

SoS SoS

# **BREAKING THE NHS**

## **STEALING ENGLAND'S HEALTH THROUGH RECKLESS REFORM**

**“The NHS will last as long as there are folks left with faith  
to fight for it,”**

**Nye Bevan**

Secretary of State for Health Andrew Lansley has repeatedly been asked to release the RISK ANALYSIS exploring the impact of the HEALTH & SOCIAL CARE BILL on the NHS.

So far he has declined to do so, failing to comply with requests from the House of Commons and the House of Lords, defying an order from the Information Commissioner and also a call from the Academy of Medical Royal Colleges, which represents doctors in all the medical specialities .

In the face of this refusal, this paper outlines the risk to the health of people in England and the British economy as a result of the Health & Social Care Bill proposals.

***'we don't know the changes we are looking for until  
they happen'***

*Andrew Lansley Sept 2011*

**This paper will demonstrate that if these proposals are not stopped, the NHS will cease to be a public service, free for all at the point of use. The health of the nation will be put at great risk.**

**It is a story told by the voices and knowledge of the people who understand how the NHS should work and how it has significantly improved the health of the country and supported the economy as a result.**

### **Key areas explored:**

- 1. Threat to Patients**
- 2. Privatisation and EU Competition Law**
- 3. Lack of Evidence**
- 4. The Economy and Wasting Funds**
- 5. Ignoring Moral Obligations**

**Each of these key risks will be explored within sections which detail the way in which our NHS is due to be delivered and the resulting serious impact upon medical practice and patient care.**

**'We can seek to dramatically improve the Bill-and make no mistake, it needs dramatic improvement-or we can reject it out of hand. If the Bill passes through the House without significant amendment, the consequences will be even more severe... .. on commissioning, public health, integration with social care, service-user engagement and quality and safety'.**

**Lord Patel, House of Lords Cross Bencher,**

**Chancellor University of Dundee**

(Chairman of the Academy of Medical Royal Colleges of Scotland 1994–95, and of the Academy of Medical Royal Colleges of the UK 1996–98. President of the Royal College of Obstetricians and Gynaecologists from 1995 to 1998, having been Honorary Secretary from 1987 to 1992 and Vice-President 1992–95)

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### De-coding index

CAP	the agreed % of private provision allowed
NICE	National Institute for Clinical Excellence
INTEGRATED CARE PATHWAYS	patient needs identified and linked across a range of specialist areas
TARRIFF	agreed pricing limits for agreed treatments

## **BACKGROUND**

In 2010 the NHS was shown by the World Health Organisation to be the most efficient and one of the best health services in the world.

Patient satisfaction in 2010 was at its highest ever rating.

The NHS helps to support the economy through maintaining a healthier population and workforce as well as providing jobs and training.

We believe this needs to be built upon through continuous improvement, not dismantled as Andrew Lansley has said he wants to do.

There is no mandate for these changes which were not mentioned in either of the Conservative or Liberal Democrat manifestos.

A highly expensive top down re-organisation which is not based upon any evidence of success risks the health of the nation at a time when the NHS is more valued than ever before and at a time when every pound counts.

The vast majority of those working in the sector have clearly stated that the drastic changes in the Bill are a big mistake, riddled with danger for everyone who either uses the NHS or works for the NHS in England ~

ie the majority of the English population

## **Forward Summary**

### **Risk Area 1 : Threat to Patients**

**Competition will lead to fragmented rather than integrated care**

**A focus on finance and profit is likely to lead to a reduced focus on patient need**

**Poorer accountability because health organisations will be able to hide behind commercial confidentiality**

**Clinical Commissioning Groups will be able to restrict the services they offer to local populations**

**Guaranteed waiting times for treatment are being chopped away and thus patients will be more sick and unwell by the time they obtain their appointment/ treatment and may become more expensive to treat. For some who cannot pay it may be too late.**

**If patients are not protected then there will be a negative effect on society and thence upon the economy for these reasons :**

**~ people will become sicker and take longer to get better**

**~ there will be avoidable harm to children**

**~ sicker patients are often more expensive to treat**

**~ sick people will struggle to keep up at work**

**~ sick people in these circumstances will suffer from stress**

**~ workplaces will suffer which will impact upon their productivity**

**~ health inequalities will increase**

**~ national productivity will suffer**

**~ the benefits bill will rise**

**~ those unable to obtain benefits or retain employment will become destitute**

**Patients will have nowhere to go to challenge decisions except by mounting their own legal challenge.**

## **Risk Area 2 : Privatisation and EU Competition Law**

It is clear that the invasion of US-style health companies is designed to split up and fragment the historic and successful fabric of our National Health Service.

Companies who are in this for profit – meaning that money making is the primary motive, will implement methods which mean that patient health and welfare will cease to be the main priority. Where services fail, people – including children, will suffer.

Rather than being the central focus, patients will effectively become a means to an end – ie profit.

Millions will be squandered in defence actions against private companies opposing commissioning decisions using EU Competition Law criteria.

It is completely inappropriate for patients in England to be trapped in such a purchasing squeeze

## **Risk Area 3 : Lack of Evidence**

The medical profession is an evidence based profession. There is absolutely no evidence that any of the proposed measures will be of any benefit to the wider population. Just like the bankers, the only people to benefit will be the profiteers. Large amounts of funding will also be wasted in legal wrangling over contracts.

## **Risk Area 4 : The Economy and Wasting Funds**

The Bill carries huge risks to every individual and every family who wishes or needs to access NHS provision paid for through the National Insurance scheme which was first set up in 1912 and also our taxation system.

A mutual tax payer investment in national healthcare services produces a mutual benefit - from having a healthier work force, from keeping epidemics in check, from a greater mean level of health in the population

The impact upon the health of the nation – and thereafter the national economy – will be profound

The population of England will bear the brunt of the Bill, but afterwards Scotland, Wales and Northern Ireland will experience the fallout from the economic downturn which will result in England.

## **Risk Area 5 : Ignoring Moral Obligations**

We now have the knowledge about the best way to support human life and the means to improve the quality of life of the population - however that much of that knowledge will be squandered in the name of profit for the few at the expense of the many if this Bill becomes law.

Given what we now know about how to make the system work for the greater good and this fact that this Bill creates a huge risk to keeping and building upon that gathered knowledge, we believe the content of The Health & Social Care Bill 2011 to be an infringement of the human rights of the people of England

The top risks are the consequence of

- The Secretary of State ‘shrugging off’ his responsibilities and leaving services in local hands which are unlikely to have the capacity to safeguard services
- Introducing a profligate and wasteful experiment at a time when the country is under a severe financial squeeze
- The introduction of a model which is based on no evidence of success and which puts at risk everything that has been achieved within the health service in England
- Leaving staff and particularly patients at the mercy of the market which will lead to irrational decision and the fragmenting the NHS in such a way that patients will find it difficult to access specialist services – those with multiple and complex conditions will be particularly challenged
- Hectoring staff into engaging in a wasteful and time consuming re-organisation in direct disregard of their best advice
- Dismantling the infrastructure and earmarking funding previously allocated to patients to the setting up of a new and unnecessarily complex replacement
- Fragmenting training and research to the detriment of patient safety
- Deliberately engineering a two tiered service which will see patients who are unable to pay or who have pre-existing conditions which prevent them from obtaining insurance suffer in the same way as similar patients in the USA
- Wilfully encouraging chaos in a predominately efficient system
- Putting the health and the economy of England at grave risk

***‘no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means’***

**Nye Bevan**

## Profligacy not Savings

At a time when the public sector is in the grip of downsizing and the clear message from government is all about cuts, it is clear that the large scale top-down reorganisation being undertaken through the Bill is not in line with this requirement.

**These measures will result in a huge increase in costs – not a saving**

**The cost of these changes is likely to be a massive £3bn – a large % of PCTs' budgets, almost £2bn, is being held back from patient care to cover the costs and risks of the reorganisation.**

**It is estimated that there will be 20,900 redundancies amounting to a £1bn redundancy bill. It is also estimated that a significant % of staff, consultants and researchers will then end up being reemployed.**

**Hospitals are having to make deeper cost cuts of an additional 2.5% because of the reorganisation in each of the next four years, or £1.1bn each year, on top of the 4% they are already having to find.**

**Rather than safeguard our nation's health, all this expenditure and waste will only put services at risk**

**➤ If fiscal shrinkage is meant to be the current watchword of public sector management then why this contradictory risk?**

Columnist and scourge of health mismanagement Roy Lilley supplies us with a long forgotten Lansley speech which was made on 9/7/05 and missed during the sad aftermath of the 7/7 bombings but prior to any economic threat – which spells out the answers :

<http://www.andrewlansley.co.uk/newsevent.php?newseventid=21>

## Management Waste

Despite it being proven that the best performing hospitals have the best performing managers, administrators have often found themselves being demonised during this process. This has prevented the design of a clear pathway to effective delivery.

As a trust we had a cull of "bureaucratic" staff around 18 months ago and the performance of the trust dipped, if not dramatically then to a noticeable degree. It's very easy to say we need more nurses and doctors and less managers because people don't realise how much value is gained from the managers.

Guardian NHS Reform Live Blog contributor April 2011

The new structure has been promoted as being designed to save on the costs of bureaucracy ~ however under the Bill proposals, the number of management bodies (or so-called quangoes) has increased from **161 to 550**. These include the NHS Commissioning Board, Clinical Commissioning Groups, Monitor, the Care Quality Commission, Health and Well Being Boards, HealthWatch (**for full details of assessed risk see Appendix 1 P55**)

Even before the Bill has gone through the full Parliamentary process, structures are already being dismantled and staff re-hired at huge cost in rejection of our democratic process.

Primary Care Trusts have lost so many staff that they can no longer properly oversee healthcare in their locality, including in key areas such as child protection and patient safety, or maintain the same range of health services. In Surrey, Dr John Doyle, chair of the local medical committee to which most doctors belong, says: "The PCT here preparing for its own demise has caused problems because there are so few staff left. The staff who are left are so stretched that GP practices aren't getting the help that they used to get"

Guardian January 17<sup>th</sup> 2012

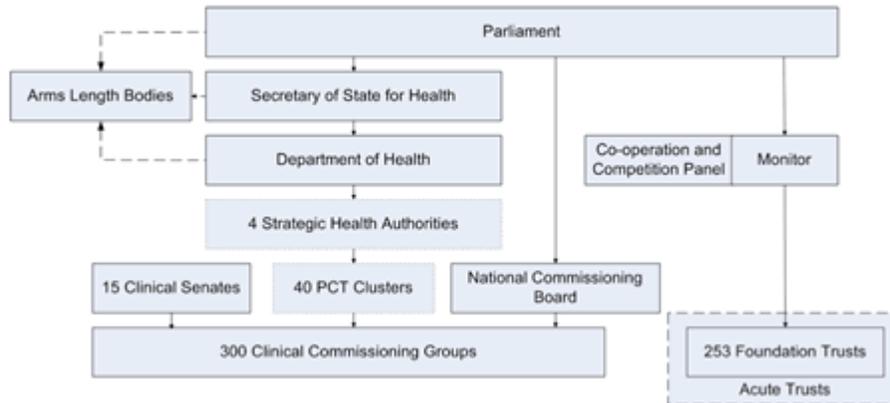
Far from rushing to embrace the new model, GPs were told that if they do not comply the Department of Health will offer their patch to a private concern instead – so the often touted statistics of engagement are misleading. This is a step-change under the cosh.

When Lansley is challenged on these facts he responds.....

**‘when you want to dismantle a service**

**– the secret is to do it quickly!’ ( Sept '11)**

## CUTTING BUREAUCRACY? IMPROVING MANAGEMENT?



**500 NEW 'QUANGOES'!**

### The Dangers of Introducing the Free Market

➤ **Free marketeering is a completely inappropriate economic model for health care**

1. health is not a commodity
2. the element of risk per patient bears no relation to the ability of the patient to pay for their care, which means that patients without funds or eligible insurance suffer very badly when they cannot pay for their care

There is no proof that the market leads to improvements for service users, indeed there is more evidence to suggest a detriment. This is likely to mean unplanned and chaotic decisions and closures.

