmentation of commissioning, a feature under fundholding, once again threatens a return of the same "postcode lottery" on whether patients are offered certain treatment, as different consortiums exert their own rights to decide.

Different decisions between one consortium and the next on what level of services to commission would leave patients in some areas with access to certain treatments and others in other areas without.

Neighbouring consortia could even take opposing views on whether to commission local services from hospitals or mental health providers: the danger here is that the withdrawal of even part of the current funding for some services could in some cases force Trust bosses into wholesale cutbacks or service closures, reducing the choices for patients.

The proposal to limit the management budgets for the new consortia is likely to restrict the resources to buy in locum care to enable GPs from smaller practices to get involved in decision-making.

This would strengthen the influence in consortiums of the larger and more wealthy practices, which tend (as with the pioneers of Fundholding) to be based in the wealthier areas.

So the needs of more affluent patients are in many areas likely to dominate over those on lower income with greater health needs who live in relatively deprived and inner city areas. This could bring the very opposite of the "Excellence and equity" promised in the White Paper.

The cost of replacing PCTs

Of course Lansley chose soft targets when he singled out the PCTs and SHAs for closure, and cunningly pushed the right buttons with some frustrated GPs when he suggested they take over the commissioning role. It would be hard to find anywhere else in the public sector where the possible loss of 60,000 jobs creates so little anger or militant resistance.

Few PCTs or SHAs have done anything to endear themselves to local communities – many of which have been systematically patronised and ignored in spurious "consultation" exercises – or to the many sections of staff in NHS staff in provider services who have been on the receiving end of some of their decisions.

So it's true that nobody could build a credible campaign simply to defend PCTs or SHAs. But by no means everything they have done has been without value, nor are all their staff pointless bureaucrats. Nor is it true that simply scrapping them will necessarily produce anything better.

Subdividing 150 PCTs into 5-600 GP consortia, each of 80-100 GPs, will inevitably raise the question of how these are to work either singly or together.

It seems certain that many of them will resort to re-hiring staff made redundant from PCTs – or spend even more to bring in private management consultants to do much of the administrative work that still needs to be done: and with NHS providers having to negotiate with more separate groups of "purchasers" the total bill for bureaucracy will not fall by much – if it falls at all.

But the new bureaucracy will be even less accountable than the PCTs.

Caps off for private patients

Another experiment ignoring negative experience is the proposal in the White Paper to remove the legal "cap" which restricts the proportion of a Foundation Trust's income that can be derived from private medicine or deals with the private sector.

This strict limit, confining Trusts to the percentage of income from private work that they had before Foundation status, was introduced back in 2003 as part of the government effort to push the controversial plan for Foundation Trusts through Parliament.

Sceptical MPs demanded an assurance that the new free-standing non-profit businesses would not simply concentrate on private work: the Bill eventually scraped through with a majority of just 17.

One reason for such strong concerns was that it was well known that in the early and mid 1990s one of the first "freedoms" that the new NHS Trusts began to exploit was the freedom to build or expand their private patient wings – although there is little evidence that many, if any, of them made much actual profit from them.

This siphoning off of resources from NHS patients resulted in another widening of inequality within the NHS, driven by market forces.

One attraction to Foundation Trusts of income from commercial medicine is that it is not restricted or squeezed in the same way as public sector NHS budgets will be for at least the next five years.

So this also means that as budgets are frozen in real terms, and pressures increase, Foundation Trusts will be more tempted to seek out profitable paying customers – whether from the UK or abroad – to compensate for shrinking NHS income, and to prioritise this work over the treatment of NHS patients. Some specialist Foundation Trusts are already looking to expand their income from overseas patients.

Foundations of privatisation

Foundation Trusts are another area of concern. The White Paper has made it quite clear that all NHS Trusts must become Foundations, or be taken over by one by 2013.

It is also clear that if Lansley gets his way, Foundations will be removed from the NHS balance sheet. This would mean that their staff would no longer NHS employees, while their assets would be privatised, whether they remain as non-profit 'social enterprises' or are eventually absorbed into the for-profit private sector.

Although the White Paper declares that "Foundation Trusts will not be privatised", that only means that the legislation to impose these changes will not privatise them.

However once they are off the NHS balance sheet, and run as free-standing businesses, answerable only to Monitor – the same body that is also supposed to regulate for-profit private providers – what is to stop Foundations being taken over by a private company, or even deciding to become a for-profit business?

