HEALTH EMERGENCY

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United effort can block Tory attack

When the Health and Social Care Act received the royal rubber stamp, the Tory led coalition achieved a victory – but at a heavy political price. LibDem credibility has been reduced to near zero, and the Conservative poll ratings are down to 30% – dragged down by public opposition to the Bill.

Nor did the government win the argument. The forces opposing the Bill were able to challenge and refute all of the claims made by ministers as they tried to bluff and lie their way through.

Two big lies

The two big lies were of course the GPs would be put in charge, and that the Lansley Bill was "not privatisation". Of course most GPs were never fooled, and made clear every time they were asked that most – 98% on the final poll – were against the Bill. It is now estimated that the total number of GPs actively supporting and engaged in commissioning under the Act is little more than 25.

But even while they opposed the Bill most GPs sadly did little or nothing to fight it: neither did the BMA or most of the medical Royal Colleges which eventually came out against the Bill took many months to do so, and failed to join the campaign efforts to stop it.

Public opposition is also still strong, with people especially angry at having only seen so late what was happening to the NHS – not least because of the lack of accurate information in some appalling press coverage, and most notably really poor coverage from the BBC.

But now the Act has been passed, the reality is biting home.

Privatisation is rampant – led by Richard Branson's Virgin Care, with other profiteers also lining up to carve profitable slices out of the NHS budget: community health services are the most common early targets, with other NHS services up for grabs later.

COMMON CAUSE: a King's Lynn campaigner on the TUC March 7 Day of Action links pensions fight with the battle against Lansley's Health & Social Care Bill

GPs are finding they have been stitched up – with extensive powers in the hands of the National Commissioning Board. Clinical Commissioning Groups are being forced to merge into bigger and bigger units, making a laughing stock of the claim that they offer local control and accountability. Commissioning Support Services are being planned and dictated by the NCB – with the private sector waiting in the wings, looking for opportunities, with a market for commissioning support estimated at £1.3 billion a year.

CCGs are also realising that they are inheriting deficits and immediate responsibility to impose unpopular local cuts.

More cuts to come

Cuts that were kept on the back burner while the Bill went through are now being accelerated. Jobs, beds, wards, services and whole hospitals are being axed. NHS Midlands and East is looking to cut at least 9,000 jobs. And when the first £20 billion of cuts are complete, there is at least as much to cut in a second massive round.

At the centre of many of these cuts is what is being called a 'tsunami' of trust mergers – heralding yet another huge round of rationalisation, closures of local services, job losses and misery for local communities, especially the elderly and those with limited mobility.

And PFI is still siphoning hundreds of millions from the NHS into the pockets of shareholders, having been given another lease of life by Andrew Lansley: PFI debts are driving another round of cuts (see page 6)

But of course all of this is highly unpopular: and the full force of the Act does not kick in until next year. So now is the best time to make a stand: make it as hard as possible for ministers and for local health bureaucrats to push through the cuts, create the market they want in health care, or to privatise local services.

Trade unions must link up with local campaigners, pensioners groups, and even with local councillors and MPs to monitor the damage done by the Act, and by cuts in every area.

We need to bring together information on every deal that is being done, every contract being signed, every bonus being offered to bureaucrats or to GPs, and every cutback being contemplated or carried out.

Armed with this information health unions must link up with the wider public and with the campaigners who have been raising these issues consistently. The fight against cuts and for jobs and conditions in the NHS connects completely with the fight against Lansley's market reforms and privatisation.

Don't get sore – get even. It's our NHS – and we still have a lot to defend. Let's not give up on the fight to keep our NHS and keep it public.

Organising to fight the new Act

A conference

SATURDAY June 23

Friends House
Euston Road NW1 2BJ
(Tube: Euston)

Linking up campaigners and unions

www. keepournhspublic.com

Community services up for grabs

Privatisation is gathering pace in community health services, where each PCT has to open at least three community services to any qualified provider.

Tendering is also rife. In Devon, children's services are among those to be parcelled out, with Virgin and multinational all-purpose privatising company Serco both in the running for the contract.

In Suffolk Serco has just been awarded a £140 million three-year contract to provide community health services. Virgin has scooped up the £450m 5-year contract for community services in Surrey.

Richard Branson's recently rebranded Virgin Care has also incongruously netted contracts to deliver sexual health services in West Sussex (where there appears to have been no consultation on the deal) and Buckinghamshire.

In North Yorkshire Virgin has won a Competition Panel ruling that York Hospital could be in breach of competition rules if York Hospital retains more than 40% of community referrals for musculoskeletal treatment: the panel calls for further measures to ensure the maximum possible number of patients are referred out of the NHS for treatment.

But major questions remain over the quality of the care on offer from private providers. 3,000 patients are without a GP in Camden after a disastrous privatisation of GP contracts went wrong.

And as this issue goes to press there is an inquiry in north west London into the failure of Care UK, one of the larger private providers to process 6,000 X-rays at what is supposed to be an Urgent Care Centre.

EUROPEAN NEWS IN BRIEF

Greece

Greece is going into a general election in May with the right wing opposition narrowly leading in the polls with 20% as we go to press, the PASOK ruling party next with 14% and a left coalition on 13%. Cuts in health and welfare are a major issue.

Spending on health care has been cut by $2.5 billion (13 percent) in the last two years, with almost $1 billion more to cut this year to comply with the so-called "bail-out" imposed by the Euro zone countries.

This follows on several years of recession and crisis: according to a *Lancet* article, hospital budgets dropped by 40% between 2007 and 2009, resulting in understaffing, shortages of medical supplies and patients paying bribes to medical staff to jump queues.