If the Health and Social Care Bill is not stopped, we will speedily return to the worst aspects of the postcode lottery, people will die on trolleys in corridors like they did in the 80's and in their homes without care, just as they did before the NHS was born.

So far none of the amendments which have since been offered by the Coalition government in the House of Lords Committee Stage, or since will rectify this situation - which leaves the NHS in grave danger.

## The Expert Voices

The Secretary of State and the Cabinet have so far failed to listen to the voices of reason and skill, knowledge and experience –

The British Medical Association, the Royal College of GPs, Royal College of Nursing, Chartered Society of Physiotherapists, Society and College of Radiographers – all oppose the Bill, which it is now clear is set up deliberately to privatise the NHS in England.

Unison described the reforms as “unnecessary, badly-timed, ill-thought through and damaging”. Head of Health, Karen Jennings said: “Lansley’s so-called consultation was a sham and a foregone conclusion. By forging ahead with his plans in the teeth of fierce opposition from leading health experts, patient groups, staff, unions and GPs themselves, he is showing an utter disregard for the long term future of the NHS.” <http://bit.ly/iikgvO>

➤ **Lansley calls these knowledgeable voices nothing more than vested interest**

This is not why they object so strongly to what he wants to do – they object because they know that his plans will be a disaster for patients, for their profession and for the future of the country.

Meanwhile Lansley has met regularly over the years of designing his ‘new model’ health service with a number of high profile private companies – including private health insurers, private health insurers, global accountancy firms and companies such as Mars and Unilever. Unlike NHS medical practitioners whose primary interest is in patient health, these companies have vested interest in profit and little or no interest in patient health.

## Ethics

‘ I had five children and we never had to worry – we have all completely relied upon the NHS and all benefited enormously. The worst thing is that this has been introduced without a mandate. Nobody voted for it. Commercialism is going to be a disaster – it is naïve and misguided to think that the operation of the market will come in and save money’

Baroness Mary Warnock

Chaired the Committee of Inquiry into Human Fertilisation and Embryology.

*(“perhaps the greatest achievement of the Warnock committee is that it managed to get an ethical consensus that people understood as well as shared” Suzy Leather )*

## GPs

- **98% of RCGP members who responded to a survey voted against these measures. The College has now called for the full-scale withdrawal of the Bill. This is why:**

All patients rely upon their GP as the gateway to help and expertise when health problems arise. They are trained to have an overview of general health and an understanding of when to refer the patient for specialist attention. GPs do not enter General Practice to become clinical specialists or to be involved large scale commissioning services responsible for managing 80% of the NHS budget.

The transfer of £80 billion pounds of public money to Clinical Commissioning Groups (CCGs ) is a giant shift in power away from the underpinning principles of the NHS <http://bit.ly/w7iiE>

**'I want politicians of every stripe to understand that we do not need to increase marketisation of the NHS. It creates duplication that is wasteful and gives NHS money to private shareholders.'**

**'GPs don't need to have borders redefined, care patterns made more complex, patients turned into commodities or another reorganisation. We need to be left to get on with our core business - clinical generalists making people better.'**

Laurence Buckman CGP

## GPs and CCG accountability

Contrary to how it is presented, CCGs will be able to make decisions that make virtually no reference to local people's wishes. This is likely to make conflicts of interest easier to hide and is particularly dangerous given the added potential for unscrupulous profiteering which comes with this new commissioning model. Also, redesigns are likely to be poorer and less well used if patients are not involved in the redesign. There is a lack of safeguards to avoid

- **hiding behind commercial confidentiality**
- **lack of effective scrutiny**
- **lack of accountability to the public for commissioning**

Rather than simply focusing on patient care, GPs will be forced to consider an ever increasing and conflicting range of financial incentives and barriers. <http://bit.ly/zjQN9B>

There is likely to be a negative impact on the GP/patient relationship because patients will be anxious that decisions are being made for financial reasons rather than in the interests of their health.

**GPs' financial considerations will include:**

- **Referring patients to their own company**
- **Gaining financial reward if the consortium does well financially**
- **Shareholder pressures**
- **Potential risk of DoH penalties**
- **Requirement to 'save for a rainy day' as instructed by DoH**
- **Challenges in the courts for anti-competitive behaviour**

GPs are being taken away from their usual practice duties to undertake training in CCG management and competitive practices by KPMG, PWC etc who are earning large amounts of money from this work, money which would otherwise have gone into NHS which is meanwhile experiencing enormous cuts. <http://bit.ly/xsBLky>

GP practices who struggle to manage will choose instead to employ private contractors to do the work, and their decisions will be subject to the laws of trade and competition, rather than based strictly on clinical concerns. Practices will get bigger and, like lawyers and accountants, migrate to more hierarchical organisations which rapidly distance themselves from the patient

It is worrying that GPs will have a contract that potentially fixes their prime loyalty to the CCG and their shareholders who will be able to create business companies to which they can refer patients. Thus profit rather than patient care may become the main concern. There are already examples of this starting to emerge. In addition, the government will pay GPs if they save money for the CCG. They will also fine them if they fail to meet their contract.

As a result GPs are much less likely to be thinking exclusively about the patient in front of them. They will think:

- **Can I save money by not referring or by doing less for this patient?**
- **Can I make money by referring to my own company?**
- **Can I avoid taking on this patient because they are likely to be expensive to the CCG?**

**Former Southern Cross advisor, Bolti Partners to be manager of  
£300m GP portfolio**

There are already a small number of GPs who see this as a chance to make personal profit and at least one practice has already tried to charge patients for procedures which it pretended were not still available on the NHS

### Example 1:

Haxby: in anticipation of this, a GP practice just outside York set up its own private company ( HGB Ltd ) and falsely explained to patients that certain procedures were no longer available on the NHS. Patients were then asked to pay for said procedures via the private company. <http://bit.ly/pZBoys>

These GPs ceased this practice when their actions were made public. However if the Bill becomes an Act of Parliament, they – and any other GP who chooses, will be able to return to this approach.

### Example 2 :

In the St Paul's area of Tower Hamlets, the local GP surgery was taken over by ATOS in 2008, the private company which also manages the DWP disability assessment process. Patients reported that they were unable to forge a relationship with a GP because temporary and part time staff replaced their long term family doctors. They found it difficult to obtain appointments. After 3 years of failed delivery, Atos finally pulled out of what should have been a 10 year contract.

Local GPs see this as a very cautionary tale.

“There's an unavoidable contradiction between running something to maximise profit as opposed to running a service designed to meet the needs of patients,”

says Anna Livingstone, a GP who opposed Atos's takeover. <http://bit.ly/dUHDa4>

- **This will all cause a direct conflict within the treasured patient/ doctor relationship with a loss of trust in the GP**

It is very clear that the new model as proposed will result in doctors being faced with a conflict of interest – rather than the patient being the most important factor, they will be pressurised by other priorities <http://bit.ly/xsBt4J>

Far from providing seamless patient oriented services, the Bill threatens the physical break up of the NHS. On January 31<sup>st</sup>, 365 GPs wrote to the Telegraph to alert the readers to impending fragmentation of the NHS <http://tgr.ph/y6yPkl>

➤ **Following the huge majority vote by the Royal College of GPs to call for the Bill to be dropped, Chair, Dr Clare Gerada said :**

We are not a political organisation but these results speak volumes about how our members – across the UK – feel about these reforms and the effect they will have on the NHS and the care we provide to our patients.”

<http://bit.ly/o8pnRV>      <http://bit.ly/wUBWtl>

Then on Feb 3rd in a BBC interview following the RCGPs call for full withdrawal of the Bill:  
‘GPs are very worried how they will care patients and how services are to join up ... and what will happen when they become rationers of care rather than patients’ advocates’

<http://www.bbc.co.uk/news/health-16861672>

It is interesting to note that David Cameron flagged up a Doncaster GP as being supportive of the Health & Social Care bill in Prime Minister’s Question time on 25<sup>th</sup> January, it was afterwards revealed by a GP Online reporter that the doctor had previously resigned from his local CCG. <http://bit.ly/xVXmB8>

**Now, Charles Alessi, one of the few GPs who support the Bill is revealed as trying to offload more expensive elderly patients onto neighbouring Surrey practices. This is early evidence of the cherry picking that we were told would not be possible <http://bit.ly/qhxwj9>**

**‘Many GPs are privately considering leaving their commissioning roles due to widespread disillusionment and distrust’**

Chair of the NHS Alliance, Dr Michael Dixon      Jan 2012

The Bill would transform the English NHS from a nationally-mandated public service required of the government under primary legislation into a service based on commercial contracting, underpinned by ministerial and local discretion and secondary legislation, and exacerbated by non-accountability to Parliament of commissioners and providers.

Prof Allyson Pollock <http://bit.ly/AvS6tq>

## Hospital Consultants

- Dr Clive Peedell and Dr David Wilson have just completed Bevansrun – They ran a gruelling 6 marathons in 6 days between the home of Nye Bevan and the Dept of Health, Whitehall in defence of the NHS.

<http://bevansrun.blogspot.com/> This is why:

'I am a Consultant Clinical Oncologist working for the NHS in the NE of England. I am co-Chair of the NHS Consultants' Association and a member of the BMA Council and BMA political board. I have been an active campaigner against NHS privatization and market based reforms. I believe that a publicly funded, publicly provided and publicly accountable NHS is the most cost effective and equitable way to deliver health to our nation's population'

When a patient is referred by their GP to an expert consultant for specialist assessment and possible treatment, the patient has a right to expect that any recommendations will turn into a prescription if that is required. GPs are statedly not specialists and it should not be their role to manage complex conditions.

However the new CCG model, with 80% of the budget being devolved, means that specialist hospital prescriptions are at risk of being turned down by the GP's manager, giving objections such as cost or lack of expertise in managing the condition - leaving the patient without the treatment they need. Aside from this model being disrespectful to the expertise of trained specialists, it can leave the untreated patient in discomfort or danger from a deteriorating condition, with the only remaining 'choice' of paying privately.

The Bill also builds in financial conflict where CCGs will have to grapple with catering for a potentially expensive population eg. aging, densely populated or with many patients with high cost conditions, whilst also being asked to plan for savings from their annual allocation in order to stay within budget should times get tough.

The complexities of funding in this new model means that this can only be sustained by letting a proportion of patients down – and by charging top ups to fill the gap for people who can afford to pay.

Under these measures a proportion of GP practices and hospitals will go bust – with no chance of rescue from the Department of Health. What will happen to people in these communities? Healthcare deserts are inhuman & unnecessary.

**Secretary of State Andrew Lansley was warned in 2010 of a looming A&E recruitment problem yet no proper action was taken and in January 2012 two hospitals are drafting in the army help** <http://www.egovmonitor.com/node/45579>

## Voting evidence 2011/2012 >

The **BMA, NHSCA, RCN, RCM** all want the bill withdrawn

**98% of a vote by the Royal College of GPs** came out against the Health & Social Care Bill  
<http://bit.ly/wUBWtl>

**59% of delegates at the annual British Medical Association** conference voted in favour of calling for the Health and Social Care Bill to be withdrawn. The BMA Council calls for the Bill to be withdrawn and finally the BMA itself. <http://bit.ly/AnXlJL>

**Royal College of Nursing** passed a vote of no confidence in SoS Andrew Lansley and his reforms and have since called upon him to Drop the Bill – they are also now considering industrial action as their only remaining means of voicing their concerns. <http://bit.ly/xTenFf>

**The Royal College of Midwives** has also called for the Bill to be dropped. ‘The government has failed to present sufficient evidence that its proposals are necessary. They have failed to present evidence that the upheaval will result in an improvement in services to the people of England..... and they have failed to answer the concerns of the people who fear for the future of the NHS under these plans.’ <http://bit.ly/ygl8oG>

Likewise the **Royal College of Radiologists** have grave concerns and have asked the same  
<http://bit.ly/AEunbv>

The **Royal College of Physicians** <http://bit.ly/wVfDCZ>

**Past Public Health Faculty Presidents** also call for withdrawal

<http://www.bmj.com/content/343/bmj.d8286> <http://www.bmj.com/content/344/bmj.e690>

**Royal College of Psychiatrists**

<http://www.rcpsych.ac.uk/publications/collegereports/collegereports.aspx>

**The Community Practitioners and Health Visitors Association (CPHVA)** say they believe the Bill will put private financiers in the driving seat and fragment services & agree the Bill should be withdrawn

**The NHS Support Federation** has produced an interesting balance of opinion chart which demonstrates support versus opposition to the Health & Social Care Bill <http://bit.ly/wV9sQ9>

## Hidden Intentions

**'My Lords, we have before us a monster of a Bill. It is complex and confusing.** Many people who depend on the NHS are concerned about what the results will be when it becomes law. There are improvements that should be made to the NHS but it will be a tragedy if good and excellent things are lost or downgraded. We do not have enough high-dependency beds. We are well down the European list, which is headed by Germany and France. We have many critically ill patients. There is a gulf between intensive care and the general wards.