Even if they don't go this far, the competitive National Health Market system outlined in the White Paper will force all social enterprises and Foundations to run just like private businesses – and that's not good for staff or for patients.

Foundations that went wrong

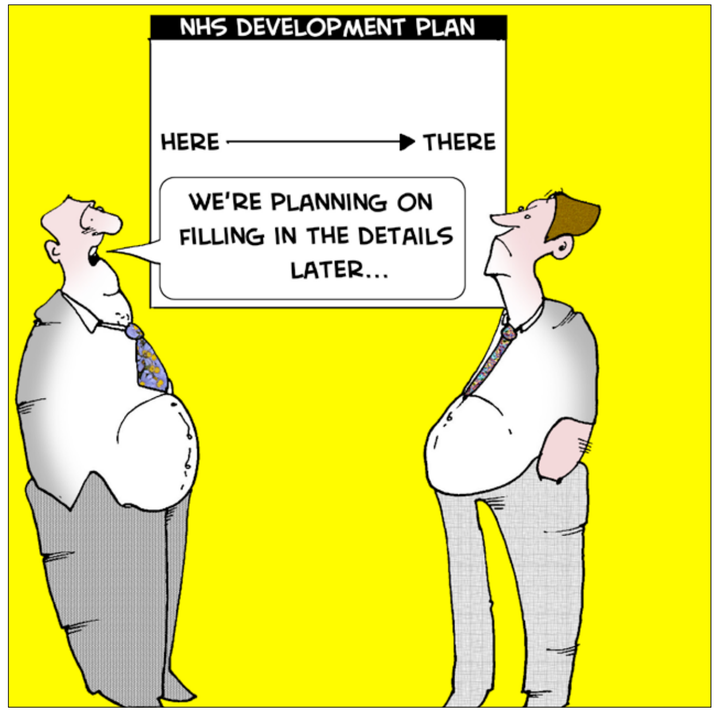
Experience in other countries where hospitals have been floated off as foundation trusts also gives grounds for concern.

One early foundation-style hospital was privatised – swallowed up by the private sector. This is what happened to one of the first Swedish Foundation Trusts, St Goran's in Stockholm. Now it's the country's biggest private hospital.

In New Zealand in the ill-fated market reforms of the 1990s the equivalent to NHS Trusts were allowed to borrow money freely from the private sector: they quickly ran up hundreds of millions in debts, which it eventually took the government years to pay off.

In both Sweden and New Zealand the government had to step in to bring the hospitals back under control and prevent worse damage.

However the White Paper reforms will push the Foundations and their massive multi-billion assets so far outside the control of the Health Secretary and NHS Commissioning Board that only radical legislation on the scale of the 1948 NHS Act – which nationalised the mish-mash of municipal, charitable and teaching hospitals delivering health care – could bring them back into the pubic sector.



Ignoring history lessons

So what is the historical experience of wholesale organisational changes like those proposed in the White Paper?

In its recent survey on this, the NHS Confederation points to a rapid succession of changes in the NHS especially over the last ten years, all of them based on little hard evidence, and subject to little if any proper evaluation.

Conspicuously it notes that after 1997: "99 health authorities were split into a large number of primary care groups and then primary care trusts because it was thought that they were too large to create to primary care. The 302 PCTs were then reduced to 152 …

"One reason given for this was that the small groups had high overheads and did not map closely enough to local government boundaries. There were also questions about whether there were enough high-calibre managers to staff 302 organisations."

(*The triumph of hope over experience*: page 8)

By contrast Andrew Lansley is now proposing to increase again even further – from 152 PCTs to 500 or more local GP consortiums, and seeking to cut management costs. This appears to be ignoring the lessons learned the hard way in the last decade.

Former NHS Commissioning Director Mark Britnell, now firmly in the private sector, has warned Lansley that his GP consortiums are too small to work effectively, and to succeed would need to be as big as PCTs: "It won't work if we create 500 cottage-sized commissioning bodies".

One head of procurement at an NHS Trust, speaking anonymously to Supplymanagement.com echoed the same point, arguing that GP commissioning will lead to a "fragmented service".

The Nuffield Trust also argues that the disruption flowing from the reorganisation and the need for GPs to learn new skills and new ways of working mean that it would take "several years" for the new system to make any savings, and that in the meantime big deficits could be run up.