The rocketing levels of unemployment and plunging living standards have triggered a collapse in private health insurance, and as a result public health facilities have seen a 25 to 30 percent increase in patients. many families are struggling to afford bus fares, let alone the $6.50 fee levied at public clinics.

Breast cancer patients now often have to wait three months to have tumours removed. Rates of suicide and HIV are rising rapidly, and vaccination services are failing while hospitals run out of money for drugs and equipment, with services deteriorating.

Spain

The recently-elected right wing Rajoy government has just announced a massive 10% cutback in health and education spending on top of the monster €27 billion cuts and tax increases rev ealed in the budget. These cuts follow hefty reductions in health spending in most of Spain's devolved governments, with Catalonia leading the way with a 10% cut in spending last year, closures of beds and operating theatres and a 20% pay cut for junior dictors.

Spain's health minister has floated the idea of ending free health care for the wealthiest Spaniards, which would not only break the social solidarity of Spain's National Health Service, but also mean that the richest would no longer contribute towards the cost of the services for the poor and massive army of unemployed.

The system is facing €11 billion in accumulated debts to suppliers and drug companies with repayments delayed by years. Gloomy drug companies saw sales fall by 10% last year and expect a further 15% drop in 2012.

Portugal

Portugal last year announced a massive 11% cut in spending on its National Health Service. NHS debt to suppliers rose to €2.72bn last June, up from €2.48bn at the end of 2010, as was expected to hit €3bn by the end of this year.

The cuts have brought increased charges for seeing a doctor. A visit to the emergency room costs €20 instead of €9. A consultant costs €7.50while the minimum wage is now just €432 per month.

The government blamed flu and cold weather for a 20% increase in the winter mortality rate, but newspapers have begun to publish scare stories about people who claim to have been priced out of the public health service.

Romania

In Romania mass protests in the streets in January forced President Traian Băsescu to agree both to withdraw his privatisting health reform programme and to ask popular Health under-secretary Raed Arafat to withdraw his resignation.

On January 17, five days after having left his post at the health ministry, the creator of the country's emergency health services agreed to be reinstated. The retreat by the President was a desperate attempt to halt the demonstrations that hadshaken the country following

Romanians stop health reform

Arafat's resignation.

Arafat has now been appointed to a committee of experts charged with devising new health reform proposals.

With elections looming, the threat of reform to the system established in 2006 has been postponed for some time.

Arafat had resigned immediately after being branded an "enemy of health reform," by President Băsescu, who phoned in live to a television show in which Arafat was denouncing the use of public finance for private health initiatives, and spoke against the reform of the emergency rescue service and the privatisation of public hospitals.

The proposed reform would have limited Romania's main public health provision to a basic healthcare package covered by the state, meaning that only a limited list of medical services would be reimbursed, with the package to be topped up patient co-payments and voluntary healthcare insurance from private health insurance houses for additional care.

Faced with massive protests, Băsescu ended up asking Prime Minister Emil Boc to withdraw the reform proposal.

Private firms complain of "slow progress" on commissioning

The private sector has big doubts on how much of the expected £1.3 billion market in "commissioning support" services for Clinical Commissioning Groups will materialise in the near future, and how long they may have to wait to get their hands on the money, according to *Healthinvestor* magazine.

While Andrew Lansley's Bill may have passed through Parliament, reporter Tom Ireland argues that: "there is likely to be public resistance to the first big contracts awarded to the private sector by GPs."

He notes "slow progress" in the development of a commissioning support services market, with most services to be 'hosted' by the National Commissioning Board until 2016.

Big business is reported to be "keeping an eye on the size of budgets available to CCGs, and a hostile public mood."

Key players who will certainly still have ambitions to move in and offer consultation services, and increasingly run CCGs include Capita, KPMG, United health and McKinsey.

Campaigning efforts against the Bill have been more effective than many of us have realised: the private sector is feeling the heat.

Another article in the April *Healthinvestor* describes the Health Bill as a "debacle" and questions how much damage it has done to the image of the private sector which it says was "cast as public enemy number one".

But with the private sector clearly remaining nervous, there is a golden opportunity for campaigners to exploit this by challenging and exposing plans for privatisation as they appear.

A database listing the companies involved, their links, and any inroads they make into NHS trusts and CCGs is vitally needed.

'You've got affordable cancer'

New private hospital for Kent

As NHS Trusts face a mounting squeeze on resources, with frozen NHS funding and PCTs seeking to reduce hospital referrals, the private sector, spurred on by the passing of the Health & Social Care Bill, is looking to scoop up more NHS work.

Now a new £114m, 74 bed private hospital is being built in Kent claiming to "help reduce referrals to London trusts". It says that when it opens in 2014 it will have the only tertiary care cardiothoracic and neurosurgery beds in Kent for NHS and private patients. It plans to make up to a quarter of its capacity available for NHS patients.

The Clydesdale Bank is one of the companies getting in on the act, having agreed a £34m loan to help build and run the "Kent Institute of Medicine and Surgery".

NHS commissioners spend around £250m a year sending patients to be treated at central London hospitals such as Guy's and St Thomas' Foundation Trust.

According to the *Health Service Journal*, around 250 clinicians involved in the project have agreed to transfer a proportion of their private practice – principally for Kent based patients currently treated in London – to the hospital.

Elderly: could government care any less?

BUPA Care Homes in Liverpool is the latest private provider to be castigated publicly for "disgraceful" neglect of a 90 year-old resident with dementia. This follows the shocking revelations from Winterbourne View Care home of abuse.

According to a recent RCN report, 38% of care home nurses felt there was a lack of staff to meet patients' needs. Most care homes run on a bare minimum staffing, with many unqualified staff on minimum wage, and relatively few registered nurses and therapists: and funding is squeezed by continued, brutal cuts in local government social services.

