Final SHA draft will be compiled on Sunday 1st Dec so please submit comments in advance.
Members can also submit individual responses.
https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future

DRAFT SHA response - the 10 year plan for the NHS

The Socialist Health Association (SHA) calls for the NHS to be reinstated as a publicly provided service, operating within the context of a functioning welfare state, and which is planned according to the needs of the whole population and accountable to national and local elected bodies. We support strong links to local government which must be funded to provide public health and social care as part of a National Care Service.

In areas where the NHS does not exist or is patchy we know inequality increases - as with hospices[1] and dentistry[2].

We believe that a reinstated NHS is the most effective and efficient method of delivering health care. By removing the market a significant layer of transaction costs is minimised and perverse incentives to 'game' the system are largely removed.

We believe the NHS can be run more efficiently if 'demand management' choke points, largely introduced in recent decades at the behest of US management consultants, are removed, allowing the service to run without distortion, which in turn will allow us to identify genuine bottlenecks and start to resolve them so that wait times can be appropriate. "F1 Pit Stop" surgery[3] and other innovations result in unmanageable commissioning costs in the current system.

The plan to Reinstate the NHS has overwhelming support in the Labour Party[4] and has been the subject of parliamentary bills[5] [6]. Furthermore, a publicly provided NHS is supported by the majority of the public[7].

We support the three shifts Proposed in the Consultation

Shift to Community-based Care

- The SHA supports a shift to community based care from hospitals but recognises that such a change will be highly complex. We also need massive reinvestment in

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[1] https://publications.parliament.uk/pa/cm200304/cmselect/cmhealth/454/45406.htm
[2] https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary
[3] https://www.pulsetoday.co.uk/news/politics/streeting-announces-formula-one-crackdown-on-hospital-waiting-lists-in-sick-areas/
[4] Labour Conference Arrangements Committee report CAC-4-FINAL..pdf
[5] Valuable explanation can be found here: https://allysonpollock.com/?p=2663
[6] https://bills.parliament.uk/bills/2282
[7] EveryDoctor survey 2024: 63% think the NHS should be a fully public service, without private companies delivering NHS services. https://everydoctor.org.uk/wp-content/uploads/2024/07/Information-Pack-RebuildTheNHS-v.2.1-1.pdf

emergency, intensive care and specialist services, especially in areas where we are lagging such as cancer, mental health, palliative care. A decade of totally inadequate workforce planning impacts both primary and secondary care and our failure to retain staff shows the current strategy of demanding ever lengthening working hours is doomed to failure. As we shift to some community based care much secondary care will need to be retained. It is *absolutely essential that those systems are not dismantled or defunded as new community services are set up.*

- The promise of improved access through community care is coupled with concerns that such services, particularly in social care, have been largely destroyed[8] and there will be inadequate expertise, facilities and equipment in the community. Indeed an expensive replication of services at a local level might even mean increased staffing shortages and fewer services. Time originally spent with patients can end up being spent on the road. It is essential to recognise that community-based care will not be cheaper, systems will still need to resource the fixed costs of running emergency and complex hospital services, and any economy of scale in caring for patients in hospital settings will be lost.

  Workforce issues are huge. It requires the correct skill mix, a mobile, connected, highly skilled, well coordinated, plentiful workforce. Distributed services will be more difficult to manage effectively, particularly when they require coordination between GP surgeries, NHS Community Trusts, pharmacies and local government commissioned (but highly fragmented) care services. Most worrying, as the *Inverse Care Law*[9] might predict, particularly with the increased use of the market, the provision of local services may be worse where need is greatest.

- Services, such as pharmacies are being consolidated under the pressure of market forces as are some GP practices; these partners may no longer exist in the community for the NHS. The NHS will need to step in thus reversing this drive to outsource the delivery of services. This will mean the direct provision of clinical staff including salaried general practitioners. Darzi reported that many community facilities pre-date the NHS. These facilities need to be upgraded or replaced while avoiding the use of ruinously expensive LIFT / PFI style financing deals which also lead to more outsourcing of workers.