Even the NHS Alliance, which has taken an ambiguous position on the proposals has warned that the deficits which PCTs are likely to pass on the GP consortiums could mean that the experiment in commissioning is "doomed to fail".

The biggest-ever privatisation of health care

If the White Paper is carried through to its logical conclusion, by 2014 there will be no NHS or public sector providers delivering health care services in England. Hospitals, community health services and mental health will all have been forced to become, or join Foundation Trusts, or will have been put out to tender to 'social enterprises' or the for-profit private sector.

Privatisation on this scale is unprecedented anywhere in the world, so there are no direct comparisons that can be made.

However we do know that competition and private sector providers can force standards *down*, as happened when hospital cleaning services were privatised under Thatcher in the 1980s.

The result of that experiment has now been widely recognised as a catastrophe: a break-up of the NHS team, the casualisation of the workforce, a plunge in hospital hygiene, and the spread of MRSA and hospital infections.

The minimal apparent short-term cash savings made at the expense of their lowest-paid staff by the hospitals which contracted out these services have been subsequently more than swallowed up by inferior quality of services and the costs of additional bed days, closed wards and other problems from hospital-acquired infections.

There is more unhappy experience of private sector involvement.

Repeated attempts by New Labour to draw the private sector into providing NHS services have also proved costly and delivered questionable results.

Contracts with private hospitals to deliver waiting list treatment have cost massively more than normal NHS costs, while the delivery of minor elective surgery in "Independent Sector Treatment Centres" cost an average of almost 12% more than the standard NHS price, but also wound up spending millions on operations that did not take place as patients chose to go to NHS hospitals instead.

Private sector bids for primary care contracts have tended to force down the quality of care, reducing prices by employing fewer, less qualified staff than established local GP practices.

Huge questions hang over the quality of services and poor regulation and monitoring of private companies delivering out of hours GP cover.

Business as usual, as

Lansley drops "moratorium" on closures

Andrew Wiard

Andrew Lansley's much-vaunted "moratorium' on closures of A&E and maternity units, which he theatrically unveiled at one of the threatened hospitals, Chase Farm in Enfield, is already dead and buried.

In fact even as he announced it, Lansley pointed out that it would probably not apply to closures that had already gone through the usual sham NHS "consultation" procedure.

The pledge to halt amy closures was only ever an opportunist electoral ploy, and once the Lib Dems had smoothed the path to Tory power there was no need to maintain the pretence any longer.

One early embarrassed casualty of this was Bexley MP James Brokenshire, who had rather unwisely trumpeted his claim to have a personal promise from Lansley to rescue the threatened Queen Mary's Hospital in Sidcup.

Brokenshire was left publicly dangling for a few weeks after the election, until a "review" of the closures at QMH was announced – to be conducted by Simon Robbins, the chief hitman driving through the closure!

Other services like to be hacked back on a similar basis of already completed consultation include Chase Farm (yes the same one where Lansley drew his line in the sand).

The end of the moratorium was flagged up at the end of July by NHS Chief Executive David Nicholson, who explained that it would be up to Strategic Health Authorities to decide, by October 31, whether contested closures should go ahead, and warning against "potentially vexatious objections" from stakeholders who remained opposed.

And there is evidence from around the country that the effective veto that Lansley appeared to offer GPs, apparently allowing them to block closures they did not support, is being brazenly disregarded by desperate Trust and PCT bosses trying to force through spending cuts.

In Kent, GP organisations have complained that a controversial closure of maternity and paediatric services at Maidstone Hospital are being pushed through despite then overwhelming (91%) opposition of local GPs.

In North East London, GPs are furious that their objections are being ignored as health chiefs press ahead with the closure of A&E and other services at King George's Hospital in Ilford. Health for North East London even admitted that there had been "more disagreement than support" for their plans to axe services at King George's – but insisted that patients "would benefit" from the changes.

The NHS Confederation has warned NHS bosses that they must "think big" and seek large-scale changes if they are to meet tough targets to squeeze down costs and spending.

This could mean that "beds and wards need to be closed, but also entire buildings and possibly whole sites."

And the Confed report 'Dealing with the Downturn' also challenges the myth widely spread by NHS managers at every level that savings of this scale can be made with no further impact on frontline staff.