But time and again reports on how to improve the desperately poor level of elderly care appear to be based in Fantasy Island rather than address the real problems.

An interim report of a commission of inquiry set up by the NHS Confederation, Age UK and the Local Government Association has called for "root and branch reform" of the care system, and heard suggestions that staff be recruited on the John Lewis Partnership system – selecting applicants according to their personal qualities, and then training them. But on minimum wage, how many people with the necessary qualities will apply?

Meanwhile another report from the Care Quality Commission, found that 40% of hospitals failed to deliver dignified care to elderly patients, triggering another media feeding frenzy in which poor nursing (and by implication front line staff) was blamed rather than their senior managers and a cash-starved system that has run down staffing levels, and crushed morale and professionalism rather than working to ensure basic standards are guaranteed.

It's high time the Code of Professional Conduct that rightly applies to front line nurses was also used to bring bullying and callous nurse managers to account in front of the Nursing and Midwifery Council.

According to *Healthinvestor* magazine, spending on older people's care has been falling year by year since at least 2005: last year alone it fell by £300m (4.5%). Age UK has argued that an extra £1 billion is needed from the government this year simply to stop things getting any worse.

But with another £20-£30 billion NHS cuts package in the pipeline as soon as the present round of cuts is complete in 2014, there is no prospect of elderly patients getting any more than warm words and windy rhetoric, while standards of care slide ever downwards.

'You're not helping us to raise our game, Mr Thompson'

Cuts chaos looms in London as McKinsey declares 16 hospitals non-viable

As NHS London boss Dame Ruth Carnall prepares to decamp for pastures new and spend more time with her bank balance, the shambles in the capital's hospital services continues to worsen after a McKinsey report last year suggested that only two out of 18 non-foundation Trusts are likely to be viable.

In **North East London** a megamerger of Barts & The London, Whipps Cross and Newham hospitals has left the debtridden Barking Havering and Redbridge Hospitals Trust high and dry, with King George's Hospital in Ilford facing renewed threats to dismember it in order to help pay the ruinous cost of the £240m Queens PFI hospital in Romford.

South London Healthcare Trust, formed from welding together three indebted SE London Trusts, and covering two basketcase PFI hospitals and the doomed Queen Mary's Hospital in Bexley, is predicting a £65 million shortfall in 2011-12, and £30 million deficits every year for the next five years.

Desperate efforts to balance the books include axing 695 jobs, and the possible outsourcing of "middle and front office functions" – HR, estates, finance as they struggle to pay the rent on costly PFI hospitals in Bromley and Woolwich.

The *Health Service Journal* has even speculated on rumours that the Trust be allowed to go bust in a high profile warning to others to make even bigger cuts.

South West London NHS bosses, seeking to £370 million from spending by 2016, have said they want to close one of the four A&E units, with only St George's safe. Croydon Council has rushed to the defence of its local Mayday Hospital, leaving Kingston and St Helier hospitals in the frame.

St Helier is the weak link, facing £57 million cuts over five years after a planned merger with St George's fell through.

Plans drawn up by **NHS North West London** suggest up to four A&E units there could also be closed in pursuit of massive cost savings.

Even Hammersmith and Fulham's former Tory council leader Stephen Greenhalgh has described the cuts as a "piecemeal dismantling of hospital services".

The 220-bed Central Middlesex Hospital, Park Royal, is to be severely downgraded to "local hospital" status, losing its A&E: the relatively small Hammersmith Hospital A&E is also vulnerable as is Ealing Hospital, with 358 beds, which could be downgraded to a community hospital with few if any acute services.

But another hospital mist also be in the frame, since Dr Mark Spencer, medical director for NHS North West London, told the *Evening Standard* that "local A&E units" would remain on all the sites, but the number of major emergency departments would be cut to five.

Brum to axe hip ops

A CRISIS IS BREWING in Birmingham, where the five CCGs are drawing up plans to deliver efficiency savings by restricting activity with the biggest acute providers, which include the £500 million PFI Queen Elizabeth Hospital.

Previous plans to restrict the use of hospitals, and especially elective admissions, have failed to bear fruit, with elective admissions running more than 4% above plan in the last financial year at the Heart of Birmingham Foundation Trust: but A& E attendances were also higher, running 9% above plan.

Three of the four local PCTs ended the last financial year with a deficit: in Solihull it was £27.1 million. Together these deficits create a budget gap of £58 million, and this problem has been dumped on the plate of Birmingham GPs.

The probability is that they will follow the example of the PCTs – and simply pass problem on to local hospital trusts and community health services.

But it seems there are also looking to add to the list of so-called 'low clinical value' procedures to which access will be restricted: hip and knee replacements are to become even harder to get as a result. This apparently is classed as an efficiency saving.

NHS to the rescue . . .of private hospitals

According to market analysts Laing & Buisson patients with private medical cover accounted for just 59% (£2.3bn) of private hospital revenues in 2010 – compared to 65% in 2005, while spending on NHS patients has risen to 25% from 14% – £957m.

Pay-as-you-go patients provided 14% of revenues (£534m).

The "private healthcare pot" of income is being shared by an increased number of independent medical hospitals, with 515 by mid 2011, compared with 454 in mid-2010.

Of these, 304 provide only day surgery, while 211 offer 9,545 inpatient beds.

There are now 73 private patient units (PPUs) within NHS hospitals, and these have now been encouraged by the Health Bill to generate up to 49% of their income from private patients.

NEW BOSS, SAME OLD STORY

Stephen Eames, the new Chief Executive taking over the crisis-ridden Mid Yorkshire Hospitals Trust, tantalisingly promised a "fresh start" as he tackles a £20m deficit and the need to cut £24m this year.

