DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

ACOs by Stealth: Why action is needed now

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Published quarterly. Contributions welcome.

Can We Look Forward to a Happy Birthday?

As we approach the seventieth birthday of the NHS, the threat to continuity of the NHS as a comprehensive, universally accessible, high-quality public service funded entirely through general taxation is probably higher now than at any time in its existence.

Through a combination of (intentionally?) incompetent work-force planning, coupled with deprofessionalisation, and demoralisation; inadequate levels of funding with diversion of huge amounts of money, time and attention into the commercialisation of the NHS; the rush towards the introduction of Accountable Care Organisations, bypassing the normal legislative processes; the fire-sale of publicly-owned land and buildings, limiting options for future models of service delivery, when enough land has already been sold off to keep builders busy for the next 15 years.

Fake news and deliberate over-complication of the issues are contributing to public apathy: the general public do not realise just how critical the situation has become, nor how far advanced the plan for the dismantling of the National Health Service and its replacement with a constellation of profit-driven organisations.

As members of Doctors for the NHS, we are presumably largely in agreement with the founding principles of the NHS, in line with our motto, 'Service, not profit'. How can we contribute actively to defending those principles, that are simple to describe, easy to understand, but which have had such a profound impact on the quality of so many peoples' lives since 1948?

Doctors for the NHS is a unique organisation. It was founded in 1976 as the NHS Consultants' Association, by consultants with a strong commitment to the NHS and its founding principles, and Peter Fisher, our President, was one of the founding members. It changed its name in 2014 to Doctors for the NHS, recognising that NHS doctors other than consultants share these commitments and that the organisation would be strengthened by the inclusion of general practitioners, career grade doctors and doctors in training, all of whom could contribute their perspective and increase the level of authority with which we can speak.

We have a distinctive voice: we can bring the experience of professionals who have a deep understanding of the value that the public service ethos brings to the delivery of a comprehensive and universally accessible NHS into the public and political arena. The organisation is not politically aligned, so we have been willing to work with anyone in public life, and any organisation, in pursuit of these principles. We have members in both Houses of Parliament and many members are politically active as individuals.

Over time, NHSCA has given birth to two organisations that are still at the forefront of the campaign for the NHS: the NHS Support Federation (1989), which is particularly strong on research and making the results of that research available to inform campaigns; and Keep Our NHS Public (2005), which is very strong in leading campaigns through its network of local groups. We are proud to continue to be able to provide some financial support to both organisations, from our members' subscriptions, as well as to Health Campaigns Together and the Centre for Health and the Public Interest (CHPI).

Thanks to Eric Watts

I would like to take the opportunity to thank Eric Watts, who has been such an able and articulate Chair of DFNHS since 2014, and who is standing down after guiding the organisation with skill and energy during such turbulent times, when

the NHS has never been out of the headlines. Mind you, looking back at my collection of old newsletters, there does not seem to have been a time when that was not the case. He has worked with Alan Taman, our Communications Manager, in developing the DFNHS website and Facebook page and the revamp of the quarterly newsletter, which now has a very professional look to it. He has been an eloquent spokesperson for us, in dealings with the media, with politicians and with other campaigning groups.

Eric has strengthened our links with Keep Our NHS Public (KONP) and with the more recently formed Health Campaigns Together (HCT), to which DFNHS is affiliated, which brings together locally based campaigning groups across England, national campaigning groups like DFNHS and a number of powerful trade unions representing NHS workers. It allows us to share experience and acts as an early warning system by monitoring what is happening in different localities (such as their STP Watch, which gives information on the 44 different STPs across the country); it allows us to learn from each others' experiences in developing campaigning tactics, and can mobilise support for local campaigns or bring groups together for national demonstrations such as that in London last March.

> "Make contact with your local campaigning groups ... these groups value highly the contribution of experienced doctors"

Future plans

I have been selected to succeed Eric and I am conscious that his will be a hard act to follow. I was a Consultant Ophthalmologist, initially in Aberdeen (1986-1995) and then in Halifax and Huddersfield until 2015, when I retired. I was Clinical Director of Head and Neck Services for 10 years and also Clinical Lead for the Skin Cancer Multi-disciplinary Team, so I have experience of working with, and managing, a wide range of specialties. I was particularly interested in developing links between the hospital services and those in the community, working with the various manifestations from GP Commissioning, to Primary Care Trusts and, latterly, Clinical Commissioning Groups. My wife was a District Nurse and Community Matron and was able to provide me with insight into community health issues.

Since my retirement, I have had the time to be involved in local campaign groups, in West Yorkshire, to try and influence decisions on cuts and closures of hospital services despite inadequate provision of community and primary care services. I have spent more time than I had anticipated, sitting in meetings of Clinical Commissioning Groups, Council Scrutiny Committees and Health and Wellbeing Boards, trying to understand how to influence the democratic process. I have met and lobbied politicians of various parties; bothered members of the public while they have been shopping or on the doorstep and met many good, interesting, well-informed and creative people in the process.

I would encourage all of you to make contact with your local campaigning groups, if you have not done so already. The KONP and HCT websites are good places to start: they have links to local branches and campaign groups. These groups value highly the contribution of experienced doctors, particularly in interpreting the jargon and the masses of information about clinical services and the way that they are delivered, so that they can cut through the spin and concentrate their campaigns on the most important issues. The involvement of seasoned professionals can lend confidence to 'ordinary' members of the public and increased credibility to their message and it also seems to make a difference when asking questions at public meetings of Council and CCG

committees, or when speaking to local MPs in their constituency surgeries, if constituents arrange meetings to raise concerns about local services.

Over the coming year, I would like to build on the work that Eric Watts has done, to strengthen our links with KONP, which was originally founded as the campaigning wing of DFNHS. If you have not been there for a while, I would recommend a visit to the KONP website (accessible by a direct link from the DFNHS website), particularly the 'Resource' site, which has links to an extensive library of useful articles and references covering many of the important issues affecting the NHS and also links to most of the important campaigning organisations.

I would also encourage members to sign up to be on the KONP mailing list for the monthly Newsletter, which will keep you up to date with NHS issues which rarely make it into the national media, for one reason or another.

Obviously, joining KONP as an individual member and making contact with your nearest local group would be a very valuable and tangible way to contribute your personal knowledge and experience to support the other members of these groups.

One of our priorities over the coming year is to try and boost DFNHS membership numbers and broaden the membership base. We are finding that the average age of the membership is increasing and the proportion of members still in active clinical practice is falling. The junior doctors' dispute was supposed to have increased the politicisation of that generation of medics, but it does not appear to have resulted in recruits to DFNHS. I would be very grateful if all members could make a point of speaking about DFNHS to any colleagues, friends or family members that are in the profession and who might share our values: encourage them to visit our website, read an edition of this Newsletter and, hopefully, become members – and encourage them to pass on the contact details through their social networks.

Although we have some members in each of the four countries of the UK, and we want to retain our voice in supporting the NHS across the UK, the great majority live in England. As the NHS evolves in different ways in each country, it would be very helpful to be able to compare and contrast the experiences of doctors working and living within each of these systems. The more members we have, the greater our chance of realising our goals.

I am hoping that my involvement in the campaign against the introduction of Accountable Care Organisations, described later in this edition (see page 6), might increase the awareness of DFNHS as an active force in the struggle for the principles of the NHS. If we are not always doing it at present, we need to remember to flag up our membership of DFNHS whenever we participate in campaigns, broadcasts or other activities, to maintain our profile and our relevance as a distinctive voice in the campaign to restore a thriving NHS that delivers its full potential towards the quality of life in all parts of the United Kingdom.

I wish all our members a Happy New Year and hope that, together, we can make the seventieth birthday of the NHS a cause for real celebration.