"The changes that will be required are so significant that it is almost certain that frontline services will be affected."

London health chiefs dust off their plans for cuts and closures

A look at the Strategic documents covering London's health care seems like a real blast from an already-forgotten past of polyclinics, Darzi plans, and the mumbo-jumbo of "World Class Commissioning".

But as the cash squeeze tightens on Trusts and PCTs, the cuts proposed in the dying days of Gordon Brown's government are the only real proposals on the table, and controversial closure plans are being dusted off again after the brief Lansley moratorium.

Health for North East London certainly seems determined to grind on with controversial cuts and closures it outlined at the end of last year.

Under the plans, just two hospitals, The Royal London in Whitechapel and Queen's Hospital in Romford, would become "major acute" hospitals: others (Homerton, Whipps Cross and Newham) would be downgraded to "local hospitals" – and King George's Hospital in Ilford would be stripped of most of its acute services and effectively reduced to a large polyclinic with as few as 50 beds.

827 acute beds would be cut in NE London, just over 20% of the total. More than half of them would be at King George's, but also 146 in Whipps Cross Hospital and a hefty 234 beds in Bart's and the London, raising extremely serious questions over the affordability of the Trust's £1 billion PFI scheme, which will not even open until 2013.

So massive would be the reduction in activity at King George's that its remaining acute services would require just one third of the space it currently occupies, and more than half the site to be mothballed or stripped of services and sold off. The plans include a £6 million allocation for redundancies.

Hospital outpatient appointments would be more than halved, with almost a million appointments in NE London moved out of hospital clinics to primary care "settings" including polyclinics.

With hefty losses of income from this relocation of work, the financial viability of hospital Trusts in NE London could only be maintained if they generate massive 'productivity gains' totalling over £500 million a year.

The financial projections suggest that if no 'savings' are made, inner NE London would on a best case ("upside") face a £118m shortfall by 2017, while the worst case would see a gap of £257m. The figures for outer NE London are similar, with a best case gap of £144m and a worst case of £283m.

To redress this gap the sector plan suggests a combination of measures:

"Decommissioning services" (estimated savings £60m-£150m)

"Shifting acute activity to a lower cost setting" with (unexplained) estimated savings ranging from £10m to £70m.

Putting a range of primary care, mental health and community services out to tender, with forecast "potential" savings of £200m to £550m "depending on how aggressive the commissioners chose to be".

The NE London estimates "assume net savings of £142m from decommissioning and shifting settings of care," and another £273m a year to be cut from non-acute services, giving a grand total of £415m of savings by 2017, with the lion's share of these savings to be generated by local hospitals, mental health Trusts and community services.

The biggest savings target is a 35% saving on expenditure by the Barking Havering & Redbridge Trust, but Bart's & the London is required to generate the largest amount in savings (£211m), equivalent to 32% of its current spending.

Among the "opportunities for productivity gains", the NE London health bosses propose:

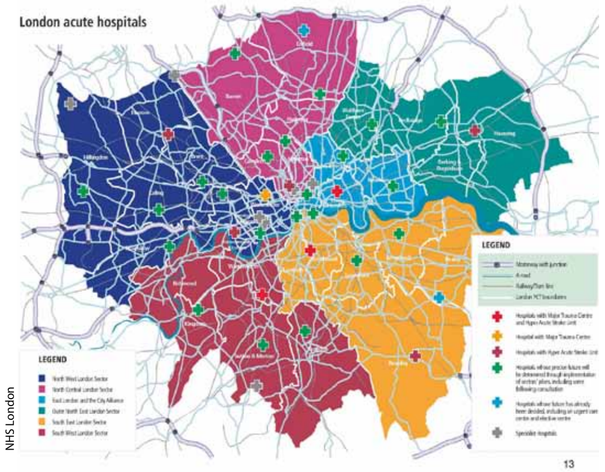
A 21% to 37% saving on nursing costs

A saving of between 9% and 43% in spending on doctors

Slashing drug spending by 22-25%

Reducing overhead costs to "benchmarked best practice", saving 34-42% of overhead costs

Other "productivity gains" (such as in theatres and diagnostics) to save up to 32% of costs.



North Central London

North Central London's Strategy is driven by the need to bridge a projected resource gap of £560m by 2017, and seeks to 'reconfigure' hospital services with the loss of 250-500 beds, and to reduce the number of mental health beds in addition to squeezing more "efficiencies" from staff and shifting large volumes of A&E and other work from hospitals to primary care.

