# NHS Sustainability and Transformation Plans (STPs)
# Don't Slash, Trash and Privatise our NHS!

**A Briefing prepared by campaigners from NE London STP area – November 2016**

## Introduction

STPs are driven by a combination of NHS underfunding, new budget cuts, and the Government's determination to shift the NHS from a clinically-driven service towards US-style models that fit more readily with private insurance-based and corporate-managed healthcare. These changes will have a devastating impact on the NHS and on services and healthcare for local people.

The population of NE London is set to increase by 18% over the next 15 years but there are no plans to increase services – only to 'reduce demand' for healthcare. Most of the published STPs – including NE London's – contain little or no detail of proposals for specific service, funding or sites. Instead they are replete with vacuous intentions for happier populations keeping themselves healthier and out of hospital.

*'Everyone will submit an STP because they have to, but it means there is a lot of blue sky thinking, and then a lot of lies in the system about the financial position, benefits that will be delivered - it is just a construct, not a reality.'* Julia Simon, until Sept 2016, Head of NHSE Commissioning Policy Unit.

## How STPs will affect the NHS

An HSJ poll of leaders of England's 209 Clinical Commissioning Groups has revealed the extent of "service changes likely or planned" over the next 18 months[i]:

- 52% would be closing or downgrading community hospitals – *in NE London, we will not be getting the additional hospitals we need to service the massive population growth predicted over the next 15 years (a rise of 270,000 – the size of Brighton & Hove – in the Barts Health boroughs alone) and 18% population growth across the NEL area as a whole.*
- 46% were planning an overall reduction in in-patient beds – *the STP includes reducing Barts Health emergency bed days by 21,053 by 2017-18, to save up to £6.6m over the next five years – on top of the loss of 550 additional beds that would normally be required for the expanding population in the Barts area alone.*
- 44% intend to centralise elective services. *NEL STP promises 'a joint vision for surgical hub model across NEL'.*
- 31% would be closing or downgrading A and E – *St George's A&E looks set to close and, despite population growth which would be expected to add an additional 92,000 attendances over the next 10 years, the Barts Health area plans to hold A&E attendance down at current levels*
- 30% intend to close an urgent care centre or similar provision
- 23% are planning an overall reduction in acute services staff
- 23% intend to stop in-patient paediatrics in one or more hospitals
- 21% would be reducing consultant-led maternity provision

## Funding

- £22bn cuts to be imposed through 44 STPs across England by 2020-21: £578m across NEL. In the Barts Health area alone, despite population growth, the plan is to cut between £104-165m over five years
- No growth in services despite sharply rising costs, growing population numbers and rising health needs – means a devastating decline in what's available to individuals. These are CUTS, masked by ambiguous and hollow language.

| | % GDP spent on health (new definitions) | $ per head on healthcare |
|---|---|---|
| France | 11.1 | 4,367 |
| Germany | 11.0 | 5,119 |
| The Netherlands | 10.9 | 5,277 |
| Norway | 9.3 | 6,081 |
| Sweden | 11.2 | 5,065 |
| Switzerland | 11.4 | 6,787 |
| United Kingdom | 9.9 | 3,971 |
| **Average (excl. UK)** | **10.7** | **5,264** |

- **UK spending on healthcare is significantly below the average of major European economies**[ii]. If the UK were to increase its spend to 10.7% of GDP, this would equate to an extra £15bn pa.

## Lack of evidence to support NHS England's Five Year Forward View (5-YFV) 'new models'

- The **NHS has a proud track record of evidence-based practise**. This is all but abandoned in the 5-YFV.
- **The 'new models of care' are cost-driven**. We campaigners don't oppose changes to services – but changes need to be driven by combination of clinical need & requirement for good patient access and rigorously assessed against these criteria.
- **STP changes are being imposed with no such assessment, and lack of valid, peer-reviewed research evidence-base**. Anecdotes claiming success are routinely substituted for valid evidence that also takes account of a wider picture. Examples include:
    - **decisions to focus services on specific outcomes** often take no account of the impact on patients with multiple conditions who may lose co-ordinated care.
    - **Arguments about the need to centralize highly complex specialized care are misused** to justify closure of units offering excellent care for routine conditions. Often no account has been taken of increased risks of extended blue-light journeys to A&E or difficulties for patients and visitors facing of longer journeys.

## The New Models of Care for the NHS mean:

- **Fewer sites for NHS services** – people will have to travel further for healthcare. We can't assume a reduction in locations is acceptable without full analysis of travel implications for local patients and visitors - especially the impact on elderly or disabled relatives, families with children and people with limited English.
- **Specialist hubs**: some specialist focus is needed for complex and rare conditions – but not for routine health issues where local services and accessibility / travel are more important. Local clinicians could access specialist advice if needed via good NHS networks.
- **Selling off the NHS family silver/estate**. A one-off boost for treasury finance, with few or no guarantees for local funding. When it's gone -much of it handed over to private housing - it's gone forever *– The London Chest Hospital land has already gone that way and there are plans to sell land at Whipps Cross Hospital too.*
- **No new capital money – so rely on PF2** - Many of the new models of care require different, potentially larger premises than currently available. We fear a repeat of disastrous consequences of PFI. *Barts Health NHS Trust is already paying more than £2.5m a week in unitary charges for its PFI hospital buildings.*
- **Reliance on enhanced self care, Skype apps and unproven technology** to avoid hospital admission and clinical care amounts to magical thinking! And relies heavily on unpaid family carers (mainly women). *The NE London plan includes a 10% shift away from GP attendances in the Barts Health boroughs – despite the high levels of deprivation and language difficulties in east London.*
- **A major shift of services away from hospitals and back towards primary care** – Overstretched GPs will be expected to take on additional outpatient work.
- **The most vulnerable and socially excluded patients and families & women** will be hardest hit. *NE London includes some of the most deprived wards in the country.*
- **Restructuring of the NHS** involves less clinical, more corporate management. Ripe for privatisation. *An FOI request to the drafters of Transforming Services Together found they had spent £3.5m on 20 corporate consultants, while the STP drafters had spent £800k on consultants in a matter of months.*
- **Data-sharing.** We are very concerned about proposals to share confidential medical data across a range of health and social care providers, leading to major potential for confidentiality breaches.