**There is a dark cloud hanging over England, which must save £20 billion when the NHS has increasing lists of patients who need treatment and medication.** With commissioning being done by clinicians who might have self-interests, perhaps I may ask the Minister if there are enough safeguards in the Bill. If patients become suspicious of their doctors and trust is lost, that will be a tragic disaster. There should be integrated healthcare, and patient and public involvement to help with commissioning.

Many members of the public who have paid their taxes and national insurance feel that the National Health Service is there for them when they need it.'

Baroness Masham HANSARD 11<sup>th</sup> October 2011

<http://bit.ly/qO6f7B>

**'This Bill has the handprints of the US insurance industry all over it'**

**Wendell Potter US Insurance Industry Whistleblower**

Wendell Potter has famously blown the whistle on the practices of the US insurance industry. Not only does he expose Medicare for being inadequate, he shows how increasing numbers of patients have found themselves pushed into the Medicaid category because insurers have continually changed the categories of conditions which they are willing to cover and increased the charges for those they do cover.

**As an example of the risk,** Wendell Potter has photos of desperate patients queuing in fields for consultations in disused sheds – travelling up to 500 miles to be seen by Remote Area Medical doctors who more normally fly into the Amazon jungle.

<http://wendellpotter.com/>

<http://bit.ly/oabMjS>

These two experts fully understand the widest implications of the Lansley Health and Social Care Bill. There is no need to re-iterate their words for they state the truth of the matter in the most knowledgeable terms. Let's hear from others who are also very aware of the real intent & accompanying risk:

### Example 1 :

Councillor Paul Bell bravely confides

'I have cancer – leukaemia to be precise, and while I am currently in remission, I am frightened by the changes proposed; I have to take daily medication that makes my immune system weak. This is quite a shocking statement for a 40 year old man to admit, but I am, as this government is on a determined path to bring in American style healthcare to this country.

I used to live in the United States; I worked for a charity that campaigned to end hunger and poverty, not just in the developing world, but also in the USA. Speaking with the sick and poor Americans, they said time and time again three chilling words 'pre-existing medical conditions'... a get-out clause for insurance companies whose motivator is not to treat the sick based on clinical need, but how to make the most profit. Bonuses and incentives are paid if less people are approved for medical treatment.

Do you know someone with cancer? What about an older person, a child from a poor family, an asthma sufferer? We will not get treated. I will not get treated'

**'this Bill needs serious scrutiny and improvement'**

Viscount Eccles – Conservative Benches

<http://bit.ly/xXGcbd>

### Example 2 :

A surgeon contributing to the Guardian NHS Reforms Live Blog in April 2011 argued that the impact on quality of care for patients would be a more significant problem than increased costs with a switch of operations from NHS to private providers

'We provide many of the consultants who work in private practice. It is true that many operations will be conducted by juniors, but we conduct very few revisions. The majority of our revisions are to work carried out poorly in the private sector by consultants we don't employ ourselves. Poor quality, un- or under-moderated work in the private sector is a significantly worse problem than poor quality NHS work.

**'there is big money to be made for you (private providers ) by taking patients away from the NHS'**

Earl Howe, leader of the government's health team in the House of Lords

<http://abetternhs.wordpress.com/>

### Example 3

There is no protection from US firms with a track record of being found guilty of defrauding the US government through poor practices. One example is NETCARE Limited, an investment holding company, which 'operates through its subsidiaries the largest private hospital network in South Africa and the United Kingdom' who were **found guilty of removing kidneys of minors and selling them**. Currently there is no provision in the Bill for proper safeguards from these 'vulture companies' and little information as to how patients can protest this.

As Dr Lucy Reynolds, Public health strategist at London School of Hygiene, also reveals – safeguards are urgently needed to prevent private equity firms from engaging in buy-outs of the ex-NHS employee social enterprises (which they have been encouraged to develop following mass redundancies and ahead of the legislation being approved), and then dumping them once there is no further income to be had.

Dr Reynolds rightly highlights

- **the example of Southern Cross offers us a high risk example for alarm.**

These examples clearly demonstrate that when the underbelly of the private sector becomes involved in healthcare provision, patients are put at great risk. Sadly the bill contains no safeguards to prevent this from happening.

- **The BMA warns that proposals to replace NHS Litigation Authority with a private model 'mimics worst aspects of US healthcare'**

The organisation highlights the flip-side of sneaking in un-fit or unethical procedures is the loss of life saving knowledge and skill :

**'potentially lifesaving procedures could disappear from the health service because of the high risks involved will force doctors to take out an un-affordably expensive medical insurance'**

Fewer doctors will specialise in the more risky but much needed specialist areas such as emergency medicine, general surgery, orthopaedic surgery, neurosurgery, obstetrics/gynaecology, and radiology

<http://bit.ly/Aze8cl>

## Clinical Specialism & Care Pathways Risk Chart

Specialism	Diagnostic risk	Treatment/Care Management risk
Diabetes	Integrated communication barred by competition	Care pathways - GP - podiatrist - ophthalmology - dietician  Medication
Cancer	Waiting times	Medication Surgery Radiotherapy Chemotherapy FIR
Neurology	Insufficiency of local specialists	Insufficient local recourses  Threat to specialist nurses  Medication & mobility aids
Paediatrics	Vital communication links threatened by competition	Looked after children  Autistic children  Multiple & complex hereditary conditions

It would be normal for policy to be developed with input from experts, however in this vital life-saving area we are faced with a politician who seeks to do quite the opposite. Despite the Future Forum listening phase, which in the end largely only served to complicate matters, we still find ourselves blocked with intransigence of epic proportions from the current Secretary of State for Health

<http://tgr.ph/zZ7Ch>

- **David Cameron's listening exercise was just a tactic admits former aide**  
<http://bit.ly/xAGzXh>

## Patients

- **Patient levels of satisfaction with the NHS were at their highest ever rating in 2010.** <http://bit.ly/zCfvX>

This complex new organisational model which is being driven into England like a runaway train, threatens the essential element of trust between patient and doctor.

Whilst patients like the recognition of '*Nothing About Me Without Me*', in reality this is revealed as nothing more than a smokescreen to cover up the fact that many patients will actually suffer as a result of these measures. It is to be noted that after early enthusiasm for promised patient involvement and benefits, the Patients Association have also come out in opposition to the Bill <http://bit.ly/ytJQmi>

Who could possibly disagree with 'putting patients first', a 'focus on clinical outcomes' and empowering health professionals'. And that is the KEY POINT.. The government are using the language of rhetoric – saying one thing and meaning another... In the case of 'putting patients first' and having 'more choice' this is a mechanism designed to increase competition in the new healthcare market. A market cannot work without choice and competition..... this is also key to the functioning of the market, because in order to choose services between different providers of services, patients need to the information to do so.

... the reforms will lead to healthcare rationing and eventually a mixed funding system, so it will be clinicians ( GPs) that will be held accountable, not the Secretary of State. This is why Clause 1 of the Bill (and its associated clauses ) on the duties and powers of the Secretary of State for Health are so crucial

Dr Clive Peedell

Lansley speaks of the development and implementation of integrated care pathways to provide seamless care for patients. However it is clear that this is an ideal which is incompatible with enforced competition between providers, as is clearly being steered by the Bill.

- **Care pathways are dependent upon co-operation between practitioners. Competition stifles co-operation.**

## Example 1

Circle chief executive of Circle Ali Parsa accused Ramsay Health Care UK of “dispensing with basic human decency” by deciding to revoke the practising privileges of a group of consultant just before Christmas (2011). He also accused Ramsay of “private profiteering” and claimed the dispute boiled down to a difference of business models between the two firms.

What of those patients with multiple and complex needs or long term chronic conditions? For these patients it is vital that the care pathways involving communication between various teams are maintained.

## Example 2

**I see a Bill that will cause fragmentation rather than integration**

**On Diabetes:** My own testing and treatment - comprising GP surgery, podiatry clinic, retinal screening, specialist eye clinic and dietician, is a perfect example a pathway of services where primary, secondary and community healthcare and social care are integrated around my needs. My early diagnosis and this integrated pathway of care will keep me free of the worst and most costly consequences of this disease.

One big concern for me is that the need to demonstrate that competition requirements have not been infringed will drive elements of the diabetes care pathway to be opened to competition and will be fragmented. It will not be the joined-up treatment and understanding of the podiatrist knowing what the dietician is advising. It will break the trust between elements of the pathway over time. I understand from Diabetes UK that there are discussions currently about the possibility of integrated pathways being commissioned rather than individual parts of the pathway.

But it is suggested that this could happen only if the whole pathway was subject to competition. Diabetes UK believes that this is impracticable and so do I.

Lord Collins October 11 2011 HANSARD

Problems are already being encountered by patients :

### Example 3

A patient reports receiving a much need prescription for a cost effective and well used medication from her hospital specialist. However her GP is now a Pathfinder CCG and the management of the prescription goes via her surgery instead of the hospital. The surgery refuse to manage or fund the prescription on the premise of cost ( the medication is not expensive) and lack of expertise. The PCT – which is now just a skeleton body, have no solution because of the new model which leaves no process for appeal. The patient is now paying privately so that she can receive her treatment but does not know how long she can afford to do so.

GPs themselves say that they are not trained to know the best treatment – they are trained to have a broad, not a specialist knowledge. How exactly will these vital needs be met?

### Example 4

A patient on the Wirral with a long term condition finds that her GP has gone bankrupt – which causes a great deal of disruption to patients, including the retention of records by the landlord. The surgery is taken over by with a chain of surgeries. The patient requires an ENT appointment for a suspected collapsed larynx ( laryngeal malacia ) and the GP puts her on the waiting list – however the referral goes straight to a private clinic rather than the list for the usual NHS clinic. Neither the patient nor the GP have requested this. The wait for the private clinic is more protracted than the usual NHS wait.

When the patient finally has her appointment where her condition is confirmed, she is told that the private clinic does not have the expertise to deal with her condition or the A&E or ITU provision needed in the instance that a required risky procedure results in a blue light alert. She is referred for speech therapy but with no indication of length of wait. The patient could have had her NHS ENT clinic appointment by now but has to start all over again from the start of the NHS clinic waiting list – again via her GP. Her speech has deteriorated in the meantime and the situation is now urgent.

The use of the word choice is misleading. CCGs will direct their patients to the providers which are 'in their loop' – and because of the new structural design this is more likely to be about profit than standards of care or medical skills which are appropriate to the specific patient's condition.

Where choice is offered in the fullest sense it will be difficult for patients to have any knowledge of quality in amongst a long list of options.

Previously when a GP practice failed, there were safeguards in place – however under the new model, patients will not be assured of alternative provision, or appropriate specialist knowledge of/budgets for complex conditions <http://bit.ly/xumKgl>

<http://bit.ly/zNAObo>

Many patients with long term conditions rely upon local specialist support staff - a workforce who are recognised to have long term benefits on their patient group, but whose number are under threat.