The five acute Trusts within the sector face a potential combined deficit of over £350m by 2016/17 – almost 20% of their current combined revenue.

The publication of the plan came in the midst of growing public anger at plans that threaten the future of A&E services at Islington's Whittington hospital and the running down of services at Enfield's Chase Farm Hospital, where A&E services remain controversially under threat, along with obstetric, neonatal, inpatient paediatric and emergency gynaecology services.

North West London

Covering eight London boroughs and accounting for almost a quarter of London's health spending NW London faces a huge cash gap for both commissioners and providers, seeking a £796m reduction in hospital budgets through shifting work elsewhere, "decommissioning" services, "cost improvement plans" and other cuts.

As a result NW London faces some of the more drastic upheavals in the capital, and health chiefs admit in their Integrated Strategic Plan that it will "inevitably result in fewer beds in the acute sector" and "substantial acute hospital reconfiguration". This could potentially leave no major acute hospital between St Mary's Paddington and the M25 (17 miles) or Heathrow airport (15 miles).

Chelsea and Westminster Hospital is to be effectively downgraded to a "specialist and local hospital," as is Central Middlesex Hospital.

Andrew Wiard

But the biggest doubts hang over the future of Ealing Hospital and the financially challenged West Middlesex Hospital in Isleworth. Ealing is to be merged with the newly-merged PCT provider services in Ealing, Brent and Harrow to become an 'Integrated Care Organisation' – In other words the hospital will effectively wither away and close, leaving nothing more than a polyclinic at best on the site.

The West Middlesex board has apparently "clarified that they do not believe that their organisation has an independent future'. It seems it could follow Hinchingbrooke Hospital, in Huntingdon as one of the first to have its management put out to tender, and it could be reduced to a 'local' hospital or to purely an elective centre.

South West London

In South West London only St George's is guaranteed to retain its existing services, since it has been designated as the only "major acute" hospital in the sector. This means that Kingston, Epsom & St Helier and Mayday Trusts all have a doubtful future, with the possibility of the loss of maternity, paediatrics, or other services

The Case for Change document warns that

"If no changes are made we estimate that by 2016/17 the NHS in south west London could be spending around £300 million more than its predicted budget".

South East London

In South East London Powerpoint slides from Simon Robbins, the "senior responsible officer," project a funding gap of £467m to 2014. By 2016/17 the potential gap is projected to reach £810-£1,090m.

SE London apparently plans to tackle the funding gap through imposing cuts to the tariff for acute care (£224m) and significantly also for mental health (£62m) – equivalent to 13% of the income of the two mental health Foundation Trusts that deliver services to the sector (Oxleas and South London & Maudsley).

Substantial disinvestment from mental health is planned.

SE London is also looking to save £31m by transferring acute activity to "lower cost settings," £79m by decommissioning services, preventive measures and better management of long term conditions, and a hefty £109m from reducing costs in non-acute services (community and primary care).

The NHS London map shows that the decision on one SE London hospital (Queen Mary's Sidcup) has already been taken: it will be downgraded to an "urgent care centre" and elective centre, losing most of its acute inpatient services.

Jobs on the line

The most recent global estimate is that 11,000 job losses have been announced in the NHS this year by 106 Trusts, raising the concern that 40,000 could be lost in England alone.

● Plymouth's Derriford Hospital has announced plans to cut £27.5m from its £370m budget: no job cuts yet identified.

● Reading's Royal Berkshire Hospital is to cut £60m with 600 job losses from its 4,500 staff.

● Kent's three PCTs have revealed plans to axe 40% of management posts over three years.

● Nurses in Shropshire have been asked voluntarily to cut their shifts to help management avoid axing jobs. Bizarrely the same managers at the Royal Shrewsbury and Telford's Princess Royal Hospitals are also trying to cut use of agency staff.

● York Hospitals Foundation Trust has announced the need to cut £30m over three years and asked staff to suggest how it should be done.

● 130 PCT management jobs are to be axed by NHS Leeds over three years to save £5 million.

● Wakefield PCT is to cut more than 40 management jobs to save £1.4m. Further cuts of £4m will follow in the next two years.