The trust had predicted it would break even, despite the soaring costs of its brand new PFI hospitals. So what was Mr Eames's cunning plan to sort out the finances?

Offering staff unpaid leave, along with job cuts and reduced working hours.

No change there, then. Eames said: "We cannot deliver savings on the scale needed without reducing the workforce."

Cuts IN BRIEF

Blanket refusal

KIDNEY patients in Chelmsford's Broomfield Hospital are being asked to bring their own blankets to dialysis sessions, in what is called an "efficiency saving".

Concerns that blankets from outside the hospital could bring in infections were brushed aside in the quest for short-term savings.

A £145m PFI Hospital at Broomfield is set to cost £739m over the next 30 years.

Staffs staffing nightmare

THE MISERY goes on for patients needing treatment in mid Staffordshire. With the enquiry report still awaited on the catastrophic staffing cuts that resulted in the deaths of dozens of patients as the local Trust tried to fit financial demands for Foundation status, the A&E at Stafford Hospital is still closed at night until at least mid-May for lack of staff.

There are even warnings that other acute services may yet be closed in the troubled Foundation trust.

The knock-on crisis from mid-Staffs patients seeking treatment elsewhere is impacting on the University Hospital of North Staffordshire in Stoke, where A&E performance is now well below target.

Slower Bucks

CAPACITY in Bucks's hospitals is lagging way behind local health needs, as waiting times the surgery continue to increase. The weight has gone up by 169% since the spring of 2010, driven partly by 35% increase in demand for elective surgery. 15% of Bucks patients were waiting longer than the 18 weeks target. Far from attempting to meet demand, Bucks health bosses have continued to shed jobs by the hundred.

Do it yourself physio

A NEW NOTTINGHAMSHIRE CCG, pretentiously calling itself Principia, is breaking new ground – by seeking to save money through restrictions on physiotherapy referrals, and creating a bizarre ban on physios touching their patients.

The Rushcliffe-based CCG's use of leaflets and websites in place of therapy has been ridiculed by the Chartered Society of Physiotherapists which notes that this is the only such policy in the country.

Ipswich Hospital faces 'meltdown' threat

UNISON has echoed the concerns of an anonymous whistleblower at Ipswich Hospital who has publicly warned of possible "meltdown" as spending cuts force severe and chronic staff shortages and put patient safety and quality of care at risk.

Speaking in confidence to the East Anglian Daily Times, she also warned that experienced staff with a wealth of specialist knowledge could be lost from the hospital.

A year ago the hospital was criticised by the Care Quality Commission over its care of older patients.

Ipswich Hospital Trust has been battling to achieve a £16.7m cost improvement target in the harsh conditions of NHS finances, and has opened up consultations on redundancies as it tries cut a further 150 jobs on top of the 100 axed last year . Morale has predictably slumped, with just over a third of staff saying they would recommend the Trust as a place to work in the latest staff survey.

The Hospital it is losing a specialist service, with major vascular surgery to be "centralised" at a new regional centre at Colchester Hospital, obliging patients to travel there rather than be treated locally.

Its bid for Foundation status has foundered on the Trust's rocky finances: by the end of December the Trust was £7m in deficit, more than £6m worse than the target, with income from clinical services.

It is also beeing squeezed by NHS Suffolk's efforts to reduce the numbers of patients treated in hospital, which is set to continue.

One scheme involves sending one patient in ten back to the GPs who referred them to hospital – making a nonsense of GP clinical decisions and patient choice.

CCGs+ NCB+ CSOs +AQP – PCTs + SHAs = **CHAOS**

NHS: a guide through the wreckage

UNISON members at the massive TUC March 7 rally against the Bill

Andrew Lansley's Health & Social Care Act, which eventually passed through parliament in March despite massive and growing opposition – not just from health unions and campaigners, or the wider public, but also from GPs and from hospital doctors.

It's set to change the landscape of the NHS. The changes are not instant, but will be imposed at a forced march, with most to be implemented within a year.

It will sweep away the 150 or so Primary Care Trusts that currently hold the budgets to commission services for defined population areas, and also carry out over 120 Statutory Duties, many of which involve protecting patients' rights, protecting the vulnerable and properly accounting for hundreds of millions of pounds of public money.

Also disappearing are Strategic Health Authorities, whose role included coordinating PCTs, overseeing NHS Trusts, and organising the education of medical and professional staff.

Neither set of bodies was especially popular with the public or a model of democracy, although PCTs and SHAs are at least obliged to meet in public and publish their board papers: they have been the main vehicle for unpopular government policies, and recently for driving through spending cuts and imposing cutbacks and closures on local hospitals. But they currently

Labour's Andy Burnham and Ed Miliband have now promised Labour would reverse the new Act

plan and control budgets of around £80 billion, and are set to be wound up by April 1 next year.

Their replacement will be far worse: a new and even more complex many layered bureaucracy, including:

A new National Commissioning Board

This will have 3,500 staff, nine national directorates and "a national network of local offices", and will initially work through 52 transitional "clusters" of PCTs to oversee the establishment of Clinical Commissioning Groups (CCGs) (see below).

The NCB will be the body that commissions primary care services, specialist health services, and oversees CCGs, with extensive powers to select their leaders, intervene and to decide whether or not to agree CCG proposals.

237 Clinical Commissioning Groups

These will be the local level commissioners, composed largely of GPs, with a token involvement of a hospital consultant and a nurse from outside the area, and in many cases management roles taken by non-GPs. CCGs need to seek authorisation from the NCB, which will be considered in "waves" from autumn 2012 through to January 2013.