### Example 5

As the debate on 9<sup>th</sup> December led by Lord Dubs identified, the UK attention to Neurology is already behind that of similar countries. Speaking of diseases such as multiple sclerosis, Parkinson's, epilepsy and Alzheimer's

Just as the many other supporters of specialist medicine, Lord Dubs lamented the absence of the requirement for a national strategy to tackle the various conditions. He also took the opportunity to describe the day to day disability challenges that accompany patients with a neurological condition and spoke of his fears for a worsening of the current situation

'I want to address commissioning because it affects neurology in a very important way. The problem concerns how the commissioning of services for people with MS and other neurological conditions will take place under the new CCGs. There is a sense that there is a strategic gap between CCGs and the national Commissioning Board. CCGs, as at present devised, will cover relatively small populations and it will be difficult for them to be cost-effective in commissioning services for less common conditions...the national Commissioning Board, which might have an oversight, will be too far removed from the localities.

HANSARD <http://bit.ly/sqHz2O>

### Baroness Gardner :

*'it is crucial that the Government should support the roles of specialised nurses, physiotherapists, occupational therapists and other healthcare professionals'.*

HANSARD <http://bit.ly/AqWjWG>

## Example 6

The recorded scenes of assault and bullying of mentally disabled residents at Winterbourne View had been allowed to continue unchecked because the Care Quality Commission ( see Appendix 1 ) runs registration on the basis of self-certification with very rare on-site inspections – largely due to budget restrictions. Many inspectors have no medical qualifications. Now the CGQ will have the key role in ensuring the safety and quality of patient care at NHS and social care organisations. Patient safety and security under the new free market proposals is therefore highly questionable.

HealthWatch England will replace LINK as the route by which patients will have a local voice within the health service, however the fact that the Patients' Association has now also called for the Bill to be scrapped ably demonstrates concerns that the structure as presented is merely a token gesture to protecting patient interests. **Reference to Appendix 1** demonstrates the risk which the lack of attention to necessary detail will cause. Once again, key learned members of the House of Lords have highlighted the gaps in design -

HealthWatch England should :

- have a capacity to carry out research that is needed by local Healthwatch organisations to support their work.
- support the development of local expertise to gather information and data from all sources- public, patients, complaints and serious incident investigations-so that it has a well developed and informed view of the state of local health and social care services.
- support the development of regional Healthwatch organisations so that a powerful regional voice on services and commissioning can be developed.
- provide the capacity to elevate local and regional demands for better health and social care to the NHS Commissioning Board, the Secretary of State, Monitor and the CQC.
- support the co-ordination of major demands for changes to health and social care policy and commissioning, integrating local Healthwatch.

Lord Patel : HASARD 22<sup>nd</sup> Nov 2011

<http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111122-0001.htm>

However, it seems that far from tightening up the loopholes, in readiness for the Report Stage the government are designing a Bill amendment to remove even the ill-fitting false teeth of HealthWatch

<http://bit.ly/y8HDoe>

## Front Line Cuts

The combined effects of the need to implement savage cuts to service budgets along with the impact of all the structural changes relating to the Health and Social Care Bill has now started to be recognised by the press and the wider public

**Evil cuts injure patients, say doctors.** Patients are being denied treatments and having procedures postponed as the NHS struggles to meet the biggest financial challenge in its 60-year history, doctors' leaders are warning  
**Financial Times**

- **In a survey, 4 out of 5 doctors who responded said that they had seen patient care suffer as a result of front line cuts.**

<http://bit.ly/AEqwTS>

<http://bit.ly/w2PktP>

## Medication and Medical Aids

Medication and medical aids which have hitherto been seen as vital – and agreed as such by the National Institute for Clinical Excellence (NICE), are already being cut back and are no longer assured within the wording of the Bill even for the most sick – this includes the most basic items.

### Example 1

**Baroness Masham :** highlighted the fact that not only medication but essential items such as incontinence aids are no longer assured for lifelong and long-term sick due to the way which the Bill is worded.

‘Supplies of such products and medication are at risk of being deemed ‘non-essential’ - robbing patients of quality of life and dignity.

**HANSARD 30<sup>th</sup> November**

- **In Lambeth the numbers of patients who are eligible to receive incontinence pads has already been cut**

## Example 2

Increasing numbers of patients are reporting that their GPs are offering less effective cheaper drugs.

A clinical manager in Lewisham reports that her father has been refused treatment which had previously kept him mobile. He has now lost his independence and is housebound. His treatment was not expensive. His care needs are increasingly expensive.

Dr Peter Kandala a GP in Ashford, Middlesex reports the same experience

## Example 3

Neurology patients are already reporting that their specialists are not being replaced when they retire – even resulting in their care falling by the wayside because there are already so few specialists. When this also coincides with the cessation of DLA allocation due to lack of appropriate specialist input the impact is devastating

### ➤ The H&SC Bill flies in the face of basic health economics

These are not cost effective savings because patients become too ill to hold down a job and/or need extra care at extra cost. The mental health of patients in this category suffers – also at extra cost. Their physical condition deteriorates – which also has additional cost. The impact on the family has both an emotional and a financial cost.

Where patients want to appeal for their treatment being refused there is nothing in the new structure to help them. They will have to launch a legal appeal which could cost the CCG more than the treatment itself – and cost the patients huge amounts of stress.

### ➤ Also remember that the new changes to Legal Aid will mean that most patients will not be able to afford this route. What will happen to them?

The release of the NHS London Risk Register demonstrates the level of threat to services in the capital. <http://bit.ly/u9P92r> What will the National Register hold?

## Hospitals

‘ Nowhere in this 445-page mammoth is there any clear statement, let alone requirement, as to equality of clinical treatment and healthcare between NHS and private patients within an NHS institution ‘  
**Lord Philips**      **HANSARD**      <http://bit.ly/xzvXZD>

By 2013, all hospitals will be expected to function as stand alone Foundation Trusts – with the expectation that they will have to survive by their own income. As well as having to deal with cuts, most still have high levels of PFI bills to pay off after the pressing need to improve hospitals buildings, however many of these are unfavourable to the hospital and favour the private contractors.

Almost 2,000 nursing jobs have been taken out of the system in the two months since October 2011 and more will follow. The upheaval of change coupled with front line staff reductions is putting lives at risk. It is also one of the causes of much increased waiting times now that the 18 week target has been scrapped. Some patients now report having to wait over a year for treatment. At the end of 2011, almost 250,000 patients in England had been waiting more than 18 weeks, including 100,000 who had to wait at least a year and 20,000 who had been waiting for more than a year. <http://bit.ly/yppuk3>

The government has decided that increasing the allowed numbers of private patients will help NHS hospitals to pay their bills. After some bartering with the Liberal Democrats, the private provision CAP for hospitals has been set at 49% -

It should be noted that Lansley wanted to remove the CAP altogether which would have meant hospitals could in effect remove any non-paying patients from their lists. There is of course the possibility that this trend could be loosened more in line with Lansley’s wishes in further legislation.

Where hospitals bring in increasing numbers of paying patients a **TWO TIER SYSTEM** will develop – but what of the patients who cannot afford to pay for their care?

**Patients who can pay or who can obtain sufficient insurance cover will find themselves in the fast track scheme, leaving the patients who are in the free at the point of use category to join the longer and slower queue. Just as in the 1980’s, many patients had to wait 2 or 3 years for consultations and treatment, patients in this category will find their conditions worsening as they wait**

**ADDED RISK** > *Baroness Warnock has voiced concern that patients may be frightened into paying for unnecessary treatments in the name of profit*

## Food and Laundry

So-called hotel costs have always been covered through the Department of Health – it is currently an obligation on the Secretary of State through the DUTY clause. However if the Duty clauses are overturned, patients may increasingly start to be asked to pay for their food and laundry costs. Elderly patients and those who are on low income will find this difficult or impossible – which will have a drastic impact on their care and recovery and also on the running of the hospital.

Means testing sick people for their capacity to pay for clean sheets and meals will be distressing and demeaning. <http://bit.ly/AsOL7F>

- **So many of the measures in the Bill risk the mental and emotional wellbeing of patients**

## Maternity Care

Seeing the threat to maternity services, where cuts have already resulted in increased maternal deaths, Prof Cathy Warwick of the RCM cites the Health & Social Care Bill as a **'pointless waste'** and on behalf of her profession has now called for the Bill to be withdrawn.

<http://bit.ly/z4ZAdh>

## Example

Maternity Care on the Wirral : the first to opt for a private provider to take over the service. One to One have been awarded the contract to deliver Midwifery services on the Wirral and is working towards expanding this arrangement across more areas across England. This has provoked concerns from a number of quarters – predominately due to the risk of charges being introduced. Likewise because this is the first time that births have been included in such a contract – One to One had an early arrangement with Wirral PCT to manage ante-natal care, with births being taken care of by the NHS. <http://bit.ly/ziOvz9>

The EU Council of Ministers directive requiring all midwives to have professional liability insurance must be in place by September 2013 in order to be registered with their regulatory body, the NMC. Without registration, midwives will not be able to practise midwifery legally.

As Baroness Cumberledge has highlighted – rather than focusing upon a wasteful Bill - the government needs to attend to the urgency of the matter ***'independent midwifery will disappear, unless a solution to the insurance conundrum is found. Can we really afford to let this happen when the maternity services are in such desperate need of experienced, skilled midwives?.....The clock is ticking and the issue is urgent'***. <http://bit.ly/x7RIUJ>

## Paediatric Medicine and Childrens Services

All the gains of recent years through the Every Child Matters programme are at huge risk – already services are being reduced by the cuts, but the government are adding to this by taking out requirements which protect and support children. Child Health experts in the House of Lords have voiced much concern regarding lack of provision for cared-for children, speech and language specialists, and provision for autism.

**Professor Terence Stephenson, the president of the Royal College of Paediatrics and Child Health, talks to us about how shortages in fully qualified staff leave some children's centres "cobbled together" with a detrimental effect on children's care.**

**In this Audiobook interview**, Stephenson points out that although his proposed solution to merge some children's centres predates Lansley's reforms, the health secretary's push towards decentralisation may make it more difficult to solve these problems on a national scale. <http://bit.ly/fcE1tx>

## Elderly Care

**Baroness Joan Bakewell observed in debate that 'there is worrying lack of clarity of the relationship between clinical and social care – which puts care for the elderly under threat'**

**HANSARD 30<sup>th</sup> November '11**

There is currently an urgent situation known as 'bed blocking' where elderly and frail patients are kept in hospital because there is nobody to look after them in the community – this has worsened with cuts in recent Council care budgets. The Dilnot Report, which the government have so far rejected has proposed numerous solutions.

The all party Parliamentary Health Committee report of Jan 2012, chaired by Stephen Dorrell, has expressed frustration that Lansley's plans fail to grasp the real challenge facing a cash-strapped NHS – that of moving more care into the community in order to provide better, more affordable and more integrated social and health services for the elderly. Members of the committee, including Dorrell, are known to be concerned at the rising cost to the NHS of caring for elderly patients, many of whom could be kept out of hospital if they were offered help to live at home or in the community.

The report states that they can find little or no evidence for recommending the upheaval which comes with the Lansley Bill. Instead it is a risk to maintaining and building an NHS for the 21<sup>st</sup> Century – already evidence by soaring waiting times

<http://bit.ly/zbRYMs>

<http://bit.ly/IC5NJs>

## Mental Health

The potential for confusion about roles and responsibilities for disputes in funding decisions. Oversight of service providers and commissioning will lie with the newly created NHS Commissioning Board, but local commissioning of many mental health services will be done by clinical commissioning groups when care is provided upon the basis of a generalised tariff established by Monitor for what a care episode can cost. This is a system that seems designed to fail the most complex and difficult cases

During debate in the Lords, Lord Patel stated 'I am in agreement with the Law Society, which states that: "The separation of commissioning responsibilities for mental health services could lead to divergence in strategy and commissioning intent, and increase commissioning disputes to the detriment of service users". <http://bit.ly/qvbRVo>

### Example 1

Exemplar Children & Adolescent Mental Health ( CAMHS) services in Lewisham have already suffered a £500k cut. If implemented, the Bill does not seem to be written in a way which will safeguard what remains

### Example 2

A South London PCT Clinical Commissioning Group is currently seeking tenders for an integrated adult psychological and counselling service in Primary Care. An NHS organisation bidding for this tender is proposing the current counselling service undertake a 75% cut in order to come within the revised budget –using trainees and volunteers rather than experienced qualified counsellors and therapists (which brings with it an ethical problem). Meanwhile... at the same time the content of private tendering remains unknown.