Colin Hutchinson
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An Appeal to all Members

Accountable Care Organisations should not be introduced without public consultation. Please help, if you can

Jeremy Hunt, the Secretary of State for Health, is planning to make changes to secondary legislation, probably within the next couple of months, to facilitate the introduction of Accountable Care Organisations (ACOs) to become major players in the NHS in England. ACOs are not recognised in any Act of Parliament and there is no proposal to bring forward any primary legislation to allow the proposals to be tested by parliamentary scrutiny (see http://bit.ly/2kpm62T).

ACOs will be non-NHS bodies which will hold the contract for allocating resources for most of the health and adult social care provision for the population in a defined area of the country.

They can include private companies (e.g. Virgin in Frimley, Circle in Nottinghamshire), including private insurance and property companies, which will make money from charging.

They will be allowed to sub-contract all "their" services.

They can also include GP practices, in which case people on their lists will automatically transfer to the ACO in order to be entitled to services – new patients will also have to register with the ACO.

The ACOs will each be able to decide on the boundary of what care is free and what has to be paid for. They will be paid more if they save money.

They will be given multi-billion pound budgets in contracts that may last 10 or 15 years, and are being presented as a way of "dissolving the boundaries between health and social care." There has been no public debate on the way that such a potentially massive reorganisation of public services should take place, despite the obvious risks of bringing together a service that is free at the point of use with one in which means-testing and payment for services is a major feature.

The Secretary of State has conducted a consultation on technical changes to regulations in order to facilitate ACOs, but he has done this before providing any serious information about ACOs themselves and without consulting the public or parliament about what his plans entail. For example, why is it necessary to create ACOs to achieve the stated policy objectives; what impact would they be likely to have on the range of services provided and the entitlement and access to these; what effect would they have on outcomes of care and inequalities; how would the public be involved in the decision-making of ACOs; what would be the governance framework within which they would operate?

(See http://bit.ly/2i2HWES for a more detailed discussion.)

There are also concerns that the introduction of ACOs could increase the likelihood that the NHS would lack protection in future trade deals and make it much more difficult for any future government to return it to public ownership and public provision.

The consultation ended on 5th November 2017. The Secretary of State will be able to lay the regulations before parliament and they will automatically become law unless the House of Commons or the House of Lords votes against them within 40 days.

Against the public interest

ACOs will fundamentally change the NHS and

involve a radical reorganisation of health and social services. They will have control over the allocation of NHS and taxpayers' money. Their accountability for spending it and their obligations to the public will be under commercial contracts, not statutes. This will not be in the public interest.

It is also against the public interest that they are being introduced without proper public consultation and without full parliamentary scrutiny.

Four health professionals believe that this is a radical and fundamental change to the way in which health and social care are provided in England. We are seeking a judicial review to stop the introduction of these new commercial, non-NHS bodies to run health and social services without proper public consultation and without full parliamentary scrutiny.

Who are we?

Professor Allyson Pollock, Professor of Public Health, Newcastle University, founding member of Keep Our NHS Public, former Chair of NHS Consultants' Association (now DFNHS), and co-author of the NHS Reinstatement Bill.

Professor Sue Richards, former senior civil servant in the Cabinet Office, a Director of the National School of Government and Professor of Public Management at Birmingham University, Co-Chair of Keep Our NHS Public.

Dr Graham Winyard, former Deputy Chief Medical Officer, Vice President of the Faculty of Public Health, and Medical Director of the NHS in England.

And the newly-elected Chair of Doctors for the NHS, Dr Colin Hutchinson, former Consultant Ophthalmologist and Clinical Director at Calderdale and Huddersfield NHS Foundation Trust.

What are we doing?

We have responded to the limited and inadequate consultation and told the Secretary of State that he must withdraw his support, through the regulations, for the ACO contract until a proper public consultation has been carried out.

Our solicitors have also been in correspondence with him and with NHS England, making clear our intention to seek a judicial review. As the Newsletter goes to press, our lawyers are studying their responses and advising on next steps.

How can Doctors for the NHS help?

Harry Keene and Peter Fisher enlisted the help of the NHS Consultants' Association and three thousand doctors in gaining a judicial review of Margaret Thatcher's introduction of the internal market, almost 30 years ago. The fact that the court found in favour of the government on that occasion does not mean that we should simply acquiesce in this latest challenge to the concept of a National Health Service. The more support that we can attract and the more public awareness that the case generates, the greater the chance of returning to an NHS 'For service, not for profit', in line with the principles of DFNHS.

What do we need to pursue this case?

We are likely to need to raise a substantial sum of money in the near future, to be sure that we can pursue this fight to its conclusion and to make sure the Secretary of State and NHS England know it as well.

An appeal for support towards the lawyers' work up to preparing and filing the case for court raised £26,020 in 26.5 hours through a CrowdJustice appeal. This work is underway. See the appeal website for further details:

https://www.crowdjustice.com/case/jr4nhs-round2

The appeal will resume once we have agreed the legal response with our lawyers.

If you agree with us, that the introduction of ACOs poses a serious threat to the continuation of the NHS, and might be able to make a financial contribution towards the cost of the legal challenge, please contact me: Colin Hutchinson, Chair of DFNHS, by email (colinh759@gmail.com) or mobile (0796 332 3082).

I should be able to answer any questions you might have and I will record your name and contact details and an idea of the amount you might be able to donate.

This would allow us to contact willing supporters rapidly, if and when we need to fund the continuation of the legal case.

We will keep supporters informed of the progress of the case and provide any further information you might wish.

Even if you are unable to offer financial support, please encourage friends and acquaintances to find out more about Accountable Care Organisations and do not accept them as an inevitability.

Colin Hutchinson
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an

The erosion of a sense of professional

In the decades of NHS history there have certainly been sporadic stress-symptoms amongst its healthcarers before, but never such gathering fractious unhappiness and demoralisation.

Often this is now expressed in disputes about money, or working hours or contracts, but these surely also signify deeper frustrations: for older doctors remember much longer hours for less pay – yet they were happier.

Why? What have we lost?

Much of our institutional dis-ease can be attributed to our serial reforms. These have mostly extinguished our erstwhile *family*-like professional relationships, affiliations and modus operandi. Instead, our reforms have replaced these with *factory*-modelled systems, procedures and regulations. Collectively these have precipitated a new kind of restive loneliness and anomie.

An important aspect of this disconnection is *deprofessionalisation* – the focus of this short analysis.

In medical practice being professional used to mean that an individual doctor carried responsibility for the competence, compassion and probity of their practice: themselves and, often, their staff.

The individual practitioner was accountable for assuring high standards in these matters: it was usual to assume their presence, unless there were contrary indications. Their absence had to be adduced by real-life events, not putative or theoretical risk. Any such real-life failures then became major and serious responsibilities for management.

This old system thus usually allowed –

ened to Professional Judgement nd Responsibility?

lism is now often cited as a major factor in the collapsing morale of NHS doctors. How has this happened?

depended upon – a basis of trust in the professionals' capacities for judgement and responsibility. Relative autonomy, dependent on good motivation and colleagueial vigilance, was the implied norm. Innocence was assumed, not – as now – guilt, which can only be removed by procedural compliance to an endorsing authority.

But such a trusting regime had its failures, just as families do. So our serial reforms were set up to prevent any failures and protect us all: systemising pre-emptive *risk-management,* displacing the reactive by the proactive, and turning our healthcare culture from family to factory. Through these we would transform our healthcare by increasingly emulating manufacturing industries.

Let us consider how these operate.