Up to 40 Commissioning Support Organisations

CCGs will be advised, and in many cases much of their commissioning work would be shaped, by up to 40 Commissioning Support Organisations, initially to be hosted by the National Commissioning Board, but no later than 2016 these will be hived off as commercial concerns, selling their services to CCGs. These have to present business plans in August 2012 and seek authorisation, with decisions announced in October.

Referral Management Centres

GPs' clinical decisions on which patients to refer where, and for what treatment will also be second-guessed by a growing network of "referral management" organisations, some operated by the private sector, which already cover at least one in four GP practices.

15 'Clinical Senates'

The composition, role and purpose of these has still not really been explained except as a sop to placate marginalised hospital consultants for their exclusion from any role in commissioning.

108 NHS Trusts

Those that have not been able to make the transition to Foundation Trusts are now on a forced march towards Foundation status – or face the threat of dismemberment and mergers by 2014.

For many of them the process will be painful, because the stumbling block to FT status is their parlous state of finances – in many cases centred on the massive cost of PFI hospitals.

143 Foundation Trusts

These were originally the high-flying, financially strongest Trusts, but the cash squeeze has meant that a growing number are struggling to balance the books.

Any Qualified Provider

Between them, Monitor and the CQC will be charged with drawing up a register of organisations deemed "qualified" to be licensed to deliver health care in England: GPs will be required to offer patients the option of "any qualified provider" in an increasing range of services, beginning with three locally-chosen community and mental health services from September this year.

Up to 152 Health & Wellbeing Boards

These are to be run by local councils. 138 are already operational, although the form is likely to vary widely from one council to the next.

In theory, according to the Department of Health "Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way.

As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future."

In practice, HWBs can be composed of as few as six people, only one of whom may be an elected councillor, and their actual powers, which come in from April 2013, will be limited, especially where the political leadership of the council clashes with the leadership of its local CCG(s).

Council Health Oversight and Scrutiny Committees

Still running, although of varying effectiveness, these survive the new Act: composed of elected councillors, who have the power to co-opt, they will continue to offer a forum to which health and social care managers and services can potentially be held to account, but in sadly few HOSCs are these powers used effectively.

Public Health England:

This new special health authority is to be set up to oversee the transfer of public health functions (and the staff with the knowledge on planning services for whole populations) from PCTs to local councils.

There will be an allocation to councils of allegedly 'ringfenced' funding from April 2013 for public health services – while every other council service is facing a massive and continuing squeeze in the drive for 28% cuts.

Campaigner June Hautot brought the campaign to front pages and TV screens when she gave Andrew Lansley a piece of her mind outside Downing Street. This woke up the general public, who had been lied to by ministers with the help of awful, uncritical BBC coverage: polls moved sharply against the Bill – and the coalition

Monitor

The body that regulates Foundation Trusts is to have new powers. It is required first and foremost to "exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services." So despite a formal requirement not to discriminate between public and private provision, its task is to ensure maximum private sector challenge to existing NHS providers.

But the Act also says that where it chooses to do so, it is also free to decide whether or not to "exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way". Nobody really expects this to happen: it was one of the LibDems' token, toothless amendments.

Cooperation & Competition Panel:

This grim relic of New Labour's eagerness to turn the NHS increasingly into a competitive market lingers on under the chairmanship of fanatical privatiser Lord Carter of Coles. It will continue to act as a complaints panel for aggrieved private sector companies demanding the right to a slice of NHS budgets in profitable services, and will serve as an advisory panel to Monitor.

Care Quality Commission

This was formed in 2009 from the merger of three previous regulators and is supposed to regulate the quality and safety of over 21,000 care providers , but according to the Commons Public Accounts Committee it has "failed to fulfil this role effectively". The PAC declared it has serious concerns about the CQC's "governance, leadership and culture".

Its effectiveness is certainly questionable. Later this year the CQC is required to register 10,000 GP practices – by asking GPs themselves to declare whether or not they are meeting the essential standards.

The CQC chair Dame Jo Williams recently complained that it had been obliged to abandon 580 planned inspections in order to comply with Andrew Lansley's instruction to conduct a spot check on 250 abortion clinics (at a cost of over £1 million) – indicating how little independence the CQC actually has from government.

The CQC has admitted an "unforgivable error of judgment" in failing to act on a whistle-blower's "grave" concerns about the behaviour of staff at Winterbourne View care home, later exposed in footage shown on Panorama.

The PAC points out that while whistleblowers have to be a key source of intelligence in helping the CQC to monitor the quality of care, but it has closed its dedicated whistleblowing hotline.

In March, Celia Bower, the CQC chief executive resigned after a Department of Health report said the CQC had faced "operational and strategic difficulties" with delays having "seriously challenged public confidence in its role".

Baroness Young, its previous chairman, resigned after Basildon Hospital, in Essex, was exposed for having filthy wards and a high death rate despite being rated as "good" a month previously.

Healthwatch England

This new quango, is to be a subordinate "independent" part of the Care Quality Commission, to be followed by local Healthwatch groups.

Healthwatch is the latest, even more toothless incarnation of a "patients' voice" and follows a growing list of inadequate and marginalised bodies set up after Labour scrapped Community Health Councils and stripped away their extensive statutory powers.

Exploit the few loopholes in the Act

Foundation Trust members and Governors

Foundation Trusts are obliged to have members and a board of governors. To be a member, you have to be over 16 and live in the catchment area of the FT. The trust will define what "catchment" means.

As a member you will be able to speak at members' meetings and attend trust board meetings – which means that you'll be able to ask the board questions.

Members can also stand to be governors: the governors have to approve the trust strategy and appoint the auditors. They also appoint non-executive directors (NEDs, including the Chair of the trust) who sit on the trust board.