Dr Lucy Reynolds writes that the privatisation of psychiatric services as encouraged in the Bill, will leave the vulnerable to being sectioned in the name of profit – with incentives for long term or permanent interment. There is also statedly no compensation for patients in cases of mistakes or the prescribing of drugs with long term irreversible after effects. This is a policy which has ramifications similar to the Russian Gulag – but in England.

### Example 3

'the possession of the right to lock people up and to be paid for doing so (under a contract) and the ability to approve people to section others to approve people to section others (who as well as approval need the minimum qualifications specified under the Mental Health Act 1986 ); and the deprivation of liberty involved could be long-term or permanent.'

**Dr Lucy Reynolds**

<http://abetternhs.wordpress.com/>

## Surgery

On January 24<sup>th</sup>, statement from the Royal College of Surgeons and the British Orthopaedic Association clarified the fast approaching crisis :

**‘there is now a list of ‘forbidden operations’ – due in part to bed blocking caused by lack of discharge care following cuts in council services, which means the elderly and frail are being kept in hospital for much longer.** **RCS**

**‘GPs are not being allowed to refer patients’** **BOA**

In his **‘Still Fatally Flawed’** <http://bit.ly/ynnfvA> Lord Owen relates how ophthalmology surgeons express great anxiety about the future of cataract surgery being contracted out to untrained providers.

Managers are squeezing for short term gains under the ‘cosh of the combination of cuts and reforms, which Stephen Dorrell, Chair of the Health Committee expresses as ‘demands being placed on the system which it is not able to meet’

### Example

Obese patients in Hertfordshire are being asked to lose weight before they can be considered for routine surgery. The regime, implemented by the Herts Valleys Clinical Commissioning Group, which covers 50 practices, is thought to be the first in the country. Thousands of patients awaiting procedures such as gall bladder surgery, tonsil removal or hernia treatment will be affected.

## Physiotherapy

From April 2012, eight areas of community and mental health services will be opened up to competition for the first time. The NHS will lose its monopoly on treating back and neck pain, feet problems and leg ulcers, providing wheelchairs for disabled children and "talking therapies" to tackle mental health problems. PCTs will have to let private firms, voluntary groups or charities, not just the NHS, bid for contracts.

Phil Gray, chief executive of the Chartered Society of Physiotherapists, three-quarters of whose members work in the NHS, says that **“AQP .....is already proving to be a disaster for patient care”**. He points to a slew of complaints from patients that have followed the introduction of an AQP-style variety of providers of musculo-skeletal services in a few parts of England.

### Example 1

In Nottinghamshire, there are now 14 different providers of NHS-funded physiotherapy services where there used to be just one. The inherent difficulty in knowing which of the 14 is the best makes a mockery of patient choice, says Gray.

### Example 2

Sufferers of Rheumatoid Arthritis have discovered that NICE recommended physiotherapy is becoming increasingly difficult to access. The National Rheumatoid Arthritis Society have little faith in the decision to implement a Long Term Conditions policy rather than safeguard and promote specialist routes which clarify the treatment and care needs for specific conditions. This concern has repeatedly been echoed by expert commentators in the House of Lords <http://bit.ly/pR5AaL>

- **The Chartered Society of Physiotherapists has also called for the Bill to be withdrawn**

Despite the government presenting their work on the NHS as being all about investment and expansion of services, it is now evident that services are already being cut and delayed -

#### Baroness Thornton: leader of the Shadow health team in the House of Lords:

‘My Lords, this weekend the Royal College of Nursing reported that around 50,000 nursing posts are either in jeopardy or lost completely due to the ill conceived implementation of the economies being driven through the NHS’ <http://bit.ly/x1TBkM>

Baroness Jolly: ‘My Lords, approaching 250,000 patients have been waiting for more than 18 weeks and I expect that they would like to know why, as would the House’

Far from all these measures being a long term and cost effective solution, three eminent medical publications have joined forces and produced a document which demonstrates that ‘In five years the NHS will require another reform’. In addition, the Editors from the BMJ, Nursing Times, and Health Service Journal, request a public debate regarding the NHS's future to "salvage some good" from the government's "damaging" reforms.

- **According to a second BMJ report, discarding the Health and Social Care Bill, now would save more than £1 billion in 2013.**

<http://bit.ly/xvTyuO>

## The Dangers of Privatisation

In his document **Fatally Flawed**, former Health Minister, and qualified GP, Lord Owen most ably described the difference between the Internal Market and the External Market. He now develops it further in **Still Fatally Flawed** <http://bit.ly/ynnfvA>. It is this giant shift of bringing in the full extent of the free market which is one of the things which makes the Lansley Bill so dangerous. <http://bit.ly/hC26su>

There is absolutely no evidence that this method of delivery across the NHS will meet with success - there is only a small amount of evidence which shows some improvement in results with health competition, and this relates to outcomes from heart attacks, <http://bit.ly/xVC1Us> with no evidence that it helps more complex medical cases. Patients fare much better when medical staff collaborate – not compete.

Although private provision has played some part in delivery for more than 25 years since it was first introduced under the Thatcher government, it only amounts to around 3% with a small number of specialist hospitals operating in excess of that.

**Andy Burnham, Shadow Secretary of State for Health, House of Commons :**

'This House believes there is an important role for the private sector in supporting the delivery of NHS care; welcomes the contribution made by private providers to the delivery of the historic 18-week maximum wait for NHS patients; recognises a need, however, for agreed limits on private sector involvement in the NHS; notes with concern the Government's plans to open up the NHS as a regulated market, increasing private sector involvement in both commissioning and provision of NHS services; urges the Government to revisit its plans, learning from the recent problems with PIP implants and the private cosmetic surgery industry; believes its plan for a 49 percent private income cap for Foundation Trusts, in the context of the hospitals as autonomous business units and a 'no bail-outs' culture, signals a fundamental departure from established practice in NHS hospitals; fears that the Government's plans will lead to longer waiting times, will increase health inequalities and risks putting profits before patients; is concerned that this House has not been given an opportunity to consider such a significant policy change; and calls on the Government to revise significantly downwards its proposed cap on the level of private income that can be generated by NHS hospitals.'

16<sup>th</sup> January, 2012 : Opposition Debate explores the safe limits of private engagement.

<http://bit.ly/xiMkYj>

## The CAP

Hospitals being asked to stand alone financially has resulted in the instruction to transform their function into a 49% private hospital bed, clinic and testing space – leaving just 51% allocated to NHS patients.

It should be noted that 49% is only a compromise proposed from Baroness Williams – Lansley wanted to lift the cap altogether meaning that some NHS hospitals could potentially operate on a 100% private basis.

Where CCGs or a hospital run out of funds because not enough local people can pay for services, local families will have a stark choice – pay the new private provider or do without. People will die in pain and suffering as a result – just as they used to do before the NHS was set up.

### Example

Again – a healthcare worker from the Guardian NHS Reform live blog :

My biggest concern is that the private sector just won't provide what the NHS does - and that no one has costed for everything the NHS provides currently. Most NHS frontline staff work overtime everyday, but that just isn't counted (I don't know anybody who claims for their overtime unless it's at least three hours). And the "extras" that we do in our spare time - like audits, or coming in on your holiday for teaching sessions. It's all supposed to come out of our normal day, but it ends up happening out of hours. We don't take all our annual leave or study leave entitlement because there simply isn't time - but we're not entitled to the funds back. So we all work a few days for free every year.

## Any Qualified Provider ( AQP )

First introduced as Any Willing Provider, and subsequently changed after concerned voices from across the range of medical professions, the replacement AQP is being waved at patients under the banner of choice – however it is in reality a method of elbowing out NHS providers in favour of private clinics.

## Property

Furthermore, as Dr Lucy Reynolds states – there is high risk of NHS properties being transferred to private companies for a nominal sums at huge loss to the taxpayer – and at great cost to the effective delivery of the NHS. Also detailed in <http://www.dutytoprovide.net/>

The Hidden Outcomes section of this document (P17-20 ) demonstrates the compounded risk

## Private management

As with many areas of the delivery of health services, instead of waiting for legislative approval, Secretary of State Lansley has already started the 'ball rolling', heralding private management take-overs of NHS hospitals

### Example 1

Private health provider Circle takes over the management of Hinchinbrook Hospital

<http://bit.ly/xVC1Us>

One of their first actions has been to contract with Sterile Services on an on call rota instead of having a full time team of workers who ensured that the hospital meets safe hygiene standards. They have no experience of A&E or Maternity. <http://bit.ly/zpjDnc>

In terms of Clinical Commissioning Groups, far from being at the helm of this new model, GPs will operate at the behest of these large private accounting companies who will put profit before patients

Private organisations such as KPMG, McKinsey and Deloitte are being encouraged to take over the management of Clinical Commissioning Groups which after months of hesitation have now been designed to cover the same areas as PCTs. A very expensive and risky makeover – with PCTs running on a skeleton crew and unable to meet the needs of GP surgeries in the meantime, as well as staff having been made redundant being taken on again in a similar function under the CCG. What a waste of money!

- **Commissioning by private companies as a support to CCGs is highly dangerous**

Private companies will be tempted to design pathways that would afford them profits, rather than improve patient care. Sometimes those two things will coincide, but often they will not. Shareholder pressures will also potentially lead to biased and possibly even dangerous commissioning decisions.

### Example 2

a private company designing COPD pathways in order to ensure the use of their machines, even though the evidence for their effectiveness is poor.

NHS experts know that they often have to look after patients whose care has been mismanaged in the private sector which is well known do not have the range of expertise available under the NHS

Lansley would leave private providers to continue to be unaccountable and put increasing number of patients at risk

The involvement of large scale private provision which is being pushed through in this Bill will result in more NHS patients being pushed into private clinics who have less expertise than the NHS or who use substandard products and who are unwilling to help when procedures go wrong

Examples of private sector mismanagement are now becoming more widely known:

### Example 1

The PiP implant scandal, whereby 40,000 women have been implanted with substandard industrial silicone, is a key example of the problems faced by patients whose private healthcare provider refuses to take responsibility for botched procedures.

*“And unfortunately what we are seeing with the breast implant scandal is the future of the NHS, it will be destroyed.”*

*Dr Richard Horton Editor Lancet*

### Example 2

Hundreds of NHS patients blighted by faulty hip replacements are embroiled in a landmark legal battle. One patient reported black liquid oozing from his hip after the metal joint started to poison his bones and muscles <http://bit.ly/Aj66Gu>

### Example 3

The Southern Cross Healthcare scandal is setting off alarm bells about the future risk to elderly care in the UK. The huge expansion based upon a high risk financial strategy resulted in what was the largest provider of care homes and long-term care beds in the UK, operating 750 care homes, before it announcing its impending closure in July.

<http://bbc.in/nwPMoU>

In December 2011, the Parliamentary Public Accounts Committee issued a stark warning that ‘it is deeply worrying’ that the government has failed to make clear what will happen if another provider of care homes runs into financial difficulty – which is seen to be a very real risk. <http://bit.ly/tQPDrE> <http://tgr.ph/rJ6X4r>

## Risk to Public Health

'I always knew the consequence of giving local authorities health responsibilities carried with it a risk of no longer being embedded in the NHS – but we wanted to give it to LAs for a reason – to work alongside all their other key areas of responsibility. However if there are any uncertainties they will specifically look at the NHS contribution and those relationships ... Andrew Lansley Sept 2012

<http://bit.ly/yQKkL>

<http://www.fph.org.uk/>

The government have recently taken public health out of health management and given local authorities the responsibility to manage wide ranging issues such as obesity, air quality and epidemics. Although joined up working is a good thing, this is a high risk when budgets are under attack.

Private corporations such as McKinsey, Mars and Unilever have played a key role in Department of Health planning meetings since September 2010. This demonstrates exactly which priorities this new model is promoting. <http://bit.ly/yY9bWb>

**“The Department of Health is putting the fast food companies McDonald’s and KFC and processed food and drink manufacturers such as PepsiCo, Kellogg’s, Unilever, Mars and Diageo at the heart of writing government policy on obesity, alcohol and diet-related disease”**

Public health also entails vital work on epidemic management and the management of acquired conditions

My concern with the Bill is the disconnect in planning between prevention and treatment, plus the strong probability that public health budgets will be severely limited, leading to even further underfunded ( HIV )prevention campaigns.