Factories derive their efficiency, reliability and safety from two inseparable and essential principles: *strict compliance* to a *rigid hierarchy.* These work as a kind of relay. A manufactured object, for example, typically depends on the stages shown below:

1. **Invention:** Inventor + prototype designers/engineers etc = *what* is to be made
2. **Management:** Financial backers + factory owners + directors + financial managers + production managers + personnel managers etc = *how* it is to be made
3. **Compliance/production:** Factory workers/machine operators/robots etc = the making

The hierarchy here manufactures an object by, 1: defining *what* is to be made, 2: defining *how* it should be made, and then 3: *strict obedience* to the precise instructions from 2. Nothing less than complete and automatic compliance of the workers can assure reliability of the object.

This, increasingly, is how we attempt to design and deliver our healthcare.

So how does this translate, from manufacturing industries to healthcare?

On the surface, theoretically, quite well. In providing our (intended) reliably commodified healthcare we now have three similar stages to assure governance. These are as follows:

1. **Executive 'expert' committees** (policy makers, specialists, academics, management consultants etc) who design and prescribe schemes and action plans = *what* is to be done.
2. **The Control Tower** (managers and their extensive devices to signal and monitor) who implement these executive plans by issuing strict instructions, and ensuring compliance = *how* it is to be done.
3. **Healthcare workers**, whose job is to do precisely what they are told = *doing it.*

We can call this design-control-and-command system *REMIC* (remote management, inspection and compliance). It has evolved rapidly and massively since mandatory – so ubiquitous – computerisation. Synchronised gigantism – the tendency to ever-larger institutions – greatly helps both industrialisation and REMIC. So, while IT is essential to REMIC, gigantism expedites it. We must acknowledge how

these 'modernising', industrialising influences have streamlined and improved those parts of healthcare that are truly mass producible. Equally, such modernising devices have helped eliminate some hazardous outliers – our DSRs (duffers, slackers and rotters).

Elsewhere we are less fortunate, for as we develop REMIC and gigantism, our managers, then practitioners, become increasingly detached from understanding relationships, human vagaries of context and meaning, and therefore what may be most possible and wisest in any particular and difficult situation. For wisdom is often about knowing what to overlook: an antithesis to REMIC.

These increasing anomalies are a serious matter. This is because they deracinate not just the art and heart of medical practice, not just its professional judgements and responsibilities, but also the subtle but deep personal pride and gratification we may get from our work … *when* we are trusted and dignified to be both personally and professionally responsive and responsible. Generally this wiser trust sustained previous generations of doctors with much better morale and motivation than now.

But our excessive use of command-and-control systems has constituted a kind of confiscation of such professionalism. Such systems replace our human intelligence with artificial intelligence, our professional judgements with corporate algorithms. Yet the losses turn out to be much more than cognitive, they are also deeply relational and affective: for as such alienating proceduralism has massed, it has sapped our spirit and heart for the work.

So now our professional body suffers a kind of heart failure. We can extend this metaphor, too, to its understanding: procedural overload and inadequate human perfusion.

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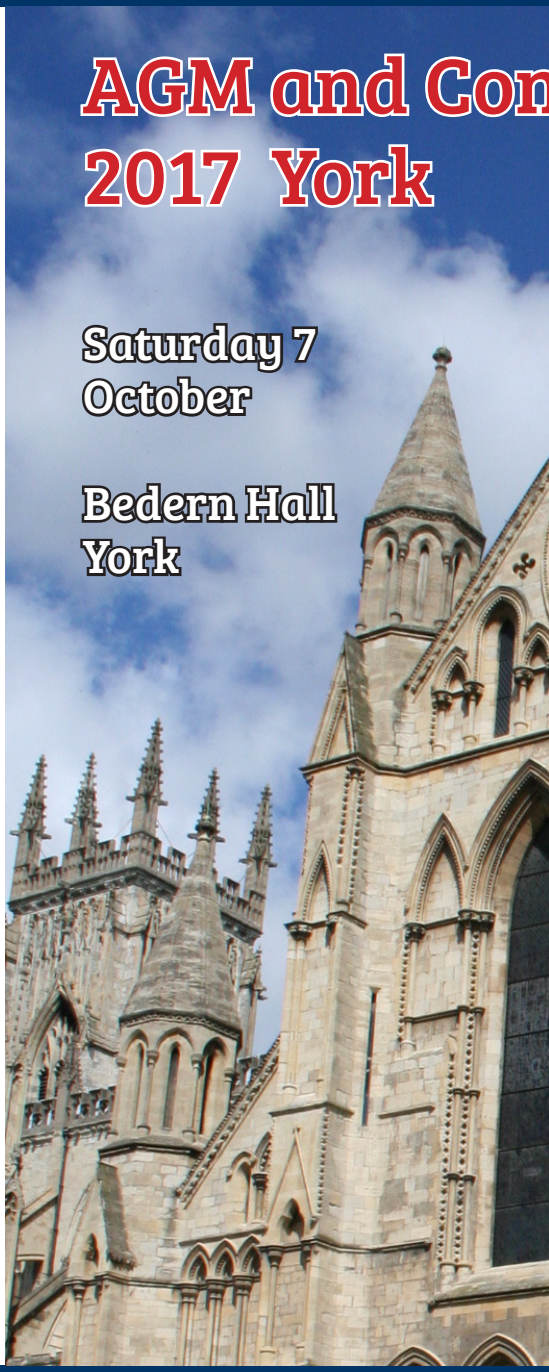

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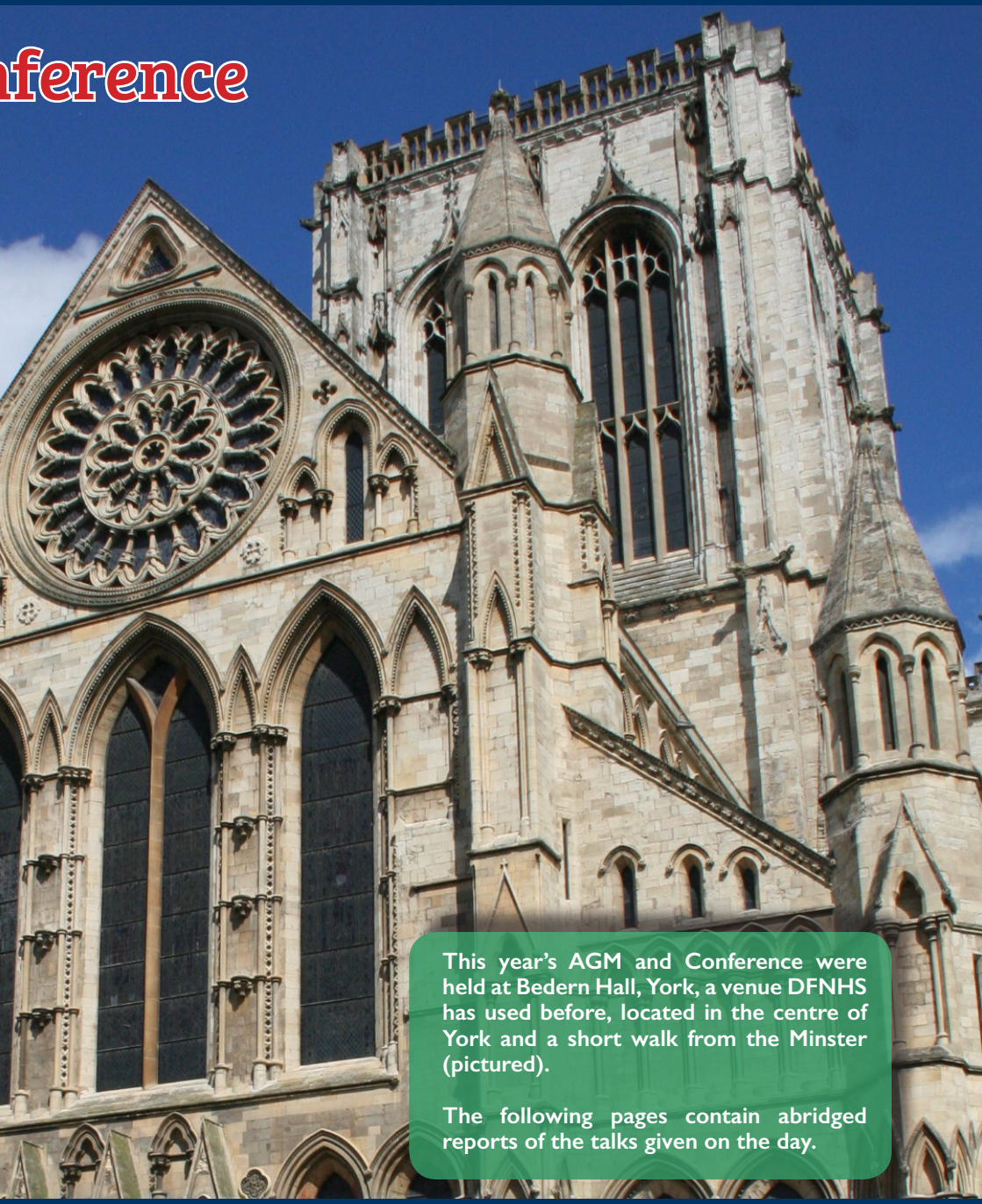

