THE lowdown

Health news, analysis and campaigns.
PILOT ISSUE #1
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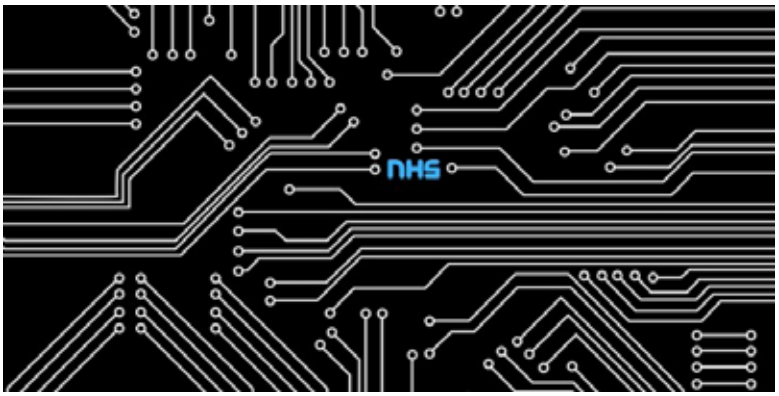
Informing, alerting and empowering NHS staff and campaigners

New rules to protect GPs from digital privateers



Private companies hoping to attract patients away from their current GP to sign on with digital GP services were dealt a blow by a change to funding rules this week.

The *HSJ* has revealed that NHS England announced that under the new GP contract, private companies providing the new 'digital-first' GP services will typically receive around *20% less income*.

NHS England are aiming to protect GP practices from a loss of income because of the precedent set by Babylon Health, a private company that has been marketing online GP services and video appointments to NHS patients.

The private company has signed up 30,000 people who live across London or who work in the capital, to its GP at Hand service.

Patients have to de-register from their current local GP to join the digital service, which runs out of a GP surgery in Fulham in West London.

Increasing costs to the CCG hosting GP At Hand could threaten other health and care services in the area.

Younger, fitter patients

The company's patients are predominantly younger and fitter than those registered at the average GP surgery and the company has been accused of destabilising the payment system in London and of 'cherry-picking' and undermining the integrity of the NHS.

The decision is a reward for local campaigners such as the Tower Hamlets KONP group who have organised protests around GP at Hand practices

Tower Hamlets LMC chair Dr Jackie Applebee, a local GP and taking part in the protest said GP at Hand 'seems to be deliberately targeting healthy young people' taking money from the NHS, by picking the most profitable patients'.

The changes announced in the GP contract will apply from 1 April 2019 and are being seen as a way to improve the fairness of the funding system and avoid such issues in the future.

Despite receiving the public endorsement of Health Secretary Matt Hancock, the GP At Hand service is only now being evaluated by *Ipsos Mori*.

According to *Pulse* magazine its impact on other GP practices and whether or not it destabilises primary care services are being investigated by the *Care Quality Commission*

At present, Babylon Health is the only company that has taken advantage of a rule that allow patients to register with a GP surgery despite outside of their catchment area.

NHS England has said that a hypothetical future "digital first" GP practice that covered all of England would receive about 20% less funding under the rule changes.

However, a further threat to Babylon Health's business strategy would be changes to the current rules on catchment area, which allow patients to register with a GP outside of the area in which they live.

This rule has been key to Babylon's expansion, but NHS England has announced a review.

Babylon Health has accused NHS England of "penalising providers" like them who "have invested in technology" and argues that it "sends the wrong signal."

Do ministers really want to change the regulations?

One obstacle to a number of the proposed changes in the Long term Plan is the current legislation and regulations, which require trusts to compete with each other and to stand separately from commissioners rather than collaborate.

The Plan seeks government action to repeal "the specific procurement requirements in the Health and Social Care 2012 Act" [Andrew Lansley's controversial Act pushed through by Conservative and Lib Dem MPs] to "allow – and encourage – the creation of a joint commissioner-provider committee in every ICS, which could operate as a transparent and publicly accountable Partnership Board".

However much of this results not from the Act itself but subsequent regulations which as Peter Roderick has explained were imposed by – and can be simply removed by – ministers, with no further requirement for legislation.

If ministers really do endorse the objectives set out in the Plan, why have they not already acted to remove the legal obstacles?

IN THIS PILOT ISSUE

Genome sequencing threatens core principle of the NHS

A plan to sell gene sequencing services performed by the NHS to healthy people has been condemned by experts as leading to a two-tier system and potentially overwhelming services with the worried well, according to a report in *The Times*.

The plan is to allow people to pay for their DNA to be fully sequenced and a personal report produced and aims to provide an insight into future potential health problems.

Matt Hancock, Health and Social Care Secretary, told the commons health select committee that he believes that such large-scale sequencing will lead to a highly detailed prediction of the risks of conditions such as cancer and dementia.

The MPs on the committee warned that the scheme could swamp GPs with queries from the worried well and lead to inequality.

In a *letter to The Times*, experts in the field expressed concern. The signatories included Andrew Goddard, president of the Royal College of Physicians, Jo Martin, president of the Royal College of Pathologists and Helen Firth,

chairwoman of the Joint Committee on Genomics in Medicine, wrote:

"Selling whole genome sequencing to healthy people breaches a core principle of the NHS. It will create two-tier access to services, where people who can pay are able to access services that are denied to those who cannot."

There is also concern that this form of genetic testing breaches NHS guidance on mass checks and that unreliable information could lead to patients having needless drugs or surgery.

The *Guardian reported* that it was unclear whether people who opted for the service would be offered counselling. There is also doubt and over how the NHS will cope with the extra workload from people unduly worried and for those whose sequencing has turned up something to be concerned about.

Anneke Lucassen, the chairwoman of the British Society for Genetic Medicine, told the *Times*:

"There is still a lot of misunderstanding of what whole-genome sequencing can deliver. There is a view that it will give you clear clinical predictions and, most of the time, it will not."

The sequencing of DNA has already opened up a whole new area of ethics in the medical profession. In late 2018, the *Guardian* reported on a legal case being brought against a St George's hospital trust, in which a woman is suing doctors because they failed to tell her about her father's fatal hereditary disease before she had her own child.

