

Editorial:

This issue is devoted to our first analysis of the Coalition Government's Health proposals. This is quite long and detailed, but not at all definitive. More details are emerging, and a White Paper is expected shortly, so it seems more important to get our first impressions out now than to perfect our critique, especially as the Coalition document is quite sketchy in places. It is also not original. We have shamelessly pinched ideas from Ruth Marsden at NALM, from the Health Service Journal and from Andy Cowper at Health Policy Insight, among others.

For anyone who was unhappy at the centralising tendency of Labour's health policies there is quite a lot that can be welcomed, although it is not clear how or when many of these ideas will actually be implemented. Our expectation is that the economy drive is likely to eclipse most of these proposals in so far as they involve public expenditure. But there is a repeated commitment to patient and doctor power, although nothing about any conflicts that might imply.

The Coalition's central proposal is to replace central direction with a much more developed market mechanism, driven by what sounds like GP fundholding on steroids. It is not at all clear that most GPs want to do this, or are capable, and even if they were, replacing 150 PCTs commissioning services with 8500 GP practices would cost more. So the GPs will presumably be formed into something which might be called a Primary Care Group and might employ some of the managers who will no longer have jobs with the PCTs. As most of the PCTs work will go to these groups we won't need so many PCTs. Central direction is to be given by an independent NHS Board which will, presumably, have the effect of distancing Ministers from the day to day management of the NHS.

The Socialist Health Association, like the Labour Party, will have to relearn the skills of opposition and we will have to build a new relationship with the Labour Party, with the Government and with other players. We certainly hope to play a role in supporting Labour health spokespeople, both in exposing the weaknesses of coalition health policy and in devising alternative health policies. We may want to get more actively involved in both local and national campaigning and think about creative ways of doing so. We will also want to try to make constructive use of the Coalition's proposals about empowering patients and communities, however cynical we might feel about them.

Between now and September we will be raising health issues with the contenders for the Labour Leadership and considering the strengths and weaknesses of Labour's health policies during the last 13 years. We also plan to organise a special Health Hustings where the five candidates will be asked their views on the health policies the Party has pursued over the last 13 years and what the future should look like.

The Association will be balloting all its members with email to see which candidate we should officially endorse. If you haven't got email and wish to participate please let us know and we will contact you by phone. All members will be given an opportunity to vote in the Leadership election and you will be contacted separately about this.

Coalition plans for NHS

The Tory/Lib Dem coalition has published their agreement as a framework of policy. The significant sections on the NHS are set out in **bold** below with preliminary comments for discussion. There are also some snippets of other policy announcements.

Reference is made to the Tory pre-election document – Renewal Plan for a better NHS part of the Plan for Change. In this there are many references to the failures and deficiencies of the NHS. The best and most authoritative summary based on research comes from the Kings Fund - A high-performing NHS?

“In summary, there is no doubt that the NHS is closer to being a high-performing health system now than it was in 1997. It is capable of delivering high-quality care to some patients, in some areas, some of the time. Even though there are considerable financial challenges ahead, the next government must aspire to create an NHS that can deliver quality to all patients, in all areas, all of the time – in a way that is demonstrably fair, efficient and accountable to the society that pays for it.”

There is scant mention of integration with an apparent continued acceptance of an arbitrary divide between primary, secondary, community and social care. There is surprisingly little about hospitals either.

There is nothing about the complex issues around mergers, acquisitions and takeovers.

There is nothing about major workforce issues and the whole minefield around professional training and development – some major changes to funding (commissioner/provider split) are only partly implemented – do they continue?

Will Transforming Community Service (TCS), which splits commissioning from primary care provision, be continued on its timetable to complete early next year? Will the exemptions from proper market testing, for example for new social enterprises, be continued?

Will Agenda for Change and the national bargaining framework be continued? Does the policy of Partnership with trades unions continue – exhibited through mechanisms such as the Social Part-

nership Forum and regional and local structures?

What will be done to accelerate progress of trusts to Foundation Trust (FT) status and what happens to those that do not make the grade – is there a new cut off date? What about community provider FTs? What happens if FT status is withdrawn by Regulator?

What is the role for Strategic Health Authorities – to be renamed Regional Offices? What is relationship between SHAs and PCTs to the NHS Board?