This year's AGM and Conference were held at Bedern Hall, York, a venue DFNHS has used before, located in the centre of York and a short walk from the Minster (pictured).

The following pages contain abridged reports of the talks given on the day.

AGM Reports

Opening address: Eric Watts, Chair

This has been another turbulent year with increasing pressures on the NHS and inadequate funding leading to the worst performance figures seen in a decade.

DFNHS continues to assert that the NHS is the best system for health delivery and that with adequate funding it will deliver better outcomes. In the last year we have heard the same message from many other quarters including the House of Lords, whose committee on the Sustainability of the NHS concluded "A tax funded, free at the point of use NHS should remain in place as the most appropriate model for delivery of sustainable health services". We have also seen support for the NHS from the Conservative chair of the Health Select Committee who has called, in public , for funding to be increased to 12%.

The current plans, STPs, contain many dangers to the quality of our services through over-centralistaion with reduced access and downgrading of smaller units providing essential services to local people. Many such schemes have been justified on the basis that centralised services allow greater access to specialist care in spite of the fact that most emergency admissions do not require a high level of specialist intervention – 90% of hospital admissions require rapid access to standard DGH care.

Whilst debate continues over how to restructure emergency care the DoH is keen to push through STPs in the face of opposition from the public and from many councils. We have seen excellent work for our colleagues in CHPI and KONP in publicising the effects of downgrading A&E services.

A key point made in support of STPs is that many patients are in hospital unnecessarily and more care will be provided in the community to which the natural response is to ensure the improvements are in place in the community before services are downgraded in the hospital.

Some success can be claimed in the reversal of plans to downgrade A&E services, e.g. in South Essex. One opportunity to oppose harmful plans is through statutory guidance published in April [1], as ever the benefit of involvement will depend on the authorities' willingness to listen.

DFNHS has strengthened its involvement with other campaigners, particularly Health Campaigns Together (HCT), who organised the successful NHS demonstration in London in March with the People's Assembly (a HCT member). HCT has been one of most important developments in last 12 months. It was formed in 2015. Chaired by DFNHS member Louise Irvine and Merryl Hammer. Newspaper number 8 is now available [*Number 9 is due out in January*]. A news briefing had been put together by HCT, reported on in the September newsletter. Meetings are held bi-monthly, with a growing number of member organisations.

Other prominent events included *Talk NHS,* made famous by Steven Hawking. Philippa Whitford, SNP MP and DFNHS member, attended and spoke. Moves by DoH to make asylum seekers pay for

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care have been opposed. Jeremy Hunt was trying to slip this through parliament without debate.

We provide funding for KONP, Centre for Health in the Public Interest, NHS Support Federation and HCT.

Reference

[1] NHS England (2017) 'Involving people in health and care guidance' [online] available at www.england.nhs.uk/participation/involvementguidance

Treasurer's Report: Peter Trewby, Treasurer

Our reduction in total assets from £13,000 last September to £8,000 this September is partly due to a reduction in subscriptions.

52 members have not renewed their subscriptions and have failed to reply to exhortations from your Treasurer and President, 9 have died or are seriously ill, 2 have moved abroad, 1 has declared that "I am seriously out of line with the view of some of your members", 1 preferred "not to think about what politicians are doing to the NHS – sorry" and 1 insisted on resigning having joined the Labour Party.

The median length of membership of those resigning is 14 years. The income from subscriptions (June to June) has reduced from £27,500 to £24,500. The reduction is also due to there being no recent life subscriptions. The good news is that 28 new members have joined in the past 12 months including 11 GPs and 1 trainee. Net loss is 38. Members' subscriptions remain by far the greatest source of our income so from the financial point of view as well as for the health of our organisation we must continue to recruit new members and follow up defaulters.

Despite this since the last AGM we have still been able to donate a total of £5925: £1675 to Keep Our NHS Public, £2000 to the Centre for Health and the Public Interest, £2000 to NHS Support Federation and £250 to Health Campaigns Together.

Apart from donations, our principal outgoings remain £12,000 per year for our Communications Manager, Alan Taman. This will be reduced by £3000 next year as Alan starts on a PhD course [*this has now been ratified at the November 2017 EC meeting, for which Alan outlined the proposed reduced working hours and change in priorities*].

There has been a reduction of over £1000 printing and postage costs for the newsletter. There have been no donations this year and no other significant alteration in income and expenditure between this year and last.

Figures 1 and 2 show our deposit account balance in historical perspective and the month by month figures over the past year. Our current assets as of September 19th stand at £4,579 (deposit account) + £3500 (current account).

Depending on the views of members and bearing in mind the reduction in our outgoings to Alan we should be in position to donate £2000 to £3000 in the coming year .

My grateful thanks go to our auditor Robert McFadyen and to those members of the Association who pay their accounts promptly by standing order or respond quickly to letters from the treasurer when they fail to do so!

Comment from the floor

Tony O'Sullivan (Chair, Keep Our NHS Public) said that there was more mileage in making best use of each other and suggested a joint meeting to outline this further.

HCT was launched by KONP to bring in joint action. Some juniors were working with KONP in HCT but had not joined KONP yet. DFNHS had encountered similar difficulty in engaging juniors.

AGM and Con

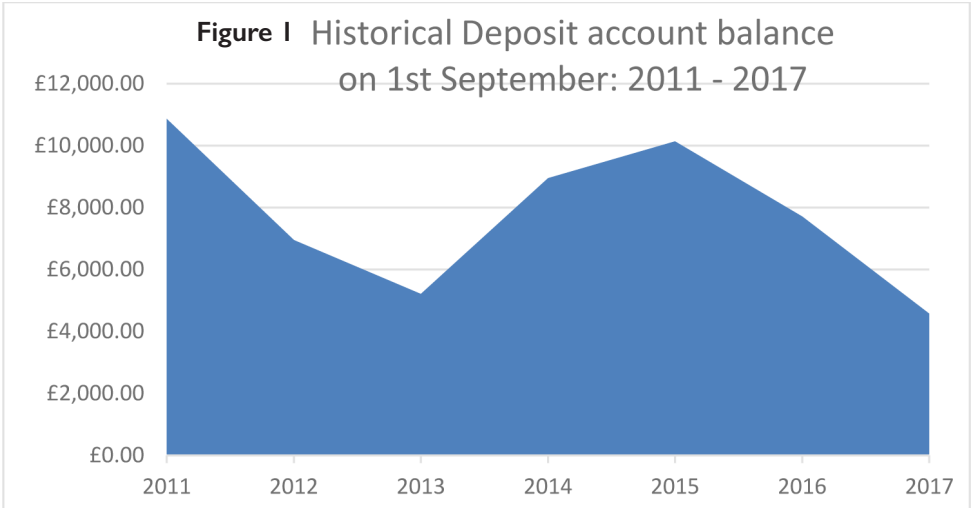
Figure 1 Historical Deposit account balance on 1st September: 2011 - 2017
£12,000.00
£10,000.00
£8,000.00
£6,000.00
£4,000.00
£2,000.00
£0.00
2011
2012
2013
2014
2015
2016
2017