● NHS Northamptonshire is to cut 56 jobs and leave 22 vacant posts unfilled as it struggles to cut management costs by £3.5m.

● Aintree Hospital is planning to cut the equivalent of at least 300 jobs, and is asking all 5,000 staff to consider voluntary redundancy or moving on to flexible hours.

Cambridge

UNISON in Cambridge University Hospitals Trust has pledged to fight plans to axe 170 nursing jobs as part of a £40m cuts programme over three years. But the local Scrutiny Committee has warned that the cuts could be as high as 500 jobs in total, with vacancies left unfilled. UNISON will oppose any staffing cuts which put patient care and standards at risk.

North East

Hundreds of jobs are at risk and 450 beds (14% of the total) threatened with closure in the North East by 2104 to carry through savings of £800m, driven by the Condem government's £20 billion target for "efficiencies'. The first redundancies could begin as early as October. 1,700 jobs are to go in Cumbria and the North East. County Durham and Darlington NHS Trust is aiming to cut £60m, 300 beds and 300 nursing jobs.

Bristol

Campaigners who raised £4 million to fund a specialist children's unit at Frenchay Hospital are furious that it will now be closed and the services moved to the other side of Bristol, at a cost of £20 million.

Frenchay will be downgraded to a community hospital, as a new "superhospital" funded through the Private Finance Initiative opens in Southmead.

Mid Yorks £55m cuts: 500 jobs

UNISON has warned for years that the full cost of the new £353m Private Finance Initiative (PFI) hospitals in Wakefield and Pontefract would mean massive cuts in staff, pay and conditions.

Trust Chief Executive Julia Squire has now admitted to the local Express that the Trust aims to cut £55m by 2012 – including £38m this year, which means cutting the wage bill by £20m by next March.

500 jobs are affected, with an estimated 150 redundancies: in other words the Trust is looking to squeeze out another 350 staff without paying a penny in severance.

That helps explain the new attacks on staff terms and conditions and the draconian new management regime for staff transferring into the new building.

This is not incompetent or thoughtless management, but a deliberate plan to press more staff to walk away – and dump the work on those staff who remain.

That's what they mean by 'natural wastage' and 'staff turnover': either way it means more work, and more stress on the staff who stay on.

The opening of the new Pinderfields Hospital brings a cut of 100 elderly care beds – a reduction of 43% – and the loss of 64 whole time equivalent staff. But the Trust is already facing severe bed shortages, and scouring the local community for additional beds, while Julia Squire insists that "more care will move closer to people's homes."

Ms Squire claims to the Express that the workforce plan has been the product of discussions and 'open meetings' with staff: but the reality is a hard-faced management who have refused to answer questions, consult with the unions or even respond when grievances and disputes are formally notified.

Of course the "public sector deficit" driving the squeeze on NHS spending flows from the crisis of the private sector – the banks – which are now pocketing huge profits once again.

The Mid Yorkshire Hospitals Trust's financial problems flow in large measure from the increased costs of the PFI project, which delivers guaranteed profits to the private sector for the next 32 years, and which means the NHS will fork out £1.2 billion for a hospital valued at £353m.

The UNISON branch has vowed to fight "any redundancies whatsoever, whether compulsory or 'voluntary'", and demanded the full nationalisation of the Royal Bank of Scotland, "to eliminate profiteering from health care and lift the burden of PFI".

Brum's £2.6bn PFI fiasco

The new £627m super-hospital in Birmingham opened to patients in a fanfare of publicity in June, but within a couple of weeks the 1213-bed hospital was diverting patients to surrounding hospitals because it couldn't cope.

Plumbing problems compounded the misery, with patients complaining of scalding showers and freezing water in wash basins, while nurses could not get cold water out of taps in clinical areas.

One patient was almost struck by a light fitting which fell from a ceiling.

Short-staffed nurses under stress were heard by patients arguing with doctors about staffing rotas and inadequate numbers to cope with a higher than expected number of emergencies.

The hospital is one of the first PFI-funded hospitals to exclude non-clinical support services from the contract: but it will still cost the Trust a massive £2.58 billion over 35 years, with payments beginning at £47m, and ending in 2048 with a payment of £108m.

Firms bid to run Hinchingbrooke Hospital

If these companies are the answer ...

UNISON Eastern Region has been battling to prevent the privatisation of the management of Hinchingbrooke Hospital in Cambridgeshire.