What role for Overview and Scrutiny (OSC)? Many Local Authorities (LAs) find it frustrating as it is, and DH worries about them slowing down reconfiguration and reforms.

What happens to DH which already has its own “Board” and how is the divide between the still named Department of Health (DH) and NHS breached? Will there still be an NHS Chief Executive as well as a DH Permanent Secretary?

The government has already announced plans to make GPs the lead commissioners for care worth up to £60bn. This will mean 500-600 GP consortia contracting directly with a new independent NHS board, removing all of PCTs’ existing GP contracting and performance management functions.

We will guarantee that health spending increases in real terms in each year of the Parliament, while recognising the impact this decision will have on other departments.

Wanless and others have shown that NHS inflation is higher than the general rate and also that demographic changes and new drugs and technologies also drive costs within the NHS. The plans to reduce overall NHS expenditure by £15 - £20bn remain with expectations of 5% pa efficiency savings within trusts. Matching inflation will deliver funding well below the historical trend. The share of GDP spent on Health will fall back well below the average in Europe.

We will stop the top-down reorganisations of the NHS that have got in the way of pa-

tient care. We are committed to reducing duplication and the resources spent on administration, and diverting these resources back to front-line care.

This commitment lasted for a whole fortnight.

In a letter sent to NHS confederation members about the meeting last week Nigel Edwards said most commentators had “underestimated” how radical the changes would be. “In the NHS we are used to reform and reorganisation which changes the architecture: the organisations get bigger or smaller and titles change but mostly existing power relationships remain intact,” he said. “The proposed programme goes beyond this to fundamentally change the healthcare system. “The intention seems to be to put all the enabling mechanisms and the policy framework in one set of reforms and allow the detail of how they work on the ground to be developed locally, as opposed to the approach of the last 10 years of a more step-wise approach.”

We will significantly cut the number of health quangos.

A helpful list of health quangos can be found in the Bow Group paper which says there are at least 74. Many do things which probably need to be done in some way so the likelihood is amalgamations and re-naming rather than abolition. Watch for highly creative accounting and reporting.

We will cut the cost of NHS administration by a third and transfer resources to support doctors and nurses on the front line.

How they determine the baseline cost to be reduced is anybody’s guess. Are ward clerks counted as administration? Last time they “reduced costs” by merging PCTs, Ambulance Services and SHAs the accounting for reductions and savings was a bit opaque. It is unclear how they will transfer the resources to support doctors and nurses – more pay, more employed or what?

We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.

Few changes are directly dictated but follow as a consequence either of efficiency savings or else

because of clinical guidance. The need for efficiency savings and the need for quality of care are still there so the closures will still be needed. This is a cunning way for the politicians to blame local organisations for the consequences of responding to central policy – a tactic widely used already against local government.

The “central dictates” are usually guidance from recognised bodies or recommendations from expert reviews, which tend to set expectations on levels of activity in order to give a safe clinical environment. Some clinicians argue that a population of 500,000 is needed to support a proper A&E department and there are views on minimum numbers for birthing centres and for maternity departments at a proper DGH.

Some A&Es apparently threatened with closure were never A&E departments anyway – more like Walk in Centres, Urgent Care Centres or Minor Injuries Units. An A&E department needs 24/7 surgical coverage including vascular surgery. There is some logic at the moment about where real A&Es are placed in mainly rural areas – but in some urban settings the oversupply of A&E is pretty obvious. 3 tier arrangements for trauma already exist informally but formal arrangements might mean reductions in scope for some A&Es, and ambulance drive pasts – but that is hardly centrally dictated. This trend will continue as it is clinically driven but it can be fought by “localism” every step of the way!

There are real clinical concerns about birthing units, and the need for 4000 births a year for a maternity unit at a DGH is recognised. There are gradations of maternity units anyway determined by clinical assessments; what are you supposed to do with a unit which falls below the threshold?

We will strengthen the power of GPs as patients’ expert guides through the health system by enabling them to commission care on their behalf.

Some GPs are up for this and will be good at it— but many aren’t and won’t be. The idea that patients and doctors might not always see eye to eye does not seem to have been considered.

We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust. The remainder of the PCT’s board will be appointed by the relevant local authority or authorities, and

the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.