The father had refused to allow the doctors to tell his daughter before she had the baby and the doctors were bound by patient confidentiality.

The Guardian quotes Anna Middleton, head of society and ethics research at the Wellcome Genome Campus in Cambridge:

"This could really change the way we do medicine, because it is about the duty that doctors have to share genetic test results with relatives and whether the duty exists in law,"

This project to allow large-scale whole genome sequencing could lead to many more cases with such major ethical dilemmas.

Doctors will come under increasing pressure to consider not only their patients' needs but also those of relatives who may share affected genes.

NHS England to ban GPs from advertising private services

GPs are to be banned from advertising private services to their NHS patients in a bid to a stop the blurring between public and private treatment options.

The new rules mean that GPs won't be able to market their own services or those of any other provider if those services are available on the NHS.

The new GP contract states that:

"from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private, paid-for GP services that fall within the scope of NHS-funded primary medical services".

According to a report in the *Guardian* it will also stop the GP surgeries from allowing patients to jump the queue by paying to pay to see a GP.

The increase in rationing of services by Clinical Commissioning Groups (CCGs) has led to an increase in private services being offered by GPs, including vaccinations, foot care, and mole removal.

GPs will continue to be allowed to charge for signing passports, providing medical reports for insurance or other purposes, or for physiotherapy.

As well as not allowing GPs to advertise their own private services, they will not be able to advertise private services performed by another company.

This ban will not prevent GPs working privately

In late 2017, Care UK was criticised for distributing a list of operations to GPs in Bristol and encouraging them to discuss the possibility of self-pay with patients to jump the queue. The list of procedures ranged from for ear wax removal to hip replacements.

According to the *Guardian*, the company wanted to use spare theatre time for private patient at two treatment sites - that it uses for NHS care. This is despite the fact that the waiting times for NHS care at their Emersons Green clinic were *6-20 weeks*.

This ban will not prevent GPs working privately and having a separate list of private patients.

GP Online reported in *January 2019* that a growing number of GPs were interested in setting up private patient lists. There is no restriction on practices providing private services to patients not currently on their list, however there is a limit on how much income practices can earn from private work.

Dr Richard Vautrey, chair of the BMA's GP committee, said: "This change will provide clarity for patients about what treatment is available on the NHS and what they have the option of paying for privately."

Angry consultants slam review of 4-hour A&E target

The Royal College of Emergency Medicine (RCEM) has responded angrily to recent media speculation that NHS England is about to dismantle the four-hour Emergency Care Standard (ECS).

NHS England boss Simon Stevens dropped *heavy hints* on this during the launch of the Long Term Plan. But it's clear that whatever discussions have taken place have not included the front line consultants running emergency departments.

According to a statement from *Dr Taj Hassan, RCEM President*:

"The College has not been consulted at any stage on this issue since 2017. As the expert academic body on the standards of safety and clinical care delivered in Emergency Departments (EDs) this is surprising and of serious concern."

It argues that the 4-hour target "has been a resilient, sophisticated and very successful overall marker of a hospital's emergency care system performance for the last 15 years".

"So Mr Stevens, who are these doctors with such contempt for the patient interest?"

However the past five or six years has seen a steady deterioration in system performance due to under investment in acute hospital bed capacity, cuts in social care funding and understaffing in EDs.

This has resulted in a significant increase in the number of crowded EDs "which scientific evidence clearly shows is linked to increased mortality and morbidity for patients." The increased pressure in under-resourced departments also piles added stress on to staff "which further compromises patient care."

Dr Hassan points out that the RCEM's concern that much of the good work that has been done "will be wasted effort if we now choose to 'move the goal posts' without any evidence review, expert discussion or clear collaborative planning."

The anger in the College is underlined by a sharply-worded *open letter to Simon Stevens* from its lay group chair Derek Prentice, which expresses the fear that he is "hell bent on undermining the benefits that the four-hour A&E standard has delivered to patients over many years, a decision you claim that so called 'top doctors' want."

The letter goes on:

"It begs the question who are these 'top doctors' you quote? They are not from the leaders of the body representing over 8,000 people working in our A&Es, the Royal College of Emergency Medicine, who believe the target is vital for timely, high quality patient care.

"…The public has a right to know who these individuals are who want the target removed, not least given that in the NHS Plan with many laudable objectives, this attack on the patient interest stands out alone as the only cut in services proposed.

"So Mr Stevens, who are these doctors with such contempt for the patient interest?"

Private midwifery firm's collapse leaves mums-to-be in the lurch

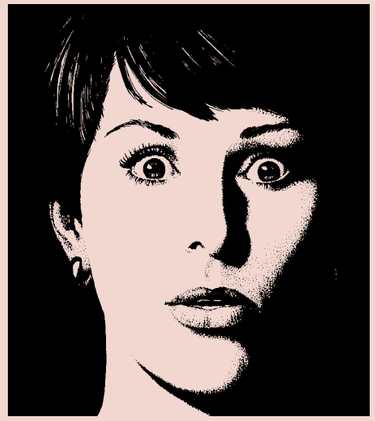
John Lister

The opening of the *BBC report* on January 31 was misleading. It simply began "Mothers-to-be have been left "high and dry" after an NHS midwifery service ended with just a week's notice."

This clearly gives the impression that an NHS service had failed. In fact, as the BBC report does concede later on, the collapse was a private company, to which Waltham Forest CCG had been unwise enough to contract out midwifery services. In other London boroughs the same company, *Neighbourhood Midwives*, operated as a straightforward – but expensive – private provider.

Its website, which has since announced the company's closure for business from January 31, welcomes people to "a private, independent midwifery service offering personalised packages" in which "every woman has her own dedicated private midwife" offering "one-to-one care during labour, at home or in hospital".

However the demise of the company, and the fact it claims only 1,000 customers since it was established back in 2013, reflects the fact that only a small wealthy minority of women would ever be able to afford its services.



In 2015 a promotion of the company in the Mail on Sunday stated that the cheapest package on offer for pregnant women was £2,800.

Since then the costs have gone up considerably and the range of services expanded into postnatal care.