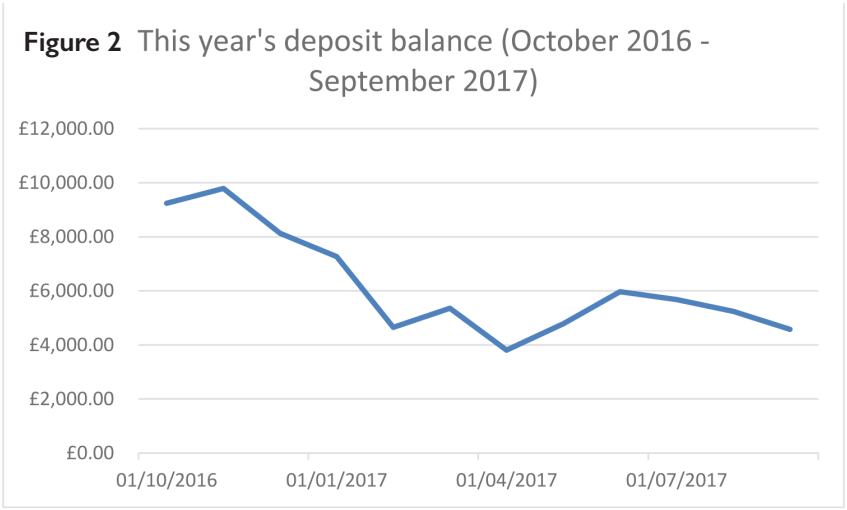
Figure 2 This year's deposit balance (October 2016 - September 2017)
£12,000.00
£10,000.00
£8,000.00
£6,000.00
£4,000.00
£2,000.00
£0.00
01/10/2016
01/01/2017
01/04/2017
01/07/2017

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Eric agreed. Doctors in Unite was also suggested as an organisation to link with.

Communication Manager's Report: Alan Taman

Most of the areas identified as needing to be a focus for growth or improved performance last year have yielded encouraging results but new priorities have emerged and are now being addressed.

Areas that have been successful:

- The newsletter continues to be well received and an increasing number of 'third parties' are submitting articles for publication. Production and distribution costs were reduced significantly with the introduction of an A5 format and are now stable.
- The website has undergone further structural changes but not at great cost. There were some technical problems throughout the year but these were resolved.
- Twitter continues to grow and now stands at over 1600 followers. Facebook is also growing steadily.
- The e-mail letter to all members is being sent out to mark 'special' occasions, roughly at monthly intervals.
- Press liaison was given more priority and achieved success throughout the year. DFNHS was quoted in the *Mirror*, the *Independent* and the *Morning Star* on several occasions. There were also several requests for radio comment (LBC). *Pulse* magazine ran an article authored by DFNHS members which attracted some comment.

Areas that have emerged as priorities:

- The need to attract more recruits has become more urgent recently and attempts are being made to engage politically active junior doctors through social media.
- The need to make social media posts more frequent and targeted more at potential new members, and increase the number of new blogs on the website was identified.

Future actions:

Social media and website: more frequent posts, linked back to the website, will be maintained. Blogs will be uploaded more often and will aim to attract more juniors and GPs.

Recruitment and liaison: Engaging juniors via social media is a major focus with a view to recruit more members. The medical press will be approached more often to publicise DFNHS. DFNHS is to continue to contribute to Health Campaigns Together.

Plans for the future

The importance of social media was stressed as a vehicle for increasing recruitment, as was the unique nature of DFNHS.

It was suggested that regional doctors' committees could be contacted. Peter Fisher (President) outlined traditional methods of recruitment and appealed to members to give potential members' details.

Election of Executive Committee

All members of the current EC were invited to stand again and there were no other nominations.

AGM and Con

[Colin Hutchinson was proposed as Chair at November's EC meeting at Eric Watts's invitation. Colin was elected Chair as Eric stood down.]

Keep Our NHS Public Report

Tony O'Sullivan, DFNHS member and co-chair of KONP, presented the report to the meeting.

Since the last AGM KONP had most definitely made a difference in the world of NHS campaigning. They were a stronger organisation in membership and in terms of politial impact. They had strengthened their social media and website and, through these media, were strengthening their links with their close allies, including DFNS.

Tony thanked DFNHS for its financial support during the last year.

John Dunking (centre) presents DFNHS President Peter Fisher (left) with a memorial medal for his contribution to DFNHS as Peter Trewby (Treasurer) looks on.

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KONP had achieved notable campaigning successes in the last year. These included the OurNHS demonstration on 4 March in London, which drew over 200,000 people; and the NHS Roadshow which was run by several junior doctors.

KONP's national newsletter was now much improved (DFNHS members are welcome to subscribe to this, which is sent out by e mail; please contact KONP to be added to the circulation list). It had re-designed its website and built substantially on its social media profile.

KONP's ambition is to get a campaign manager resource with the aim of linking NHS campaigns and organisations more closely, raising the collective game in defence of the NHS.

NHS Support Federation Report

Eric Watts reported that the NHS Support Federation continued to thrive and had succeeded in securing additional funding for its important work.

The Paul Noone Memorial Medal

Peter Fisher recounted a short history of the Memorial Medal, which DFNHS had awarded in earlier years but which had lately fallen out of use.

DFNHS 'founder member' John Dunking, from Edinburgh, had retained the medal mould for safekeeping, and handed it back to Eric Watts in a short ceremony

John then presented DFNHS President Peter Fisher with a medal of thanks (photo), reflecting all the years of effort Peter has made in being one of DFNHS's forerunner NHSCA's founders and a driving force for much of its achievements over the years.

More than thanks

The presentation of a medal to Peter Fisher (photo opposite) at the AGM was a small token of thanks to Peter for the ceaseless and unremitting work he has done over the years to protect our NHS from the evils of privatisation.

Peter qualified in 1957 at the Cambridge and Middlesex Hospital. He held Junior Hospital posts at Hemel Hempstead, Truro, and Redruth before joining the South Pacific Health Service,1960-63, for Fiji and Western Samoa. He was then Registrar/ Senior Reg at Northallerton and Liverpool for 5 years before becoming Consultant Physician, Horton General Hospital, Banbury in1969 until his retirement in 1997.

Peter was a founder member of the NHS Consultants' Association (DFNHS's forerunner) and Chairman from 1989 to 1998. He has been President since 1998.

He was Oxfordshire County Councillor (Labour) Group Social Services spokesman between 1979 and 1993. He has represented the Council on the District Health Authority and chaired the Joint Consultative Committee. Since retirement he has been an active member of Keep the Horton General campaign and various bodies monitoring health care in Oxfordshire.

The Challenge of STP

Chair: Eric Watts

Report by John Puntis

This session of the conference was introduced by Eric Watts. Eric provided some useful background for those campaigning against non-evidence based service reconfigurations, reminding us that the NHS Constitution gives valuable support by insisting "the patient is at the heart of everything we do", the NHS "belongs to all of us", and that we have "a right to be involved" with decisions about service commissioning.

He also highlighted the statutory guidance on patient and public participation in commissioning health care, which requires not only that consultation takes place, but also that sufficient information and reasons must be put forward to justify reconfigurations with adequate time given for a response, and that the product of the consultation must be conscientiously taken into account.