The government says that before an FT can increase its private patient income to over 5% it has to have the approval of the Council of Governors.

Governors should also monitor all of the trust's finances carefully.

Health and Wellbeing Boards

Councillors (district, county or unitary) can stand to be a member of the local Health and Wellbeing Board, which will be able to challenge local commissioners (CCGs) on their commissioning decisions, including those that involve transferring NHS services to private companies.

HWBs also have discretion to widen their participation: campaigners should press their local councils to make them big, vocal and active.

HealthWatch

HealthWatch will be local organisations with a mandate to inspect their health and social care services. Local HealthWatch will be hosted by local councils and are intended to be largely toothless.

However, HW will put together reports on local services, which can be escalated to the national HealthWatch and CQC (Care Quality Commission).

A HW member will also sit on the local HWB and can challenge commissioning decisions.

HW will also have a mandate to inspect all providers.

Patient involvement

The Act says that there has to be patient involvement in commissioning. Your local GP will have a patient participation group (if not, then it will have very soon).

The actual commissioning decisions will be carried out by the CCG, but you may find that the GP group will give you access to the CCG patient involvement group.

CCGs have to have a policy on patient involvement. Ask your local CCG what patient consultation they are carrying out, and ask to be involved.

If you are involved in the formulation of the CCG policy and the CCG decides to use the private sector you could make this public and spark a local debate.

Lansley's lifeline aims to keep PFI afloat

SEVENTEEN NHS Trusts in England have already paid out at least the full cost of building new hospitals – but still face years of increasingly heavy payments under the Private Finance Initiative (PFI).

The latest Treasury figures show that between them the 17 Trusts have already paid out more than £3.2 billion for hospitals which were costed at £1652m: but they still have a total of £14.2 billion to pay off between them.

Six Trusts have already paid more than double the cost of the hospital, but still have years to pay: four have paid more than three times the capital cost – and Wycombe and Amersham Hospitals Trust top the bad value league table having shelled out more than FIVE TIMES the cost of its £45m hospital, while still having another £354m to pay – the total payments stacking up to almost 14 times the cost of the building.

Ten times cost

Almost as shocking is the Birmingham & Solihull mental health unit built for £18m, which has already cost £58m and will eventually cost £247m under PFI. Also costing more than ten times the original cost is the £158m Norfolk & Norwich Hospital, which has paid out £460m, but has another £1.2 billion to find.

In all 20 Trusts in England face outstanding PFI bills of more than £1 billion – a total of £40bn – headed of course by the £5.7 billion for the £1m per bed Barts & the London project, followed by Coventry's University Hospital (£3.4bn to pay), Central Manchester (£2.5 billion to pay) and the Oxford Radcliffe Hospitals, whose two schemes add up to liabilities of £2.4 billion.

The Treasury figures show that in England alone PFI hospitals worth £11.bn have already cost £8.1bn, and will cost another £62.6bn before they are paid off – an overall average of 6.4 times the original cost.

These bald figures help explain why PFI keeps raising its head as a major problem for successive governments: the deals were unbelievably expensive, and rotten value for money – and now services and staffing levels are having to be cut

Some of the most recent schemes have caused the swiftest crisis: Mid Yorkshire Hospitals' £311m scheme has only been open a short time, but is already driving a massive debt crisis, with the Trust needing to save £2m a month.

Peterborough health bosses are wrestling with the soaraway cost of 'unitary charge' payments on the £289m PFI-funded City Hospital and the £25m City Care Centre which came with it, currently siphoning £3m a month from the kitty, but scheduled to rise each year until the final payment of £60m in 2043. Debts for the current year were projected to be a staggering 25% of the Trust's income.

Maternity cuts

The Foundation Trust faces a projected £100m deficit by 2015, and has been scraping the barrel for cuts. Plans put forward so far include cuts in maternity and in GP surgeries. Hopes of balancing the books hinge on attracting in more patients from outside Peterborough to boost the revenues: but this may be no more than wishful thinking.

A Treasury Select Committee report last summer panned PFI. It concluded:

"* The use of PFI has the effect of increasing the cost of finance for public investments relative to what would be available to the government if it borrowed on its own account.

* The substantial increase in private finance costs means that the PFI financing method is now extremely inefficient.

* There is no convincing evidence to suggest that PFI projects are delivered more quickly and at a lower out-turn cost than projects using conventional procurement methods.

* We have received little evidence of the benefits of these arrangements, but much evidence about the drawbacks, especially for NHS projects.

* Owing to the current high cost of project finance and other problems related to PFI we have serious doubts about such widespread use of PFI."

In September the *Health Service Journal* reported that '60 hospitals face "collapse" over PFI deals', having admitted that their 'clinical and financial stability' was at risk because of the spiralling costs of PFI contracts.

The hospitals at risk include the Oxford Radcliffe and Nuffield Orthopaedic Centre, Worcester Acute Hospitals, Portsmouth, Buckinghamshire and North Bristol.

In February the Department of Health announced that it would make £1.5 billion available - in grants not loans - to seven hospital trusts in England with the heaviest PFI debt, to enable them to make PFI payments.

Strings attached

But to qualify for the cash Trusts have to pass four tests on their debts, services and productivity savings.

The hand-out was part of a bid by Andrew Lansley to buy the government's way out of problems on PFI while leaving PFI schemes (and the hefty profits they offer to shareholders) still intact – and diverting attention from the Health & Social Care Bill..

But far from unpicking PFI, Lansley, following the lead of Chancellor George Osborne, has been busily signing new PFI deals since taking office, compounding the long term financial problems of more and more Trusts.