## Downgrading professional staffing

- Development of **new roles such as Physician Assistant/ Associate** (PA) (just 2-years' training) are part of a general move to reduce costs while de-professionalising (dumbing down) the NHS and heightening management control – *the plan for the Barts Health boroughs includes recruiting 85 PAs over the next 10 years, to replace an expected shortfall of 195 GPs*
- These changes have a poor evidence base, often reporting 'acceptability' rather than outcomes. Evidence for success is often anecdotal and much of the 'research' would not meet professional standards or peer-review requirements.
- Proposals to engage PAs rather than experienced nurses have been justified by 'too many professional limits' placed by professional bodies on nurses!
- There is no mandatory registration for PAs, raising major concerns about regulation.
- There is robust (and unsurprising) evidence that PAs are less effective than doctors at diagnosis
- BMA warnings that PAs are not a substitute for fully trained doctors are likely to be ignored
- Concerns that PAs will not recognize important signs that a fully trained doctor would spot
- Pressure to grant PAs independent prescribing powers will lead to enhanced risk to patient safety and increased risk that PAs will be used to substitute for, rather than support, doctors.

- Concerns that **GP receptionists** may in future be triaging patients and directing them to PAs who will miss more subtle indications
- Concerns that patients directed to PAs are more likely to be **elderly, vulnerable, speakers with poor English** etc – while articulate middle class patients will be able to get GP appointments
- **Similar concerns apply to other proposed new roles**, substituting minimally trained staff for professional clinicians, nurses, pharmacy and professions allied to medicine throughout the NHS.
- As the Nuffield Trust puts it[i] *'……. In the future, care will be supplied predominantly by nonmedical staff, with patients playing a much more active role in their own care. Medical staff will act as master diagnosticians and clinical decision-makers'*.[iii]

## Implications for community care services

- **Local Councils have already presided over 30% cuts in adult social care**, with over 400,000 fewer people receiving social care services since 2010, and those in receipt getting fewer hours[iv]. We have not heard councils explaining these cuts and protesting loudly and very publicly about them.
- **Local councils have outsourced the future of the social care sector to large financialised businesses** which want to be paid more for doing the same (with no questions asked about their accounting and finance decisions). These businesses manoeuvre politically to reduce risk and avoid consequences, while threatening to hand back vulnerable residents when they go bust[v].
- **We are concerned** that Councils will preside over a similar demise of our NHS.
- **Fewer hospital beds, and early discharge mean more pressure on GPs, primary care and community care services.** The changes will mean repeated tightening of eligibility criteria and more people excluded.
- **Social care staff** increasingly required to take on tasks previously done by NHS professional staff. Safety risks and extra burden on family carers – predominantly women - and vulnerable patients have not been evaluated.
- "**There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets** will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true."[vi]

## A better future for the NHS: the risks and The NHS Bill

- Our health service is being re-modelled in a way that will be ripe for wholesale privatization and insurance-based care, leaving a low quality rump NHS for those who cannot afford private insurance.
- We are very concerned that this is the Government's plan for future healthcare.
- **At least £4.5bn per year is wasted on simply managing the NHS market**, and more on private profit
- Procurement Rules mean that any marketized service is prey to international healthcare corporates.
- **There IS an alternative to this wholesale devastation. We want out Councils to support the NHS Bill[vii] that will reinstate a publicly funded, publicly provided, accountable NHS**. This Labour private members' Bill, drafted by Professor Allyson Pollock and barrister Peter Roderick, is supported by Labour, the Greens and the SNP, and will receive a second reading in Parliament on 24th February 2017.

## What we want from CCGs and councils

We understand and accept that CCGs and Councils are required to manage sharply diminishing resources – but we ALSO expect our political representatives, together with other councils, to explain and shout from the rooftops to protest the devastating impact of these cuts and service changes to local people, and refuse -as other councils have done - to sign up to the STP. We also want our councillors to campaign forcefully for the NHS Bill.

## *The NHS will last as long as there are folk left with the faith to fight for it.* Aneurin Bevan, 1948

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i http://www.telegraph.co.uk/news/2016/10/30/almost-half-of-nhs-authorities-to-cut-hospital-beds-and-third-to/
ii https://chpi.org.uk/wp/wp-content/uploads/2014/11/CHPI-Long-term-sustainability-NHS-submission-to-House-of-Lords.pdf
iii http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce
iv https://www.adass.org.uk/media/4345/key-messages-final.pdf
v http://www.cresc.ac.uk/medialibrary/research/WDTMG%20FINAL%20-01-3-2016.pdf
vi https://www.theguardian.com/society/2014/nov/19/parties-plans-nhs-future-wishful-thinking-experts
vii www.nhsbill2015.org/