Eric showed data for a number of common acute conditions requiring emergency admission demonstrating that mortality increases in proportion to distance travelled to hospital, and commented on the success of local campaigns in preventing downgrading of A&E departments such as the one in Southend.

Vivek Kotecha

The next speaker was Vivek Kotecha, a research officer at the Centre for Health and the Public Interest (CHPI) who addressed the problems of STP, and how funding pressure in the NHS affects STP decision making. Currently news stories are common regarding the NHS deficit (around £2.45 bn) and deteriorating performance such as record waiting lists for elective surgery. There is wide, if not universal, agreement that the NHS is underfunded, and in fact this was acknowledged in the *Five Year Forward View* (5YFW) that foresaw a funding gap of around £30 bn by 2020/21 if the annual NHS funding increment remained around 1% rather than the previous 4% while demand continued to grow.

The 5YFV anticipated that the gap might be closed if there was extra government funding to help through the transformation that would be brought about by STP, but also factored in 2-3% efficiency savings each year. Is this level of efficiency savings realistic, given that the 5YFW recognised it would represent strong performance compared with the NHS' historical performance record and that of the wider UK economy? The following key assumptions were made:

1. sufficient capital would be available to transform organisation and operation of NHS services;
2. there would be a fall in the rate of growth of health care in acute hospitals from 2.0% to 1.3% a year (despite increasing demand, for example from changing demographics);
3. hospitals would find 2% cost savings each year;
4. pay for permanent staff would continue to grow at no more than 1% a year

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5. agency costs would fall by 4% a year;
6. investment in public health and education would improve health and enable more patients to 'self care', reducing costs to the NHS;
7. there would be adequate investment in social care to ensure elderly patients did not need admission to hospital, or get admitted and then not be able to be discharged home.

Vivek went on to show how easily all these assumptions can be challenged, and that if only 1% efficiency savings were achieved, this would still leave a £34 bn cumulative gap to 2020/21. If in fact NHSE assumptions are wrong, clearly STP cannot fulfil their goals of delivering service change at lower cost without detriment to patients, but will inevitably come up with plans that will lead to a reduction in services and quality of care.

In reality there is an uncoordinated response to the funding gap, with a tug of war going on between CCG and providers, and short-term initiatives being promoted in order to bring in additional funding such as through asset sales.

One example is the recently attempted sale of the staff agency 'NHS Professionals', despite the fact that this organisation was saving the NHS money. Another is the capital to revenue transfers taking place despite a backlog of over £2 bn urgent repairs. These are short-sighted interventions that underline the general lack of any long-term forward thinking.

Consequences of underfunding

The consequences of underfunding are now being manifested as (among other things) increased waiting times for elective surgery, and limitation of access and eligibility to elective care. Around one third of CCGs have already implemented or proposed limits on some treatments. Manpower issues have become acute, with desperate commitments to get more GPs but not thinking through how these will be recruited or how those currently in post will be retained. There are tens of thousands of unfilled nursing posts, with the likelihood that Brexit will have a negative impact on recruitment.

All of the above issues are exacerbated by the lack of legal framework and accountability for STP and the general poor state of NHS planning. There is a continuing passing of the buck between different departments and organisations, with no one taking overall responsibility. It is clear that we are heading for another winter bed crisis, with bed occupancy already running at a high level over the summer. The treasury is holding on to money because of uncertainties around Brexit planning, and showing no sign of increasing NHS funding.

The overall focus appears to be on getting through the day rather than on long-term planning. There are difficult conversations to be had about service quality, coverage, and waiting times but government is happy to leave STP and front line staff to handle the inevitable fallout.

(For the full CHPI report see Kotecha, V. (2017) *The Five Year Forward View: do the numbers add up?* [online] available at http://bit.ly/2BDlvOz)

Clinical Aspects

Chair: Tony O'Sullivan

Report by Colin Hutchinson

Can we afford to close any more A&E departments? Evidence from North West London: Dr Gurjinder Singh Sandhu

STPs are planning to close up to 24 emergency departments in England. The planning process began in 2012 in North West London and 2014 saw the closure of two Type 1 A&E units, at both Central Middlesex and at Hammersmith Hospitals; also the closure of the maternity and paediatric units in Ealing. (Type 1 Emergency Departments provide a consultant-led 24-hour service, with full resuscitation facilities and designated accommodation for accident and emergency patients.)

The A&E units that are due to close are situated in the areas of greatest deprivation, while units in the leafier suburbs remain open. This leaves the most vulnerable patients, who are less able to afford it, to travel the furthest distance for hospital treatment. These areas are also the most populous and have a greater proportion of elderly residents.

The closure of neighbouring units does have a measurable impact on the performance of the A&E departments that remain open. Before the closure of A&E at Central Middlesex and the Hammersmith, Type 1 A&E departments met the 4-hour target between 78% and 95% of the time during the winter months. After these two units closed (see Figure 1), this fell to between 60% and 80%. Performance dipped at Northwick Park and has never recovered. Hillingdon Hospital has the worst Type 1 performance of all 140 Type 1 trusts in the country. The same pattern has been noted at the other hospitals in NW London, apart from at the Chelsea and Westminster Hospital.

The reduction in Type 1 A&E provision has been based on studies that estimated that between 15 and 50% of patients attending A&E could be dealt with in less acute settings. Urgent Care Centres seem to have attracted new groups of patients that would not have previously used A&E, but there has been no fall in the number of patients reaching the remaining Type 1 A&E units.

Patients are subjected to triage, with one-third being directed to Type 1 Departments and two-thirds directed to Type 3 Urgent Care Centres, but this has not reduced the number of attendances to Type 1 services across the region: there are just fewer Type 1 departments to cope with them and their performance figures are now some of the worst in the country.

There has been a large increase in the diversion of emergency ambulances from their initial hospital to a less over-stretched unit (so-called ambulance "intelligence conveyances"!). At Northwick Park, 446 hours of ambulance time was spent in just one month, waiting outside A&E before they could hand over their patient; if that is multiplied across England it would equate to a huge waste of resources.

In North West London, there has been a change

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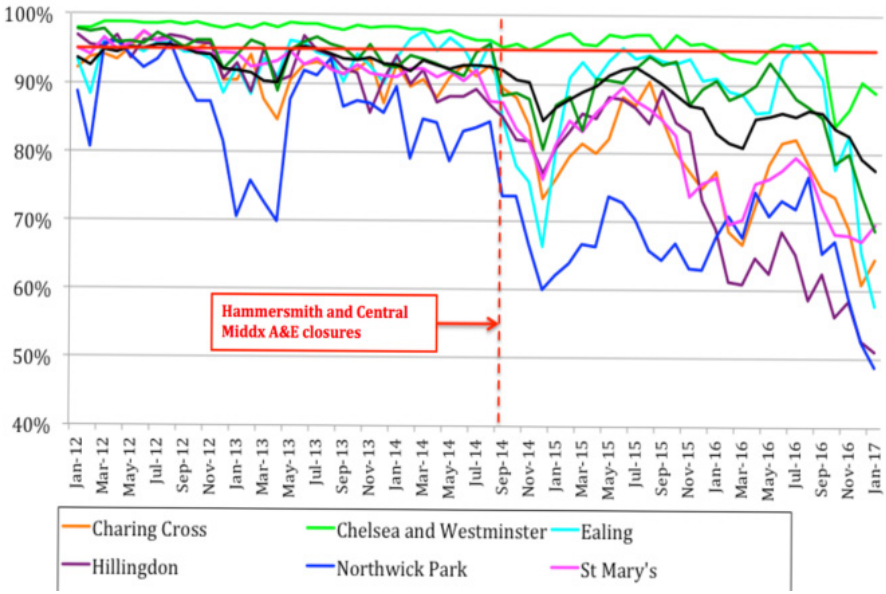

Figure 1 Effects of unit closure on neighbouring A&E waiting times

in that the total number of days lost in delayed transfer of care is now greater due to social care reasons than due to NHS reasons. The greatest proportion of elderly people live in Ealing, Hillingdon and Brent – the projected growth of overall population is also highest in these areas.