Amazing that the first attempt to bring democracy into the English NHS is by the Tories. The first Health Boards in Scotland have just had their elections. However this looks to be totally unworkable and to be like the Police Authorities that they are scrapping as ineffective. If the senior staff are not appointed by the Board and not accountable to the Board then this is nonsense. Are all existing directors/senior staff required to be appointed or just new ones?

What is the Board for? PCT boards are pretty pointless now as they are dominated by their SHA performance managers and are required to implement top down policies. Their actual discretionary spending is a tiny fraction of their stated income. PCTs will still not be coterminous with Local Authorities. Nothing is said about reducing the number of PCTs even though they will have much less to do and many argue we have far too many already.

The new PCT bodies will sit alongside the powers of the same Local Authorities through OSC or otherwise to challenge their decisions. Who performance manages these new PCTs? Is democracy sufficient to waive any external performance management. What about role for OSCs in this system? It misses the opportunity to make commissioning the responsibility of LAs and gives the worst of both worlds. It does not explain how patients get a voice in provider decisions which for most are the important ones – most patients and the public have no idea what PCTs are for.

The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.

Public health spending accounts for approximately £4bn a year - just 4.7 per cent of the total £84bn now allocated directly to PCTs. The further “residual” commissioning responsibilities likely to be left with PCTs include maternity care, optome-

try, pharmacy, dental services and services for patients “GPs don’t want” such as homeless people.

If a local authority has concerns about a significant proposed closure of local services, for example an A&E department, it will have the right to challenge health organisations, and refer the case to the Independent Reconfiguration Panel. The Panel would then provide advice to the Secretary of State for Health.

OSCs can already do this, and they have. How is “significant” judged – at present OSCs tend to interpret this to mean anything that significantly affects patients (could be small numbers eg moving a GP surgery) – but DH want this to mean significant in terms of the total health provision in the area, so has to be pretty major and affect many. Is this a test at strategic level or does it apply to the changed experience of a patient? IRP is a quango we could do without. Secretary of State makes the final decision, which is highly top down..

We will give every patient the right to choose to register with the GP they want, without being restricted by where they live.

Is this the GP or GP practice/polyclinic? Can the GP refuse a patient? Many people would want it to guarantee continuity of an actual GP. Which non quango has the job of strategic management to ensure there are enough GPs in the right places?

We will develop a 24/7 urgent care service in every area of England, including GP out-of-hours services, and ensure every patient can access a local GP. We will make care more accessible by introducing a single number for every kind of urgent care and by using technology to help people communicate with their doctors.

The current urgent care system is a hopeless mess, brought about by fragmentation and the obsession with contracting out and tendering. Some previously integrated systems run by ambulance services have actually been broken up.

The single number is already being pilot tested in parts of East of England, East Midlands and North East. The 3 digit number still sits alongside 999. The obvious solution is to have only one number 999 and allow the call takers and their supporting technology to route the response appropriately. The new numbers to avoid Police 999 calls did not

work. The introduction of NHS Direct to reduce A&E demand did not work. These innovations find lots of new demand but have little effect on current patterns of demand and do not allow A&E departments to be closed or scaled down.

Many facilities like WICs, UCCs and the out of hours service are a result of the difficulty in accessing GPs in hours, and this could be addressed by the renegotiation of the GP Contract. Getting out of numerous contracts currently in force for out of hours provision will not be easy or cheap. Better use of existing A&E departments can be cheaper and safer but less patient friendly – difficult choice to make.

We will renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas.

Good intention but the evidence around outcomes from additional funding to alleviate health inequalities in deprived areas is weak. Renegotiation of the GP contract is hardly a simple step. It will have to cover many other changes. It sounds very expensive as it appears to be central to much of the change programme and will need to be done early. At present the negotiators in NHS Employers are still unsure if they are one of the quangos to be axed – so not clear who does the negotiating.

We will make the NHS work better by extending best practice on improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and where possible enabling community access to care and treatments.

Brilliant, why has nobody ever thought of this before? Or rather why since everybody has been working to this agenda for years, has it not happened? How will it be made to work better?

We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.

Again - why since everybody has been working to this agenda for years, has it not happened? Who funds the community support – NHS?

We will prioritise dementia research within the health research and development budget.

The bottom up approach doesn't apply to clinical research then. That is to be dictated by Ministers.

We will seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests.

Rather a lot of NHS staff are "foreign". Are they to be subject to different standards than indigenous staff?