Lord Collins October 11 2011 HANSARD

<http://bit.ly/aSQVZJ>

<http://bit.ly/uSflzE>

The management of Swine Flu in 2009 was an indicator of the challenges involved in ensuring accurate public awareness and access to sufficient medical supplies and treatment plans for the most severely affected. With this background experience, Andy Burnham has expressed grave reservations about the lack of preparedness and co-ordination which the Bill seems to encourage.

Likewise the change in emergency management for incidents such as the polonium exposures in 2006, means that the dismantling of the Health Protection Agency and other emergency infrastructure functions leaves the public vulnerable to a poorly co-ordinated response.

There is also great concern that the Public Health White Paper completely excluded reference to healthy homes or safe workplace environments. The government should have a responsibility for ensuring that its citizens have these as a fundamental human entitlement.

- **On 27<sup>th</sup> January – the UK's most experienced Public Health doctors voted to oppose the Bill 'in its entirety'**

### **Risk through lack of accountability**

How will the £80 billion funding to GPs and CCGs be managed? Clinical Commissioning Groups – even with their wider commissioning interests than just General Practices (GPs) will be audited as per the current requirements for the individual General Practice. CCGs will be funded via a Clinical Commissioning Group which in turn is to be funded by the NHS Commissioning Board, who will be responsible for commissioning primary care. The National Audit Office will be responsible for auditing the NHS Commissioning Board. Essentially there will be a hands-off approach to auditing CCGs along with a concerning lack of clarity re the overall proposed audit trails ( **see Appendix 2** ). <http://bit.ly/w4dCCd>

The conflict between cost-savings, quality and safety are key faults in the proposed system. Outsourcing health services to private companies which will use commercial confidentiality to conceal much of their operations, only adds to the layers of unaccountability

The current issues surrounding the complex pricing structures around the privatised energy providers gives us due warning that this model will simply not work in the far more complex arena of healthcare provision.

- **An OfCOM/OfWAT/OfGem model is inappropriate to health & high risk.**

CCGs are not obliged to be transparent. Their governance is decided by them. It is highly likely that many will hide behind commercial confidentiality and/or opaque processes. Their decisions will not be transparent or publicly accountable. Their boards as proposed will not have the necessary skills to deploy budgets appropriate to patient need.

- **Boards will be a business partnership – essentially an enterprise established for the benefit of the partners and shareholders.**

The lack of accountability and transparency are key faults in the proposed system. 90% of all doctor consultations are with a GP, however the assessment of GP performance is problematic – it is unclear which measures will be used by Monitor

- **Past reference to the failure of ‘GP Fund-holding’, which was an integral part of the NHS internal market introduced by the Thatcher government in the 1990s demonstrates the risk.**

## Confidentiality Risk

- **Prime minister David Cameron has confirmed that he will give private firms access to NHS patient data. This seems to be in breach of the confidentiality code :**

How will patients be sure that their personal health details remain confidential?

How will patients be sure that these details are not then circulated for profit-making purposes?

<http://bit.ly/tEVVCG>

**I don't want to know about waiting times,  
I want the NHS to become a fantastic business'** David Cameron

<http://bit.ly/us1UHy>

## Credit Rating Risk

It was announced in January 2012 that the same credit rating agencies who failed to spot the pending financial disaster in 2008 will be charged with assessing the £80billion finances of NHS providers if the Bill goes through.

Monitor, the NHS regulator, proposes replacing its current assessment, which looks at clinical quality and how well hospitals "co-operate" in the NHS, with a new regime that will ask major credit ratings agencies (Standard & Poor's, Moody's and Fitch) to report on the financial strength of the hospital 'and the perceived capabilities of its board and executive team"

<http://bit.ly/w5lEqh>

Any hospital who failed to comply with their criteria would risk losing its licence to operate in the NHS – and based upon the past track record of these credit rating agencies, there is no guarantee about accuracy. There is also no guarantee that an NHS service would be provided instead of a hospital which was closed down.

IPPR Associate Fellow Joe Farrington Douglas noted that the US financial crisis inquiry commission called the three agencies "key enablers of the financial meltdown". He says that the new system will be riven by "conflict of interests" within the NHS which risks repeating the mistakes of the collapse of Southern Cross. "The consultation document implies that providers will have to pay one of the agencies in return for a rating. If so there is a conflict of interest with providers having an incentive to select the agency that gives them the lightest touch and best rating, perhaps allowing them to hide the risks of splitting operations from property, as happened in the broken Southern Cross model." <http://bit.ly/wadyAk>

Outsourcing the planning of the NHS to private companies is also likely to result in distorted planning decisions that benefit those companies. The root cause of these decisions are unlikely to be apparent in day-to-day business.

- **Patient and public involvement will be weak. There is almost no constraint on CCGs by the public or by local authorities.**

### Risk to Training and Research

We all expect that our doctors and nurses have been through the same rigorous standard of training. However the Health & Social Care Bill has proposed a large scale change to the medical training model which has hitherto been the backbone of the NHS. Instead of a national standard, under the eroding of the Bill, training is to become localised.

Eminent medical Lords Walton and Patel highlighted the uncertainty surrounding the future of education and training. This included postgraduate training of the NHS workforce, plus the provision of such services and facilities if NHS organisations are taken over by a provider from another sector.

**'The proposed end to the current training infrastructure is very dangerous. It will lead to poorly coordinated training within a fragmented service delivery and result in widely differing standards in both the short and the long term'**

25<sup>th</sup> October 2011 HANSARD

In addition, the rise in private provision will result in fewer NHS training bases – as the private sector has no obligation to provide training nor indeed a tradition in providing training. This will impact significantly on the capacity of England's hospitals and universities to train sufficient medical professionals.

There is already a dearth of midwives, of A&E staff and a large scale reduction in nursing recruitment and training – how can this clause reconcile population need for a qualified and skilled medical workforce?

- **Opposition and Cross Bench Lords have been rigorous in response and amendments won – it remains to be seen whether the government will agree to keep these or overturn them in the Commons as happened with clauses in the Welfare Reform Bill relating to cancer patients and disabled children?**

## Risk from European Competition Law

NHS Confederation ‘as NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition law will increasingly become applicable. This means that resistance to any form of competition in health services would be legally challengeable.’ <http://bit.ly/dSUktT>

This Bill is counter to the aims of the Ljubljana Charter on EU healthcare reform which recognized that ‘*the improvements in the health status of the population are an indicator of development in the society*’. This Bill will bring about patient detriment and undermine quality care and early intervention

The shifting of EU Competition Law – or the EXTERNAL MARKET into the very centre of the patient/doctor relationship by means of the is at variance with the Hippocratic ethic and is thus evidence of the inappropriateness of these measures and also promises significant future conflict if the Bill is passed, entailing highly expensive court cases from private companies battling for contracts – wasting monies which should far better be spent on patient care, particularly at a time when frontline budgets are being cut.

- **This will result in numerous hugely expensive and time consuming law suits by private providers who seek to challenge commissioning decisions that do not go in their favour – which has already started to happen :**

### Example 1

Circle Health launched a legal action against two PCTS ( Wiltshire and Bath and NE Somerset ) when they failed to win contracts in the first Pathfinder areas

<http://bit.ly/z7G3a5>

<http://bit.ly/wdAzt8>

## Example 2

### Private company Assura, take legal action after failure to win NHS contract

This month saw Co-operation and Competition Panel (CCP) escalate to “phase 2” of its investigation of the conduct complaint by Assura’s East Yorkshire primary care company against North Yorkshire and York PCT and York Hospitals Foundation Trust (the FT). The complaint was made by the Assura Company after it lost out to the FT on a tender for orthopaedics, musculoskeletal clinical assessment, triage and treatment services

<http://bit.ly/ytRmTH>

Lord Warner, former Minister of Health refers to this element of the Bill as leading to ‘**complete confusion**’, which will invite expensive litigation in potentially fruitless actions against a series of inaction loopholes – so written as to be very difficult to challenge - and potentially solve nothing which is ‘in the interests of the health service’

➤ **This is a recipe for chaos and must be stopped.**

The expansion of this area of the market means that provision may also be fined up to 10% of turnover by the regulator.

We note that this is only to apply in England. Wales and Scotland with their devolved powers have developed integrated models of delivery which are starting to meet patient needs in a cost effective and co-productive way where the internal market has been declared void.

➤ **Why are people in England to be treated so differently and with an unproven and dangerous model?**

‘Health services are actually a spectrum.

You cannot divide the actions of one from another, because they have a knock-on effect’.

Baroness Finlay

Crossbencher, Professor of Palliative Medicine, Past President Royal Society of Medicine

Far from promoting collaboration, this marks the loss of the JOINED UP PRINCIPLE.

The full breadth of the privatisation risk is detailed in **Destabilising Our Healthcare** - how private companies could threaten the ethics and efficiency of the NHS <http://bit.ly/xrJzNc>

## Threat to Our Right to Information

Underpinning all of these changes would be the hope that patients and professional staff alike will at least be able to monitor ( no pun intended ) the level of risk to themselves as individuals and to the population as a whole, were these measures to go ahead

However Autumn 2011 marked Lansley both expressing the view that effective data would underpin the success of his plans, whilst simultaneously making dangerous behind-the-scenes moves to implement the cessation of data gathering concerning waiting lists and staff training. Action was also taken to enable the private sector to have fewer obligations concerning the Freedom of Information requirements - thus many actions would essentially be kept from public scrutiny and government accountability.

As blogger David Hencke reveals, <http://bit.ly/qQokmA> not only has Lansley prevented his Risk Analysis from being released in time for a properly informed debate, he has also been busy changing the data gathering goal posts so that the worst elements of his work can be covered up.

‘The two changes appear to be unconnected, but are extremely helpful to new private providers of NHS medical services. One will limit information the private firms have to provide under the Freedom of Information Act to patients and relatives, the other will help them by abolishing the collection of health statistics on the services they provide and the quality of staff they employ’

Suppose there is concern about the use of potentially contaminated medical supplies by hospitals. For an NHS hospital, the FOI Act could be used to obtain details of stocks of the product, the number of doses administered, the numbers of affected patients, the quality control measures in place, correspondence with suppliers, minutes of meetings at which the problem was discussed and information showing what measures were considered, what action was taken, how promptly and with what results. This level of information would clearly not be available in relation to independent providers treating NHS patients. This would represent a major loss of existing information rights.

‘Half the statistics collected on the NHS workforce – which are used to improve staff training and forecast the need for skilled staff – are to be dropped. The consultation document says: “This will be of significance for non-NHS providers of NHS services as it will determine the minimum workforce information they would be required to provide.”

**The number of people waiting more than legal maximum 18 weeks for treatment in Devon rose 14% in 12 months to November 2011**

Hencke continues : ‘also being reduced are the statistics on the very sensitive political area of waiting times, targets for treatments and capacity of hospitals’. The spin on this is “the burden to the NHS is minimised.”

- **vital information concerning patient safety, length of waiting and also staff competence will be obliterated.**

### **Un-Parliamentary**

- **The backdrop to all of this chaos is the fact that each of the current ruling parties vowed that they would protect the NHS and these measures were total absent from either manifesto. There is no mandate for this Bill.**

It is also evident that hundreds of thousands of pounds in donations to the Conservative Party have come from private health companies who will profit from this legislation by many millions, whilst funding is cut to patient care.

The fact that the contents of the Bill have been railroaded through the medical profession without any evidence for success along with the fast track implementation of changes even before the Bill has become statute is nothing short of reckless.

The government has an ethical obligation and duty to care for the nation’s health – it is a fundamental part of their role. This Bill seeks to renege on this and will put the nation’s health at grave risk.

Such legislation will turn the clock back to the days before the NHS was set up when millions of families suffered from poor health and poor living conditions,

It is completely unnecessary to return to these times – the fact that we now have the knowledge to stop this means that the deliberate dismantling of the NHS is completely unethical.