These closures are being driven by the Naylor Review: they allow and encourage the sale of NHS land to private developers.

London requires 1600-1700 additional acute beds, but, instead, more closures are in the pipe-line.

[Dr Gurjinder Singh Sandhu is a Consultant Physician, specialising in Infectious Diseases and Acute Medicine. He has a specialist interest in tuberculosis, poverty and health inequalities. He was awarded a Wellcome Trust Tropical Fellowship and completed his PhD in 2010, studying tuberculosis in resource-poor countries. Dr Sandhu currently works in Acute Medicine at Ealing Hospital and is developing an interest in health inequalities in elderly care medicine. He is author of the CHPI Report, *Can we afford to close any more A&E Departments? Evidence from North West London* available at http://bit.ly/2j05ZZb]

Issues in general practice: Dr David Wrigley

General practice is in crisis, due to excessive workload, insufficient work-force, escalating costs of indemnity insurance, inadequate funding and increasing numbers of frail elderly patients. GPs feel increasingly unsafe, because of the volume and intensity of their work: they regularly make 60-80 patient contacts each day, with no breaks to catch up with their thoughts or for essential bodily functions.

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The GMC do not take working conditions or intensity into consideration when mistakes happen: the BMA have set up a working party to study this.

Unlike a hospital, a practice cannot issue an OPEL 3-4 if it runs out of capacity; it cannot divert its patients to an adjacent health centre. The pressure is so great that GPs are now willing to close their lists to new patients, although there are contractual problems with this.

GPs are retiring early due to stress, and many training schemes have vacancies. The government says that they will recruit 5,000 more GPs, up to 3,000 from overseas, but so far the numbers recruited have been pitiful, with only 38 recruited in the first 6 months of 2017. The overall number of whole-time equivalent GPs in England has fallen by 350 since the starting date for the increase, in September 2015, according to NHS Digital figures.

The cost of medical indemnity insurance has risen to £8-10,000 per year; more if you are doing out-of-hours work. Negotiations are underway to try and get Crown Indemnity.

There has been a large fall in the proportion of the NHS budget that is allocated to primary care. In 1995 it represented 9.6% of the total NHS budget: now it is only 7.9%. The capital funding for premises has been reduced. *GP Forward View* has not delivered. The privatised Social Care Services often refuse to send carers to remote areas at the weekend.

There are some developments that are having a small, but welcome, impact. The ability to employ pharmacists in GP practices has been positive and there are examples of closer working with secondary care clinicians coming into the community.

[David Wrigley is a GP in Carnforth, Lancashire, where he has practised for many years. He was Deputy Chair of the BMA from 2016-17 and is the Chair of Doctors in Unite (formerly the Medical Practitioners' Union). He has published extensively on the impact of politics on the NHS.]

Obstetrics: Brigid Hayden

[Brigid could not attend the meeting; her notes were presented by Tony O'Sullivan.]

I had hoped to be able to talk about the impact of the Sustainability and Transformation Plans (STPs) on my specialty of Obstetrics & Gynaecology. I have to say that it has not been easy to gather the desired information, and most of the following is from Google searches.

Information is sparse from my College (the RCOGL) despite direct requests. Be that as it may, here goes.

The STP in maternity care is a 5-year plan, based on the Report of the National Maternity Review entitled *Better Births,* published in February 2016 [1]. This report is, in my humble opinion, 'Motherhood and Apple Pie' without the recipes.

Its stated aims are to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injury, with precise targets of 20% by 2021, and 50% by 2030. So far so good, as these meaningful targets echo the WHO's Millennium Development Goals and subsequent Sustainable Development Goals.

What worries me is that the means to achieve these desired results is not specified.

My distinct impression is that, far from steering a course towards improving our results, we are skating on very thin ice, with a distinct risk of sinking catastrophically into icy waters.

Coming now to the people leading on the maternity STPs, I understand, from published information, that the Maternity Transformation Chair is Sarah-Jane Marsh, who is married to David Nicholson, the Chief Executive of NHS England from 2011 to 2014.

David Nicholson was Chief Executive Officer of the West Midlands Strategic Health Authority, which

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had oversight of the Mid-Staffs NHS Foundation Trust at the time of the trouble there in 2005 to 2009. He was knighted in the 2010 New Year Honours, and he became Chief Executive of NHS England in 2011.

The Midwifery input to the panel is provided by Professor Jacqueline Dunkley-Bent OBE, Head of Maternity, Children & Young People at NHS England.

The O&G input is provided by Dr Matthew Jolly, who, as I understand, has been engaged in clinical practice, with feto-maternal subspecialisation, up to 2015, at which time he became employed by NHS England as National Clinical Director for Maternity Review and Women's Health.

Coming back to my attempts to gather information on the STPs, I tried contacting the Royal College of Obstetricians & Gynaecologists, of which I'm a Fellow, via my local Council Member, but to no avail.

All that I could find is an RCOG update document of Spring 2017, which states that the RCOG is working closely with the nine work streams, and which invites Fellows and Members to inform the RCOG of their involvement in the STP process.

Without wishing to criticise my own professional college, I would have thought that the shoe should have been on the other foot, with the College keeping Fellows and Members informed of their endeavours to engage in the STP process, while seeking the views of Fellows and Members on the best way forward.

Meanwhile, the care of patients continues in the NHS, with an increased birthrate, coupled with a significant increase in the complexity of maternal conditions.

Interestingly, the Royal College of Midwives, last year, expressed their disappointment that there is so little reference to Maternity Services in the nationwide STP plans, and stated their intention to call for this to be addressed.

I have found no similar published concern expressed by the RCOG, and no mention anywhere of the impact of STPs on gynaecology provision.

As we will all be aware, the Care Quality Commission continues to report evidence of substandard care in the NHS, including the recently published report about the Royal Cornwall Hospitals Trust [2], springing from an inspection in July of this year. Among the particular concerns are the maternity and paediatric departments, with staff shortages highlighted as major problems. One of the consequences referred to in the CQC report is the inability to provide same-day assessment of women presenting with reduced fetal movements in pregnancy. (This component of maternity care is one of the most basic of the ways in which we address the physical and psychological concerns of our patients.)

In conclusion, I see the STP as whistling in the wind for hugely improved outcomes, whilst, at the same time, starving the system of the means whereby to provide the care required. And I note that gynaecological provision does not seem to have been addressed.

To finish, I have to allude to the current, and worsening, staffing crisis in Obsterics & Gynaecology, in common with all acute specialties.

Sadly, Jeremy Hunt's bright idea of a clinical staffing App, as announced at the Conservative Party Conference, only serves to highlight the fact that the problem is not even being recognised, let alone addressed.

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What Action Can We Take?

Chair: Eric Watts

Report by Andrea Franks

Colin Hutchinson opened this session by pointing out how much our expert knowledge can help with local campaigns. In his area, local pressure to stop the closure of Huddersfield Royal Infirmary led to unseating of the local MP who was replaced by the Labour candidate. The closure plans were referred to the Secretary of State.

Colin also spoke of the importance of influencing MPs. Most Conservative MPs would support some type of NHS, but for many this would just be a minimal and basic service, often outsourced to private companies. Most Labour MPs do say they fully support the NHS but they may not understand all the issues.

Our speaker, Simon Watt, an economist and campaigner with Leeds KONP, has been developing a strategy to 'sharpen up Labour MPs' ideas to develop the NHS'.