Doctors and nurses need to be able to use their professional judgement about what is right for patients and we will support this by giving front-line staff more control of their working environment.

How? Does this mean National Service Frameworks are to be abandoned? In the new interview podcast for Doctors Net UK, Health Secretary Andrew Lansley makes one of the most unintentionally hilarious promises imaginable.

There has been much question over whether and how Lansleyism would keep its pre-electoral promises that, in David Cameron's phrase "those targets you hate, they're gone".

In this interview, Lansley reveals that the process, waiting time measures will become secret targets, hiding in the cupboard and waiting for the NHS to be naughty: "'If I get rid of the 18 week target, for example, what happens as a consequence? Do people in the NHS go, 'Oh right, so it doesn't matter how long people wait'? [If so] then it is hopeless and you will end up with all the impositions coming back".

So there you have it: nice and clear. Process waiting time targets are being abolished. Unless of course, people start to breach these abolished targets. Then they'll be back.

We will strengthen the role of the Care Quality Commission so it becomes an effective quality inspectorate. We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.

The need to make the CQC effective and to have clarity of its role in both health and social care is widely accepted. There is a need to reduce over regulation through duplication as perhaps as many as 70 have some role in regulation of major trusts. There is a major issue around how different regulators and rating type agencies such as Dr Foster find different things and give conflicting messages about the same organisation. Why have two regulators? If Monitor sets the prices in the internal market what criteria does it use or does this imply the market itself sets the prices?

Does access mean access for patients or does it mean access of a provider to the market? This appears to imply the amusingly named Cooperation and Competition Panel is to be axed. Does this escalate the response to actual sanctions as opposed to investigation of alleged misbehaviour? The CCP actually principally dealt with commissioners but Monitor only regulates providers?

We will establish an independent NHS board to allocate resources and provide commissioning guidelines.

This step has been the subject of academic papers and opinions vary. It is not clear who would be on the board; would there be a role for appointed non executive directors? Does it meet in public and publish all its papers? It appears that it will take over most of the responsibilities of the Dept of Health, so it is unclear what sort of independence it will have.

We will enable patients to rate hospitals and doctors according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

The duty of candour is an excellent idea, and the subject of a long campaign by AVMA which should be supported. Rating doctors and hospitals should be encouraged, but it needs careful organisation. Patients are interested in the part of the hospital that they use, not the whole thing.

We will measure our success on the health results that really matter – such as improving cancer and stroke survival rates or reducing hospital infections.

(There is quite a lot about this in the Tory pre

election paper, Renewal Plan for a better NHS.) See comments about targets above. Lots of papers have been written on the efficacy or otherwise of targets – the impact on patients and the impact on culture. All the polling evidence shows that length of wait, which is a process target, is very important to patients. What is measured and how will be crucially important, - there are still endless problems with data collection, definitions and interpretation of the existing measures. No mention of inequality as something that matters.

We will publish detailed data about the performance of healthcare providers online, so everyone will know who is providing a good service and who is falling behind.

There is already an enormous of data available. The difficult part is turning into useful information. The argument about Hospital Standardised Mortality ration and what it means is an example and the Dr Foster Good Hospital Guide gives different answers to the CQC ratings and Monitor's traffic light assessments. Quality can vary widely within a single provider; aggregated data may be of little value.

What about the performance of commissioners?

We will put patients in charge of making decisions about their care, including control of their health records.

How? In what sense will patients be in control of their health records? It is already possible for most patients to access their GP records, although GPs have been reluctant to enable this.

We will create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them, paid for using money saved by the NHS through our pledge to stop the rise in Employer National Insurance contributions from April 2011.

Why just cancer drugs? Why not fund any drug that a doctor thinks will help a patient? How is this consistent with the existence of NICE—this appears to be money to pay for drugs which NICE reckons are not worth paying for.

We will reform NICE and move to a system of value-based pricing, so that all patients can access the drugs and treatments their

A lot depends on how they reform it. NICE is one of Labour's most significant achievements in health. Will this remove any role for local decision making and so eliminate any post code lottery at the expense of weakening local choice? Are the pharma companies signed up to value based pricing? The experiment with new drugs for Multiple Sclerosis turned out to be a disaster. It is easy to sell false hope to desperate patients.

We will introduce a new dentistry contract that will focus on achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.