Packages

The website outlines a range of different care packages, attractively named after flowers, at rates varying from one off payments from £120-£180 for the Fresia tongue-tie treatment, through various packages for postnatal support from £950 upwards, up to the £3,650-£4,400 Daisy 'mini-package' designed for women who have had a baby before, the Rose package (£5,400 one-off or £5,670 by instalments), or top of the range Orchid at a hefty £6,250 or £6,563 on instalments.

While Neighbourhood Midwives claims they were able to show, not surprisingly, that with adequate resources the "continuity of midwifery care model really does work for women, babies, families – and for midwives"

It's clear that at these prices the sample size was inevitably not only small but also unrepresentative of the wider spectrum of women from with varied social needs and levels of deprivation.

The NHS has to take all comers, and can't pick and choose the wealthiest, who are also likely to have the fewest health problems.

It's just as well Barts Health and the NHS are still there to *pick up the pieces* and continue maternity services as normal as another failed private sector venture collapses for lack of any viable market amongst paying patients.

The model has proved that however desirable complete continuity of care might be, it is impractical and unaffordable as the basis for the whole NHS without significantly increased budgets and a much larger midwifery workforce.

Below the radar

Despite the Long Term Plan, the drive to cut, downgrade and 'centralise' services continues

John Lister

If we believe the promises made by the NHS *Long Term Plan*, published last month, then there is at least a truce if not an end to the war of attrition on hospital bed numbers that has been running for the last 25 years.

The Plan differs from many previous plans in setting out what appears to be a more sensible approach, recognising the need to reduce the level of pressure on front line beds and staff, with many acute hospitals running close to 100% occupied for weeks and months on end.

It says (page 9): "In the modelling underpinning this Long Term Plan we have … not locked-in an assumption that its increased investment in community and primary care will necessarily reduce the need for hospital beds.

"Instead, taking a prudent approach, we have provided for hospital funding as if trends over the past three years continue. But in practice we expect that if local areas implement the Long Term Plan effectively, they will benefit from a financial and hospital capacity 'dividend'."

This follows on NHS England's "fifth test" that *since April 2017* supposedly must be met before cutting back on bed provision:

"local NHS organisations will have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)"

This all sounds much more sensible and civilised than the previous rush to closures.

Local plans

Unfortunately the LTPs' apparent national change of line is sharply at variance with the continued drive in many areas to implement ill-conceived local plans for "centralising" emergency services and specialties – with little regard for the problems of access these plans create for communities living near the downgraded and downsized hospitals.

From Dorset to Sunderland, Somerset to Lincolnshire, from Kent to Chorley, in the East and West Midlands, in north and south London and in many other areas, a whole raft of plans to centralise services, many of them pre-dating the 44 controversial *Sustainability and Transformation Plans* (STPs) drawn up in 2016, are still being forced through in the teeth of local opposition.

Reductions in acute bed numbers and numbers of A&E departments were key to *over 50% of published STPs* in 2016; the Long Term Plan and the associated *Operational Planning and Contracting* document published before Christmas make proposals based on the STP areas, bringing these plans back into focus. They were not good or complete plans.

Derbyshire STP had the greatest level of explicit bed closures with plans to close 530 by 2020/21. Kent and Medway STP proposed to reduce 2,896 beds to 2,600 in 2020/21, based on optimistic assumptions about reduced activity, reduced length of stay in hospital, and sustainable levels of bed occupancy.

Hampshire and the Isle of Wight aimed to cut 300 beds, Nottinghamshire 200 and Herefordshire and Worcestershire STP – covering two crisis-ridden acute hospitals with chronic capacity problems – wanted to close 202 community beds.

However Leicester, Leicestershire and Rutland STP, following on from a previous reconfiguration plan, has had to back away from its initial plan to close 243 acute beds because of a severe and obvious lack of capacity in the winter of 2017. Its current plan is under *attack from campaigners* for offering no increase in beds to meet rising demand.

A&E downgrades

Three years after the STPs were drawn up A&E downgrades to "urgent care centres" are still threatened or under way in various places including Shropshire, Lancashire, Dorset, North West and North East London, and Weston Super Mare, while similar plans have been forestalled by vigorous campaigns in North Devon and Mid and South Essex.

Many of these plans, which have generally been delayed rather than abandoned, rest on claims that medical staff shortages mean that only one hospital in the area can be properly staffed to deal with specialist cases and emergencies.

However these staff shortages have in almost every case been worsened over years by the blight of uncertainty that Trust and CCG managers have created over the future of the hospital that is to be downgraded.

The conditions for staff, especially those who will have to transfer to more distant hospitals, are also ignored, despite the evidence across the NHS that relentless pressure generates stress and burn-out for doctors and other professional staff, undermining quality of care and leading to sickness absences, burn-out and new staff shortages.

Plans based on this approach also almost invariably fail to address the problem of ensuring there is sufficient capacity in the new system to accommodate the likely level of demand for care: many completely ignore the issue of distance and travel times, the non-existence or inadequacy of public transport, and the impact of longer journeys in delaying access and impeding relatives and visitors.

Some try to bamboozle local people with largely spurious "research" on travel times by management consultants who are clearly ignorant of local conditions, and cite figures researched online from miles away that ignore local geography, traffic congestion, delays in making connections and the gaps in public transport provision especially to rural areas out of normal working hours: none seem willing to admit the costs of taxi fares for patients and visitors for whom no private or public transport option exists.

Staff shortages have been worsened over years by the blight of uncertainty over the future of the hospital that is to be downgraded.

To make matters worse, there is a chronic *shortage of capital* to finance any expansion of redevelopment of the new "centres" to accommodate the increased caseload.

Indeed even the old, costly, standby of funding through the Private Finance Initiative has been halted since Chancellor Philip Hammond's announcement *last November* (amid growing evidence of the cost to the taxpayer of the collapse of PFI giant Carillion last year) that the government would not sign off any more new schemes. Other ways of delivering private funding are being explored instead, but not yet being rolled out in the NHS

'Centralisation of services' without capital investment and the development of alternative services to support patients locally is just another way of describing cuts. And despite the claims that such plans are "clinically led" and aimed at improving the quality of services the reality is that most are financially driven, and seeking so-called efficiency savings regardless of the consequences for unfortunate local communities whose services are to be sacrificed.