Simon started by talking to his own MP who seemed uninterested in a Health Campaigns Together newspaper (and left it behind after the meeting) but did join briefly in a local campaign after the election. He plans another meeting, but meanwhile discovered that of 34 Labour MPs in Yorkshire, only four have pledged support for the NHS Bill. Why is this? Do they not understand what is going on? Are they still committed to New Labour? Or is it all just too difficult so they are trying not to think about it?

He has prepared a flow chart and Powerpoint presentation with the aim of meeting all the Yorkshire MPs to try to engage them actively before the next election. It explains why the Health and Social Care Act must be repealed, and the absolute need for the Reinstatement Bill.

The 2017 Labour manifesto made important commitments to repeal the Health and Social Care Act, to provide free and universal health care and to reinstate the powers and responsibility of the Secretary of State, though it stated that the NHS would be the preferred (not the only) provider. At the autumn Labour Conference, however, Composite 8, passed at the conference, called on the party to reverse all privatisations so that care would be both publicly provided and publicly accountable. STPs and accountable care systems must be permanently halted and funding cuts opposed and reversed so that the NHS once more meets European funding levels.

There is a political choice; continuation of the neoliberal ideology of the last 40 years or a return to social democracy. After so long, we almost need to start from scratch in making the arguments for the NHS and explaining its principles.

We know, but need to explain to MPs, why markets do not increase efficiency in health care, how insurance systems favour the well and ignore the chronic sick, and we must point out that the commercial influence results in the first duty of private firms being to investors rather than the service and the patients. At least £10 bn, and probably far more, is now wasted on the extra administrative and contracting costs of the NHS market, although this is still less than the 30% overhead costs in the privatised US system in which over 10% of people have no health cover.

There have been 20 reorganisations of the NHS between 1948 and 1974. Internal markets were introduced in 1989, then in 2012 the Health and

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Social Care Act ('a dog's breakfast of a law, mostly written by McKinsey's') was yet another top-down reorganisation which fragmented national planning of health and social care. These changes all appear to be leading to a US–style private health insurance system. Recent introductions such as STPs are set to become American-style Accountable Care Organisations, with grossly inadequate funding which would completely negate any possible advantages of integration. These constitute another major reorganisation which has never been discussed in parliament.

We must tell MPs why the NHS Reinstatement Bill is so badly needed and what it would achieve. MPs may say it would bring in 'yet another reorganisation', but in fact it would halt the major upheaval already being caused by the imposition of STPs. It would end all marketisation and outsourcing and restore the NHS fully as an accountable and publicly provided public service.

Labour created the NHS and must defend it. Bevan in 1948 set out three principles: universal access based on need, comprehensive care within available resources and that it must be free at the point of delivery. We can add others, including the need to get the best from the resources available, minimise disadvantage and ensure that health is reflected in all social policies and that everyone is valued as a citizen. The principles must be socially just and 'for the many, not the few'.

Principles, policy objectives and the institutional architecture to implement them must be ready for the next Labour manifesto.

Accountable Care Organisations would be the final step to a franchised, outsourced, commercialised health service run for private profit, not public good. Unless the current direction is reversed and the 2012 Act repealed, this will be the outcome.

All MPs need to be in no doubt about these issues before the next election.

You didn't come into medicine to see the NHS die. So help save it.

The Paul Noone Memorial Lecture

Health, Politics and Parliament

Justin Madders, MP

(Justin Madders is MP for Ellesmere Port and a member of the Shadow Health Team. He was elected 2 years ago. He joined the Shadow Health Team in September 2015 and is the longest serving member of that team. He sits on the front bench and his portfolio includes Accident and Emergency services, ambulance services, NHS111 and workforce)

Report by Colin Hutchinson

Despite a turbulent few years for the NHS, the public service model remains very popular: evidence suggests the public would be prepared for an increased level of taxation to pay for it. The percentage of GDP allocated to health in England is slipping compared to comparable European nations.

The introduction of Sustainability and Transformation Plans (STPs), Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs) is like rearranging the deck-chairs on the *Titanic*. They are an admission that the Health and Social Care Act is not working. These entities have no legal basis, although draft regulations for ACOs are expected soon.

On the face of it, the integration of health and social care is desirable, but STPs are not the way – one of the assumptions on which the *Five Year Forward View* (FYFV) was based, that there would be increased social care funding, has not taken place. If you cut social care, the NHS bleeds.

How did we get here?

The submission of initial draft plans for STPs took place in December 2015, with final drafts submitted less than a year ago. Justin Madders was one of the first MPs to bring these plans to public attention, in an article published in the *Huffington Post* in May 2016 [1]. He agrees with much of John Lister's critique of STPs [2]. He suspects strongly that the plans are driven by the savings targets imposed by the Treasury, but the assumptions of what they are able to deliver are false. A recent survey of hospital consultants showed that, although 10% felt that STPs may have some benefits, 75% felt that they were essentially a means of cutting expenditure.

The number of hospital beds in England is very low, in comparison with comparable countries: 2.3 beds per 1000 population compared with the European average of 3.7 per 1000.

Effective workforce planning has been neglected by government, leading to severe shortages of nurses, physiotherapists, general practitioners and consultants (especially in particular specialties). There are difficulties in filling the gaps through international recruitment, in a competitive global market.

The combination of shortages of funding and appropriately qualified staff are causing difficulties in maintaining many clinical services. There has been a recognition from NHS England that further bed closures may exacerbate the problems and they have published three conditions that need to apply before further bed reductions can occur, but these

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conditions are poorly defined and easy for cash-poor providers to circumvent [3].

So far, £21m has been spent on management consultants and other such support for the STP process, although realisation seems to be dawning that they will not deliver improved care. They are supposed to bring together health, social care and public health by the integration of NHS and Local Authority services, but there is a perception in many local authorities that the agenda is being dominated by NHS England. There is a democratic deficit – in Nottinghamshire, for example, the STP board includes three council officers (employees of the council), but no elected councillors.

The "new models of care", including ACSs and ACOs, are not mentioned in any Act of Parliament. They have not been subject to parliamentary scrutiny. The government would appear to be intending to avoid debate and scrutiny by using secondary legislation that does not require debate or a vote to become law.

The Naylor Review [4], which recommends the selling-off of publicly owned land to private developers, has raised serious issues. 119 of the sites proposed for sale still have clinical services on them. These actions will exacerbate the effect of more and more space in NHS buildings being handed over to private providers, leaving much less in the control of NHS bodies.

We have only reached the middle of the longest financial squeeze in the history of the NHS. NHS Trust deficits were reported as £791 m in 2016/17, but that was only after application of various tricks of accountancy: the underlying deficit was £3.7 bn. Money that was intended to fund buildings, building maintenance and purchase of equipment (the capital budget) has been diverted to plug the hole in the budget for day-to-day running of the service (the revenue budget), leaving a £5 bn hole in the capital budget, with an increasing back-log of building maintenance work, aging and out-dated equipment and infra-structure and little opportunity to adapt premises to the needs of modern clinical practice.

There are serious fears about the ability of the NHS to provide adequate services through the coming winter.

What would a Labour government do?

Labour is committed to increasing the funding of the NHS by £45 bn over the life-time of the next parliament.

Labour would reintroduce NHS training bursaries.

Effective work-force planning has been neglected for so long that the problems will take longer to resolve than correction of funding, but Labour will make this a priority.

The pernicious effect of the legislation that was brought forward in 2012 has contributed greatly to the current state of the NHS: Labour is committed to the repeal of the Health and Social Care Act 2012, and the introduction of an NHS Reinstatement Bill.

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[4] NHS England (2017) *NHS Property and Estates: The Naylor Review* [online] available at http://bit.ly/2s4i16x

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