- It is absolutely essential that hospital based services are not shut down or starved of resources before such community services can be developed and run reliably. There will likely be a period of double running costs, which will also need to be resourced.

  We commend what will be a relatively quick gain, to commit to rebuilding local authority social care as part of a National Care Service. The process of marketisation, privatisation and breakup of Social Care is very nearly complete. In fact it offers a hellish vision of a possible NHS. An important step in reversing this process

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[8] How outsourcing has contributed to England's social care crisis https://doi.org/10.1136/bmj-2024-080380
[9] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/fulltext

would be to rebuild council provided social care. This would restore a reliable and professional public service, collective organisation and agreements. Staff in this service can be trained relatively quickly and put on the road to the full professional development which they and their clients deserve. It would have an important impact on the NHS, as Darzi estimated that some 13% of NHS beds are unavailable because of delayed transfers of care. This process should begin with out-sourced domiciliary care contracts being taken in-house as they continue to fail or come to an end.

The recent Budget gave Local Government £600 million of extra grant funding for social care in 2025/26 (adults and children social care services). It is not an adequate[10] uplift for a service that now costs approximately £30bn and which is failing to deliver a comprehensive service.

And we need to remember that social care is about more than just easing pressure on the NHS. It is about improving the quality of life and life chances of our most vulnerable citizens – from cradle to the grave.

While our main objective is to see the return of social care to the public sector, there is a welcome proposal as part of the 'New Deal for Working People' for 'Fair Pay Agreements' in adult social care. We note severe exploitation of migrant workers in conditions of servitude particularly in this sector. This is totally unacceptable. Restrictive work visas must be abolished and the whole practice of migrant charging for services must end if we are to value this indispensable section of our workforce.

Short Term

- Maintain and increase funding for secondary care while seeking to ease patient pathways by resourcing Local Government to start bringing Social Care back in house. Require Fair Pay Agreements across social care.
- Bring domiciliary care services in-house as an immediate first step.
- Make urgent progress on providing a fully registered social care workforce.
- Increase training for community based teams e.g. district nursing, physios, occupational therapists and health visitors. The issue of Physician Associates which are undermining public and professional confidence in primary care must be tackled as a matter of urgency. Our motion to Labour Conference lays out proposals[11].
- Address the growing inequalities in community health care provision.

Medium Term

- Work with local authorities to create the foundations of a National Care Service

Making better use of technology in health and care

[10] LGA analysis shows that service spending in 2022/23 was 42.1% lower than it would have been had spending moved in line with cost and demand pressures since 2010/11. This means that councils have made £24.5 billion in service cuts.

[11] Replacing Qualified Doctors motion to conference (not debated) https://sochealth.co.uk/2024/09/03/labour-conference-motion-replacing-qualified-doctors/

NHS data are hugely valuable for researchers to understand patterns of disease. The quantity of NHS data is of international significance particularly because the NHS covers a whole population. Effective analysis of this volume of data requires powerful systems including artificial intelligence (AI). It is essential, for public confidence and the ownership of the intellectual property likely to flow from this analysis, that these systems remain in the hands of public bodies. We are aware AI systems are 'trained' in the prejudices of their society. There is a risk the findings of AI systems are treated as unchallengeable 'objective' facts yet the very algorithms which generate them are often deemed commercial secrets. A recent report even pointed to the possibility of using such systems to develop biological warfare;[12] this is particularly concerning considering the partners the NHS is being required to work with. Our colleagues in the campaign group 'Keep Our NHS Public' have undertaken some valuable work on this[13].

Data should be used primarily for the delivery and clinical audit of care, service planning and monitoring, and training. Any other use must involve clear and transparent consent from the public.

Regarding the use of AI and robotics in clinical practice we believe that in the hands of skilled professionals these systems could be very beneficial. The quality of the systems, however, seems variable. We are concerned about possible abuse of data for the interests of giant corporations, not the public.

The SHA suggests that the NHS and social care sector should explore the feasibility of establishing a "public service cloud" to store and protect vital personal data.