**‘At this rate we will have not a National Health Service but a national health shambles’**

Lib Dem Baroness Jenny Tonge speaks out in support of the NHS

## Immoral Chaos

On January 21<sup>st</sup> it was revealed that the Parliamentary Health Committee which comprises a majority representation from government MPs has highlighted major concerns that the large scale changes proposed in the Health and Social Care Bill are having a detrimental impact upon the NHS and its capacity to manage these £20billion cuts <http://bit.ly/wgxZNj>

- **That these changes are taking place in tandem with the ‘Nicholson Challenge’ – or the need to cut expenditure by £20billion, puts the NHS at even greater risk.**

Stephen Dorrell – former Health Secretary and Chair of the Parliamentary Health Committee, led by government MPs, alerts us to the resulting dangers of what he terms ‘**Salami slicing**’ - where medical services are being pushed into looking for short term expedients through the combination of drastic cuts and the demands of the Health Bill – Instead of finding long term solutions. ‘demands will be placed upon the system which it will not be able to meet’.

January 24<sup>th</sup> 2012

- **Andrew Lansley simply replies that the Committee is ‘out of touch’.**

**In response, the Tory Reform Group have also declared the Bill a danger :**

Mr Lansley seems like a man clinging to a time-bomb that only he cannot hear ticking. The Government urgently needs to look at what he is trying to do and accept that it needs drastic, perhaps total, reconsideration.

That we need urgently to consider what this Health Bill is doing is obvious. In all likelihood that means starting all over again. Moreover, it is clear to me that the current Health Secretary is not the man to preside over this process.

For the good of the NHS, Andrew Lansley must admit defeat and head to the backbenches

[Toryreformgroup.tumblr.com](http://Toryreformgroup.tumblr.com)

<http://bbc.in/yMAoBM>

<http://bit.ly/x2cnYY>

<http://bit.ly/xfKIGk>

<http://bit.ly/xowmY5>

**So there we have it. The deliberate dismantling of the most efficient health service in the world into immoral chaos, simply in the interests of private profit.**

**A costly and wasteful exercise, based upon absolutely no evidence, at a time when every pound counts. A threat to professional standards and quality care which will herald a profit focused approach and result in EU Competition Law costing the service millions in law suits from a dissatisfied private sector - who will nevertheless be ravenously devouring our health and wellbeing services, leaving millions to suffer as a result.**

**This Bill urgently needs to be stopped and a rescue scheme identified.**

Dr Kailesh Chand gov e.petition 22670 <http://epetitions.direct.gov.uk/petitions/22670>

Andy Burnham petition

[www.droptbill.com](http://www.droptbill.com)

## APPENDIX

### Appendix 1 Management Infrastructure

#### NHS Commissioning Board

##### Role :

'The NHS CB's overarching role is to ensure that the NHS delivers better outcomes for patients within its available resources..... providing national leadership for improving outcomes and driving up the quality of care'. ( DoH) by delivering the NHS Outcomes Framework <http://bit.ly/wFEhJH>

It was set up as a 'shadow form' in October 2011 and will be established as an independent statutory body in October 2012. The board will be charged with managing the £80 billion budget which will be shared across all the Clinical Commissioning Groups which essentially replace PCTs

##### Risk:

The CCB will employ 3,500 people and its Chief Executive, Sir David Nicholson, has said it could become the *'greatest quango in the sky we have ever seen'*

**'Are we really considering putting this vast block of government expenditure out into the void with no requirement or capacity for the Government to be held to account by Parliament?'**

Lord Owen 22<sup>nd</sup> November HANSARD

<http://bit.ly/xu33mY>

<http://bit.ly/qvbRVo>

#### Clinical Commissioning Groups

##### Role :

Clinical commissioning groups – originally known as GP Consortia - will take over responsibility for commissioning the majority of NHS services in England, with primary care trusts (PCTs) who have been responsible for local fund management due to be abolished by April 2013. All GPs in England will be required to join one of the clinical commissioning groups, which will begin to assume their new statutory responsibilities from 2013/14.

The first of these – which are already operating, are known as Pathfinders. PCTs are still operating but on a skeleton basis – which is causing problems for ongoing delivery of services as these changes are rushed through before Parliament has agreed with them.

**Risk :** The Department of Health has recommended that Commissioning support should also be opened up to competition, according to the document 'Towards Excellence': 'The NHS sector, which provides the majority of commissioning support now, needs to make the transition from statutory function to free standing enterprise.'

As part of this enterprise, CCGs will be able to have shareholders to whom GPs will be answerable - and could then take priority over patients

As CCGs are designed, they have no obligation to provide a comprehensive service and there is no assurance that every member of the population will have access to the health service they need.

The private Nuffield Trust advertises itself as 'establishing a network of clinical commissioning groups to 'test out' commissioning plans among peers....

*' Our international work on commissioning has seen our researchers examine the experiences of doctors' groups in the United States, who have held the equivalent of a commissioning budget for the past two decades.'*

The Nuffield Trust makes a charge – and thus a profit- for this training of NHS staff in the ways of US health models.

**NHS North of England has highlighted problems with the structure of 14 prospective clinical commissioning groups in the patch including one in Wirral of which prominent GP commissioner James Kingsland is a member.**

Health Service Journal January 2012

<http://bit.ly/u5Jh2z>

<http://bit.ly/usDg75>

## Monitor

### Role :

Monitor is to be the 'sector regulator'. They will regulate prices through 'the Tarriff' and will issue licenses to Foundation Trusts and all providers wishing to offer NHS-funded services.

### Risk:

The Chair is not a fan of regulation so there are likely to be loopholes.

There are elements of parallel working with the Care Quality Commission.

Instead of the changes recommended by the Future Forum after the listening phase in summer 2011, Monitor has a new duty to "prevent anti-competitive behaviour" – in other words meaning a promotion of competition

There is a direct conflict in the requirement on Monitor to promote competition and integration – one cancels out the other.

**Monitor is likely to face "numerous" allegations of improper conduct unless it can clearly separate its future healthcare regulatory role from its responsibility for foundation trusts, its chairman has warned.**

David Bennett, Chair of Monitor January 2012

After concerns, Monitor is now proposing the an emergency cover fund to manage Commissioned Services who may wobble financially – until they can either be closed/downsized or integrated with another provider...

*'initially this will comprise mandatory services currently provided by foundation trusts ( hospitals ). Subsequently, commissioners may request that other services, provided by any licensee, should become Commissioner Requested Services, or that services should no longer be treated as Commissioner Requested Services. Licensees providing Commissioner Requested Services will be subject to all of the Continuity of Services license conditions".*

Got that? Simple isn't it?!

<http://bit.ly/xFkFkE>

## Care Quality Commission

### Role :

Responsible for inspecting the safety and quality of patient care at NHS and social care organisations, including independent, voluntary and charitable providers.

### Risk

This is the body responsible for letting the problems at the Mid Staffordshire NHS Trust accumulate to the point of danger at Stafford Hospital – likewise Winterbourne View where mentally disabled residents were horribly abused which was only revealed by hidden cameras. Both the leadership of the CQC and the ‘unhealthy organisational culture’ have been called into question. Without the pressures of the Health & Social Care Bill, proper attention could be put into improving quality where it is evidently needed.

<http://bit.ly/vqbQLL>

Further risk analysis of the CQC by Dr Lucy Reynolds is to be found in Appendix 6

## HealthWatch England

### Role:

The proposed duties of HealthWatch England as described by the Dept of Health are intended to provide local healthwatch organisations ‘with advice and assistance in relation to promoting and supporting the involvement of people in the commissioning, provision and scrutiny of local care services’.

### Risk:

Although it is supposed to offer protection to patients through an independent local focus ( it replaces LINK – whose budgets have already been reduced by 65%), HealthWatch is being wrapped up inside the Care Quality Commission which is the national complaints body. This set up will therefore not be independent in a way which will protect the interests and needs of patients.

Nor does the Bill give local HealthWatch organisations any specific role in relation to monitoring CCGs. They have no direct role in influencing the commissioning arrangements of CCGs in relation to the needs of local people, nor do they have any say in it. In addition, it has no stated role in helping patients who wish to appeal prescribing and treatment decisions – in fact there is nothing in the Bill which offers patients any such facility. As designed in the Bill, HealthWatch is an empty vessel.

## Health & Wellbeing Boards

### Role:

Health and wellbeing boards will be a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area.

### Risk:

As the Bill stands, the clauses relating to these Boards are full of ‘may’ – nothing is compulsory. For instance Health and well-being boards' role in bringing health and social care together with health-related services is optional. The National Children's Bureau and its Every Disabled Child Matters campaign believe this role must be strengthened so that there is a clear duty on all health and well-being boards to promote joined-up commissioning and delivery of services in their area.

It seems that the model is based upon the expectation that all of these loose frameworks will result in services which will fail and fall... What a terrible waste.

## Appendix 2 : Scrutinising Expenditure

Our current understanding of the proposals is based on a publication published by the NHS Commissioning Board Authority “Developing Clinical Commissioning Groups: towards authorisation.” <http://www.commissioningboard.nhs.uk/commissioningboard/files/2011/10/Developing-CCGS-towards-authorisation.pdf> ).

There will be an application process and based on criteria, which are still being developed, the NHS Commissioning Board will grant or withhold authorisation. This authorisation may be with conditions. There will be an annual assessment following the initial application to ensure that the criteria are still met. There will be an application process and based on criteria, which are still being developed, the NHS Commissioning Board will grant or withhold authorisation. This authorisation may be with conditions. There will be an annual assessment following the initial application to ensure that the criteria are still met. Additionally as the NHS Commissioning Board will fund the Clinical Commissioning Groups and consolidate their accounts into its own, and the NAO will audit the NHS Commissioning Board, we will have audit access to the Clinical Commissioning Groups through this route, as well as the C&AG's right to follow all public funds.

Source : Audit Commission

( it should also be noted that in 2010 the Audit Commission was told it would close – now downsized)

## Appendix 3

# Position Statement from Labour House of Lords Front Bench Team

Labour's frontbench in the Lords continues to share the view of almost every external stakeholder organisation to the NHS that the Health and Social Care Bill is unnecessary and poses risks to the patient care. Despite the legislation remaining incomplete, the unprecedented scale of re-organisation continues apace, bringing destabilisation and huge additional costs at a time when the NHS is facing major financial pressures.

During 15 days in Committee, the much delayed Bill came under thorough scrutiny from peers across the Lords, led for the most part by Labour, often working with crossbenchers and, occasionally, backbench Liberal Democrats. As with the Commons stage of the Bill, the Government has to date given no significant concessions while at the same time losing most of the arguments. With the next version of the Bill just published, Lords Report Stage will start in early February and last for 4 to 5 weeks.

During the Committee stage, we have effectively seen a second "pause" in the Bill, so that issues around the duties of the Secretary of State can be examined. There is general agreement that the Bill has to be changed in this area, backed up by a report from the Lords Constitutional Committee recommending significant changes

The thorny issue of the lack of availability of the Bill's Risk Register remains unresolved, raised through an FoI request by Labour . Consequently, the final timetable for Report Stage has yet to be formally agreed.

The main concerns with the Bill remain unresolved and in considering the key Part 3 (which deals with Competition and the role of Monitor as Regulator), Labour put forward a full rationale for an alternative approach to NHS reform. Whatever concessions are made before Report, it is clear the government will not be persuaded that changing the NHS from a managed system into a full blown market will be detrimental to patient care.

During Report, it is already clear that many key issues will have to be addressed. Many Labour peers have signalled their intention to put down amendments for consideration and in January we will circulate further briefing material. For now however, these are the areas likely to be covered:

Secretary of State's (SoS) powers and autonomy

- **SoS must remain both politically and legally accountable for a comprehensive NHS**
- Powers and duties of the SoS must be broadly compatible with those in the 2006 Act
- The complete removal of any (unearned) autonomy presumption.