That was the intention of the last dentistry contract. How will this one be different? Who will commission dentistry? GPs?

We will provide £10 million a year beyond 2011 from within the budget of the Department of Health to support children's hospices in their vital work. And so that proper support for the most sick children and adults can continue in the setting of their choice, we will introduce a new per-patient funding system for all hospices and providers of palliative care.

Does this move this kind of care into the mainstream NHS as a service which will be commissioned and paid for from NHS funds – if not why not if it is so important.?

We will encourage NHS organisations to work better with their local police forces to clamp down on anyone who is aggressive and abusive to staff.

All good trusts already do this.

We are committed to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers.

This implies a greater role for other providers but it is not clear how this will improve quality at the heavy end. Are we expecting local charities to be running Intensive Care Units?

We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers.

This already applies for most of planned acute care – it is not clear what else is covered. In areas such as emergency care or mental health there will be obvious limitations on choice. Will the tariff allow for the additional costs born by NHS badged organisations but not by private providers? Does this imply there will be active market development and incentives (as with for example ISTCs).

Non- health issues relevant to health

These points are taken from other parts of the coalition programme

We will work to rebuild the Military Covenant by...providing extra support for veteran mental health needs.

Not much about mental health for the rest of the population

We will ensure that injured personnel are treated in dedicated military wards.

We will introduce new protections for whistleblowers in the public sector.

A good idea, but what sort of protection is proposed? There is already protection against dismissal, but nothing done up to now has encouraged junior doctors to speak out. A more competitive environment seems unlikely to encourage whistleblowing.

We will take steps to open up government procurement and reduce costs; and we will publish government ICT contracts online.

We will create a level playing field for opensource software and will enable large ICT projects to be split into smaller components.

We will require full, online disclosure of all central government spending and con-

tracts over £25,000.

Does this mean the end of the Commercial confidentiality get out for Freedom of Information requests?

We will create a new ‘right to data’ so that government-held datasets can be requested and used by the public, and then published on a regular basis.

We will explore alternative forms of secure, treatment-based accommodation for mentally ill and drugs offenders.

We already have secure prisons and secure mental hospitals. The problem is not the security but the effectiveness of the existing provision.

We will ensure greater access to talking therapies to reduce long-term costs for the NHS.

Interesting that this is in the public health section, not NHS

We will establish a commission on long-term care, to report within a year. The commission will consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless.

The aims of the previous administration to move to a national care system over time is neither accepted nor rejected. How will yet another commission help?

We will break down barriers between health and social care funding to incentivise preventative action.

How? While health care is free and social care is means tested there will be barriers.

We will extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power. We will use direct payments to carers and better community-based provision to improve access to respite care.

This appears only to apply to social care. No

mention of the pilots of personal budgets in health care. Page 8

We will reform Access to Work, so disabled people can apply for jobs with funding already secured for any adaptations and equipment they will need.

We will support the creation and expansion of mutuals, co-operatives, charities and social enterprises, and enable these groups to have much greater involvement in the running of public services.

We will give public sector workers a new right to form employee-owned co-operatives and bid to take over the services they deliver. This will empower millions of public sector workers to become their own boss and help them to deliver better services.

A cheeky attempt to prise the co-operative movement away from the Labour Party? But for this initiative to get anywhere with the existing NHS workforce the problem of NHS conditions and especially pensions will have to be resolved. Not many NHS staff will want to swap their pension for the chance to be their own boss.

Public Health— directly relevant issues

This selection does not include general points about taxation and economic policy, which probably has much more impact on public health than these proposals.

We both want a Britain where social mobility is unlocked; where everyone, regardless of background, has the chance to rise as high as their talents and ambition allow them.

It was this idea which inhibited the Labour Government from doing anything serious about equality. At present we have a society where every child has the opportunity to rise as high as their parents' wealth allows them.

The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strat-

egy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health.

Innovative, or evidence based? We know what promotes public health—economic equality. And maybe increasing the price of unhealthy food and drink.

We will give local communities greater control over public health budgets with payment by the outcomes they achieve in improving the health of local residents.

Does this imply that payment will only arrive when health improvements can be demonstrated—possibly many years later? The big problem in public health has always been the timescale. And are PCTs not to be in charge of public health? They are pretty poor at relating to local communities—wouldn't it be better to give the job to local councils?

We will give GPs greater incentives to tackle public health problems.