Doctors versus doctors

Recent statements by the Royal College of Emergency Medicine reported elsewhere in this issue of The Lowdown highlight the need to question claims that plans are "clinically led" or led by "doctors" since opinions can be quite different depending upon which doctor you ask, and in any case their views can be misrepresented.

For example the plans for reconfiguration of services in Calderdale and Huddersfield claimed endorsement from the Yorkshire and Humber Clinical Senate, while in fact the Senate *report* was posing sharp questions about the viability of the proposal and challenging the lack of any detail or proper engagement with local GPs.

Another line of argument dating back to the 1990s is to argue that demand for hospital care can somehow be miraculously reduced by *GPs taking on more responsibility*, or by expansion of community-based and other "out of hospital" services. This is made less plausible not only by the quite obvious year by year increases in emergency and elective hospital caseload ever since the 1990s, but also by the severe and growing problem of recruiting and retaining GPs. Three years of international recruitment have yielded just *34 GPs*.

"Integration"

More recently the notion of "integration" – vaguely defined and ambiguous on whether it means integration of NHS services or integration with (largely privatised and under-resourced) social care – has been thrown in to the mix as a magical means to reduce demand for hospital beds, length of stay and costs.

Of course it would be foolish to denounce any serious efforts to integrate NHS services. Any steps to reverse the disintegration and fragmentation of services through contracts and outsourcing (which were massively increased by Andrew Lansley's 2012 Health and Social Care Act) would obviously be welcome.

The *National Audit Office* (NAO) in 2017 cast doubt on savings plans associated with health and social care integration and its likelihood to reduce hospital activity, putting its conclusion bluntly: "There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity" (pp7-8).

Similar findings from the King's Fund, the Health Foundation and most recently the *Nuffield Trust* all underline the same point: integration may well, if done correctly and with adequate resources improve patient care, but it is unlikely to save money or even reduce the need for hospital treatment where improved services begin to address previously unrecognised needs.

So before we get too excited by this and other promises in the Long Term Plan we need to take a good hard look at the situation on the ground, and the policies actually in play.

Where there is a contradiction, we need to use this to strengthen the hand of those fighting to defend local access and adequate provision of services against ill-judged and short-sighted attempts to make savings.

Staffordshire war-chest for legal challenge

A new alliance has been formed to mount a legal challenge to the NHS Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups (CCGs) plans formalise the 'temporary' closure of NHS community hospital beds.

NHS Care for All is the alliance, bringing together the North Staffs Pensioners' Convention, Save Leek Hospital and Save Bradwell Hospital campaigns, local campaigning group Healthwatch, the local branch of the Green Party, representatives of trade unions, local councillors of all political persuasions and local MPs.

They have raised the £4,300 needed to kick start the challenge with 19 days to go.

They argue that the proposals put forward by the CCGs would put vulnerable people of all ages at risk and damage the NHS as a whole.

The CCGs plans will see the number of community beds halved, from 264 to 132. Of the 132 remaining beds, 55 would be commissioned from private care homes, where standards are often inferior to NHS Community Hospital care.

The CCGs say that they are providing better services in people's own homes to replace NHS community hospital care.

However, they have failed to provide convincing evidence, and ignored all the representations put to them by local communities and refused to compromise in any way.

Having raised the initial £4,300 the campaign has now set a higher "stretch target" of £10,000, to be raised before the end of February. The appeal can be found *here*.

Ouch – time to end the pain and injustice of NHS dentistry

Paul Evans - Comment

When it comes to our teeth and oral health, getting the care you need is different to the rest the of the NHS, but why?

Recently a friend discovered that she had an abyss in her tooth. Her dentist started root canal treatment, but after inflicting several body-jerking shocks of pain, the dentist decided that the procedure needed a specialist. The wait on the NHS in her area was six months.

Her choice was either to wait, risk complications and endure the discomfort, or to go for a private slot by paying £600, seeing the same specialist. There was only one NHS option in the area for difficult cases and he was hugely over booked.

Reluctantly she chose to pay up, shocked that, effectively there was no NHS service to help her. An unusual story?

Not according to the British Dental Association who estimate that ***135,000*** dental patients a year go to A&E because they can't access care for a problem.

It believes that a further 600,000 seek treatment from a GP, adding to the pressure on family doctor services.

Desperate measures

Some patients avoid steep charges by heading to the garden shed to have a go at DIY dentistry. It's a wince inducing throwback to the Victorian age, but reaching for the *pliers* is not as rare as you might think, according to BDA chair of General Dental Practice, Henrik Overgaard-Nielsen,

'Whenever Governments fail to invest in NHS dentistry, we find desperate patients opting for "DIY" alternatives,'

'In a country with supposedly universal healthcare these access problems are man-made.

They're borne of failed contracts and cut budgets'.

Many patients who can't pay will be put off going to the dentist. Enduring pain, popping painkillers and hoping the problem goes away. According to official statistics, almost one in five patients have delayed treatment due to its cost.

If only more of us listened to the official advice and got our teeth checked more regularly, before the rot sets in. Actually, many of us are trying to do the right thing, but space on NHS dental lists is very hard to find. Figures show that one million patients were unable to register with an *NHS* dentist last year.

The poor are hit hardest. The British Dental Association point to the fact there has been a big decline in the number of visits to the dentist by people with low incomes, falling by 23% over four years, that's two million fewer treatments.

The root cause?

NHS charges are going up, but the number of new NHS dentists is falling back. People are being driven towards the private dental market, but many can't pay.

The NHS charging structure is a baffling arrangement, perhaps meant to distract us from the fact that it is a tax on health. Patients are being asked to contribute a much bigger share of the cost of treatment.

According to the British Dental Association NHS patients will soon be contributing a third of NHS England's dental budget in charges and this will rise to a half by 2032.

Patients are paying more, but the money going to practices for NHS work hasn't risen nearly as fast, causing NHS contracts to be handed back and a decline in the number of NHS dentists that can make their businesses viable. Austerity has been felt.

In the last five years government funding has *fallen* by 10%.

Dentists are also getting harder to recruit. A recent survey found that 68% of *practices* had difficulty in filling vacancies in the last year. Numbers have dropped to 2010 levels.

Brexit factor

EU dental professionals are no longer applying to come. Brexit deters like halitosis. Of those already working in the UK a third are thinking of leaving and 80% blame Brexit.

