CAMPAIGN AGAINST NHS PRIVATIZATION
SUBMISSION TO THE HEALTH AND WELLBEING SCRUTINY COMMISSION, LEICESTER CITY COUNCIL REGARDING
THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND
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Endangering the future of the NHS through chronic underfunding

The Sustainability and Transformation Plan poses a significant threat to the quality of health services in Leicester, Leicestershire and Rutland. The primary purpose of the STP is to restructure health services so that the unit cost of health care is reduced.

Not only have Conservative governments tended to fund the health service less generously than Labour governments historically but in addition they have taken a more ambivalent stance towards the very principle of the service. The Conservative opposition voted against the National Health Service Bill in 1946; under Margaret Thatcher, policies of privatisation were initiated and, since 2010, Conservative-led administrations have prioritised marketization and restructuring over quality health care.

Between 1950 and 2010, the average real terms annual increase in health service funding was almost 4% but since 2010, these annual increases have averaged 1% a year. Around 4% is estimated to be necessary by the Nuffield Trust to cover cost pressures arising from the growing and ageing population, increasing levels of chronic illnesses, the cost of medical innovation and health service specific inflation. NHS providers have made efficiencies but, overall, have been unable to avoid running deficits. The autumn statement of 2015 required cuts in both the public health budget and capital budget of the Department of Health and effectively money was transferred to NHS England to counter the growing deficit. (The Department of Health budget is run separately from the budget given to NHS England for providing NHS services.) Despite creative accounting, NHS providers across England, such as University Hospitals of Leicester and Leicestershire Partnership Trust locally, ended the last financial year (2015-16) with an underlying collective deficit of £3.7bn. The primary purpose of the STP is to restore financial balance by 2020/21 by reducing the gap between the amount of funding made available and the cost of continuing to provide health services on the current basis.

The financial settlement for the NHS since 2010 makes it clear that the government's vision is for a health service which fits into a smaller share of national income. While relatively high levels of funding of the NHS are associated with relatively low levels of private health insurance coverage, the danger is that reducing access to health care by restricting NHS capacity and reducing the quality of health care provided by the NHS could lead to a rise in take-up of private health insurance by those who can afford it or in out of pocket payments (fee for service), eroding the principle that health care should be available on the basis of need alone. The majority of us would be left with a poorer service.

Government policy reflects both a lower priority for health care and also a broader determination to reduce the redistributive impact of policy. Spending on benefits and public

services is our society's major vehicle for redistribution. Good quality health services are important in reducing inequalities since NHS care is available independent of the individual's ability to pay for it: health care can be equally provided to the rich person and the poor person. Moreover, good services form an important part of the 'social wage', the element of our standard of living which comes not from our own salaries or benefits but from the services we pay for collectively. Households which, during these difficult times, suffer a drop in personal income face a double whammy when public services such as the NHS are simultaneously cut back.

This cannot be seen as an unavoidable side effect of dealing with the deficit. Other comparably rich countries, which have also faced economic challenges following the financial crash of 2007/8, have continued to maintain noticeably higher levels of funding for their health services than the UK both in terms of the amount spent per person and in terms of the proportion of GDP devoted to health care. The NHS continues to have far fewer beds per head of population than most rich countries and continues to have fewer doctors and nurses per head of population compared with other rich countries.

Nor is the claim that the NHS is no longer affordable convincing. The NHS is an important part of the economy and additional spending on health care produces economic growth through the fiscal multiplier. £119bn was spent on the NHS 2016-17; 4% of this is around £5bn. The Office for Budget Responsibility produced an analysis in September 2016 which looked forward to what would be needed for NHS funding by 2030. It claimed that adequate funding for the NHS could be found by giving the NHS the proceeds of economic growth plus £1.7bn each year. From an economy of just under £2 trillion, this can be found if political decision-makers want it to be found.

We call upon the City Council to recognise that the threat posed by the STP is a direct consequence of government's policy and vision for the NHS and to oppose it.

Cuts in local health care

Given the financially-driven nature of the STP, it is not surprising that large-scale cuts are proposed. Hundreds of acute beds are threatened with closure, despite the fact that bed occupancy is running at 95% and over (that is, at any given time, 95%+ of beds are occupied), while the safe occupancy level is 85%. The clinical dangers posed by excessively high levels of occupancy have been summarised by the Nuffield Trust and include disruption in the care of sick patients, extra pressure on staff and threats to the ability of staff to contain infection and to prevent infection spread. Two community hospitals and 38 community hospital beds are also threatened with closure in the County and Rutland which is likely to lead to additional pressure on beds in Leicester. The plan to close the Leicester General Hospital as an acute hospital which also offers consultant-led maternity care is particularly startling given the relatively high proportion of acute care and maternity care provided on the site. We do not believe that closure can be undertaken while maintaining safe patient care.

The new models of care are to some extent experimental. Relying on 'emerging evidence' is not satisfactory. If new models of care are piloted, double running for a long enough period to establish the outcomes (intended and unintended) and impact of the new services is the minimum required. The closure of acute beds should not be considered until bed occupancy is consistently well below 85%. The Plan's timescale of five years is inadequate and has led to short-termist proposals likely to create more problems than they solve by 2021, particularly

by cutting services which are needed. Projections for population growth and envisaged morbidities are required and should be in the public domain.