£11.bn
value of new PFI-financed hospitals
£8.1bn
the total paid off so far
£62.2bn
the remaining payments
£247m
the cost of an £18m mental health building

Hedge funds are the power behind Circle Healthcare

The government's decision to sign a 10-year contract worth £1 billion for an untested private profit-seeking company to manage the heavily indebted Hinchingbrooke Hospital really is the triumph of hype over experience.

The hype has come thick and fast from Circle's smooth talking boss, former Goldman Sachs banker Ali Parsa who has tried to create the impression in acres of tame media coverage that Circle is some kind of benevolent workers' cooperative, while in fact it is controlled by hard-nosed private equity and hedge funds.

Far from being a new type of company handing control to the workers, Circle is hostile to trade unions, and will have to resort to old-fashioned cuts in the workforce if it is to generate the "efficiency savings" it needs to put the hospital into surplus.

The hospital faces a £10m gap between income and costs in 2012-13. Meanwhile NHS Cambridgeshire has decided stroke patients will be treated at Addenbrooke's – further reducing the income.

The NHS workforce that Circle is attempting to manage at Hinchingbrooke is three times larger than the grand total of 568 people working for the whole Circle group.

And so far managers have set out no concrete proposals on how they plan to save money and turn around the finances when they take over in February.

Its vacuous 16-point "improvement plan" is better at spending money than saving it – promising "Michelin-quality" meals, a new "value-for money entertainment system" for patients and "fairer car parking", and even hinting at improving nurse staffing levels.

And its suggestion of raising more income for the Trust by "capturing 5,000 patients from a 30-mile radius" flies in the face of Cambridgeshire and Peterborough commissioning plans to reduce the tariff and cut referrals for hospital treatment.

The uncertainty over the Hinchingbrooke contract is even greater since Circle will only be paid a share of any surplus the hospital makes. It might not make any.

Circle itself is already heavily dependent upon the NHS: its main current income stream comes from an NHS contract.

Its business plan to expand its private hospitals is dependent upon it continuing to build a workforce by poaching consultants, nurses and other staff trained by the NHS.

Behind the hype, overall *control* of Circle is firmly in the hands of a separate for-profit company, Circle Holdings, 95% owned by a private equity and other city interests, including some of the world's biggest hedge funds. Over the last six years they have funnelled £140m into the company – so far for no return.

For all its talk, Circle has yet to make a success even of running its two extravagantly expensive and tiny (30 bed) private hospitals and has run up six years of losses so far.

The company has already lost two NHS-funded Treatment Centre contracts: its £34m a year ISTC contract in Nottingham has only one more year to run. In the last three years Circle's losses were £40m, £20m and £35m.

So the staff and services at Hinchingbrooke will be right in the firing line as Circle takes the reins.

How hard NHS staff will want to work at making surpluses for Circle is open to doubt.

How many of them will lose their jobs and how many services will be sacrificed in the bid to make surpluses we can only wait and see.

The Hinchingbrooke contract is a gamble with high stakes: yet remarkably it's already being discussed as a model for other struggling Trusts, even Peterborough.

Other theories suggest the project is set up to fail horribly.

Time will tell.

(From UNISON Eastern Region newspaper *Eastern Eye*)

Will GPs hold Lansley to the lies he told them?

Say no to "Any Qualified Provider"

Andrew Lansley's vision for the new competitive healthcare market centres on "the vast majority" of NHS services being provided by "Any Qualified Provider".

But this aspect of the new Act starts relatively slowly: with Primary Care Trusts still in control for the first year, just three services from a list of community and mental health services must be opened up letting patients choose from "Any Qualified Provider" from September this year.

The phased roll-out of the extension of Any Qualified Provider (AQP) means that in the short term local CCGs can decide where to apply this policy – although it is not clear how far CCGs will have any say in the longer term on how it operates on their patch.

Details will only begin to come out now the Act has been passed. They will be set out in secondary legislation which is very seldom debated in Parliament, and in the rules which Monitor and the National Commissioning Board will operate.

A minority of services, for which even Lansley admits it's impossible to have competing providers (such as accident and emergency, emergency ambulance services and so on) will instead be opened up to competitive tendering, to ensure "contestability".

Some other services where integration is important, such as end of life care, may also be put out to tender for a "prime contractor" – NHS East of England has already started down this road.

But it's clear that the sticking point will be on the imposition of AQP for most other services. It would mean private providers, once their names are included on the register drawn up by Monitor, would be free to operate anywhere across the country – with no discretion allowed to local GPs and CCGs to choose which providers should be involved.

A year ago this was spelt out clearly by the Department of Health, in a document tellingly entitled 'Making Quality Your Business: A Guide to the Right to Provide'. It said:

"Commissioners **cannot refuse** to accept qualified providers once qualified, unless providers fail quality standards, reject the agreed price, or refuse to comply with any reasonable, additional, locally set standards… It will be the commissioners to decide when to use tendering, but **the presumption will be that for most services patients will have a choice of any qualified provider.**"

In February this year, as he struggled to gain any credibility amongst GPs, Lansley wrote to CCGs to reassure them they would not be forced to put any services out to tender: but he said nothing about Any Qualified Provider.

Even the most ardent fans of commissioning are suspicious of the imposition of a list of providers by Monitor and forcing GPs to get patients to choose between them: Dr Mike Dixon of the NHS Alliance has said it is "completely bonkers", and Dr Charles Alessi of the National Association of Primary Care has also opposed AQP.

Campaigners are calling on GPs to press for every CCG to exploit this uncertainty and division in the ranks of the marketeers, and adopt a policy of refusing to engage with AQP, along the lines of this statement:

"This CCG will uphold the principle of "first do no harm": we will take no action and adopt no policy that might undermine our patients' continued access to existing local health services that they need, trust and rely upon. "In the spirit of clinically-led commissioning, we reserve entirely the right to decide who we contract with to provide services for our patients. We will take those decisions on the basis of the best interests of our patients and wider local communities.