We can't afford to lose their support though, we already rely on it. Around 17% of the UK workforce consists of EU dentists and they deliver 22% of NHS dentistry.

Deprived areas stand to lose most from the Brexit fallout. EU dentists undertake 30% of the dental work in poorer areas, according to the *dentistry* website.

All the evidence points to a shrinking NHS service, underfunded and crying out for a boost in capacity.

Matt Hancock was recently seen endorsing a private company that makes money from the lack of NHS capacity.

The obvious move is to invest heavily in a new body of NHS community dentists – that have no tie to the private sector, so all their time goes on NHS patients.

Funding more urgent care dentistry would help to reduce the pressure on our overworked GPs and A&E services.

Mr Hancock's Solution?

At first glance such a move would appear to be in tune with the new NHS long term plan. In it we are promised more community services, better primary care and more prevention – all cornerstones to improving oral health services. And yet there is virtually no mention of dentistry in the NHS plan.

Is this a sign? Many governments have been neglectful of NHS dentistry. Unlike the endless shakeups elsewhere in the NHS, dentistry policy has remained largely untouched.

But is the government going further, driving down the NHS service and effectively reducing it to a safety net?

Dentistry is a mixed market, although most practices still provide NHS and private care, but the huge pressure on NHS funding has shifted the market towards *private* provision.

According to market analysts Laing and Buisson the number of NHS-only practices has dropped from 15% to 4% of the overall total.

Unsurprisingly demand for private work has risen by around 10% in just the last three years.

So far no reassurances over the future of NHS dentistry have come from health secretary, Matt Hancock. In fact the reverse could be said. He was recently seen endorsing a private company that makes money from the lack of NHS capacity.

MyDentist targets areas with shortages of NHS practices and offers prices that are slightly *higher* than the NHS for basic work, but much higher for anything more complicated.

The health secretary was warm in his praise:

"Companies like MyDentist play a really important role in delivering a good service to keep our nation's teeth strong."

The fate of NHS dentistry offers an allegory for the NHS as a whole.

Charges open the door for reduced funding, less public funding leads to private provision, a two-tier system quickly emerges and before you know it access to care then depends on your spending power, which is the very opposite of the NHS.

Charges

Charges for dentistry first appeared in 1951, an attempt to curb demand. They have now become deeply set in the system and dominate people's decisions about when and if to access dental care.

Over the last 60 years our view of oral health has changed. It is now very much a field of healthcare.

Dentists treat our decay, but they also monitor our health watching out for mouth and neck cancers and taking action against conditions like gum disease - which has recently been *linked* to Alzheimers.

Some of their work is cosmetic, but most should be housed within the NHS, as a crucial part of our healthcare and connected with our other health services.

Today a quarter of children start school with some tooth decay, record numbers of children are having teeth removed each year.

A million of us cannot get access to NHS dentistry. This is the time to invest in public health and NHS dentistry provision.

We must change the focus, to look at solutions that can improve the health of everyone in our society.

Kent trusts plan for 6 months of no-deal disruption as NHS gears up for Brexit

Kent Community Health Trust, in the south-east of England, has revealed some of its contingency plans for health services in the event of a no-deal Brexit.

The plans revolve primarily around the travel disruption that could be caused around the Channel ports if Britain leaves the EU with no-deal. The plans involve the possibility of asking staff to sleep at work so that health services can continue to be provided in the face of travel disruption.

The Kent Community Health Trust along with East Kent Hospitals University Trust are likely to be the most disrupted by any major travel delays, with the latter's trauma unit being just minutes from the M26, a key route to Dover.

Any transport gridlock will delay the delivery of medicine and equipment, ultimately risking patient safety. The trust is concerned that disruption could last up to six months. The report warns:

"The potential impact of Brexit on Kent's roads could be significant. The police are planning for between three and six months of disruption to Kent roads."

Sleep at work

The plans include staff sleeping at hospitals, nursing homes or clinics to ensure continuity of patient care in the county, staff working nearer to their homes and the use of the voluntary sector.

Chief executive Paul Bentley said: "We have a duty to make sure we are always able to look after our patients and deliver high quality services, as well as making sure our staff are able to provide that care."

This recent news is just the latest released regarding non-deal Brexit planning for the NHS. At the end of 2018, an NHS troubleshooting team was set up to make plans for the health service leading up to the 29 March deadline for leaving the EU.

The team had initially been made up of 10 staff but now has 150-200, according to Matthew Swindells, NHS England's deputy chief executive.

According to the HSJ, NHS England is touring NHS trusts talking to NHS providers and professional bodies to make sure they know what plans are in place and everyone is geared up to deal with [Brexit]."

Moreover, the health secretary Matt Hancock has disclosed plans for special flights to be chartered from the Netherlands to the UK to bring in medicines.

Moreover, he urged NHS hospitals and trusts to buy fridges so that drugs could be stockpiled if necessary.

However, the reports into planning for a no-deal brexit from individual trusts sound far from positive:

- London North West University Hospitals Trusts, which runs three major hospitals, warned that its pharmacy departments could be at an "increased risk of burglary";
- Dr David Rosser of University Hospitals Birmingham (UHB) said that, despite NHS stockpiling, shortages would likely occur due to "unprecedented" distribution challenges;
- and Guy's and St Thomas' Foundation Trust has a group considering which patients will be at the front of the queue for treatment if a disorderly Brexit causes drugs to run short.

The *Evening Standard* reported that Professor Marcel Levi, of University College London Hospitals, told a UCLH board meeting that communications from NHS England were now "almost daily" and "are very close to panic."

The doctor's union the BMA, has been very concerned about the impact of Brexit on the NHS for some time and has produced a series of briefing papers.

These outline the many positives of EU membership and the risks on leaving the EU.

The BMA notes "Any form of Brexit could have wide ranging, and damaging consequences for health services across the UK and Europe, including on workforce and immigration, Northern Ireland, access to medicines, reciprocal health care, professional qualifications and patient safety, access to medical radioisotopes, medical research and rare diseases."