Social care

Publicly funded health and social care services in Leicester have been particularly vulnerable over the last few years as the City Council has grappled with real terms cuts in budgets. The result has been that publicly funded care and support needed in old age are failing to meet rising demand. Leicester Council has no care homes, while the fragility of private ones, especially from a financial and staffing point of view, is a real concern. The number of private care homes in England has fallen from 18,000 in September 2010 to around 16,600 in July 2016. Social care in communities is under strain and needs proper financial investment. In our view they will only really succeed when there is taxation based funding and renationalisation of social care.

Vulnerability in communities

When the STP says services are being transferred into 'the community' we have to think what we mean by community. We already have a 'community' under severe strain. The city in a number of areas has high levels of poverty and deprivation. In part this is due to an economy built on low wages, low job security and a growth in zero hour contracts. Even some people in work struggle to feed themselves, pay the rent or mortgage and may even rely on foodbanks. Some people have to hold down several jobs to make ends meet but the STP seems to assume family members or friends will be available to look after people in their own homes. Many experience the stress of low wages and insecure work and meanwhile mental health services are also under strain. Public health funding has been cut back and support for prevention is reduced. So overall we should view the community as in many respects vulnerable and we should not assume that transferring services into the community is automatically desirable.

If there is an expansion of community services, the Plan must take account of the social care crisis and vulnerability in communities and make sure the new services are properly invested in and fully proven before hospital services are reduce. Otherwise the quality, safety and sustainability of care to Leicester residents will be at risk.

Privatisation

Setting aside the possible use of the Private Finance Initiative for hospital reconfiguration, there will be at least three factors in the STP proposals which accelerate the privatisation of health care. Community based services are more attractive to private companies, market regulation will require commissioners to undertake competitive contracting and funding shortages will create pressures on CCGs to accept low cost tenders.

Transferring services to the private sector remains a key part of government policy. We have seen how this has led to the fragmentation of services and a lowering of quality. The performance of the non emergency patient transport contract held by Arriva and the catering and cleaning contracts previously held by Interserve have proved highly unsatisfactory. Likewise there have been concerns about the performance of some companies providing home care services. Companies can just pull out either if they lose money or if they find another way of making more money. Low pay, poor training and support, lack of continuity

of care staff and impossible workloads result in high staff turnover – this is not good for the patients and their carers and reduces value for money.

Private companies generally do not want to take on acute hospitals because of the complexity and uncertainty involved and because it is hard to make any money out of it. Instead, they like to cherry pick those services where they believe they can reliably make a good profit. This leaves the NHS with less revenue but the more complex aspects of health care to provide. Privatisation inevitably results in the downskilling of the workforce and the management of professionals so that they service the company's goals rather than the needs of the individual patient. The purpose of an NHS organisation is to serve patients. The purpose of a private company is to generate income and create a surplus. We believe private companies have no role in the provision of health care.

How might the changes affect your constituents?

Councillors deal with a wide variety of casework. It is an important and valued part of the role. As the distinction between the NHS and community care becomes blurred and access to services becomes more restricted, patient dissatisfaction will grow and councillors could find an increase in their workload.
Some points to consider:

- Access to GPs. Leicester has a shortage of GPs. Patients are already finding it difficult to book appointments yet more services are to be devolved down to GPs from UHL. The new model of care sees GPs restricted to working with patients with multiple and complex needs whilst far less qualified staff such as physician assistants, nursing assistants and others will manage all other patients. Some of your constituents will find it harder to see their GPs and the quality of care may suffer.
- Access to services. We are fortunate that our three hospitals are all on bus routes. When treatments are moved out into community settings patients may have to travel to a variety of venues other than their GP surgery to receive treatment. This may present difficulties for those relying on public transport. For example, more primary care will be provided in a limited number of surgeries rather than in all surgeries. This will entail more travelling as patients find they have to obtain some primary care services at surgeries other than their own.
- Quality of care. Shorter stays in hospital and initiatives to avoid hospital admission are to be welcomed but only if there are good services available to support patients at home. Good numbers of staff, well qualified staff and continuity of care are essential. However, there is a well-known problem with recruiting and retaining NHS staff and many experienced staff have either left or are planning to retire. We are not sure where the staff are going to come from and we reject the notion that equally good care will be provided by less qualified staff. If services are privatised, a reduction in quality can be expected.
- Waiting times. Your constituents can expect longer waiting times if hospital beds are to be cut back when the pressure on beds is already there for all to see. This will be very compromising for the health and wellbeing of some residents. If beds are cut, trolley waits may also become more common which is potentially dangerous for patients admitted in an emergency.
- Regulation and safeguarding. What mechanisms will be put in place to monitor these effects and to protect both patients and staff?
- Support for staff. Many constituents work in the NHS and social care. The new model requires many staff to move out of a hospital setting where they have worked as part of a team, with expertise at hand, and into patients' own homes where they will be working alone.

This may be stressful for staff and needs careful planning. The Commission should request evidence from the representative organisations of NHS staff regarding the views and experiences of staff.

The Campaign Against NHS Privatization calls for:

- A clarification regarding the legal status of the STP
- Access by the public to full detailed financial calculations, workforce plans, demographic assumptions and so forth
- Proposals to be evidence-based
- Recognition that expanding community services may absorb some rising need for care but will not itself make possible large scale bed closures
- Recognition that expanding community services requires a much larger budget
- Double running new services in the community alongside existing hospital services for at least two years to establish their value and impact, if community services are to be piloted
- No bed closures unless bed occupancy is consistently over a year well below 85%
- Full formal consultation on major changes being proposed including changes in the way primary care is being delivered
- Assurances that care which is currently free at the point of use will not be re-categorised as social care and charged for
- Clear opposition to any investment which is intended in part to reduce hospital bed provision.