## **Competition and Monitor**

- A provision should be inserted that defines the NHS as a universal system provided for the purposes of social solidarity – to deter inappropriate intrusion of competition legislation
- Monitor must be the financial regulator of providers not the economic regulator of the health system; the role as regulator of Foundation Trusts (FTs) must be separate
- There must be no presumption that competition is necessary or required or to be promoted; it is to be used when appropriate within a framework defined by the SoS
- The poorly thought out regime for dealing with “failure” must be simplified extensively and the power to de-authorise FTs continued

## **Governance of new bodies: Clinical Commissioning Groups (CCGs) and NHS Commissioning Board**

- CCGs must be coterminous with local authorities and be free of Conflicts of Interest
- CCGs must have proper governance arrangements including a Board with a majority of independent non-executive directors
- The NHS Commissioning Board should not commission local services

## **Independence for Public Health England**

- Many issues have been raised by the professional bodies to ensure Public Health England is adequately funded, has enough influence within local authorities and remains connected to the NHS

## **Independence from Care Quality Commission (CQC) for Health Watch England (HWE)**

- HWE should not be part of CQC

## **Powers for Health and Wellbeing Boards (HWBBs)**

- HWBBs must produce an integrated commissioning plan covering NHS, PHE and social care
- HWBBs must agree the commissioning plans of CCGs

Other amendments certain to be moved by others, will include:

- Training & Education
- Research
- Monitor's role in continuing oversight of FTs
- Private Patient Cap
- Regulation of the workforce

Labour's position on these matters will depend on the actual amendments proposed but in general terms we agree with views already expressed that extensive changes to the relevant aspects of the Bill are required.

**Labour's Lords Health Team, 22nd December 2012**

## **Appendix 4**

### **Position Statement from Labour House of Lords Front Bench Team ( updated )**

Despite a further raft of Government amendments Labour's frontbench continues to believe that the Health and Social Care Bill is unnecessary and poses risks to patient care. We share the view increasingly held by patients, those who work in the NHS and the professional bodies that less damage will be done to our health service if Ministers were to withdraw the Bill rather than continue with an increasingly reckless pre- legislative implementation.

Working with partner organisations, Labour is also developing a detailed explanation of how the NHS could be stabilised if the Bill was dropped and how existing legal powers and structures could be used to continue with reform. One of the most pressing challenges for the health service in England is the need to provide patients with integrated systems of care. But if this Bill goes through, it will result in the exact opposite: a market driven NHS that will lead to the fragmentation of services.

**While the Government has made a small number of positive changes to some sections of the Bill, the vast majority of concerns expressed during Lords Committee stage have not been adequately addressed. Labour believes it remains a rotten Bill.**

**As the Chair of the Royal College of General Practitioners has said today: "*We must once again raise our concerns in the hope that the Prime Minister will halt this damaging, unnecessary and expensive reorganisation which, in our view, risks leaving the poorest and most vulnerable in society to bear the brunt.*"**

Issues around the duties of the Secretary of State have been a matter for negotiation for peers across the House and, with the help of the Lords Constitution Committee, new amendments move back towards restoring the 2006 Secretary of State powers and responsibilities. But while better safeguard are being offered, Labour remains of the view that the autonomy clauses should be removed altogether.

The thorny issue of the Bill's Risk Register and its lack of availability remains unresolved – an issue first raised by Labour almost a year ago through an FoI request and pressed continually in the Lords during Committee:

<http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111221-0001.htm#11122136000502> (see from column 1789)

Dates have now been set for early March to hear the appeal by the Government, but it has been made clear that even if the appeal is lost, Ministers will continue to use every means possible to prevent disclosure. However, various procedural options are being explored by Labour and the Crossbenches which seek to prevent implementation of the Bill before the Risk Register issue is properly resolved.

Throughout the troubled passage of the Bill, our central concerns have been with Part 3. This is the section of the legislation dealing with Competition and the role of Monitor as Regulator, and the real reason why the Bill exists. During Committee, Labour put forward a full rationale for an alternative approach to NHS reform, but the Government position has remained essentially unchanged – they support extending the scope and scale of competition and the introduction of a full market. Labour believe that our NHS is not the same as gas, water, electricity – it is not a market and it is not to be privatised.

It is already clear that many key issues will still have to be addressed during Lords Report. As we approach the first session, these are the priority areas for Labour's frontbench team:

### **1. Secretary of State's (SoS) powers and autonomy**

SoS must remain both politically and legally accountable for a comprehensive NHS

Powers and duties of the SoS must be compatible with those in the 2006 Act

The complete removal of any (unearned) autonomy presumption

## **2. Competition and Monitor**

A provision should be inserted that defines the NHS as a universal system provided for the purposes of social solidarity – to deter inappropriate intrusion of competition legislation, and reference should be made to appropriate EU Treaty Articles to put the matter beyond doubt

Monitor must be the financial regulator of providers not the economic regulator of the health system

Monitor's role in overseeing NHS Foundation Trusts (FTs) should continue

The role of Monitor as regulator of FTs must be separate from any role in relation to economic regulation

Changes in Monitor must not come into force until after the end of the period for allowing all Trusts to achieve FT status (currently set as 2016)

Any changes to the PPI Cap would need to be modest, and agreed through local governance arrangements, with tougher tests to ensure NHS patients benefit from any change

There must be no presumption that competition is necessary or required or to be promoted; it is to be used when appropriate within a framework defined by the SoS

The poorly thought through regime for dealing with “failure” must be simplified extensively and the power to de-authorise FTs continued

Any role for the Competition Commission should be removed

## **3. Governance of new bodies: Clinical Commissioning Groups (CCGs) and NHS Commissioning Board NHS CB**

CCGs must be coterminous with local authorities and be free of Conflicts of Interest (progress has been made on this issue but not enough)

CCGs must have proper governance arrangements including a Board with a majority of independent non-executive directors (progress has been made on this issue but not enough)

The NHS Commissioning Board should not commission local services

The huge new bureaucracy being created by the NHS CB should be constrained

#### 4. Independence for Public Health England

Many issues have been raised by the professional bodies to ensure Public Health England is adequately funded, has enough influence within local authorities and remains connected to the NHS

#### 5. Independence from Care Quality Commission (CQC) for Health Watch England (HWE)

HWE should not be part of CQC

#### 6. Powers for Health and Wellbeing Boards (HWBBs)

HWBBs must produce an integrated commissioning plan covering NHS, PHE and social care

HWBBs must agree the commissioning plans of CCGs

Other amendments certain to be moved by peers from across the House will include: **Public Health; Training & Education; Research; Monitor's role in continuing oversight of FTs; and Regulation of the workforce.** Where appropriate, Labour's frontbench will add a name to indicate support but in general terms we agree with views already expressed that extensive changes to the relevant aspects of the Bill are required.

**Labour's Lords Health Team, 3rd February 2012 – also working with other members of the House from other parties/Cross Benches/Bishops who are dedicated to supporting the NHS**

## Appendix 5 Article by Dr Lucy Reynolds ( via AbetterNHS Blog )

1. How does Earl Howe explain the comments he made at the Laing and Buisson Independent Healthcare Forum on 7<sup>th</sup> September (during 3<sup>rd</sup> reading) in which he informed the audience of private sector providers that there were big opportunities for them to make money by taking patients away from the NHS

[www.pulsetoday.co.uk/newsarticle-content/-/article\\_display\\_list/12663018/big-opportunities-for-private-sector-in-health-bill-says-minister](http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/12663018/big-opportunities-for-private-sector-in-health-bill-says-minister)

2. What safeguards are to be put in place to prevent private equity firms companies from taking a stake in NHS ex-employee buyout social enterprises, gearing them up( raising loans against them and extracting the principle, a standard asset stripping monoeuvre ), extracting the cash and dumping the remains once no more income stream can be extracted ie. The Southern Cross Story
3. There are sections of the Bill which pertain to property transfers ( 134, 299, 300 and Schedule23 ), but none of them mention the value at which land and buildings may be transferred under their provisions. What safeguards are in place to prevent NHS land and buildings being transferred at undervalue? Can Earl Howe guarantee that these transfers will not take place for a nominal sum? The Bill contains no provision for public scrutiny of such transactions involving the Secretary of State and ‘qualifying companies’. How will public oversight be arranged for this?
4. Several of the US companies which are hoping to come into the NHS either as providers or commissioners have been in trouble for defrauding the US government. What safeguards will be put in place to stop them applying the same low business standards to their dealings with patients, GP’s and the UK government?
5. One large company which has been lobbying for access to the post-reform NHS is a South-African company ( Netcare, parent of the General Healthcare Group ) which was found guilty of removing the kidneys of minors and selling them. What ‘fit and proper person’ tests are to be applied for the new entrants to our state funded health system? Will the general public be allowed to lodge protests against particular providers who seem to have demonstrated themselves not to be fit and proper persons to be involved running of services for the NHS? The Mirror alleges that GHG is under consideration for contracts to run transplant services in the UK.

<http://www.mirror.co.uk/news/politics/2011/09/06/organ-selling-firm-in-nhs-talks-115875-23399313/>

6. Once NHS hospitals are required to make their money through selling services, they will have to balance their books or go out of business. Is it planned for those burdened by expensive PFI deals to be left to sink or swim, or is the government planning to force the taxpayer to take over all over the PFI deals so that such hospitals have a chance of survival in the new market -place
7. The Care Quality Commission has been running regulation on the basis of self certification and has a track record of believing those assessments rather than inspecting in person, the Winterbourne View case demonstrated that self-assessments by profit-making private equity funded suppliers are not to be trusted. For the last year the CQC has recruited no-one with any medical qualifications for any of its management or inspection roles. The reason appears to be systematic under-funding and management which fails to protest about the fact that it has insufficient funding to do the job properly. The Bill puts the responsibility for technical insurance on the underfunded and underskilled CQC and mandates no extra funding. Can Earl Howe please elaborate on how the system will be changing to safeguard patients properly? For instance, how will the figure for an adequate amount of CQC funding for arrived at? What is the planned frequency of facility inspections by medical doctors?
8. What safeguards are to be put in place to stop GPs denying patients treatment under the NHS (and retaining the money saved, as would be permitted by the Bill) then offering to give private treatment for the same complaint (as also permitted by the Bill). None are at present included in the Bill
9. What proportion of the referrals budget is expected to be spent on commissioning overheads and profits ( of contactors to which the commissioning tasks are outsourced)? Is it reasonable to expect this is to be in the 20-40% range as applies to similar arrangements in the USA? What do your projections show for the amount of the budget given to GPs consortia which will be consumed by the outsourcing of commissioning costs?
10. The Bill (s13) allows privatisation of secure psychiatric services; s35 allows the SoS to nominate whoever he likes to approve people to section individuals thought to be a danger to themselves or to other people. The Bill states that the SoSH may or may not arrange compensation for this task. Clearly there is potential for abuse in this combination of changes. There has been a recent related abuse in the USA : <http://www.nytimes.com/2009/02/13/us/13/judge.html?pagewanted=all> but in that case the scheme required bribery of judges and the sentences were for months only.

In the NHS case abuse would not require any illegality, merely the possession of the right to lock people up and to be paid for doing so ( under a contract) and the ability to approve people to section others (who as well as approval need the minimum qualifications specified under the Mental Health Act 1986 ); and the deprivation of liberty involved could be long-term or permanent. This seems to be a duty which should not be taken out of state supervision. What safeguards are to be put in place to protect the general public from being involuntarily admitted to profit-making secure mental hospitals which are paid by the number of inmates held?

11. What safeguards are in place to prevent inmates of secure psychiatric facilities privatised under s13 from being pacified with drugs which have serious permanent side-effects, or with ECT, in order to enable lower levels of staffing to be maintained and more profits made?

Source : <http://abetternhs.wordpress.com/author/abetternhs/>

<http://abetternhs.wordpress.com/2012/01/08/questions/>

Other Evidence :

<http://www.sochealth.co.uk/> Stabilisation Narrative – the way forward

<http://nhsalert.org.uk/news/> Running bulletins

<http://blogs.channel4.com/factcheck/factcheck-the-truth-about-the-nhs-reform-bill-myths/8160>

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[www.dropthbill.com](http://www.dropthbill.com)

<http://epetitions.direct.gov.uk/petitions/22670>

Authored for SOSNHS

Granville Feb 2012