Mysterious notes and a US company create confusion in Weston plan

John Lister

The controversial plans to reconfigure services at Weston General Hospital in north Somerset are grinding onwards, with new documents nodded through a February meeting of Bristol, North Somerset and South Gloucestershire CCG. But the proposals are less than clearly explained in the *documents* that have now appeared.

The plans centre on three basic proposals:

- to make permanent the long-running "temporary" night time closure of Weston's A&E – with patients diverted to Bristol or Taunton (each 28 miles away)
- a reduced level of care from Weston's high dependency unit,
- and reduced coverage of emergency surgery to "day time" hours in place of 24/7.

However some of the accompanying data, with minimal if any explanation, appears to be contradictory. For anyone with the energy to wade through the 133 pages of 'Case for Change' data, there are some intriguing, if confusing revelations.

Private hospitals

For example, on page 25 a note on a graph reveals an astonishingly high level of NHS referrals to private hospitals: the orthopaedic caseload figures "Do not include independent sector commissioning of orthopaedics from CCG – up to £40m in 2016/17."

Yet there is no discussion on repatriating this work (and revenue) to the NHS.

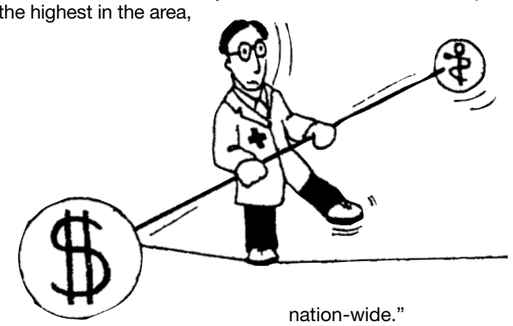
More figures show that while 71% of Weston hospital non-elective inpatients stay longer than 8 days, this is only slightly higher than the 70% figure for Taunton, which has a much higher proportion of patients staying 8-30 days.

The 33% of Weston patients staying over 31 days is only slightly higher than the 32% at North Bristol.

The data does not offer any explanation for these variations, or any proposals to address them.

The fact that Weston has by far the highest proportion of patients aged 65 might be a factor – but Weston also has by far the lowest level of delayed transfers of care compared with Bristol, North Bristol and Taunton.

Weston's bed occupancy levels are also consistently the highest in the area,



remaining at or above 96% throughout the year, raising serious questions about the impact on capacity in the wider area if its emergency surgery and HDU support are reduced: where will the additional patients have to go?

There is no discussion at all of the logistics of travel for their relatives seeking to visit patients who are admitted to Bristol or Taunton, or the liaison required to facilitate their discharge 28 miles or more away from home.

Footnote

Some of the footnotes and comments are revealing. On page 56 figures on length of stay, which appear to make no reference to costs, carry the curious footnote:

"Figures calculated assuming that all patients in this category currently stay for 31 days, will go down to trust average LOS for NEL patients, and ***each reduction of a 20 bed unit saves a hospital £2M"***. [emphasis added, JL]

Is this quest for cash savings perhaps the underlying purpose of some of the changes which are being promoted as "clinically led"?

On page 120 another note on a graph sets out a hypothetical argument:

"According to a yellow paper commissioned by the BNSSG STP, over £20M could be saved across the system by reducing mental health patients use of the acute care system to a level closer to that of their peers nation-wide."

Yet again the claim is included with no explanation on who the "yellow paper" has been commissioned from, or how such a dramatic improvement in mental health is to be achieved.

Florida based

But perhaps the most perplexing is page 108, where there are comparisons of bed days per 1,000 population aged over 65, which mysteriously throw in an unexplained comparison with the *Florida-based Chen Med*, a company offering "VIP treatment" for older patients – at a price. Their sales blurb boasts that they offer:

- A personal physician who comes with an entire team dedicated to the patient to help promote and coordinate their care.
- "Head-to-toe executive physicals" and ongoing preventive care to detect and treat disease early.
- Access to call their doctor's cell phone and patients in need are encouraged to simply walk in without an appointment.
- Comprehensive care in one location, including prescription pick-up and refill, blood testing, x-rays, and selected specialists.
- Door-to-doctor transportation.
- Welcoming centers with a cafe, health classes, literacy sensitive educational materials, and special events where everything is built only with seniors in mind.
- 24/7 support for medical questions. The best clinical medicine complemented by alternative medical services such as acupuncture.

Contrast

The contrast between this Cadillac service and existing primary care services available in North Somerset will be immediately obvious: but what is not obvious is why this page is included in the data for changing services at Weston General.

Are the CCG proposing to invest in upgrading primary care to the Chen Med level, with reduced patient lists, personal support including mobile phone numbers, etc.?

If so, why is there no other mention of Chen Med or US models anywhere in the documentation?

How would such a huge upgrade be paid for?

Chen Med's promotional literature coyly notes that the extra cost of its services for low to moderate income pensioners is "kept affordable" by prepayment and a "financial hardship policy": are supplementary charges perhaps what the CCG has in store as a special surprise for local people?

The process is still at an early stage: last month saw a "Preconsultation Business Case".

But with Weston's A&E already closed overnight, it's clear that the implementation of the cutbacks is already under way.

Many more questions remain to be answered from the hundreds of pages of documentation. ***The Lowdown*** will be following with interest.

Shropshire appendices removed

At the end of January, in a venue seemingly selected to be as remote and inaccessible as possible from the community in Telford and Wrekin, whose hospital services were to be downgraded and cut back, a joint meeting of Shropshire and Telford and Wrekin CCGs took just one hour, with no significant debate, before rubber stamping their controversial 'Future Fit' plan.

The decision, which had been expected, was immediately challenged by *Telford & Wrekin council*, invoking its scrutiny powers to refer the plan to the Secretary of State.

Many of the county's Tory MPs and councillors fearful for the consequences will be covertly hoping Matt Hancock either rejects the plan or drags out the process of agreeing it, so that the axe does not start to fall on local services at least until after the local elections in May, or even after a general election.

A 136-page *"Decision Making Business Case"* was passed: the *Future Fit website* promises that this and the 21 Appendices can be downloaded by anyone with the energy to plough through them.

Strangely however the Appendices have not been published by the CCGs, despite the numerous references to them in the Business Case.

It has been left to campaigners challenging the plans, who have wisely archived their collection of the documents, to make them available on a *Google Drive*.