There is quite a lot GPs could do to tackle public health problems, particularly if they work together in groups. Could they organise to eradicate damp and overcrowded houses or poor school meals? Not all public health problems can be tackled by medical intervention. The most likely interventions will be to reward GPs for encouraging their patients to stop smoking and drinking—much easier in prosperous areas than in the places where it would do more good.

We will investigate ways of improving access to preventative healthcare for those in disadvantaged areas to help tackle health inequalities.

Perhaps giving the poor money would help?

We will create Britain's first free national financial advice service, which will be funded in full from a new social responsibility levy on the financial services sector.

If this really happens it might make a big difference to problems around mental illness.

We will review employment and workplace laws, for employers and employees, to ensure they maximise flexibility for both parties while protecting fairness and providing the competitive environment required for enterprise to thrive.

Work is good for your health. But good work is better. If this review leads to less protection for vulnerable workers it will not be health enhancing

We will reinstate an Operating and Financial Review to ensure that directors' social and environmental duties have to be covered in company reporting, and investigate further ways of improving corporate accountability and transparency.

This could be a useful lever for a public health approach.

We will promote the radical devolution of power and greater financial autonomy to local government and community groups. This will include a review of local government finance.

We could make Council Tax relate better to the value of housing by having more bands, or moving to a percentage system. Or we could perhaps try a Poll Tax?

We will ban the sale of alcohol below cost price.

What is cost price?

We will review alcohol taxation and pricing to ensure it tackles binge drinking without unfairly penalising responsible drinkers, pubs and important local industries.

Does this mean unit pricing, or not? Lansley is now saying "Supply and price are far from the only factors in driving alcohol misuse. Demand and attitudes are crucial."

We will introduce a system of temporary bans on new 'legal highs' while health issues are considered by independent experts. We will not permanently ban a substance without receiving full advice from the Advisory Council on the Misuse of Drugs.

We will work towards full compliance with European Air Quality standards.

We will promote equal pay and take a range of measures to end discrimination in the workplace.

We will extend the right to request flexible working to all employees, consulting with business on how best to do so.

We will undertake a fair pay review in the public sector to implement our proposed '20 times' pay multiple.

Not a bad idea, but there are not many public sector jobs where the pay of the richest is 20 times the lowest. Is this principle not to extend to the private sector?

We will maintain the goal of ending child poverty in the UK by 2020.

But will they do anything about it? Abolishing the Child Trust Fund was not a good start.

We will bring forward plans to reduce the couple penalty in the tax credit system as we make savings from our welfare reform plans.

But the £150 tax incentive for married couples has been dropped.

We support the provision of free nursery care for pre-school children, and we want that support to be provided by a diverse range of providers, with a greater gender balance in the early years workforce.

Is it to be made free? That would be big step to reduce health inequality.

We will take Sure Start back to its original purpose of early intervention, increase its focus on the neediest families, and better involve organisations with a track record of supporting families. We will investigate ways of ensuring that providers are paid in part by the results they achieve.

This seems to mean taking Sure Start away from any families which are not the neediest. A tricky issue.

We will refocus funding from Sure Start peripatetic outreach services, and from the Department of Health budget, to pay for 4,200 extra Sure Start health visitors.

Is this a good trade off? We certainly need more health visitors— but there is a shortage. They won't appear this year, or next.

We will investigate a new approach to helping families with multiple problems.

We will crack down on irresponsible advertising and marketing, especially to children. We will also take steps to tackle the commercialisation and sexualisation of childhood.

We will encourage shared parenting from the earliest stages of pregnancy – including the promotion of a system of flexible parental leave.

We will train a new generation of community organisers and support the creation of neighbourhood groups across the UK, especially in the most deprived areas

Community development can have very considerable health benefits and should definitely be welcomed, especially if it can be linked to the proposals for incentives for GPs to tackle public health problems—which might give the organisers some resources. But it appears that though there may be some training provided these organisers will be required to raise money to pay for their own salaries, which may be difficult in disadvantaged areas

We will support sustainable travel initiatives, including the promotion of cycling and walking, and will encourage joint working between bus operators and local authorities.

How? Just by exhortation, or by positive steps to make walking and cycling easier and safer compared with car travel? Can we link this to the incentives for GPs, so for example, a group of practices could pay for a cycle track on the basis that they would get some money for every patient who used it?