The Huntingdon hospital seems set to become one of the very first District General Hospitals franchised out to a profit-seeking private company.

The "franchise" to manage the district general hospital was controversially put out to tender by NHS East of England 18 months ago, on the flimsiest of evidence – and despite being reminded of the disastrous failure of the only previous attempt to franchise out management of a whole hospital to a private company.

After the only remaining public sector bid, from the Cambridge University Hospitals Trust, was withdrawn in February, blaming "the huge cost, both in time and money, of the bidding process", the short list of five private companies has now been whittled down to just two: Circle Health, and Serco, the services company that runs the Docklands Light Railway

The only company with any substantial experience of running (private) hospitals, Ramsay Health Care, an Australian company, was excluded from the running by East of England in August.

Hinchingbrooke Hospital is less than 27 years old, and has a total of 310 adult beds, in addition to 25 paediatric beds and 12 SCBU cots on the site (run by the PCT). It has employed up to 2,000 staff.

Its scale and mix of services makes it more than six times bigger – and many times more complex to run – than the average private sector hospital.

Private hospitals in England have an average of just 50 beds, and focus exclusively on elective treatment for non-complex conditions: they do not offer emergency surgery or medicine, and any patient developing complications will be transferred by ambulance to an NHS hospital.

Private hospitals have relatively few full-time staff (mainly nursing and support staff) with doctors mostly working only on sessional basis.

Neither Circle nor Serco has any previous experience of running a large, busy general hospital. Each of them has a questionable record of involvement with the NHS.

UNISON has argued from the beginning that none of the shortlisted companies is suitable to take on the management of Hinchingbrooke, and that the quality of patient care is being put at risk.

If these companies are the answer, then NHS East of England has been asking the wrong questions.

● The track record of private sector management attempting to take over and turn around NHS hospitals has been disastrous. It was a lamentable failure at Good Hope Hospital in Solihull. There a

3-year contract with Secta to manage the 550-bed hospital began amid a welter of optimistic publicity in September 2003, but was terminated eight months early, at the end of 2005, when the running of the hospital was handed to the management of Birmingham Heartlands Hospital Trust.

During the contract the company successfully jacked up its own fees by 48% in its first year, and by the time the acting chief executive, finally cleared her desk, the Trust was in a far worse state that when she started – losing money at £1 million per month, heading for a £47 million deficit , and threatening to pull down the entire local health economy.

Why won't NHS East of England learn from this failure?

John Harris reportdigital.co.uk

Top ten deceptive claims ...

NHS East of England continue to frustrate and annoy local people and campaigners by pumping out deceptive statements such as their claim in the "Top Ten Facts" that:

"Hinchingbrooke is not being privatised. What is being offered is a franchise to operate the hospital."

So who are the shortlisted companies to win that franchise? Two private companies, with no public sector contender left in the frame: the management is being privatised.

Or what about this whopper?

"The successful franchisee *will not be making a profit at the expense of patient care*. They will be subject to the same clinical and operational scrutiny as every NHS hospital."

So have East of England bureaucrats told the companies that they are expected to carry out the work for no profit? Of course not, or they would have pulled out even earlier than managers at Addenbrookes.

With the future of SHAs looking gloomy, those overpaid East of England jokers just keep on making it harder to find the will to fight the Condem plans to abolish them.

2-year pay freeze – and threat of pension "review"

The ConDems are imposing a pay freeze on all NHS staff paid more than £21k/year, with a below inflation increase of just £250 for those paid less than this.

This would mean only 38% of NHS staff in England who are on pay points 1-15 getting a rise next year.

The so called independence of the PRB will be tested once again if a pay freeze is imposed from above by the government after evidence is submitted as usual by unions in September.

The biggest health union UNISON is going ahead with the data cleansing needed to ensure that its members are able to take industrial action without legal interference as agreed in the motion on pay passed at its Health Conference this year.

UNISON members will be consulted on how to respond to the pay freeze: but this is by no means the only threat that NHS staff face. This autumn the ConDem Review of Public Sector Pensions makes its report.

The review, which has disgracefully been chaired by former Labour Minister "Lord" John Hutton, is expected to slash NHS pension benefits, as well as those of other public sector workers.

UNISON national conference in July voted for national industrial action across the public sector if pensions are attacked.