Cock-eyed Optimityism

One document which Shropshire and Telford & Wrekin CCGs have wisely chosen not to publish as part of the discussion, is the report expensively compiled by US and multinational consultancy Optimity Advisors.

The CCGs confine themselves to quoting a few confusing extracts in the Business Case,

The first Optimity document, published in March 2017 (but for some reason based on ancient 2013/14 figures), makes the unsurprising point that patients over 60 accounted for 41% of emergency caseload and 45% of elective admissions, and that:

"Health care costs increase with patients' age […] average cost per head significantly rises over the age of 60".

Hypothetical

Optimity go on to discuss the hypothetical advantages and cash savings that might result from improving out of hospital services. These were summed up at the February 2018 *Shropshire CCG governing body* meeting with the claim that:

"The Optimity review identified there would be £11m savings in admissions if the right services were in place in the community."

However the same report to the CCG went on to concede the community services had been reducing rather than

improving, and that neither the necessary staff nor the funding was actually available to expand them.

Not published

In fact the July 2017 *Optimity report* was never published, but quoted by campaigner Gill George's powerful *Alternative to Future Fit*.

Optimity drew on what it argued were useful comparisons from a number of other countries as well as an abstract model developed by the NHS:

- Buurtzorg, the Netherlands;
- Network Mobile Unit, West Skaraborg, Sweden;
- Coordinated Community Care, Oregon, US;
- Geriant Model, the Netherlands;
- "Primary Care Home" Model, UK; and
- Project Hälsostaden, Ängelholm, Sweden.

It's not clear whether the Future Fit leaders made any effort to check any of the claims made for these very different systems.

However the Business case rests upon this second even more optimistic Optimity report, which assumes it is possible to give older patients an extra 5 years of healthier life, effectively making them younger:

"If we assume that a new model of out of hospital care can deliver a shift in population health (an increase in healthier lives lived for the population of Shropshire) of five years, a saving of £19m -£21.9m could be made in acute care from reductions in emergency, elective and day case admissions; outpatient appointments; and A&E attendances." (page 31).

Aspirational

This assumption was at best aspirational (the next sentence pointed out "These are gross figures only and do not include the investment that will be needed to deliver a new model of out of hospital care.")

Few people other than 'Future Fit' leaders would regard such tenuous assumptions as a basis to plan for a reduction in bed numbers and emergency services.

Now the plan has been referred to the Health Secretary, it will be interesting to see whether they stand up to any external scrutiny.

Just when you think privatisation is going away

Richard Bourne

One change that was driven by obsession with ideology was the enforced removal of Community Health services from the then Primary Care Trusts frpm 2007. In the South West this resulted in a number of non NHS 'Community Interest Companies' being set up.

So, across the Bristol, North Somerset and South Gloucester STP area there are three such companies providing community health services.

But now the CCG for this area has decided to put all these services out to tender.

They are hell-bent on awarding a single 10-year, legally binding contract for (most of) adult community health services.

The CCG does not really know what it wants: so it is running a complicated negotiated procurement process, asking bidders to tell the CCG what they need and how much they will have to pay for it. Efforts to persuade them that this is a bad idea have failed.

Local MP Karin Smyth has *indicated her concerns* and the Secretary of State has agreed they should be taken seriously – but to no avail.

Nor has the NHS Plan changed things. It is pretty damning (as was the recent *NAO Report*) about CCGs and argues for forming integrated systems drawing the public services commissioning and delivery together; not a contracting out model at all.

How can that work when contracts for 10 years, enforceable in the Courts, have been put in place? Nonetheless the CCG refused to even pause its procurement process.

Virgin will now be putting its best people on drafting its bid, and whatever happens the result will be that these community health services are set to be in the private sector.

NHS campaign groups in and around Bristol and the South West need to get work out how best to fight this short-sighted and ill-intentioned process before the deal is done.

What the (research) papers say

Clerical support

While trusts and NHS England keep up the pressure to cut so-called "back office" jobs in the name of efficiency savings, a very interesting *research paper from Australia*, published on open access in the BMJ has shown the increased efficiency that can be achieved by increased clerical support for doctors.

The article is catchily titled "Impact of scribes on emergency medicine doctors' productivity and patient throughput: multicentre randomised trial": but don't let that put you off. The term "medical scribe" is simply explained at the start of the article:

"A medical scribe helps the physician by doing clerical tasks. The scribe stands with the physician at patients' bedsides, documenting consultations, arranging tests and appointments, completing electronic medical record tasks, finding information and people, booking beds, printing discharge paperwork, and doing clerical tasks.

"They do this via a computer-on-wheels connected to the hospital's electronic medical record system. The aim of the role is for scribes to do clerical tasks otherwise done by the physician, enabling the physician to manage more patients in the same amount of time."

The research compared the results between thousands of medical shifts with and without the use of scribes and found they delivered a significant advantage, with no disadvantages: "The cost-benefit analysis based on productivity and throughput gains showed a favourable financial position with use of scribes."

"Scribes improved emergency physicians' productivity, particularly during primary consultations, and decreased patients' length of stay."

So when management next come seeking to cut back on support staff, refer them to the ***BMJ*** and suggest they take on a few more scribes to increase efficiency.

The Plan includes a list of over 60 uncosted commitments

Integration no panacea

A Nuffield Trust *report* at the end of January investigated whether Age UK's Personalised Integrated Care Programme (PICP) had been able to reduce cost pressures on health and care systems and whether there had been any impact on the levels of hospital use.

The scheme set out to improve the lives of older people who are deemed to be at risk of a future emergency admission, through practical support.

On a sample of almost 2,000 older people, the Nuffield researchers concluded that it had "almost certainly not been able" to reduce either costs or emergency admissions.

Indeed there was no sign of a reduction in use of hospital care. Overall there was a higher than expected use of emergency and outpatient services, and a corresponding increase in costs, although in some areas there was no apparent impact on hospital activity.

While this might appear to suggest that the project had delivered the very opposite of its objectives, the reality is not so negative. "The scheme may be identifying unmet need in the population, which manifests in greater use of hospital care. This might be to the ultimate benefit of the older people in the longer term."