"Among other priorities, and in the interests of offering the best care for our populations, we shall increase the integration of services between different parts of the NHS and between the NHS and social care. We shall not be diverted from this by concerns about anti-competitive behaviour.

"In the interests of transparency we will not engage in any contracts or negotiations which impose conditions of commercial confidentiality: will consult local communities before implementing any changes that affect them, and our Board will make all major decisions relating to services in public session."

Countdown to Tory health care market

"Spring" 2012:
Consultation on a public health workforce strategy: appointment of chief executive designate for Public Health England and agree PHE structure

May:
National Commissioning Board's "new organisational design" takes shape.

June:
Health Education England kicks off in shadow form
NHS Trust Development Authority (NTDA) launched "to create a dynamic organisation able to provide oversight and accountability for the remaining NHS trusts".

July:
Authorisation of CCGs begins (further waves in September , October and November)

August:
Commissioning Support Organisations (CSOs) must submit business plans to NCB

September:
Patients must be offered "Any Qualified Provider" for at least three locally chosen services
Healthwatch England launches

October:
CSOs hear if they have been authorised

April 2013
CCGs established with statutory powers
Public Health England launched
Local Healthwatch launced
New NCB system operational
Health Education England operational
NHS Trust Development Authority operational

2013-16:
CSOs hosted by NCB

2014
NHS Trust status abolished

WEASEL WORDS

Andrew Lansley letter seeks to reassure "prospective CCGs"

"1. You will have the freedom, with your new powers and responsibilities, to commission services in ways that meet the best interests of your patients.

"You will, for example, be able to determine where integrated services are required and commission them accordingly.

"You will be able to work with existing providers of health and care services to deliver better results for patients.

"Or you will be able to commission new services to address weaknesses in current levels of provision .

"I know many of you may have read that you will be forced to fragment services, or to put services out to tender. This is absolutely not the case.

"It is a fundamental principle of the Bill that you as commissioners, not the Secretary of State and not regulators, should decide when and how competition should be used to serve your patients' interests.

"The healthcare regulator, Monitor, would not have the power to force you to put services out to competition."

February 16 2012

Anti social enterprises pave the way to privatisation

Photos: Matt Archibald

Caroline Molloy, Stroud Against the Cuts

Last month in the high court a Stroud pensioner, 76-year-old Michael Lloyd, and his lawyers stopped Gloucestershire PCT transferring nine hospitals and 3,000 nurses and health workers out of the NHS.

The plan had been to hand over community health services to a so-called 'social enterprise', or 'community interest company'.

Whilst across most of the rest of the country, community health services have found homes within existing or new NHS Trusts, without the need for a tender, in much of the SW these services were handed over to 'social enterprises' on 1 October last year.

However in Gloucestershire, services and staff remain in the NHS, though the campaign to keep them there continues.

The PCT has had to accept a consent order that made it go back to the drawing board, involve the public, and look at NHS options, though disappointingly they are continuing to 'spin' that they are likely to end up offering the services to the private sector – something that is totally unnecessary. As David Lock QC who took the case said,

"The real lesson from the case is that there is almost certainly a stage for NHS bodies to consider before they decide if they want to undertake a tender process.

"PCTs are almost certainly entitled to conclude arrangements with an NHS trust to deliver services without a tender, because such a process is arguably entirely outside EU procurement law."

Community strength

The case shows how local community groups, working with unions, can achieve results which unions alone cannot deliver, mobilising people, demanding information, and obtaining legal aid for an affected individual.

Local anti-cuts groups, notably Stroud Against the Cuts, organised a number of events to raise both awareness, and funds for a legal challenge, including a 500-strong demonstration and a 350-strong public meeting.

Feelings ran high in Stroud, that the 'social enterprise route' was just a back door to privatisation, less accountability, more bureaucracy, and cuts.

SATC chair James Beecher said "Whilst social enterprises may be a good thing when they are taking over services from the private sector, they should not be used to take services out of the public sector.

"The management of NHS Gloucestershire claimed that the 'spinout' to social enterprise was driven by staff, and would lead to greater local involvement, but it is clear that no-one in Gloucestershire wanted this: staff views had been ridden over roughshod, and the public were kept totally in the dark until the last minute.

"The documents revealed in court also showed that the main advantage of the 'social enterprise' route, from management's point of view, was that it would allow them to lower staff terms and conditions, despite assurances to the contrary that were given to unions.

"Social enterprises are just another form of private enterprise and their use exposes the NHS to the full weight of the market."

This point is borne out by the fact that where social enterprise transfers have taken place, elsewhere in the South West, terms and conditions are already being lowered, and services cut.

Where services have been spun out of the NHS into a social enterprise they soon have to be re-tendered – and then in step the bigger financial guns like Virgin, as seen recently in Surrey.

Attempts by commissioners to pursue 'social enterprises' in future are likely to lead to services having to go out to tender, but they can (and should) choose not to outsource, and should consider the perfectly legal option of giving services to another NHS trust without need for a full competitive tender.

As responsibility for commissioning decisions transfers from Primary Care Trusts to the Clinical Commissioning Group over the next year, it is important for campaigners to be clear on the current legal duties on commissioners.

There is nothing in the Act that requires services to be tendered – but campaigners will need to keep a close eye on how the secondary legislation develops, as well as the review of the NHS constitution currently underway, and the guidance coming out of the Department of Health and National Commissioning Board.

The campaign continues, to ensure services within Gloucestershire are now kept within the NHS, as most of the public wants. For more information see www. ***keepglosnhspublic.posterous.com***.

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