Patient Power

Andrew Lansley, gave his first speech on health policy in the Bromley by Bow Health Centre in east London. The event was put on jointly by the DH, National Voices and the Patients' Association.

He gave a commitment to an NHS free at the point of use and highlighted shared decision-making between patient and clinical staff and putting the patient at the centre of health care. He said that power needed to move from the institutions and the DH the people so that patients and doctors had real power in everything that is done in the NHS.

LINKs will be merged with national Health-watch, so there is contact between the national and local but the model is not yet developed. There will be no structural upheaval as he recognises that constant change is harmful.

Lansley said that action would be taken to reduce the number of emergency readmissions and that following treatment the hospital would maintain responsibility for the patient for a further 30 days. He said this was about making the NHS more outcome focussed. His priorities are to:

- * make a cultural shift from a culture responsive to orders from the top, to one responsive to patients, in which patient safety is put first.

- * devolve power through meaningful information to patients. Patient experience will drive up standards, as the data will influence patient choice.

- * engage people in their care, “no decision about me, without me”, and give patients the opportunity to provide feedback in real time, reflecting the experience of their care.

- * embrace leadership by setting NHS professionals free from a targets without meaning to one focussed on the quality, innovation, productivity and safety required to improve patient outcomes.

- * adopt a holistic approach by looking at the entire patient pathway from preventative health

and well-being measures, through to hospital and community care.

- * introduce payments which encapsulate a more integrated care pathway by giving hospitals responsibility for a patient's care for 30 days after they are discharged.

- * Local authorities and PCTs will have to work together

The SoS will end the previous government's bureaucratic approach and perpetual interference and end top-down process targets. The NHS must be responsive to patients and patient safety a top priority. Patients must be in the driving seat, informed and engaged.

Lansley concluded with remarks on the need to “empower patients and health professionals. That means we will have to disempower someone. And I think it might be me! I know that others know better about their care and are better placed to make certain decisions.

“So we will disempower the hierarchy, the bureaucracy, the Primary Care Trusts and the Strategic Health Authorities. I don't want the whole of the NHS to wait to hear from me. I want it to listen to patients, and to take responsibility for action”.

This action, he promised, would be “to give patients and care-users more control, to exercise choice – from choice of GP to choice of treatment, all the way through to personal budgets ... to empower patients collectively in thinking about what quality standards and commissioning guidelines should look like, as well as patients and the public locally, impacting on decisions about access and design of local services to meet local needs ... (and) to empower patients through access to information, from a plurality of information providers, with the ability to hold their own patient records, to interact more readily with their clinicians. To be able to use this new information ecology, to secure the quality of care and service we want as patients – and collectively, to drive an improvement in standards and outcomes”.

Future Events

Lessons from 13 years of Labour Health Policy

York Guildhall
Saturday 19th June noon

Professor Alan Maynard

Every Person a Well Fed Person

Brunswick Parish Church Brunswick Street Manchester M13 9TQ
Tuesday 29th June 10am - 3pm

Dr Charles Clutterbuck Environmental Practice at Work
Hazel Andrews Community Dietician
Kath Gleeson Independent Consultant Nurse in School Health

Enter and View - the power of the LINK

Huddersfield 9th July 11- 4pm
Hudawi Cultural Centre, Great Northern Street, Huddersfield, HD1 6BG

Valuing a diverse workforce in the NHS

Coventry Quaker Meeting House
Saturday 10th July 11am-3pm

David Amos

Prof Roger Seifert Professor of Industrial Relations Wolverhampton Business School
Patrick Vernon Chief Executive The Afiya Trust
Vivienne Lyfar-Cisse NHS BME Network

Costs for the events above vary but are reduced for SHA members (and delegates from affiliated organisations, such as CSP, SoR, Unite, and Unison).
Further details will be on our website www.sohealth.co.uk or from the office.

Articles, Letters, Announcements and Comments should be sent to the editor
Gavin Ross, 21 Connaught Road, Harpenden, Herts AL5 4TW.
The deadline for contributions to the Autumn 2010 edition is 30th September.
Tel/Fax 01582-715399 or by e-mail to gavros.ross@btopenworld.com

Socialist Health Association 22 Blair Road Manchester M16 8NS
Tel 0161 286 1926 admin@sohealth.co.uk