So as campaigners and unions have argued for some time, integrating and enhancing patient care can deliver benefits: but they are not likely to reduce costs.

Long Term Plan

Living in DENIAL

John Lister

The NHS Long Term Plan, published on January 7 is 120 densely-packed pages: but it skates around any real engagement with the state of play, making only the vaguest references to a list of awkward facts, including:

- largely ignoring the flagging performance of struggling front line hospital trusts missing more and more targets, with apparently no hope of returning to pre-2010 standards;
- understating the financial plight of trusts, with deficits, endless demands for "efficiency savings" and cumulative borrowing of £11 billion in bail-out funds;
- underplaying the scale of the workforce crisis – compounded by the Brexodus of EU-trained staff and near-total collapse of recruitment from EU countries (the word Brexit appears just twice in the Plan);
- the chronic shortage of acute beds and capacity to provide a full range of services 12 months a year;
- the vast £6 billion backlog bill for maintenance after years of siphoning off NHS capital into revenue to cover deficits;
- the fact that inequalities in society between rich and poor have widened and are still growing as a result of government austerity, taking a toll on life expectancy and health of the poorest;
- the years of cutbacks in public health budgets;
- the decline in mental health staffing and services that has taken place since 2010;
- the cutbacks in community health services, the services that were supposed to divert some patients from hospital care.
- the continuing cutbacks in social care funding and staffing gaps in the heavily privatised and fragmented system.

With these problems set aside, curtains drawn and the door firmly closed on the real world, the Plan embarks on a fantastic spending spree.

It sets out a list of more than 60 uncosted commitments to improve, expand or establish services and reach patients with enhanced care, many of which are welcome in themselves but unrealistic together.

NHS Providers responding to the Plan in the *Health Service Journal* warned against "an undeliverable wish list that makes too many promises as over-promising sets the NHS up to fail."

The air of unreality is also clear in the timescale for implementation.

Instructions sent out to NHS bodies last month in advance of the Plan made clear that NHS England is once more trying to push through an immense and complicated series of changes at a break-neck timetable.

The first deadline for decisions to be made was January 14, just 13 working days after the orders went out as 'Operational Planning and Contracting' just before Christmas.

The timetable seems even more surreal when we realise that the Plan itself admits that key pieces of the jigsaw are missing.

A 'national implementation framework' will not be published till "the spring", the workforce plan is not yet complete, and we won't know how much capital is available until the Spending Review in the autumn.

The Plan includes a list of over 60 uncosted commitments

Long term plan pushes privatisation

Tucked away in the NHS Long Term Plan are hard-edged proposals for increased use of private hospitals to deliver NHS funded care to limit waiting times (LTP p24 and *already being actioned by NHS England under the radar*).

The December Operational, Planning and Contracting Guidance document which accompanies the Plan also calls on trusts to increase their links with the private sector to "grow their external (non-NHS) income" and "work towards securing the benchmarked potential for commercial income growth." (p12)

There also is an implicit threat of privatisation in the proposals for new pathology networks and imaging networks to be established, given the absence of the necessary NHS capital for investment and lack of public sector bids in London and the South East.

Trusts are told they must also aim to increase the funds they get from charging patients for treatment – "overseas visitor cost recovery."

Everybody knows this policy will raise little money in relative terms: but it will undoubtedly deter some patients from accessing the services they need, and undermine the principles and values of the NHS. Information released in response to Freedom of Information requests shows that just one London Trust demanded proof of entitlement from 1640 expectant mothers in the first year of the regulations and imposed charges on 540 of them

The charges and their impact on public health have been is opposed by medical *Royal Colleges*.

THE lowdown

Who we are – and why we are launching *The Lowdown*

The Lowdown is launching in February 2019 with this pilot issue and a searchable *website.*

We aim to develop in the next few months into a weekly source of evidence-based journalism and research on the NHS – something that that isn't currently available to NHS supporters.

We are seeking **your support** to help establish it as an important new resource that will help to create enduring protection for the NHS and its staff.

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Information is power, and we aim to provide people with the information tools they need to negotiate, communicate, campaign and lobby in defence of the NHS.

We will summarise news from across the media and health journals, provide critical analysis, and where necessary highlight news that might otherwise be missed, and make complex proposals understandable through a range of briefings. We will bring stories and insights you won't find anywhere else.

And we are keen to follow up YOUR stories and ideas. We welcome your input and feedback to help shape what we do.

Paul Evans of the NHS Support Federation and **Dr John Lister** (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) have almost 60 years combined experience between them as researchers and campaigners.

They are now leading this work to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

This package is therefore something quite new, and a genuine step-up in the resources that are currently available.

As we go we will build an online archive of briefings and articles, and use the experiences and comments of NHS staff and **users to support and guide our work.**

In time we believe this will become a resource that will establish credibility with academics and journalists and which they will use to support inform and improve their own work.

The project aims to be self-sustaining, enabling it also to recruit and train new journalists, undertake investigations and research that other organisations aren't undertaking.

By donating and backing the mission of the project, our supporters will help develop this new resource, ensuring it is freely available to campaigners and activists, get first sight of each issue, and be able to choose more personalised content.

Why is it needed?

Public support for the NHS is high: but understanding about the issues that it faces is too low, and there is too much misinformation on social media.

The mainstream news media focuses on fast-moving stories and has less time for analysis or to put health stories into context.

NHS supporters do not have a regular source of health news analysis tailored to their needs, that is professionally-produced and which can speak to a wide audience.

In our first year we will:

- establish a weekly one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally

Help us make this information available to all

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We are therefore planning to fund the publication through **donations from supporting organisations and individuals** – and we are very grateful for those individuals and organisations who have already given or promised generous donations to enable us to start the project going.

Our business plan for the longer term includes promotion of *The Lowdown* on social media and through partner organisations, and to develop a longer-term network of supporters who pay smaller amounts each month or each year to sustain the publication as a resource.

But we still need funding up front to get under way and recruit additional journalists, so right now we are asking those who can to as much as you can afford to help us ensure we can launch it strongly and develop a wider base of support to keep it going.

We would suggest £5 per month/£50 per year for individuals, and at least £10 per month/£100 per year for organisations.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it.

On the website and in the bulletin from Number 1 we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info