The use of the NHS app has been compared with Netflix. The NHS App will only work if it is a gateway to NHS services. This is not, as is sometimes presented, primarily a technological issue: it is a problem of triage and capacity. At present its most common use seems to be to order repeat prescriptions and check records. Connecting the App to a host of private services risks diverting more resources from the NHS and may even encourage inappropriate treatment.

The future is not just about AI but also research and technology to deal with Antimicrobial Resistance, emerging infections and indeed the next pandemic.

We are concerned that the transition to digitalisation is leaving many vulnerable users behind and this is contributing to health and care inequalities[14]. Patients and service users must be able to access services by the means of their choice.

Focusing on preventing sickness, not just treating it

[12] https://www.ft.com/content/37ba7236-2a64-4807-b1e1-7e21ee7d0914
[13] https://keepournhspublic.com/health-data-working-group/
[14] https://www.arc-oxtv.nihr.ac.uk/research/DigitalInclusionandExclusionAccessingtheNHSApp

This will involve more than the NHS or the government exhorting the public to take greater care of themselves. The determinants of health and well-being includes good housing, well-paid work, clean air, opportunities for leisure and recreation, the best start in life and healthy ageing. We welcome this shift in focus to prevention.
It should be noted that the key role of local Public Health is to promote measures to prevent ill health. Such measures can deliver very effective intervention which can have disproportionate benefit in areas of high deprivation[15]. Public Health now is largely based in local government which is currently facing a severe financial crisis. The COVID pandemic shows how severely under-resourced and weakened this function is.

Virtually all preventive health services are provided in the community but, as the Darzi Review shows, community services are getting an ever smaller share of the NHS budget. And delivering preventive services must not be seen as just the cheap option to be discarded when financial pressures present. Because of the nature of primary care at present, its provision is of variable quality - for instance high quality work is being done in areas of deprivation by some of the "Deep End GPs" and other progressive practices yet other GPs simply run their Practices as small businesses. This means that the areas with the greatest need are not properly supported. Services must be planned and delivered on the basis of need. Similar arguments apply with NHS dental care - and the lack of it.

Short Term

- Restoration of the Public Health grant £1.4bn pa[16]. The Health Foundation has explored some options.[17]
- Embedding some of the best elements of the 'deep end initiative' across primary care.

Medium Term

- Developing Primary and Community care while sustaining the hospital service to clear waiting lists that are already unacceptably long, while at the same time delivering emergency care to agreed standards

We believe the NHS needs to be understood in its social context. No health system can cope in a society with poverty and homelessness, with deplorable housing, low skills, abysmal pay and a collapsing welfare state. The NHS needs to return to its founding principles. This includes the equitable ***provision*** of healthcare rather than acting as a mere broker in a marketplace of competing providers. The latest Health and Care Act 2022 now deals with the fragmentation of the market by supporting the supervision of competing providers to form cartels to deliver health and care within Integrated Care Board (ICB) boundaries

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[15] https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP166_Impact_Public_Health_Mortality_Morbidity.pdf
[16] https://www.thelancet.com/journals/langas/article/PIIS2468-1253(21)00394-0/fulltext
[17] https://www.health.org.uk/publications/long-reads/options-for-a-future-public-health-system-in-england

The NHS, of course, was a product of its time, a hierarchical society at the height of empire with embedded prejudices towards women, ethnic minorities, gay people not to mention deeply ingrained class prejudice and frequently appalling attitudes towards those with mental illness. These issues must be addressed centrally and rapidly in the process of reinstating the service, as must the last minute compromises Bevan was forced into in order to get the NHS launched.

This sounds as if it is a long project. It is. But there are many short term wins and many structural changes have a minimal impact on management of front line staff and services in the short term. Important early gains can be achieved by unblocking patient pathways, identifying key areas of capital expenditure, fixing crumbling NHS buildings, accelerating training and most importantly support for young professionals, rebuilding NHS teams though a ‘huge wave of insourcing’ and investing in much needed equipment and staff training. Social care must be tackled in its own right and because of its impact on the NHS. Again rapid progress can be made on the road to establishing a National Care Service.