White Paper threat to mental health

Mental health professionals and campaigners have rounded on the ConDem government for its combination of damaging cutbacks, and the threat that mental health services will lose out even further under the new plans to hand over the commissioning role to GPs.

In July a heavyweight medical journal, the Lancet , published an editorial demanding Health Secretary Andrew Lansley "tell the truth about NHS cuts" in front-line services, singling out the brutal cuts being carried through against mental health services in Oxfordshire, and contrasting this with Lansley's pre-election pledge to "increase health spending every year".

Oxfordshire and Buckinghamshire Mental Health Foundation Trust is pushing through plans to slash £5.3m from its £42m budget (12.6%) over the next four years, hitting front-line services for both adults and older adults.

Adult services are to lose 3 out of 19 consultant psychiatrists, 16 coordinators and 9 other staff, along with cuts in clinical psychologists.

Older adult services will also face cuts in professional staff.

Meanwhile a trade union representing some of the community mental health staff, Unite, has warned that up to 50 of the Trust's 200 staff in adult mental health teams could lose their jobs in the cuts, after in-patient services have already been cut "to the bone".

Poorer service

The document leaked to the Lancet admits that the cuts will bring a "reduction in quality of service", poorer service response with "patients waiting for care" and "dissatisfaction" among patients and carers.

The impact on staff is also admitted to be serious, with the Trust predicting "potential negative impact on staff from them perceiving an increase in their workload", "poorer staff retention and reduction in staff satisfaction with their role".

Perhaps even more worrying the document also warns the decreased patient satisfaction could lead to "possible patient withdrawal from care".

At a time when demand for mental health care is increasing and the severity of the problems faced by patients is increasing, with a greater expectation that services will be available "closer to home", home visits in Oxfordshire and Buckinghamshire would be cut.

Other cuts are taking shape in mental health services in London and other parts of the country including Sussex, where a quarter of inpatient beds are to close, affecting services in Haywards Heath, Eastbourne and St Leonards to save £4m.

In central London, NHS Camden is planning to put psychological services out to tender, triggering fears that a private company could step in. Indeed other government policies are also causing problems for mental health patients, not least the latest onslaught on the benefits system which will target people on incapacity benefit.

The new "fit to work" policy could mean that people suffering from mental illness would be declared capable of work. Mental health charity Mind has warned that the new test for incapacity benefit does not take proper account of the fluctuation condition of many with mental illness, and that staff running the assessments are insufficiently trained in awareness of mental health issues.

Philip Wolmuth reportdigital.co.uk

Workers at the Hackney Centre for Forensic Mental Health join a Unison protest outside East London NHS Foundation Trust against privatisation and cuts

GPs say no

Long-term concerns for the future of mental health services under the White Paper proposals have been reinforced by the survey of GPs in July which showed that as few as one in three felt equipped to take on any responsibility for commissioning on mental health.

Mental health charity Rethink, which conducted the survey, warned that unless there was rapid action to educate GPs on mental health, many of the 1.5 million people with severe mental illnesses may fail to get the treatment they need.

Rethink's Chief Executive Paul Jenkins said: "We often hear from people with mental illness that GPs don't understand mental health and want to quickly refer them on to specialists. Now GPs themselves are telling us that they have concerns too.

"The proposals expected in the white paper can work, but only if GPs are given proper training and support to understand the needs of people with severe mental illnesses such as schizophrenia and bipolar disorder."

Another survey of GPs by the doctors.net website in July found that two thirds of those responding did not welcome the Lansley white paper, and 80% said they were not adequately equipped to take over commissioning mental health services.

Mind's chief executive Paul Farmer also warned of weaknesses in GPs' approach to mental health issues: "There is still an instinct for some GPs to reach for the pills too quickly – we have 36 million prescriptions a year for anti-depressants, a vast amount at primary care level."

Mental health problems on average take up between 10%-20% of the time of a GP, with around three out of every four people who experience mental health problems seeking treatment from their GP.

Every year 300 out of every 1,000 people experience some form of mental health problem: but it seems that the NHS has a long way to go before this scale of importance is recognised in the allocation of resources.

Instead of moving towards meeting this level of demand, the White Paper proposals will create an even more random "postcode lottery" for mental health patients … and place millions in commissioning budgets in the hands of GPs who recognise that they are not trained to it properly, and don't want to do it.

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